**Controlled Substances Prescribing**

Prescribers have an obligation to protect health care service users from substance abuse at all cost. Opioid prescribing for pain alleviation can lead to drug abuse and addiction problems that put the prescriber at risk of legal pursuits. Moreover, opioid use alone led to the death of more than 42,000 individuals in 2016 in the United States by stopping their respiratory mechanisms (Centers for Disease Control and Prevention, 2017). Therefore, prescribers can perform drug toxicity screening when they cannot determine the patient’s motivation for seeking treatment. This strategy will enable the prescriber to identify drug abuse in case the patient is positive for drug screen in the urine.

My experience in opioid prescription enabled me to discover the vastness of opioid overdose epidemiology. Cancer patients in our unit who are on palliative care received a combination of methadone, non-steroidal anti-inflammatory analgesics, and acetaminophen to manage cancer pain. However, some patients could return for refill of their analgesic doses earlier than the scheduled date. Therefore, I think that our health care facilities can use electronic prescription to monitor acquisition of drugs from the pharmacy. Prescription drug monitoring systems enable agencies to detect individuals who obtain opioids from multiple prescribers (Twillman, Kirch, & Gilson, 2014). Therefore, electronic prescribing can monitor the amount of the dose and frequency from various prescribers.

On the other end of this spectrum, patients can become problematic and exhibit an overwhelming desire to get opioid prescriptions too often. In this case, the prescriber should evaluate the patient for signs and symptoms of opioid abuse such as sweating on the palms, pin-point pupils, euphoria, and complaints of craving. The prescriber should then inform the patient about the risks of continued abuse of opioids such as death due to cardiorespiratory depression. Once the patients accept that opioid addiction is their problem, they should begin treatment for withdrawal and tapering off of the opioid dose (Mohlman et al. 2016). Therefore, in case I prescribe opioids to “difficult” patients, I would educate them and monitor their medication through drug screening. Additionally, I will avoid prescription based on a patient’s demand and refer to a pain specialist if I suspect fraudulent demand for opioids.

**References**

Centers for Disease Control and Prevention. (2017). *Opioid overdose.* Retrieved from https://www.cdc.gov/drugoverdose/index.html.

Mohlman, M. K., Tanzman, B., Finison, K., Pinette, M., & Jones, C. (2016). Impact of medication-assisted treatment for opioid addiction on Medicaid expenditures and health services utilization rates in Vermont. *Journal of Substance Abuse Treatment*, *67*(1), 9-14. doi: 10.1016/j.jsat.2016.05.002.

Twillman, R. K., Kirch, R., & Gilson, A. (2014). Efforts to control prescription drug abuse: why clinicians should be concerned and take action as essential advocates for rational policy. *Cancer Journal for Clinicians*, *64*(6), 369-376. doi: 10.3322/caac.21243.