“Drug Seeking” and Controlled Substances in Outpatient Settings

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Objectives and Overview

- Controlled substances and the DEA
- Discuss epidemic of Rx drug abuse
- Addiction neurobiology and other important concepts
- Define Drug Seeking
- Describe safe practices
Difficult Scenarios in the Outpatient Setting

- ADHD and stimulants
- Anxiety, PTSD, Personality disorders and benzodiazepines
- Chronic non-cancer pain and opiates
- Any controlled substance with history of substance use disorder
- Inheriting patients with controlled substances on their med list
CDC declares drug overdose deaths an epidemic

- Every 18 minutes someone in the US dies by drug overdose
- Over 60% of drug overdose deaths involve opioids or benzodiazepines
Drug deaths have surpassed MVA’s as Cause of Death
• Drug deaths rival death rates during the height of the AIDS epidemic in the 80’s
Increasing Benzodiazepine Prescriptions and Overdose Mortality in the United States, 1996–2013

Objectives: To describe trends in benzodiazepine prescriptions and overdose mortality involving benzodiazepines among US adults.

Methods: We examined data from the Medical Expenditure Panel Survey and multiple-cause-of-death data from the Centers for Disease Control and Prevention.

Results: Between 1996 and 2013, the percentage of adults filling a benzodiazepine prescription increased from 4.1% (95% CI = 3.0, 4.2) kilogram lorazepam equivalents per 100 000 to 9.0% (95% CI = 6.1, 6.8). The overdose death rate (95% CI = 0.55, 0.62) to 3.07 (95% CI = 2.99, 3.14) per 100 000 adults, v 2010.

Conclusions: Benzodiazepine prescriptions and overdose mortality have increased. Fatal overdoses involving benzodiazepines have ever, no evidence of decreases was found in any group. Interventions to improve their safety are needed. (Am J Epidemiol online ahead of print: February 18, 2016: e1-e3. doi:10.1093/AJELZ/PMW258).
Increased opiate availability = increased overdoses

- From 1991-2011 Doctors tripled opioid rx’s from 76 million to 219 million
- Tripling of opioid related death over the same period
- Mexican heroin increased from 8 metric tons (2005) to 50 metric tons (2009)
Twelve states have more opioid prescriptions than people

Opioid Pain Reliever Prescriptions by State

Source: Centers for Disease Control
What causes overdose deaths?

- Apnea - you stop breathing and die
- High dose opiates (>100mg morphine equivalent) → respiratory depression
- Benzos+opiates+alcohol → Potentiation (multiplying effect, not additive) of respiratory depression
- Monitor for toxicity (red flags):
  - falls
  - Sedation, nodding
  - Slurred speech
  - Confusion
  - Poor concentration/cognitive problems
What is a controlled substance?

http://www.dea.gov
DEA Drug Schedules

- 5 schedules
- As you increase in schedule, abuse potential and dangerousness decrease
- Schedule I, illegal, no medical use
- Schedule II - no refills, one month supply only
- Schedule III-V
  - verbal orders allowed, up to 5 refills/6 months
- Schedule V lowest abuse potential
- What they have in common
  - Habit forming, reinforcing, reward pathway
  - street value, physiologic tolerance and withdrawal
DEA Drug Schedules

- **Schedule I** – no acceptable medical use, highest abuse potential, most dangerous
  - Heroin, cannabis, LSD, Ecstasy

- **Schedule II** - high abuse potential, also considered dangerous
  - Oxycodone, hydromorphone, ritalin, adderall, fentanyl, cocaine
  - Needs signed paper copy or Fax, one month supply, no verbal orders
  - **No refills, Nursing intensive**

- **Schedule III** - moderate to low potential for abuse
  - Ketamine, steroids, codeine

DEA Drug Schedules

- Schedule IV - low abuse potential
  - Xanax, soma, valium, ativan, ambien, tramadol

- Schedule V - lowest abuse potential
  - Robitussin AC, Lyrica

Adverse effects of Benzodiazepines

- Cognitive impairment
- Falls
- Confusion
- Respiratory depression and death
- Addiction, Dependence and tolerance
- High risk with sedatives other resp depressants like benzos, opiates and etoh
Adverse Effects of Stimulants

- Anxiety
- Psychosis and mania in those vulnerable
- Weight loss
- Addiction
- Dependence and tolerance
Adverse Effects of Opiates

- Falls
- Opioid induced hyperalgesia
- Hypogonadism, infertility through suppression of sex hormones
- Constipation
- Overdose and death
- Addiction, Dependence and tolerance
- High risk with
  - high dose 100mg of MED
  - with sedatives other resp depressants like benzos and etoh
DEA’s Do’s and Don’t’s

**DO:**
- perform a thorough examination appropriate to the condition.
- document examination results and questions you asked the patient.
- request picture I.D., or other I.D. and Social Security number. Photocopy these documents and include in the patient's record.
- call a previous practitioner, pharmacist or hospital to confirm patient's story.
- confirm a telephone number, if provided by the patient.
- confirm the current address at each visit.
- write prescriptions for limited quantities.

**DON’T:**
- "take their word for it" when you are suspicious.
- dispense drugs just to get rid of drug-seeking patients.
- prescribe, dispense or administer controlled substances outside the scope of your professional practice or in the absence of a formal practitioner-patient relationship.
DSM-5 substance use disorder

- Mild = 2-3 criteria, Moderate 4-5, Severe 6-7
  1. Taking the drug in larger amounts and for longer than intended
  2. Wanting to cut down or quit but not being able to do it
  3. Spending a lot of time obtaining the drug
  4. Craving or a strong desire to use drug
  5. Repeatedly unable to carry out major obligations at work, school, or home due to drug use
  6. Continued use despite persistent or recurring social or interpersonal problems caused or made worse by use
  7. Stopping or reducing important social, occupational, or recreational activities due to use
  8. Recurrent use in physically hazardous situations
  9. Consistent use despite acknowledgment of persistent or recurrent physical or psychological difficulties from using
  10. *Tolerance as defined by either a need for markedly increased amounts to achieve intoxication or desired effect or markedly diminished effect with continued use of the same amount. (Does not apply for diminished effect when used appropriately under medical supervision)
  11. *Withdrawal manifesting as either characteristic syndrome or the substance is used to avoid withdrawal (Does not apply when used appropriately under medical supervision)
Drug addiction is a chronic, relapsing disorder in which compulsive drug-seeking and drug-taking behavior persists despite serious negative consequences. Addictive substances induce pleasant states (euphoria in the initiation phase) or relieve distress. Continued use induces adaptive changes in the central nervous system that lead to tolerance, physical dependence, sensitization, craving, and relapse (Table 1). The addictive drugs discussed here are opioids, cannabinoids, ethanol, cocaine, amphetamines, and nicotine.

The World Health Organization\(^1\) and the American Psychiatric Association\(^2\) use the term “substance dependence” rather than “drug addiction.” “Drug addiction,” however, emphasizes the behavioral connotation of the term and is less likely to be confused with physical dependence.\(^3\) We use both terms interchangeably in this review. The American Psychiatric Association’s definition of substance dependence\(^2\) requires a patient to meet at least three of the seven criteria listed in Table 1. Tolerance and physical dependence reflect physiological adaptation to the effects of a drug, whereas the remaining criteria define uncontrollable drug consumption. However, tolerance and physical depend-
Neurobiology of Addiction

- Disruptions in the balance between the reward system and impulse control system, mediated by the limbic system and increased [Dopamine] in the Nucleus Acumbens and impaired orbitofrontal function.

- Progressive shifting of reward seeking to compulsive use.

- Eventually, the reward system that adaptively reinforces pro-social and survival behaviors—food, sex, water, employment, social functioning, is hijacked by drug seeking and compulsive use.

- The drug has greater salience than those other adaptive rewards.
Figure 1. Stages of the Addiction Cycle.

During intoxication, drug-induced activation of the brain’s reward regions (in blue) is enhanced by conditioned cues in areas of increased sensitization (in green). During withdrawal, the activation of brain regions involved in emotions (in pink) results in negative mood and enhanced sensitivity to stress. During preoccupation, the decreased function of the prefrontal cortex leads to an inability to balance the strong desire for the drug with the will to abstain, which triggers relapse and reinitiates the cycle of addiction. The compromised neurocircuitry reflects the disruption of the dopamine and glutamate systems and the stress-control systems of the brain, which are affected by corticotropin-releasing factor and dynorphin. The behaviors during the three stages of addiction change as a person transitions from drug experimentation to addiction as a function of the progressive neuroadaptations that occur in the brain.
Skinner Box and Cocaine
PCP relationship as skinner box

- Repeatedly asking and pressuring clinician to prescribe
- The prescriber/visit is the **lever**, the affected person asks for drugs repeatedly
- Instead of **shocks** in primary care relationship you have the destruction and interference of the therapeutic relationship with your PCP
- Taking it personally or moralizing the behavior is not very effective
Drug Seeking Behaviors

- Drug seeking—poorly defined term describing manipulative demanding behavior with the goal of obtaining a drug
  - Symptoms that deviate from physical exam
  - *Insistence of controlled substance at first visit and “nothing else [non addictive] works”*
  - Multiple allergies to non addictive drugs used to treat condition
  - Runs out of rx’s early, loses rx’s
  - “I have a high tolerance”
  - Uses other family members’ rx’s
  - Pits the opinions of different physicians
  - Threatens to get drugs from a “smarter” or “more caring” doc
  - Refuses non pharm options like therapy
  - May offer bribes or sex
  - May threaten physical harm to others

Drug Seeking Behaviors

- Doctor shopping - PMP and taking the concerns of the pharmD seriously
- Escalating doses - not consistent with clinical practice
- Scams
  - Exerting pressure on prescriber to get the trade name (higher street value)
  - Initial “no” turns into a “yes” highly suggestive of rx drug abuse
  - Project helplessness and misery onto doc
  - Scam will continue until a doc says no
  - Present after hours, right before the clinic closes, covering doc rx’s the drugs, ED

Controlled substance agreement

- Establishes one provider, one pharmacy for rx’s
- Pill counts
- Urine tox screens
- No early refills even if lost or running out early
- Requires engagement in other therapies
- Allows communication with other providers
- Establishes expected behaviors-threats and abusive language are not acceptable
- Makes pt aware of PMP
PMP- Prescription Monitoring Program

- Query will indicate quantity of pills dispensed, date, pharmacy prescriber
- Identifies when pt is due for refills and if doctor shopping
These medicines are helping me so much. Do you want me to just go buy drugs on the street?

Response: No. If you feel a need to buy drugs off the street despite my clear recommendation that you stop taking them, then I'd like to refer you to get treatment for substance abuse. I think these drugs are doing you more harm than good.
I don’t know what happened to my medication. I think my daughter’s no-good boyfriend took it out of the medicine cabinet when he was over last weekend. So I need a new prescription.

Response: You need to treat your prescriptions and pills as if they were cash. If lost, they cannot be replaced. It is your responsibility to make sure they are not lost or stolen. I cannot refill this early.
I can't give you a urine sample now. I just peed.

Response: Unfortunately, you are going to have to wait here to give a sample until you can pee again. If you leave clinic today without leaving a urine sample, I will no longer be able to write you prescriptions for controlled substance prescription.
My only hope is my pain medication. If you don’t give me my pain medication, I can’t go on. I can’t live like this. I don't know what I'll do.

Response: It is awful when you have pain without an end in sight. I would be discouraged too. But pain itself does not make you suicidal. Pain plus depression and hopelessness can make you suicidal. So the answer to your desperate feelings in not just more pain medication. We must address your depression and hopelessness.