SOUTHWESTERN VIRGINIA PRESCRIPTION SUMMIT

WYTHEVILLE, Virginia

November 14, 2012

PLEASE READ THROUGH THIS BEFORE THE PANEL PRESENTATION!!!!!!!!

WHERE ARE ALL THE PILLS COMING FROM???

(A MEDICAL PERSPECTIVE)

Mary G. McMasters, MD, FASAM

Expert Witness, DOJ

Adjunct Instructor, DEA

Old Country Addictionologist

Comprehensive Behavioral Health

57 N. Medical Park Dr., Suite 105

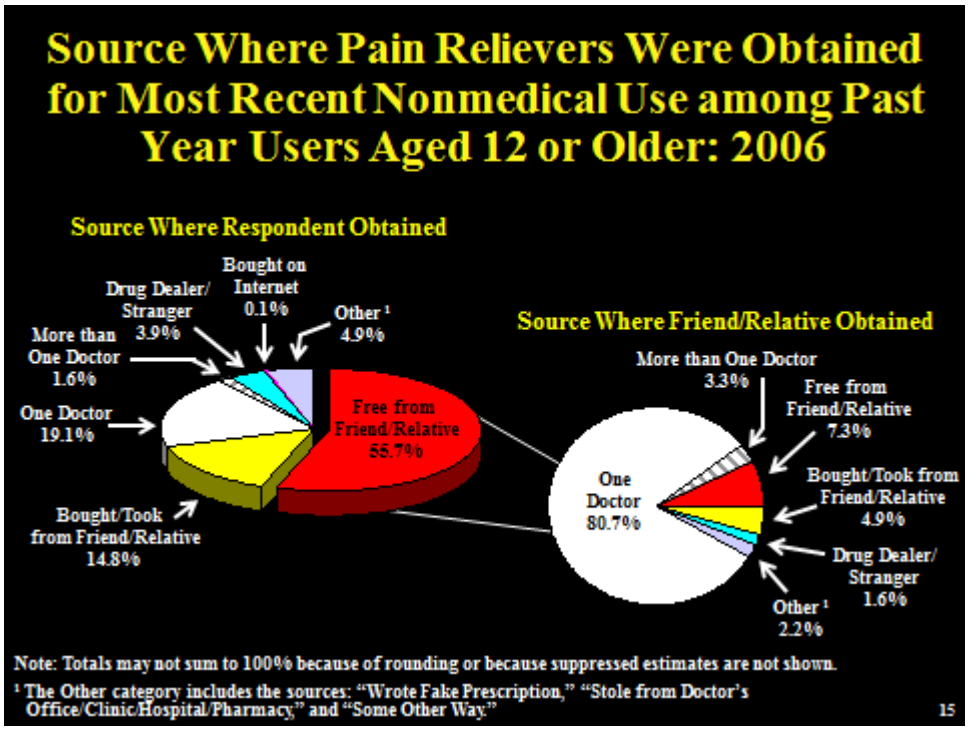
Fishersville, VA 22939

540-941-2500

Fax 540-941-2535

FACT: Most diverted prescription drugs come from physicians.

In fact, *most* come from ONE physician prescribing to ONE patient:



From NSDUH 2006 www.fda.gov/ohrms/.../2008-4356s1-02-Guest-Gfroerer.pp

-NOT from drug dealers

-NOT off the internet[i]

WHY ARE ALL THESE PILLS BEING PRESCRIBED?

FACTS:

1. Better recognition and treatment of pain

2. Better forms of pain relief (stronger, longer lasting pain relief)
3. Marketing
4. LUCRATIVE!!!!!
    a. For patients

- 100 Vicodin $500-$800
- 100 Xanax 2mg $1,000
- 4 Fentanyl patches 100ug $400
- 100 Dilaudid 8mg $4,000-16,000
- 100 Oxycontin (new) 80mg $2,000-8,000
- Methadone 1$ per milligram
- Percocet 10mg $32/pill (8/25/11 personal report)
  Confirmed with Virginia State Police Drug Diversion Officer Lear 9/12

    b. FOR PHYSICIANS!!!!!!
        i. Bad prescribers (indiscriminate controlled substance prescribing) make as much as TEN TIMES more money than good prescribers do.
        ii. Addicts are the most vulnerable patient-consumer population in the world. They are ASHAMED, they are DESPERATE, and they will pay anything to get “the monkey” off their backs. Unfortunately, there are many prescribers who believe it is OK to take advantage of these people because “dirty junkies” deserve what they get: bad care.

5. Physicians get little/no education on recognizing/treating diversion, substance abuse and addiction
    a. DOES ***YOUR*** University have a Board Certified Addictionologist (ASAM[ii]) on faculty?

6. Few consequences for being a bad prescriber
    a. The Virginia State Police Drug Diversion unit has only ***TWENTY-SEVEN*** officers for the entire state of Virginia. ***Who are we trying to fool???***

        --- *"Whether you are raising teenagers, or trying to govern a county, don't make rules you can't enforce." Grandma M*

    b. The Standards-of-Care and the Laws regulating controlled substance prescribing are two different things. Laws are enforced by law enforcement (see 6.a. above). The Standards of Care are enforced by the Board of Medicine. Standards of Care are often hard (and expensive) to prove.

WHERE DO WE START????

1. Define the problem
    a. Physiological Adaptations to Medications ***(THESE ARE NOT THE SAME THING AS ADDICTION!!!!!!)***

i. Tolerance: Tolerance: it takes more of a substance (therapeutic or non-therapeutic) to achieve a goal (therapeutic or non-therapeutic)
Examples:
-A few months after starting it, a patient needs more beta blocker (an anti-hypertensive medication) to control their blood pressure.
(Nothing else has changed.)
-A regular user of Oxycontin can tolerate a dose which would make a non-user stop breathing.
TOLERANCE NORMALLY HAS A CEILING!!!!!!!!

ii. Physical Dependence: Physical Dependence: the sudden cessation of a substance to which the body has become accustomed (therapeutic or non-therapeutic) resulting in a withdrawal syndrome.
Examples:
-A physician stops an anti-hypertensive medication abruptly without weaning it and the patient feels panicky, has high blood pressure and a fast heart rate.
-An opiate addict can't get his/her fix and becomes nauseated, shaky and sick.

b. Substance Misuse Disorders

i. Diversion ***<u>IF WE REALLY WANT TO MAKE A DENT IN OUR NATIONAL DEBT, WE NEED TO</u>***

DEAL WITH THE ECONOMICS OF DIVERSION:

large flow of non-taxed money, decreased productivity of the work force, crime, disease, disability

ii. Substance Abuse- "the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological (or social or occupational) problem that is likely to have been caused or exacerbated by the substance."

iii. Addiction- "the substance use is continued despite knowledge of having a persistent or recurrent physical or psychological (or social or occupational) problem that is likely to have been caused or exacerbated by the substance."

PLUS "the persistent desire or unsuccessful efforts to cut down or control substance use."[iii]

Addiction ALWAYS comes down to functioning.[iv]

Addiction is a CHRONIC Brain Disease.[v]

Addiction IS NOT substance specific.

Most patients diverting controlled substances ARE NOT addicted. Most are doing it for profit. However, the patients with Addiction are the ones who are dying!!!!!

2. Make a plan based on Evidence Based Medical Information, NOT stigmatization and name-calling.

WHAT IS THE IDEAL?

FIRST: Responsible Controlled Substance Prescribing:

UNIVERSAL PRECAUTIONS FOR PRESCRIBING CONTROLLED SUBSTANCES

EVERY PATIENT, EVERY TIME

1. Confirm the diagnosis
2. Try the less risky interventions for pain first: PT, NSAIDS, etc
3. Controlled Substance Agreement. This should always include permission to query the Prescription Monitoring Program.
4. Do a UDS. This protects the patient AND YOU.
5. Assess Risk Factors for Substance Misuse Disorders
    a. Family History (Addiction is a GENETIC disease)
    b. Current Addictions (This includes smoking)
    c. Behaviors symptomatic of a Substance Misuse Disorders (Legal problems, MVAs, DUIs, etc)
6. Assess Functioning

7. Do a Time limited Trial (Expectations: No problematic behavior, IMPROVED FUNCTIONING)
8. Have an Exit Strategy (know how to wean what you start; know where to refer patients with substance misuse problems)
9. Periodic Reassessment
10. Give the fewest number of pills possible with the lowest abuse potential
11. DOCUMENT, DOCUMENT, DOCUMENT

THE BOTTOM LINE:

<u>FUNCTIONING</u>

IF YOU ARE TREATING PAIN (ADHD, ANXIETY),
FUNCTIONING GETS BETTER
IF YOU ARE FEEDING AN ADDICTION, FUNCTIONING GETS WORSE

Adapted from Gourlay Mary G. McMasters, MD, FASAM

SECOND: Recognize and Treat Addiction- Addiction is a common brain disease which should be recognized and diagnosed by all

responsible physicians. An appropriate treatment plan should be made for each patient with the disease (primarily counseling). Physicians should recognize Addiction as an iatrogenic condition resulting from some medications they prescribe, and they should always consider Addiction when weighing risks and benefits of those medications. Development of the disease of Addiction is not an excuse to abandon, "fire", a patient. The physician should cease prescribing substances of abuse, educate the patient about the dangers of substance abuse, and refer the patient to appropriate treatment (most basic referral: local 12 step programs).

ADDICTION IS A TREATABLE DISEASE!!!!!!!!! Treatment:

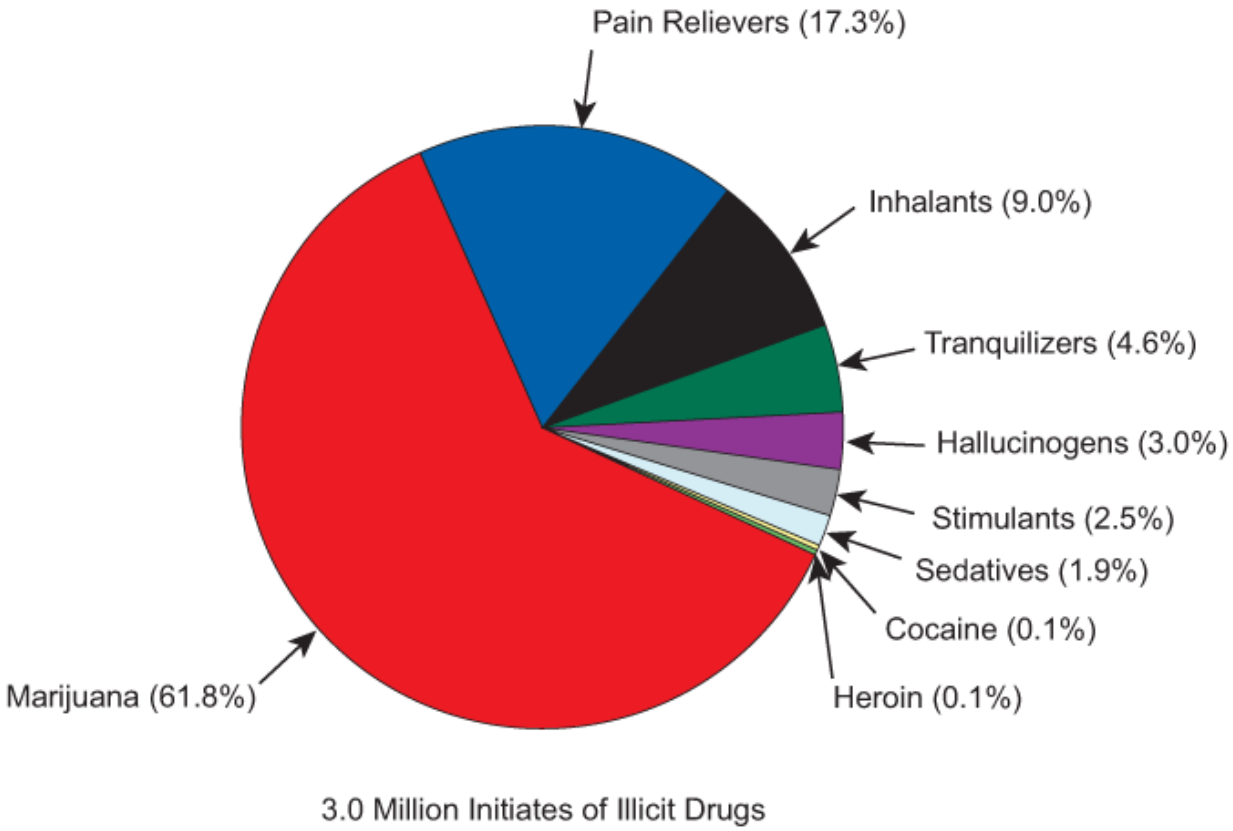
MAJORITY: ABSTINENCE COUNSELING- for most communities these are the 12 STEP PROGRAMS. 12 Step programs are NOT A RELIGION, NOT HOCUS-POCUS, AND NOT A CULT. They are a COST EFFECTIVE (FREE) A WAY TO "RE-PROGRAM" THE BRAIN.

MINORITY: ADDITIONAL MEDICATION ASSISTANCE

REFERENCES:

EPIDEMIC: RESPONDING TO AMERICA'S PRESCRIPTION DRUG ABUSE CRISIS, Office of National Drug Control Policy, http://www.whitehouse.gov/ondcp

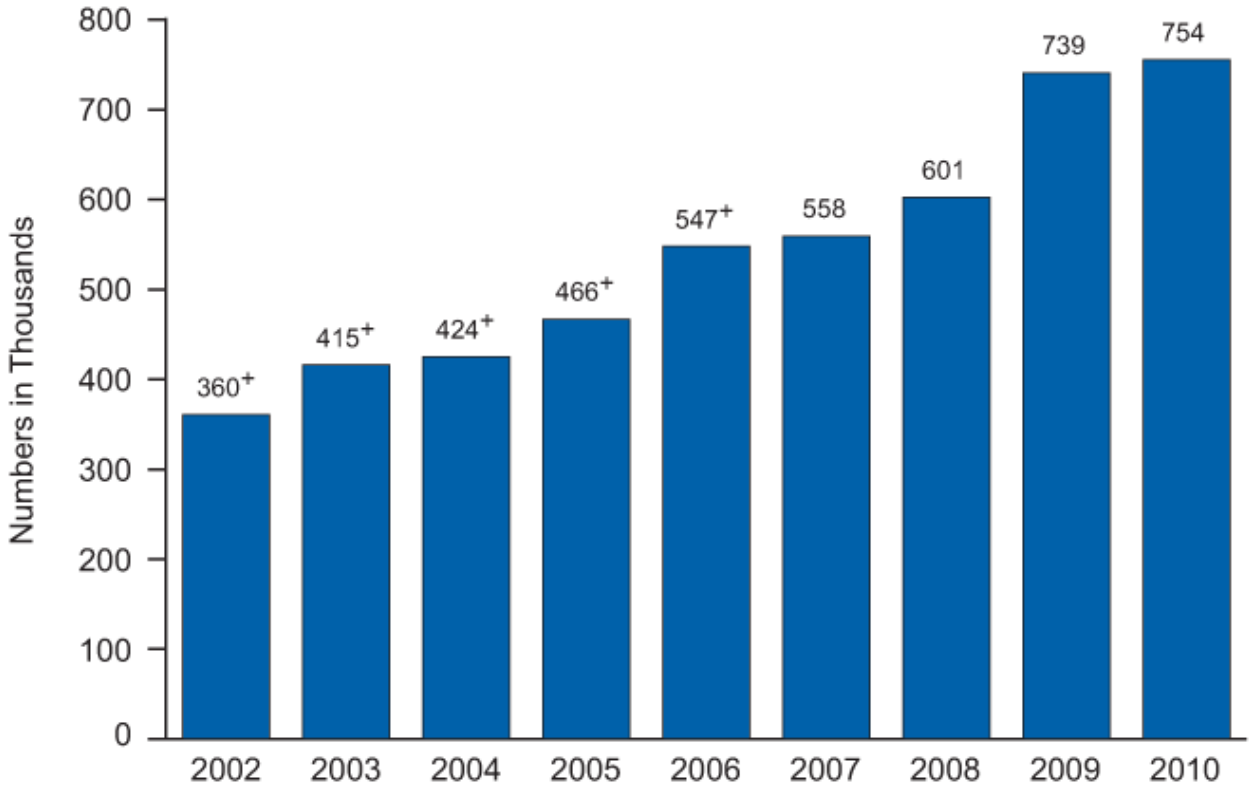
i



Psychotherapeutics

- Psychotherapeutics include the nonmedical use of any prescription-type pain relievers, tranquilizers, stimulants, or sedatives. Over-the-counter substances are not included. In 2010, there were 2.4 million persons aged 12 or older who used psychotherapeutics nonmedically for the first time within the past year, which averages around 6,600 initiates per day. The number of new users of psychotherapeutics in 2010 was similar to the 2009 estimate (2.6 million), but lower than the 2004 estimate (2.8 million). In 2010, the number of new users of pain relievers was 2.0 million, a number that has remained fairly constant since 2005 and was a decrease from 2002, 2003, and 2004 levels (2.3 million, 2.5 million, and 2.4 million, respectively). Among other specific psychotherapeutics, the number of initiates was 1.2 million for tranquilizers, 624,000 for stimulants, and 252,000 for sedatives.
- In 2010, the average age at first nonmedical use of any psychotherapeutics among recent initiates aged 12 to 49 was 22.3 years. More specifically, it was 24.6 years for tranquilizers, 23.5 years for sedatives, 21.2 years for stimulants, and 21.0 years for pain relievers.
- In 2010, the number of new nonmedical users of OxyContin® aged 12 or older was 598,000, with an average age at first use of 22.8 years among those aged 12 to 49. These estimates are similar to those for 2009 (584,000 and 22.3 years, respectively).

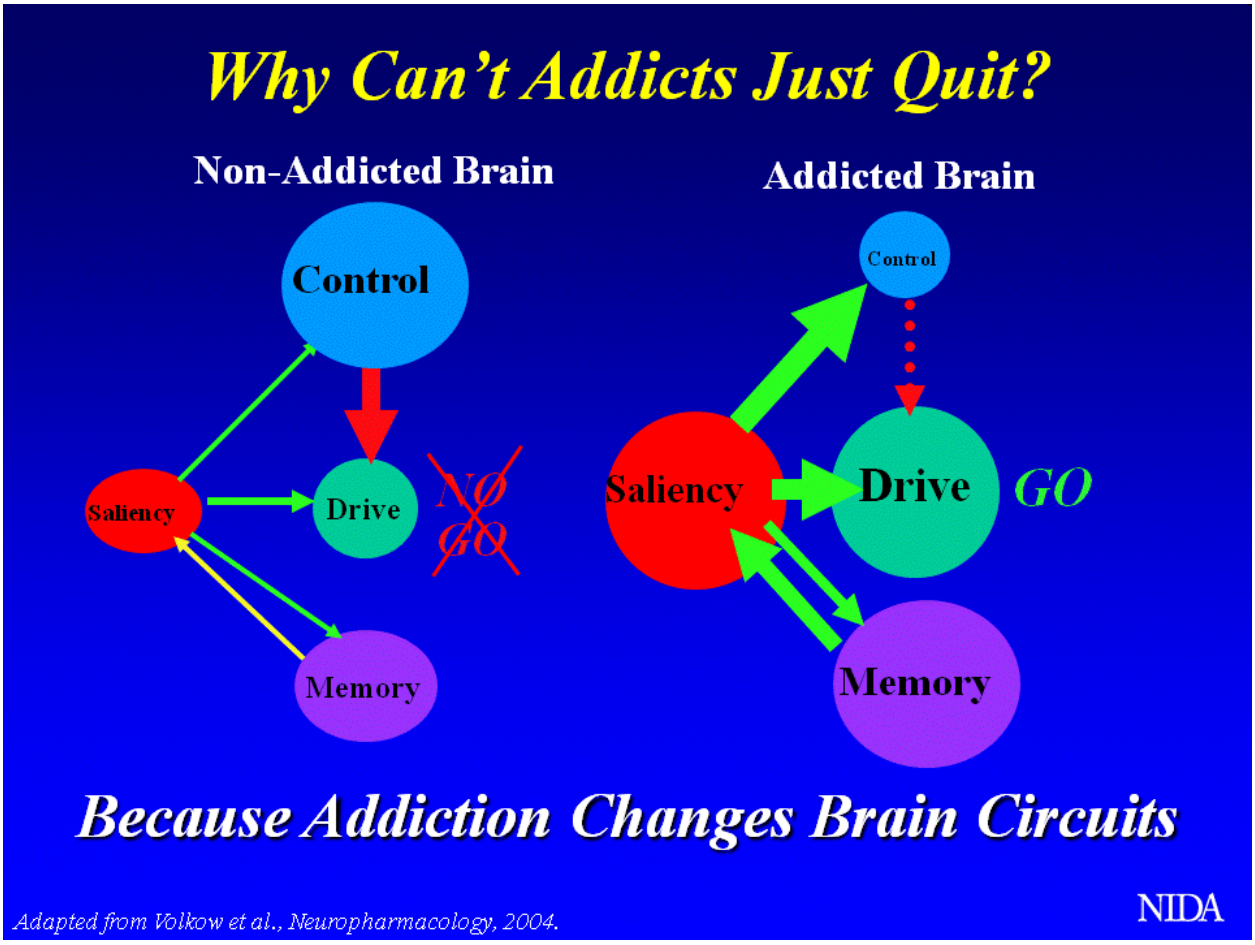
Figure 7.9 Received Most Recent Treatment in the Past Year for the Use of Pain Relievers among Persons Aged 12 or Older: 2002-2010



http://www.samhsa.gov/data/nsduh/2k10nsduh/2k10results.htm Substance Abuse and Mental Health Services Administration, *Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-41, HHS Publication No. (SMA) 11-4658. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2011.

[ii] American Society of Addiction Medicine
[iii] Ries, Fiellin, Miller, Saitz, PRINCIPLES OF ADDICTION MEDICINE, 4th ed., 2009, American Society of Addiction Medicine

iv



- Diversion
  - A MAJOR Public Health Crisis
    - Failing to practice safe prescribing contributes to it
      - Opioid abuse: 24-31% of primary care patients abuse their prescribed narcotics
      - High School Seniors: 10% misuse Vicodin
      - Economic Costs of Diversion & Substance Abuse
        - » 180.9 BILLION dollars in 2002 alone
        - » Greatest dollar loss is in Productivity

The Economic Costs of Drug Abuse in the United States
1992–2002 Office Of National Drug Control Policy
http://www.whitehousedrugpolicy.gov/publications/economic_costs/

v

Addiction: A Disease of Learning and Memory Steven E. Hyman, M.D. If neurobiology is ultimately to contribute to the development of successful treatments for drug addiction, researchers must discover the molecular mechanisms by which drug-seeking behaviors are consolidated into compulsive use, the mechanisms that underlie the long persistence of relapse risk, and the mechanisms by which drug-associated cues come to control behavior. Evidence at the molecular, cellular, systems, behavioral, and computational levels of analysis is converging to suggest the view that ***addiction represents a pathological usurpation of the neural mechanisms of learning and memory that under normal circumstances serve to shape survival behaviors related to the pursuit of rewards and the cues that predict them.*** The author summarizes the converging evidence in this area and highlights key questions that remain. (Am J Psychiatry 2005; 162:1414–1422)