Combating the US Prescription Opiate Epidemic: Applying Principles of SBIRT to the Prescribers of Controlled Drugs

Brief Power Point #1

Controlled Drugs and Substance Use disorders

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Application of SBIRT to C Rx

- High risk RX to High Risk Patients:
  - SA Tx Programs can do Utox + PMP
    - ID who RX and who fills RX for High Risk Pt
      (SCREENING)
  - Can contact prescriber and pharmacy
    (BREIF INTERVENTION)

- If continued prescribing ...
  - Can assess readiness / diagnose deficits / refer for treatment (credentialing / licensing agency)
Euphoria Producing Drugs = High Risk Drugs
Euphoria Producing Drugs = EPD’s

- EPD’s include: opioids, stimulants, sedative-hypnotics, cannabinoids, and phencyclidine
- Very different substances
- Totally different primary brain effects
- **ALL** produce and acute surge of dopamine from the mid brain to the fore-brain
- Dopamine surges mediate addictive disease
Controlled drugs ARE Euphoria Producing Drugs: CRx = EPD’s

- EPD’s include: opioids, stimulants, sedative-hypnotics, cannabinoids, and phencyclidine
- Very different substances
- **Totally** different primary brain effects
- **ALL** produce an *acute surge* of **dopamine** from the mid brain to the fore-brain
- Dopamine surges dictate *controlled drug designation!* (and mediate substance use disorders)
Substance abusing or addictive brains = High Risk Brains
The Continuum of Substance Use Disorders

Adult Population

Abst.  SU  SA  CD

Use

Consequences
SBI and DSM IV v. Substance Use Disorder Mild / Moderate / Severe in DSM V

- Risky Use = SUD MILD
- Substance Abuse = SUD MILD
- Hazardous Use = SUD MILD or Moderate
- Severe substance abuse = SUD Moderate
- Chemical dependence = SUD Mod / Severe
- Addictive disease = SUD Mod / Severe
SUD Moderate-Severe: A Brain Disease!!!

- Brain functions:
  - Movement
  - Intelligence
  - **Behavior**

- Diseases of the brain in each area of function:
  - Parkinson’s, M.S., Seizures
  - Mental retardation, Dementia
  - **Addiction, Schizophrenia, Bipolar**
Chemical Dependence: Natural History (Its Brain Disease)

- Diseases of the brain that effect Behavior Control Centers:
  - Addiction, Schizophrenia, Bipolar

- Sns/Sx of the biologic disease of addiction:
  - Behavioral, Behavioral, Behavioral ...

- Not a psychological disease, just behavioral sx
Chemical Dependence
natural history

- Increased dysfunction and disability in the following domains:
  - Self image
  - Interpersonal
  - Social
  - Financial
  - Legal
  - Work
  - Physical
CRx Prescribing Decisions: 

*Avoid High Risk Drugs with High Risk Brains*

- Any prescribing decision involves:
  - Indications – establishing the reason to RX
  - Contraindication – screening for reasons not to RX

- Contraindication screening requires K,A,S.
  - K=clinically understanding contraindications
  - A=respecting the gravity of contraindications
  - S=using screening tools to ID contraindications

- K,A,S are **ALL** needed for safe CRx prescribing
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Power Point #2 Perpetuation of status quo
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What is the status quo?

- An imbalance in prescribing
Deaths per 100,000 related to unintentional overdose and annual sales of prescription opioids by year, 1990 - 2006

Source: Paulozzi, CDC, Congressional testimony, 2007
In 2009, 39,147 Americans died from drug poisonings. Nearly 14,800 deaths involved prescription opioids.

For every 1 death there are:

- 10 treatment admissions for abuse
- 32 ED visits for misuse or abuse
- 130 people who abuse or are addicted
- 825 nonmedical users


Chronic OPT Prescribing of Controlled Drugs

Who **TO** prescribe to?
- Presence of **Indications** – patient specific and disease specific
  - **AND**
  - Lack of **Contraindications**

Who **NOT TO** prescribe to?
- Lack of **indications**
  - **OR**
  - Presence of **contraindications**
Contraindications to chronic C RX TX

- **High Risk Brains (HRB):**
  - Current addictive disease = strong
  - Past addictive disease = strong
  - History of diversion = strong

- **Risky Brains (SUD MILD):**
  - Significant nonadherence = relative
  - Substantial psychiatric co-morbidity = relative
  - COPD &/or Obst Sleep Apnea = relative

***Prescribe chronic C RX to HRB’s only with expert advice and support (i.e. a methadone or buprenorphine clinic)***
Even things that should be obvious ... are not!

- Almost all patients continue to receive prescription opioids after an overdose.
- AND
- Opioid discontinuation after overdose is associated with lower risk for repeated overdose.

Annals of Internal Medicine • Vol. 164 No. 1 • 5 January 2016
Perpetuation of status quo

- High risk brains **want** high risk drugs
  - Relationship / communication challenge
- Screening for HRB poorly done
  - Poor screens
  - Incompletely used
- Under appreciated contraindications
- Blurring of basic ethical tenants
  - Above all, first do no harm
Prescribing Controlled Drugs
Mechanisms of Involvement of CRxDA

- AMA mechanisms re: RxDA – “the 6-D’s”
  - Dated
  - Duped
  - Disabled
  - Dishonest
  - Defiant
  - Distracted

- Medication Mania / Confrontation Phobia / Hypertrophied Enabling
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Power Point #3
Use of PMP to apply SBIRT to CRx
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What is a PMP

- Prescription Monitoring Program
- All C Rx filled / patient / year
  - What filled
  - Where
  - How paid
  - Rx by who
  - Contact info for Where and Who
The Continuum C Rx Prescribers

All Prescribers

CRxing

Little or none

Low Risk

Risky

Problem

Pt/Community Risk
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