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Name of CME Activity: AOA/ACOFP 114th Annual Convention & Exhibition

Dates and Location of CME Activity: November 1, 2009, New Orleans Convention Center

Topic: SUBSTANCE ABUSE

Name of Faculty/Planner/Author/Editor/Reviewer: Bradley Miller, DO

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B. I have, or an immediate family member has, a financial relationship or interest with a proprietary entity producing health care goods or services. Please check the relationship(s). (Check all that apply):

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Signature: [Handwritten Signature] Date: 9/24/09

Please fax this form to ACOFP at 866-328-1835 as soon as possible. Deadline: September 30, 2009.

Substance Abuse: Part I

**Early Evaluation and Treatment
of Substance Abuse**

Bradley J. Miller, D.O., FAAFP

**AOA/ACOFP 114th Annual Convention
New Orleans, LA
4 November 2009**

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Objectives

- Review current statistics and disease burden of substance abuse in the United States.
- Discuss addiction as a chronic illness
- Describe how to screen for, briefly intervene, refer to addiction specialists and provide treatment in the primary care setting
- Review of specific substances of abuse and some common pharmacologic treatments
- *Examples of managing substance dependence in the primary care setting*

Current Statistics and Disease Burden

- In 2006, an estimated 20.4 million Americans were current (past month) illicit drug users (= 8.3 percent of the population >12 y.o.)
- Marijuana was the most commonly used illicit drug (14.8 million past month users).
- Slightly more than half of Americans reported being current drinkers of alcohol in the 2006 survey (50.9 percent). (= 125 million people)

2006 National Survey on Drug Use and Health (NSDUH) sponsored by the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Studies (OAS).

Current Statistics and Disease Burden

- For the third and fourth quarters of 2003, DAWN estimates 627,923 drug-related ED visits nationwide
- The specific drugs most commonly associated with drug misuse- or abuse-related ED visits included:
 - Cocaine — 28 % of visits
 - Alcohol — 26 %
 - Marijuana — 20%
 - Heroin — 10%
 - Major stimulants (amphetamines/methamphetamine) — 10%
 - Benzodiazepines (anti-anxiety medications), non-medical use — 17%
 - Opiates/opioid analgesics (pain relievers) — 17%

U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Office of Applied Studies. Drug Abuse Warning Network 2003: Interim National Estimates of Drug-Related Emergency Department Visits. December 2004.

National Institute on Drug Abuse (NIDA) Website;
<http://www.nida.nih.gov/infofacts/costs.html>

Addiction as a Chronic Illness

What is an addiction?

- Need to differentiate between “dependence” and “abuse.”
- Technically, “addiction” = “dependence,” however, diagnoses may not be differentiated well by all treatment providers.

What is an addiction?

Substance Abuse

1 or more of the following at the same time in a 12-month period:

- Recurrent use resulting in failure to fulfill major role obligations
- Recurrent use in situations that are physically hazardous
- Recurrent legal problems resulting from use
- Continued use despite having persistent social or interpersonal problems caused or exacerbated by the substance
- Does not meet criteria for Dependence

Substance Dependence

3 or more of the following at the same time in a 12-month period:

- Tolerance
- Withdrawal
- Taken in larger amounts or over longer period than intended
- Persistent desire or unsuccessful efforts to cut down
- Great deal of time spent in obtaining, using, and recovering from substance
- Important activities are given up as a result of substance use
- Use continues despite knowledge of physical or psychological problem that is caused or exacerbated by the substance

Addiction as a Chronic Illness

- Addiction researchers and specialists have determined that addiction (dependence) is a *chronic illness*. That is, the characteristics of an addiction or similar to those of such chronic illnesses as asthma, hypertension, and diabetes.

Addiction as a Chronic Illness

■ Characteristics of chronic illnesses:

- There are no cures.
- Relapses are typical and considered to be a predictable part of treatment and recovery.
- Behavior change alone can sometimes maintain recovery, but medication is often also necessary.
- There is a genetic component, meaning family members need to take precautions against developing the illness.
- Compliance to the recommended course of treatment varies between people, and also within the same individual over time.

Treatment of Chronic Illnesses

Addiction

(Short-term)

- Detoxification
- Rehabilitation

(Long-term)

- Medication Treatments
- Psychosocial Treatments

Other Chronic Illness

(Short-term)

- Acute Stabilization
- Hospitalization

(Long-term)

- Medication Treatments
- Psychosocial Treatments

The Development of Addiction

- The Mesolimbic Dopamine System (MDS) = the "dependence" brain areas
- Dysregulation of neurotransmitters at the receptor level are believed to be the root cause
- The severity of dysregulation differs among individuals
- Substances can "fix" the dysregulation
- The brain has interpreted the substance that normalizes the dysregulation as a basic need, similar to food and water

The Development of Addiction

- Logical “Drugs of choice”
 - Dopamine: Amphetamines, cocaine, alcohol
 - Serotonin: LSD, alcohol
 - Endorphins: Opioids (heroin and narcotics), alcohol
 - GABA: Benzodiazepines, alcohol
 - Glutamate: Alcohol
 - Acetylcholine: Nicotine, alcohol
 - Endocannabinoids: Marijuana, alcohol
- Alcohol: A “dirty” drug

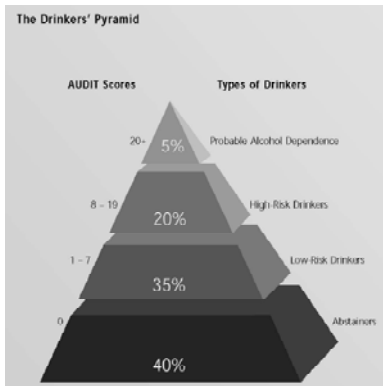
Screening and Brief Intervention

What is SBIRT?

Purpose of SBIRT in the primary care setting is to identify (***S***creen), provide intervention (***B***rief ***I***ntervention) and referral for (***R***eferral) alcohol and substance use. (The SBIR levels)

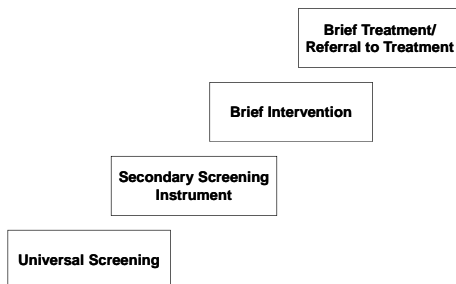
Goals of SBIRT

- Overall goals for SBIRT in primary care settings:
 - Improve the identification of substance misuse;
Target population is *non-dependent, at-risk users*
 - Decrease overall alcohol and drug use in our patients
 - Create an informed, medically-sound, evidence & prevention-based continuum of care between general medical practice and specialized D&A treatment centers



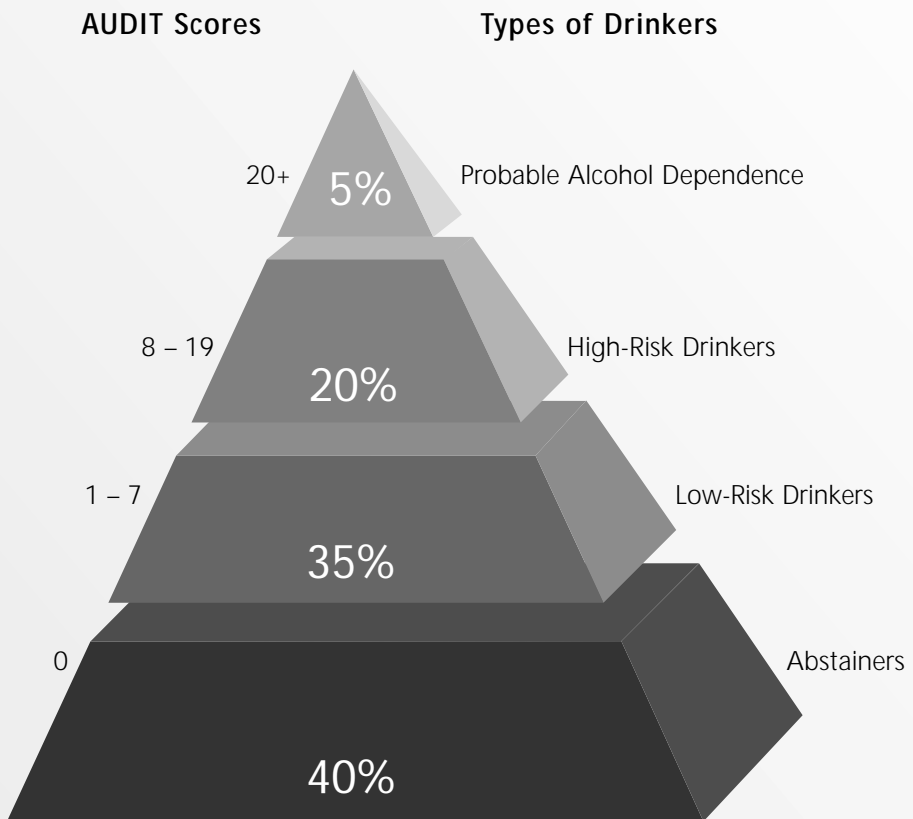
Used with permission, Department of Mental Health and Substance Dependence, World Health Organization

Use a Stepwise Approach



Panel 2

The Drinkers' Pyramid



Used with permission, Department of Mental Health and Substance Dependence, World Health Organization
http://whqlibdoc.who.int/hq/2001/WHO_MSD_MSB_01.6b.pdf

Screening

Alcohol

■ What is *Low-Risk Drinking*?:

– Females

- ≤ 7 drinks per week
- ≤ 3 drinks per occasion

– Males

- ≤ 14 drinks per week
- ≤ 4 drinks per occasion

– Adults over 65 years of age

- ≤ 7 drinks per week
- ≤ 3 drinks per occasion

Alcohol

What constitutes “1 drink”?*

- Beer – 12 ounces
- Shot – 1.5 ounces
- Wine – 5 ounces

* The definition of a standard drink varies from country to country and study to study; the above is the WHO definition, and is used by the SBIRT initiative

What is a standard drink?



One 12 oz. Can/
Bottle of Beer

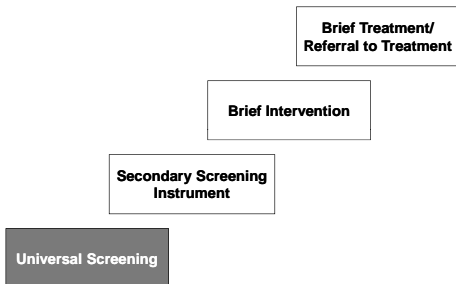


A single shot (1.5 oz.) of distilled
spirits (gin, vodka, rum, etc...)



A glass of wine (5 oz.) or
a small glass of sherry

Use a Stepwise Approach



Universal Screening

During the past year have you consumed alcohol? Yes No

If YES, move on to next series of questions. If NO, acknowledge & reinforce low-risk behavior.

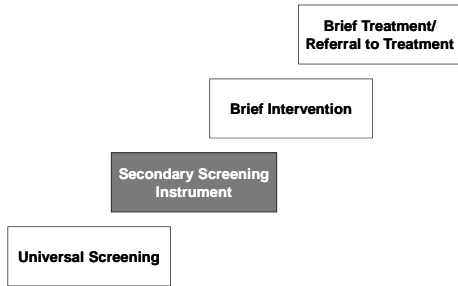
On average, how many days a week do you drink alcohol?	Risky Behavior:	
	Men	Women
On a typical day when you drink, how many drinks do you have?		
Weekly Average =	> 14	> 7
What is the maximum number of drinks you had on any given day in the past year?	> 4	> 3

If amount exceeds risk levels, move on to secondary screening instrument

In the last year, have you used any illicit drugs or misused prescription medications (i.e. more than prescribed, someone else's)?	Yes <input type="checkbox"/> No <input type="checkbox"/>
In the last year, have you tried to cut down on drug or medication use?	Yes <input type="checkbox"/> No <input type="checkbox"/>
In the last 30 days, have you used any marijuana?	Yes <input type="checkbox"/> No <input type="checkbox"/>

If any YES answer, move on to secondary screening instrument. If NO, acknowledge & reinforce low-risk behavior.

Use a Stepwise Approach



The “Alphabet Soup” of Screening Instruments

- Several instruments may be used to screen patients:
 - CAGE-Cut Down, Annoy, Guilt, Eye Opener
 - DAST-Drug Abuse Screening Test
 - MAST-Michigan Alcohol Screening Test
 - SAAST-Self Administered Alcohol Screening Test
 - T-ACE-Tolerance, Angry, Cut Down, Eye-Opener
 - ASSIST-Alcohol, Smoking and Substance Abuse Screening Test
 - AUDIT-Alcohol Use Disorders Identification Test
 - CRAFFT – Car, Relax, Forget, Family/Friends, Trouble
 - TWEAK-Tolerance, Worried, Eye-Opener, Amnesia, K(C)ut Down
 - PPPP (4 P’s) – Parents, Partner, Past, Pregnancy

Substance Abuse Screening Tests At A Glance

Measure	Substance Being Screened	Method of Administration	Special Population?
CAGE	Alcohol	Interview	No
DAST	Drugs (not alcohol)	Self	No
MAST	Alcohol	Self or Interview	No
SAAST	Alcohol	Self	No
T-ACE	Alcohol	Interview	Women/pregnant women
ASSIST	Alcohol, tobacco, illicit drugs	Self or Self and Interview	No
AUDIT	Alcohol	Self or Interview	No
CRAFFT	Alcohol, Drugs	Interview	Adolescents
TWEAK	Alcohol	Interview	Pregnant Women
PPPP	Alcohol, drugs, tobacco	Interview	Pregnant Women

Box 4**The Alcohol Use Disorders Identification Test: Interview Version**

Read questions as written. Record answers carefully. Begin the AUDIT by saying "Now I am going to ask you some questions about your use of alcoholic beverages during this past year." Explain what is meant by "alcoholic beverages" by using local examples of beer, wine, vodka, etc. Code answers in terms of "standard drinks". Place the correct answer number in the box at the right.

<p>1. How often do you have a drink containing alcohol?</p> <p>(0) Never [Skip to Qs 9-10] (1) Monthly or less (2) 2 to 4 times a month (3) 2 to 3 times a week (4) 4 or more times a week</p> <p style="text-align: right;"><input type="text"/></p>	<p>6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <p style="text-align: right;"><input type="text"/></p>
<p>2. How many drinks containing alcohol do you have on a typical day when you are drinking?</p> <p>(0) 1 or 2 (1) 3 or 4 (2) 5 or 6 (3) 7, 8, or 9 (4) 10 or more</p> <p style="text-align: right;"><input type="text"/></p>	<p>7. How often during the last year have you had a feeling of guilt or remorse after drinking?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <p style="text-align: right;"><input type="text"/></p>
<p>3. How often do you have six or more drinks on one occasion?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <p><i>Skip to Questions 9 and 10 if Total Score for Questions 2 and 3 = 0</i></p> <p style="text-align: right;"><input type="text"/></p>	<p>8. How often during the last year have you been unable to remember what happened the night before because you had been drinking?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <p style="text-align: right;"><input type="text"/></p>
<p>4. How often during the last year have you found that you were not able to stop drinking once you had started?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <p style="text-align: right;"><input type="text"/></p>	<p>9. Have you or someone else been injured as a result of your drinking?</p> <p>(0) No (2) Yes, but not in the last year (4) Yes, during the last year</p> <p style="text-align: right;"><input type="text"/></p>
<p>5. How often during the last year have you failed to do what was normally expected from you because of drinking?</p> <p>(0) Never (1) Less than monthly (2) Monthly (3) Weekly (4) Daily or almost daily</p> <p style="text-align: right;"><input type="text"/></p>	<p>10. Has a relative or friend or a doctor or another health worker been concerned about your drinking or suggested you cut down?</p> <p>(0) No (2) Yes, but not in the last year (4) Yes, during the last year</p> <p style="text-align: right;"><input type="text"/></p>
<p style="text-align: right;">Record total of specific items here <input type="text"/></p> <p><i>If total is greater than recommended cut-off, consult User's Manual.</i></p>	

Brief Intervention

If Screen is positive for **drug** use:

- Administer the **DAST-10 (Drug Abuse Screening Test)** to determine the severity of risk

Regarding the past 12 months...

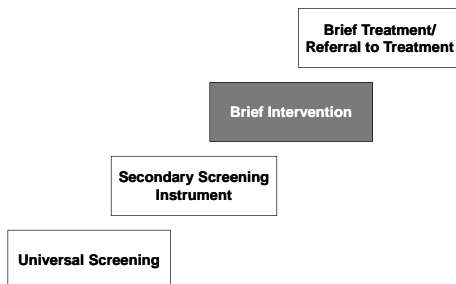
- Have you used drugs other than those required for medical reasons? Yes/No
- Do you abuse more than one drug at a time? Yes/No
- Are you able to stop using drugs when you want to? Yes/No
- Have you ever had blackouts or flashbacks as a result of drug use? Yes/No
- Do you ever feel bad or guilty about your drug use? Yes/No
- Does your spouse or parents ever complain about your drug use? Yes/No
- Have you neglected your family because of your use of drugs? Yes/No
- Have you engaged in illegal activities in order to obtain drugs? Yes/No
- Have you ever experienced withdrawal symptoms when you stopped taking drugs? Yes/No
- Have you had medical problems as a result of your drug use (e.g. memory loss, hepatitis, convulsions, bleeding)? Yes/No

Brief Intervention

Interpretation of DAST-10

Score	Degree of Problem	Suggested Action
0	No Problems Reported	Encouragement and education
1-2	Low Level	Risky behavior – Feedback & Advice
3-5	Moderate Level	Harmful Behavior – Feedback & counseling. Possible referral for specialized assessment
6-8	Substantial Level	Intensive assessment and referral

Use a Stepwise Approach



The Brief Intervention

Brief Intervention

If Screen is positive for either/both:

- Provide a Brief Intervention (and Referral if warranted)

Brief Interventions

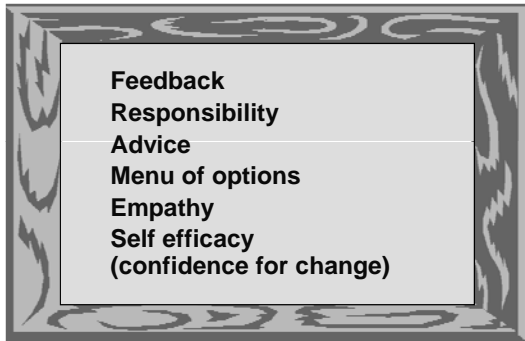
- Brief interventions (BIs) are 2 to 10-minute dialogues between the medical provider and the patient that provide feedback, education, and guidance regarding the drug and/or alcohol use of the patient.

Motivational Interviewing

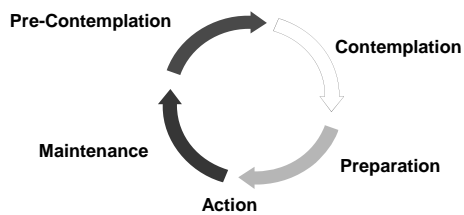
Influencing behavior change involves:

- Identifying the level of readiness for change
- Gathering information in a non-judgmental way (conversational tone)
- Negotiating an action plan with the patient, using the information the patient has provided as well as objective information, to move the patient to the next level of readiness to change.

The FRAMES Model



Brief Interventions: Key Concepts Stages of Change Model



Prochaska & DiClemente, 1986

Stages of Change Model

Stage	Definition	Brief Intervention Elements
PRECONTEMPLATION	<ul style="list-style-type: none"> • Patient is not considering change in the near future • May or may not know the potential health consequences of continued use at this level 	<ul style="list-style-type: none"> • <u>Feedback</u> about the results of the screening • <u>Information</u> about the hazards of substance use/abuse
CONTEMPLATION	<ul style="list-style-type: none"> • Patient may be aware of alcohol-related consequences but is ambivalent about changing 	<ul style="list-style-type: none"> • <u>Emphasize</u> the benefits of changing • Give <u>Information</u> about substance use problems, the risks of delaying change and discuss how to choose a <u>Goal</u>
PREPARATION	<ul style="list-style-type: none"> • Patient has already decided to change and plans to take action 	<ul style="list-style-type: none"> • Discuss how to choose a <u>Goal</u> • Give <u>Advice</u> and <u>Encouragement</u>
ACTION	<ul style="list-style-type: none"> • Patient has begun to cut down or stop use • Change has not become a permanent feature 	<ul style="list-style-type: none"> • Review <u>Advice</u> and give <u>Encouragement</u>
MAINTENANCE	<ul style="list-style-type: none"> • Patient has achieved moderate drinking or abstinence on a relatively permanent basis 	<ul style="list-style-type: none"> • Give <u>Encouragement</u>

Putting it all Together:

Negotiating Behavioral Change

Through Motivational Interviewing, utilize the FRAMES and Stages of Change models to guide the patient through the process of developing a plan of behavioral change.

- Gather information in a non-judgmental way
- Identify the level of readiness for change
- Practice reflective listening to elicit discussion about risky behavior and ambivalence to change

Putting it all Together:

Negotiating Behavioral Change

- Elicit ideas of what patient could do differently to reduce his/her use (goal-setting)
- Provide a menu of options to the patient
- Negotiate an action plan with the patient, using the information the patient has provided as well as objective information, to move the patient to the next level of readiness to change
- Foster hope and optimism that the patient's motivation and plan are appropriate steps to changing behavior
- Formally note what he/she agrees to do differently so that you can follow-up specifically on the goals and provide a copy to the patient.

Outpatient Pharmacotherapy for ETOH dependence

- Three agents approved by FDA for adjunctive therapy for the treatment of alcohol dependence (other agents exist)
 - **Naltrexone**
 - Pure opioid receptor antagonist
 - Blunts pleasurable effects of alcohol and reduces cravings
 - Reduces relapse and number of drinking days
 - Will cause opiate withdrawal – careful in pts taking opiates. Pts should notify ED of having drug on board incase pain management is necessary

Outpatient Pharmacotherapy for ETOH dependence

- **Acamprosate (Campral)**
 - Structural analog of GABA
 - Decreases excitatory glutamergic neurotransmission during withdrawal
 - 666 mg TID. May need to adjust if pt has diarrhea
- **Disulfiram (Antabuse)**
 - Deterrent- causes flushing, nausea, vomiting, tachycardia, dyspnea, HA, blurred vision, vertigo and anxiety 15-30 minutes after ingestion of ETOH

Alcohol Withdrawal Syndromes

- **Pathophysiology**
 - Abrupt withdrawal from ETOH unmasks compensatory overactivity of certain parts of the nervous system. Altered levels of GABA, Norepinephrine and Serotonin have been noted.
- **Minor Withdrawal Symptoms**
 - Due to CNS and sympathetic hyperactivity
 - Insomnia, tremulousness, anxiety, GI upset, HA, diaphoresis, palpitations, or anorexia
 - Usually present within 6 hrs of drinking cessation
 - Resolve within 24-48 hours and are consistent from one episode to the next

Alcohol Withdrawal Syndromes

- **Withdrawal Seizures**
 - Usually tonic-clinic convulsions within 48 hours of last drink
 - 3% of chronic alcoholics has withdrawal seizures of which 3% develop status epilepticus
 - Usually a single episode. Recurrent or prolonged seizures require investigation of another source

Alcohol Withdrawal Syndromes

- **Alcoholic Hallucinations**
 - Often mistaken for delirium tremens (DTs)
 - Hallucinations that develop 12-24 hrs from abstinence and resolve within 24-48 hrs (which is when DTs typically begin)
 - Usually visual but can be auditory and tactile
 - Usually associated with specific hallucinations and not global clouding of the sensorium (as with DTs)

Alcohol Withdrawal Syndromes

- **Delirium Tremens**
 - Occurs in 5% of pts experiencing withdrawal
 - Syndrome characterized by hallucinations, disorientation, tachycardia, HTN, low grade fever, agitation, and diaphoresis.
 - Typically begin between 48 & 72 hrs and last one to five days
 - Mortality rate of 5% (death usually from arrhythmias or complicating illnesses such as pneumonia)

Alcohol Withdrawal Syndromes

■ Treatment

- Exclude co-morbid conditions such as infection, trauma, metabolic derangements, drug OD, hepatic failure, GI Bleed
- Consider mechanical restraint for DTs to protect pt and providers
- Isotonic fluid replacement
- Thiamine 100 mg IV or IM prior to any glucose containing solutions decrease risk of precipitating Wernicke's or Korsakoff's
- MVIs with folate
- Repletion of K, Mg, glucose & phosphate
- ICU for pt at risk for complications

Alcohol Withdrawal Syndromes

■ Treatment

- **Benzodiazepines**- used to treat psychomotor agitation and prevent progression from minor to major withdrawal
 - **Chlordiazepoxide (Librium)** – Long half life
 - Pts with hx of DTs or prolonged heavy ETOH consumption
 - 50-100 mg PO Q 6hrs x 1 day
 - 25-50 mg PO Q 6 hrs x 2 days
 - May need to have increased frequency initially until Withdrawal Assessment scale < 8
 - Lower risk pts
 - 25-50 mg PO Q 6 hrs
 - May need to have increased frequency initially until Withdrawal Assessment scale < 8
 - **Diazepam (Valium)** – Typically IV use to halt DTs
 - 5-10 mg IV every 5 min until a calm but alert state is achieved.

Alcohol Withdrawal Syndromes

■ Treatment

- For refractory DTs consider Phenobarbital or propofol these agents require mechanical ventilation and ICU admission)
- Avoid phenothiazines and butyrophenones (including HALDOL)- these agents lower seizure threshold
- Anticonvulsants- controversial if effective. Most seizures are self limited and do not require medication. Consider phenytoin. Avoid carbamazepine

Marijuana

Marijuana

- Marijuana is the most commonly abused illicit drug in the United States
- Long-term marijuana abuse can lead to addiction;
 - compulsive drug seeking and abuse despite its known harmful effects upon social functioning in the context of family, school, work, and recreational activities.
 - Long-term marijuana abusers trying to quit report irritability, sleeplessness, decreased appetite, anxiety, and drug craving, all of which make it difficult to quit. These withdrawal symptoms begin within about 1 day following abstinence, peak at 2-3 days, and subside within 1 or 2 weeks following drug cessation. Still difficult to treat even after acute withdrawal syndrome has subsided.
- Effect on Mental Health:
 - Causes increased rates of anxiety, depress, SI, and schizophrenia. (unknown if MJ causes the mental problems, exacerbates them or is used in an attempt to self medicate)

National Institute on Drug Abuse (NIDA) Website: <http://www.nida.nih.gov/infofacts/costs.html>

Opiates

Why are opioid medications used to treat opioid addictions?

- Common myth is that all medications used to treat addictions are simply “substituting one addiction for another”
- Research has found that addiction to opioids results in significant changes in brain chemistry and function.
- Some of these changes may be permanent, meaning some individuals may require an opiate to bind to their changed receptors in order to function normally.
- Medication therapy significantly helps individuals stay in treatment more consistently, stay healthier, stay out of legal trouble, and generally function well in society.

What is buprenorphine?

- Buprenorphine is a partial agonist of the mu opioid receptor
 - Binds to and activates the receptor
 - Partial agonists have a “ceiling effect:” that is, larger doses do not produce greater highs. Therefore, it has a very low risk of abuse and overdose.

How does being a partial agonist safeguard against abuse?

- The tablet used (Suboxone) is buprenorphine mixed with the antagonist naloxone. It must be taken correctly (dissolved under the tongue) to work correctly.
 - If this tablet is injected, the naloxone will bind to the receptors and put the person into rapid withdrawal.
 - If it is swallowed without dissolving, there is no effect.

How does being a partial agonist safeguard against abuse? (cont)

- When taken correctly, Suboxone will act as an agonist and reduce craving and withdrawal symptoms. Once the “ceiling effect” is achieved, other opioids such as heroin, are not able to bind to the receptors and therefore will produce no effects.
- If buprenorphine is administered while a person is actively using other opiates, it may act as an antagonist and put the person into immediate withdrawal.

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- “Creating Opportunities for Reducing Alcohol Related Harm in the Veteran Community; Session 6: Brief Intervention.” Version 2.3. Department of Veterans’ Affairs, Australia. December 2002
www.dva.gov.au/health/younger/mhealth/alcohol/training/session6.htm
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- Gentilello et al. “Alcohol Interventions in a Trauma Center as a Means of Reducing Risk of Injury Recurrence”. *Annals Surgery* 1999;230:473-483

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www.oas.samhsa.gov/nsduh/2k6nsduh/2k6Results.cfm#Ch1
- National Institute on Drug Abuse (NIDA) Website;
<http://www.nida.nih.gov/infofacts/costs.html>

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Substance Abuse: Part II

Controlled Substances Contracts: Optimizing Structure & Application

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Objectives

- Discuss current role of the controlled substances contract
- Discuss limitations, overall effectiveness, and ethical concerns
- Discuss ideal elements and key features of such contracts
- Provide resources

Contract Definitions

“an explicit bilateral commitment to a well-defined course of action”

- Physician-patient contract basic assumptions:
 1. The terms and consequences of breaching the contract are explicitly stated.
 2. The doctor and patient have unique responsibilities.
 3. The doctor/patient relationship is consensual, not obligatory.
 4. Both physician and patient are willing and able to negotiate.

Fishman, et al. 1999

What We Know

- Despite their widespread use, efficacy of controlled substances contracts has not been proven.
- Great majority of contracts have minimal content regarding the specific responsibilities of the treating physicians.
- Unclear whether the contracts reflect adequate consent for treatment.
- Unclear whether the contracts are negotiated or that the patient has any role in negotiating the terms.

Fishman, et al. 1999

What We Know

- “Contingency Contracts” have become common for several reasons:
 - Minority of pts placed on opiates also abuse illicit drugs
 - Physicians lack tools to sufficiently identify pts who might use illicit substances
 - Abuse and diversion of prescription medications (Oxycontin) have received increased publicity
 - DEA emphasis on physician responsibility to screen for abuse
 - Legal actions

Fishman, et al. 1999

Common Justifications for Using CS Contracts

- Adherence
- Informed Consent
- Legal Risk Management

Arnold, et al. 2005

Common Justifications for Using CS Contracts

- Adherence
 - Self administration of medication in prescribed amounts in prescribed intervals.
 - Obtaining the medication from single prescriber and permission to use other medications that are abuseable unless approved by this prescriber.

Arnold, et al. 2005

Common Justifications for Using CS Contracts

- Adherence
 - No evidence to date that suggest that contingency CS contracts promote adherence.

Arnold, et al. 2005

Common Justifications for Using CS Contracts

- **Informed Consent**
 - **Most of the time, legal goals are met:**
 - Review of goals and adverse effects of opiate [controlled substance] therapy
 - Review of medically acceptable alternatives
 - Conditions of continuation of therapy
 - Respective responsibilities of **both** parties during the therapy (i.e. consequences of contract breach).

Arnold, et al. 2005

Common Justifications for Using CS Contracts

- **Informed Consent**
 - **Ethical goals that should be met but are not or cannot include:**
 - “...maximization of the patients’ capacity to exercise their autonomy to protect their well-being as they themselves define it.”
 - physicians paternalistically presume to represent their patients’ own good.
 - can infringe on patients’ viewpoint of concern for freedom, ease of obtaining meds and adequate pain control and ultimate diminish autonomy

Arnold, et al. 2005

Common Justifications for Using CS Contracts

- **Legal Risk Management**
 - **Arguments for:**
 - Contracts protect physicians from legal liability in the event of adverse consequences. (Licensing board reports that mention lack of contract = lack of monitoring compliance with controlled substances)
 - Contracts might diminish chances of patients initiating tort actions.

Arnold, et al. 2005

Common Justifications for Using CS Contracts

■ Legal Risk Management

– Debate:

- Unclear whether contracts are necessary or effective in thwarting liability.
- Shouldn't contracts be used for ALL potentially harmful drug interventions (chemo, antiarrhythmics)?
- Contracts might actually subject physicians to higher risk for tort actions.
 - Physician not strictly adherent to contract
 - Physician using contracts for some & not all patients.

Arnold, et al. 2005

So, should physicians use controlled substances contracts?

Probably

Maybe

Yes, BUT....

Use a cautious approach.

Considerations

- Remember, CS contracts can potentially:
 - lead to undertreatment of the condition (i.e. pain)
 - Stigmatize the treatment and the patients who receive it
 - Intimidate patients and create a lack of trust feeling
 - Paternalistic contracts can be demeaning and punitive and threaten the patient/doctor relationship
 - Violate patients rights to fair and equal treatment (ethnic, SA history, etc...)

Arnold, et al. 2005

Considerations

- When choosing to use CS contracts:
 - Consider utilizing contract for ALL patients being prescribed CS
 - Educate staff on how to use contracts when communicating with patients
 - Practice how to appropriately communicate justification for contract
 - Use appropriate language

Features of the Model CS Contract

- Emphasize that the medication is part of a comprehensive treatment plan
- Stress the physician's responsibility to work with the patient to improve symptoms
- State that the purpose of the contract is to promote communication, clarify frequent issues that may arise in treatment and prevent misunderstanding

Features of the Model CS Contract

- Specify behaviors that the literature suggests are red flags for opiate abuse (e.g. losing meds, getting meds from other providers).
- Describe physician behaviors that may occur if the patient engages in red-flag behaviors.
- Statements should have a neutral, nonconfrontational, and cooperative tone.

Resources

- Sample contract
 - American Academy of Pain Medicine
www.painmed.org/pdf/controlled_substances_sample_agrmt.pdf
- http://www.painmed.org/clinical_info/

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