Treating the Chemically Dependent Patient: Managing the Seemingly Unmanageable

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THE INHERENT CHALLENGES

1) You can't be an addict without being dishonest
2) The physician is being paid to not trust
3) Pain and suffering are necessary ingredients for most addicts' recovery
4) The slippery slope between helping and "enabling"
5) Addiction is generic and not just to preferred substances
IMPORTANT QUESTIONS TO ASK

1) How many times a year do you get drunk?
2) Have you or anyone in your family ever been arrested? i.e. DUI, Drunk in Public, etc.
3) Anybody in your family have a psychiatric illness and/or drug and alcohol problem?
4) How often do you drink or drug?
5) Have you ever had a seizure?
6) Have you ever had a consequence from your drinking or drugging?
7) Do you have a preferred drink?

Having Favorite Alcohol Brand May Identify Binge Drinkers

• 2/3 of 2069 respondents aged 16-20 reported they had tried alcohol in the previous 30 days
• 21% reported binge drinking in the previous 30 days
• Overall binge drinking 25% girls and 39% boys
• Preferences Girls: Smirnoff and Boys: Budweiser
• Those who choose Coors were particularly at high risk for binge drinking
• Those who had favorite brands were at higher risk of binge drinking

From the Annual Meeting of The Pediatric Academic Societies 2010
High Risk Diagnostic Group: Returning Veterans

- Often have co-occurring triad of PTSD, TBI and Pain
- From 1980-2005, heavy drinking in the military ranged from 15-20%
- Of 88,205 soldiers deployed to Iraq, 12-15% screened positive for alcohol problems
- Rates of binge drinking 53%, a sample of recently deployed personnel with combat exposure
- Recently deployed soldiers (N = 1120) 25% screened positive for alcohol misuse, 12% of alcohol related problems
- Survey of active duty (N = 25,546) 11% reported misuse of prescription medications in 2008

The Aftermath of War in Psychiatric Times, July 2011

Opioid Use, Abuse, Overdose

- According to FDA in 2009, 23 million prescriptions for extended release and long acting opioids and 257 million for all opioids were written
- 124% increase in unintentional opioid overdose in the USA in recent years
- Deaths from unintentional opioid overdose quadrupled from 1999 to 2007 (3,000 to 12,000)
- There was 5x increase in drug treatment admissions for pharmaceutical opioids in the past 10 years (19,941 to 121,091)
- Main prescribers of opioids were Family Medicine Physicians (29%), Internists (15%), Dentists (8%), Orthopedic surgeons (8%)

Overdose risk grows with Higher Opioid Doses, Clinical Psychiatric News, June 2011
Benzodiazepines

- Increase in substance abuse treatment admissions for benzodiazepines rose from 22,400 in 1998 to 60,200 in 2008
- 95% benzo related admissions included an abuse of another substance as well
- 82% of hospital admissions related to benzo abuse involved a primary substance other than benzos
- SAMHSA recommends prescribing physicians screen for alcohol and other drugs of abuse when prescribing benzos

Prescription Abuse & Internet Linked

- For every 10% increase in high speed internet use in the US, admissions to treatment facilities for drug abuse rose 1%
- Admissions for drugs that are not available online (alcohol and cocaine) either decreased or showed minimal growth
- In 2000-2007 high speed internet access grew from 1816 lines per 100,000 people to 24,674 lines per 100,000 people
- During the same period treatment admissions grew 184% for opioid abuse, 62% benzos abuse, 49% for stimulants, 16% sedative hypnotics
- During the same period alcohol and heroin abuse dropped 8% and 9% respectively
HOW TO MONITOR

1) PMP on all patients you’re prescribing opiates
2) If requests for refills are early, index of suspicion should go way up
3) If requests for refills are early, index of suspicion should go way up
4) Schedule appointments before refills are needed and count pills and recheck PMP if suspicious and at random
5) Urine drug screen when suspicious and at random
6) Referral to addiction specialist when in doubt

DO NOT PRESCRIBE ADDICTIVE SUBSTANCES IF:

- Patient will not allow you to speak with significant others
- Patient will not give ROI to speak with previous or other healthcare providers
- Patient will not give a spontaneously requested drug screen
- The Urine Drug Screen is positive for alcohol, THC, or other illicit substances and/or medications which are not prescribed
- Refills are requested prematurely

Much to the rest of the group's horror, Bob had completely misunderstood the concept of Alcoholics Anonymous.
HOW TO PROVIDE PAIN MANAGEMENT IN THE ADDICTED PATIENT

1) Circumscribed number of pills and no refills
2) Significant other to hold and dole out addictive meds
3) Optimally do not discharge addicted patients from Hospital before weaning them off addictive meds
4) If ongoing pain management is necessary, monitor tolerance, refer for none analgesic forms of pain relief, monitor UDS and d/c if dirty for other substances
5) Written contract with patient to not seek nor receive pain management from any other provider
6) Discuss with the addictive pain patient the difficult reality that the use of opioids will result in less than complete pain relief and increase risk for addiction exacerbation

PHARMACOLOGIC CONSIDERATIONS

1) Use phenobarbital for Alcohol detox rather than benzos (especially if patient prescribed or abusing benzos)
2) In addicts use alternatives to benzos and stimulants for anxiety and ADHD
3) If the patient has the addictive propensity, any addictive med will eventually be a problem
4) Methadone clinic for addiction (and as a unintended benefit pain relief)
OTHER NONE DEPENDOGENIC PHARMACOLOGIC POSSIBILITIES

- **ANXIETY**: Buspirone, Baclofen, Trazodone, Gabapentin, Tiagabine, Hydroxyzine, Chlorpromazine, Perphenazine, Imipramine, Atypical antipsychotics
- **SLEEP**: TCA’s, Trazodone, Mirtazapine, Ropinirole, Quetiapine, Olanzapine, Chlorpromazine
- **ADHD**: Strattera, Catapres, Intuniv, Buproprion, Vyvanse?, Modafinil?

**Final Thoughts**

“It’s some new thing called an intervention.”

It takes 2 minutes to write a prescription for a benzodiazepine but a half hour to say “No”