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Editor-in-Chief

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IN THIS ISSUE

Focus of the Month:
Risk Management

Learning objectives for this issue:
1. Understand some of the ways to help manage the risk of patients abusing prescription medications.
2. Describe seven factors to help assess a patient's risk of suicide.
3. Summarize some of the ways clinicians can minimize the risks to patients and their own liability when it comes to that care.
4. Understand some of the current findings in the literature regarding psychiatric treatment.

Seven Clinical Pearls for Suicide Risk Assessment

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Dr. Lineberry has disclosed that he has no relevant relationships or financial interests in any commercial company pertaining to this educational activity.

Assessing a patient's risk of suicide is one of the most common, yet challenging, exercises for the psychiatrist. You're probably familiar with the known risk factors. These include male sex, past suicide attempt(s), family history of suicide, and being divorced, unemployed, or older. Although these particular factors may clearly identify groups at risk, you can't do anything to change them. As such, they tend to be of minimal use when you are making decisions about how to manage suicide risk in a patient in your office.

The intent of this article is to provide some direct, usable interventions to improve your management of suicide risk. Here are seven clinical pearls based on emerging evidence that can be useful in your daily practice. To help you remember and translate them, each is linked with a theme.

1. Enter Sandman

Decades ago, sleep problems were identified as a short-term (defined as one year) risk factor for suicide (Fawcett et al, *Am J Psych* 1990:147(9):1189–

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Managing the Risk of Prescription Drug Abuse

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Dr. Woodward has disclosed that he has no relevant relationships or financial interests in any commercial company pertaining to this educational activity.

We've all been taught not to prescribe addictive drugs to patients who will abuse them, but in the real world it is not always easy to tell who those patients are or to manage the resulting problems. The stakes are high: unintentional overdoses of prescription medication account for 27,000 deaths in the United States each year, more than heroin and cocaine combined (*Morb Mort Wkly Rep* 2012;61(1):10–13). Prescription drug abuse leads to suicides, auto accidents, unemployment, violence, and drug-related crime.

In treatment, patients who abuse medication usually get worse rather than better. They may engage in demanding, manipulative, and threatening behavior or quit treatment altogether. Although benzodiazepines, stimulants, and opioids are among our most effective drugs for anxiety, ADHD, and pain, respectively, psychiatric patients are at increased risk of abuse because of comorbid substance use disorders; cognitive, affective, and behavioral instability; and difficulties managing relationships with their treaters.

Patients misuse medication for many reasons: stress, personality problems, histories of trauma and abuse, latent mood or anxiety problems, and exposure to addiction in their environments. But the strongest factors involve medication altering the brain's reward and stress response systems in individuals vulnerable to addiction (Kalivas PW and Volkow NE, *Am J Psychiatry* 2005;162:1403–1413.) Such a patient might tell you, "I know I can't use, but I think about it all the time. When I relapsed I felt guilty, and scared it would happen again. Since then the cravings have been even stronger." With this neurobiology in mind, you can approach your patients with an empathic understanding of the potential medication abuser's struggles.

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1194). Recent research in multiple clinical populations also emphasizes the importance of managing sleep disorders to reduce suicide risk (Pigeon WR et al, *Am Journal Pub Health* 2012;102(S1):S93–S97; Ribeiro JD et al, *J Affective Disord* 2012;136(3):743–750; Bjørngaard JH et al, *Sleep* 2011;34(9):1155–1159). Importantly, sleep problems were identified as a risk factor even *after* controlling for other variables including depression, gender, hopelessness, and alcohol problems.

It's unclear whether there is a specific sleep problem associated with suicide/suicide attempts. In practice, however, global sleep problems can be identified and treated. Fortunately, patients generally feel no difficulty or stigma describing their problems with sleep. This may be critically important in young men who may be less willing, or able, to describe depressive and anxiety symptoms or thoughts of suicide. A focus on sleep assessment and treatment can also be a point of entry for fleshing out other syndromes.

2. High Anxiety

Agitation and anxiety are critical risk factors in suicidal ideation and suicide attempts that must be addressed. Recent population-level research (Nock MK et al, *PLoS Med* 2009;6(8):e1000123) indicates that anxiety or agitation can mediate the change from *thinking* about suicide to *acting* on those thoughts. Anxiety disorders are also strongly associated with suicide (Nock MK et al, *Mol Psychiatry* 2010;15(8):868–876). And in a study of 76 patients who committed suicide while hospitalized or shortly after discharge, 79% reported "severe or extreme" anxiety or agitation, while only 22% endorsed suicidal ideation when last asked about this (Busch KA et al, *J Clin Psych* 2003;64(1):14–19).

Anxiety and agitation have purposely been placed together. Such symptoms may not be obvious on exam. It is not unusual, for instance, for a patient who does not appear anxious to endorse profound internal anxiety/agitation. Also, there are no scales to define the particular state of internal restlessness/anxiety/agitation that individuals commonly report. However, from a suicide risk assessment perspective, it's important for you to follow this symptom over time in your patients through careful clinical interview.

Asking questions such as, "Do you feel like you're crawling out of your skin?" and "Do you feel like you are going to explode?" may be helpful in identifying, and naming for patients, a key symptom in suicidal states. Distinct from akathisia, this agitation (sometimes described as psychache or anguish) drives a need to take action to resolve the internal state. Similar to akathisia, there may be motoric symptoms that can be observed on exam; however, this is not always the case. Prompt treatment of anxiety or agitation with benzodiazepines or antipsychotics can be potentially life-saving in a crisis. Consider increasing your patient's observation level on inpatient units until the symptom is well controlled.

3. Danger, Will Robinson

Though the actual risk associated with antidepressants in suicide has probably been overstated and misapplied, it is now a part of the patient's and physician's canon. After almost a decade of research, the following key principles are most relevant. First, adolescents and young adults are the group at greatest risk for suicidal ideation and are the basis for the FDA's revised black-box warning (see table), issued in 2009. For those 25 or over, the risk is the same with antidepressants versus placebo. For older adults, treatment with antidepressants appears to decrease suicidality. Nonetheless, regardless of age, it is important to keep in mind periods when risk might be greater. These include the initiation of antidepressants, the period after changes in dose (both increases and decreases), and after antidepressant discontinuation. With this in mind, tailor your informed consent with patients to address these particular points in time/risk.

Antidepressant-Related Suicidal Ideation Risk by Age

Age Range	Drug-related change in suicidal ideation or behavior per 1,000 patients treated
<18	14 more cases
18-24	5 more cases
25-64	1 fewer case
>65	6 fewer cases

4. The Safety Dance

A suicide attempt with a firearm is 90% fatal, while other methods are far less lethal. Although guns are a hot-button issue politically, there is little controversy related to their role in suicide in those with psychiatric illness. According to some research, more than half of completed suicides are by gun (Miller M and Hemenway D, *N Engl J Med* 2008; 359:989–991). In fact, more gun deaths are the result of suicide (close to 19,000 in 2009) than homicide (about 11,500 in the same time period).

Clinically, there are very clear reasons for asking about access to firearms in

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patients who are depressed, misusing substances, suicidal, or a combination of these. The APA guidelines and expert guidance are very black and white about the need for identification of access to firearms and their subsequent removal (Simon RI, *Suicide Life Threat Behav* 2007;37(5):518–526). Practical matters, however, often introduce many gray areas. It's important, therefore, to look for opportunities to build a shared understanding with your patients, and their families, of reducing firearm access, should that be necessary.

One way to do this is to systematically ask about access at the time of a patient's initial assessment and options for safe storage or removal of firearms. Another is to use a pragmatic intervention such as a "means restriction receipt," a signed receipt by the patient stating they have removed potential means for suicide (Bryan CJ, *Profes Psychology: Res Pract* 2011;42(5):339–346). This has been very effective in promoting dialogue and action in patients, and could be used not just for firearms but for supplies of medications or other potential suicide methods.

5. Replace It With a Dimmer Switch

Often, clinicians and families think of suicide risk as a binary issue: you're either suicidal or you're not. To change this conceptualization, try to think of suicide risk as a light with a dimmer switch. Psychosocial triggers, physical pain, decreased sleep, intoxication, or worsening illness—which effectively "turn up the light"—may increase suicide risk and affect one's behavior, while elimination of these triggers decreases risk.

6. Everybody Needs a Plan

Contracting for safety has no evidence base, and asking a patient to sign a document stating that they will not harm themselves is problematic on multiple levels. They may feel that they can't talk about being suicidal. They may also ignore their contract when they have actual suicidal intent. Finally, a contract may give the clinical team a false sense of security. However, developing a plan for what to do when patients are suicidal can be helpful.

Safety Planning Intervention (SPI) is a brief intervention to mitigate suicide risk that can be utilized by clinicians or support staff (Stanley B and Brown EJ, *Cog Behav Prac* 2012;19(2):256–264). Though its efficacy has not been confirmed and clinical trials are ongoing, it is a Suicide Prevention Resource Center/American Foundation for Suicide Prevention best practice. SPI involves patients writing down the signs that they are suicidal, and prioritizing and defining the psychosocial factors they can access to help decrease that risk. It helps patients to define their own internal coping strategies, to identify their social supports and how to contact them, and to determine how to make their environment safer. SPI is widely used in the Veterans Administration and has been extremely well received.

7. It's a Wrap

Assessment and management of suicide risk obviously demands careful documentation of your assessment and thought process in the medical record. To improve your documentation of suicide risk assessment, consider the dimmer switch example and the fact that people move in and out of suicidal crises. Document when a suicidal crisis has resolved, but also be sure to describe that a chronic risk may remain which can be reactivated/precipitated in the future. Intervene with medication, psychotherapy or other risk-reduction strategies during crises to resolve them, and describe your approach to reducing risk and managing current and future crises.

TCPR'S VERDICT

Though suicide can't always be prevented, a careful and pragmatic suicide risk assessment can focus on interventions to decrease suicide risk and improve symptom response. By focusing on sleep, anxiety/agitation, risk reduction strategies, and developing a plan for treatment, you can potentially make a difference in people's lives and resolve a suicidal crisis.

Managing the Risk of Prescription Drug Abuse

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Evaluating the Risk of Medication Abuse

The first step is to get your patient's family and personal histories of alcohol, illicit drug, and medication abuse. You can start with a screening tool such as the Two-Item Conjoint Screen (available at bit.ly/JpYUTU); the Relax, Alone, Friends, Family, Trouble questions (bit.ly/Ig7CaZ); or the Opioid Risk Tool (bit.ly/fo5Cns) to help identify problematic use. Risk factors in addition to substance abuse include age between 15 and 45, peers who abuse substances, and a preadolescent history of sexual abuse (Webster LR and Webster RM, *Pain Med* 2005;6(6):432–42.)

If you suspect a problem, ask open-ended, nonjudgmental questions to flesh out the substance use history, looking especially at the patient's efforts to maintain control of drug use: loss of control may be a red flag. Consider interviewing a family member, too. If your state has a prescription monitoring program, you can check online for prescriptions your patient may be filling from other prescribers.

With a picture of your patient's abuse risk, you are ready to weigh the pros and cons of medication. Is your patient on a complex regimen? Is he or she dependent on or possibly already abusing a drug given for a supposedly therapeutic purpose? Are there nonaddictive or nonpharmacologic alternatives? Have you overlooked any psychological, social, or medical problems that might need treatment? A patient whose ADHD you medicate with a stimulant, for example, might misuse the drug to self-treat mood instability that slipped under your radar. Is your patient willing to cooperate with steps to reduce the risk of abuse?

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Q&A With the Expert

This Month's Expert

How to Reduce Risk for You and Your Patients

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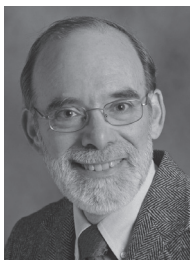

Dr. Appelbaum has disclosed that he has no relevant relationships or financial interests in any commercial companies related to this educational activity.

TCPR: When minimizing risks for patients, one concern psychiatrists regularly face is the potential side effects of medications, such as metabolic changes or weight gain that could lead to increased mortality or cardiovascular risk. What precautions should we take as prescribers to minimize the risk to patients and also our own liability?

Dr. Appelbaum: There are three key matters psychiatrists need to attend to when prescribing medications that have some risk of adverse consequences for their patients. You need to develop a rationale and document it, get the patient's informed consent, and monitor the patient and intervene appropriately.

TCPR: Can you elaborate on these three steps?

Dr. Appelbaum: The first is to develop and document a clear rationale for why you want to use a medication or combination of medications given the risks that it may present. Think through the risks, identify the potential benefits, and demonstrate why the benefits outweigh the risks. Then record that in the medical record so your reasoning process is clear to anyone who may review it in the future. Step two is engaging the patient in an informed discussion about your recommendation and the alternative options for treatment. Many physicians think informed consent just means getting the patient to sign a consent form—that is not what I am suggesting at all. I suggest a clear discussion between doctor and patient outlining the reasons for your recommendation. Discuss the likely benefits and then review the risks with the patient—whether they are metabolic syndrome, tardive dyskinesia, serotonin syndrome, or suicidality. Ultimately, it is the patient's and not the physician's choice what treatment the patient accepts. Third, after prescribing these medications with a patient's consent, the physician has an obligation to monitor the patient closely enough to ascertain whether problematic side effects are occurring, and if they are, to step in. That could mean lowering the dosage, stopping the medication, or continuing for another week to see if the problematic side effects begin to fade.

TCPR: To what extent should we involve other professionals in the patient's care? For instance, if you are concerned about metabolic side effects should you share that with the patient's primary care doctor who is managing the patient's blood pressure and cholesterol?

Dr. Appelbaum: My bias is that more coordination is always preferable to less. It helps when a psychiatrist can touch base with the patient's primary care clinician, cardiologist, or endocrinologist about such issues and document that interaction in the patient's record. It shows that the psychiatrist is concerned and has acted appropriately to alert other caregivers to the potential issue.

TCPR: Is it appropriate for a psychiatrist to manage side effects of a medication by giving additional medications that he or she might not be familiar with? Could that be construed as malpractice?

Dr. Appelbaum: Psychiatrists are physicians and all physicians can prescribe appropriate medications within the scope of their licensure. But a psychiatrist should clearly not go beyond his or her comfort zone. So if you are familiar with the treatment of metabolic syndrome, for example, and feel comfortable, there is certainly no reason not to undertake that treatment. If you lack that knowledge and aren't comfortable, it is important to listen to your inner voice and to refer these patients to someone who can monitor them and make appropriate treatment recommendations.

TCPR: What are your thoughts about the quality of informed consent as it is conducted in a typical treatment setting?

Dr. Appelbaum: Most evidence suggests that across the medical field—by no means just in psychiatry—informed consent is done rather poorly these days. Many physicians ignore the consent transaction entirely and simply say to their patient, "Well, this is a prescription that I am writing for you because I think this will help." They don't explore the rationale, the risks, the likely benefits, and the alternatives, which is what is required by the law of informed consent. In many settings, consent has become a formalistic, form-oriented process where clinics or hospital-based facilities prepare standard forms for classes of medications and give them to patients in place of having a discussion. These forms are often written in complex language that is well beyond the ability of most patients to understand. As a consequence, consent becomes a mere formality as opposed to an opportunity to teach patients about their medications and help them make informed choices.

TCPR: The flip side of that argument is that the more we explain in the patient's own language the potential risks of drugs, the less likely they may agree to treatment, and their psychiatric illness may go untreated.

Dr. Appelbaum: That is a common assumption. However, we have no data indicating that well-informed patients are less likely to accept treatment. Indeed, there are reasons to suspect that it might not be true—that patients who believe their physicians are being completely open with them might in the end be more trusting of their physicians' recommendations. The point of informed consent, both as a legal doctrine and as an ethical principle, is precisely to allow the patient to make the choice.

TCPR: We are all very familiar with the numerous class action lawsuits brought mostly against drug companies for medications that may increase suicidality or cause tardive dyskinesia. What liability might an individual doctor have?

Dr. Appelbaum: The drug companies themselves are attractive targets. But as physicians, we all know we can be sued at some point by any of our patients. The question is: are we likely to lose such a suit? To put it in a more positive way: how can we best prepare for that possibility and defend ourselves against such claims? That is where the three steps that I described earlier can play a critical role. We have a clear rationale for why we are doing what we did, we have obtained the patient's informed consent to that particular treatment, and we have followed and monitored the patient appropriately. The courts have been very clear that physicians are not guarantors—to use the language that the courts would use—of a good outcome. Sometimes things go wrong. Physicians are responsible for doing what a reasonable physician in a similar situation would do, which is essentially the definition of the standard of care. So as long as we live up to that standard and can prove that we did, we ought not to be overly concerned about lawsuits.

> **Most evidence suggests that across the medical field informed consent is done rather poorly these days.**
>
> Paul S. Appelbaum, MD

TCPR: There have been some high profile cases recently where patients have been prescribed medications and then used them inappropriately or in combination with other medications or with alcohol or drugs, resulting in a lethal outcome. What steps should psychiatrists take in protecting themselves and their patients from this sort of abuse?

Dr. Appelbaum: We begin by acknowledging that we can't control what the patient does outside the office. A patient who is intent on engaging in risky behavior is going to do it despite our best efforts. However, a physician who has concerns about such misuse would want to discuss the risks with the patient in advance.

TCPR: One of the advantages of an electronic record system is that we have ready access to the medications a patient might be taking. However, often times it is not accurate; something hasn't been reported correctly or it hasn't been eliminated from a person's medication list. Can a doctor be held responsible for an imperfection in the electronic record?

Dr. Appelbaum: Only if that physician was responsible for causing the imperfection in the first place. So if you make an error in entering a patient's medications into the record that leads to a mistake in judgment by another physician down the road, you could potentially be held responsible for that mistake. If you are concerned about the accuracy of a record, check with the patient and make sure the list in the chart is correct. Keep in mind that many medications are prescribed for patients that they never put in their mouths. We have reason to believe that more than a sixth of patients never take the prescription that they are given, with non-adherence rates even higher for psychiatric disorders (Osterberg L and Blaschke T, *N Engl J Med* 2005;353:487–497).

TCPR: Could you talk about some of the risks of doctors using social media?

Dr. Appelbaum: When you enter into the world of social media, whether via YouTube, Twitter, Facebook, or something else, you need to keep in mind that what you post is potentially available to the world—privacy settings notwithstanding—for an indefinite period of time. Physicians would be well advised not to post anything that they do not want the world at large to see and do not want to become a part of their permanent digital footprint. You take a risk posting anything that shows a lack of professionalism in your behavior. An example is a picture of you being drunk at a party or posting derogatory information about patients or the facility where you work. You risk discouraging patients from seeking care by holding up parts of the medical care system as inadequate or simply unprofessional. If you post information about a specific patient, you also risk violating that patient's privacy rights in a way that is both legally and ethically objectionable.

TCPR: What about using the Internet to find potentially valuable information about a patient that might be very pertinent to his or her care? Is that taboo?

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Managing the Risk of Prescription Drug Abuse

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At this stage, you will be wise not to give too much credence to a patient's denial of risk or promises to be careful, even if your patient is otherwise trustworthy. Similarly, don't rely solely on your alliance with the patient: addictive cravings can and often do overcome such therapeutic values as trust and openness.

Prescribing Precautions

If you decide to start your patient on a medication carrying abuse risk, you will want to tailor an individualized set of precautions and monitoring procedures. Begin with the treatment setting: do you have the resources to meet this patient's needs for visit frequency, medical monitoring, substance abuse counseling, or urine testing? Some patients you will be able to treat yourself, but others might need substance abuse programs or detoxification facilities. Spell out with your patient the specific symptoms, behaviors, and functional abilities the drug is expected to improve. Include nonmedication plans such as psychotherapy, support groups, and exercise whenever possible. Plan how you will monitor treatment response; this might include rating scales and reports from the family. Be sure the patient understands your policies for follow-up visits, refills, and the consequences of aberrant medication behavior, which may include referral for more intensive care.

There is some evidence that slow-onset, longer-acting preparations such as clonazepam (Klonopin) are less likely to be abused (O'Brien CP, *J Clin Psychiatry* 2005;66[suppl 2]:28–33), and stimulants are available in abuse-deterrent formulations, for example methylphenidate extended release (Concerta) and transdermal (Daytrana).

Since a patient who loses control of medication may take a large amount in a short period of time, you may decide

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Research Updates IN PSYCHIATRY

Section Editor, Glen Spielmans, PhD

Glen Spielmans, PhD, has disclosed that he has no relevant financial or other interests in any commercial companies pertaining to this educational activity.

PATIENT PREFERENCE

Patient Preference Not a Good Predictor of Treatment Response

Do patients with major depressive disorder (MDD) respond better when psychiatrists offer the type of treatment—medication or psychotherapy—that the patient prefers? And do patients' beliefs about what *causes* their depression influence treatment outcomes? In a new study, researchers concluded that, despite their expectations, neither factor is a good predictor of treatment response.

Researchers looked at 80 patients who participated in a 12-week randomized, double-blind clinical trial of MDD. They assessed the patients' treatment preference, the strength of that preference, and their beliefs about the causes of their depression before the subjects entered into the clinical trial. The majority (45 patients) expressed a preference for one of the two types of treatment, but all were randomly assigned to receive either 16 sessions of cognitive behavioral therapy (CBT) or a daily dose of the antidepressant escitalopram (Lexapro).

The researchers measured response by three commonly used rating scales. Contrary to the researchers' hypothesis, neither patients' preferences, nor the *strength* of that preference, influenced remission rates at the end of the 16-week trial. Futhermore, patients who did not receive their preferred treatment were no more likely to drop out of the trial than others.

The researchers also expected to find that remission rates would be greater when patients believed the cause of their depression matched the underlying mechanism of their assigned treatment. For instance, patients who believe that depression is a biochemical disorder might respond better to an antidepressant medication. However, there was no correlation between individual beliefs about the origin of their depression and remission based on treatment type.

One limitation of the study was a moderate sample size. Another was the fact that researchers did not ask about negative attitudes towards treatment, only "preferences." It's quite possible that critical attitudes toward medication-based approaches, or particularly bad experiences with therapy or medications in the past, might result in poorer outcomes. However, even if such strong beliefs existed, most (81%) patients remained in the trial for the full 16 weeks (Dunlop B et al, *J Psychiat Res* 2012;46(3):375–381).

TCPR's Take: Past studies have produced mixed results when it comes to the question of whether patients do better when offered the treatment option they prefer (see Swift JK et al, *J Clin Psychol* 2009;65(4):368–381). One study (Mergl R et al, *Psychother Psychosom* 2011;80(1):39–47) covered in the February 2011 issue of *TCPR,* compared SSRI versus group therapy for patients with minor depression, and found that no one who expressed a preference for sertraline (Zoloft) remitted with psychotherapy. Several other studies have found the opposite. It's possible that patient preference is actually a surrogate marker for some other predictor, like a personality factor (eg, inhibition in social settings) or past experience with either meds or therapy. A limitation in all randomized studies comparing highly different treatment methods is that patients with the strongest preferences about treatment are typically not included or simply choose not to participate.

TECHNOLOGY

Text Messaging Effective for Appointment Reminders

No one seems to be without a cell phone these days, so it only makes sense that we should start using these devices to carry out tasks that we used to do in a more "old-fashioned" way. One obvious application is to use text messages to remind patients of upcoming appointments. A recent study by a group at King's College London shows that it can be done cheaply and easily, and that it improves attendance even more than a direct telephone call.

In 2009 and 2010, a London mental health clinic sent text messages to patients seven and five (or seven and three) days prior to their scheduled appointments. The messages were brief and simple, giving the date and time of the appointment and a number to call if the patient couldn't come. To determine the effectiveness of the messages, researchers compared a roughly three-month period in 2009 and 2010 with the same period in 2008—before the clinic implemented the text message system.

Out of approximately 1,000 appointments each year, the researchers found that missed visits accounted for 36% of all scheduled appointments in 2008, but only 26% and 27% in 2009 and 2010, respectively. This translated into about a 25% decrease in no-shows after the text messages started. They also showed that the drop in missed appointments was not due to people calling back to cancel, as cancellation rates remained steady at about 13% each year; rather, attendance at appointments increased. There was no difference in whether the clinic gave notices five or three days prior to the scheduled appointment.

The program was safe and easy to implement. It was largely automated, didn't divulge any protected health information, and used technology that most patients already have access to; indeed, they carry them in their pockets every day. It also could potentially save money. No-show patients are estimated to cost the UK's National Health Service almost $1 billion annually, and the authors estimate this intervention could shave 25% off that sum (Sims et al, *Psych Services* 2012;63:161–168).

TCPR's Take: Finding novel and meaningful ways to use new technology can be simple and lead to significant changes in service delivery. Instead of using postcards or telephone calls for patient reminders, consider text messages as a cheaper, non-intrusive alternative with a proven beneficial outcome. While we haven't personally tested any patient text messaging products, a quick Google search turned up a couple of products you might want to check out: Doctor Connect (www.doctorconnect.net) and Patient Nudge (http://patientnudge.com).

CME Post-Test

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Below are the questions for this month's CME post-test. This page is intended as a study guide. Please complete the test online at www.TheCarlatReport.com. Note: Learning objectives are listed on page 1.

1. Unintentional overdoses of prescription medication account for how many estimated deaths in the United States each year (Learning Objective #1)?
   [ ] a. 12,000 [ ] b. 17,000 [ ] c. 27,000 [ ] d. 39,000

2. What age group is at greatest risk for antidepressant-related suicidal ideation, resulting in the FDA's revised black-box warning issued in 2009 for these medications (LO #2)?
   [ ] a. Less than age 18 [ ] b. Ages 18-24 [ ] c. Ages 25-64 [ ] d. Over age 65

3. While other methods are far less lethal, a suicide attempt with a firearm is fatal in what percent of cases (LO #2)?
   [ ] a. 55% [ ] b. 75% [ ] c. 90% [ ] d. 99%

4. Which of the following is NOT one of the key matters that psychiatrists need to attend to when prescribing medications that have some risk of adverse consequences for their patients, according to Dr. Paul Appelbaum (LO #3)?
   [ ] a. develop a rationale and document it [ ] b. document support from a consulting colleague
   [ ] c. get the patient's informed consent [ ] d. monitor the patient and intervene appropriately

5. A study by researchers at the Emory University School of Medicine in Atlanta came to which of the following conclusions (LO #4)?
   [ ] a. Patients' beliefs about the causes of their depression enhance the success of treatment
   [ ] b. How strongly patients preferred a particular treatment made a difference in outcomes
   [ ] c. Being mismatched to their preferred treatment method resulted in patients' early termination from the trial
   [ ] d. Being matched to their preferred treatment method did not influence patient remission rates

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Managing the Risk of Prescription Drug Abuse

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to write smaller prescriptions until you see how the patient responds. Electronic prescribing of controlled substances is available in some states and can prevent loss, alteration, and theft of prescriptions. Additional safety measures include asking a family member to dispense the medication, requiring the patient to bring in bottles for pill counts, and urine tests to be sure the patient is taking the medication you prescribe and not using other substances.

It's important to know the medication your patient receives from other prescribers. If any of these seem inappropriate, be sure to get the other providers' input and make sure they are aware of the possibility the patient is abusing the drug, if you suspect this. You may need to devise a solution that takes into account the overall medical and psychiatric picture. For example, a patient with a mood disorder and opioid dependence stable on buprenorphine/naloxone (Suboxone), whose addiction is activated by a prescription for oxycodone from an unwitting orthopedist, might need a family meeting, referral back to a 12-step program, and an increase in Suboxone dose in addition to cancelling the oxycodone prescription.

Monitoring Prescription Drug Use

Watch for dosage escalation, nonadherence to other treatment recommendations, deteriorating functional status, obtaining drugs from other prescribers or illegal sources, and concurrent abuse of alcohol or illicit drugs. If your patient shows such behavior, consider whether the drug you prescribed has activated addiction, or whether something else is going on. The prescribed dose may be too low; the medication may simply be ineffective; or the patient may have developed tolerance or be self-medicating an unrecognized disorder. The patient may even be giving away or selling the drug.

Your response to aberrant medication behavior will be guided by your evaluation of the underlying cause. If you are dealing with an emerging addiction, assess the severity of the problem. Motivational interviewing is a good, nonconfrontational way to do this (See *TCPR,* May 2010) and is best done when you first suspect a problem. Sometimes stopping the addictive drug is enough. Other patients will need additional measures such as relapse prevention psychotherapy, regular urine testing, 12-step groups, or substance abuse programs.

TCPR'S VERDICT Both you and your patients will be more confident with prescriptions for abusable medication if you evaluate your patients' vulnerabilities to addiction, tailor your treatment plans to manage the risk of abuse, and recognize and respond to signs of inappropriate medication use.

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Dr. Appelbaum: I think that psychiatrists and other physicians are still working out what the proper dimensions are when seeking information about their patients online. Some respected psychiatrists believe that anything that is on the Internet is public and there is no reason why they shouldn't access it. Others have concerns about intruding into patients' lives in ways that transcend what goes on in the office and perhaps strip patients of control over what they choose to tell or withhold from the psychiatrist. I think psychiatrists would do well to follow a few simple rules. First, make sure if you seek information about a patient online that it is for legitimate medical purposes as opposed to merely satisfying prurient interests. Searching for information such as real estate transactions and political contributions that have nothing to do with a patient's therapy are not warranted. On the other hand, if a patient has been in the public eye as a result of behavior that is directly relevant to the treatment, there may be a stronger rationale for seeking that information. Second, seriously consider obtaining the patient's consent prior to searching for such information because the alternative is not a very appealing one. The psychiatrist who knows things about his or her patient that the patient isn't aware that the psychiatrist knows is in an awkward position and it inevitably will put a strain on the therapeutic alliance.

TCPR: Thank you, Dr. Appelbaum.