# 7.2.25 CONTROLLED SUBSTANCE PRESCRIBING AND CLIENT CONSENT

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References:
1. Controlled Substance Act, 21 U.S.C., Chapter. 13 section 801 et seq.
2. California Health & Safety Code sections 11150-11180 and 11190-11192.
3. Los Angeles Department of Mental Health, Parameters 3.8 For Use of Psychotropic Medication in Children and Adolescents, March 15, 2023.
4. Partnership Health Plan Recommendations for Safe Use of Opioid Medications.
5. Senate Bill No. 482, Chapter 708, Controlled substances: CURES database, California Legislative Information.

Policy Owner: Behavioral Health Division, Quality Assessment and Performance Improvement (QAPI), Quality Assurance Manager

Director Signature: **Signature on File**

## I. Policy Statement

This policy contains the internal requirements, procedures, and guidelines that all psychiatric providers within the Department of Health Services, Behavioral Health Division (DHS-BHD), Mental Health Plan (MHP) must follow concerning the prescription of psychotropic controlled substances. This policy is intended to establish guidelines for managing high-risk clients and utilizes a Controlled Substance Agreement (form MHS 129), entitled “Treatment Plan for Using Controlled Substance Prescription Medicines.”

## II. Scope

This policy applies to all DHS-BHD Covered Persons including employees (full-time, part-time, extra-help), unpaid interns, paid interns, temporary agency workers,

registered volunteers, and all individual providers contractually designated as Covered Persons. Covered Persons do not include Community Based Organization (CBOs) staff.

## III. Definitions

A. Controlled Substance: Pertains to any drug or chemical substance whose use is regulated under the Federal Controlled Substances Act (CSA). All such controlled substances are classified into five (5) distinct categories or schedules (I-V), under the CSA.

B. CSU: Crisis Stabilization Unit.

C. CURES: Controlled Substance Utilization Review and Evaluation System. CURES stores Schedule II, III, and IV controlled substance prescription information that has been reported as dispensed in California. Individual client information within CURES is defined as a Patient Activity Report (PAR). CURES is maintained by the California Prescription Drug Monitoring Program (PDMP) under the authority of the State of California Department of Justice. Under California Senate Bill 482, all health care practitioners authorized to prescribe Schedule II, III, and IV controlled substances are required to utilize the CURES database in order to prescribe those substances.

D. High Risk Clients (include):

1. Individuals with prior or current substance use disorders.

2. Individuals who are taking doses of controlled substances that exceed the recommended limits.

3. Individuals who are taking multiple central nervous system depressants, such as opiates and benzodiazepines.

4. Individuals who are currently using recreational controlled substances, medical cannabis, illicit drugs, and/or alcohol.

5. Individuals with a history of requests for early refills of prescribed controlled substances, duplicate prescriptions from multiple providers, or behaviors that violate the agreement terms as specified in form MHS 129, Treatment Plan for Using Controlled Substance Prescription Medicines.

E. Pronoun Usage: Throughout this policy, the singular "they/their" is used as a gender-neutral pronoun to promote clarity, readability, and inclusivity.

F. Psychiatric Providers: Medical Doctors (MD), Doctors of Osteopathic Medicine (DO), Psychiatric Nurse Practitioners (PNP), and Physician Assistants (PA), are authorized to prescribe medication.

G. Urine Toxicology Screen: A test for the presence of controlled substances as detected by chemical traces in urine samples.

## IV. Policy

The Sonoma County DHS-BHD, MHP maintains policies to ensure that prescribing and dispensing practices are consistent within the BHD; are aligned with state and federal guidelines; and reduce and/or manage risks for inappropriate use of psychotropic medications. These policies & guidelines create a standard of practice for psychiatric providers who prescribe psychotropic medications, in the treatment of psychiatric disorders.

## V. Procedures

A. All psychiatric providers are expected to adhere to the following procedures and guidelines for prescribing controlled substances within the DHS-BHD.

**1. Evaluation and Assessment Components:**

a. Prior to initiating a prescription for a controlled substance, *a face-to-face evaluation must take place* that includes: 1) an inventory of current symptoms; 2) prior psychiatric clinical history, including any history of substance abuse or addiction; 3) medical history and history of current and past medication use; 4) a listing of allergies; and 5) a mental status exam.

i. The history must include a summary of any concurrently prescribed controlled substances, including the names of the medications, their doses, the names and locations of the prescribing providers, and the clinical purpose of each prescribed medication.

ii. The assessment should also address the risks and benefits of any proposed new controlled substance medication.

**2. CURES Registration and PARs (Patient Activity Report):**

a. All psychiatric providers employed by DHS-BHD who possess a Drug Enforcement Administration (DEA) Controlled Substance Registration Certificate must register to use CURES.
Register for CURES at: https://cures.doj.ca.gov/register/pre-registration

i. Psychiatric providers who fail to consult the CURES database are required to be referred to the appropriate state professional licensing board solely for administrative sanctions, as deemed appropriate by that board.

b. In order to obtain a client's controlled substance history, all DEA-certified psychiatric providers are required to consult the CURES database and to obtain a PAR, ***no earlier than 24 hours, or the previous business day, prior to the initial prescription*** of a Schedule II, III, or IV controlled substance. For as long as a client is prescribed a controlled substance, DEA certified psychiatric providers must consult CURES ***at least once every four months thereafter.***

   **i. Exceptions to this rule are:**

      (1) When the client is currently admitted to the DHS-BHD CSU.

      (2) Emergency situations in which any delay in the immediate administration of a controlled substance could result in imminent injury or death to the client and/or bystanders.

      (3) When it is not reasonably possible for the DEA-certified psychiatric provider to access the information in the CURES database in a timely manner; or another health care practitioner or designee authorized to access the CURES database is not available (e.g. electrical power failure, natural disaster, CURES database is non-operational and/or inaccessible to the clinician).

         (a) In such cases, the quantity of controlled substances prescribed cannot exceed a non-refillable five-day supply.

            (i) If the CURES database is not operational or inaccessible due to a technological or electrical failure, the DEA-certified psychiatric provider shall, without undue delay, seek to correct the cause of the failure that is reasonably within their control.

c. A DEA-certified psychiatric provider who does not consult the CURES database shall document the reason(s) for not consulting the database in the patient's medical record.

d. Individual prescribers are required to consult the CURES database on an as-needed basis to monitor and mitigate any real or suspected inappropriate use of controlled substances.

   **i. Examples of inappropriate use of controlled substances include:**

      (1) Early refill-requests.

      (2) Seeking duplicate prescriptions from multiple providers, including Emergency Department prescribers.

(3) Use of prescription medications by individuals other than the person for whom the medication was intended, i.e., diversion.

(4) Concurrent use of illicit recreational drugs or other controlled substances that have not been officially prescribed by any health care provider assigned to the client.

(5) Repeated requests for doses of controlled substances that exceed the recommended limits.

(6) Violations of the controlled substance agreement as specified by form MHS 129.

**3. Urine Toxicology Screen**

a. Psychiatric providers are urged to obtain a urine toxicology screen prior to the initiation of a controlled substance prescription and then on a repeat basis, as clinically indicated, to monitor and mitigate any real or suspected inappropriate use of controlled substances as outlined above in Procedures, Section 2.b, under CURES Registration and PARs.

b. Informed Consent and Treatment Agreement: Prior to prescribing controlled substances, psychiatric providers must inform the client of the purpose for the medication, possible side effects, any special precautions, and must document evidence of informed consent. Special concerns and discussions of risks and benefits should be documented in the prescriber's progress notes.

c. Psychiatric providers will present form MHS 129 for clients to review and sign. Exceptions to the use of MHS 129 involve emergency situations, when any delay in the administration of the controlled substance could result in injury or death to the client and/or bystanders.

**i. Additional exceptions to the use of form MHS 129 are as follows:**

(1) Brief courses of controlled substance use that does not exceed a ten-day duration.

(2) Controlled substance ordering and dispensing within the CSU or Main Adult Detention Facility (MADF).

(3) Prescriptions of a controlled substance that pre-date the implementation of BHD Policy MHP 18, "Controlled Substance and Prescribing Contract Policy" (Issued 11/21/2018).

(4) Use of Opiates and Other Controlled Substances for the Management of Pain:

(a) Psychiatric providers within DHS-BHD are not authorized to prescribe pain medication for chronic use. However, controlled substance pain medication prescriptions of up to a ten-day duration are permitted to ensure that the client has enough supply of a previously authorized pain management regimen to last until a next appointment with a pain management specialist and/or primary care provider. The only exception to this rule involves the ordering and administration of pain medication to clients currently treated in the CSU, which may exceed a ten-day duration. Any ordering or administration of pain medication in the CSU must be done in collaboration with the client's primary care medical provider and/or pain specialist.

B. Prescribing Guidelines

1. To ensure that prescribing standards represent the current state of best practices, DHS-BHD establishes the following prescription guidelines. Dosing limits are offered only as recommendations. Individual cases may warrant prescriptions that exceed the proposed limits.

**Dosing and Prescribing Limits:**

**a. Benzodiazepines:**

When initiating a benzodiazepine, it is important to convey to the client the expectation that the medication should not be taken on a chronic basis due to risk of tolerance and dependence. Although we recognize that some clients require benzodiazepines on a chronic basis, it is recommended that all clinicians attempt to find alternatives to the chronic use of benzodiazepines by clients, and/or to utilize the lowest effective dose. It is recommended that no more than one benzodiazepine be used at any time. If multiple benzodiazepines are prescribed, the recommended maximum dose of all benzodiazepines combined should not exceed the equivalent dose of any one benzodiazepine. Higher doses may be required for individuals being treated for benzodiazepine and/or alcohol withdrawal. It is recommended that clients taking opiate medication not be treated with benzodiazepines due to the potential for synergistic Central Nervous System suppression between these two classes of drugs. If the combination of opiates and benzodiazepines is unavoidable, careful monitoring should be conducted to ensure that the client is not overly sedated or otherwise medically compromised. The following dose range reflects data for generally healthy adults less than 65 years of age. For children and the elderly, doses may need to be adjusted.

| Benzodiazepines | | |
|---|---|---|
| **Name of Medication** | **Recommended Dose Range** | **Recommended Dose Limit** |
| **Lorazepam/Ativan** | 1-4 mg/day | 6 mg/day |
| **Diazepam/Valium** | 5-20 mg/day | 30 mg/day |
| **Clonazepam/Klonopin** | 0.5-2 mg/day | 3 mg/day |
| **Alprazolam/Xanax** | 0.5-2 mg/day | 3 mg/day |
| **Chlordiazepoxide /Librium** | 20-40 mg/day | 60 mg/day |
| **Temazepam/Restoril** | 15-30 mg/day | 30 mg/day |
| **Oxazepam/Serax** | 15-30 mg/day | 60 mg/day |

**b. Z-Drugs:**

While similar to benzodiazepines, these drugs work through alternate mechanisms and are to be prescribed exclusively for sleep. It is recommended that these drugs not be prescribed concurrently with benzodiazepines.

| Z-Drugs | | |
|---|---|---|
| **Name of Medication** | **Recommended Dose Range** | **Recommended Dose Limit** |
| **Zolpidem/Ambien** | 5-10 mg at bedtime | 10 mg at bedtime |
| **Zolpidem CR/Ambien CR** | 6.25-12.5 mg at bedtime | 12.5 mg at bedtime |
| **Zaleplon/Sonata** | 5-20 mg at bedtime | 20 mg at bedtime |
| **Eszopiclone/Lunesta** | 1-3 mg at bedtime | 3 mg at bedtime |

## c. Stimulants:

The following table is referenced from the Los Angeles County Department of Mental Health Parameters 3.8, 'For use of Psychotropic Medication in Children and Adolescents, March 15, 2023.'

| DRUG<br>(One common brand name is indicated for convenience. No preference is implied.) | DURATION OF EFFECT | DOSE (mg/d) | DOSAGE SCHEDULE | SPECIAL CONSIDERATIONS |
|---|---|---|---|---|
| SHORT ACTING | | | | |
| dextroamphetamine (Dexedrine, Dextrostat, Liquadd) | 4-5 hours | 2.5 - 40 | 1-3 x/d | Liquadd avail in liquid form |
| amphetamine salts (Adderall) * | 4-5 hours | 2.5 - 60 | 1-3 x/d | - |
| methylphenidate (Ritalin, Methylin, Metadate) | 4-5 hours | 2.5 - 60 | 1-3 x/d | Methylin avail in liquid form |
| dexmethylphenidate (Focalin) | 3-5 hours | 2.5 - 40 | 1-3 x/d | - |
| INTERMEDIATE ACTING | | | | |
| methylphenidate (Ritalin SR, Metadate ER, Methlyn ER) | 6-8 hours | 2.5 - 60 | 1-2 x/d | Must be swallowed whole |
| methylphenidate (Metadate CD) | 8-9 hours | 10 - 60 | Once daily | Sprinkle on food as long as bead swallowed whole |
| methylphenidate (Ritalin LA) - capsule | 8-10 hours | 10 - 60 | Once daily | Sprinkle on food as long as bead swallowed whole. High fat food may delay absorption |
| LONG ACTING | | | | |
| methylphenidate patch (Daytrana) | as long as patch applied + up to 3 hours | 10 - 30 | Once daily for 9 hrs | Skin irritation, remove after 9 hours |
| methylphenidate (Concerta) | 8-12 hours | 18 - 72 | Once daily | Must be swallowed whole. Inert portion of tablet may appear in stool |
| Methylphenidate (Quillivant XR) | 8-12 hours | 10-60 | Once daily | Must be reconstituted with water. |
| dexmethylphenidate (Focalin XR) - capsule | 12 hours | 5 - 40 | Once daily | Can sprinkle on food as long as Bead swallowed whole |
| amphetamine salts (Adderall XR) - capsule | 10-12 hours | 5 - 60 | Once daily | Can sprinkle on food as long As bead swallowed whole |
| lisdexamfetamine (Vyvanse) | 10-12 hours | 20 - 70 | Once Daily | Can be dissolved in water to drink immediately |

** not to be ingested with citric products*

### d. Opiates:

It is the recommendation that use of opiates for chronic pain not exceed the daily equivalent of 120 mg of morphine. Although DHS-BHD providers are not regularly prescribing opiates, it is important that they understand opiate dosing guidelines to avoid dangerous interactions with other Central Nervous System depressants such as benzodiazepines. The following table is referenced from the Partnership Health Plan, 'Recommendations for Safe Use of Opioid Medications.'

**Example of Maximum Daily Recommended Oral Doses of Opioids**

**(120 mg MED)**
**(For chronic, non-cancer pain)**
**(Before use of any comparative dose data for patient use, please refer to listed reference below for dosing calculator)**

| Drug (Generic Name) | Mg | Low Cost Generic Available? | Brand Name Examples |
|---|---|---|---|
| Morphine (PO) Chronic | 120 | Yes | MS Contin, Avinza (Long Acting) |
| Codeine (PO) | 400 | Yes | |
| Fentanyl Transdermal | 50mcg/hr | Yes | Duragesic (continuous release patch) |
| Hydrocodone (PO) | 60 | Yes | Vicodin, Norco (short acting only) |
| Hydromorphone (PO) | 15-30 | Yes | Dilaudid (short acting) |
| Levorphanol (PO) Chronic | 4 | Yes | LevoDromoran |
| Methadone (PO) Chronic | 15 | Yes | |
| Oxycodone (PO) | 40-80 | Short Acting:yes Long acting: no | Oxycontin (long acting) |
| Oxymorphone (PO) | 20-40 | No | Opana, Numorphan ( short acting generic available but not low cost) |
| Tapentadol (PO) | 150-200 | No | Nucynta |

http://www.globalrph.com/narcotic.htm

## VI. Forms

A. MHS 129, Treatment Plan for Using Controlled Substance Prescription Medicines (English and Spanish)

## VII. Attachments

Attachment #1: Los Angeles Department of Mental Health, Parameters 3.8 For Use of Psychotropic Medication in Children and Adolescents, March 15, 2023

Attachment #2: Partnership Health Plan Recommendations for Safe Use of Opioids