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“Warning: The Growing Danger of Prescription Drug Diversion April 14, 2011

Subcommittee on Commerce, Manufacturing and Trade

The Growing Danger of Prescription Drug Diversion is a topic that was a reality for my family and me for several years—it resulted in addiction, incarceration and death. My son Ryan died on September 4, 2009 from an overdose of Oxycontin. I value the opportunity to testify as a witness as I document my testimony of painful memories and facts of living with the disease of addiction.

Ryan inherited the disease of addiction. I soon learned that addiction is a progressive disease, and that it is so powerful that even the negative consequences of addiction don't stop an addict from using drugs. I sent my son to a residential treatment facility just before his 18th birthday—it was not successful, as he resumed abusing drugs little by little. I later found out he was experimenting with Oxycontin, that he obtained from unknown sources by means of diversion. By the time he was 20 years old, he commonly lost jobs; he lost his drivers license and car, his apartment, and pretty much everything else of value. I remember getting phone calls from Ryan on several occasions, saying he didn't know what was wrong with him, but that his body ached, and he was freezing one minute and hot the next. I thought he must have had the flu—he was fatigued, and his legs ached. It got so bad that we ended up at urgent care with an unknown diagnosis from the physician. At that time, Ryan did not realize that it was Oxycontin withdrawal that was responsible for the cause of these severe symptoms. He soon found out that the symptoms disappeared when he would take Oxycontin again: he was addicted. Oxycontin

would eventually steal my son's life, and though he was already abusing drugs, I feel that Ryan would still be alive if it weren't for Oxycontin.

He had to support his addiction, and was now beginning to sell drugs as a means to do so. He was not living at home, and started avoiding his family. This was not my loving son, the son that I had raised with morals and Christian values. He had begun leading a double life. He thought that if he lied to me, he would be protecting me from the world he was living in. As a mother, I found myself being consumed with trying to save my son's life, all while I had another child at home that needed parenting and attention—it was a difficult time to manage.

As time passed, Ryan found out that he could obtain a prescription for Oxycontin by simply stating to a physician in our area that he had some back pain. Even though Ryan had a prescription for OxyContin, he would often run out before he could get a refill, so he began to sell other drugs in order to support his addiction. Ryan also claimed that he had developed anxiety, and so he was prescribed Xanax (another potentially addictive drug). In my research, I found out that his anxiety could have been due to abrupt withdrawal of opiates.

The physician is currently under investigation by the California State Medical Board for prescribing issues. I have been told that he is no longer able to prescribe narcotics—a decision handed down by the DEA. In desperation to save my son's life, I reached out to a nurse at this doctor's office and managed to have several conversations with her and the doctor about my concerns regarding their prescribing practices. I also alerted them to my son's addiction. My concerns were overlooked and ignored, as they continued to prescribe addictive medications. I later received information from a recovering addict that this physician's office was an outlet for drug diversion practices. Ryan was known to have met other addicts in this office that he then

began selling drugs to.

At some point, when Ryan was receiving Oxycontin from the above physician, he stated he wanted to get off Oxycontin and admitted he had an addiction. However, he knew he could not tolerate the withdrawal symptoms. He had heard about Suboxone, a medication to treat opiate withdrawal. We located a physician approved to prescribe Suboxone and Ryan started treatment. It was very effective, but expensive with a combined cost of approximately \$600.00 a month for office visits and medication. After one month of treatment, Ryan compared the cost to Methadone (at approximately \$70.00 a month) and decided to go back to the above physician for Methadone and treat himself, against my recommendation. Within two months, that physician was again prescribing him Oxycontin, and Ryan was back into his full-blown addiction.

During the last months of Ryan's life he became eligible for medical insurance, and he utilized the benefits to feed his addiction. I have documented seven pages, including 72 entries of medical history for a thirteen-month period that I was able to obtain. This part of my testimony does not directly relate to the topic of this hearing. It indicates that prescription drugs prescribed even through legitimate means are subject to diversion when addiction is present. Ryan had now become proficient in the "ropes" of obtaining what he wanted from the attending physician. I feel that carelessness and ignorance of the danger of opioid abuse, along with lack of knowledge about addiction, created a situation that enabled my son's addiction. Again, like I did with the first physician, I begged my way into speaking with the person at this HMO facility that I thought could put a stop to this unnecessary prescribing to my son. I was fully aware of the HIPAA laws in place to protect my son's privacy, but I was desperate again to save my son's life. I was granted a face-to-face meeting with the facility director. I was told by this person that he would relay my concerns about Ryan's addiction to the physician Ryan had an appointment

with two days later. I felt relieved that this would put an end to Ryan's attempts to further his addiction with 100% free prescription drug coverage under his plan. Almost two months to the day after my conversation, it was necessary to make a 911 call...Ryan was in serious medical trouble. Once he was stabilized, he was admitted on a California Code 5150, an involuntary psychiatric hold for eight days. The diagnosis was Opiate (Oxycontin) and Benzodiazepine (Xanax) dependence. I later found out that he was prescribed Oxycontin, and Alprazolam (generic for Xanax) at the appointment I had tried to avert. I have read online from a reliable source backed up with references the following: Narcotics (Oxycontin) should never be combined with other types of drugs that depress the central nervous system, including benzodiazepine tranquilizers such as alprazolam (Xanax). Ryan was having a severe reaction that included hallucinations, most likely due to rapid dose reduction of one or both because he was abusing them. Yet, he continued to be prescribed Xanax. During the same appointment, he was referred to the pain management department, where he was again prescribed Oxycontin a few weeks later for 40 mg. of Oxycontin three times a day. In May 2007, Purdue Pharma, the manufacturer of Oxycontin, paid \$19.5 million in fines relating to the aggressive off label marketing practices. The company had encouraged more frequent dosing than the recommended interval of 12 hours, and did not fully disclose the risk of hazardous or harmful use. Apparently news of the fines did not reach the HMO that was responsible for Ryan's medical treatment. Ryan was prescribed OxyContin without a doctor verifying his claims of pain, either with an x-ray or MRI that would not have justified prescribing such a potent pain reliever. In the same two-month period, Ryan was arrested for a felony at the pharmacy on the premises, for altering a prescription for Oxycontin. I have seen multiple warnings that indicate that all patients receiving opioids should be routinely monitored for the signs of misuse, abuse or addiction. The

pharmacy, that alerted law enforcement resulting in the arrest, failed to comply with that warning and did not notify Ryan's primary care physician, who was, by the way, located in the same building. It was only six days later that Ryan went back to the same HMO and received 45 more Oxycontin. All this occurred after I had alerted the facility that my son was a drug addict and had a history of abusing narcotic medications.

Ryan also made visits to the local hospitals' emergency departments during this particular time period and received more Oxycontin. If a prescription-monitoring program were in place, this would not have happened. In addition to repeated visits to his primary care physician, the HMO authorized a referral to a psychiatric facility for his anxiety. Ryan began receiving prescriptions for the same medication from the primary care physician and the psychiatrist. In a ten day period, Ryan legally obtained 210 Alprazolam (generic for Xanax).

Situations like this repeated themselves until the day Ryan died. In fact, it got worse—there were five near death overdoses, each one of them occurred within 24 hours of Ryan being prescribed addictive drugs. My daughter and I had to live through what seemed like a nightmare, through every occasion, many of which could have been prevented. He did manage to get into treatment for addiction during the ten months prior to his death, but unfortunately after five weeks he was kicked out for abusing medication that he was prescribed while he was in a recovery program. When I questioned how this could happen, it was explained to me that privacy laws prevented the primary care physician at the HMO facility from knowing that Ryan was a patient in the drug treatment facility. So, for a sprained foot, Ryan was prescribed Vicodin, a narcotic pain reliever, and three other medications not appropriate for someone with a history of addiction, as indicated on the pharmacy information sheet. Ryan's disease must have prevented him from taking the responsibility to say he did not want a narcotic pain reliever. Dr. Drew, a

leading expert in addiction said that even when narcotics are appropriately prescribed to an addict, their life is in danger. It will change the addicts thinking and change their motivation. Ryan was back on the streets after this, and again, we were in fear of Ryan's life. Ryan's addiction took him to a place that is described perfectly by Dr. Nora Volkow, Director, National Institute on Drug Abuse: "On a personal level, as a physician I have never met an addicted person who chose to be addicted or who expected that this compulsive, uncontrollable behavior would emerge when they started taking drugs."

Ryan was admitted to the hospital several times, by way of ambulance due to an overdose. Once, while hospitalized he was interviewed by the hospital LCSW. The following is documented in a Summary of History: [Ryan] also admitted that he has a 7 year history of poly substance abuse, admitted being arrested for substance related issues, admitted his mother refused to allow him to return home and has obtained a restraining order for the patient because of his drug abuse. In the Impression/Assessment it states: He does not see himself as having a substance abuse problem and is unwilling to make any serious attempt to overcome his addiction to pain medications. Ryan often justified his addiction by stating he was only taking what the doctor gave him.

The day before Ryan died, he was prescribed 60 2 mg Alprazolam (generic for Xanax) to be taken 4 times a day, which is an extremely high dose, from the same HMO. His medical records should have showed that his tolerance would not have justified this amount, however, the records were apparently not referred to. I made a phone call one week after my son's death to inform the facility director, who I had my original meeting with almost a year earlier that my son had died. I

said, “with all the technology you have, this should have never happened.” I had been told almost a year earlier from the pharmacist who was involved in the prior arrest that “[he] won’t be getting any more prescriptions from this pharmacy.” But that was not the case. When I told the facility director about this exchange, he replied something to the effect that the pharmacy was his safety net and he does not know why it happened, and, that I was right, it should not have happened. He told me he would look into it and call me back. I never got that phone call.

As a result of all this history, and a failed attempt to file a lawsuit after my son’s death I needed answers. I was notified about six months after my son died that the HMO responsible for his medical care wanted to meet with me. In reviewing the medical history, here is the conclusion of those meetings in brief:

1. One of physicians said that he was not aware of the abuse among young people, and he was surprised after it was brought to his attention.
2. I was told that when Ryan was being prescribed Oxycontin they did not know about the dangers and believed the drug representatives.
3. I was told that their hands are tied with HIPPA laws, especially for addiction. They stated that more transparency is needed between primary care and psychiatry providers, and communication with family members.
4. I was told that Oxycontin was touted as a new safer drug than Morphine, Fentanyl and Methadone.
5. When I asked why Ryan was prescribed 2mg. 4 times a day, the day before he died, they said that Ryan was very convincing in getting what he wanted, to which I replied, “So if your child

comes to you before dinner and wants a cookie, you give it to him? Who is in charge of the situation?"

6. It was discussed, that the pendulum had swung over the years from physicians being afraid to prescribe narcotics to the opposite direction when pain management experts said, we must make our patients comfortable.