Just one opioid prescription?

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It can be said that chronic pain patients comprise a large part of general practice. It would be accepted that general practitioners treat pain to the best of their abilities and, where indicated, use opioids for this purpose. After all, opioids have been used for the treatment of cancer and acute pain for many years.[1] While a growing body of literature documents the trend of acceptance to prescribe opioids for the treatment of chronic noncancer pain,[2–4] recent evidence suggests opioids may not achieve key outcomes of chronic pain management.[5]

Australia treats medicinal opioids as 'controlled drugs' with the prescription, possession and use of these valuable medicines being regulated by state government authorities. Australian states and territories have drugs of dependence units or pharmaceutical services branches that regulate medical practitioner prescribing, pharmacist supply, and, to an extent, patient use of these drugs (*Table 1*). It has been argued that regulation of opioids in the current manner has more to do with society's historical and present attitude toward the use of 'opiates' than toward the actual risk of harm posed by these drugs when used under appropriate medical supervision.[6] Equally, it can be stated that opioids are regulated today because of their inherent abuse and addiction liability. In 2004, the United States National Survey on Drug Use and Health revealed that 2.4 million people aged 12 years and over had used prescription pain relievers for nonmedical reasons. Opioid analgesics were over-represented.[7] Australian Institute of Health and Welfare data regarding hospital admissions, where 'opioid poisoning' was the principal diagnosis, revealed that between 1998 and 2004 over 6300 admissions occurred nationally as a result of opioid poisoning (excluding heroin or opium poisonings).[8] These figures are expected to translate into significant economic and social burdens on the community.

For reasons such as the euphoric properties of opioids (with a corresponding street value of up to $800 for a pack of 20 Kapanol®/Oxycontin®), it is not surprising these drugs are the subject of illegal activities to secure their supply. In the general practice setting, such activities may manifest as opioid seekers presenting to general practice clinics with illusory or quasi medical conditions requesting opioids for pain relief. Many opioid seekers are not known to the GP they consult, and as a group may share similar characteristics, strategies, and behaviours to obtain prescription opioids including:

- admitting suffering dependence and requesting an opioid prescription 'just until formal drug dependence treatment is accessed'
- implying that 'only an opioid will work' for the type of pain being experienced
- requesting a specific opioid by name and having a better than average knowledge of opioids as a therapeutic class of drug
- stating that allergies are suffered to all nonopioid alternatives
- presenting after hours or at weekends when most regulatory authorities are not contactable, and
- giving a history of being from 'out of town' and just needing one prescription to get back to their home town/state.

Why not write just one prescription?

The majority of GPs are aware of such tactics, however may feel compelled to provide 'just one prescription' to placate the angry, persistent or aggressive opioid seeker. However, even 'just one prescription' is problematic. In cases where the opioid seeker is drug dependent, providing just one prescription may only prolong suffering associated with addiction. These patients should be referred to appropriate treatment services. Addiction is a disorder requiring treatment in its own right. Further, untreated addiction disorders can significantly complicate and diminish treatment of a patient's comorbidities, such as depression. In South Australia, where the GP has reasonable grounds to believe an opioid seeker is dependent on drugs, it is illegal to prescribe even one opioid prescription for the purpose of maintaining that person's addiction without state government authority.[9] Other Australian jurisdictions have similar legislation.

In cases where the opioid seeker is diverting prescribed opioids to third parties for money, other drugs or favours, the GP is unwittingly contributing to black market supplies of these drugs. It is illegal for a person to divert opioids, and even one prescription may contribute to this activity.[10]

Opioid seekers may attend multiple GPs to obtain drugs. What seems like just one prescription may be one

Table 1. Australian drugs of dependence units/pharmaceutical services branches

State	Telephone	Website
ACT	02 6205 0996	Not available
NSW	02 9879 3214	www.health.nsw.gov.au/public-health/psb
NT	08 8922 7341	www.nt.gov.au/health/poisonscontrol
QLD	07 3896 3900	www.health.qld.gov.au/atods/about_us/drugs.asp
SA	1300 652 584	www.dassa.sa.gov.au
TAS	03 6233 8011	www.dhhs.tas.gov.au/agency/pro/pharmaceuticals
VIC	1300 364 545	www.health.vic.gov.au/dpu
WA	08 9388 4980	www.health.wa.gov.au/s8

of many from various prescribers. Therefore a GP who provides one prescription can't be certain the drug they have prescribed won't play a part in any overdose suffered. In such situations would a prescriber's conduct be called into question in any coronial inquiry or civil litigation case?

Managing suspected opioid seekers

Perhaps to the busy GP, not providing the odd prescription to an opioid seeker may be more effort than giving it – especially if the patient is 'causing a scene' in the clinic. It may be 'easier to write than fight'.[11] However, by forming a partnership with local drugs of dependence units/pharmaceutical services branch professional staff, the amount of work may be reduced. For example, a short telephone call to unit staff may provide bona fides of the patient waiting to be seen, and perhaps break the chain of prescriptions given to a spurious pain patient.

Contacting the unit when a suspected opioid seeker is in the consulting room may help divert aggression or antisocial behaviour away from the GP and practice staff. The GP can instruct the opioid seeker in plain terms that the state government is responsible for the decision not to provide a prescription, and 'as much as you would like to help, your hands are tied'.

Obviously opioid seekers attend general practice clinics outside of unit business hours. To help fill this gap, the South Australian Drugs of Dependence Unit regularly publishes a document known as the 'Privileged circular'[12] in a secure area on its website (www.dassa.sa.gov.au). The circular contains the names and particulars of people known to the unit as prolific drug seekers or misusers. It also contains details of any medical practitioner or drug treatment clinic authorised to be involved in the patient's care, and inquiring GPs are encouraged to refer the person back to those authorised prescribers for any prescription required. Being web based, the circular can be accessed 24 hours a day, 7 days a week, and is updated regularly. The circular is a novel way for GPs to acquire drug use histories of presenting patients, thus helping to determine whether and how any opioid treatment should proceed. South Australian legislation that permits publishing of the circular appears not to have an equivalent in any other Australian state or territory. While no other jurisdiction publishes a document such as the circular, with privacy laws presenting a barrier, GPs can still register with Medicare Australia's Prescription Shopping Program to obtain similar information. Formal evaluation of the circular is yet to occur, however responses from some of the 331 registered users have been positive. South Australian GPs are encouraged to contact their drugs of dependence unit to obtain a username and password to access the service.

For prescribers who are confident negotiating with opioid seekers without the help of a third party, the following strategies may be employed:

- say 'no' to the opioid prescription, but offer alternative appropriate management of symptoms if indicated
- establish the opioid seeker's identity, as false identities may be used
- establish a diagnosis for the opioid seeker's complaint and confirm that opioids are not being sought solely to maintain or 'treat' dependence
- defer prescribing opioids until all documentation regarding the opioid seeker's pain condition is available.[13]

Conclusion

It is appreciated that general practice workloads are increasing, with growing demand for services. General practitioners are encouraged to form partnerships with their local drugs of dependence units/pharmaceutical services branch. Such a partnership is likely to save time, effort, and frustration for the prescriber, direct a drug dependent person to an appropriate path of treatment, and help reduce illegal activity associated with prescription opioid abuse.

Conflict of interest: none declared.

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