



Benny Monheit

Prescription drug misuse

Background

Recognising and dealing with patients who seek drugs for nonmedical purposes can be a difficult problem in general practice. 'Prescription shoppers' and patients with chronic nonmalignant pain problems are the main people who constitute this small but problematic group. The main drugs they seek are benzodiazepines and opioids.

Objective

To provide data on current trends in prescription drug abuse and to discuss different strategies on how to deal with this issue in the clinic setting.

Discussion

Misuse of prescription drugs can take the form of injecting oral drugs, selling them on the street, or simply overusing the prescribed amount so that patients run short before the due date and then request extra prescriptions from the doctor. Currently oxycontin and alprazolam are the most abused drugs in Australia. Adequate prescription monitoring mechanisms at the systems level are lacking so we need to rely on our clinical skills and the patient's behaviour pattern over time to detect problematic prescription drug misuse. Management strategies may include saying 'no' to patients, having a treatment plan, and adopting a universal precaution approach toward all patients prescribed drugs of addiction. Among patients with chronic nonmalignant pain, requests for increasing opioid doses need careful assessment to elucidate any nonmedical factors that may be at play.

Keywords: substance related disorders; street drugs; drug prescriptions; general practice



The earliest known records of prescriptions for drugs were found on clay tablets, used by the priest/healers in ancient Babylon around 2600 BC. For many centuries all pharmaceutical products remained totally unregulated by government. By the 19th century even drugs such as morphine, laudanum and cocaine were readily available in Western countries through travelling vendors, via drug stores and through mail order. The problem of addiction to these drugs became increasingly recognised, and in 1914 the United States of America became the first country to introduce legislation which required the sale of narcotics to be restricted to licensed physicians or pharmacists.^{1,2} Since then, there have been small groups of people and organisations that have tried to sidestep the rules on prescribing for a range of reasons, primarily revolving around pleasure, comfort and greed.

To this day, there is no universally accepted definition of prescription drug abuse, which makes it hard to diagnose and quantify the problem.³ The Diagnostic and Statistical Manual of Mental Disorders 4th revision (DSM-IV) definition of drug dependence is not very useful in this context because it relies heavily on the concepts of 'loss of control over the drug' and withdrawal symptoms which are not the main driving force in prescription drug abuse.⁴ General practitioners nevertheless need to be able to deal with the complex and often unclear clinical issues from a small but problematic group of patients who are misusing their prescriptions. This involves:

- recognising and dealing with patients who seek drugs for nonmedical purposes. This includes 'prescription shoppers' and patients who demand inappropriate types and quantities of drugs from their own doctor for illicit purposes such as selling or injecting them, and
- recognising and dealing with patients who have a chronic pain condition but who may be overusing or misusing their own medications.

Patients from both groups most commonly request benzodiazepine or opioid drugs as these can provide mood altering, analgesic and euphoric effects. Less commonly other prescription drugs such as antipsychotics, psychostimulants and nonbenzodiazepine sedatives (eg. zolpidem) are abused.^{5,6}



Emerging research is now helping to place pain control and addictive disorders on a continuum rather than as two totally separate conditions affecting different patients. In the clinical arena, both pain specialists and addiction medicine doctors routinely prescribe potentially abusable drugs to achieve therapeutic effects. Both groups of doctors continually negotiate with their patients and try to overcome prejudiced perceptions from the public and the medical field. They can learn from each other.⁷

Prescription data

The data reviewing opioid prescribing in Australia was recently published by Leong et al⁸ using information from the Health Insurance Commission. They showed that the number of different opiate formulations on the Pharmaceutical Benefits Scheme (PBS) rose from 11 in 1992 to 70 in 2007. During these 15 years there has been considerable increase in the use of prescription opioids in Australia. The total number of PBS opioid prescriptions increased from 2.4 million in 1992 to 7.0 million per year in 2007. Oxycodone had the steepest rise and tramadol (which is a synthetic analogue of codeine) also increased rapidly in use since its introduction in 2000 (Figure 1).

The data on benzodiazepine prescribing has also showed changing prescribing patterns over the past 7 years. The information shown in Table 1 was taken from PBS data published by the Australian Government. In spite of a significant overall reduction in benzodiazepine prescribing, alprazolam sales rose by 28%.⁹ Private prescriptions (non-PBS) for alprazolam comprised on average an

additional 32% of prescriptions per year, based on estimates from the Australian Statistics on Medicines.¹⁰

Is there a problem?

The extent to which these legitimate and useful medications from the benzodiazepine and opioids family are abused in Australia is not clearly known and understood. We still lack the data systems to monitor the situation adequately in Australia.¹¹ It is unclear, for example, to what extent the increasing use of all types of analgesics reflect the increasing prevalence of chronic nonmalignant pain or just the greater willingness by doctors to prescribe opioids for existing conditions. The increasing number of people with cancer being treated out of hospital (and hence on the PBS) could also be a contributing factor to rising opioid prescriptions.

But trends of increasing abuse of prescription drugs around the world has been reported by the United Nations.¹² In particular, health experts from the United States of America and Canada have expressed increasing concern at the evidence of a strong correlation between rising opioid sales and increasing opiate related mortality. In the USA, unintended drug deaths increased by 68% during 1999–2004, mostly due to opioid analgesics.^{13,14} In Australia, data exists on injecting pharmaceuticals. In 2008, the proportion of injecting drug users at needle exchange centres around Australia who reported injecting morphine or other pharmaceutical opioids increased from 7% in 2002 to 15% in 2008. Opioid medications were the third most common drug injected after heroin and amphetamines among this group of drug users.¹⁵

The potent short acting benzodiazepine alprazolam is also well known to illicit drug users. The Medical Practitioners Board in Victoria issued a warning to all doctors in 2009 that 'recent evidence suggests that alprazolam is more subject to nonmedical use and causes a disproportionately higher levels of serious harm than other benzodiazepines'.¹⁶ In particular, traffic accidents, aggressive behaviour and withdrawal difficulties are listed as prominent alprazolam related problems. The Medical Practitioners Board and the Royal Australian and New Zealand College of Psychiatrists now recommend that alprazolam has a very limited role in the treatment of panic disorder and anxiety, and that other means should be used as first line treatment.¹⁶

The warning signs for doctors that one of their patients may be abusing prescriptions are outlined in Table 2. This information is abridged from the 2008 New South Wales Health Department Bulletin which can provide further details.¹⁷

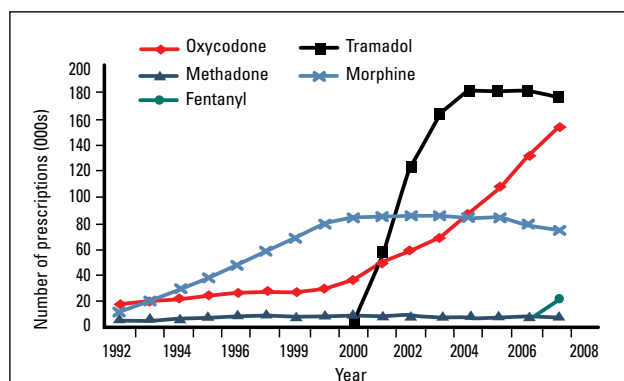


Figure 1. National opiate use 1992–2007
Source Leong M, Murnion B, Haber PS. Examination of opioid prescribing in Australia from 1992 to 2007. *Internal Med J* 2009;39:676–81

Table 1. PBS prescriptions for benzodiazepines 2002 and 2009

	Diazepam	Oxazepam	Temazepam	Alprazolam*	Total
2002	1 576 625	1 220 936	2 237 733	324 110	5 359 404
2009	1 639 952	1 015 080	1 840 222	413 526	4 908 780
% change	+4%	–17%	–18%	+28%	–8%

* Private prescriptions (non-PBS) for alprazolam comprised on average an additional 32% of prescriptions per year, based on estimates from the Australian Statistics on Medicines¹⁰



Prescription shoppers

Most GPs are familiar with ‘prescription shoppers’ (sometimes called ‘doctor shoppers’). These people go from doctor-to-doctor seeking prescriptions for drugs for nonmedical purposes where each doctor is unaware of supply by the others. The drugs are sought for a range of reasons. These include euphoria, and self medication of pain, anxiety and depression, but in some cases they are sought for amelioration of heroin withdrawal symptoms or purely for financial gain. (An 80 mg Oxycontin tablet or 100 mg MS Contin sells on the streets of Melbourne, Victoria for \$50, a similar street price as for a cap of heroin, and 2 mg alprazolam can be bought for \$5 per tablet.^{18,19})

These patients often seem to target new or overseas trained doctors and female doctors, but they are a challenge to any GP with their persuasive stories, urgent requests and occasionally even threatening manner.

The Commonwealth Government tries to keep track of these patients through the Medicare Prescription Shopping Information Service. Doctors can access this service 24 hours a day through the hotline on 1800 631 181 to find out if a particular patient is known to be a prescription shopper. The patient’s consent is not required for this inquiry. The criteria Medicare uses for defining someone as a prescription shopper is if in any 3 month period the patient gets prescriptions from six or more different prescribers, or obtains 50 or

more PBS pharmaceuticals or obtains 25 or more pharmaceuticals targeted by Medicare.²⁰

Doctors need to be registered with the service to obtain information about a patient. If the patient gives written consent to the doctor (via a PBS release form), a more detailed list regarding the PBS drugs used by the prescription shopper is made available to the doctor. There is, however, a time delay in providing this data of some weeks. There have been repeated calls by the profession for the government to provide ‘real time data’ on their patients’ prescription use, accessible via the doctor’s desktop computer. This, it is felt, would greatly assist in detecting prescription shoppers, but privacy and confidentiality issues would need to be addressed, and technological barriers would need to be overcome in order to provide a secure Australia wide drug monitoring service.²¹

Medicare Australia receives approximately 24 000 inquiries per year from doctors who suspect their patients may be prescription shoppers. This number of calls increased last year by 18% from the previous year.¹⁴ It has been estimated that there are more than 20 000 prescription shoppers in Australia in any 3 month period.¹⁷

Dealing with prescription shoppers

Once a suspected drug seeker is in the GP’s consulting room, the doctor needs to decide on a strategy of dealing with their request. A number of articles have been written by GPs, health departments and medical boards on this issue as it is a recurring area of concern to all these groups.^{22,23}

The basic strategy options open to GPs are either to say no to the request, or to try to engage the patient in a treatment program.

Option 1. Just say no and discharge the patient (Case study 1)

The emphasis here is on getting to the issue of the patient’s drug seeking request quickly and responding in a clear and respectful way with the explanation that the doctor chooses not to prescribe. Reasons for nonprescribing need to be clear and short, eg. ‘it’s my choice’, or ‘it’s clinic policy’ which gives the patient no room to manoeuvre.

Role plays with doctors, especially registrars, has shown that some doctors initially feel embarrassed or too shy to say no to their patients’ drug requests. Training techniques aim to overcome this handicap with some assertive skills training and practise, and data on drug misuse and its adverse health consequences.²⁴

Other strategies that some clinics have found helpful are to develop a clinic policy on prescribing drugs of addiction. This forces clinic staff to think about the issue within their local context and helps to ensure that a consistent message is given by all doctors. Some clinics put up signs in the waiting room stating that no drugs of addiction will be prescribed to new patients.²³ Some doctors may also find it helpful to say to a demanding patient that the health department does not allow them to prescribe that type of addictive drug, which then takes the emphasis away from the doctor. This has been dubbed ‘borrowed protection’.

Table 2. Behaviours exhibited by a patient that may raise suspicion of ‘prescription shopping’ (especially one who is new to the practice)

- Arriving after regular hours or wants an appointment toward the end of office hours
- Stating that he/she is travelling through, visiting friends or relatives
- Exaggerating or feigning medical problems
- Providing a convincing, textbook-like description of symptoms but giving a vague medical history
- Providing an old clinical report and/or X-ray (often from interstate) in support of their request
- Declining a physical examination or permission to obtain past records or undergo diagnostic tests
- Unwillingness or inability to provide the name of regular doctor, or stating that the doctor is unavailable
- Claiming to have lost a prescription, or forgotten to pack their medication, or saying their medication was stolen or damaged
- Showing an unusual knowledge about opioid medications
- Stating that specific nonopioid medications do not work, or that he/she is allergic to them
- Pressuring the doctor by eliciting sympathy or guilt or by direct threats

Source New South Wales Medical Board. Responsible opioid prescribing: identifying and handling drug-seeking patients. Board News December, 2008



Case study 1

Patient: I have just come down from the country and I can't sleep at the backpackers. If I don't get some sleep soon...

Doctor: In what way do you think I might be able to help?

Patient: Oh, I just wondered if I could get some more valium...

Doctor: I don't prescribe drugs like valium.

Patient: Oh, why is that?

Doctor: Because they're addictive drugs that cause a lot of problems, and I choose not to prescribe them.

Patient: Well, how about serepax?

Doctor: I've already said I don't prescribe valium or any of those kind of tablets, and that includes serepax. I am happy to try to help in other in other way I can, but not with those sort of tablets.²³

Option 2. Prescribe the drug requested, but with the aim of engaging the patient in a harm reduction treatment program (Case study 2)

The doctor who takes this option needs to quickly check the history with the previous prescriber, establish the diagnosis and results of previous tests, and check for prescription abuse history with Prescription Shopping Information Service. The next step would be to develop a treatment plan with the patient and a set the ground rules established for future prescribing. This may include a plan to step-wise reduce the dose of the drug of addiction. To facilitate this it may be useful to involve other services in the treatment plan, thus sharing the workload and broadening the treatment approach beyond just prescribing drugs.

However, some GPs can be naive and too trusting and not recognise that they are being manipulated by the patient who only wants drugs for nonmedical use (*Table 2*). Patients' stories that they will have a convulsion or become psychotic or relapse into heroin use if they don't get their drug of choice is hardly ever evidence based. Doctors also need to be careful not to get caught up in the patient's dramas and tales of woe. There are risks for the doctor involved in this approach.

Doctors who need help to deal with the manipulative patient can seek this from peers, clinical supervisors, drug and alcohol advisory services or medical defence insurance organisations.

Case study 2

Doctors getting into difficulty with patients seeking prescriptions for drugs of addiction is an ongoing issue before the Medical Board. In a decision to deregister a practitioner in relation to inappropriate prescribing matters the Medical Tribunal notes that:

'Overall, the flavour of the respondent's evidence was that he was the slave to the patient's request for drugs, he could counsel and advise them to reduce but in the end he submitted to their demands. The tribunal finds this demonstrates both a lack of insight but also a failure to exercise his responsibilities as a medical practitioner'.³³

Chronic pain patients and addiction

The management of patients diagnosed with chronic nonmalignant pain is a growing public health issue. Studies in Australia, New Zealand and Europe show that 5–10% of the population have severe persistent pain.¹³ Some of these patients are prescribed opioids by their GP or specialist for pain management. However, the role of opioids remains controversial in managing chronic nonmalignant pain as the evidence of effectiveness is inconclusive (see the recent Cochrane review by Noble et al²⁵). This can result in inconsistent advice given to GPs by various specialists on management issues. Some are comfortable recommending opioids, others are not because they are worried about the risk of diversion, adverse effects and addiction.

In reality, all patients on long term opioids become physically dependent and get withdrawal symptoms if they suddenly stop taking them. This is not enough to define addiction. Behavioural problems with the prescribed drug would need to be an added feature to come under that definition.²⁶

But even here there are added complexities. Requests by the patient for extra analgesic medication could be due to a number of factors that need assessment. The disease could be progressing in severity, or the patient's pain may be developing a tolerance to the opioid drug dose.²⁷ However, some pain physicians point to increasing evidence that in some people, further opioids may be aggravating the pain – the opioid hyperalgesia dilemma.²⁸ Psychological factors can also affect the response to pain, particularly if there is already a history of mental health problems or a substance abuse disorder.⁴

To assist doctors in this rapidly changing field, a number of leading clinical authorities in Canada and the USA have recently published clinical guidelines for pain management which take into account the risk of diversion and abuse of medication.^{29,30} Unfortunately, these guidelines are long and detailed which make them difficult to apply in a busy general practice. We need a more focused set of guidelines for Australian settings.

In the end though, clinicians need to be aware that there is no test or sign pathognomonic of a substance use disorder. As pointed out by Gourlay et al,³² this diagnosis is most often made over time by monitoring the patient's behaviour and ability to stay within a mutually agreed treatment plan.

The Royal Australasian College of Physicians in 2009 published a very useful policy document entitled 'Prescription opioid policy' which outlined the need in Australia for improving the management of chronic nonmalignant pain and the prevention of problems associated with prescription opioids. The Royal Australian College of General Practitioners has participated in and endorsed this policy document which is available online.¹³

Universal precautions in pain medicine

One suggested strategy of dealing with this complexity is to regard all chronic pain patients as potentially getting addicted to their opioid medications and taking appropriate steps. This has been termed 'universal precautions'.³² Such an approach is borrowed from the



infectious diseases field where it was recognised that it is often impossible to tell early in the treatment phase who is infected with human immunodeficiency virus (HIV) or hepatitis C, so everyone was treated as potentially infected. It was found that this reduces fear and stigma and improved management.

Universal precautions in the pain field would involve assessing all chronic pain patients for past or present substance abuse and psychiatric illness and providing extra support for those at risk of drug misuse. Similarly, some chronic pain patients have pre-existing personality disorders that affect their response to pain and can complicate their pain management. Those identified at risk or who start to exhibit behaviour difficulties may be best managed by a multidisciplinary team consisting of the GP, a pain specialist and a psychiatrist, together with a doctor who has experience in addiction medicine. This may be hard to achieve in reality in our stretched healthcare system. However, there is increasing interest being shown in this field. The Royal Australian College of General Practitioners has established a special interest group in pain management; The Royal Australasian College of Physicians is calling for better services; and some anaesthetists are becoming more involved in this subspecialty.

Requests for extra medication are an opportune time to review the treatment plans of patients with chronic pain (*Case study 3*). A good relationship between the doctor and the patient will enable a frank discussion to take place. A second opinion from a specialist or pain clinic can be invaluable. Other strategies that may help are:

- see the patient more frequently for a while (eg. weekly to monitor more closely)
- arrange for the pharmacist to dispense the medications daily or weekly
- request urine drug tests as part of the treatment plan to check on use of illicit drugs. (Urine screening tests for opiates will generally not detect low to moderate levels of oxycodone, as morphine is not one of its major metabolites³¹)
- switching to a methadone or buprenorphine program if there are signs of ongoing opioid drug abuse (as there is more supervision by pharmacists of the consumption of these two medications).

Case study 3

You have inherited a patient, 28 years of age, called Callum, from a colleague. Callum has been on Schedule 8 drugs for the past 6 years after developing osteomyelitis from a compound fracture in his leg. He was discharged from hospital on opioids which your colleague continued to prescribe after the osteomyelitis had resolved. He is now on Oxycontin 80 mg three times per day, MS Contin 100 mg three times per day and pethidine 100 mg/day. He wants you to continue to prescribe this regimen 'because it works'. What do you do?²²

[See the full article at www.racgp.org.au/afp/200406/20040601sim.pdf].

Conclusion

Dealing with prescription abuse requires strategies on how, at times, to say no to patients, having a treatment plan, and adopting a universal precaution approach toward all patients prescribed drugs of addiction (*Table 3*). It can also help for the clinic staff to develop a policy on

Table 3. 10 strategies to prevent misuse of prescription drugs

1. Develop a policy for your clinic on requests from new patients for drugs of addiction. Try to ensure that all staff know this policy and agree to implement it (except in very exceptional circumstances)
2. Write tamper resistant prescriptions and keep all prescription pads and computer prescription paper under control
3. Ongoing prescribing of drugs of addiction (Schedule 8 drugs) requires a permit or authority (depending on jurisdiction). Ensure this is obtained from state health authorities. Reminders to renew time limited permits can be added to the clinic's computer recall system
4. Have the telephone number of your state's drugs of dependence unit readily available as they can also provide useful information about permits, treatment programs and legal issues regarding treating drug dependent patients (see Resources)
5. Have the telephone number of the Prescription Shopping Information Service readily available (1800 631 181). Register your name with this service
6. If unsure what to do about a patient's unusual or apparently unreasonable requests for drugs consult with a peer, supervisor or drug and alcohol specialist for advice
7. In chronic pain management adopt a 'universal precaution' approach for all patients. This includes taking a brief drug and alcohol history, monitoring for aberrant drug behaviour and recognising that pain and addictive diseases exist as a continuum rather than as two distinct patient groups
8. For patients requiring ongoing prescription of drugs of dependence a treatment plan (or care plan) should be developed with the patient. There are invariably complex chronic medical and psychosocial issues involved. Share the management with others if possible, especially mental health workers, chronic pain clinics, and drug and alcohol services in your region
9. If things really go wrong, for example you are threatened by the patient, cease the treatment program immediately. The patient-doctor relationship has been violated. Advise your medical defence association, the senior person at the clinic and the police if necessary to protect you and clinic staff. You may suggest another treatment service for the patient if you wish, but you are not required to do so
10. If you are the type of doctor who is too 'soft' or gets overwhelmed by patients' requests for drugs then don't start treating drug addicts. Leave it to someone else. It is hard to justify writing a prescription just because the patient wants it. Remember, the coroner and health department holds you responsible for every prescription you write



how to deal with patients' requests for drugs of addiction (especially requests from new patients) and to know what local resources are available to assist the clinic if required.

Among patients with chronic nonmalignant pain, requests for increasing opioid doses need careful assessment. The request may be perfectly reasonable, but, on the other hand, might signal that nonmedical factors may be at play.

Having a plan and a patient centred approach can take the uncertainty and stress out of a potentially difficult situation.

Resources

State and territory health department telephone contacts for prescribing drugs of dependence:

- ACT Pharmaceutical Services Section 02 6207 3974
- NSW Pharmaceutical Services Branch 02 98793214
- NT Poisons Control Unit 08 8922 7341
- QLD Drugs of Dependence Unit 07 3328 9890
- SA Drugs of Dependence Unit 1300 652 584
- TAS Pharmaceutical Services Branch 03 6233 2064
- VIC Drugs Regulation Unit 1300 364 545
- WA Drugs of Dependence Unit 08 9388 4985.

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