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Pharmacists vs. Drug Misuse and Diversion
A new front in the war on drug abuse

As of 2006, prescription opioid overdoses have killed more people in the U.S. than have heroin or cocaine. This troubling trend directly contradicts the popular belief that drug abuse only involves illicit drugs. It's evident that drug legality has little to do with the abuse of medications. Even though prescription drugs are legal, they are being misused at increasing rates, perhaps in part to their perceived safety over street drugs. Contrary to those beliefs, drugs such as narcotic pain relievers are Schedule II because they have *high* abuse liability. Still, "Americans, constituting only 4.6% of the world's population, have been consuming 80% of the global opioid supply, and 99% of the global hydrocodone supply". The severity of this addiction epidemic is undeniable, but what remains to be seen is how our legislative and medical communities will come together to finally defeat it.

For the purposes of this post, I'll be using the term "drug abuse" to specifically mean the misuse and diversion of *prescription* drugs. (Furthermore, most of the examples listed will refer to opioid abuse, which makes up the majority of prescription drug abuse cases. It's important to note, however, that abuse of CNS depressants and stimulants is an equally serious issue.) Pharmacists need realize that while we've treated countless patients, the very same drugs, if put in the wrong hands, can enable drug misuse and feed the growing addiction epidemic. The community pharmacy is quickly becoming a hotspot within the topic of drug abuse, and it's time for us to implement effective and practical strategies against it.

Are pharmacists responsible?
A question of duty vs. ethics

As pharmacists, screening prescriptions for therapeutic fit is part of the job. But now, with prescription drug abuse on the rise, are we responsible for determining a patient's intentions, too? Isn't that something the physician would have handled before prescribing the drugs? And if the patient actually *is* misusing or diverting the medication, isn't that what the police are for? The DEA? The *FBI*?

It's a controversial topic, but the answer is actually very simple. Think back to the last time a patient gave you the classic "How long does it take to count four pills?" Do you remember how you felt, or the responses running through your head? Aside from being indignant, those are the times when we pharmacists are most acutely aware of our myriad responsibilities and the right to defend our profession. We check medical records for allergies and disease state incompatibilities. We watch for drug interactions, side effects, and appropriate dosing. We verify prescription legitimacy, adjudicate insurance claims, and counsel patients. How much of all those tasks, then, is counting pills? The point is, pharmacists are responsible for many things in order to improve

patients' health. As the last and most trusted link in a chain of healthcare professionals, pharmacists are the ones who ultimately determine if, when, and how a patient receives his or her medicinal care. Thus, regarding the issue of prescription drug abuse, it's clear that we hold more influence and potential than most laypeople recognize. Even if a case of prescription misuse is caused by physician corruption, patient dishonesty, or an accident of ignorance, pharmacists are responsible for making things right. Let me say that again. *Even though drug abuse is not "our fault", we are responsible for fixing it.* We are healthcare providers (whether Medicare B recognizes that status or not). This means putting patient welfare first, regardless of circumstance. To absolve ourselves of responsibility in the epidemic of prescription drug abuse would be unethical at best and murderous at worst. With the joint effort of physicians, legislators, and law enforcement agents, pharmacists can help bring down the levels of prescription drug abuse for good. *This* is why our jobs are so important: because we can make a difference.

Taking on this responsibility will no doubt be an intimidating task. Some pharmacists may still disagree, feeling that a patient's health should be their own initiative or that physicians should take responsibility for prescribing abused medications. In cases when physician-backed patients come to the pharmacy intending to misuse or divert medications, it may be particularly difficult to act in their best interest. First of all, how does one differentiate legitimate pain-prescription patients from addicted patients? Are there policies in place to discreetly and effectively handle a potential drug abuse/diversion case? And finally, what measures can pharmacists take *now* in order to safeguard their patients and their practice? The remainder of this post will provide pointers on how to screen patients, examine the effectiveness of current policies intended to curb drug abuse, and lastly, suggest changes that pharmacists can implement immediately to improve their practice.

Identifying at-risk patients:
Is there a difference between drug misuse and abuse?

Community pharmacists see hundreds of patients a day. Of these, only a certain number require Schedule II drugs. How can a pharmacist classify those patients as having legitimate versus illegitimate medication needs? There are a number of classic tips handed down to pharmacists over the years as well as newer adaptations, but first it's important to establish the types of patient cases and how they may differ.

A 2010 study published by the Harm Reduction Journal interviewed a series of practitioners, pharmacists, and other experts for their views on drug abusers. Although those professionals claimed to have no particular image of the stereotypical drug misuser, there turned out to be two general categories of misusing patients that interviewees had recurring experiences with. Those patients were termed either "drug abusers" or "over-users". They may not be scientifically-proven categorizations per se, but they are the result of professionals' lived experiences, which act as evidence themselves. The described patient characteristics are something that most, if not all community pharmacists have come to recognize. Of the two patient categories, "drug abusers" are those that come into the pharmacy with a premeditated intent to use or sell medication illicitly. They may carry a forged prescription, or a deceptively-obtained legitimate one. "Over-users", on the other hand, are regulars of the pharmacy who once had a medical need

for narcotic pain relievers (i.e. an accident/surgery) but have inadvertently gotten addicted. These patients have no malicious intent, and may not even be aware that they are drug dependent. (Note that both these patient situations differ from those of chronic pain sufferers, who have a legitimate medical need for pain relievers and may unfortunately have to take them throughout life.)

Despite the differences in these patient cases, each situation should be treated equally and with the same amount of care, starting from square one. As with all goings-on in the pharmacy, the catalyst in drug abuse cases is the patient's prescription. At its root, the problem boils down to first identifying whether the prescription is real or not. If the prescription is forged, then it's a good bet that the patient has something up his or her sleeve. If the prescription is legitimate and backed by the prescriber, then it's either a) a medication over-user, b) a pill mill prescriber, c) a deceptive patient, or d) perfectly ok to be filled (let's not deny those exist). Obviously, more often than not the prescription will appear to be perfectly legitimate, which is where the situation could take one of several turns. The preliminary step, however, is weeding out fraudulent scripts.

Regarding fraudulent prescriptions, most pharmacists will profess that learning to identify them is a matter of experience. While this is true, a general list of guidelines is a helpful start. The DEA's informational brochure for pharmacists suggests looking out for certain red flags such as:

- A prescriber that writes significantly more prescriptions than the average provider
- A prescription for antagonistic stimulants and depressants
- Prescriptions lacking the standard abbreviations
- Patients presenting narcotic scripts that were written on a much earlier date
- A group of patients coming in to fill the same prescription

The DEA also suggests becoming familiar with regular patients and their prescribers' signatures, which will require significant time and experience in the pharmacy.

Identifying addiction and diversion in patients with legitimate prescriptions is considerably more challenging. These will require collaboration with prescribing physicians, a task made all the more difficult due to time restrictions and sometimes even personal incompatibilities. Yet, the recent development of interprofessional education (mentioned later in this post) proves that working as a healthcare team is becoming the best method of patient care.

Current laws and policies
Do they help? How can they improve?

Since Nixon began the U.S. war on drugs in 1971, a large number of laws, policies, and programs have been put into place in an effort to end drug abuse. These efforts have each met with their own level of success or failure, but have ultimately created a country where $51 billion is contributed annually to a cause that has largely backfired. With regard to prescription drugs specifically, let's take a look at the current policies in place for pharmacies and how they can help or hurt the patient's cause:

Per the Controlled Substances Act regarding Schedule II drugs:

- Patients must present an original prescription.
- No refills are allowed.

What is *not* stated by the Controlled Substances Act, but some pharmacies still practice:

- Patients must show state picture ID at drop off and pick up.
- The pharmacy can't hold paper prescriptions: they must be turned in and filled on the day the patient picks them up.
- Pharmacists and technicians cannot reveal controlled substance inventory to patients over the phone.
- Partial fills are not allowed.

The measures listed above, although not required by the Controlled Substances Act, have been implemented in many pharmacies to avoid the heavy penalties associated with drug diversion. These extra steps are reasonable, but may often cause patients inconvenience, which gives the bad impression that pharmacies are tight-fisted. Oftentimes patients don't understand why they cannot receive a partial fill if the pharmacy doesn't have enough stock to do a complete fill for a Schedule II drug. The DEA *does* permit partial fills. However, due to the complications and difficulty in tracking split scripts, most pharmacies will not provide partials and instead choose to err on the side of caution.

Furthermore, pharmacies are facing increasing struggles as wholesalers have limited shipments of Schedule II drugs. These actions were taken due to several scandals involving Florida pill mills and Walgreens pharmacists not doing enough to stop drug abuse. Wholesalers have limited shipments to pharmacies to avoid seeming suspicious, and CVS is even cutting off prescribers that seem to prescribe too many narcotics. These actions, in response to the DEA's heavy fining and penalties for wholesalers and pharmacies, create a trickle-down effect that ultimately falls on patients. Shortages from restricted shipments have led to cases where patients suffering chronic pain have been turned away to visit other pharmacies, potentially raising suspicions yet again. In even more unfortunate cases, they may turn to illicit drugs to facilitate their pain medication's effects. The fear of brutal consequences from the DEA has immobilized pharmacies whose primary goal is to provide for patients. Unfortunately, there is no easy way to resolve this issue, lest the government consider less criminalizing ways to deal with the issue of drug abuse.

On the upside of things, pharmacies have also seen a number of positive and effective measures against drug abuse and diversion. More recent developments include:

- **PMP databases**: Each state-run prescription monitoring program collects information on controlled substance prescriptions and patients' medical history in order to help prescribers and pharmacists make appropriate decisions regarding patient health. If necessary, providers may also use the NABP PMP Interconnect database to access information across 26 states. Currently, although Massachusetts has its own PMP, its database hasn't been made available on the Interconnect system. Regardless, its benefits have made an impression on prescribers, given the results of a study done just this year.

The study, published in the PDS journal, reported that when provided unsolicited reports from their state PMP, 90% of interviewed Massachusetts providers were unaware of the prescriptions their patients had been receiving from other prescribers, and 70% felt that those prescriptions may have been medically unwarranted. This is a revealing statistic that shows just how much clarity a PMP can provide to healthcare professionals. That information is extremely valuable, and the study indicated that the majority of prescribers met with the reported patients afterwards, and also believed the reports were helpful to their practice.

- **Educational websites**: Internet sites such as Aware Rx by the NABP provide information on prescription drug handling to patients, students, pharmacists, and corporations alike. The section of the site dedicated to pharmacists provides some useful resources including educational posters and a video on red flag prescriptions. These websites are a handy tool to which pharmacists can easily refer patients who have questions about proper prescription handling.
- **Take-back programs**: In the past, the DEA has organized a "national take-back day" for patients to return unused medications to given collection sites. Just last month, however, a final statement that turned the responsibility over to pharmacists. The rule allows patients to return medication- including opioids- to participating local pharmacies. Given that this was previously prohibited under the Controlled Substances Act, this is a huge step. Instead of having unused prescription medications lying around the house, patients can now legally return them from where they were dispensed. This is an important move in keeping prescription medications away from those who have no medical need. With the new rule in effect as of October 6, however, pharmacists will now have to consider new challenges associated with keeping returned drugs secure from pilferers. What becomes of the situation remains to be seen, but it's definitely an important development to follow.

Practical suggestions for pharmacists

How to change your pharmacy

As it's highly unlikely for laws to change quickly, pharmacists need to know how to deal with the problem *now*. It's easy to get caught up in the logistics of specific cases: what do I do with the prescription? Do I call the police? These types of questions are more suited to a training course that deals with drug addiction, and I won't go into them here. My goal is to suggest broader ideas that can be immediately implemented in the pharmacy. Changing small ways in which you practice can go a long way in curbing drug abuse and improving patient care.

- **Treat patients equally.** To quote the APhA, a good pharmacist acts "with a caring attitude and a compassionate spirit…[and] avoids discriminatory practices, behavior or work conditions". The HRJ study cited previously showed that healthcare professionals tend to treat "drug abusers" with less sympathy and view them as manipulators that have to be outsmarted. On the other hand, "over-users" are treated much more kindly and providers may even be reluctant to confront them about their drug habit. These biases are

problematic not only because patients are treated unequally, but also because their health is put at risk. Pharmacists need to hold back any judgments and act professionally, even when a patient's prescription seems fraudulent. This way, innocent pain-medication patients won't be treated criminally, and actual drug-addicted patients can be referred to treatment in a professional manner. The stigma around being a drug abuser only prevents people from seeking treatment, and acts as a barrier between providers and their patients. By overcoming that barrier, pharmacists can engage with patients in a more personal, helpful way.

- **Educate patients.** Over half of all prescription drug abusers get medication for free from friends or relatives who had a prescription, whereas only 4% of abusers source them from dealers. This is an alarming statistic that underscores importance of community pharmacies in preventing prescription abuse. Uninformed patients who don't know about the abuse liability of their medications can easily make dangerous judgments. Likewise, patients who are not instructed to safeguard their medications are prone to misdirecting them to others. Educating patients about the risks, directions, and proper safekeeping of medications is key to preventing prescription drug diversion.
- **Educate yourself.** Keep with the news and make changes accordingly. Most recently on October 6, the DEA announced that hydrocodone combination products would be rescheduled as Schedule II drugs. Consequently, in an effort to maintain up-to-date recordkeeping, most pharmacies have required patients to immediately provide new prescriptions on HCPs regardless of refills remaining. Changes like these are a huge effort on pharmacists' part, but keeping up with current drug statuses is essential to giving patients correct information.
- **Work interprofessionally.** Build a network of familiar healthcare professionals, and collaborate on patient cases. Communication is absolutely essential! This allows patients to receive care that is both real-time and cohesive. Rather than having an assembly-line model of healthcare where each provider is detached from the others, a team-based approach eliminates confusion and grounds patient trust. This style of working is very different to the one pharmacists are currently used to, and will likely require different schooling, several models of which are described by a study on Medical Education Online. Regarding prescription drug abuse, interprofessional teams can be helpful in cases where patients want to know the pharmacy's stock before filling their script. Most pharmacies do not reveal their controlled substance inventory over the phone for safety reasons, but if collaborating with a familiar physician, it's easy for him or her to call the pharmacy before writing prescriptions instead.
- **Develop a list of resources.** During a 2012 APhA conference on opioid abuse and diversion, pharmacists suggested keeping an easily-accessible list of local providers, treatment centers, and trusted pain physicians. Should a patient be suspected of having struggles with drug addiction, it'll be easier to refer him or her to the right place. Pharmacists may be tempted to believe that once patients are out of the pharmacy, the issue is out of their hands- but as healthcare professionals we should always direct patients towards the right resources, even if it's outside our area of work.
- **Lobby for provider status.** Current legislature in Part B of the Social Security Act does not consider pharmacists to be healthcare providers. This limits Medicare patients' access to outpatient pharmacy services as well as compensation to pharmacists for those services. Recognizing pharmacists as valuable members of the healthcare team will not

only facilitate interprofessional work, but also communicate to patients that their pharmacists are educated professionals and not simply "pill-counters". The APhA website for provider status recognition is a great place to contribute your voice to this cause.

Final thoughts

Getting the big picture

The myriad complications in drug abuse make it an incredibly difficult issue to tackle. Yet, given that prescription medications are killing more people than some illicit drugs, the pharmacy community has been pressured to take on more responsibilities. As healthcare providers, pharmacists need to step up to the challenge. We are the professionals most qualified for handling prescription abuse, having knowledge on both drugs and pharmacy workings. This includes first-hand experience with the conflicts of balancing quality care and law. Consequently, community pharmacists have a huge influence on curbing prescription drug abuse. For the workplace, this means employing PMP databases and take-back programs, or building resources for patient education. For pharmacists, this means working collaboratively with providers as a team, and treating all patients with the same professionalism. Making these changes to existing establishments will no doubt take considerable work, but patient health has always been a worthy cause. Given the joint effort of pharmacists, physicians, and eventually the legislative community, people across the country may finally hope for an end to drug abuse in the U.S.