CME CREDIT

TAKE-HOME POINTS FROM LECTURES BY CLEVELAND CLINIC AND VISITING FACULTY

Preventing prescription drug abuse

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ABSTRACT

Prescription drug abuse is a problem with potentially grave consequences for patients and their families. Primary care physicians can play a major role in curbing prescription drug abuse by learning to recognize drug-seeking behavior and other warning signs, by educating patients about their drug regimens, and by setting firm but reasonable prescribing guidelines for their practices.

PREVENTING OR STOPPING prescription drug abuse, though seldom discussed, is an important part of primary care practice. This does not mean clinicians should not prescribe strong sedatives and pain killers. On the contrary, except for Schedule I drugs, many "controlled substances" (TABLE 1) have a useful and legitimate medical purpose and are necessary to maintain the health and general welfare of our patients.

Using the simple rules outlined in this article, clinicians can recognize the warning signs of prescription drug abuse and can take appropriate steps to prevent it.

THE EXTENT OF PRESCRIPTION DRUG ABUSE

Prescription drug abuse is a common problem, although exactly how common is difficult to say. Self-reporting surveys show that 1.4% of the population questioned admitted to nonmedical use of tranquilizers or analgesics within the last month, with a lifetime estimate of 15%. The American Medical Association has estimated that 3% of the US population misuses or abuses controlled drugs.

TABLE 1

Current US Drug Enforcement Administration drug schedules

Schedule I
Heroin, marijuana, psilocybin, LSD, mescaline

High potential for abuse and a lack of accepted safety under medical supervision. Most primary care physicians and internists would not normally prescribe these drugs.

Schedule II
Morphine, oxycodone, hydromorphone, meperidine, fentanyl, methadone, codeine, cocaine, amphetamine

High potential for abuse and a currently accepted medical use, though with severe restrictions. Abuse of these drugs may lead to severe psychological or physical dependence.

Schedule III
Acetaminophen with hydrocodone, acetaminophen with codeine

Lower potential for abuse than schedule I and II drugs, and there is a currently accepted medical use. Still, abuse of these drugs may lead to moderate or low physical dependence or high psychological dependence.

Schedule IV
Propoxyphene, pentazocine, benzodiazepines, phenobarbital, chloral hydrate, paraldehyde

Relatively low potential for abuse. They have accepted medical uses, but limited physical or psychological dependence is still possible.

Schedule V
Diphenoxylate with atropine, narcotic cough syrups

Same as for Schedule IV drugs.

PRACTICAL DEFINITIONS OF DRUG USE AND ABUSE

When discussing prescription drug abuse, some practical distinctions are helpful:

- **Appropriate use:** a medication is used as prescribed and only for the condition indicated
- **Misuse:** a medication is used for a reason or in a manner other than that prescribed (eg, using a family member's medication)

TABLE 2

CAGE questionnaire

Have you ever felt you ought to **C**ut down on your drinking?

Have people ever **A**nnoyed you by criticizing your drinking?

Have you ever felt bad or **G**uilty about your drinking?

Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (**E**ye-opener)?

ADAPTED FROM: EWING JA. DETECTING ALCOHOLISM: THE CAGE QUESTIONNAIRE. JAMA 1984; 252:1905–1907.

- **Abuse:** a medication is used outside the normally accepted standard, with negative consequences and continued use despite these consequences
- **Physical dependence:** a pharmacologic property of a medication; a withdrawal syndrome develops when a drug is stopped suddenly.

RECOGNIZING DRUG-SEEKING BEHAVIOR

Set firm policies for prescribing controlled substances in your practice

Warning signs of prescription drug abuse often surface in the course of taking the history and talking to the patient. These include a history of alcohol or substance abuse, "doctor shopping" (ie, seeing many different doctors), and escalating use of a prescribed drug, often identified when a patient requests refills of medication before the prescription runs out.

Red flags that a patient may be abusing prescription drugs include:

- Repeated complaints of acute pain syndromes such as renal colic, toothache, migraine, or tic douloureux
- Stealing prescription pads left lying in the open
- Doctor shopping
- Claiming to be "new to the area," on vacation, or "just passing through"
- Losing a prescription
- Requesting prescription drugs after hours
- More concern about getting a prescription than about discussing or dealing with the medical complaint, including refusal of a diagnostic workup or consultation
- Frequent emergency department visits
- A sophisticated knowledge of a specific drug
- Personal pleas such as "You're the only one who can help me."

How physicians contribute to prescription drug abuse: The four d's

Physicians may also contribute to the problem. Their knowledge about controlled substances and management of common pain and anxiety syndromes may be **dated**. They may allow themselves to be **duped** by patient scams. They may be **dishonest** ("script docs"). They may themselves be substance abusers or have a psychiatric disorder and are therefore **disabled**.

Furthermore, for some physicians the desire to relieve patient suffering may unintentionally lead them to foster prescription drug abuse in susceptible patients.

PRACTICAL TECHNIQUES FOR PREVENTION

Anytime you feel uncomfortable about prescribing for a given patient, take a step back and ask yourself how well you have assessed the situation. Follow your instincts. Don't hesitate to just say no when you have to.

Clarify any misunderstandings the patient may have about the prescribed drug regimen. Give the patient practical advice about the disease and the treatment regimen.

Know how to screen for chemical dependence using tools such as the CAGE questionnaire (TABLE 2).

Know how to recognize signs of escalating use of prescription drugs.

Set firm prescribing policies for prescribing controlled substances and other abused drugs in your group or private practice. State the prescribing and refill policy up front (eg, "no refills at night"). However, simply taking a "tough" stance—ie, never prescribing controlled substances—is not providing optimal care to patients in need of pain relief.

Carefully document the diagnosis to justify the use of controlled substances.

Limit access to prescription pads.

Maintain a refill flowchart for controlled drugs for patients you are concerned about. Record all refills, including those prescribed after hours. Avoid giving multiple refills without office visits.

Avoid prescribing more than one controlled substance at a time.

Use your pharmacist as an ally to determine if patients are abusing prescription drugs. The patient may be obtaining prescriptions from other physicians.

INTERVENTIONS WHEN YOU SUSPECT ABUSE

If you suspect a patient is abusing prescription drugs, demonstrate direct, empathetic concern in a nonjudgmental way. One approach is to say, "I understand you are worried about your back pain, and I want to help you, but I'm concerned that you may have problems with the pain medicine you're using."

Consult a substance abuse program if you sense a patient has a problem.

When prescribing for patients with substance abuse problems, treat acute pain syndromes or terminal pain syndromes in the same way you would treat other patients. The goal is not to punish patients for abusing drugs. Avoid prescribing controlled substances for chronic benign pain syndromes. Involve substance-abuse consultants whenever you are unsure.

SUGGESTED READING AND BROWSING

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