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Prescription Drug Abuse & Diversion: Role of the Pain Clinic

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Abstract

The goal of this research is to better understand the role that South Florida pain management clinics may be playing in the abuse and diversion of prescription drugs. This study explores 1) the characteristics and practices of pain clinics that may be facilitating the drug-seeking endeavors of prescription drug abusers and 2) the drug-seeking behaviors of prescription drug abusers who use pain clinics as a primary source for drugs. Thirty in-depth interviews were conducted with prescription drug abusers in South Florida. Interviews were transcribed verbatim and codes were generated based on thematic analyses of the data. Using grounded theory strategies, the analysis revealed six main themes: “pill mills”, on-site pharmacies, liberal prescribing habits, “sponsoring” drug diversion, pain doctor/pharmacy shopping, and faking symptoms/documentation. These findings should provide insights for law enforcement, regulatory agencies, and industry as they attempt to develop appropriate policy initiatives and recommendations for best practices.

Introduction

The abuse and diversion (the transfer of a prescription drug from a lawful to an unlawful channel of distribution or use) of prescription opioid analgesics are serious problems that have major implications for public health, criminal justice, medicine, and policy. According to the National Survey of Drug Use and Health, an estimated 5.2 million Americans (age 12 or older) reported using prescription opioids non-medically in the past month (SAMHSA, 2007). Opioid abuse is so widespread that it accounts for 75% of all prescription drug abuse in the U.S. (Colliver, Kroutil, Dai, & Gfroerer, 2006). In fact, opioid analgesics reportedly cause more deaths nationwide than either heroin or cocaine (Paulozzi, Budnitz, & Xi, 2006). Birnbaum et al. (2006) estimate that the abuse of prescription opioids costs the U.S. $9.5 billion in 2005 leading some researchers to refer to this problem as a “national epidemic” (Manchikanti, 2006). However, attempts at slowing the problem have proven largely unsuccessful as prescription drug abuse continues to grow (Kuehn, 2007).

The dramatic rise in prescription opioid abuse began in the 1990's at about the same time that opioid analgesics assumed a greater role in the management of chronic pain in the United States (Kuehn, 2007). In other words, as physicians began prescribing opioids more aggressively to treat pain, the numbers related to prescription drug abuse similarly increased. In fact, in a study comparing the increase in fatal opioid poisonings with the sales of opioid analgesics nationwide, researchers found that the increase in deaths generally matched the increase in sales for each type of opioid (Paulozzi, Budnitz, & Xi, 2006). This study concluded that the increase in prescribing of opioid analgesics for pain management may have inadvertently contributed to the increases in U.S. drug poisoning since 1990. Drugs such as oxycodone, hydrocodone, and methadone are implicated in the majority of opioid poisonings nationwide, but nevertheless continue to be among the most popularly prescribed medications in pain management (Paulozzi, Budnitz, & Xi, 2006; Wysowski, 2007). While the significant rise in prescription opioids has indeed helped to address the problem of the under treatment of pain, this trend has not come without some harmful side effects.

Although there are many legitimate pain management clinics, many others are prolific and indiscriminate distributors of opioid analgesics (Hiaasen, 2009b). The term “pill mill” is typically used to describe a doctor, clinic, or pharmacy that is prescribing or dispensing controlled prescription drugs inappropriately (Malbran, 2007). According to some observers (Hiaasen, 2009b; LaMendola, 2009; Malbran, 2007; Santana, 2009; Scott, 2009), pill mills are becoming increasingly common in the array of Florida pain management clinics. Furthermore, recent research and media reports suggest that prescription drug abusers and traffickers have been utilizing pain clinics as a source for controlled prescription drugs (Cicero, & Inciardi, 2005; Fausset, 2009; Hiaasen, 2009a; Inciardi, Surratt, Kurtz, & Cicero, 2007). Even though the increase in prescription drug abuse and diversion related to pain clinics has been documented in the literature, little research has been conducted on how and why pain clinics have become such a popular source for drugs among prescription drug abusers. This study aims to better understand the relationship between prescription drug abusers and pain management clinics.

While prescription drug diversion is a national problem, South Florida (Miami-Dade, Broward and Palm Beach counties) has received both local and national media attention for being a questionable area for diverted prescription medications (Fausset, 2009; LaForgia, 2009; LaMendola, 2009; Scott, 2009). Many law enforcement officials believe that a great deal of the prescription drugs being abused nationwide (especially in the northeast and Appalachian states) can be traced back to South Florida pain clinics (Hiaasen, 2009a; Santana, 2009). Broward County, largely considered to be the epicenter of pain management clinics, has recently been referred to as “The Painkiller Capital of the United States” and “The Colombia for Pharmaceutically Diverted Drugs” (Hiaasen, 2009b). According to the Drug Enforcement Administration (DEA), more oxycodone is distributed in Florida than any other state in the country, 40 percent more than second ranked California. Many observers attribute this trend to the proliferation of pain management clinics in South Florida (LaMendola, 2009). In 2008, the DEA estimated that pain clinics in South Florida increased from 60 to 150, with Broward County accounting for 89 of these clinics (Hiaasen, 2009b).

With regard to dispensing, a growing number of pain physicians in South Florida are designated “dispensing doctors” (physicians who can sell the prescription drugs they prescribe). Reports suggest that some pain clinics are hiring these specially licensed physicians in an effort to boost profits (LaMendola, 2009). These types of pain practitioners may be responsible for the boom in the distribution of many prescription opioids, dispensing 85 percent of all the oxycodone prescribed by doctors nationally in 2006. In the last 6 months of 2008, 9 million pills of oxycodone were dispensed by just 45 South Florida doctors (mostly pain specialists) (Hiaasen, 2009b). DEA data show that the top 50 dispensing practitioners of oxycodone nationwide are all located in the state of Florida and primarily concentrated in the southern portion of the state (LaMendola, 2009). The misuse and diversion of these dispensed pain medications are so widespread that the DEA thought it necessary to create two new special units devoted solely to curbing these phenomena (Hiaasen, 2009b).

The rapid increase in pain clinics to South Florida has not only contributed to the surge in the distribution of prescription opioids, but has also played a large role in the number of opioid-related deaths in the state (Hiaasen, 2009c). The Florida Medical Examiners Commission Interim Drug Report, which recorded drug-related deaths in the first half of 2008, helps to paint a clearer picture of the death toll that each drug had statewide (Florida Department of Law Enforcement Medical Examiners Commission, 2008). Overdose deaths caused by the commonly prescribed opioids oxycodone and hydrocodone increased by 18.5 percent and 7.7 percent, respectively, when compared to the last six months of 2007. In fact, oxycodone appears to be responsible for more overdose deaths (n = 423) than any other

opioid. Other pain medications commonly sold at pain clinics such as methadone and morphine are also among the drugs most frequently implicated in overdose deaths across Florida (FDLEMEC, 2008).

Prescription pain killers are only part of the problem. Benzodiazepines, such as Xanax and Valium, play a controversial, but prominent role in the management of chronic pain and are among the most frequently prescribed drugs at pain clinics (Dellemijn, & Fields, 1994; Hiaasen, 2009b). During the first half of 2008, benzodiazepines accounted for the second highest amount of overdose deaths statewide, 392 – including 291 deaths caused by Xanax alone (FDLEMEC, 2008).

The above data suggest that the prescription medications being dispensed in record number by pain clinics are prominent among the drugs identified in a majority of overdose deaths. This also suggests that a significant proportion of the pills prescribed from these facilities may be ending up in the hands of abusers and/or traffickers. Within this context, further study is needed to better understand the role of pain clinics in the abuse and diversion of prescription opioids. To address this knowledge gap, this study explores (from the perspective of the abuser): 1) the characteristics and practices of pain clinics that may be facilitating the drug seeking endeavors of prescription drug abusers and 2) the drug-seeking behaviors of prescription drug abusers who use pain clinics as a primary source for drugs.

Methods

Sample

The data in this paper are drawn from the South Florida Health Survey (SFHS), a 5-year qualitative and quantitative scale study initially funded in 2007 by the National Institute on Drug Abuse. The goal of the SFHS is to examine and describe the complex mechanisms and players that connect illicit supplies of prescription drugs to abusers in South Florida. By mid-2009, 650 prescription drug abusers from the South Florida area had participated in a quantitative interview regarding their lifetime history of prescription drug abuse, diversion mechanisms, physical/mental health, and other health behaviors. From this larger sample, participants were selected for in-depth qualitative interviews. Only participants who appeared to be the most heavily involved in diversion and had extensive histories of prescription drug abuse were selected for diversity across the following parameters: gender, race/ethnicity, type of primary prescription drug used, and primary diversion mechanism. A total of 54 participants completed in-depth interviews, and of these, 30 reported pain clinics as a major diversion source. These participants represent the focus of this analysis

The sub-sample included Black/African-American (n = 3), White/Anglo (n = 22), and Hispanic/Latino (n = 5), with ages ranging from 18-58 with a mean of 35 years. There were 18 men and 12 women from a variety of relevant drug abusing populations, specifically methadone maintenance clients (n = 8), drug treatment program enrollees (n = 13), men who have sex with men (MSM) (n = 2), and street based/illicit drug users (n = 7). These user groups were targeted by the SFHS as previous research indicated that prescription drug abuse is a current phenomenon in each population (Brands, Blake, Sproule, Gourlay, & Busto, 2004; Kurtz, & Inciardi, 2003; Rosenblum et al., 2007; Sigmon, 2006).

Only individuals (age 18 and above) who abused prescription drugs at least 5 times within the last 90 days and met one of the following criteria were eligible to participate in the SFHS: 1) for methadone-maintenance clients – enrolled in a methadone-maintenance treatment program as of the interview date, 2) for street based/illicit drug users – must have used powder/crack cocaine or heroin for 12 or more of the past 30 days prior to interview date, 3) for drug treatment program enrollees – must be enrolled in a drug treatment facility

for less than 45 days prior to interview date, and 4) for MSM – must be a man who has had sex with other men and have used ecstasy, methamphetamine, or powder/crack cocaine at least once in the past 30 days or for 3 or more days in the past 90 days prior to interview date. All study protocols and instruments were reviewed and approved by the University of Delaware's Institutional Review Board.

Procedures

A variety of purposive sampling strategies were used to locate study participants. Print media advertisements, online recruiting, the handing out of cards in relevant venues, and posting of flyers were largely used to recruit street based/illicit drug users and MSM, while referrals from methadone clinics and drug treatment centers served as the primary method of recruiting for methadone clients and drug treatment enrollees. Participants were paid $30 for participating in the interview, plus an additional $10 incentive for any referral that completed an interview. Each individual in-depth interview was conducted between September 2008 and August 2009 by the first author and usually lasted between 60 to 90 minutes. The majority of interviews were conducted in a private room at one of our two South Florida field office locations (Miami Beach and Ft. Lauderdale), while some were done on-site at local methadone clinics and drug treatment centers. Participants were asked a series of open-ended questions that explored 4 broad themes: 1) nature of prescription drug abuse (e.g. frequency of use, drug types, method of ingestion), 2) methods of drug diversion (e.g. dealer, pain clinic, theft), 3) impact of abuse on physical/mental health, and 4) motivations for prescription drug abuse.

Each interview was recorded using a digital voice recorder. The audio taped interview was then transcribed verbatim and was subsequently imported into NVivo 8, a qualitative data analysis computer software program. The use of this software package's search engine and query functions enhanced the researchers' ability to identify trends and search for salient themes in the data. Given the exploratory nature of the study, grounded theory strategies were utilized as the codes were generated from emergent themes in the data (Charmaz, 2000; Charmaz, 2003; Glaser, & Strauss 1967). This approach was chosen for its proven ability to explain complex social phenomenon from the perspective of the participant. Analysis was approached with a beginning awareness of the literature which served as a tentative point of origin for open coding. Initial coding consisted of highlighting commonly used words and phrases, and locating initial themes. After initial coding was complete, a more selective coding process was utilized. The most frequently occurring initial codes were used to sort, synthesize, and conceptualize the data (Charmaz, 2003). In the final step, excerpts from study participants were chosen to illustrate each theme. These emergent themes are further discussed in the following section.

Findings

The analysis of the interviews yielded six main themes: 1) “pill mills”, 2) on-site pharmacies, 3) liberal prescribing habits, 4) “sponsoring” drug diversion, 5) pain doctor/pharmacy shopping, and 6) falsifying symptoms/documentation.

“Pill Mills”

The pain clinics visited by participants tended to possess characteristics that are typically associated with pill mills such as patients being allowed to choose their own medications and cash being the only acceptable form of payment (Malbran, 2007). In fact, there was a prevailing feeling among most participants that pain management clinics' lone motivation was making a profit. Interestingly, participants tended to have disdain for pain doctors even though they were helping to facilitate their habits. The idea that pain doctors did not care

about their well-being was clearly articulated by most of the abusers. To this point, most participants felt that the doctor knew about their misuse, but prescribed anyway. For example:

> They knew it was being abused, but nothing is ever spoken. I weighed about 90 pounds. I was so sick, and my blood pressure was so low it was bottoming out. I was having seizures. My physical health just deteriorated. I mean, it's obvious if you walk in, you can tell if someone is an active crack head or actively abusing pills (Hispanic female, 41, drug treatment enrollee).

> They're making money. Do you know how much money those doctors are making? They're seeing like – Say, they see like 45 patients in a day, which I know they see more than that. They're getting $150 just for the visit, plus if they have a pharmacy there, then they can pull money off the pills. They're making $20,000 or $30,000 a day. They don't want to stop that, and if they stopped all the junkies, then they're not going to have any customers (White male, 21, drug treatment enrollee).

The pill mill characteristic of cash only as payment was possessed by almost all the pain clinics that our participants' frequented:

> They don't care. They don't give a crap. They are there for the money; that's all it is. It's money, only cash – just cash. I mean I have sat there and watched people come in completely dope sick, literally feel like they're dying when they walk into the door. They are coming there to get their fix; they get it, they're eating them right out of the bag out of the office and they're on their way. They are cash only businesses like selling drugs on the street, except they've got an office for it (White male, 39, drug treatment enrollee).

This quote illustrates the pill mill characteristic of participants instructing the doctor as to what drugs made them feel better:

> The doctors are drug dealers. That's how they take it. They open up a pain management center, they get their little doctor's license so they can prescribe drugs, and they make 200 bucks a pop. You go in there and you don't even need to have – the X-rays don't even need to be legit. I went in there with my girlfriend's mother's x-rays. I took a black permanent marker and put (name) on top of it, handed it to the doctor, and he's like, “So what do you want? You have pain?” I'm like, “Yeah, it hurts right here and here.” And he's like, “Okay, well what would you like? Would you like Oxy's (Oxycodone)? Roxi's (Roxicodone)?” And I'm like, “Hmm. How about this – you give me 200 Roxi's and 100 Oxy 80's so that if I have a lot of pain I can take the Oxy 80's and if it's small I can take these?” And he's like, “Okay, just go see (name) at the front and pay for your visit and I'll see you next month” (White male, 19, drug treatment enrollee).

According to participants, alternative methods of treating pain were never suggested by the doctor. The characteristic of treating pain exclusively with pills is also consistent with the profile of a pill mill:

> They are prescribing like 180 to 200 Roxi's a month along with Xanax. They are just legal drug dealers is all they are…'cause they say they specialize in “pain management”, but we're not talking about massage therapy or acupuncture, they are talking about giving you pills to make you feel better, that's it (White male, 31, drug treatment enrollee).

Although not on Malbran's list of pill mill characteristics, the unusual advertising campaigns of many pain clinics were frequently mentioned. Pain management clinics aggressively advertised in the back pages of free weekly local newspapers, atypical for most doctors.

Sales tactics as “first visit free”, “buy 1 pill, get the 2nd free”, or “receive $30 gift card for referrals” were commonly utilized by pain clinics to get customers in the door. The overwhelming majority of participants were not only aware of the advertisements, but reported using these papers to identify which pain clinics to visit. It appeared that the nature of some of these advertisements contributed to their impression of the pain clinic as a “shady” enterprise:

> Look on the back of *Excel* (local paper). It's called *Excel*. It's on any of these newsstands. Flip the magazine over, and there are about 500 pain clinics, and the biggest ones are on the back page and then flip, flip, flip. All it has is pain doctors and escorts. I mean, have you ever heard of a doctor running ads with an escort service side by side? They're legal drug dealers (White female, 33, drug treatment enrollee).

Some of the other pill mill characteristics commonly mentioned by participants included unusually long lines and being directed to the doctor's pharmacy.

On-Site Pharmacies

An increasing number of pain management physicians have been granted special permission from the state to dispense prescription medications, much in the same way a pharmacy would. Participants consistently favored these pain management clinics for their ability to fill prescriptions on-site. This was especially important for pain doctor shoppers who went to several pain management clinics to obtain multiple prescriptions. By not having to fill their prescriptions at an “outside” pharmacy, abusers no longer had to worry about inadvertently taking different prescriptions to the same pharmacy and risk being caught:

> A lot of them have a pharmacy inside. So, you'd go there, you get the prescription, you walk around to the front. The pharmacy's right there, you'd give them the prescription, and they'd fill it for you, and you'd leave. Those are the ones that a lot of the people that doctor shop like because those pharmacies they know aren't connected to another pharmacy that they already went to like 20 days earlier (White male, 21, drug treatment enrollee).

Another factor that was highlighted by participants was the fact that some “outside” pharmacies were not always able to fill the entire prescription as they did not keep a large enough inventory of some of the stronger opioids commonly prescribed by pain clinics. In addition, participants cited the advantage of having the prescription drugs in their possession as they walked out of the clinic. This was usually so that they could quickly ingest the pills to provide rapid relief from withdrawal symptoms such as vomiting and uncontrollable shaking:

> They're easy. You walk in, and you walk out with the drugs in like 10 minutes. With the pills, I mean, you can snort them right in the car before you leave because they have the pharmacy right there. And you just pay, and they give you everything (White female, 42, street based/illicit drug user).

Liberal Prescribing Habits

Almost all of the participants talked about the liberal prescribing habits of pain management doctors as an appealing attribute of pain clinics. Terms such as “easy”, “liberal”, and “loose” were all used by abusers to describe how easily pain doctors wrote prescriptions relative to “regular” doctors (e.g. primary care physicians). Some participants shared their frustrations in regards to primary care physicians and their unwillingness to write prescriptions for the “stronger stuff” such as OxyContin (80 mg) and Roxicodone (30 mg). All participants felt that pain management doctors were far more comfortable prescribing the stronger types of

prescription medications that they desired. In fact, the overwhelming majority of participants exclusively sought drugs from pain management doctors for this very reason:

> I don't know anyone who would go to a hospital or a general practitioner because they pretty much – they treat you different. They look at you like you are a drug addict. They won't write you a prescription as easily, as quickly, and as much as a pain clinic will. Most doctors are kind of weird about writing Oxy's unless you go to a pain clinic. I just go in and say, “Listen, I want 240 Roxi's, I want 190 Oxy's, and I want 90 Xanax” and he gives it to me (White male, 27, drug treatment enrollee).

Participants themselves were often surprised at how much medication pain doctors would prescribe them and how easy it was for them to get it. It quickly became evident that pain doctors were viewed by participants as prescription drug merchants rather than health care practitioners. This was evidenced by them consistently being referred to by participants as “legal drug dealers”, “fake doctors”, or even the “candy man”:

> I don't even think they're real doctors. They don't even examine you. You just bring in an MRI, and anybody could type one up, you know? You just walk in, they ask you what hurts, they take your blood pressure, they weigh you, and they say actually – literally sometimes, “What do you want?” “How many do you want?”, “How many do you take a day?” You could be ridiculous and say 40. I mean, I could get 200 of each, Roxi's and Oxy's at the same time, which makes no sense, and Xanny bars (Xanax) at the same time. They just ask you what you want (White female, 41, street based/illicit drug user).

This participant marvels at how many drugs the doctor was willing to include in one prescription. It was not uncommon for the size of the prescription to exceed even the participants' expectations:

> Every three weeks he would give me 60 Xanax, 25 Trazapans, 300 thirties (30 mg) of Roxicodone, the little blue ones. He would give me 120 Percocets to go in between the blue ones, which makes no sense to me but I'm not going to fight it – plus another 120 wafers, which are the 40 milligram methadone. And then later on he added in Dilaudid, like 30 of those and the Oxy eighties. He put those in place of the Percocets, which made no sense but again whatever. Okay so now he's giving me eight times the amount, and that was every three weeks (White male, 39, drug treatment enrollee).

> You could tell him Oxy's, Xanax or whatever's out there, and he'd write for you. And he'd write you for the month. He'd write you so much for the month that it would be like, “Hey.” You couldn't even afford it. I mean, I went to the drug store one day to pick up the prescriptions, and they were like $2,000 for all this medicine (White male, 42, methadone maintenance client).

In fact, several participants mentioned that some of the pain physicians they visited either are or were under investigation by law enforcement for excessive prescribing:

> I mean one doctor I went to is still around. He's even gotten in trouble. He's been in the paper for uh – he actually wrote people too much stuff and I think it was nine people died. Look in the paper the last couple of months, you'll find him (White male, 39, drug treatment enrollee).

Not surprisingly, participants rarely complained about not being able to obtain enough pills to satisfy their habit. A more common occurrence was for participants to have such an abundance of prescription drugs that they were able to sell off their “extra” pills to help pay

for their next visit to the doctor as most pain clinics did not accept health insurance and required cash as payment.

"Sponsoring" Drug Diversion

All participants reported at some time selling their "extra" pills to friends and other abusers to generate income. The volume of pills being sold ranged from selling just enough to have some "money in my pocket" to making a profit of "five to six g's a month". While the amount and type of pills that were sold varied, among the most commonly diverted were Xanax (2mg), OxyContin (80mg), Roxicodone (30mg), and other various forms of hydrocodone (e.g. Vicodin, Lorcet, Lortab). While there were a few who considered themselves "dealers", the vast majority of participants viewed it as something they did "on the side" just to help pay for their next visit to the pain clinic or make some extra money:

> It started costing more and more to keep me and my friends high, so I started selling them. Then you go out on the street and you flip all the pills, and you can make like $5,000 in a month. And then you do it again that next Monday, and you do it again and again and again, and then you and your friends can get high (White female, 33, drug treatment enrollee).

Abusers who could not afford to pay for the cost of the doctor visit and the cost to fill the prescription usually took part in a practice known as "sponsoring". This consisted of two individuals entering into a mutual arrangement to obtain prescription drugs, the sponsor and the sponsored. The sponsor is responsible for all the upfront costs associated with obtaining the medications (e.g. cost of visit, cost of prescription, money for gas); while the one who is being sponsored uses that money to physically obtain the pills which typically included making the doctor appointment, obtaining the prescription, and filling that prescription at a pharmacy. Once the pills were obtained, the sponsor was given half of the total amount for his/her role in the endeavor, while the sponsored individual was allowed to keep the remaining half. Here is a participant's description of how he first began sponsoring others:

> One day a guy was saying to me that he had a prescription, but he just doesn't have the money to pick them up. He said, if I pay for it, he would give me half. Well, I did the math and I would still be making out. So me and this guy started doing that also. A lot of kids do that (Hispanic male, 47, methadone maintenance client).

There were several incarnations of the sponsoring phenomenon among participants. Some claimed to have been sponsored by "dealers", while others played the role of sponsor to fellow abusers. Here is another account from a participant who would drive crack addicts around to pain clinics and sponsor their visits:

> They got prescribed the pills, so I'd pay for half of their prescription – I'd pay for their prescription, and get half of it. And I'd drive them to the doctor because they were crack heads. They had no car. They had no money. They just wanted to get their pills, so I'd pay for it, and they'd give me half. I was getting them for like $5, and then I could sell them for $15 or $20 (White male, 21, drug treatment enrollee).

This participant gives some insight as to why she preferred sponsoring others to actually going to the pain clinic herself:

> So what I did was I started sponsoring people who are down on their luck, but take the pills as well, and you say look I'll pay for you to get your MRI, the visit, and the pills every month, but you just have to give me half of them. This way I can still get my pills at a discounted rate and that person has to go through all the work. That way I didn't have to deal with the paper trail and if they ever get caught it's on them (White female, 23, drug treatment enrollee).

Another common variation of this practice was for groups of abusers to pool together their money to pay for someone's prescription. In these cases, pills were then divided up according to the amount of money each person contributed:

> So, what they would do was they would come in the deal with me. You know? If it was $3,000, they'd put in $1,000 each, I'd put in $1,000, and we split the pills up, pool it all together and then that's how we got it. Because we didn't want to get (dope) sick (White male, 42, methadone maintenance client)

Every participant disclosed selling their prescription drugs at some point to make money. Participants consistently reported being prescribed enough pills to satisfy their drug habits while still being able to sell enough to subsidize the cost of their next visit to the pain clinic.

Pain Doctor Shopping

The sale of their pills was a major source of income for most of the participants. Most pain management clinics limited their patients to one visit a month. Some participants mentioned that they consistently ran out of pills before the month was up or needed to get more pills to sell to pay their bills. A common way to circumvent this waiting period was to visit more than one pain doctor, usually ones with on-site pharmacies. Visiting several pain management clinics for the purpose of obtaining multiple prescriptions was a practice that all the participants engaged in at some point in time. For example:

> It's like you go to one doctor, and you get a prescription. You know? And, say, that you're a person that's selling them or you're using way too many, well, you're going to run out way before that month is up, so you go see another doctor, like, in another part of town, and you have him write you a script, and then maybe you go to maybe another pain clinic or something, and get yourself a third script. You know? So then that way, you pretty much got them all month long (Black female, 44, methadone maintenance client).

Pharmacy Shopping

For those who used “outside” pharmacies, they usually visited smaller, single entity, family owned pharmacies, affectionately called “mom and pop” pharmacies. Participants felt they tended to ask fewer questions about the validity of the prescription and felt there was less regulation among these types of pharmacies versus larger chain pharmacies:

> The mom and pop ones are usually cheaper. The corporate ones have more rules and regulations. A lot of the mom and pop places are family-owned or whatever. On top of that, there's a million different mom and pop places. But if you take one prescription to one place and then a month later you take a different prescription to the same place, you're screwed. Now I don't care which Walgreens you go to, they're all Walgreens! You know what I mean? (White male, 27, drug treatment enrollee)

> Mostly we would go to the little places (pharmacies) that are more, like, privately-owned. You know? Like, there was a little medicine shop that we'd go to, it was easier to do them there. They didn't question them. That was much better. Really, we did them mostly there (Black female, 44, methadone maintenance client).

Falsification of Symptoms/Documentation

Another main theme that emerged was the falsification of documents and symptoms by participants for the purposes of receiving prescription drugs. Exaggeration and outright fabrication of symptoms were extremely common occurrences. Symptoms that were commonly given to doctors were back pain, headaches, and difficulty sleeping. Some

admitted to putting on a “show” for the doctor, using props such as canes, walking with a limp, and sometimes even crying out in pain:

> I'd go in, see a doctor trying to get something. Then I would say that I had a problem that I didn't have to get the pills that I needed. Shoulder stuff or any old injuries that I could think of that I had from football or basketball. I'd research it too and then know what to say. I'd become street smart but beyond. You know, pull out the PDR (laugh) (White male, 35, methadone maintenance client).

> I'm 100% healthy. I've never had any kind of sports injury, never had a surgery, and never even broke a bone in my body in my whole life. I would just go in there walking slow, like you're not feeling good, don't laugh or smile, and just act like you're real depressed. “Poor pity me, pity, pity, pity”. Use reverse psychology, and make them really feel bad for you (White female, 33, drug treatment enrollee).

Here is a participant talking about lying to her pain doctor in an effort to get a prescription written for her while she was pregnant:

> You just go in and fake your pain and say you fell or something. Headaches, you can do the headache thing, migraines. Sometimes they'll give you a shot; but it's usually a prescription. I was actually four months pregnant, and lied to my doctor and said I wasn't pregnant, so I could get Xanax and Valium back then (White female, 38, methadone maintenance client).

While these quotes illustrate some of the ways in which abusers deceived pain doctors to get prescription drugs, elaborate stories were seldom necessary. The prevailing sentiment among participants was that pain doctors rarely put patients' claims under heavy scrutiny:

> I've never been touched by a doctor in a pain clinic. Never except to shake their hand or say goodbye or to take my money. I've never been examined, never laid on a table. They don't even have a table. They just have a desk. There's not even an examining room or nothing; just where the lady takes your blood pressure in this little area where they keep all their records. Just go to the pain clinic and say you have back pain, that you were in a car accident or you have bad migraines (White female, 42, street based/illicit drug user).

> He asked me how I was feeling, I mean – he'll ask you a couple of questions and things. I tell him I got in a car accident, this and that, I basically told my brother's story but just said it was me. I mean, I used to go in high and falling over, but from my experience, most of the doctors really don't care. As long as you have your paperwork and they're not going to get in trouble, most of them will just give it to you (White male, 27, drug treatment enrollee).

When written documentation was asked for to substantiate patients' claims, the document of choice was almost always a copy of a magnetic resonance imaging (MRI) report. According to participants, having this document all but guaranteed that a pain doctor would write them a prescription. However, most participants either could not afford it or were unwilling to pay for the cost to have an MRI done which can cost upwards of $3,000. A reoccurring practice was for participants instead to present pain doctors with fake MRI's usually created on a home computer, switching the name on an already existing MRI, printing one from the internet, or purchasing one from an unauthorized source. For example:

> There's a doctor you can go to, pay some money, and they'll write you a fake MRI. Before I did that though, I would take my brother's MRI, I whited out his name, and I wrote my name down on it and I photocopied it. I went to a (pain) doctor, and it worked (White male, 27, drug treatment enrollee).

> We'd get somebody else's MRI report, which is hard to do now because they call the MRI place, and see if it's their report…Because all it is, is a piece of paper with a name on it and shit. You just scan it onto the computer, take their name off, put somebody else's name on it, and go into the doctor…show it to them, and "Alright, here's a whole bunch of pills" (White male, 21, drug treatment enrollee).

Discussion

The findings of this exploratory study suggest that both the practices of some pain clinics and the drug seeking efforts of prescription drug abusers are indeed contributing to the diversion and abuse of prescription drugs. These results lend further support to the findings of Cicero & Inciardi (2005), and Inciardi Surratt, Lugo, & Cicero (2007), who also uncovered evidence of the utilization of pain clinics as a significant diversion source. The data presented here not only confirm the prominence of pain clinics in drug diversion, but also shed new light on exactly how abusers have been obtaining controlled prescription drugs from these facilities.

Prescription drug *diversion* has been defined as the transfer of a prescription drug from a lawful to an unlawful channel of distribution or use (Inciardi et al., 2007). Diversion, furthermore, can occur in many ways, including: the illegal sale of prescriptions by physicians and what are referred to on the street as "loose" pharmacists; "doctor shopping" by individuals who visit numerous physicians to obtain multiple prescriptions; theft, forgery, or alteration of prescriptions by health care workers and patients; robberies and thefts from manufacturers, distributors, and pharmacies; and thefts of institutional drug supplies (Chandra, & Ozturk, 2004; Forgione, Neuenschwander, & Vermeer, 2001; Gilson, Ryan, Joranson, & Dahl, 2004). Moreover, there is growing evidence that the diversion of significant amounts of prescription opioids and benzodiazepines occurs through residential burglaries as well as cross-border smuggling at both retail and wholesale levels (Valdez, Cepeda, Kaplan, & Yin, 1998; Valdez, & Sifaneck, 1997). In addition, anecdotal reports suggest that diversion occurs through such other channels as: "shorting" (undercounting) and pilferage by pharmacists and pharmacy employees; recycling of medications by pharmacists and pharmacy employees; medicine cabinet thefts by cleaning and repair personnel in residential settings; theft of guests' medications by hotel repair and housekeeping staff; and Medicare, Medicaid, and other insurance fraud by patients, pharmacists, and street dealers (Haddox, 2005; Leiderman, 2005).

The qualitative data presented in this study suggest an additional dimension to the diversion array – the unscrupulous prescribing practices of the many so-called pain management clinics that are numerous in South Florida and likely elsewhere. The data indicate that, from the point of view of prescription drug abusers who were interviewed for this study, many of the clinics are no more than pill mills with on-site pharmacies run by physicians with liberal prescribing habits. Interestingly, many of the pill mill attributes that Malbran (2007) lists were consistently mentioned by our participants. Among the characteristics commonly referenced by participants were accepting cash only, directing clients to "their" pharmacy, treating pain with pills only, clients picking their own medicine, crowded waiting rooms, and getting a set number of pills and being given a specific date to return for more.

Prescription drug diversion has also been described as a "black box," in that it is unclear as to the extent to which each mechanism of diversion contributes to the growing availability of opioids and benzodiazepines on the street (Inciardi et al., 2009). However, while diversion remains a black box, this study suggests that the amount of drugs being dispensed through unscrupulous pain clinics is significant – likely tens of thousands daily in the three populous counties that comprise South Florida.

Within this context, it would appear that reducing the amount of prescription opioids and benzodiazepines being prescribed and dispensed by pill mills, and the diffusion of these drugs to the street community, is to some extent a law enforcement issue, but primarily a regulatory problem involving manufacturers, distributors, and dispensing physicians. Part of this problem will likely be addressed through the Food and Drug Administration's (FDA) proposed Risk Evaluation and Mitigation Strategy (REMS) which, in effect, will result in closer monitoring of prescribing and dispensing practices, as well as patient and physician education. The REMS strategy may also encourage manufacturers to take a closer look at the quantities of opioids delivered to distributors, and identifying which distributors are shipping unusually large amounts of opioids to on-site pharmacies.

Although the proposed REMS initiative focuses only on extended release opioids, prescription monitoring programs (PMP) would encompass all drugs. Run by state regulatory agencies, PMP's provide data bases on patients' prescription drug histories. In April 2009, the Florida Senate approved the creation of a PMP. And although Florida's PMP has received criticism by some law enforcement officials and pharmacy experts as being “too easy to beat”, most agree it is a step towards reducing excessive prescribing and doctor shopping (Alanez, & LaMendola, 2009). However, the full impact of Florida's PMP is not expected to be felt until another several years.

A few methodological issues warrant mention. The qualitative methods utilized in this study were well suited to the “hidden” and relatively unexplored nature of these phenomena. However, as this was a non-probability sample, any generalizations should be made with caution. Although data gathered in this study will not necessarily be representative of all prescription drug abusers throughout the U.S., it is reasonable to assume that South Florida presents a drug abuse profile similar to, if somewhat more active than, other urban locales in the U.S. In conclusion, the data presented here is important for better understanding the role that questionable practices in some pain management clinics play in the diversion and abuse of prescription drugs.

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