

Real-time prescription monitoring: helping people at risk of harm

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SUMMARY

Misuse of opioid analgesics and other psychoactive medicines is a serious and increasing problem in Australia. Measures are being taken to try and prevent this progressing to a public health crisis like the opioid overdose epidemic seen in the USA.

One measure is real-time prescription monitoring. This provides real-time information about the patient's supply of psychoactive medicines which have a high risk of being misused.

Having identified a patient at risk, many factors may delay appropriate management or result in the patient being discharged from care. These factors include subconscious negative stereotyping, a focus on preventing 'doctor shoppers' diverting psychoactive medicines, and a fear of sanction by regulators.

The Medical Board of Australia provides guidance about good practice. Patients should be treated with respect, free from bias and discrimination, and without prejudicing care because of the belief that their behaviour has contributed to their problems.

Introduction

Misuse of opioid analgesics, benzodiazepines and other psychoactive medicines is a serious and increasing problem in Australia. Since 1999 thousands of Australians have died from an opioid overdose.¹ New strategies and tools have been developed to manage this risk and help clinicians ensure the safe use of high-risk drugs.

Many deaths involve people obtaining multiple prescriptions from multiple healthcare providers. Some deaths might be prevented if information about the supply of high-risk drugs is available to health professionals at the time of prescribing. This can be provided by new Australian real-time prescription monitoring systems. While this may prompt management of the patient's drug use, there could be unintended consequences.

Patients with multiple healthcare providers

Real-time prescription monitoring may identify high daily doses of opioids, high-risk combinations and patients with multiple prescribers whose treatment is not coordinated. The risk of overdose increases if supply is not coordinated.

Patients with multiple providers are a heterogeneous group. They range from patients with approved indications taking recommended doses, patients with an iatrogenic addiction who are unaware that they are at risk, and those deliberately and fraudulently

seeking psychoactive medicines for their intoxicating effect or for trafficking.²

Trust is basic to the doctor-patient relationship. When this is exploited by a drug-seeking person it may cause negative feelings and indiscriminate refusal to continue treatment for other patients assumed to be fraudulently seeking prescriptions. The focus on preventing 'doctor shoppers' may influence this attitude but, like any other medical condition, patients with multiple providers will benefit from a patient-centred approach.

Escalating opioid prescribing

There was a 15-fold increase in the supply of prescription opioids between 1992 and 2012.³ During this time several new, potent opioids and many new formulations were marketed in Australia. Approximately three million Australians now use opioids each year. About 2.5 million report lifetime non-medical use of pharmaceutical drugs. In 2016 more than 700,000 Australians used opioid analgesics non-medically to achieve a drug effect.⁴

Every day there are nearly 150 hospitalisations, 14 emergency department presentations and three deaths involving opioids.⁵ Increasing numbers of people are being treated in alcohol and drug clinics or being prescribed medicines to treat pharmaceutical opioid dependence.

Opioids and benzodiazepines are commonly involved in overdose deaths. Non-medical use of opioid

analgesics predisposes some people to transition to heroin or other illicit opioids.⁶ Further vulnerability and risk can emerge from concomitant mental health disorders.

The USA is experiencing a public health crisis due to an epidemic of opioid overdoses. Since 1999 there have been more than 400,000 deaths from opioid overdose with 47,600 in 2017 alone.⁷ Between 8 and 12% of patients with chronic pain may be addicted to opioids.⁸ It is conceivable that, without action, the same problems could occur in Australia.

Real-time prescription monitoring

Australian governments are developing strategies to prevent harm from misuse of prescription opioids.⁹ One strategy was to reschedule analgesics containing codeine from being available over-the-counter to Schedule 4, requiring a prescription for supply.^{10,11} The states and territories are now introducing real-time prescription monitoring. This provides the prescriber with an up-to-date history of the patient's supply of high-risk psychoactive medicines to help identify those with an established or emerging problem.¹²

Risk and bias

Real-time prescription monitoring will change clinical practice but could have unintended effects.¹³ Authors of a study of mortality after discontinuation of opioid therapy suggested that these deaths could reflect interruption of other medical care, loss of tolerance, or destabilisation of an underlying opioid use disorder.¹⁴ Primary care is well-placed to manage substance use disorder, but without support many GPs are reluctant to take on new patients being treated with opioids¹⁵ or to prescribe opioid substitution therapy.¹⁶ They may indiscriminately discharge patients with problems identified by real-time prescription monitoring from their practice.¹⁷

This reluctance to manage opioid addiction may develop because of:

- lack of time, confidence, or training in managing substance misuse (practitioners are more confident managing smoking than other substance use disorders)
- negative experiences with drug-seeking individuals or illicit drug users¹⁶
- stigma associated with substance misuse and dependence,¹⁸ as patients with substance use disorder are stereotyped as being dangerous or unpredictable, having a character weakness or moral problem, and being blameworthy for their condition¹⁹
- fear of sanction from regulatory authorities, such as professional registration boards.

Prevailing negative stereotypes are passively absorbed, causing subconscious bias and discrimination. During their undergraduate and early careers health professionals see a biased sample of people with substance use disorder – homeless and intoxicated people with alcohol or drug problems, or people injecting illicit drugs who may be hostile and aggressive. They are less exposed to professional and business people who misuse drugs. However, many patients at risk will be identified by real-time prescription monitoring. Whatever their background, all people need and deserve treatment that may prevent ongoing and serious harm, including death from overdose.

Patients who have become dependent on drugs prescribed by their doctors often differ from illicit drug users. Those iatrogenically addicted may respond more favourably to treatment. They are often highly functioning, with more social supports, higher levels of education, more likely to be employed with fewer legal problems and are not connected to illicit drug markets.^{20,21} These patients feel that they are more socially and economically active²² and unsuited to treatment in drug and alcohol clinics. However, some of them will also use illicit drugs. These patients are at heightened risk of serious harm and will need treatment tailored to their circumstances.

Pre-existing bias is often exacerbated by public and professional media, indemnity insurers, and other communications that focus on preventing the diversion of psychoactive medicines by 'doctor shoppers'. This focus may promote a climate of enforcement or policing of psychoactive medicine supply instead of identifying patients at risk and in need of treatment.

Possible unintended consequences

Activities intended to prevent harm can result in unintended consequences if they are not supported by the right clinical approach.¹³ For example, abrupt cessation of opioids can have serious adverse effects.

The tapering of opioid doses requires special care, especially given that many patients taking opioids have a history of mental health disorder or substance use disorder.²³ Patients rapidly or involuntarily tapered from opioids may have an increased risk of overdose so discussions of risk and ensuring patient agreement before tapering starts are high priorities.²⁴

In 2016 the US Centers for Disease Control published evidence-based guidelines about the use of opioids for chronic pain²⁵ that recommended caution with the dose and duration of opioid therapy. Misapplication of these dosing guidelines exposed patients to involuntary and abrupt tapering of opioid doses

without being offered alternative treatment.²⁶ Patients experienced increases in pain and distress, and mental health problems such as depression, with some turning to suicide. Many clinicians and organisations voiced their concerns,²⁷ including that patients might be forced to seek opioids elsewhere, including the illicit opioid market.²⁸ The US Department of Health and Human Services responded with guidance about tapering that promoted a cautious, respectful approach to tapering, and advocated active agreement of patients in the decision to taper, and consideration and treatment of comorbid mental health disorders. Rapid tapering was to be avoided in most circumstances.²³

Primary care providers in the USA describe difficulties in discussing the findings of prescription monitoring programs with patients and sometimes avoid talking about these findings.²⁹ Some health professionals in New York State responded to the mandatory use of a prescription monitoring program by using it to purge their practices of 'deceptive' or 'bad' patients, rather than as a method of identifying patients who needed professional help and setting them on the path to recovery.³⁰

How to respond

The use of the term 'doctor shopper' suggests all people with multiple prescribers are drug-seeking for non-medical purposes. There is a need to help each patient according to their individual circumstances and avoid this stigmatising language that prejudices patients.

A patient-centred approach to opioid use³¹ focuses on the patient's understanding of their situation

and the underlying cause and its effects on daily functioning. Ask how they would prefer to manage it and offer realistic options consistent with professional responsibilities to provide safe care,³² including referral for, or treatment with, methadone or buprenorphine if appropriate (see Box).³³

Specialist telephone alcohol and other drug advisory services are available to support health professionals in most states and territories.³⁴

The Medical Board of Australia provides guidance about good medical practice. This should be applied to the care of patients with multiple providers as much as any other patient. Care should be respectful, free from bias and discrimination, and needs to avoid prejudices because of the belief that the patient's behaviour has contributed to their condition.³⁵

Conclusion

The relief of suffering is one of the guiding principles of clinical practice. Patients with opioid addiction are a heterogeneous group and it is important to determine the circumstances of each individual so that a professional response can be tailored to their needs.

Clinical practice constantly evolves, changing as evidence of more effective treatments emerge. Real-time prescription monitoring will identify people not previously known to have a substance-related disorder. There is a need to avoid unfairly stigmatising these patients and to act to provide potentially life-saving treatment. ◀

Conflict of interest: none declared

Box **How to respond when real-time prescription monitoring finds a patient has obtained psychoactive medicines from other providers**

It is essential to determine the underlying motivation of behaviour by people with multiple healthcare providers, to respond appropriately and avoid indiscriminate refusal of care for vulnerable patients.

Assess whether the problem is one of substance use disorder and, if so, offer referral or treatment as the sole prescriber.

Frame discussions as an expression of concern about the patient's safety and the need to coordinate treatment with high-risk drugs.

Avoid using the stigmatising term 'doctor shopper'.

1. Discuss the finding and confirm with the patient that the real-time monitoring is correct. If the patient denies attending a particular provider, contact that provider to establish whether or not they prescribed.
2. Assess whether there is a reasonable explanation for obtaining drugs from other prescribers and explain that for safety reasons there is a need to know every time drugs are prescribed by other providers.
3. Assess whether the dose is appropriate for their clinical need.
4. Either continue treatment as the patient's sole prescriber, or arrange referral to their preferred prescriber. Communicate this arrangement with that provider through the contact details included in the patient's monitoring record.
5. If there are concerns about diversion or misuse, discuss this, assess the clinical need and suggest a urine drug screen. If appropriate, offer a short-term supply, then review the results of the urine drug screen and real-time prescription monitoring at the next consultation.

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