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Problem-Oriented Guides for Police

No. 24

Prescription Drug Fraud and Misuse

2nd Edition

Julie Wartell and Nancy G. La Vigne

Center for
Problem-Oriented Policing

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The Internet references cited in this publication were valid as of the date of this publication. Given that URLs and websites are in constant flux, neither the author(s) nor the COPS Office can vouch for their current validity.

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About the Problem-Specific Guides Series

The *Problem-Specific Guides* summarize knowledge about how police can reduce the harm caused by specific crime and disorder problems. They are guides to prevention and to improving the overall response to incidents, not to investigating offenses or handling specific incidents. Neither do they cover all of the technical details about how to implement specific responses. The guides are written for police—of whatever rank or assignment—who must address the specific problem the guides cover. The guides will be most useful to officers who:

- **Understand basic problem-oriented policing principles and methods.** The guides are not primers in problem-oriented policing. They deal only briefly with the initial decision to focus on a particular problem, methods to analyze the problem, and means to assess the results of a problem-oriented policing project. They are designed to help police decide how best to analyze and address a problem they have already identified. (A companion series of *Problem-Solving Tools* guides has been produced to aid in various aspects of problem analysis and assessment.)
- **Can look at a problem in depth.** Depending on the complexity of the problem, you should be prepared to spend perhaps weeks, or even months, analyzing and responding to it. Carefully studying a problem before responding helps you design the right strategy, one that is most likely to work in your community. You should not blindly adopt the responses others have used; you must decide whether they are appropriate to your local situation. What is true in one place may not be true elsewhere; what works in one place may not work everywhere.
- **Are willing to consider new ways of doing police business.** The guides describe responses that other police departments have used or that researchers have tested. While not all of these responses will be appropriate to your particular problem, they should help give a broader view of the kinds of things you could do. You may think you cannot implement some of these responses in your jurisdiction, but perhaps you can. In many places, when police have discovered a more effective response, they have succeeded in having laws and policies changed, improving the response to the problem. (A companion series of *Response Guides* has been produced to help you understand how commonly-used police responses work on a variety of problems.)

- **Understand the value and the limits of research knowledge.** For some types of problems, a lot of useful research is available to the police; for other problems, little is available. Accordingly, some guides in this series summarize existing research whereas other guides illustrate the need for more research on that particular problem. Regardless, research has not provided definitive answers to all the questions you might have about the problem. The research may help get you started in designing your own responses, but it cannot tell you exactly what to do. This will depend greatly on the particular nature of your local problem. In the interest of keeping the guides readable, not every piece of relevant research has been cited, nor has every point been attributed to its sources. To have done so would have overwhelmed and distracted the reader. The references listed at the end of each guide are those drawn on most heavily; they are not a complete bibliography of research on the subject.
- **Are willing to work with others to find effective solutions to the problem.** The police alone cannot implement many of the responses discussed in the guides. They must frequently implement them in partnership with other responsible private and public bodies, including other government agencies, non-governmental organizations, private businesses, public utilities, community groups, and individual citizens. An effective problem-solver must know how to forge genuine partnerships with others and be prepared to invest considerable effort in making these partnerships work. Each guide identifies particular individuals or groups in the community with whom police might work to improve the overall response to that problem. Thorough analysis of problems often reveals that individuals and groups other than the police are in a stronger position to address problems and that police ought to shift some greater responsibility to them to do so. Response Guide No. 3, *Shifting and Sharing Responsibility for Public Safety Problems*, provides further discussion of this topic.

The COPS Office defines community policing as "a philosophy that promotes organizational strategies, which support the systematic use of partnerships and problem-solving techniques, to proactively address the immediate conditions that give rise to public safety issues such as crime, social disorder, and fear of crime." These guides emphasize *problem-solving* and *police-community* partnerships in the context of addressing specific public safety problems. For the most part, the organizational strategies that can facilitate problem-solving and police-community partnerships vary considerably and discussion of them is beyond the scope of these guides.

These guides have drawn on research findings and police practices in the United States, the United Kingdom, Canada, Australia, New Zealand, the Netherlands, and Scandinavia. Even though laws, customs, and police practices vary from country to country, it is apparent that the police everywhere experience common problems. In a world that is becoming increasingly interconnected, it is important that police be aware of research and successful practices beyond the borders of their own countries.

Each guide is informed by a thorough review of the research literature and reported police practice, and each guide is anonymously peer reviewed by a line police officer, a police executive, and a researcher prior to publication. The review process is independently managed by the COPS Office, which solicits the reviews.

For more information about problem-oriented policing, visit the Center for Problem-Oriented Policing online at www.popcenter.org. This website offers free online access to:

- The *Problem-Specific Guides* series
- The companion *Response Guides* and *Problem-Solving Tools* series
- Special publications on crime analysis and on policing terrorism
- Instructional information about problem-oriented policing and related topics
- An interactive problem-oriented policing training exercise
- An interactive *Problem Analysis Module*
- Online access to important police research and practices
- Information about problem-oriented policing conferences and award programs

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The project team that developed the guide series comprised Herman Goldstein (University of Wisconsin Law School), Ronald V. Clarke (Rutgers University), John E. Eck (University of Cincinnati), Michael S. Scott (University of Wisconsin Law School), Rana Sampson (Police Consultant), and Deborah Lamm Weisel (North Carolina State University).

Members of the San Diego; National City, California; and Savannah, Georgia police departments provided feedback on the guides' format and style in the early stages of the project.

Kimberly Nath oversaw the project for the COPS Office. Phyllis Schultze conducted research for the guide at Rutgers University's Criminal Justice Library. Nancy Leach coordinated the Center for Problem-Oriented Policing's production process.

The Problem of Prescription Drug Fraud and Misuse

This guide describes the problem of prescription drug fraud and misuse and reviews some of the factors that increase their risks. It then identifies a series of questions to help you analyze your local problem. Finally, it reviews responses to the problem, and what is known about them from evaluative research and police practice.

What This Guide Does and Does Not Cover

For the purposes of this guide, prescription drug fraud, which falls under the broader heading of pharmaceutical diversion, is defined as the illegal acquisition of prescription drugs for personal use or profit. This definition excludes theft, burglary, backdoor pharmacies,† and illegal importation or distribution of prescription drugs. This guide also discusses common forms of prescription drug diversion, as not all cases of diversion are fraudulent. For example, sharing medication and taking medication without permission are not acts categorized as fraudulent yet still warrant police attention. The related issue of prescription misuse and addiction is also covered, as many offenders become addicted and begin more widespread use through illegally obtaining prescription drugs from family and friends.

Prescription drug fraud and misuse is but one aspect of the larger set of problems related to the unlawful use of controlled substances. This guide is limited to addressing the particular harms created by prescription fraud and misuse. Related problems not directly addressed in this guide and requiring separate analysis (such as other illegal methods by which offenders obtain prescription drugs), include the following:

Prescription Drug-Related Problems

- **Medicaid fraud.** Pharmacy workers sometimes commit Medicaid fraud, usually by substituting generic drugs for name brands, short counting pills, filling prescriptions without a refill, and then overbilling Medicaid. They may also bill Medicaid for drugs they never dispensed.[1]
- **Over-the-counter (OTC) drug misuse.** Those who purchase OTC drugs to achieve a "high" are typically youth seeking cough and cold medicines, sleep aids, antihistamines, and anti-nausea agents.[2] It is not known to what extent the misuse of OTC drugs increases the risk for prescription drug misuse and/or fraud, or illegal controlled substance use (e.g., heroin use).

† "Backdoor pharmacies" are businesses not licensed/authorized to distribute pharmaceutical drugs.

- **Theft from pharmacies, hospitals, and doctors' offices.** Pharmacy workers and healthcare providers, both of whom have easy access to prescription drugs, sometimes steal them.
- **Burglary and robbery.** Offenders obtain prescription drugs by either burglarizing or robbing pharmacies.

Other Drug-Related Problems

Some of the following problems related to prescription fraud and misuse are covered in other guides in this series, all of which are listed at the end of this guide:

- Open-air drug markets
- Drug dealing in apartment complexes
- Marijuana growing operations
- Rave parties
- Clandestine methamphetamine labs
- Mobile drug dealing
- Drug-impaired driving

For the most up-to-date listing of current and future guides, see www.popcenter.org.

General Description of the Problem

Prescription drug fraud and misuse is a significant and growing problem. State and local police agencies are increasingly reporting diverted pharmaceuticals as their greatest drug threat, based on both prevalence of the problem and related issues of misuse-related crime involvement and gang activity.[3] According to a 2009 survey, between 28 and 58 percent of police agencies, varying by region, reported street-gang involvement in pharmaceutical drug distribution.[4]

Nationwide in 2010, 7 million people self-reported illegal use of prescription drugs in the previous month.[5] It is a serious form of illegal drug activity, rivaling activity that involves more traditional street drugs. In fact, a recent study found that following marijuana, prescription drugs are the second most misused category of drugs among young people.[6]

The healthcare costs alone of nonmedical use of prescription opioids—the most commonly misused class of prescription drugs—are estimated to total $72.5 billion annually.[7] The local scope of the problem is similarly dire. Prescription drug fraud and misuse is common across the nation, but its intensity varies from place to place. For example, prescription-opioid pain-reliever overdoses are higher in states with greater retail sales volume of these prescription drugs.[8] Overdoses range from a low of 5.5 per 100,000 residents in Nebraska to 27 per 100,000 residents in New Mexico.[9] South Florida, and particularly Broward County, is viewed as the epicenter of prescription-opioid misuse, attributed in large part to the prevalence of pain-management clinics, a fair share of which dispense prescription medications inappropriately.[10] Users obtain prescription drugs unlawfully in numerous ways, including the following:

- Forging prescriptions
- Consulting multiple doctors to obtain prescriptions ("doctor shopping")
- Obtaining prescribed drugs illegally through the Internet
- Acquiring drugs that were legally prescribed to family members or friends
- Altering prescriptions to increase the quantity[11]

The true scope of prescription fraud and misuse is largely unknown, due to a number of factors. As with any crime, successful offenders get caught less often, and police never detect most of their offenses. Unlike other crimes, however, much prescription fraud goes undetected because it is not a high police priority; very few local agencies systematically track it. Limited awareness and lack of oversight among doctors and pharmacists may contribute to the problem. Limited education during physician training concerning pain, assessment of addiction liability, and how to use tools to reduce addiction liability also likely contribute to the problem.[12]

Indeed, nonmedical prescription drug use is a complex issue. From a police perspective, some aspects of prescription drug misuse fall more than others in the domain of policing. For example, doctor shopping or prescription drug theft from healthcare providers, family, and friends, represent clear policing issues. Likewise, police have a lead role in addressing the impact of prescription-drug trafficking and misuse on organized-crime and gang activities, related criminal acts, and vehicle crashes.

But other components of the prescription drug fraud and misuse problem require collaboration with public health departments, substance abuse treatment providers, emergency rooms, and other entities whose missions are more squarely aligned with addressing the addictive potential of misused drugs.

Harms Caused by Prescription Drug Fraud and Misuse

Prescription drug misuse can lead to serious consequences: overdoses from prescription pain relievers and emergency room visits due to pharmaceutical misuse have increased steadily in recent years.[13] Misuse of these medications can rapidly escalate into abuse or dependence and require costly rehabilitative treatment. The number of people seeking treatment for prescription drug abuse has also increased: the 2010 National Survey of Drug Use and Health shows that since 2002 the number of Americans receiving treatment for prescription opioid abuse has risen from an estimated 306,000 to 754,000. Whether prescription drug use leads to more dangerous behavior and negative consequences than other drugs is not established; however, one study showed that among a cohort of prescription drug users in rural Kentucky, initiating use with certain medications including benzodiazepines, illicit methadone, and oxycodone, was associated with a higher risk of later injecting behavior.[14] This study also found that these individuals' partners and their criminal involvement predicted the transition to injecting. This suggests coordination among police, criminal justice, and health officials may help reduce negative outcomes resulting from prescription drug use disorders.

The need for money to purchase prescription drugs for nonmedical use can also contribute to the incidence of burglaries: prescription drugs are chief among items most commonly stolen in residential burglaries, along with cash, jewelry, and guns.[15] As you contemplate how to approach the problem and impact of prescription fraud and misuse, you should carefully consider the contexts in which they may play a lead crime-control and prevention role versus a secondary, or referral, role—one of aiding stakeholders in making connections to entities that are best equipped to address the issue.

Factors Contributing to Prescription Drug Fraud and Misuse

Understanding the factors that contribute to prescription fraud and misuse will help you frame your own local analysis questions, determine good effectiveness measures, recognize key intervention points, and select appropriate responses.

Misuse of and Addiction to Prescription Drugs

Prescription drug misuse is significant and rising rapidly, with some observing that it is the nation's fastest-growing drug problem.[16] In 2010, about one in four illicit-drug users reported that their initiation into illegal drug use began with prescription drugs.[17] This amounts to 2 million Americans over the age of 12 who illegally used pain relievers for the first time in 2010 alone.[18] Although this number is similar to that of people reporting first-time use in 2000, addiction rates are on the rise. For example, substance abuse treatment admissions associated with prescription opiate abuse increased from 8 percent of all opiate admissions in 1999 to 33 percent in 2009.[19] Moreover, drug overdoses from prescription opioids in 2008 exceeded those for cocaine and heroin combined.[20]

Research shows that people who misuse opioids often obtain them through a legitimate prescription to treat pain or a medical condition. In this case misuse may constitute taking more than prescribed. People with mental health conditions such as depression or anxiety are also vulnerable to this type of misuse.[21]

Types of Prescription Drugs Misused

Overall, the most commonly misused prescription drugs fall within the class of controlled substances termed opioid pain relievers, such as hydrocodone and oxycodone. The prescription drugs that police agencies most frequently report as commonly misused include Vicodin® (hydrocodone), OxyContin® (oxycodone), Lorcet®, Dilaudid®, Percocet®, Soma®, Darvocet®, and morphine. Many of these top the list of prescription drugs used non-medically by youth and young adults, who tend to favor pain relievers such as codeine, methadone, Demerol® (meperidine), Percocet, Vicodin, and OxyContin.[22]

Many experts attribute the growth in prescription drug misuse in part to the introduction in the mid-1990s of OxyContin, an oral, controlled-release form of oxycodone that acts for 12 hours. Oral OxyContin is a very effective pain reliever. However, when injected or snorted, users experience euphoria with rapid onset. In addition, nonmedical use of prescription stimulants prescribed for attention deficit/hyperactivity disorder (ADHD), such as Adderall® and Ritalin®, are increasingly common, particularly among college students.[23]

Types of Offenders

Unlike perpetrators of other drug-related crimes, prescription drug fraud and misuse offenders span a wide range of ethnic, social, educational, and economic backgrounds. Often, they become addicted to drugs legally prescribed to them and then try to obtain additional drugs illegally. Other offenders, who are already addicted to street drugs, discover how to convert prescription drugs into more potent substances.

Youth and young adults. The most dramatic increases in illegal prescription drug use in recent years have been among youth. Of the estimated 6.2 million Americans using prescription drugs non-medically in 2010, nearly half were age 12 to 25.[24] Nonmedical use of prescription psychotherapeutic drugs among 12- to 17-year-olds increased by more than 60 percent between 1999 and 2006.[25] Nonmedical prescription drug use is often accompanied by other illicit drug use: about half of teenagers who have misused prescription painkillers reported drug and/or alcohol use,[26] and nearly two-thirds of 12- to 25-year-olds who had used prescription drugs non-medically in the past year had also used marijuana in the past year.[27] The nonmedical use of prescription drugs is often the first type of drug misuse in which young people become involved: for example, one-third of people age 12 and older reported that their first illicit drug use was of a prescription drug.[28]

Another trend is the nonmedical use of prescription stimulants such as Adderall, Ritalin, and generic amphetamine salts by high school and college students, primarily to gain focus and improve studying.[29] Students have also reported combining Xanax® with cola drinks and taking Vicodin before alcohol consumption to speed the onset of intoxication.[30]

Youth are a particularly vulnerable population for prescription drug misuse, perhaps due to peer pressure and a lack of knowledge of the law. Indeed, roughly half of teenagers reported misusing prescription drugs because they are not illegal.[31] Smaller but meaningful shares of teens also reported that there is less shame in being caught using prescription drugs compared with using controlled substances.[32]

College students also engage in nonmedical prescription drug use, particularly opioid use. Roughly 7 percent of college students reported nonmedical use of prescription opioids,[33] and 4 percent reported abuse of prescription stimulants,[34] in the past year alone. The nonmedical use of prescription drugs among college students is most commonly facilitated by students sharing their legally prescribed drugs with others.[35] Students reporting misuse of prescription drugs also report much higher levels of marijuana and cocaine use, binge drinking, and drunk driving.[36]

Women.[37] Although women and men have roughly the same rates of nonmedical use of psychotherapeutic drugs and pain relievers,[38] among women and men who use a sedative, anti-anxiety drug, or hypnotic, women are almost twice as likely to become addicted.[39]

Older adults. The nonmedical use of prescription drugs among adults age 50 to 59 nearly doubled between 2002 and 2009.[40] Older adults may be more susceptible to prescription drug misuse because they are prescribed such drugs at a rate three times that of the general population, and also often have trouble following their doctor's dosage instructions.[41] Pain relievers are the most commonly misused prescription medicine among older adults, followed by anti-anxiety and insomnia medications.[42]

People with existing substance use disorders. Several police agencies have observed increases in prescription drug misuse among heroin addicts and users of other illegal drugs, who take prescription drugs to ease the effects of those other drugs.[43] Others combine multiple drugs to produce new and different highs.[44] Conversely, some experts have observed that those who become addicted to oxycodone and lose their health insurance often turn to heroin for a similar, cheaper, high.[45]

Healthcare workers. Healthcare workers are in a unique position to acquire and misuse prescription drugs. Offenders may steal drugs while working, steal prescription pads, or write illegal prescriptions for friends. Of the approximately 250 felony arrests made by the Cincinnati Police Department's Drug Diversion Unit, on average annually, almost 20 percent involved healthcare workers, including doctors, nurses, and hospital workers, who were either diverting the drugs to support their own drug addictions or selling them for profit on the black market.[46]

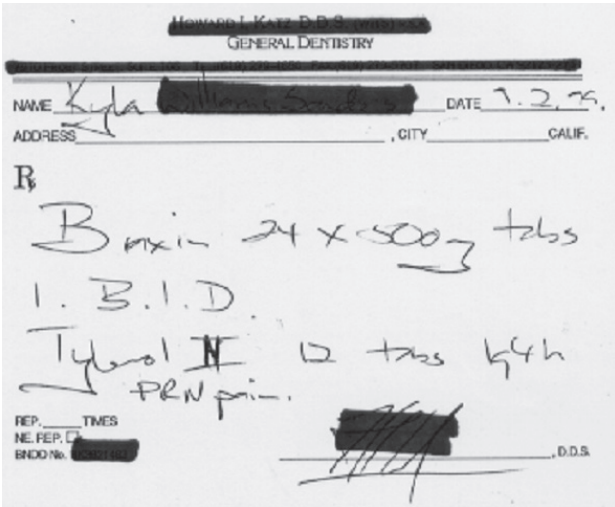
Types of Fraud

Prescription drug fraud can take many forms. The most common tactics are to forge or alter a prescription, to doctor shop, and to phone in fraudulent prescriptions posing as a doctor's office employee. Theft of prescription pads is also common.

Forging prescriptions. Forging prescription slips has become easier as the cost of high-quality copying equipment has dropped. Some offenders even go so far as to paint glue on the top edge of the slip to make it appear it was ripped from a pad.

Altering prescriptions. The first resort of many users who are addicted to legally prescribed drugs is to alter a legitimate prescription by changing the type of drug, increasing the number of refills, increasing the quantity, or adding drugs (see Figures 1-4 on pages 11–13). Another tactic is to copy legitimate prescriptions for multiple uses.[47]

Figure 1. Prescription altered to change the type of drug from Tylenol II to Tylenol IV


GENERAL DENTISTRY

NAME Kyla DATE 7.2.95.

ADDRESS , CITY CALIF.

℞

Bmxin 24 x 500 mg tabs

1. B.I.D.

Tylenol IV 12 tabs q4h

PRN pain.

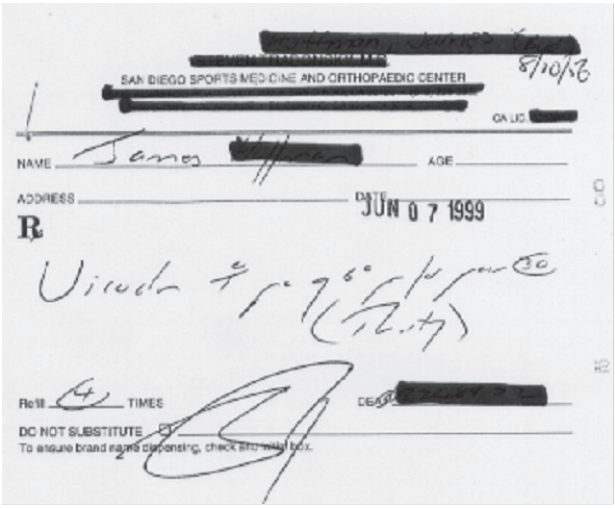
REP. TIMES

NE. REP.

BNDD No.

D.D.S.

Figure 2. Prescription altered to change the number of refills from one to four


SAN DIEGO SPORTS MEDICINE AND ORTHOPAEDIC CENTER

NAME James

AGE

ADDRESS

DATE JUN 07 1999

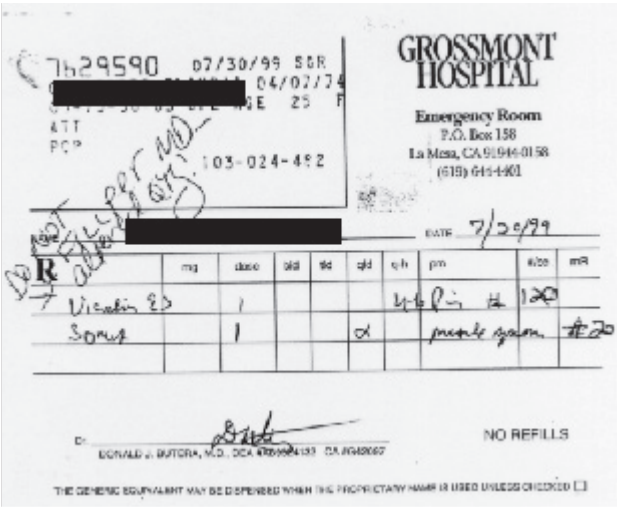
℞

Refill 4 TIMES

DO NOT SUBSTITUTE

To ensure brand name dispensing, check this box.

Figure 3. Prescription altered to change the quantity from 12 to 120


GROSSMONT HOSPITAL

Emergency Room

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La Mesa, CA 91944-0158

(619) 644-4001

7429590 07/30/99 SGR

ATT

PCP

103-024-492

DATE 7/30/99

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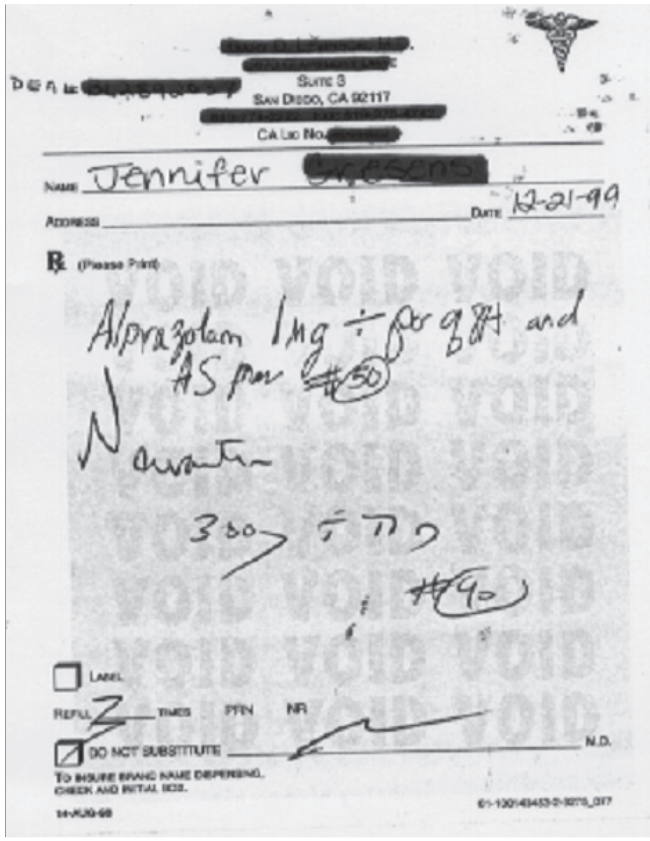
	mg	dose	qid	tid	qid	q.h.	pm	#/ss	mR
Vicodin ES		1				4-6 hrs		#120	
Soma		1			x		muscle spasm	#20	

NO REFILLS

DONALD J. BUTORA, M.D.

THE GENERIC EQUIVALENT MAY BE DISPENSED WHEN THE PROPRIETARY NAME IS USED UNLESS CHECKED ☐

Figure 4. Prescription altered to add a drug (alprazolam)



Doctor shopping. Those who doctor shop often go to multiple doctors, emergency rooms, and pharmacies and feign symptoms or gain sympathy to obtain prescriptions. Common feigned ailments include migraine headaches, toothaches, cancer, psychiatric disorders, and attention deficit disorder.[48] In addition, offenders may deliberately injure themselves to obtain a prescription from an emergency room. Other approaches include claiming to be from out of town and to have forgotten to pack prescription drugs,[49] and claiming to have lost the drugs from a legitimate prescription.[50] Given statistics on the number of prescriptions doctors write, doctor shopping may be the prescription fraud tactic with the highest success rate: the Centers for Disease Control and Prevention reports that the number of written prescriptions per office visit increased by 34 percent between 1985 and 2000 alone.[51]

Some legal sources of prescription medicines make it particularly easy for substance abusers and drug dealers to obtain prescription drugs. These pain clinics, or "pill mills," dispense prescription pain killers (often on a cash-only basis) and have lax restrictions on the volume that may be purchased.[52] Pain clinics have been especially prominent in Florida, which historically has lacked regulation and a prescription monitoring program (although one was recently established), giving the state the dubious reputation of being called "the Oxy Express."[53, †]

Calling in prescriptions. Prescription fraud in the form of impersonating medical staff and calling in false prescriptions poses the greatest challenge to identifying suspects. Typically, offenders call in a prescription when the doctor's office is closed, in case the pharmacist calls the office to confirm the prescription is legitimate; some offenders leave their own phone numbers for verification. Offenders are often patients or employees of the doctor they are impersonating, and they tend to act overly friendly to give the impression they regularly call in prescriptions.

Stealing blank prescription forms. Some offenders steal prescription pads from prescribers' offices[‡] and write prescriptions for either themselves or fictitious patients. They may change the phone number so that they or an accomplice can answer verification calls.[54]

Purchasing drugs on the Internet. Prescription drugs are readily available on the Internet.[55] The anonymous nature of online purchases and potentially lax requirements regarding proof of doctors' prescriptions may lead offenders to acquire drugs through Internet sources. In an online search for commonly misused opioids, half of the results were websites that did not require a doctor's prescription.[56] Indeed, some have observed that these websites have taken the doctor out of doctor shopping.[57] However, survey research suggests that only a very small share of those who acquired prescription drugs illegally did so via the Internet.[58] The National Survey on Drug Use and Health reports that fewer than 1 percent of those engaged in nonmedical prescription drug use in 2009 obtained those drugs through the Internet.[59] One researcher concluded, "The assertion that the Internet has become a dangerous new avenue for the diversion of scheduled prescription opioid analgesics appears to be based on no empirical evidence and is largely incorrect."[60]

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† Florida recently tightened regulation of pain clinics, shut down those that served as drug pipelines, and plans to launch a prescription monitoring program (Alvarez 2011).

‡ Doctor's offices include physician's, veterinarian's, and dentist's offices.

Understanding Your Local Problem

The information provided above is only a generalized description of prescription drug fraud and misuse. You must combine the basic facts with a more specific understanding of your local problem. Analyzing the local problem carefully will help you design a more effective response strategy.

Stakeholders

The following groups have an interest in the prescription drug fraud and misuse problem and ought to be considered for the contribution they might make to gathering information about the problem and responding to it:

- *Law enforcement agencies* are an excellent source of data on the problem of prescription fraud and misuse, and at the national level, the Drug Enforcement Administration (DEA)'s Office of Diversion Control serves as a central source for national policy guidance, support, and the collection and sharing of intelligence information regarding pharmaceutical diversion issues.
- *Healthcare providers* can offer information on prescription drug trends they are experiencing and provide insight into training and current and future policies in the medical field.
- *Pharmacist*s may have a wealth of insight—that has not been reported to police—regarding offenders, methods of operation, and prescription drug trends.
- *Parents and educators* may have experience in dealing with youth who are abusing drugs but have not yet come to police attention. Educators could also assist in conducting surveys in the schools to measure the extent of the problem.

In addition to the above, other key stakeholders are pharmaceutical companies and a variety of state and federal government agencies, such as pharmaceutical and medical licensing boards, public health agencies, the Environmental Protection Agency (for the safe disposal of unwanted or expired prescription drugs), and the U.S. Food and Drug Administration (FDA), which controls drug scheduling.

Asking the Right Questions

The following are some critical questions you should ask in analyzing your particular problem of prescription fraud and misuse, even if the answers are not always readily available. Your answers to these and other questions will help you choose the most appropriate set of responses later on.

Incidents

- How many police calls for service and cases involve some aspect of prescription fraud and/or misuse?
- What is the precise nature of these cases and calls for service? (Determining this might require some careful analysis of police reports, as the precise involvement of prescription drugs may be revealed only in the report narrative of a wide range of call and case types.)
- What is the cost to the community—in both monetary and nonmonetary terms—to respond to the problem of prescription fraud and misuse?

Victims

- Whom does prescription fraud directly victimize? Pharmacists (who are duped into dispensing drugs not legitimately prescribed)? Doctors (who unknowingly prescribe to doctor shoppers, whose prescription pads are stolen, or whose names are used for prescription call-ins or forgeries)? Insurance companies and Medicaid (who sometimes pay for fraudulent prescriptions)?
- Whom does prescription fraud and misuse indirectly affect (those who commit the fraud and are addicted and their loved ones)?

Offenders

- What are the offenders' characteristics (e.g., age, gender, profession)?
- Where do they live, go to school, or work? How do those locations correspond to fraud locations (e.g., are some pharmacies or doctor's offices more likely targets than others)?
- What is the pattern of offending? Is the fraud intermittent or regular? Is there a regular time span between fraudulent acts (e.g., based on how long it takes to exhaust a supply of drugs)?

- What are the offenders' motives? Are they addicted to prescription drugs? Are they selling the drugs on the black market? Both? (You can interview offenders to collect this information.† Undercover investigations, buys, and surveillance can reveal more about their practices.)
- Do offenders act alone or as part of a group?
- What are their preferred tactics?

Locations/Times

- Where do prescription fraud and misuse occur? To detect patterns, you should conduct location analyses based on the tactic used (e.g., doctor shopping patterns will spatially differ from prescription call-in patterns). Location analyses can also help you determine which targets are most vulnerable. For example, fraud in specific areas may indicate where offenders live or work.
- In which specific locations do fraud and misuse offenses most commonly occur? Are certain doctors or pharmacies less likely to detect and report fraud? Are certain types of pharmacies (e.g., independent stores versus chain stores) more susceptible to fraud?
- What specific types of prescription drugs are diverted in your community or region? (The prescription fraud problem and types of drugs diverted can vary greatly from region to region.)
- When does prescription fraud occur (i.e., when do offenders try to have prescriptions filled)? What time of day? What day of the week? As with location analyses, temporal analyses should be tactic specific. Those who phone in prescriptions, for example, are more likely to do so during doctors' off hours, when pharmacies cannot verify the prescriptions.
- Do you have ongoing prescription drug "take-back" programs in your jurisdiction? If so, how do the locations where those programs operate geographically relate to your higher fraud locations or offender locations?

† See Problem-Solving Tools Guide No. 3, *Using Offender Interviews to Inform Police Problem Solving*, for further information.

Current Responses

- Does your agency have policies and procedures specific to taking prescription fraud reports? If so, do you capture and analyze the data generated in those reports?
- Does your agency participate in local, state, or federal prescription drug "take-back" efforts?
- Does your agency work with healthcare professionals, the schools, or community organizations on prescription drug misuse and fraud prevention and education?
- What are the state and local laws relating to prescription fraud monitoring and enforcement?
- Does your state have an automated prescription drug monitoring system?

Capturing and Analyzing Data

Prescription fraud poses a unique challenge to local police because it is not typically captured in computer-aided dispatch or records management systems. Departments that have succeeded in measuring and analyzing prescription fraud in their jurisdictions have done so by creating a separate database for prescription fraud and other pharmaceutical diversion incidents. When considering creating a database, you should examine the questions above, and decide how to track each incident to best answer the most questions. In addition, there are several national data-collection efforts that provide state- and regional-level information on trends and patterns in substance abuse, including misuse of prescription drugs.

National Data Sources with State, Regional, and/or Local Data

Sponsored by the National Institute on Drug Abuse, the Community Epidemiology Working Group is a consortium of more than 20 researchers from major metropolitan areas who meet annually to report on local drug abuse patterns and trends. Local police agencies can consult the group's website. The site directs users to annual meeting reports and other publications on local trends in drug abuse and diversion.

The Arrestee Drug Abuse Monitoring (ADAM) program collects data through drug tests and self-reported drug use of adult male arrestees in 10 major metropolitan areas. ADAM data are particularly useful to local police in identifying shifts in regional trends in prescription drug abuse. Annual reports of ADAM data can be found on the White House Office of National Drug Control Policy's website. In addition, some other metropolitan areas (e.g., San Diego County through the San Diego Association of Governments) are collecting their own ADAM-type data.

The Treatment Episode Data Set, supported by the Substance Abuse and Mental Health Services Administration (SAMHSA), reports admissions to hospitals by state and primary abused substance, enabling local police to identify statewide trends over time. The data set's website has a search engine enabling users to select data by year and state.

The Drug Abuse Warning Network (DAWN) reports deaths related to drug abuse by drug type and by state. These data are also available at the local level from several major metropolitan areas.

The Monitoring the Future Survey and the National Survey on Drug Use and Health are both excellent sources for examining trends in youth and U.S. population substance use respectively.

State Data Sources

Most states (39 to date) have implemented prescription drug monitoring programs (referred to as PMP or PDMP). These programs are designed to aid in detecting prescription-drug diversion while also preventing it by increasing the risk of identifying and apprehending offenders. PMPs document all retail sales of certain prescription drugs. Police can analyze this data to identify unusual sales volumes by retailer, healthcare provider, and drug type. You may contact your state data collection entities to gain access to the data, which can illustrate the types of prescription drugs that are dispensed, the degree to which certain medical prescribers appear to be overprescribing, and other statewide patterns of potential misuse and diversion.[†]

Local Data Collection

The above sources are limited to data at the state or metropolitan area level, but they may not tell the local story. Police agencies that have tackled the problem of prescription fraud and misuse typically create their own data collection tools in order to capture the true local context and underlying causes of the problem. The Reno (Nevada) Police Department, for example, conducted surveys of area pharmacists and doctors and also reviewed and revised the way the department coded reported incidents of prescription fraud and misuse to enable the agency to isolate those cases from other drug-related crimes.[61]

† More information on prescription monitoring programs can be found on the Bureau of Justice Assistance website.

Measuring Your Effectiveness

Measurement allows you to determine to what degree your efforts have succeeded, and suggests how you might modify your responses if they are not producing the intended results.

You should take measures of your problem *before* you implement responses, to determine how serious the problem is, and *after* you implement them, to determine whether they have been effective. All measures should be taken in both the target area and the surrounding area. For more detailed guidance on measuring effectiveness, see Problem-Solving Tools Guide No. 1, *Assessing Responses to Problems: An Introductory Guide for Police Problem-Solvers* and Problem-Solving Tools Guide No. 10, *Analyzing Crime Displacement and Diffusion*.

The following are potentially useful measures of the effectiveness of responses to prescription fraud and misuse. Process measures show the extent to which responses were properly implemented. Outcome measures show the extent to which the responses reduced the level or severity of the problem.

Process Measures

- Changes in arrest patterns for drug possession and sales in your and neighboring jurisdictions
- Changes in types of prescription fraud and misuse (e.g., if you curtail phone-ins, offenders might change tactics)
- Changes in locations of prescription fraud and misuse
- Changes in types of drugs obtained through prescription fraud and misuse
- Changes in the number of prescriptions filled for certain target drugs, such as oxycodone

Outcome Measures

- Reduced number of reported prescription fraud and misuse cases
- Reduced number of police calls for service related to illicit prescription drugs
- Reduced number of motor-vehicle crashes in which prescription drug intoxication was a contributing factor
- Reduced number of overdoses from prescription drugs
- Reduced number of people seeking treatment for prescription drug addiction
- Reduced availability of illicitly obtained prescription drugs
- Increased price of illicit prescription drugs (an indication the drug is harder to obtain or riskier to sell and buy)

It is important to remember that some of these measures may be misleading, depending on the types of responses your department applies to the problem. For example, if you launch a public education campaign for pharmacists and doctors, you may find that the incidence of prescription fraud—as measured by crimes reported and calls for police service—increases, which is desirable in the short term, but which should subsequently decline as prevention measures take effect.

Responses to the Problem of Prescription Drug Fraud and Misuse

Your analysis of your local prescription fraud and misuse problem should give you a better understanding of the factors contributing to it. Once you have analyzed your local problem and established a baseline for measuring effectiveness, you should consider possible responses to address the problem.

The following response strategies provide a foundation of ideas for addressing your particular prescription fraud and misuse problem. These strategies are drawn from a variety of research studies and police experiences. Several of these strategies may apply to your community's problem.

It is critical that you tailor responses to local and state circumstances, and that you can justify each response based on reliable analysis. In most cases, an effective strategy will involve implementing several different responses. Law enforcement responses alone are seldom effective in reducing or solving the problem.

Do not limit yourself to considering what police can do: carefully consider others in your community who share responsibility for the problem and can help police better respond to it. In some cases the responsibility of responding may need to be shifted toward those who have the capacity to implement more effective responses. For more detailed information on shifting and sharing responsibility, see Response Guide No. 3, *Shifting and Sharing Responsibility for Public Safety Problems*.

For further information on managing the implementation of response strategies, see Problem-Solving Tools Guide No. 7, *Implementing Responses to Problems.*

Unfortunately, there is limited information about the effectiveness of many of the strategies presented below because few of the strategies have been evaluated. The government has provided some funding to police to reduce prescription fraud, but to date there have been no national evaluations of task force or state and local police efforts to combat this problem. Although the government has funded state prescription monitoring programs and general awareness campaigns, with the exception of Utah's educational campaign as part of their Prescription Pain Medication Program, only prescription monitoring programs have been empirically evaluated.[62]

General Requirements for an Effective Strategy

Police have a limited role in changing the fact that some people will find a way to misuse and become addicted to prescription drugs, but you can use various strategies, in concert with other stakeholders, to reduce and prevent prescription fraud and misuse in your jurisdiction.

Because the prescription fraud and misuse problem crosses several disciplines, addressing it must be a coordinated effort at all stages. The stakeholders described in the previous section are among the most critical in controlling prescription fraud and misuse. Sharing information among agencies about prescription drug use implicates healthcare privacy, so stakeholders should be aware of the federal Health Insurance Portability and Accountability Act (HIPAA) and comparable state laws.†

- *Law enforcement agencies* may perform a number of roles. Many states and local jurisdictions have specialized personnel, units, or task forces to implement prescription fraud prevention strategies. Although there has been an increase in knowledge among specialized groups, most police officers still need specialized training on: controlled and non-controlled substances and the drug scheduling system that pharmacists use; state criminal laws and pharmacy regulations; types of forged and altered prescriptions; typical diversion tactics; and prescription fraud prevention techniques. You should also educate prescribers about the various prescription fraud tactics and the extent of your local problem. The National Association of Drug Diversion Investigators has a variety of resources for police.
- *Healthcare provider*s should register with their prescription drug monitoring program (PMP) and consult it as part of their practice; prescribe medication only when necessary and only in amounts necessary; give instructions on returning leftover medications; identify misuse and addiction; and provide resources to help patients handle addiction problems. They also should report all thefts of prescription pads to police and local pharmacies. Moreover, they should advise patients of the dangers of procuring prescription medications through the Internet, which can lead to misuse and addiction.‡

† Some guidance on HIPAA can be found at the U.S. Department of Health & Human Services, Office for Civil Rights website.

‡ The U.S. Substance Abuse and Mental Health Services Administration (2009) created an informational brochure for healthcare practitioners that gives specific guidance and outlines the responsibilities for preventing prescription drug abuse and diversion. Canada's Ministry of Health produced an Abuse and Diversion Guide. Although some aspects are unique to Canadian laws, there is a variety of material applicable to any health professional.

- *Pharmacist*s should provide clear information to users about how to take their prescribed drug; give instructions about safe disposal and return of leftover medications; be able to recognize fraudulent prescriptions; inform police about problem people and prescriptions; and follow through with investigations and court proceedings. In an informational brochure for pharmacists, the DEA recommends using common sense, sound professional practice, and proper dispensing procedures and controls (see *Fraudulent Prescription Prevention Techniques* on page 26). Others have also created guidelines to help pharmacists recognize misuse and fraud.[63]
- *Parents and educators* have a key role in educating children on the dangers of prescription drug use. Given the increasing prevalence of youth abusing prescription drugs and the fact that many youth obtain drugs through friends and family members, parents also need to secure their legally prescribed drugs. Teachers can also convey these messages, as can police, who can visit the schools and underscore the fact that prescription drug misuse is illegal and dangerous.[†]

States are responsible for enacting laws that govern the prescribing and dispensing of prescription drugs, licensing drug prescribers, investigating complaints, and imposing sanctions for violations of state medical practice laws. States also regulate pharmacy practice and license pharmacists and pharmacies, ensure compliance with state and federal laws, and require the maintenance of prescription records.

A number of local, state, and federal efforts to discuss the problem of prescription fraud and misuse, make recommendations, and create plans have emerged over the last decade. These include: the Orange County, California, Health Care Agency study (2009); the California State Task Force on Prescription Drug Misuse (2009), the Ohio Prescription Drug Abuse Task Force (2010); the Massachusetts OxyContin and Other Drug Abuse Commission (2006); and the National Center on Addiction and Substance Abuse study (2005). In 2011, the Executive Office of the President issued a Prescription Drug Abuse Prevention Plan to reduce prescription drug misuse through education, monitoring, proper disposal, and enforcement. Many of these plans and recommendations have excellent ideas, but very little documentation exists on their implementation and effectiveness.

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† The U.S. Substance Abuse and Mental Health Services Administration (2009) produced a brochure designed to educate students about the dangers of prescription drug misuse. PEERx is a National Institute on Drug Abuse website for teens that may be used as part of comprehensive efforts. A number of local efforts have also produced videos to educate youth about the harms and consequences of prescription drug misuse: two examples are the Reno (Nevada) Police Department (2010) and the Middlesex County, Massachusetts, District Attorney (2004).

Fraudulent Prescription Prevention Techniques[64]

1. Know the prescriber and his or her signature.
2. Know the prescriber's Drug Enforcement Agency (DEA) number.
3. Know the patient (or get a profile if you do not).
4. Check the date on the prescription. Ensure it has been presented within a reasonable time.
5. Telephone the prescriber for verification or clarification if you have any questions. The patient should give a plausible reason for any discrepancy before you dispense the drug.
6. If you are in doubt, request proper identification; doing so increases an offender's risk of getting caught.
7. If you believe a prescription is forged or altered, do not dispense it—call the local police.
8. If you believe that you have discovered a pattern of prescription misuses, contact the state pharmacy board or the DEA.

Specific Responses to Prescription Drug Fraud and Misuse

Increasing the Risk of Detection

1. **Informing doctors and pharmacists of and about fraudulent activity.** Many police agencies, task forces, and pharmacy associations deem it effective to share information on prescription fraud scams and offenders through bulletins and mass communication. If prospective scam targets (e.g., the emergency room doctor who is about to be the third person in one day to see John Doe about his bad back, or the pharmacist who does not know about the stolen prescription pad) are informed, the offender's risk of being detected greatly increases.

   Jurisdictions such as Albuquerque, New Mexico; San Diego, California; and Tarrant County, Texas, use FaxAlert to notify doctors, pharmacies, and medical clinics of drug diversion-related activity. Each month, the Tarrant County Medical Society also distributes a health-scam report. The Texas Pharmacy Association has set up an online system for reporting fraud or stolen prescription pads. The state of Colorado and Johnson County, Kansas, use a PharmAlert hotline for notification, while Abington, Pennsylvania, police handed out fliers describing the scam and including a photo of the suspect or fraudulent prescription. After implementing this strategy in 1991, Abington saw arrests of prescription fraud offenders increase from one per year to one to two per month.[65]

In addition to notifying practitioners and pharmacists about specific prescription scams, police should also inform and update them on the methods and profiles of offenders in their jurisdiction. Oftentimes, healthcare professionals and pharmacists have not had extensive training on prescription misuse and fraud so they may not be aware of the symptoms, or how they may be inadvertently contributing to the problem. Police can partner with the related professional organizations to encourage and/or conduct continuing education and in-service training on the risks and prevention measures of misuse and fraud.

2. **Improving pharmacists' screening of prescriptions and patients.** Pharmacists are the last line of defense against prescription fraud. They should always check the patient's identification, verify the doctor's information when it is not familiar, and use their experience and knowledge to judge when a patient's behavior is suspicious or a prescription may be fraudulent. One resource is the previously mentioned DEA informational brochure, "A Pharmacist's Guide to Prescription Fraud." Another is Pharmaceutical Diversion Education, which offers fraud-detection training for pharmacists and police.†

3. **Educating the public about prescription fraud and misuse.**‡ Several large-scale efforts have been made to educate the public about prescription fraud and misuse. Although these usually have not been police-led efforts, police can play a role in making the public aware that misuse and addiction are the underlying causes of much prescription fraud. Although most offenders commit prescription fraud to get drugs for personal use (due to addiction), and most crime-prevention efforts have targeted this underlying cause, this does not lessen the importance of dealing with offenders who commit fraud strictly for financial gain.

   In 2000, the Community Antidrug Coalitions of America developed and distributed prescription drug misuse messages, materials, and methods to better educate the public, education departments, healthcare providers, and community-based organizations.§ The FDA and SAMHSA launched a prescription misuse prevention education effort in 2003. More recently, there were two statewide efforts: in 2008, Utah launched "Use Only as Directed," which targeted prescription overdose deaths, and, in 2010, Ohio created "Prescription for Prevention: Stop the Epidemic."

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† More information can be found at www.rxdiversion.com.

‡ See Response Guide No. 5, *Crime Prevention Publicity Campaigns*, for further information.

§ Coalition organizations included the American Pharmaceutical Association, Pharmaceutical Research and Manufacturers of America, American Academy of Family Physicians, AARP, National Council on Patient Information and Education, National Community Pharmacists Association, and National Chain Drug Store Association.

Purdue Pharma's 10-Point Plan to Reduce Prescription Drug Abuse and Diversion

1. Educate healthcare professionals about the problem.
2. Create tamper-resistant prescription pads.
3. Implement programs such as Painfully Obvious™, a prescription drug abuse awareness and education initiative for middle and high school students.
4. Provide opioid therapy documentation kits to physicians for pain assessment.
5. Distribute educational brochures about the problem.
6. Implement prescription monitoring programs.
7. Establish educational programs with the law enforcement community.
8. Conduct research on abuse, diversion, and addiction.
9. Work with the DEA to curtain cross-border smuggling.
10. Develop abuse-resistant drugs.

Source: Eworldwire.com.

Campaigns such as these let offenders know that police and the health field are paying attention and that they are at risk of being detected. In addition, such campaigns can help enlist offenders' friends and relatives to provide informal guardianship by better detecting suspicious activity and providing help before the problem escalates.

Although a few of the larger pharmaceutical companies have recently partnered with police to curtail prescription fraud and misuse, it is most important that they continue to educate people about taking drugs safely under a doctor's care.†

† For example, Purdue Pharma (the maker of OxyContin) has sponsored meetings with DEA and FDA officials, hired police officers to educate company personnel and serve as liaisons, and analyzed demographic data about geographic areas of abuse to help predict where the next problem will be and focus their efforts accordingly. Through informational forums, Abbott Laboratories (the maker of Vicodin) instructs prescribers and pharmacists about the potential for Vicodin abuse.

Increasing the Effort Required to Commit Prescription Drug Fraud

4. **Verifying prescriptions.** Pharmacists should try to verify every prescription. This includes making callbacks on all phoned-in prescriptions and checking doctors' names, phone numbers, and DEA numbers. They should also keep a file of doctors in their jurisdiction, with contact information and signatures. Finally, if they cannot immediately verify a prescription, they should dispense only 24 hours' worth of medication, until they are able to make the verification.

5. **Employing security measures.** Health profession stakeholders can use several strategies to control prescription fraud, including the following:

   5a. Using tamper-resistant prescription pads. Such pads should include some or all of the following features: serial numbers, prescriber information, watermarks, intricate lines, and/or heat- or light-sensitive messages. Each feature increases the effort needed to copy or alter a prescription. Several states have found secure prescription forms to be an effective deterrent to prescription forgery and counterfeiting.[66] New York State estimated a $75 million annual savings on private sector insurance fraud with the implementation of secure forms.[67]

   5b. Increasing precautions taken by the practitioner's receptionist and answering service. One practice is to use a security code to prevent people from impersonating the practitioner in an attempt to fraudulently authorize a new prescription or refill. Another is to refrain from sharing the practitioner's DEA number to unauthorized or non-verified persons or entities (e.g., someone claiming to be calling from an insurance company).

   5c. Checking photo identification. Pharmacists should ask for photo identification to verify that people are who they say they are and that names match those on prescriptions.† Oftentimes, offenders use an alias or have someone claiming to be a friend or relative pick up prescriptions.

   5d. Keeping prescription pads in a secure place. The U.K. Department of Health issued a publication outlining measures to secure prescription forms.[68] The measures include maintaining a record of forms received, keeping a minimum supply of forms in the office and securely storing them, keeping access to a minimum, and reporting lost forms immediately.

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† A similar, but as yet unimplemented, strategy is to take a fingerprint for identification purposes. In Pulaski, Virginia, large-pharmacy owners successfully fought a proposed requirement to do so, and, in Arizona, neither proposed statewide legislation to take a fingerprint for Medicaid purposes nor a Peoria municipal ordinance requiring people buying certain drugs to be fingerprinted passed.

6. **Prescribing drugs electronically (e-prescribing).** With e-prescribing, the prescriber electronically transmits prescriptions directly to the pharmacist via a certified, secure system. This eliminates the problems of phony call-in prescriptions, forged and altered prescriptions, and stolen prescription pads. It also eliminates pharmacist errors due to illegible prescriptions. In addition, the process itself is more accurate, cost-effective, and time-efficient. A project in Denmark showed that both the pharmacist and patient saved time they would have otherwise spent on the telephone and waiting for a callback.[69]

   Electronic prescribing is at different stages of exploration and implementation in the United States and abroad. In the United States, the Medicare Modernization Act included the idea of e-prescribing; although it is optional for physicians and pharmacies, the act provides an incentive program for using it. Private companies have created ePrescribing networks that link physicians and pharmacies across the United States.† In 2010, the DEA published a rule outlining the process for using the e-prescribing system.‡ Prescribers are encouraged to sign up for these programs.

7. **Enacting or changing prescription fraud laws.** All 50 states and the District of Columbia have implemented laws to more effectively deal with prescription fraud, but only 14 states have a statute specific to doctor shopping.[70] Three states (Texas, Florida, and Tennessee) and several local jurisdictions have recently enacted "pill mill" laws. These laws increase the penalty or punishment for prescription fraud, and/or specifically address individual aspects of it, such as going to multiple doctors for similar prescriptions or creating pain clinics for the express purpose of issuing a high volume of prescriptions with little oversight. Such well-defined laws make it easier to prosecute and convict offenders.

8. **Promoting safe storage and disposal.** A common belief across the police and health communities is that prescription drug abuse can be reduced if the drugs are not easily available to others in the home. This entails securely storing currently used drugs—such as in locked cabinets—as well as disposing of leftover, unused drugs. Nurses, doctors, and pharmacists should all instruct patients on the reason for and methods of safe storage and disposal. The DEA biannually sponsors the National Pharmaceutical Take-Back Day, and the National Association of Drug Diversion Investigators (NADDI) provides a Drug Take Back Toolkit that

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† The largest network, SureScripts, was created by the National Association of Chain Drug Stores and the National Community of Pharmacists Association and then merged with RxHub, which was created by CVS, Medco, and Express Scripts. According to the SureScripts website, they routed nearly one million prescriptions a day.

‡ The details on this rule can be found on the DEA website.

Figure 5. An example of a home medicine safe and drug drop box

jurisdictions can use to host their own take-back days. The DEA is also working on the Secure and Responsible Disposal Act to amend the Controlled Substances Act concerning take-back disposal of controlled substances. In addition, several states and local jurisdictions have created programs or guides, such as *Safe Medicine Disposal for Maine* and Texas' *Primer on Conducting Medication Take Back Programs*.† In Broward County, Florida, "Operation Medicine Cabinet" involves a partnership between police, United Way, pharmacists, and pharmacy students.[71] Operation Medicine Cabinet has been replicated in several other jurisdictions since its inception in 2009.

Increasing numbers of police stations are installing prescription drug drop boxes, where community members can safely dispose of unwanted prescription medications. Typically, the drop box is located inside the station, requiring the station to be open and staffed, but some stations place boxes in their outside entryways. Dane County, Wisconsin, has 10 drug drop box locations in police stations with year-round accessibility. Additionally, police in some jurisdictions are working with residents, schools, and community groups to promote and distribute home medicine safes. Officers can promote the use of such safes during calls for service involving prescription drugs, school events, and community meetings.

† The websites for DEA's program, NADDI's resources, and Maine's program provide a wealth of information about conducting safe disposal programs. The DEA notes that 4,000 state and local law enforcement agencies participated in the last two national take-back days, collecting more than 309 tons of pills. Unfortunately, there have been no evaluations to determine if these types of programs have reduced abuse.

These take-back programs may be seen as similar to the popular, but ineffective,† "gun buy-back" programs of the 1990s. While there are similarities in that people are voluntarily turning in something that may be illegal, with no questions asked, they are different in that no money, vouchers, or goods are being given in exchange. Other possible similarities include that people dispose of their old, uninteresting drugs much in the same way that the majority of firearms turned in are antique and inoperable. Anecdotal evidence from the Reno Police Department suggests that drug take-back programs increased awareness of the dangers of prescription drugs and their potential misuse, but the medicines collected were not high on the list of misused or fraudulently obtained prescription drugs. Regardless, encouraging and facilitating drug disposal should theoretically reduce some share of accidental overdoses and decrease the availability of some dangerous pills to children, teenagers, and burglars who rummage through medicine cabinets.

9. **Maintaining a Prescription Monitoring Program and Cross-State Data Exchange.** Prescription Monitoring Programs (PMP) entail varying methods of tracking and monitoring certain prescription drugs. The general goals of the programs are to educate and inform prescribers, pharmacists, and the public about specific prescription drugs; use information for public-health initiatives and for early intervention and prevention; and assist in investigations and enforcement. Underlying this is the need to protect patient confidentiality. Recently, the National Association of Boards of Pharmacy instituted PMP InterConnect, a secure communications exchange platform through which PMPs can share data. Although only a handful of states are currently using it, 20 more have agreed to start within a year. There is also a PMP Information Exchange Program (PMIX), funded by the U.S. Bureau of Justice Assistance, which provides an infrastructure and network for states that include data sharing in their legislation.‡ The Office of the National Coordinator for Health Information Technology is currently implementing a series of workgroups to develop guidance and conduct pilot studies on real-time data exchange and integration of PMPs with existing electronic records systems.

   As noted in Appendix B, state programs vary regarding the type of monitoring used (almost all are now electronic), the schedule of drugs covered (all cover Schedule II controlled substances, but many do not cover Schedule V), and the type of agency

† See Problem-Specific Guide No. 23, *Gun Violence Among Serious Young Offenders*, for further information.

‡ More information on PMP InterConnect can be found on the National Association of Boards of Pharmacy website. Sample memoranda of understanding and related guidance can be found on the Alliance of States with Prescription Monitoring Programs website.

administering them. In addition, every state program decides who may request patient information (it varies across prescribers, pharmacists, police, licensing boards, and patients) and whether its goal is "proactive" (analyzing data to identify patterns and trends) or "reactive" (using the data to investigative questionable prescribers or patients).† The accompanying map in Appendix B depicts each state's status in sharing program information with others.

Several studies and publications have addressed how PMPs affect diversion and medical practice, the preliminary findings of which show positive results.[72] Although PMPs have shown to be successful in identifying and preventing drug diversion, they still may have some negative impact on medical practice.[73] In addition, requirements regarding usage of and awareness of PMPs vary widely by state and by type of doctor.[74] Although states mandate that pharmacies use PMPs, they do not necessarily require physicians to use them. One study of Ohio physicians concluded that medical specialty drove awareness and use of PMP data.[75]

An extensive study of Maine's PMP found that prescribers have used PMP data to confirm doctor shopping, and make referrals for substance abuse. It also found that "a chilling effect has *not* occurred."[76] Michigan found that its electronic system reduced handling time and did not increase cost,[77] and a satisfaction survey conducted in Kentucky revealed that "nearly 90 percent of prescribers have used a Kentucky All Schedule Prescription Electronic Reporting (KASPER) report to help with the decision to deny medication to patients" and 94 percent of police strongly or somewhat agree that KASPER is an effective tool for obtaining evidence in the investigative process.[78]

Although some PMP and licensing boards are either unwilling or legally restricted from sharing data on habitual-offending patterns (both of patients and health professionals), police might nonetheless encourage those boards to conduct their own analyses to identify potential abusers. Alternatively, the boards might allow police to analyze data with the identifying information removed: police could then just report back that pharmacist X or doctor Y is suspicious and merits closer scrutiny. In order for PMPs' promise to be fully known, it is imperative that physicians use the data to make prescribing decisions.‡

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† According to the National Alliance for Model State Drug Laws (NAMSDL), as of May 2012, 47 states have some provision in their PMP law regarding police access. Ten states require showing probable cause, and 16 states allow access only with a court order. Detailed information by state can be found on the NAMSDL website.

‡ The state of New York is proposing mandatory use of the PMP by physicians as part of a comprehensive package of legislation to address the prescription drug abuse and diversion epidemic. Details of this proposal can be found on the website of the New York State Office of the Attorney General.

Addressing Prescription Drug Abuse in Reno, Nevada†

In spring 2009, the Reno Police Department was contacted by Join Together Northern Nevada (a non-profit substance abuse coalition) and asked to meet with the parents of a teenager who had died of a methadone overdose. After that meeting, Reno police decided to design a multi-faceted prevention plan, applying for and receiving funding through the U.S. Department of Justice Bureau of Justice Assistance's Smart Policing Initiative, to do so.

The program's goal since January 2010 has been to reduce the abuse of prescription drugs, especially among youth by 1) decreasing the availability of prescription drugs; 2) educating healthcare professionals and the public about prescription abuse and diversion; and 3) enforcing prescription fraud and diversion laws. In addition to Join Together Northern Nevada, other partners include Truckee Meadows Water Authority and Waste Management, Retail Association of Nevada, pharmacy retailers, the State Boards of Pharmacy and Medical Examiners, and the Washoe County School District.

The project team's strategies include "Drug Round Up" events; distributing MedSafe locking medicine cabinets; educating the public with a pharmacy bag sticker campaign; training healthcare professionals and patrol officers; educating middle school and high school students using a tailor-made video; and targeting prescription fraud investigations and enforcement. In addition, the team has met with the Pharmacy Board about collecting and analyzing data from the state's PMP.

To date, surveys were completed for the training and teen video distribution, and an outside researcher is currently evaluating all aspects of the program.

Reducing Rewards to Offenders

10. **Curbing distribution.** Specific efforts have been made to limit the dosage or distribution of a particular drug in a target population or region. For instance, Florida and four other states limit OxyContin prescriptions to 120 pills per month per patient.[79] Besides dosage, the number of refills could be limited. When prescribers do not specify a refill number, patients can illegally add one. Another method is to limit distribution via a specialized dispensing machine. One example is the "Automated Dispensing System" which is provided by pharmacies to long-term care facilities in several states.[80] These types of electronic pill dispensers also allow physicians to monitor usage.

† This information is based on e-mail correspondence with Reno Police Department personnel during August 2011, as well as from a presentation at the Problem-Oriented Policing Conference in October 2011. For further information on the Reno initiative, see the BJA SMART Policing Initiative website.

11. **Re-formulating drugs.** Several drug manufacturers have altered their drug formulation in order to reduce the potential for misuse. Two ways of creating misuse-deterrent formulations are via a pharmacological barrier or a physical barrier. Examples of this include Purdue Pharma's re-formulation of OxyContin, which, when crushed, can no longer be inhaled or put in a syringe, and Alpharma's Embeda®, which contains naltrexone that passes through the gastrointestinal tract if used properly, but if chewed or crushed, releases and blocks euphoria caused by the opioid. AcelRx Pharmaceuticals is working on a drug that retains its dose even when crushed.

Removing Excuses

12. **Facilitating compliance with the law.** There are currently three main approaches to facilitating drug offenders' compliance with the law: drug treatment/rehabilitation, Narcotics Anonymous, and Drug Court.† Although all have been evaluated extensively, none has been evaluated specifically for prescription fraud offenders, and only one study targeted pharmaceutical misusers.[81] Yet a recent multi-site evaluation revealed that Drug Court (in conjunction with Narcotics Anonymous, attendance of which is a requirement) has a significant and cost-beneficial impact on substance abuse and crime.[82] One distinct advantage of Drug Court over jail is that, upon successful completion, the charges are expunged from the offender's record. This is especially important to first-time offenders who do not want a black mark on their records. Because of the high number of prescription fraud offenders who are professionals (many in the healthcare field), police investigators believe this is an important factor in an effective response. Similar to the Drug Court concept is Nevada's Pre-Criminal Intervention Program where an intervention officer from the Board of Pharmacy works with prescription drug users who have a high potential for misuse and fraud. Candidates are identified through PMP data and doctor-shopping criteria. A study of the program showed a large reduction in the average number of prescribers, dispensers, and prescriptions filled.[83]

† Additional information about Drug Court is available from the National Association of Drug Court Professionals and from the Center for Court Innovation.

Responses with Limited Effectiveness

Because many of the responses discussed here have not been evaluated, it is difficult to determine which ones have limited effectiveness. It is possible that the existing state monitoring systems, although effective, would be even more so if all states had such programs and the databases were nationally linked. Some progress in linking PMPs has been made through a pilot project called PMIX.[84, †]

13. **Conducting enforcement crackdowns.** Enforcement crackdowns usually yield an immediate but limited impact and often do not produce long-term results. A police or medical-board crackdown on a specific doctor, pain clinic, or pharmacy prone to prescription fraud and misuse may put that doctor, pain clinic, or pharmacy out of commission, but prescription drug misusers will simply move on to the next doctor or pharmacy that does not have sufficient prevention measures in place. Given the inadequate amount of resources devoted to crackdowns on prescription fraud, the practice cannot be sustained as a means to prevent or reduce the problem.[‡]

14. **Creating a pharmacy-based prescription database.** Many pharmacies maintain a database of their customers. These "patient profiles" track previous prescriptions filled and provide information that aids in filling current ones. Although a pharmacist may note a customer's repeat prescriptions at his or her pharmacy, the customer's attempts to get prescriptions filled at other pharmacies go undetected. Only a limited number of chain pharmacies share a common database, and we are not aware of any database shared among all pharmacies in a jurisdiction for the purpose of preventing prescription fraud.[§] Detecting a customer who is getting a high number of prescriptions filled at multiple pharmacies in one city is much more efficient through a jurisdiction-wide prescription database. The Internet would be an easy means to share such information.

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† In response to a survey of all 32 states with PMPs, 64 percent reported they would like a hub to screen requests. Review of data in Kentucky, Maine, and Massachusetts revealed that prescriptions collected in those states had originated in all 50 states, the District of Columbia, and the U.S. territories. A pilot collaboration between California and Nevada is producing guidelines and lessons learned.

‡ See Response Guide No. 1, *The Benefits and Consequences of Police Crackdowns*, for further information.

§ Some Canadian provinces have some form of a pharmacy network. Most of these connect pharmacies to provincial drug programs; four have systems that provide complete drug profiles to pharmacists; and some are connected to hospitals and physician offices.

15. **Monitoring Internet sites.** There is still some question about the amount of fraud occurring through Internet sites. With that said, some Internet sites may have lax requirements regarding purchasers' proof of prescriptions, and others may require no prescription at all. Many of these sites operate outside of the United States and require an international drug policy and regulatory response.[85]

Appendix A: Summary of Responses to Prescription Drug Fraud and Misuse

The table below summarizes the responses to prescription fraud, the mechanism by which they are intended to work, the conditions under which they ought to work best, and some factors you should consider before implementing a particular response. It is critical that you tailor responses to local circumstances, and that you can justify each response based on reliable analysis. In most cases, an effective strategy will involve implementing several different responses. Law enforcement responses alone are seldom effective in reducing or solving the problem.

Response No.	Page No.	Response	How It Works	Works Best If…	Considerations
Increasing the Risk of Detection					
1	26	Informing doctors and pharmacists of and about fraudulent activity	Sharing information on offenders and scams through bulletins and mass communication increases the risk of apprehension, thereby deterring potential offenders	…the information is shared quickly throughout the jurisdiction	A means of networking/ communication that reaches the most people possible (e.g., faxes or the Internet) should be used
2	27	Improving pharmacists' screening of prescriptions and patients	Pharmacists act as "gatekeepers" by checking ID, verifying doctor information, and detecting suspicious behavior	…pharmacists are consistent in screening and report fraudulent activity to police	Takes time, effort, and experience, both for pharmacists and police
3	27	Educating the public about prescription fraud and misuse	Increasing awareness of prescription misuse and fraud through local and national efforts allows more people to identify friends and family members engaged in fraudulent activity	…informational campaigns are multidisciplinary and target specific populations	Initiatives should provide statistics and other specific information (e.g., if the target group is youth, use youth-related data); can be resource-intensive

Response No.	Page No.	Response	How It Works	Works Best If…	Considerations
Increasing the Effort Required to Commit Prescription Drug Fraud					
4	29	Verifying prescriptions	Pharmacists do callbacks on phoned-in prescriptions and check doctors' information, maintain a file of doctors, and dispense only a limited dosage until they can verify prescriptions	…pharmacists are consistent in the verification process, refuse to fill unverifiable prescriptions, and report suspicious activity to police	Takes time, effort, and resources
5	29	Employing security measures	Strategies include using tamper-resistant prescription pads, increasing the precautions the practitioner's receptionist and answering service take, checking photo ID, and keeping prescription pads in a secure place, all increasing the difficulty for would-be offenders	…all security measures are consistently used, and fraud is not being committed internally (by employees of the doctor's office)	Tamper-resistant pads can be costly; checking ID can be time consuming; measures are ineffective against internal fraud
6	30	Prescribing drugs electronically (e-prescribing)	Direct transmission of prescriptions (via computer) from prescribers to pharmacists eliminates the problems of false phoned-in prescriptions, forged and altered prescriptions, and stolen prescription pads	…all pharmacists and prescribers in the jurisdiction are doing so	Cost of setting up systems and maintaining system security; getting buy-in from doctors and pharmacists; once implemented, very cost-effective and time-efficient
7	30	Enacting or changing prescription fraud laws	Specific, targeted laws make it easier to prosecute and convict offenders	…used in conjunction with other prevention and education efforts	Can be time- and resource-intensive; does not address the underlying problem

Response No.	Page No.	Response	How It Works	Works Best If…	Considerations
8	30	Promoting safe storage and disposal	Reduces easy availability of prescription drugs that can be misused	…drug companies and health professionals also educate consumers through labeling, prescribing, and dispensing the drugs	Consistent education and marketing of disposal procedures is needed; take-back programs need to be flexible and easy for participants
9	32	Maintaining a Prescription Monitoring Program and Cross-State Data Exchange	Tracking and monitoring prescription drugs aids in identifying patterns of problem behavior	…the program covers the drugs most often misused, and data are used proactively	Patient confidentiality may be breached; effect limited to drugs covered; program administration can be costly
Reducing Rewards to Offenders					
10	34	Curbing distribution	Limiting the dosage or distribution of a drug reduces the opportunity for offenders to easily obtain large quantities of it	…focused on a particular problem drug or target group/region	Some patients need higher dosages or more frequent refills and must be accommodated
11	35	Re-formulating drugs	The drug is manufactured using a misuse-deterrent formulation, either a pharmacological or physical barrier, to reduce the drug's intoxicating effects	…the drug is created with this in mind initially, not after widespread misuse occurs	Drug companies may need to be held accountable to manufacture the drugs with misuse-potential in mind

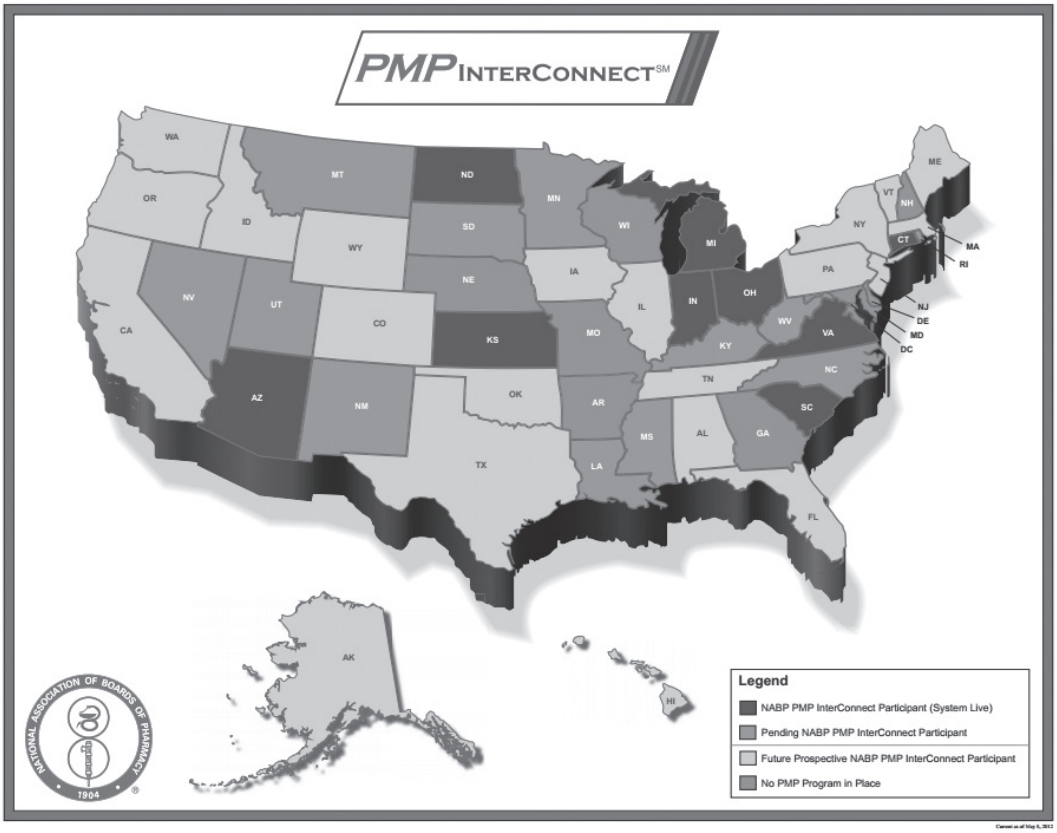
Response No.	Page No.	Response	How It Works	Works Best If…	Considerations
Removing Excuses					
12	35	Facilitating compliance with the law	Programs such as drug treatment/ rehabilitation, Narcotics Anonymous, and Drug Court help to prevent repeat offenses	…used in conjunction with one another, there are consequences for nonparticipation, and offenders want to change	Resources are needed to ensure attendance and compliance with program rules
Responses with Limited Effectiveness					
13	36	Conducting enforcement crackdowns	Increases likelihood of detection and punishment	…the effort can be sustained for multiple people or pharmacies over an extended period	Extensive resources are required (and not generally available); without prevention measures in place, illegal activity will resume in the long term
14	36	Creating a pharmacy-based prescription database	Pharmacies are able to verify patient information and monitor the number of prescriptions previously issued	…multiple—or all—pharmacies in the jurisdiction share the database	Cost of, and cooperation required for, implementing a networked system; patient confidentiality may be breached
15	37	Monitoring Internet sites	Regulatory and enforcement agencies identify and monitor websites that sell prescription drugs, both in the U.S. and internationally	…policies and regulations are implemented and enforced	Non-U.S. countries have different drug and Internet sales regulations; ease and invisibility of creating Internet companies undermines effectiveness

Appendix B: Prescription Monitoring Programs by State†

State	Program Enactment Year	Program Type	Schedule of Drugs Covered	Administrative Agency
Alabama	2004	Electronic	II-V	Public Health
Alaska	2008	Not yet operational	II-V	Prof. Licensing
Arizona	2007	Electronic		Pharmacy Board
Arkansas	2011	Not yet operational	II-V	Public Health
California	2005	Tamper-resistant/ electronic	II-IV	Law Enforcement
Colorado	2005	Electronic	II-V	Pharmacy Board
Connecticut	2007	Electronic	II-V	Consumer Protection
Delaware	2010	Not yet operational	II-V	Controlled Substances
Florida	2009	Electronic	II-IV	Public Health
Georgia	2011	Not yet operational	II-V	Law Enforcement
Hawaii	1997	Electronic	II-V	Law Enforcement
Idaho	1997	Electronic	II-V	Pharmacy Board
Illinois	2005	Electronic	II-V	Public Health
Indiana	1997	Electronic	II-V	Prof. Licensing
Iowa	2006	Electronic	II-IV	Pharmacy Board
Kansas	2008	Electronic	II-IV	Pharmacy Board
Kentucky	1998	Electronic	II-V	Public Health Inspector General
Louisiana	2006	Electronic	II-V	Pharmacy Board
Maine	2003	Electronic	II-IV	Substance Abuse
Maryland	2011	Not yet operational	II-V	Substance Abuse
Massachusetts	1992	Electronic	II-V	Public Health
Michigan	1995	Electronic	II-V	Public Health/ Prof. Licensing

† This table, current as of September 2011 (National Association of State Controlled Substances Authorities and Alliance of States with Prescription Monitoring Programs), includes only those states that have (or have had) some form of a PMP. The program enactment year is when the program was enacted, not when it became operational (several states are not yet operational). Several states had previous triplicate- or serialized-form databases, but these are not included if there is a more current electronic database.

State	Program Enactment Year	Program Type	Schedule of Drugs Covered	Administrative Agency
Minnesota	2007	Electronic	II-IV	Pharmacy Board
Mississippi	2005	Electronic	II-V	Pharmacy Board
Montana	2011	Not yet operational	II-V	Pharmacy Board
Nevada	1995	Electronic	II-IV	Pharmacy Board
New Jersey	2008	Not yet operational	II-IV	Law Enforcement
New Mexico	2004	Electronic	II-IV	Pharmacy Board
New York	2010	Electronic	II-V	Public Health
North Carolina	2005	Electronic	II-V	Public Health
North Dakota	2005	Electronic	II-V	Pharmacy Board
Ohio	2005	Electronic	II-V	Pharmacy Board
Oklahoma	2005	Electronic	II-V	Law Enforcement
Oregon	2009	Electronic	II-IV	Public Health
Pennsylvania	1972	Electronic	II	Law Enforcement
Rhode Island	1997	Electronic	II, III	Pharmacy Board
South Carolina	2006	Electronic	II-IV	Public Health
South Dakota	2010	Not yet operational	II-IV	Pharmacy Board
Tennessee	2003	Electronic	II-V	Pharmacy Board
Texas	2008	Electronic	II-V	Law Enforcement
Utah	1995	Electronic	II-V	Prof. Licensing
Vermont	2006	Electronic	II-IV	Public Health
Virginia	2002	Electronic	II-IV	Prof. Licensing
Washington	2007	Electronic	II-V	Public Health
West Virginia	1995	Electronic	II	Pharmacy Board
Wisconsin	2010	Not yet operational	II, III, others by rule making	Pharmacy Board
Wyoming	2004	Electronic	II-IV	Pharmacy Board



Source: Pfraud_AppB-map.tif. www.nabp.net/programs/assets/PMPInterconnectMap.pdf

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About the Authors

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Julie Wartell is an independent advisor on public safety issues relating to crime analysis, problem solving, and justice systems. She has previously served as crime analyst coordinator for the San Diego District Attorney's Office; project director of the East Valley COMPASS Initiative (a regional analysis effort); crime analyst for the San Diego Police Department, researcher for the Institute for Law and Justice and the Police Executive Research Forum, and fellow at the National Institute of Justice Crime Mapping Research Center. Wartell has performed a wide range of research on and analysis of various crime problems and police-related issues, worked on strategic planning efforts, and coordinated the development of a series of crime mapping training modules. She has conducted extensive training and made presentations to officers and analysts around the world on topics relating to crime analysis and problem-oriented policing, has edited or authored numerous publications, and currently teaches GIS in Urban Studies at the University of California–San Diego. Wartell has a master's degree from San Diego State University in public administration with an emphasis in criminal justice administration.

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Prior to joining the Urban Institute, La Vigne was the founding director of the Crime Mapping Research Center (since renamed the Mapping and Analysis for Public Safety program) at the National Institute of Justice, the research, technology, and evaluation arm of the U.S. Department of Justice (DOJ). She later served as special assistant to the Assistant Attorney General for the Office of Justice Programs within DOJ. She has held positions as research director for the Texas sentencing commission, research fellow at the Police Executive Research Forum, and consultant to the National Council on Crime and Delinquency. Her research interests focus on criminal justice evaluation, prisoner reentry, policing, crime prevention, and the spatial analysis of crime and criminal behavior. She has published widely on these topics, her work appearing in a variety of scholarly journals and practitioner publications.

La Vigne holds a bachelor's degree from Smith College, a master's in public affairs from the Lyndon B. Johnson School of Public Affairs at the University of Texas-Austin, and a doctorate from the School of Criminal Justice at Rutgers, The State University of New Jersey.

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