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Pharmacy Security: A Survey on Pharmacists' Perceptions and and Preparedness to Handle Prescription Fraud and Pharmacy Robbery

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Amy Nicole Lenell

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Pharmacy Security: A Survey on Pharmacists' Perceptions and Preparedness to Handle Prescription Fraud and Pharmacy Robbery

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Background: The community pharmacy is intended to be a place for patient care, however the rise in addiction to prescription drugs has heightened the incidence of both prescription fraud and pharmacy robbery. Currently, research is lacking in the area of pharmacist education on drug diversion.

Objective: To evaluate the perceptions of the community pharmacist with respect to prescription fraud and pharmacy robbery as well as their preparedness to handle such situations, with the intent to assess the need for a continuing education program on this topic.

Methods: A survey was sent to licensed Indiana pharmacists using a listserv provided by Butler University. Only data from pharmacists currently practicing in the community (retail) setting was accepted and analyzed. The survey includes questions regarding prescription fraud, pharmacy robbery, security measures and demographics.

Results: Of 1000 surveys sent, 80 surveys were returned, 47 met selection criteria, and 43 completed the study. Of those who responded, 58% perceive fraud as a major problem in their area, whereas 18.6% perceive robbery a major problem. 25.6% rated their own preparedness for handling fraud as excellent or very good. 20.9% felt that their preparation was excellent or very good for robbery. The majority of respondents (88.3%) agreed that a continuing education course on the topic of security would be helpful.

Conclusions: Results of the study indicate that pharmacists are concerned about security in the community pharmacy regardless of gender or work experience. Although most of those surveyed do not perceive robbery to be a major problem in their area, they are interested in further education on the topic of security.

BACKGROUND

Abuse of prescription medicines is the fastest growing form of substance abuse; exceeding cocaine, hallucinogens (excluding marijuana), inhalants, and heroin combined.¹ The most frequently abused medications include opioids, stimulants, tranquilizers, and benzodiazepines.^{2,3} As the number of patients using prescription medications for nonmedical reasons has risen, the illegal diversion of drugs through prescription fraud and pharmacy robbery has also increased.^{1,3} According to the 2005 National Center on Addiction and Substance Abuse at Columbia University (CASA) survey, 48% of the pharmacists surveyed had received instruction in the prevention of drug diversion since their graduation from pharmacy school, and 49.6% had received instruction in identifying prescription drug abuse and addiction. Community pharmacists are now more likely to encounter prescription fraud and pharmacy robbery in the workplace, however they may not receive any training that prepares them to appropriately manage these potentially dangerous situations.¹

The Drug Enforcement Administration (DEA) defines drug abuse as the “use of drugs in a manner inconsistent with the medical or social patterns of a culture.”⁴ Nonmedical use is a term used interchangeably with abuse and refers specifically to the abuse of medicines. The National Institute on Drug Abuse (NIDA) defines addiction as “a complex brain disease, characterized by drug seeking and use despite harmful consequences.”⁵ Addiction may be present in patients that habitually abuse medication, but not all patients who abuse a medicine are addicted to it.⁵

The epidemic growth in nonmedical use or abuse of prescription medications is confirmed by multiple studies. The 2005 CASA study reports that the United States

population increased by 14% from 1992 to 2003, but the abuse of controlled prescription medicines increased by 94% during that time.¹ The National Survey on Drug Use and Health (NSDUH) evaluated drug use from 2002 through 2004, finding a yearly average of 14.8 million persons over the age of 12 using prescription medications for nonmedical reasons. Of that total, 11.3 million abused pain relievers and 2.4 million persons did so for the first time.² The CASA study recorded a similar finding, with 15.1 million people using prescription medications for nonmedical reasons in 2004.¹ Prescription drug abuse is second in the number of reported users only to marijuana use. The 2005 National Survey on Drug Use and Health reported 25 million users of marijuana, with fewer first time users of marijuana than nonmedical use of painkillers, at 2.1 million people using marijuana for the first time. This survey also examined the nonmedical use of prescription medications by state. Indiana, the location for our survey, was identified as one of the top 10 states in abuse of psychotherapeutic drugs (7.6% of the population) and in abuse of painkillers by persons aged 18 to 25 (15.1% of the population in this age group).²

Prescription drug abuse was estimated to cost the healthcare system \$100 billion in 2001, a number that is likely to rise with increasing trends in abuse.³ Although the cost to the healthcare system is substantial, the toll of prescription drug abuse on human life is more significant. Families are devastated by substance abuse, as the individuals involved in addiction may no longer be able to maintain a job or support their family. The Drug Abuse Warning Network (DAWN) examined drug-related emergency department (ED) visits in 2005 and found approximately 598,542 visits involving pharmaceuticals. This is a 21% increase from 2004. In this study, "pharmaceuticals" encompasses prescription

drugs, over-the-counter products and dietary supplements. Abuse of opioids increased by 24% from 2004 to 2005, methadone abuse increased by 29% and abuse of benzodiazepines increased by 19%. According to the study, pharmaceuticals were involved in 93% of drug-related suicide attempts.⁶ Although prescription and over-the-counter medications typically have good safety data for appropriate use, the dangerous nature of these drugs should not be underestimated in situations of drug abuse.

Drug diversion is a product of the rising addiction to prescription medicines. Prescription fraud and pharmacy robbery are forms of drug diversion. Drug diversion includes retail theft by an employee or “doctor shopping” which occurs when a patient sees several physicians in order to obtain multiple prescriptions for the drugs they are abusing. Drug diversion also includes diversion at the manufacturer or distributor, before the medication reaches the retail pharmacy.^{1,7} The Controlled Substances Act of 1970 established harsh penalties for drug diversion, and individual states may have separate laws to enact even stricter penalties.⁸ In Indiana, drug diversion with the intent to sell or distribute the drug is a felony offense.⁹

Prescription fraud may involve a valid prescription that is later altered, a prescription written on a stolen prescription pad, or a prescription that is given over the phone by someone other than the prescriber or an agent of the prescriber. Alterations may be simple, such as adding “ES” to increase the strength of a prescription for Vicodin® or as complex as washing a prescription with acetone and carefully drying and rewriting a prescription.⁷ Pharmacists may recognize prescription fraud when a prescription contains two different types of ink, the person phoning in the prescription is not confident, or by simply having an intuitive feeling that something is not right. According to the 2005

CASA survey of retail pharmacists, 92.8% call the prescriber when they believe a prescription might be fraudulent. Other responses included refusing to fill (76.6%), documenting the occurrence (71.3%), and contacting police (47.6%). Of the pharmacists surveyed, 32.3% would confront the patient and 1.7% would do nothing.¹ Prescription technology has also been mandated in order to reduce the incidence of prescription fraud. The requirements for the Indiana controlled prescription blank include an opaque “Rx” in the upper left corner that disappears when the prescription is lightened, a latent “Void” that appears when the prescription is photocopied, a watermark on the back that is seen at a 45 degree angle, and six quantity check boxes.¹⁰ Pharmacists can identify prescription fraud if they are aware of the security features on the prescription blank and notice an abnormality. Receipt of prescriptions for medications that are schedule III-V by facsimile or through an electronic prescribing system do not typically utilize this security technology.

The 2005 study by CASA revealed that 28.9% of pharmacists responding had experienced robbery or theft within the previous 5 years.¹ Pharmacy robbery is not as common as prescription fraud, but the implications may be much more grave. The robber may be armed, may have accomplices, and may even jump over the counter to take what he or she wants. Pharmacy robberies frequently target brand name controlled substances, such as Vicodin®, Percocet®, Oxycontin®, and Xanax®.⁷ In the CASA survey, 20.9% of pharmacies no longer stocked certain medications, such as Oxycontin® and Percocet®, in order to protect themselves from pharmacy robbery.¹ Robbery statistics are not well-documented, however reporting websites such as RxPatrol.org, a site sponsored by the manufacturer of Oxycontin®, and the National Association of Drug Diversion

Investigators website (www.naddi.org) list several unsolved robbery cases in a given area.^{11,12} In one search on Indiana, www.naddi.org listed five unsolved robbery cases within the previous 8 months, and many more cases are not reported to monitoring websites such as these.¹² When utilized, reporting mechanisms provide a useful way to share information between practitioners, law enforcement and the general public.

The rise in drug diversion has seized the attention of physicians, law enforcement and the government. Physicians have developed organizations and committees, such as the Joint Liaison Committee on Pain and Addiction, to address this issue. To combat diversion, the American Society of Interventional Pain Physicians (ASIPP) introduced a bill called the National All Schedules Pharmacy Electronic Reporting Act (NASPER). This bill was signed into law in 2005 and provides funding for states to initiate and maintain a system for electronic reporting of controlled substance dispensing.³ The DEA has a division dedicated to drug diversion, and police forces around the country have developed training materials to prepare officers to isolate and arrest drug diverters.⁷ Community pharmacists are the most likely people to stand face to face with a diverter, yet many pharmacists work without formal training or acknowledgement of the risks.

Pharmacy school, continuing education, and employer training may not adequately prepare a pharmacist to handle the growing problem of fraudulent prescriptions and pharmacy robbery. Gathering information on the perceptions and the preparedness of community pharmacists with regard to prescription fraud and pharmacy robbery as well as the available security measures in pharmacies will increase awareness of the problem and provide a forum for ideas to improve education and keep the focus of community pharmacy on patient care.

OBJECTIVE

The primary objectives are to identify the perceptions and concerns of the community pharmacist regarding prescription fraud and pharmacy robbery and to assess the preparedness of the pharmacist to handle security issues in the pharmacy. The secondary objective is to evaluate the need for a continuing education program on the topic of pharmacy security.

METHODS

Data Source

The survey was administered through SurveyMonkey and sent by email to 1,000 pharmacists licensed to practice in Indiana using a listserv provided by Butler University. The study was approved by the Institutional Review Board at Butler University on August 8, 2006.

Selection Criteria

Pharmacists licensed in Indiana and currently practicing in the community (retail) setting were eligible to participate in the study.

Exclusion Criteria

Pharmacists that did not meet inclusion criteria were excluded. Additionally, the survey was sent to a listserv that only contained pharmacists licensed to practice in Indiana in order to obtain a sample in which the respondents have all taken the Indiana Multistate Pharmacy Jurisprudence Exam (MPJE) law exam as laws regarding controlled substances and pharmacy security may vary by state.

Study Design

A survey was developed to meet primary and secondary study objectives. The survey instrument contained four sections separated into questions regarding prescription fraud, pharmacy robbery, security measures and demographic information (Appendix 1). For the purposes of this survey, prescription fraud was defined as a fake or altered prescription, as well as a fake prescription given over the phone. Robbery was defined as theft by an outside person (not an employee) while the pharmacy is either open or closed. Questions in the sections on prescription fraud and pharmacy robbery were designed to assess the frequency of fraud and robbery, whether the pharmacist perceived fraud and robbery to be a problem, how prepared the pharmacist feels, and how the pharmacist might respond in a scenario. The third section contained questions regarding available tools, such as counseling or security measures, to assist the pharmacist. The fourth section, demographics, contained questions about both the pharmacist and the primary pharmacy in which he or she works in order to provide a basis to compare and contrast the responses among groups.

Statistical Analysis

Statistical analysis was completed using SPSS 14.0 for Windows. Primary statistical analysis is descriptive in nature. Secondly, groups are compared using a Chi-square test of association to determine if responses correlate to gender, management experience, type of pharmacy (chain or independent), years of experience, shift worked (day/evenings or overnight), full or part time status, and prescription volume. P value ≤ 0.05 indicates statistical significance. The sample size was too small to support statistical significance in most cases.

RESULTS

Demographics

Demographics are presented in Table 1. The survey was completed by 80 pharmacists, of which 47 met selection criteria, and 43 completed the survey. Of the respondents, 21 (48.8%) are male and 22 (51.2%) are female. The majority of the pharmacists (79.1%) work in a chain pharmacy and 72.1% work full time. Only 3 pharmacists (7%) work the overnight shift. The respondents were reasonably divided between management and staff, as 20 (46.5%) are pharmacy managers. Years of experience ranged from less than one year to greater than twenty years, with 24 pharmacists (55.8%) with greater than ten years of experience as a community pharmacist.

Fraud and Robbery

Results are presented in Tables 2-6. Respondents were asked in separate questions to categorize the frequency of prescription fraud and pharmacy robbery as weekly, monthly, 2-4 times a year, yearly, or less than yearly (Table 2). Equal percentages (37.2%) of respondents reported that prescription fraud occurs monthly or 2-4 times a year. Only 2 stores reported weekly occurrences of prescription fraud, both were chain pharmacies ($\chi^2=4.479$, $p=0.345$). Pharmacy robbery, however, was much less frequent, as 90.7% of respondents indicated that robbery occurs less than yearly at their store.

Although frequency data was collected, pharmacists were also asked in separate questions to rate their perception of prescription fraud and pharmacy robbery as problems in their area (Table 3). Greater than half of all pharmacists surveyed (58.2%) agreed or strongly agreed that fraud was problematic in their area. Only 18.6% agreed that robbery

was a major problem, whereas a majority (55.9%) either disagreed or strongly disagreed that robbery was a major problem.

When asked to rate their own preparedness to handle prescription fraud, 11 (25.6%) rated their preparation as "Excellent" or "Very Good," whereas 18 (41.9%) rated their preparation as "Fair" or "Poor" (Table 4). Comparatively, 9 (20.9%) of respondents rated their preparedness to handle robbery as "Excellent" or "Very Good" and 21 (48.8%) selected "Fair" or "Poor."

In addition to obtaining data on frequency and preparedness, pharmacists were given a general scenario for prescription fraud and pharmacy robbery and asked how they would likely respond (Figure 1-2). When presented with a prescription that they have verified with the physician as fraudulent, 5 (11.6%) would "Refuse to fill only," 18 (41.9%) would "Refuse to fill and alert authorities," and 20 (46.5%) would "Fill and alert authorities (pursuing arrest)" (Figure 1). Zero respondents chose "Fill and dispense." When faced with robbery (Figure 2), 39 respondents (90.7%) selected "Always give the robber what he/she wants."

Pharmacists were asked in separate questions how frequently they would alert neighboring stores of prescription fraud and pharmacy robbery (Table 5). Pharmacists were more likely to alert neighboring stores of a robbery than fraud as 72.1% said that they always would alert neighboring stores of robbery compared to 41.9% who always alert neighboring stores of fraud. However, combined responses for those that always or frequently alert neighboring stores are similar at 81.4% for fraud and 86.1% for robbery.

The efficacy of the Indiana controlled prescription blank as a means to deter fraud was assessed (Table 6). Responses were varied, as 11.6% felt the blank is excellent or very good, 46.5% felt it is adequate, and 41.9% felt it is fair or poor.

Security Measures

Respondents were asked if the primary pharmacy in which they work has a panic button, functional security camera, empty (fake) security camera, a full-sized door that is kept locked at all times, a pass-through window, or caller identification on the phones available as security measures. Security features are detailed in Table 7. The most common security features were a functional security camera (76.7%) and a full-sized door that is kept locked at all times (41.9%). A pass-through window was the least common feature, found in 5 (11.6%) of respondents' pharmacies. Use of caller identification was reported in 16.3% of pharmacies, an "empty" security camera in 20.9%, and a panic button in 23.3% of the pharmacies included in the survey. Respondents were also asked if employee counseling is available following a robbery or a serious threat. A majority of respondents (60.5%) were unsure of this offering. Only one respondent indicated that counseling was not available.

Overall interest in further education on the topic of pharmacy security was assessed in a single question. The majority of respondents (88.3%) agreed or strongly agreed that a continuing education program on pharmacy security would be helpful (Table 8).

Sub-analysis

Results were further analyzed by the Chi square test of association to determine if responses correlate to gender, management experience, type of pharmacy (chain or

independent), years of experience, shift worked, full or part time status, and prescription volume. There were no significant differences between groups for most of the sub-analyses.

Nearly half of pharmacy managers (45%) reported excellent or very good preparation for prescription fraud, whereas only 8.7% of non-managers reported very good preparation and 0% reported excellent preparation ($\chi^2=10.859$, $p=0.028$). Two respondents (4.7%) rated their preparation to handle prescription fraud as "Excellent," both are pharmacy managers, one male and one female. The remaining responses were also evenly divided by gender. Results for preparation for a robbery situation did not reveal a statistically significant difference between managers and non-managers.

Respondents working part time felt their preparedness to handle prescription fraud was neither poor nor excellent, with 33.3% responding "Adequate" and 58.3% of those working part time responding "Fair." All 6 respondents who rated their preparedness as "Poor" work full time. These results are statistically significant ($\chi^2=9.884$, $p=0.042$), but lack practical significance and may be due to the small sample size.

In response to a scenario of prescription fraud, all 5 respondents that chose "Refuse to fill only" are male; 33.3% of males chose to "Refuse to fill and alert authorities," 42.9% of males chose to "Fill and alert authorities (pursuing arrest)." Female respondents were split evenly in each of the latter two categories ($\chi^2=6.609$, $p=0.048$). In spite of marginal statistical significance, little practical significance is noted and this result is likely due to small sample size.

Results for the efficacy of the Indiana controlled prescription blank at deterring fraud were analyzed by gender. It was found that the majority of females (95.5%) rated

the efficacy of the Indiana controlled prescription blank as “Adequate” or “Fair,” whereas male respondents gave more varied responses, with 19.1% rating it as “Excellent” or “Very Good,” 61.9% rating it as “Adequate” or “Fair,” and 19% rating it as “Poor.” These results are statistically significant ($\chi^2=11.269$, $p=0.024$), but may lack practical significance due to small sample size. There were no significant differences based on work experience.

Data was analyzed for any differences between security measures found in chain and independent pharmacies (Table 7). A minority of chain pharmacies (17.6%) had panic buttons, whereas 44.4% of independent pharmacies have them ($\chi^2=2.863$, $p=0.091$). Proportions were similar between chain and independent pharmacies for functional and empty security cameras and pass-through windows. Nearly half (47.1%) of chain pharmacies use a full-sized, locked door compared to 22.2% of independent pharmacies ($\chi^2=1.804$, $p=0.179$). Greater than half (55.6%) of independent pharmacies have caller identification, whereas only 5.9% of chain pharmacies use caller identification ($\chi^2=12.883$, $p < 0.001$).

DISCUSSION

Although the sample size is small, it is clear that pharmacists do not feel fully prepared to make the right decisions when prescription fraud or pharmacy robbery occurs. Notably, concern and lack of preparedness are present regardless of gender and work experience. Prescription fraud and pharmacy robbery are perceived to be problematic at stores regardless of affiliation with a national chain.

The survey analysis can be divided into two entities, the pharmacist and the pharmacy. The pharmacists' responses may be affected by gender, work experience and

management experience, although this was rarely the case in our survey. Pharmacy managers may be more familiar with company policies and therefore it was thought that they would be more likely to feel prepared. The results indicated that pharmacy managers did feel more prepared to handle prescription fraud, but there was no significant difference in preparation for robbery.

Overall, respondents did not perceive robbery to be a major problem in their area, however results indicate that they feel less adequately prepared in the event of pharmacy robbery. Additionally, the percentage who indicated less than yearly robberies (90.7%) is greater than the percentage that disagreed or strongly disagreed with pharmacy robbery as a problem in their area (54.9%). This disconnect may be due to incidence of robbery at neighboring stores, the media influence, or the inherent danger of a robbery situation.

When provided with a scenario for prescription fraud or pharmacy robbery, the respondents had varied responses to the prescription fraud scenario and a more unified response to the robbery scenario. Based on the survey, pharmacists have more experience with prescription fraud and results indicate that they feel more confident to operate effectively when prescription fraud occurs than pharmacy robbery. However, the heterogeneous responses to prescription fraud indicate that the pharmacists' course of action is not standardized, but rather that pharmacists respond differently and with their own judgment. When responding to the robbery scenario, the majority of pharmacists surveyed (90.7%) selected the same response, "Always give the robber what he/she wants." Of the remaining 9.3%, 4.6% were independent pharmacists (22.2% of the independent pharmacists as a whole). This may be a reflection of pharmacist owners who are more directly affected by the money lost in robbery than the pharmacist working in a

large chain. However, the sample of independent pharmacists is too small to hold statistical significance.

Responses may also be affected by the location of the primary pharmacy in which the pharmacist works. Factors such as the location, prescription volume, and operation as a chain or independent store may impact the level of preparedness or perception of risk. Perceptions and preparedness are difficult to analyze by store type, location, or prescription volume as pharmacists may be more likely to choose to work in a certain location based on their personality or preferred work environment. Variation in response due to location of the pharmacy, rural or urban, was not assessed in this survey. The survey questions that directly addressed variation in pharmacies primarily referred to security features. Some pharmacies had only one feature, such as a functional security camera, other stores had several features. Differences in security amenities may be related to monetary resources or, in the case of chain pharmacies, may be dependent on the standard pharmacy layout for the chain. Future study could examine the most effective security measures in the prevention of pharmacy robbery. Additionally, most pharmacists (60.5%) were not aware of the availability of counseling following a robbery or a serious threat. By providing awareness of security and support measures as well as company procedures for fraud and robbery, employers can better prepare their pharmacists.

This survey has several limitations. First, the sample size is small due to non-response bias. The survey was sent to 1,000 licensed pharmacists by email, however 231 of the emails were returned with error messages and many of the recipients of the email were not practicing in the community (retail) setting. A future study might be more

successful if it were distributed directly through pharmacy management at various chain and independent pharmacies. This manner of distribution was avoided in this study due to concern over bias as pharmacists may not answer honestly to a survey distributed by their employer, and a random sample of different pharmacies would be difficult to attain. Additionally, one of the major chains has antiviral software that blocks SurveyMonkey, the survey administrator used for this study. Recall bias and self-reporting bias were inherent to the survey as respondents were asked to recall information and results were based upon the reliability of respondents to accurately answer the questions.

The survey was intentionally limited in order to gain a broader perspective of the problems facing pharmacists. Future studies might examine incidence of fraud or robbery, address neighborhood watch programs, or ask more specific questions about training. Additional studies could focus specifically on pharmacy robbery or prescription fraud alone, perhaps asking more detailed questions about educational experiences or ways pharmacists and pharmacies are taking action.

Employers and educators can and should equip pharmacists with the knowledge to identify fraudulent prescriptions, suspicious activity and addiction. The majority of respondents (88.3%) showed interest in a continuing education program on pharmacy security. Continuing education programs are one of the most important ways pharmacists can stay informed about best practices in the profession. Pharmacists should know their rights, legal responsibilities, and appropriate ways to manage drug diversion. However, pharmacists must not forget about the best interests of the patient. For a person who develops an addiction to painkillers while taking them with a valid prescription, for example, a program for addiction and rehabilitation will help this patient more than being

arrested in his or her community. If patients do not receive treatment for prescription drug addiction, the cycle of addiction and criminal activity to satisfy the need for the drug will not be broken.

CONCLUSION

Prescription fraud and pharmacy robbery are forms of drug diversion that are nearly inescapable for the community pharmacist. Education is needed in pharmacy school, through employers, and through continuing education programs to train pharmacists to identify drug diversion and addiction, manage a potentially dangerous situation effectively, and refer patients to treatment programs for addiction. Community pharmacy is a place for patient care and education, and it should also be a safe place for pharmacists to practice.

Table 1: Demographics (N=43)	
	No. (%)
Gender	
Male	21 (48.8)
Female	22 (51.2)
Pharmacy Manager	
Yes	20 (46.5)
No	23 (53.5)
Full or Part Time	
Full Time	31 (72.1)
Part Time	12 (27.9)
Shift	
Days/Evenings	40 (93)
Nights (Overnight)	3 (7)
Years Experience	
<1 year	3 (7)
1-5 years	6 (14)
6-10 years	10 (23.3)
11-20 years	16 (37.2)
>20 years	8 (18.6)
Type of Store	
Chain	34 (79.1)
Independent	9 (20.9)
Rx Volume	
Average Rx/day	
<150	9 (20.9)
150-300	15 (34.9)
301-450	11 (25.6)
451-600	4 (9.3)
>600	4 (9.3)

Frequency	Rx Fraud	Robbery
	No. (%)	No. (%)
Weekly	2 (4.7)	0 (0)
Monthly	16 (37.2)	0 (0)
2-4 times a year	16 (37.2)	3 (7)
Yearly	3 (7)	1 (2.3)
Less than yearly	6 (14)	39 (90.7)

	Rx Fraud	Robbery
	No. (%)	No. (%)
Strongly Agree	6 (14)	0 (0)
Agree	19 (44.2)	8 (18.6)
Neutral	9 (20.9)	11 (25.6)
Disagree	9 (20.9)	18 (41.9)
Strongly Disagree	0 (0)	6 (14)

Preparation	Rx Fraud	Robbery
	No. (%)	No. (%)
Excellent	2 (4.7)	1 (2.3)
Very Good	9 (20.9)	8 (18.6)
Adequate	14 (32.6)	13 (30.2)
Fair	12 (27.9)	12 (27.9)
Poor	6 (14)	9 (20.9)

	Rx Fraud	Robbery
	No. (%)	No. (%)
Always	18 (41.9)	31 (72.1)
Frequently	17 (39.5)	6 (14)
Sometimes	6 (14)	6 (14)
Infrequently	2 (4.7)	0 (0)
Never	0 (0)	0 (0)

Figure 1

Response to Prescription Fraud (N=43)

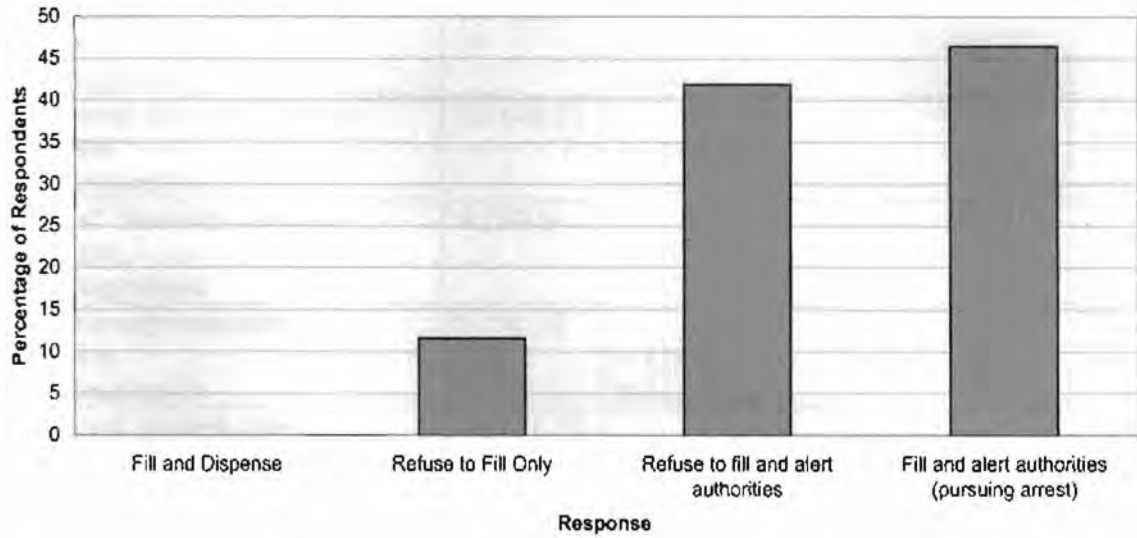


Figure 2

Response to Pharmacy Robbery (N=43)

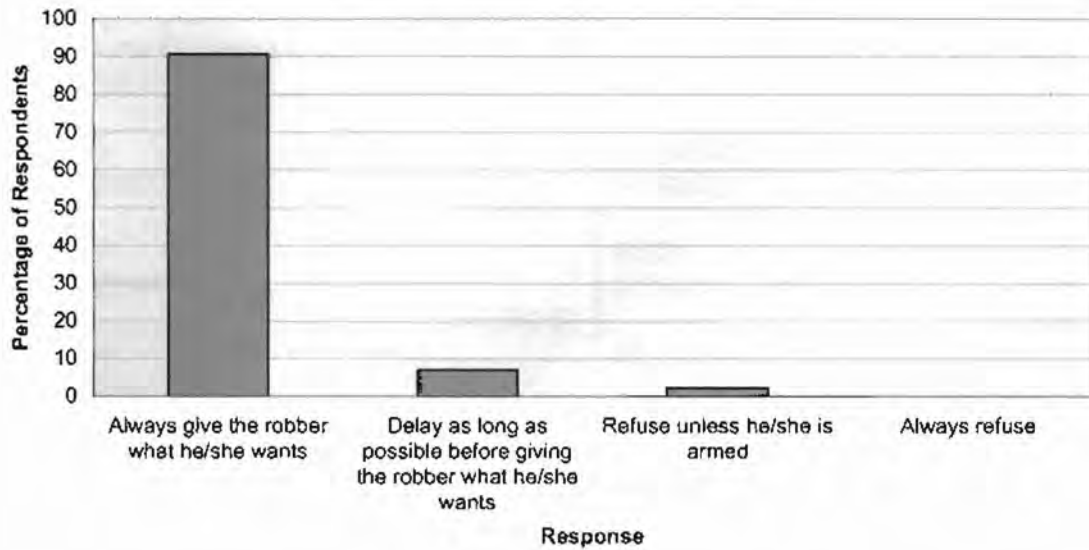


Table 6: Efficacy of Indiana controlled prescription blank at deterring fraud (Question 7) (N=43)

	No. (%)
Excellent	1 (2.3)
Very Good	4 (9.3)
Adequate	20 (46.5)
Fair	14 (32.6)
Poor	4 (9.3)

Security Feature	No. (%)	No. (% within Type of Store)	P Value
Panic Button	10 (23.3)		
Chain		6 (17.6)	
Independent		4 (44.4)	0.091
Functional Security Camera	33 (76.7)		
Chain		27 (79.4)	
Independent		6 (66.7)	0.421
"Empty" Security Camera	9 (20.9)		
Chain		8 (23.5)	
Independent		1 (11.1)	0.415
Pass-through window	5 (11.6)		
Chain		4 (11.8)	
Independent		1 (11.1)	0.957
Full-sized, locked door	18 (41.9)		
Chain		16 (47.1)	
Independent		2 (22.2)	0.179
Caller ID	7 (16.3)		
Chain		2 (5.9)	
Independent		5 (55.6)	<0.001
Following a robbery or a serious threat, is employee counseling available?			
Yes	16 (37.2)		
Chain		13 (38.2)	
Independent		3 (33.3)	
No	1 (2.3)		
Chain		0 (0)	
Independent		1 (11.1)	
Unsure	26 (60.5)		
Chain		21 (61.8)	
Independent		5 (55.6)	0.144

	No. (%)
Strongly Agree	13 (30.2)
Agree	25 (58.1)
Neutral	5 (11.6)
Disagree	0 (0)
Strongly Disagree	0 (0)

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Appendix A

Survey Questions

Instructions: Please mark the one best answer unless otherwise indicated. For the purposes of this survey, "fraudulent prescriptions" shall refer to fake or altered prescriptions, as well as fake prescriptions given over the phone. "Robbery" shall refer to theft by an outside person (not an employee) while the pharmacy is either open or closed.

1. Are you currently working in a community (retail) pharmacy?
 - a. Yes
 - b. No

2. How frequently do you encounter fraudulent prescriptions?
 - a. Weekly
 - b. Monthly
 - c. 2-4 times a year
 - d. Yearly
 - e. Less than yearly

3. Please choose the best answer based on the following statement: Prescription fraud is a major problem in my area.
 - a. Strongly Agree
 - b. Agree
 - c. Neutral
 - d. Disagree
 - e. Strongly Disagree

4. How would you rate your preparedness to deal with a fraudulent prescription based on any training in pharmacy school or by your employer?
 - a. Excellent
 - b. Very Good
 - c. Adequate
 - d. Fair
 - e. Poor

5. When faced with a fraudulent prescription, which of the following best describes your response after verifying that the prescription is fake?
 - a. Fill and dispense
 - b. Refuse to fill only
 - c. Refuse to fill and alert authorities
 - d. Fill and alert authorities (pursuing arrest)

6. When faced with a fraudulent prescription, how frequently do you/would you alert neighboring stores?
 - a. Always
 - b. Frequently
 - c. Sometimes
 - d. Infrequently
 - e. Never

7. How would you rank the efficacy of the current Indiana controlled prescription blank at deterring fraud?
 - a. Excellent
 - b. Very Good
 - c. Adequate
 - d. Fair
 - e. Poor

Appendix A

8. How frequently have you encountered robbery in the pharmacy?
 - a. Weekly
 - b. Monthly
 - c. 2-4 times a year
 - d. Yearly
 - e. Less than yearly

9. Please choose the best answer based on the following statement: Robbery in the pharmacy is a major problem in my area.
 - a. Strongly Agree
 - b. Agree
 - c. Neutral
 - d. Disagree
 - e. Strongly Disagree

10. How would you rate your preparedness to deal with pharmacy robbery based on any training in pharmacy school or by your employer?
 - a. Excellent
 - b. Very Good
 - c. Adequate
 - d. Fair
 - e. Poor

11. When faced with a robbery situation, which of the following best describes your response?
 - a. Always give the robber what he/she wants
 - b. Delay as long as possible before giving the robber what he/she wants
 - c. Refuse unless he/she is armed
 - d. Always refuse to give the robber what he/she wants

12. Following a pharmacy robbery or attempted robbery, how frequently do you/would you alert neighboring stores?
 - a. Always
 - b. Frequently
 - c. Sometimes
 - d. Infrequently
 - e. Never

13. Following a robbery, assault or serious threat, my employer offers the use of critical incident or employee assistance counseling.
 - a. Yes
 - b. No
 - c. Not sure

14. Which of the following security features does your pharmacy have? (Mark all that apply)
 - a. Panic button/silent alarm
 - b. Functional security camera
 - c. "Empty" security camera
 - d. Pass-through window
 - e. Full-sized, locked door at entrance to pharmacy, which is closed at all times
 - f. Caller ID on incoming calls

Appendix A

15. A continuing education program on this topic would be helpful.
 - a. Strongly Agree
 - b. Agree
 - c. Neutral
 - d. Disagree
 - e. Strongly Disagree

16. Gender:
 - a. Male
 - b. Female

17. Which of the following describes the store you work in?
 - a. Chain
 - b. Independent

18. Approximately how many prescriptions does your store fill per day?
 - a. <150
 - b. 150-300
 - c. 301-450
 - d. 451-600
 - e. >600

19. What is the zip code for the store where you most frequently work? _____

20. What shift do you work most frequently?
 - a. Days/Evenings
 - b. Nights (Overnight)

21. Which of the following describes your position? (Mark all that apply)
 - a. Full time
 - b. Part Time
 - c. Pharmacy Manager

22. How long have you worked in a community pharmacy as a licensed pharmacist?
 - a. < 1 year
 - b. 1-5 years
 - c. 6-10 years
 - d. 11-20 years
 - e. >20 years