Six Strategies for Reducing Prescription Drug Abuse

This Issue Brief highlights six strategies and provides recommendations for governors committed to reducing prescription drug abuse in their states.

Approximately seven million Americans misuse or abuse prescription drugs, according to the latest survey data from the U.S. Department of Health and Human Services.[1] In 2010, 2.4 million Americans aged 12 or older illicitly used prescription drugs for the first time, and most of those users started with opioid pain relievers, such as oxycodone and hydrocodone.[2] Opioid pain relievers are powerful narcotics that, in the last decade, have contributed to a dramatic increase in the number of drug-related deaths.[3] In 2009, more than 15,500 people died in the United States by overdosing on those drugs, nearly four times the number who died in 1999.[4] Today, the number of overdose deaths from opioid pain relievers surpasses the number of deaths from heroin and cocaine combined.[5]

The economic costs associated with prescription drug abuse are significant. A 2011 study estimated that the total cost in the United States of nonmedical use of prescription opioids was $53.4 billion.[6] Of that total, $42 billion was attributable to lost productivity, $8.2 billion to criminal justice costs, $2.2 billion to drug abuse treatment, and $944 million to medical complications.

Sources of prescription drugs used for illicit purposes include "pill mills," or illegal pain clinics; prescription fraud; pharmacy theft; illegal online pharmacies; and "doctor shopping," the practice of visiting several different physicians to obtain multiple prescriptions. The biggest source, however, is friends and family. According to the same Health and Human Services survey, 70 percent of people who abused or misused prescription drugs got them from a friend or relative, either for free, by purchasing them, or stealing them.[7] Because most people do not properly dispose of leftover prescription drugs, or secure medications they are still using, home medicine cabinets often serve as repositories for expired and unused pills.

The challenge for states in addressing prescription drug abuse is implementing a comprehensive and coordinated statewide strategy that restricts access to prescription drugs for illicit use but ensures access for those who legitimately need them. Developing an effective strategy will require balancing the needs and concerns of patients, public health, law enforcement, and the medical community. In addition, states must consider: Which populations are the most vulnerable? Are there geographic regions where prescription drug abuse is more concentrated and could benefit most from a targeted response? What are the major illicit sources of prescription drugs in the state? What measures or indices can be used to track the progress of efforts to reduce prescription drug abuse? What opportunities exist for collaboration among public health, law enforcement, and the medical community?

Governors play a critical role in developing and implementing a coordinated and effective statewide response to prescription drug abuse. To assist governors in their efforts, the National Governors Association Center for Best Practices (NGA Center) developed the *Prescription Drug Abuse Reduction Policy Academy*, a year-long project led by Alabama Gov. Robert Bentley and Colorado Gov. John Hickenlooper.* The goal of the policy academy is to assist governors in reducing prescription drug abuse by helping them develop and implement comprehensive and coordinated strategies that take advantage of all available tools and resourc-

es. To help plan the policy academy and identify key strategies that states can adopt to reduce prescription drug abuse, the NGA Center convened a roundtable of leading researchers, practitioners, industry experts, and representatives of federal agencies, which resulted in the following recommendations.

Make better use of prescription drug monitoring programs. Critical to an effective statewide strategy for reducing prescription drug abuse are prescription drug monitoring programs (PDMPs). PDMPs are centralized databases where authorized users can access prescribing and dispensing data submitted by prescribers and pharmacies.[8] PDMPs allow states to collect and analyze prescription data much more efficiently than can be done without such tracking systems. Currently, 49 states and one territory have legislation authorizing the creation of a PDMP. However, PDMPs are currently operating in only 41 states, and many remain underfunded and not fully operational.[9]

PDMPs remain underused in two key ways: First, PDMPs are not being widely used as real-time tools. States can ensure that prescribers and pharmacists have access to accurate, real-time prescription histories to help them make clinical decisions about whether to prescribe or dispense prescription drugs. **Oklahoma** became the first state to implement real-time submission of prescription data. Pharmacists now submit data at the point of sale, making the state's PDMP current up to the minute. [10]

Second, PDMPs could be more effectively used as an analytic tool by law enforcement, licensing boards, and regulatory bodies to gain a better picture of the extent of prescription drug abuse within a state. Analysis of PDMP data can reveal geographic characteristics of abuse, potential doctor shopping, and patterns of anomalous prescribing practices. Those data could also help identify regional interstate patterns of abuse. Currently, several states are working to link their state PDMPs to facilitate cross-state information sharing.

Enhance enforcement by coordinating operations, providing specialized training, and strengthening existing laws. States can improve their law enforcement and regulatory oversight activities by ensuring a coordinated approach to investigating and prosecuting cases. States can launch multijurisdictional task forces that target specific geographic areas or corridors where prescription drug abuse may be more prevalent. Governors can encourage collaboration and promote key partnerships, for example, between the state attorney general's office, the U.S. attorneys' offices, and local law enforcement. Health professional boards can also contribute significantly by helping law enforcement to identify potentially illicit activity among prescribers and pharmacists. By collaborating with one another, law enforcement and regulatory authorities can share information and resources, avoid duplication of effort, and develop a coordinated strategy so that actions are targeted.

Although law enforcement personnel may have extensive experience in illegal drug interdiction, they may not have the same expertise in investigating and prosecuting prescription drug cases. Providing training for them on pharmaceutical crime investigation and prosecution can be an important step toward improving law enforcement's response to prescription drug abuse. Likewise, licensing boards may benefit from additional education and training on how to recognize potentially illegal or inappropriate activity. Through their licensing authority, professional bodies can exercise more initiative in stopping illicit access to prescription drugs, for example, by revoking the licenses of physicians acting outside the limits of accepted medical practice or adopting regulations and policies that require increased disclosure and transparency standards for any website that delivers, distributes, dispenses, or facilitates the sale of prescription drugs. According to the National Association of Boards of Pharmacy, 96 percent of entities selling drugs online are illegitimate and operating in violation of U.S. law.[11] These illegal online drug sellers provide easy access to opioid pain relievers.

Finally, opportunities may exist for states to strengthen enforcement of existing laws or enact new ones that more effectively target the abuse of prescription drugs. For example, to prevent prescription fraud, states can consider passing a law requiring pharmacists to request identification from persons seeking to obtain controlled substances. As of 2010, 18 states required or permitted pharmacists to request identification.[12] In 2011, **Florida** passed a law targeting pill mills, a key provision of which prohibited doctors from dispensing opioid pain relievers directly to consumers. The new law, supported by regional strike forces, has been credited with helping to reduce the number of pain clinics in the state from 800 to 508.[13] In 2010, before the law was passed, Florida was home to 90 of the nation's top oxycodone purchasing doctors; by March 2011, only 13 were in the top 100.[14]

Ensure proper disposal of prescription drugs. As noted earlier, the majority of people who abuse or misuse prescription drugs get them from friends and family—many of those drugs are leftover medicines. One of the challenges to ensuring proper disposal is a lack of patient education on proper disposal procedures. In general, people do not know how to dispose of medications safely and responsibly. The Drug Enforcement Administration (DEA) is expected to release regulations on prescription drug disposal in 2012, but in the meantime states can act to address the problem of leftover prescription drugs.

States can help ensure the proper disposal of expired, unwanted, or unused medication by educating the public, health care providers, law enforcement, consumers, and policymakers about safe and effective drug disposal methods. States can consider collaborating with local coalitions, pharmacies, health professional boards, and the DEA in take-back activities, such as designating times and places where the public can safely dispose of unused prescription medication.[15]

Leverage the state's role as regulator and purchaser of services. As regulator and purchaser of health care services, the state has significant leverage over health care practices and can drive system wide changes in the way care is delivered. Among the strategies that states can adopt are increasing educational opportunities and requirements for health care providers, adopting guidelines on appropriate prescribing practices, and restricting when and how patients access prescription drugs.

Most health care providers receive minimal training on how to recognize substance abuse.[16] Moreover, many receive only limited training on treating pain.[17] They may not be aware of the risk of addiction that opioid pain relievers pose, and they may not be aware of complementary and alternative treatments available to treat pain. By educating providers, states can help reduce overprescribing of medication and the number of excess pills that end up unused in bathroom medicine cabinets. States can consider making continuing education credits in pain management a requirement for health care providers for insurance reimbursements and licensure renewal. States might also use state funds spent on graduate medical education as an incentive to integrate education on pain, addiction, and the misuse of prescription drugs into medical training.

States can also develop guidelines based on best practices in pain management to help practitioners prescribe drugs safely and effectively. **Washington State** adopted opioid dosing guidelines for prescribers, including rules for when alternative, non-opioid treatment would be a more appropriate remedy and when to discontinue opioid treatment based on patient outcomes.[18]

Additionally, states can use Medicaid and workers compensation data to identify doctor shoppers. Medicaid recipients are prescribed opioid pain relievers at twice the rate of non-Medicaid recipients, and they are six times more likely to overdose on them.[19] For those patients identified as being at risk for abusing prescription drugs, states can institute "lock-in" programs—public and private insurer reimbursement guidelines requiring patients to receive prescription drugs from only a limited number of physicians and/or one phar-

macy. To support pharmacy benefits managers' gatekeeping function in screening for possible addiction, states can develop guidelines to help them recognize at-risk individuals. Alternatively, states could integrate a "flagging" system into PDMPs, based on an algorithm for identifying people whose prescribing history suggests that they may be addicted to, or misusing, prescription drugs.

Build partnerships among key stakeholders. Reducing prescription drug abuse will require agencies, consumer groups, provider groups, industry, and other organizations that may not typically work together to partner to develop an effective and comprehensive strategy. Governors can promote interagency collaboration by creating task forces or working groups through executive order.

Governors can build support among non-executive branch organizations, such as local law enforcement, public health, private organizations, and medical and pharmacy boards, by including them early in the planning process and soliciting their feedback. Medicaid and pharmacy boards can be important partners in developing a provider-based strategy complementary to broader state efforts. Likewise, medical, hospital, and health plan associations can be key partners in educating health care providers about proper prescribing practices. Finally, by engaging local community coalitions and other groups already working to reduce prescription drug abuse, governors can build on their experiences to ensure that reforms are successfully implemented at the local level.

Use the bully pulpit to promote public education about prescription drug abuse. Much of the public remains unaware of the dangers of prescription drugs. A common perception persists that prescription drugs are safer than illegal drugs, and less likely to lead to abuse, because they are prescribed by a health care provider. Along with public and private sector partners, states can launch public awareness campaigns spearheaded by governors to educate the public, providers, public officials, and state policymakers about the risks associated with prescription drugs and the scope of the prescription drug abuse problem. Many tools and resources already exist that states can use as a foundation for developing statewide campaigns. For example, governors can help promote the Partnership at DrugFree.org's "Medicine Abuse Project," a national education effort and call to action to inform people about the dangers of prescription drug abuse, safeguard and properly dispose of unused medicine, and eliminate improper prescribing and dispensing practices.[20]

In 2010, **Utah** launched the "Use Only As Directed" media and education campaign with funding from the state's Commission on Criminal and Juvenile Justice and a federal grant.[21] The goal of the campaign is to reduce and prevent the misuse and abuse of prescription pain medication by providing information and strategies regarding safe use, safe storage, and safe disposal. The state's broader goals include reducing the availability of prescription drugs for abuse; increasing people's perception of the risks associated with misusing prescription drugs, including physical and psychological harm and legal sanctions; and influencing the public's attitude to be less tolerant of nonmedical use of pharmaceutical drugs.

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Endnotes

1 Written Statement of R. Gil Kerlikowske to the Senate Caucus on International Narcotics Control, "Responding to the Prescription Drug Epidemic," Wednesday, July 18, 2012, citing "Results from the 2010 National Survey on Drug Use and Health: Detailed Tables," Substance Abuse and Mental Health Services Administration, U.S. Department of Health and Human Services, September 2011, http://www.samhsa.gov/data/nsduh/2k10NSDUH/tabs/LOTSect7pe.htm#TopOfPage. The survey results are limited to prescription-type psychotherapeutic drugs, which include pain relievers, tranquilizers, stimulants, or sedatives, and do not include other types of prescription drugs or over-the-counter drugs.

2 Ibid.

3 Ibid.

4 Ibid.

5 Ibid.

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8 Alliance of States with Prescription Monitoring Programs, http://www.pmpalliance.org/content/prescription-monitoring-frequently-asked-questions-faq (accessed July 25, 2012).

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10 "Notes from the Field: Real Time Reporting: Oklahoma's Pioneering PMP," Prescription Monitoring Program Center of Excellence, Brandeis University, 2012, http://www.pmpexcellence.org/sites/all/pdfs/ok_real_time_data_nff_11912.pdf.

11 National Association of Boards of Pharmacy, "Internet Drug Outlet Identification Program: Updated Progress Report for State and Federal Regulators, April 2012 (Re-Issued May 14, 2012). Available at http://www.nabp.net/news/assets/IDOIReportApril11.pdf

12 These states include: Connecticut, Delaware, Florida, Hawaii, Idaho, Louisiana, Maine, Massachusetts, Michigan, Minnesota, Nevada, New Mexico, New York, North Carolina, Oklahoma, South Carolina, Virginia, and West Virginia. Center for Disease Control and Prevention: State Rx Drug Laws, available at http://www.cdc.gov/HomeandRecreationalSafety/Poisoning/laws/id_req.html (accessed August 30, 2012).

13 Felix Gillette, "American Pain: The Largest U.S. Pill Mill's Rise and Fall," *BloombergBusinessWeek,* June 6, 2012, http://www.businessweek.com/articles/2012-06-06/american-pain-the-largest-u-dot-s-dot-pill-mills-rise-and-fall#p5.

14 Ibid.

15 The American Medicine Chest Challenge has a list of permanent disposal sites on their website: www.americanmedicinechest.com. Governors can promote these permanent disposal sites in their states and also work with local law enforcement to create additional sites.

16 "Epidemic: Responding to America's Prescription Drug Abuse Crisis," White House Office of National Drug Control Policy, 2011, http://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/rx_abuse_plan.pdf.

17 Ibid.

18 "Medical Treatment Guidelines," Washington State Department of Labor and Industries, http://www.lni.wa.gov/ClaimsIns/Files/OMD/MedTreat/Opioids.pdf.

19 "Policy Impact: Prescription Painkiller Overdoses," Centers for Disease Control and Prevention, http://www.cdc.gov/HomeandRecreationalSafety/rxbrief/.

20 See www.drugfree.org/medicineabuse (accessed July 25, 2012).

21 See www.useonlyasdirected.org (accessed July 25, 2012).