ISSUE REPORT

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Prescription Drug Abuse:

STRATEGIES TO STOP THE EPIDEMIC 2013





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Acknowledgements

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Introduction

Prescription drug abuse has quickly become a major health epidemic in the United States.

In the past two decades, there have been many advances in bio-medical research – including new treatments for individuals suffering from pain, Attention Deficit Hyperactivity Disorder (ADHD), anxiety and sleep disorders.[1]

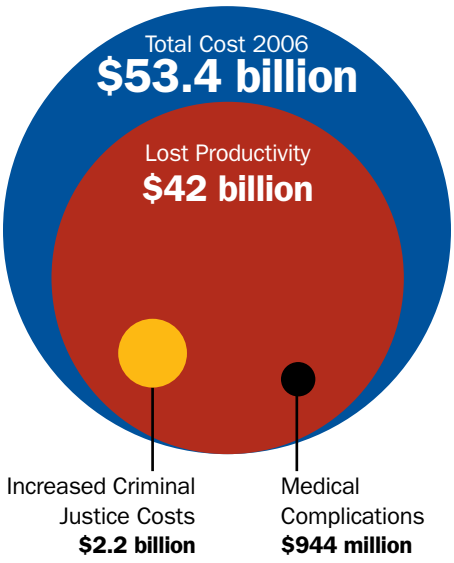
At the same time, however, there has been a striking increase in the misuse and abuse of these medications — where individuals take a drug in a higher quantity, in another manner or for another purpose than prescribed, or take a medication that has been prescribed for another individual.

Approximately 6.1 million Americans abuse or misuse prescription drugs.[2] Abuse, particularly of prescription painkillers, has serious negative health consequences and can even result in death. Overdose deaths involving prescription painkillers have quadrupled since 1999 and now outnumber those from heroin and cocaine combined.[3]

"The misuse and abuse of prescription medications have taken a devastating toll on the public health and safety of our Nation. Increases in substance abuse treatment admissions, emergency department visits, and, most disturbingly, overdose deaths attributable to prescription drug abuse place enormous burdens upon communities across the country. So pronounced are these consequences that the Centers for Disease Control and Prevention has characterized prescription drug overdose as an epidemic, a label that underscores the need for urgent policy, program, and community-led responses."

– R. Gil Kerlikowske, Director of the Office of National Drug Control Policy[4]

Cost of prescription drug abuse on the U.S. Economy (2006)



Sales from prescription pain killers quadrupled from 1999 to 2010.

MAGNITUDE OF PRESCRIPTION DRUG ABUSE AND OVERDOSES

- Drug poisoning deaths — the majority of which are related to prescription drugs — surpassed traffic-related crashes as the leading cause of injury death in the United States as of 2009.[5]
- Around 50 Americans die from prescription painkiller overdoses each day.[6] Prescription painkillers are responsible for more than 16,000 deaths and 475,000 emergency department visits a year.[7, 8]
- More than 70,000 children go to the emergency department due to medication poisoning every year. In many of these cases, the poisoning is due to a child taking medicine belonging to an adult.[9, 10] Children visit emergency departments twice as often for medication poisoning than for poisonings from household products.

RAPID RISE

- Sales of prescription painkillers per capita quadrupled from 1999 to 2010 — and the number of fatal poisonings due to prescription pain medications has also quadrupled.[11, 12] Enough prescription painkillers were prescribed in 2010 to medicate every American adult continually for a month.[13]
- Emergency department visits for prescription drug misuse more than doubled between 2004 and 2011. The most commonly involved drugs were anti-anxiety and insomnia medications and prescription painkillers (160.9 and 134.8 visits per 100,000 population, respectively).[14]

HIGH COSTS

- A 2011 study estimated that in 2006, nonmedical use of prescription painkillers imposed a cost of about $53.4 billion on the U.S. economy — including $42 billion in lost productivity, $8.2 billion in increased criminal justice costs, $2.2 billion for drug abuse treatment, and $944 million in medical complications.[15]
- There are also high costs to Medicaid due to fraudulent or abusive purchases of controlled substances. A 2009 Government Accountability Office (GAO) investigation found tens of thousands of Medicaid beneficiaries and providers involved in potential fraudulent purchases of controlled substances, abusive purchases of controlled substances, or both, through the Medicaid program in California, Illinois, New York, North Carolina, and Texas. About 65,000 Medicaid beneficiaries in the five selected states acquired the same type of controlled substances from six or more different medical practitioners during fiscal years 2006 and 2007 through "doctor shopping," with the majority of beneficiaries visiting between six and 10 medical practitioners.[16]

Reducing prescription drug abuse and misuse has become a top priority for the White House Office of National Drug Control Policy (ONDCP), the Centers for Disease Control and Prevention (CDC), the Substance Abuse and Mental Health Services Administration (SAMSHA), state and local public health agencies and a range of medical and community groups around the country.

A number of promising strategies have been developed to address the problem — particularly focusing on prevention and providing effective substance abuse treatment.

Since the problem has grown so quickly, there is not yet an extensive amount of research on the most effective strategies to address the issue, but a range of approaches have been developed based on the best advice from medical professionals and public health and drug prevention experts.

There are signs that a rapid response can yield rapid results. A number of strategies have already been showing positive changes. For instance:

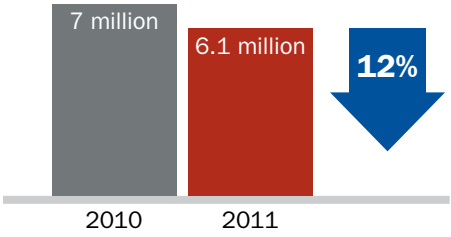
- The latest survey data found that the number of people 12 years or older currently abusing prescription drugs decreased from 7 million in 2010 to 6.1 million in 2011 — a 12 percent decrease. Misuse by teens and young adults has started to show some decreases. Misuse by 12- to 17-year-olds decreased from 4 percent in 2002 to 2.8 percent in 2011, and misuse by 18- to 25-year-olds decreased from a range of 5.5 to 6.4 percent from 2003 to 2010 to 5 percent in 2011.[17]
- A number of states taking a comprehensive approach to the problem have achieved improvements. For example, after Florida initiated a strong effort combining a range of public health strategies and legislative changes, such as instituting a prescription drug monitoring program and closing down "pill mills," the number of prescription drug-related deaths in the state decreased in 2011, with deaths related to oxycodone decreasing by more than 17 percent.[18]

The Trust for America's Health (TFAH) worked with a range of partners and experts to identify promising policies and approaches to reducing prescription drug abuse in America. The contents of this report include:

Section I: An examination of state laws to combat prescription drug abuse. States are evaluated on 10 key approaches, based on input and review from public health, medical and law enforcement experts, and using indicators where information is available for all 50 states and the District of Columbia.

Section II: A review of national policy issues and recommendations for combating prescription drug abuse.

Number of People 12 Years or Older Currently Abusing Prescription Drugs



KEY FINDINGS FROM REPORT CARD

- **Appalachia and Southwest Have the Highest Overdose Death Rates:** West Virginia had the highest number of drug overdose deaths, at 28.9 per every 100,000 people — a 605 percent increase from 1999, when the rate was only 4.1 per every 100,000. North Dakota had the lowest rate at 3.4 per every 100,000 people. Rates are lowest in the Midwestern states.
- **Prescription Drug Monitoring Programs:** While nearly every state (49) has a Prescription Drug Monitoring Program (PDMP) to help identify "doctor shoppers," problem prescribers and individuals in need of treatment, these programs vary dramatically in funding, use and capabilities.
- **Mandatory Use of PDMPs:** 16 states require medical providers to use PMDPs.
- **Doctor Shopping Laws:** Every state and Washington, D.C. has a law making doctor shopping illegal.
- **Support for Substance Abuse Treatment:** Nearly half of states (24 and Washington, D.C.) are participating in Medicaid Expansion – which helps expand coverage of substance abuse services and treatment.
- **Medical Provider Education Laws:** Fewer than half of states (22) have laws that require or recommend education for doctor and other healthcare providers who prescribe prescription pain medication.
- **Good Samaritan Laws:** Just over one-third of states (17 and Washington, D.C.) have laws in place to provide a degree of immunity from criminal charges or mitigation of sentencing for individuals seeking to help themselves or others experiencing an overdose.
- **Rescue Drug Laws:** Just over one-third of states (17 and Washington, D.C.) have a law in place to expand access to, and use of naloxone — a prescription drug that can be effective in counteracting an overdose — by lay administrators.
- **Physical Exam Requirement:** 44 states and Washington, D.C. require a healthcare provider to either conduct a physical exam or a screening for signs of substance abuse or have a bona fide patient-physician relationship that includes a physical exam, prior to prescribing medications.
- **ID Requirement:** 32 states have a law requiring or permitting a pharmacist to require an ID prior to dispensing a controlled substance.
- **Pharmacy Lock-In Programs:** 46 states and Washington, D.C. have a pharmacy lock-in program under the state's Medicaid plan where individuals suspected of misusing controlled substances must use a single prescriber and pharmacy.
- **Severe Treatment Gap:** Only one in 10 Americans with a substance abuse disorder currently receives treatment.
- **Limited Care Options:** More than two-thirds of states have fewer than six medical professionals per every 100,000 people authorized to treat patients with buprenorphine – a medication often recommended for painkiller addiction treatment; and many states lack sufficient numbers of licensed and trained substance abuse treatment professionals.
- **Antiquated Treatment:** Treatment approaches largely lag way behind developments in brain research and knowledge about the most effective forms of treatment.

This report provides the public, policymakers, public health officials and experts, partners from a range of sectors, and private and public organizations with an overview of the current status of prescription drug abuse issues. It features important information to the broad and diverse groups involved in issue from the fields of public health, healthcare, law enforcement and other areas; encourages greater transparency and accountability; and outlines promising recommendations to ensure the system addresses this critical public health concern.

WHAT IS A PUBLIC HEALTH APPROACH TO REDUCING PRESCRIPTION DRUG ABUSE?

"This is a problem that has cast a terrible shadow across our nation and led to a public health crisis of devastating proportions. It is a crisis that has affected us all, and meaningful and enduring solutions will require all of our collective efforts."

– Douglas C. Throckmorton, M.D., Deputy Director for Regulatory Programs, Center for Drug Evaluation and Research, U.S. Food and Drug Administration[19]

A range of strategies and policies can help to reduce the overall rates of prescription drug abuse in America. Curbing the epidemic requires understanding the causes behind it, identifying individuals and groups most at-risk for potentially abusing drugs, knowing the latest science about addiction, and recognizing the most effective approaches for treatment.

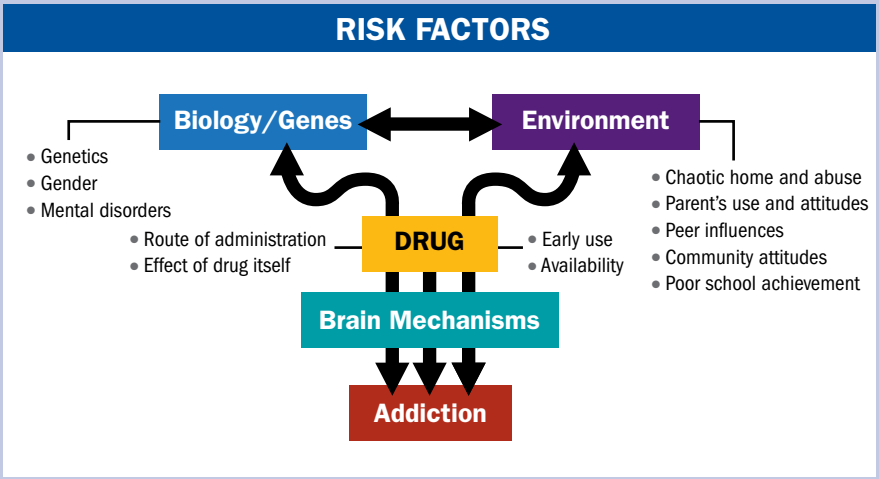
Prevention is "the best strategy," according to the National Institute on Drug Abuse (NIDA), to avoid misuse in the first place.[20] Many people are not aware of the serious health hazards that prescription drugs can pose when not used properly. Key approaches to preventing misuse in the first place include:

- **Educating the public:** Making sure everyone, particularly people in high-risk groups like teens, young adults and their parents, are aware of the serious consequences of misusing prescription drugs.
- **Educating healthcare providers:** Doctors, dentists and other healthcare providers generally act with appropriate intentions, prescribing medications with the goal of helping their patients. Increased education can help providers better understand how some medications may be misused by patients, how some patients can become addicted to different types of medications, and how to better identify patients who may have drug dependencies. Education can also provide information about how providers can connect at-risk patients to effective forms of treatment.
- **Educating about safe storage and disposal of medications:** More than half of individuals who used prescription painkillers, tranquilizers, stimulants and sedatives nonmedically reported using pills that were prescribed to a friend or family member, according to the National Survey of Drug Use and Health.[21] Educating individuals about effective ways to store and dispose of medications safely, including "Take Back" programs that allow people to turn in unused medications for safe disposal, help reduce the potential for family and friends to have access to and misuse medications prescribed to someone else.

Access to and availability of effective treatment options must be a key component of any strategy to combat prescription drug misuse and abuse. Addiction — including prescription drug addiction — is "defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. It is considered a brain disease because drugs change the brain — they change its structure and how it works. These brain changes can be long lasting, and can lead to the harmful behaviors seen in people who abuse drugs."[22]

- **Identifying patients and connecting them to care:** Once an individual is determined to have a substance abuse disorder, it is important to connect them to proper care and services. Research supports that treatment can be highly effective and, without effective treatment, individuals continue to suffer and are highly prone to relapse or use of other substances to try to self-manage their disorder. For instance, medication-assisted treatment is one of the most effective approaches for painkiller addictions, which involves combining treatment medications with behavioral counseling and support from friends and family.[23] While strategies such as PDMPs and "doctor shopping" laws can help healthcare providers, pharmacists, law enforcement agencies and others identify individuals with a substance abuse issue, in order to be truly effective in reducing abuse, those tactics must be combined with strategies to connect these individuals to treatment.

According to the NIDA, "the initial decision to take drugs is mostly voluntary. However, when drug abuse takes over, a person's ability to exert self control can become seriously impaired. Brain imaging studies from drug-addicted individuals show physical changes in areas of the brain that are critical to judgment, decision making, learning and memory, and behavior control. Scientists believe that these changes alter the way the brain works, and may help explain the compulsive and destructive behaviors of addiction."[24]



Source: NIDA



HIGH-RISK GROUPS

Strategies, particularly public education campaigns and community-based prevention programs, can be tailored to reach different high-risk groups in the most effective ways possible. According to CDC:

- **Men ages 25 to 54 have the highest numbers of prescription drug overdoses and are around twice as likely to die from an overdose than women, but rates for women ages 25 to 54 are increasing faster.**[25]
  - Since 1999, the percentage increase in deaths from prescription drug abuse was 400 percent among women compared to 265 percent among men.[26] Around 18 women die each day from prescription painkiller overdoses and for every one woman who dies, 30 more visit an emergency department for painkiller misuse or abuse.
  - Prescription drug abuse in women can also affect newborns. Neonatal abstinence syndrome (NAS) is a problem that occurs in newborns exposed to prescription painkillers or other drugs while in the womb. NAS cases increased by nearly 300 percent between 2000 and 2009.[27]
- **While rates are high in both urban and rural communities, people in rural counties are around twice as likely to overdose on prescription drugs than people in big cities.**[28]
  - Teens living in rural areas were more likely than their urban peers to abuse prescription drugs, with 13 percent of rural teens reporting nonmedical use of prescription drugs at some point in their lives, compared with 11.5 percent of respondents living in suburban or small metropolitan-area counties and 10.3 percent of those in urban areas, according to the 2008 National Survey on Drug Use and Health.[29]

Some other high-risk groups include:

- **Teens and young adults.** Youth are at higher risk for all forms of drug misuse. One in four teens has misused or abused a prescription drug at least once in their lifetime.[30]
  - One in eight teens — 13 percent — reports that they have taken the stimulants Ritalin or Adderall at least once in their lifetime when it was not prescribed for them.
  - Nearly one in 12 high school seniors reported nonmedical use of Vicodin and one in 20 reported nonmedical use of OxyContin.[31] And, 2.8 percent of 12- to17–year-olds reported nonmedical use of psychotherapeutics, such as OxyContin or Vicodin, during the past month in the 2012 National Survey on Drug Use and Health.[32]
  - According to survey results by The Partnership at Drugfree.org and MetLife Foundation, parent permissiveness and lax attitudes toward abuse and misuse of prescription medicines, coupled with teens' ease of access to prescription medicines in the home, are key factors linked to teen medicine misuse and abuse. The study found that almost one-third of parents (29 percent) say they believe ADHD medication can improve a child's academic or testing performance, even if the teen does not have ADHD; one in six parents (16 percent) believes that using prescription drugs to get high is safer than using street drugs; and more than half of teens (56 percent) indicate that it's easy to get prescription drugs from their parent's medicine cabinet.[33]
- **Soldiers and Veterans.** With the high number of injured service members coming home from Iraq, Afghanistan and elsewhere, and more veterans surviving serious injuries, the number of veterans receiving painkiller prescriptions is continuing to increase, as is the risk for prescription drug abuse.[34]
  - According to a survey conducted by the Department of Defense (DOD), one in eight active duty military personnel are current users of illicit drugs or misusing prescription drugs. This is largely driven by prescription drug abuse, reported by one in nine service members — more than double the rate of the civilian population.[35]
- **Occupational Injuries:** The overuse of painkiller therapy to treat chronic pain conditions is becoming an epidemic in workers' compensation systems, with a growing reliance on prescription medications to treat injured workers.
  - An August 2009 study by the Washington State Division of Labor and Industry estimated that the volume of opiate prescriptions in that state's workers' compensation program had increased 50 percent between 1999 and 2007.[36]
  - A study by the National Council of Compensation Insurance (NCCI) estimated that painkillers accounted for 25 percent of all workers' compensation drug costs nationwide and that the use of these drugs increases as claims age.[37]



"When OxyContin was first approved by the FDA over a decade ago, it seemed at first glance that its extended-release technology was a godsend for patients suffering from chronic pain. What no one could foresee was that when you crush these pills, they actually create pain in the form of addiction, abuse and senseless, tragic overdose deaths."

– Rep. Harold (Hal) Rodgers, (R-KY), co-founder and co-chairman of the Congressional Caucus on Prescription Drug Abuse. [38]

MOST COMMON MISUSED PRESCRIPTION MEDICATIONS[39]

Prescription Opioids, or "painkillers," include powerful and addictive substances such as oxycodone (OxyContin, Percocet), hydrocodone (Vicodin), fentanyl, morphine and methadone. Prescription opioids act on brain receptors and can be highly addictive. Heroin is an illegal, nonprescription form of opioid. Abuse of opioids, alone or in combination with alcohol or other drugs, can depress respiration and lead to death. Injecting opioids also increases the risk of HIV and other infectious diseases through use of contaminated needles.

Central Nervous System Depressants, such as benzodiazepines, hypnotics and barbiturates, are sometimes referred to as sedatives or tranquilizers and are used to treat anxiety and sleep problems. These drugs can be addictive. High doses can cause severe respiratory depression. The risk rises when the drugs are combined with other medications or alcohol.

Stimulants are used to treat ADHD and narcolepsy. These drugs can be addictive, and can cause a range of problems, including psychosis, seizures and heart ailments.

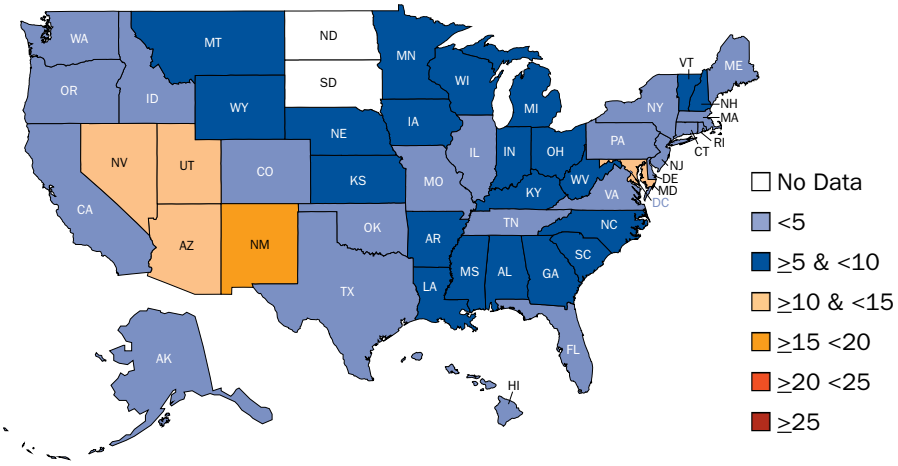
State Indicators

Deaths from drug overdoses, which include prescription drug misuse, have grown dramatically in the past decade — and now exceed deaths caused by motor vehicle crashes in 29 states and Washington, D.C.

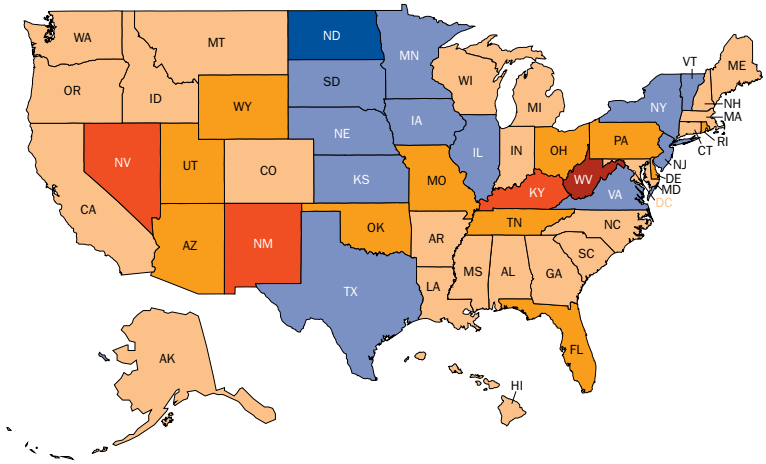
As of 2010, rates were highest in West Virginia at 28.9 per every 100,000 people, a 605 percent increase since 1999 when the rate was only 4.1 per every 100,000 people in the state.

- In 2010, four states had rates above 20 per 100,000 people, and 40 states had rates of 10 or above per every 100,000 people. In 1999, no state had a rate above 15.0 per every 100,000 people, and the mean rate was 6.0 per every 100,000 people in 1999 and 13.0 per 100,000 people in 2010.
- Drug overdose deaths have doubled in 29 states from 1999 to 2010. The rates quadrupled in four of those states and tripled in 10 more of those states.

Drug Overdose Mortality Rates per 100,000 People 1999



Drug Overdose Mortality Rates per 100,000 People 2010



DRUG OVERDOSE MORTALITY OVER THE YEARS

	Drug Overdose Mortality Rate (per 100,000)						Drug Overdose Mortality Rate Change		Motor Vehicle Deaths vs. Drug Overdose Deaths	
State	1979[a]	1990[a]	1999[b]	2005[b]	2010[b]	2010 Rank	1979 to 2010	1999 to 2010	MV Death Rate 2010[c]	DO > MV in 2010
Alabama***	1.6	2.3	3.9	6.3	11.8	26	638%	203%	19.4	No
Alaska	N/A	3.7	7.5	11.4	11.6	29	N/A	55%	10.4	Yes
Arizona	4.1	4.8	10.6	14.1	17.5	6	327%	65%	12.3	Yes
Arkansas**	1.7	1.1	4.4	10.1	12.5	25	635%	184%	20.7	No
California	6.7	5.9	8.1	9.0	10.6	37	58%	31%	7.7	Yes
Colorado	4.1	4.0	8.0	12.7	12.7	24	210%	59%	9.5	Yes
Connecticut	1.1	1.7	9.0	8.5	10.1	39	818%	12%	9.1	Yes
Delaware**	N/A	3.6	6.4	7.5	16.6	10	N/A	159%	12.5	Yes
D.C.	5.0	N/A	8.3	13.7	12.9	21	158%	55%	6.0	Yes
Florida**	3.7	3.4	6.4	13.5	16.4	11	343%	156%	13	Yes
Georgia***	2.6	2.3	3.5	8.2	10.7	36	312%	206%	13.9	No
Hawaii	3.8	2.0	6.5	9.4	10.9	34	187%	68%	9.1	Yes
Idaho**	2.1	2.6	5.3	8.1	11.8	26	462%	123%	13.8	No
Illinois	2.6	4.1	6.7	8.4	10.0	40	285%	49%	7.9	Yes
Indiana****	1.8	2.0	3.2	9.8	14.4	17	700%	350%	11.8	Yes
Iowa****	1.7	1.7	1.9	4.8	8.6	45	406%	353%	12.7	No
Kansas**	2.2	1.9	3.4	9.1	9.6	43	336%	182%	16.6	No
Kentucky****	2.3	2.7	4.9	15.3	23.6	3	926%	382%	18.8	Yes
Louisiana***	1.8	2.6	4.3	14.7	13.2	19	633%	207%	15.8	No
Maine	2.9	2.2	5.3	12.4	10.4	38	259%	96%	12.2	No
Maryland	2.8	2.1	11.4	11.4	11.0	32	293%	-4%	8.8	Yes
Massachusetts	2.5	3.7	7.5	12.0	11.0	32	340%	47%	5.5	Yes
Michigan***	2.6	2.6	4.6	9.8	13.9	18	435%	202%	10.3	Yes
Minnesota**	1.7	2.5	2.8	5.4	7.3	47	329%	161%	9.5	No
Mississippi***	1.7	1.7	3.2	8.8	11.4	30	571%	256%	22.9	No
Missouri***	2.4	2.4	5.0	10.7	17.0	7	608%	240%	14.4	Yes
Montana**	N/A	N/A	4.6	10.1	12.9	21	N/A	180%	19.6	No
Nebraska**	N/A	2.0	2.3	5.0	6.7	49	N/A	191%	11.3	No
Nevada	5.1	6.2	11.5	18.7	20.7	4	306%	80%	10.7	Yes
New Hampshire**	2.5	2.8	4.3	10.7	11.8	26	372%	174%	10.1	Yes
New Jersey	1.7	2.1	6.5	9.4	9.8	41	476%	51%	6.5	Yes
New Mexico	4.3	7.8	15.0	20.1	23.8	2	453%	59%	16.4	Yes
New York	2.9	3.3	5.0	4.8	7.8	46	169%	56%	6.6	Yes
North Carolina**	2.1	3.1	4.6	11.4	11.4	30	443%	148%	14.5	No
North Dakota	N/A	N/A	N/A	N/A	3.4	51	N/A	N/A	14.5	No
Ohio***	2.7	2.7	4.2	10.9	16.1	12	496%	283%	10.6	Yes
Oklahoma***	2.0	1.7	5.4	13.8	19.4	5	870%	259%	19.0	Yes
Oregon**	3.0	4.8	6.1	10.4	12.9	21	330%	111%	8.1	Yes
Pennsylvania	2.6	4.5	8.1	13.2	15.3	14	488%	89%	11.0	Yes
Rhode Island**	5.1	4.3	5.5	14.3	15.5	13	204%	182%	8.2	Yes
South Carolina***	1.9	2.3	3.7	9.9	14.6	16	668%	295%	17.5	No
South Dakota	N/A	N/A	N/A	5.5	6.3	50	N/A	N/A	17.3	No
Tennessee**	2.4	2.8	6.1	14.5	16.9	8	604%	177%	17.1	No
Texas	2.2	3.2	5.4	8.5	9.6	43	336%	78%	13.4	No
Utah	4.4	3.8	10.6	19.3	16.9	8	284%	59%	10.6	Yes
Vermont**	N/A	N/A	4.7	8.5	9.7	42	N/A	106%	11.8	No
Virginia	2.7	2.7	5.0	7.5	6.8	48	152%	36%	9.0	No
Washington	3.9	5.0	9.3	13.0	13.1	20	236%	41%	7.9	Yes
West Virginia****	2.5	2.4	4.1	10.5	28.9	1	1056%	605%	16.2	Yes
Wisconsin**	2.7	2.4	4.0	9.3	10.9	34	304%	173%	10.6	Yes
Wyoming***	N/A	N/A	4.1	4.9	15.0	15	N/A	266%	23.1	No

** Drug Overdose Mortality Rates doubled from 1999-2010

*** Drug Overdose Mortality Rates tripled from 1999-2010

**** Drug Overdose Mortality Rates quadrupled from 1999-2010

SOURCES:

a Centers for Disease Control and Prevention, National Center for Health Statistics. Compressed Mortality File 1979-1998. CDC WONDER On-line Database, compiled from Compressed Mortality File CMF 1968-1988, Series 20, No. 2A, 2000 and CMF 1989-1998, Series 20, No. 2E, 2003. http://wonder.cdc.gov/cmf-icd9.html (accessed August 2013).

b Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2010 on CDC WONDER Online Database, released 2012. Data are from the Multiple Cause of Death Files, 1999-2010, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. http://wonder.cdc.gov/mcd-icd10.html (accessed July 2013).

c Centers for Disease Control and Prevention. Deaths: Final Data for 2010. *National Vital Statistics Report,* 61(4) table 19, 2013.

RATES OF NON-MEDICAL USE OF PRESCRIPTION OPOIDS, AND SALES

State	Sales of Opioid Pain Relievers, 2010.[i] Source: Drug Enforcement Administration, 2011	Nonmedical % Use of Prescription Pain Relievers in the Past Year by Persons Aged 12 or Older, 2010-2011. Source: National Survey on Drug Use and Health
Alabama	9.7	4.4
Alaska	8.2	5.3
Arizona	8.4	5.7
Arkansas	8.7	5.6
California	6.2	4.7
Colorado	6.3	6.0
Connecticut	6.7	4.4
Delaware	10.2	5.6
D.C.	3.9	4.7
Florida	12.6	4.1
Georgia	6.5	3.8
Hawaii	5.9	3.9
Idaho	7.5	5.7
Illinois	3.7	4.1
Indiana	8.1	5.7
Iowa	4.6	3.6
Kansas	6.8	4.6
Kentucky	9.0	4.5
Louisiana	6.8	4.9
Maine	9.8	4.2
Maryland	7.3	3.9
Massachusetts	5.8	4.3
Michigan	8.1	5.1
Minnesota	4.2	4.6
Mississippi	6.1	4.5
Missouri	7.2	4.8
Montana	8.4	4.9
Nebraska	4.2	4.2
Nevada	11.8	5.6
New Hampshire	8.1	4.6
New Jersey	6.0	4.2
New Mexico	6.7	5.5
New York	5.3	4.0
North Carolina	6.9	4.0
North Dakota	5.0	3.8
Ohio	7.9	5.0
Oklahoma	9.2	5.2
Oregon	11.6	6.4
Pennsylvania	8.0	4.2
Rhode Island	5.9	5.2
South Carolina	7.2	4.6
South Dakota	5.5	3.7
Tennessee	11.8	5.0
Texas	4.2	4.3
Utah	7.4	4.3
Vermont	8.1	5.1
Virginia	5.6	4.6
Washington	9.2	5.8
West Virginia	9.4	4.8
Wisconsin	6.5	4.5
Wyoming	6.0	4.7
National Rate	**7.1**	**4.6**

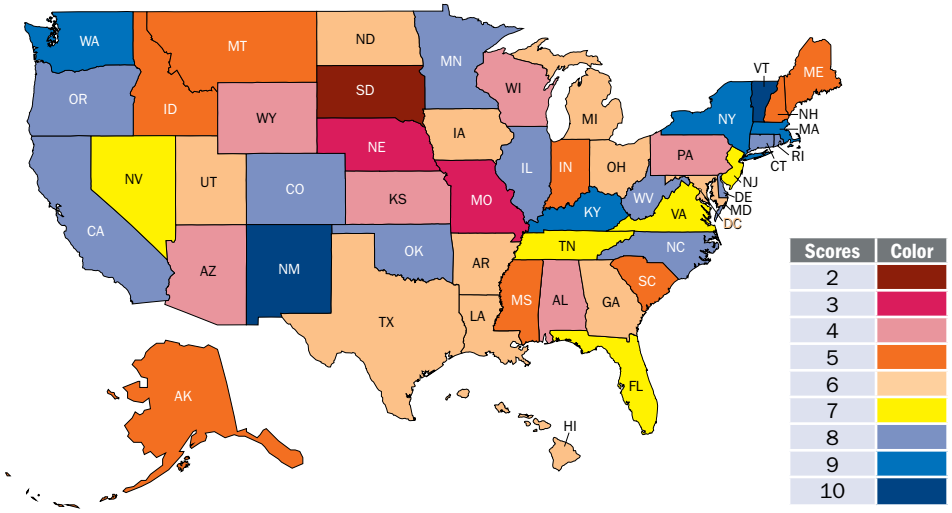
i Kilograms of opiod pain relievers sold per 10,000 population, measured in morphine equivalents.



Prescription drug abuse and misuse laws vary greatly in states. This report includes a series of 10 indicators on a range of evidence-informed policies in place in different states. It is not a comprehensive review but collectively, it provides a snapshot of the efforts that states are taking to reduce prescription drug misuse. The indicators were selected based on consultation with leading public health, medical and law enforcement experts about the most promising approaches, and took into consideration the availability of data in most or all states. It is important to note the indicators measure whether a law, regulation or policy is in place but does not assess how the measures are enforced or if there is sufficient funding to carry them out.

Each state received a score based on these 10 indicators. States received one point for achieving an indicator or zero points if they did not. Zero is the lowest possible overall score (no policies in place), and 10 is the highest (all the policies in place).

The scores ranged from a high of 10 in New Mexico and Vermont to a low of 2 in South Dakota.



SCORES BY STATE

10 (2 states)	9 (4 states)	8 (11 states)	7 (5 states)	6 (11 states & D.C.)	5 (8 states)	4 (6 states)	3 (2 states)	2 (1 state)
New Mexico	Kentucky	California	Florida	Arkansas	Alaska	Alabama	Missouri	South Dakota
Vermont	Massachusetts	Colorado	Nevada	D.C.	Idaho	Arizona	Nebraska	
	New York	Connecticut	New Jersey	Georgia	Indiana	Kansas		
	Washington	Delaware	Tennessee	Hawaii	Maine	Pennsylvania		
		Illinois	Virginia	Iowa	Mississippi	Wisconsin		
		Minnesota		Louisiana	Montana	Wyoming		
		North Carolina		Maryland	New Hampshire			
		Oklahoma		Michigan	South Carolina			
		Oregon		North Dakota				
		Rhode Island		Ohio				
		West Virginia		Texas				
				Utah				

Data for the indicators were drawn from a number of sources, including the National Alliance for Model State Drug Laws (NAMSDL), CDC, the Alliance of States with Prescription Drug Monitoring Programs, the National Conference of State Legislators, the Network for Public Health Law, the Kaiser Family Foundation and a review of current state legislation and regulations by TFAH. In August 2013, state health departments were provided with opportunity to review and revise their information.

INDICATORS
1. Prescription Drug Monitoring Program: Does the state have an operational Prescription Drug Monitoring Program?
2. Mandatory Use of PDMP: Does the state require mandatory use of PDMPs by providers? (any form of mandatory use requirement)
3. Doctor Shopping Law: Does the state have a doctor shopping statute?
4. Support for Substance Abuse Services: Has the state expanded Medicaid under the Affordable Care Act, thereby expanding coverage of substance abuse treatment?
5. Prescriber Education Requirement: Does the state require or recommend education for prescribers of pain medications?
6. Good Samaritan Law: Does the state have a law in place to provide a degree of immunity from criminal charges or mitigation of sentencing for an individual seeking help for themselves or others experiencing an overdose?
7. Support for Naloxone Use: Does the state have a law in place to expand access to, and use of, naloxone for overdosing individuals given by lay administrators?
8. Physical Exam Requirement: Does the state require a healthcare provider to either conduct a physical exam of the patient, a screening for signs of substance abuse or have a bona fide patient-physician relationship that includes a physician examination, prior to prescribing prescription medications?
9. ID Requirement: Does the state have a law requiring or permitting a pharmacist to ask for identification prior to dispensing a controlled substance?
10. Pharmacy Lock-In Program: Does the state's Medicaid plan have a pharmacy lock-in program that requires individuals suspected of misusing controlled substances to use a single prescriber and pharmacy?

STATE PRESCRIPTION DRUG SCORES

	(1) Existence of PDMP: Have active prescription drug monitoring program Source: NAMSDL (through 6/30/13) & Alliance of States with Prescription Monitoring Programs through 10/12	**(2) PDMP: Mandatory Utilization** Source: NAMSDL (through 6/30/13)	**(3) Doctor Shopping Laws: A statute specifying that patients are prohibited from withholding information about prior prescriptions from their health care provider** (CDC as of 8/31/10 & NAMSDL as of 10/11)	**(4) Substance Abuse Treatment: Medicaid Expansion** Source: Kaiser Family Foundation, as of 6/20/13	**(5) Prescriber Education Requirement or Recommended** Source: NAMSDL (through 12/31/12)	
Alabama	✓		✓			
Alaska	✓		✓			
Arizona	✓		✓	✓		
Arkansas	✓		✓	✓	✓	
California	✓		✓	✓	✓	
Colorado	✓	✓	✓	✓		
Connecticut	✓		✓	✓		
Delaware	✓	✓	✓	✓		
D.C.			✓	✓		
Florida	✓		✓		✓	
Georgia	✓		✓		✓	
Hawaii	✓		✓	✓		
Idaho	✓		✓			
Illinois	✓		✓	✓		
Indiana	✓		✓			
Iowa	✓		✓	✓	✓	
Kansas	✓		✓			
Kentucky	✓	✓	✓	✓	✓	
Louisiana	✓	✓	✓			
Maine	✓		✓			
Maryland	✓		✓	✓		
Massachusetts	✓	✓	✓	✓	✓	
Michigan	✓		✓	✓	✓	
Minnesota	✓	✓	✓	✓	✓	
Mississippi	✓		✓		✓	
Missouri			✓			
Montana	✓		✓		✓	
Nebraska	✓		✓			
Nevada	✓	✓	✓	✓		
New Hampshire	✓		✓			
New Jersey	✓		✓	✓		
New Mexico	✓	✓	✓	✓	✓	
New York	✓	✓	✓	✓		
North Carolina	✓	✓	✓			
North Dakota	✓		✓	✓		
Ohio	✓	✓	✓		✓	
Oklahoma	✓	✓	✓		✓	
Oregon	✓		✓	✓	✓	
Pennsylvania	✓		✓			
Rhode Island	✓	✓	✓	✓		
South Carolina	✓		✓			
South Dakota	✓		✓			
Tennessee	✓	✓	✓		✓	
Texas	✓		✓		✓	
Utah	✓		✓		✓	
Vermont	✓	✓	✓	✓	✓	
Virginia	✓		✓		✓	
Washington	✓		✓	✓	✓	
West Virginia	✓	✓	✓	✓	✓	
Wisconsin	✓		✓			
Wyoming	✓		✓			
Total States	**49**	**16**	**50 + D.C.**	**24 + D.C.**	**22**	

		(6) Immunity Laws: Good Samaritan (Source: Network for Public Health Law, 6/13)	(7) Immunity Laws: Allow use of Naloxone (Source: Network for Public Health Law, 5/13)	(8) Physical Exam Requirement: Requirement of a physical exam before prescribing Source: NAMSDL (through 3/15/13) & CDC AS OF 8/31/10	(9) ID Requirement: Requirement of showing identification before dispensing Source: NAMSDL (through 12/31/12 & CDC AS OF 8/31/10)	(10) Lock-In Programs Source: NCSL, as of 2010	Total Score
	Alabama			✓		✓	4
	Alaska	✓		✓		✓	5
	Arizona			✓			4
	Arkansas			✓		✓	6
	California	✓	✓	✓		✓	8
	Colorado	✓	✓	✓		✓	8
	Connecticut	✓	✓	✓	✓	✓	8
	Delaware	✓		✓	✓	✓	8
	D.C.	✓	✓	✓		✓	6
	Florida	✓		✓	✓	✓	7
	Georgia			✓	✓	✓	6
	Hawaii			✓	✓	✓	6
	Idaho			✓	✓	✓	5
	Illinois	✓	✓	✓	✓	✓	8
	Indiana			✓	✓	✓	5
	Iowa			✓		✓	6
	Kansas			✓		✓	4
	Kentucky		✓	✓	✓	✓	9
	Louisiana			✓	✓	✓	6
	Maine			✓	✓	✓	5
	Maryland	✓	✓			✓	6
	Massachusetts	✓	✓	✓	✓		9
	Michigan				✓	✓	6
	Minnesota			✓	✓	✓	8
	Mississippi			✓		✓	5
	Missouri			✓		✓	3
	Montana				✓	✓	5
	Nebraska					✓	3
	Nevada			✓	✓	✓	7
	New Hampshire			✓	✓	✓	5
	New Jersey	✓	✓	✓		✓	7
	New Mexico	✓	✓	✓	✓	✓	10
	New York	✓	✓	✓	✓	✓	9
	North Carolina	✓	✓	✓	✓	✓	8
	North Dakota			✓	✓	✓	6
	Ohio			✓		✓	6
	Oklahoma	✓	✓	✓	✓		8
	Oregon		✓	✓	✓	✓	8
	Pennsylvania			✓		✓	4
	Rhode Island	✓	✓	✓		✓	8
	South Carolina			✓	✓	✓	5
	South Dakota						2
	Tennessee			✓	✓	✓	7
	Texas			✓	✓	✓	6
	Utah			✓	✓	✓	6
	Vermont	✓	✓	✓	✓	✓	10
	Virginia		✓	✓	✓	✓	7
	Washington	✓	✓	✓	✓	✓	9
	West Virginia			✓	✓	✓	8
	Wisconsin			✓		✓	4
	Wyoming				✓	✓	4
		17 + D.C.	**17 + D.C.**	**44 + D.C.**	**32**	**46 + D.C.**	

1. EXISTENCE OF A PRESCRIPTION DRUG MONITORING PROGRAM

FINDING: 49 states have an active Prescription Drug Monitoring Program.

49 states have an active PDMP.		1 state and D.C. do not have an active PDMP.
Alabama	Nebraska	D.C.
Alaska	Nevada	Missouri
Arizona	New Hampshire	
Arkansas	New Jersey	
California	New Mexico	
Colorado	New York	
Connecticut	North Carolina	
Delaware	North Dakota	
Florida	Ohio	
Georgia	Oklahoma	
Hawaii	Oregon	
Idaho	Pennsylvania	
Illinois	Rhode Island	
Indiana	South Carolina	
Iowa	South Dakota	
Kansas	Tennessee	
Kentucky	Texas	
Louisiana	Utah	
Maine	Vermont	
Maryland	Virginia	
Massachusetts	Washington	
Michigan	West Virginia	
Minnesota	Wisconsin	
Mississippi	Wyoming	
Montana		

Prescription Drug Monitoring Programs hold the promise of being able to identify problem prescribers and individuals misusing drugs.

WHAT THESE LAWS DO:

Prescription Drug Monitoring Programs are state-run electronic databases used to track the prescribing and dispensing of controlled prescription drugs to patients. They hold the promise of being able to quickly identify problem prescribers and individuals misusing drugs — not only to stop overt attempts at "doctor shopping" but also to allow for better treatment of individuals who are suffering from pain and drug dependence. They also can quickly help identify inadvertent misuse by patients or inadvertent prescribing of similar drugs by multiple doctors. Based on the system in a given state, physicians, pharmacists, law enforcement officials and other designated officials can have access to the information to help identify high-risk patients.

The National Drug Control Strategy and Centers for Disease Control and Prevention have identified PDMPs as a key strategy for reducing prescription drug misuse.[40, 41] The Prescription Drug Monitoring Program Center of Excellence at Brandeis University, the National Alliance for Model State Drug Laws, the Alliance of States with Prescription Monitoring Programs, the School of Medicine and Public Health at the University of Wisconsin-Madison, the American Cancer Society and other organizations have stressed the importance of PDMPs in fighting prescription drug diversion and improving patient safety, and have issued a variety of recommendations and best practices for PDMPs including interstate operability, mandatory utilization, expanded access, real-time reporting, use of proactive alerts, and the integration with electronic health records.

A review by the Congressional Research Service (CRS) found that the available evidence suggests that PDMPs are effective in reducing the time required for drug diversion investigations, changing prescribing behavior, reducing "doctor shopping," and reducing prescription drug abuse but notes that the research is still limited since PDMPs are relatively new.[42] The advantages of PDMPs are that they can help identify major sources of prescription drug diversion such as prescription fraud, forgeries, doctor shopping and improper prescribing and dispensing; they can provide critical information to practitioners and third-party payers, giving them information on patients' use of controlled substances; and they can help doctors provide better patient care to individuals who may be in need of treatment.[43]

A survey by the National Association of State Alcohol/Drug Abuse Directors in 2012 found that only 43 percent of 28 reporting State Substance Abuse Agencies (SSAAs) were involved with the PDMPs.[44] Without these connections and more specific policies that direct states to connect individuals identified through PDMPs with treatment, PDMPs are not being used to their full potential.

Some examples showing early signs of the effectiveness of PDMPs include:

- A national study of 15 states conducted by the General Accountability Office noted that the existence of a PDMP in one state appeared to increase the diversion of prescription drugs in surrounding states without PDMPs.[45]
- A review of 2010 data from Virginia's PDMP found that in the period following a rapid increase in PDMP data utilization, there was reduced prescribing by 44 percent for those individuals meeting the criteria for doctor shopping.[46]
- A study of Wyoming's PDMP indicated that as prescribers and pharmacists received unsolicited PDMP reports concerning likely doctor shoppers, and as they requested more reports on patients, the number of likely doctor shoppers in the database declined markedly.[47]
- A 2008 study of medical providers in Ohio emergency departments found that 41 percent of those accessing PDMP data altered their prescribing for patients receiving multiple simultaneous painkiller prescriptions — with 61 percent of emergency departments prescribing fewer opioids than originally planned.[48]
- Substance abuse treatment programs in Maine consult PDMP data when admitting patients into treatment (patient consent required) to help validate patient self-reports on use of medications.[49]
- A report from the medical director of an opioid addiction treatment program indicates that PDMP data are an important clinical tool in monitoring use of controlled substances by patients addicted to painkillers, keeping patients safe and increasing the effectiveness of treatment.[50]

WHAT STATES ARE DOING:

PDMPs vary among states, including differences in the information collected, who is allowed to access the data and under what circumstances, the requirements for use and reporting, including timeliness of data collection, the triggers that generate reports, and the enforcement mechanisms in place for noncompliance. States finance PDMPs through a variety of sources including the state general fund, state and federal grants, and licensing and registration fees.

Forty-nine states currently have passed legislation authorizing a PDMP, which is the first step necessary for states to benefit from this potentially useful tool. However, while it is a sign of progress that nearly every state has an authorized PDMP, the variety of state laws creating PDMPs and authorizing their operations may have a significant impact on their effectiveness in combating the problem of prescription drug abuse.

Missouri is the only state that does not have PDMP legislation and the District of Columbia has pending legislation.

2. MANDATORY UTILIZATION OF PRESCRIPTION DRUG MONITORING PROGRAMS

FINDING: 16 states require mandatory use of Prescription Drug Monitoring Programs for providers.

16 states require mandatory use of PDMPs for providers. (Includes any form of mandatory use requirement)	34 states and D.C. do not require mandatory use of PDMPs for providers.	
Colorado	Alabama	Mississippi
Delaware	Alaska	Missouri
Kentucky	Arizona	Montana
Louisiana	Arkansas	Nebraska
Massachusetts	California	New Hampshire
Minnesota	Connecticut	New Jersey
Nevada	D.C.	North Dakota
New Mexico	Florida	Oregon
New York	Georgia	Pennsylvania
North Carolina	Hawaii	South Carolina
Ohio	Idaho	South Dakota
Oklahoma	Illinois	Texas
Rhode Island	Indiana	Utah
Tennessee	Iowa	Virginia
Vermont	Kansas	Washington
West Virginia	Maine	Wisconsin
	Maryland	Wyoming
	Michigan	

WHAT THESE LAWS DO:

In most states with operational PDMPs, enrollment and utilization are voluntary for prescribers and dispensers of prescription drugs. One way to ensure broader use is to make enrollment in a PDMP mandatory for certain practitioners or in certain circumstances. The National Alliance for Model State Drug Laws recommends that health licensing agencies or boards establish standards and procedures for their licensees regarding access to and use of PDMP data. The Prescription Drug Monitoring Program Center of Excellence at Brandeis University suggests mandating utilization of PDMPs for providers.

WHAT STATES ARE DOING:

Currently, 16 states mandate utilization of the state's PDMP in some circumstances and a state received a point for this indicator if they have any kind of mandatory utilization requirement. Eight of these states (KY, MA, NM, NY, OH, TN, VT and WV) have laws that establish objective triggers for utilization — requiring the PDMP to be accessed before the initial prescribing or dispensing of a controlled substance and at a designated period thereafter. Six of these states (CO, LA, MN, NC, OK and RI) require accessing the PDMP in limited situations, including for only certain prescribers and specific drugs. Delaware and Nevada have more subjective triggers that require the prescriber to access the PDMP data if there is a "reasonable belief" that the patient wants the prescription for a nonmedical purpose.

While this indicator examines mandated use requirements, it does not measure the actual usage and whether providers are trained to effectively recognize individuals who may be misusing or abusing prescription medications.

All states and D.C. have a doctor shopping statute.			No states do not have a doctor shopping statute.
Alabama	Kentucky	North Dakota	
Alaska	Louisiana	Ohio	
Arizona	Maine	Oklahoma	
Arkansas	Maryland	Oregon	
California	Massachusetts	Pennsylvania	
Colorado	Michigan	Rhode Island	
Connecticut	Minnesota	South Carolina	
Delaware	Mississippi	South Dakota	
D.C.	Missouri	Tennessee	
Florida	Montana	Texas	
Georgia	Nebraska	Utah	
Hawaii	Nevada	Vermont	
Idaho	New Hampshire	Virginia	
Illinois	New Jersey	Washington	
Indiana	New Mexico	West Virginia	
Iowa	New York	Wisconsin	
Kansas	North Carolina	Wyoming	

3. DOCTOR SHOPPING LAWS

FINDING: All states and D.C. have laws in place to make doctor shopping illegal.

WHAT THESE LAWS DO:

"Doctor shopping" is the practice of seeing multiple physicians and pharmacies to acquire controlled substances — for their own use and/or to try to obtain drugs to resell them. The Drug Enforcement Agency (DEA) has identified "doctor shopping" as one way that individuals obtain prescription drugs for nonmedical use, although the majority of individuals who use prescription painkillers use drugs prescribed to someone else, such as family or friends.[51] Some analyses have illustrated the problem of doctor shopping, including:

- Patients who doctor shop bought an estimated 4.3 million prescriptions for painkillers in 2008.[52]
- According to a study by the West Virginia University School of Pharmacy, among the 700 drug-related deaths in the state between July 2005 and December 2007, about 25 percent of those who died visited multiple doctors to receive prescriptions and nearly 17.5 percent visited multiple pharmacies.[53]
- A Government Accountability Office report found that about 170,000 Medicare patients sought prescriptions for frequently abused drugs from five or more physicians and other health professionals in 2008.[54]

"Doctor shopping" laws are designed to deter and prosecute people who obtain multiple prescriptions for controlled substances from different healthcare practitioners by intentionally failing to disclose certain prescription information. While PDMPs are one approach to prevent "doctor shopping," many PDMPs are currently limited in their capabilities, so states also have statutes they can use to prohibit obtaining prescription drugs through fraud, deceit, misrepresentation, subterfuge and/or concealment of material fact.

WHAT STATES ARE DOING:

All states and D.C. received a point for this indicator for having a general fraud statute that prohibits obtaining drugs through fraud, deceit, misrepresentation, subterfuge, or concealment of material fact — where a prosecutor must prove intent as well as the act of withholding information — and/or a specific doctor shopping law which prohibits patients from withholding from any healthcare practitioner that they have received either any controlled substance or prescription order from another practitioner, or the same controlled substance or one of similar therapeutic use within a specified time interval or at any time previously — where the act of withholding the information becomes the offense. Eighteen states (CT, FL, GA, HI, IL, LA, ME, NV, NH, NY, SC, SD, TN, TX, UT, VT, WV, and WY) have a specific doctor shopping law.

4. EXPANDING COVERAGE OF SUBSTANCE ABUSE SERVICES — MEDICAID EXPANSION

FINDING: 24 states and D.C. have expanded Medicaid under the Affordable Care Act (ACA), thereby expanding coverage of substance abuse treatment.

24 states and D.C. have expanded Medicaid under the Affordable Care Act (ACA).		26 states have not expanded Medicaid under the Affordable Care Act.	
Arizona	Michigan	Alabama	New Hampshire
Arkansas	Minnesota	Alaska	North Carolina
California	Nevada	Florida	Ohio
Colorado	New Jersey	Georgia	Oklahoma
Connecticut	New Mexico	Idaho	Pennsylvania
Delaware	New York	Indiana	South Carolina
D.C.	North Dakota	Kansas	South Dakota
Hawaii	Oregon	Louisiana	Tennessee
Illinois	Rhode Island	Maine	Texas
Iowa	Vermont	Mississippi	Utah
Kentucky	Washington	Missouri	Virginia
Maryland	West Virginia	Montana	Wisconsin
Massachusetts		Nebraska	Wyoming

WHAT THESE LAWS DO:

Accessible, affordable treatment is critical to helping individuals with substance abuse disorders be successful in recovery. Substance abuse treatment is paid for through a combination of federal, state and local government programs and services and/or coverage through private and public health insurance programs.

Currently, the United States faces a "treatment gap" — where treatment is not readily available for millions of Americans who are in need. In 2011, 21.6 million Americans ages 12 and older needed treatment for a substance abuse problem, but only 2.3 million received treatment at a substance abuse facility.[55] As prescription drug abuse has increased, so has the need for treatment. In the past decade, there has been more than a five-fold increase in treatment admissions for prescription painkillers.[56] Between 1999 and 2009, treatment admissions for abuse of prescription painkillers rose 430 percent.[57]

There is currently no uniform consensus about the extent to which state governments or private insurers require coverage for substance abuse treatment. About one-third of those who are currently covered in the individual market have no coverage for substance use disorder services.[58] Often, even if addiction treatment is covered, there is a cap on how long or how many times a person can receive services. Furthermore, the shift towards managed care has resulted in shorter average stays in treatment programs.[59]

Medicaid coverage of substance abuse treatment is one of many essential components in any strategy to ensure millions of Americans in need of treatment have affordable, accessible care. State Medicaid programs currently provide a significant percentage of overall spending for substance abuse treatment — accounting for one in every five dollars spent as of 2009.[60] Total U.S. spending on substance abuse treatment was $24 billion.

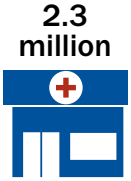
While Medicaid provides health insurance to many lower-income

SUBSTANCE ABUSE TREATMENT GAP IN 2011

Number of People Needing Treatment for Substance Abuse Problems



Number of People Who Received Treatment at a Substance Abuse Facility



Americans, each state determines its own citizens' eligibility, typically in relation to the federal poverty level ($15,415 for an individual or $26,344 for a family of three in 2013). As of 2013, Medicaid and the Children's Health Insurance Program (CHIP) provided coverage to around 60 million Americans.[61]

The Affordable Care Act allows states to expand their Medicaid programs to cover all adults earning up to 138 percent of the federal poverty line beginning in 2014. The ACA also establishes 10 mandatory "essential health benefits" (EHBs) for newly eligible Medicaid enrollees, with substance abuse treatment being one of the required benefit categories. The Congressional Budget Office (CBO) estimated that 12 million previously uninsured Americans would have health coverage if every state expanded their Medicaid coverage — which would include substance abuse treatment coverage.[62] As of September 2013, 24 states and Washington, D.C. are participating in Medicaid expansion, making affordable substance abuse services available to an increased number of individuals in their states.

Medicare coverage is also extended to cover the mandatory essential health benefits under the ACA.

WHAT STATES ARE DOING:

As of July 1, 2013, 23 states and the District of Columbia have decided to expand Medicaid under the ACA. Five states — Indiana, New Hampshire, Ohio, Pennsylvania and Tennessee — are still considering whether or not to expand. States received a point on this indicator if they have decided to expand their Medicaid program in 2014.

It is important to note that states also differ greatly in terms of the Medicaid coverage for three Food and Drug Administration (FDA) approved painkiller treatment medications — methadone, buprenorphine/naloxone and naltrexone (oral and injectable).

According to a June 2013 report by the American Society of Addiction Medication (ASAM), 30 states and the District of Columbia have Medicaid fee-for-service programs that cover methadone maintenance treatment provided in outpatient narcotic treatment programs, including: Alabama, Arizona, California, Connecticut, Delaware, D.C., Florida, Georgia, Hawaii, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nevada, New Hampshire, New Jersey, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, Rhode Island, Texas, Utah, Vermont, Virginia, Washington and Wisconsin.[63] Another three states reported that methadone treatment is funded in their state through using funds from their Substance Abuse Prevention and Treatment Block Grant (SAPT) (federal program) and/or state or county funds: Alaska, Illinois and Nebraska.

The ASAM report also notes that 28 states were found to provide Medicaid coverage for all three FDA-approved medications for the treatment of painkiller dependence, including: Alabama, Alaska, Arizona, California, Connecticut, Delaware, Florida, Georgia, Illinois, Maine, Maryland, Massachusetts, Michigan, Minnesota, Missouri, Nevada, New Hampshire, New Mexico, New York, North Carolina, Ohio, Oregon, Pennsylvania, Utah, Vermont, Virginia, Washington and Wisconsin.[64]

According to the Substance Abuse and Mental Health Services Administration, buprenorphine coverage also varies under Medicare.[65] Medicare does not typically cover buprenorphine unless it is given at a treatment center (inpatient or outpatient). It may also be covered as part of emergency care, such as detoxification or early stabilization treatment, if it is administered at a Medicare-certified facility and buprenorphine is on its list of eligible drugs. Currently, there is no fee-for-service coverage for buprenorphine as part of outpatient care under Medicare. Some Medicare supplement programs may provide coverage but it varies under different plans.

5. PRESCRIBER EDUCATION

FINDING: 22 states require or recommend prescriber education for pain medication prescribers.

22 states require or recommend prescriber education for pain medication prescribers.		28 states and D.C. do not require or recommend education for pain medication prescribers.	
Arkansas	New Mexico	Alabama	Missouri
California	Ohio	Alaska	Nebraska
Florida	Oklahoma	Arizona	Nevada
Georgia	Oregon	Colorado	New Hampshire
Iowa	Tennessee	Connecticut	New Jersey
Kentucky	Texas	Delaware	New York
Massachusetts	Utah	D.C.	North Carolina
Michigan	Vermont	Hawaii	North Dakota
Minnesota	Virginia	Idaho	Pennsylvania
Mississippi	Washington	Illinois	Rhode Island
Montana	West Virginia	Indiana	South Carolina
		Kansas	South Dakota
		Louisiana	Wisconsin
		Maine	Wyoming
		Maryland	

Medical Students Only Receive Around 11 Hours of Training in Pain and Pain Management.



WHAT THESE LAWS DO:

While much of the prescription drug abuse problem is caused by illicit use, legitimate use of painkillers can lead to adverse consequences, including addiction and death, when prescription drugs are overprescribed or improperly prescribed.[66] It is important to educate providers about the risks of prescription drug misuse to prevent them from prescribing incorrectly and/or to ensure they consider possible drug interactions when prescribing a new medication to a patient. Most medical, dental, pharmacy, and other health professional schools currently do not provide in-depth training on substance abuse and students may only receive limited training on treating pain.

- According to ONDCP, outside of specialty addiction treatment programs, most healthcare providers have received minimal training in how to recognize substance abuse in their patients.[67]
- Some studies have found medical students only receive around 11 hours of training in pain and pain management.[68]
- A national survey of medical residency programs in 2000 found that, of the programs studied, only 56 percent required substance use disorder training, and the number of curricular hours in the required programs varied between 3 hours to 12 hours. A 2008 follow-up survey found that some progress has been made to improve medical school, residency and post-residency substance abuse education; however, these efforts have not been uniformly applied in all residency programs or medical schools.[69]
- A 2011 GAO report found that FDA, the National Institutes of Health (NIH) and SAMHSA use a variety of strategies to educate prescribers — including developing continuing medical education programs, requiring training and certification in order to prescribe certain drugs, and developing curriculum resources for future prescribers — but found more education was needed.[70]

Improved education for prescribers has been supported by the federal government. FDA laid out three key roles for prescribers in curtailing the U.S. painkiller epidemic which included ensuring that they have adequate training in painkiller therapy. In July of 2012, the FDA approved a Risk Evaluation and Mitigation Strategy for prescription painkillers that requires manufacturers to offer voluntary painkiller training programs, at little to no cost, to all U.S. licensed prescribers. FDA then issued a letter to prescribers, which was distributed by the American Medical Association (AMA), American Academy of Family Physicians (AAFP), the American Academy of Physician Assistants (AAPA), the American Academy of Pain Management (AAPM) and ASAM, which recommended that they take advantage of those educational programs that are designed to promote responsible painkiller prescribing.

A working group convened by the National Alliance for Model State Drug Laws, comprised of doctors, pain management experts, law enforcement representatives, a district attorney, a pharmacist, regulatory officials, and prevention and addiction treatment specialists, stated that improved education for prescribers on proper pain management was a priority.[71] The Alliance found that education for practitioners is a critical component to reducing incidences of prescription drug abuse and misuse.[72] Recommended subjects of learning include knowledge and awareness to treat pain in a holistic manner, appropriate prescribing of medications, critical thinking skills, use of state prescription drug monitoring programs, and addiction identification and referral to treatment, and it has been suggested that these topics be incorporated into the existing educational requirements at all stages of a prescriber's career.



WHAT STATES ARE DOING:

Twenty-two states received a point for this indicator for possessing a statute or regulation either requiring or recommending that physicians who prescribe controlled substances to treat pain receive education related to prescribing for pain. Education topics include pain management, prescribing for pain, addiction and treatment, and use of the state's PDMP. While this indicator includes both mandatory and recommended prescriber education requirements, there is a strong belief that mandatory requirements and ensuring that licensing is tied to fulfilling them are needed.

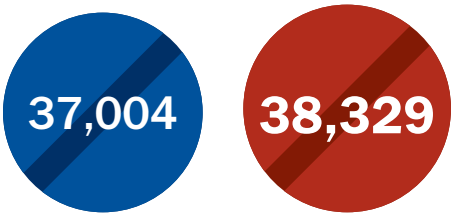
Education for practitioners is a critical component to reducing incidences of prescription drug abuse and misuse.

6. GOOD SAMARITAN LAWS

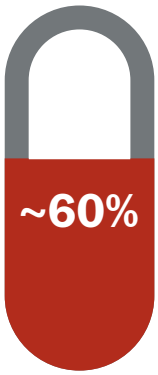
FINDING: 17 states and D.C. have a law in place to provide a degree of immunity from criminal charges or mitigation of sentencing for an individual seeking help for themselves or others experiencing an overdose.

17 states and D.C. have a law in place to provide a degree of immunity from criminal charges or mitigation of sentencing for an individual seeking help for themselves or others experiencing an overdose.	33 states do not have a law in place to provide a degree of immunity from criminal charges or mitigation of sentencing for an individual seeking help for themselves or others experiencing an overdose.	
Alaska	Alabama	Nebraska
California	Arizona	Nevada
Colorado	Arkansas	New Hampshire
Connecticut	Georgia	North Dakota
Delaware	Hawaii	Ohio
D.C.	Idaho	Oregon
Florida	Indiana	Pennsylvania
Illinois	Iowa	South Carolina
Maryland	Kansas	South Dakota
Massachusetts	Kentucky	Tennessee
New Jersey	Louisiana	Texas
New Mexico	Maine	Utah
New York	Michigan	Virginia
North Carolina	Minnesota	West Virginia
Oklahoma	Mississippi	Wisconsin
Rhode Island	Missouri	Wyoming
Vermont	Montana	
Washington		

NUMBER OF DRUG OVERDOSE DEATHS 2009 & 2010



PERCENTAGE OF DRUG OVERDOSE DEATHS INVOLVING PHARMACEUTICAL DRUGS – 2010



WHAT THESE LAWS DO:

The number of deaths from prescription painkiller overdoses has quadrupled since 1999.[73] According to CDC, drug overdose deaths increased for the 11th consecutive year in 2010. Although most of these types of deaths can be prevented with quick and appropriate medical treatment, fear of arrest and prosecution may prevent people who witness an overdose or find someone who has overdosed from calling 911.

- CDC's analysis shows that 38,329 people died from a drug overdose in the United States in 2010, up from 37,004 deaths in 2009. In 2010, nearly 60 percent of the drug overdose deaths (22,134) involved pharmaceutical drugs. Prescription painkillers, such as oxycodone, hydrocodone, and methadone, were involved in about three of every four pharmaceutical overdose deaths (16,651).[74]
- Good Samaritan" laws are designed to encourage people to help those in danger of an overdose. For instance, a study following passage of Washington's 911 Good Samaritan Law found that 88 percent of prescription painkiller users indicated that once they were aware of the law, they would be more likely to call 911 during future overdoses.[75]

WHAT STATES ARE DOING:

State laws have been put in place to provide a degree of immunity from criminal charges or mitigation of sentencing for an individual seeking help for themselves or for others experiencing an overdose. They remove perceived barriers to calling 911 through the provision of limited legal protections.

A state received a point for this indicator for having any form of Good Samaritan law that reduces legal penalties for an individual seeking help for themselves or others experiencing an overdose. These laws, however, vary significantly from state to state. Among the Good Samaritan laws, 13 states (CA, CO, CT, DE, FL, IL, MA, NJ, NC, NM, NY, RI, and WA) and the District of Columbia's laws prevent an individual who seeks medical assistance for someone experiencing a drug-related overdose from either being charged or prosecuted for possession of a controlled substance. Vermont has the broadest version of the law — providing protection from arrest or all drug offenses, as well as protections against asset forfeiture, the revocation of parole or probation or the violation of restraining orders, for people who seek help for overdose victims. Some states have more limited laws where people assisting an overdosing individual receive protection but the individual themselves may not be protected from legal action. Alaska and Maryland have more limited Good Samaritan statutes. Alaska requires and Maryland permits courts to take the fact that a Good Samaritan summoned medical assistance into account at sentencing.



7. SUPPORT FOR RESCUE DRUG USE

FINDING: 17 states and D.C. have a law in place to expand access to, and use of, naloxone for overdosing individuals given by lay administrators.

17 states and D.C. have a law in place to expand access to, and use of, naloxone for overdosing individuals given by lay administrators.	33 states do not have a law in place to expand access to, and use of, naloxone for overdosing individuals given by lay administrators.	
California	Alabama	Missouri
Colorado	Alaska	Montana
Connecticut	Arizona	Nebraska
D.C.	Arkansas	Nevada
Illinois	Delaware	New Hampshire
Kentucky	Florida	North Dakota
Maryland	Georgia	Ohio
Massachusetts	Hawaii	Pennsylvania
New Jersey	Idaho	South Carolina
New Mexico	Indiana	South Dakota
New York	Iowa	Tennessee
North Carolina	Kansas	Texas
Oklahoma	Louisiana	Utah
Oregon	Maine	West Virginia
Rhode Island	Michigan	Wisconsin
Vermont	Minnesota	Wyoming
Virginia	Mississippi	
Washington		

188
community-based overdose prevention programs distribute naloxone



Training provided to more than
50,000
people



RESULT:
10,000
overdose reversals



WHAT THESE LAWS DO:

Naloxone is an opioid antagonist and can be used to counter the effects of prescription painkiller overdose. It has been approved by the FDA and its brand name is Narcan. Administration of naloxone counteracts life-threatening depression of the central nervous system and respiratory system, allowing an overdose victim to breathe normally. It may be injected in the muscle, vein or under the skin or sprayed into the nose. It is a temporary drug that wears off in 20 to 90 minutes.[76] Although naloxone is a prescription drug, it is not a controlled substance and has no abuse potential. Furthermore, it can be administered by minimally trained laypeople.

According to CDC, at least 188 community-based overdose prevention programs now distribute naloxone, have provided training and naloxone to more than 50,000 people, and have led to more than 10,000 overdose reversals.[77] Expanding access to naloxone has been supported by the U.S. Conference of Mayors (2008 Resolution), the American Medical Association (2012 Resolution), the American Public Health Association (APHA), and a number of other organizations. In a survey of states' naloxone and "Good Samaritan" laws conducted by the Network for Public Health Law, the group concluded that, "it is reasonable to believe that laws that encourage the prescription and use of naloxone and the timely seeking of emergency medical assistance will have the intended effect of reducing opioid overdose deaths," and found "such laws have few if any foreseeable negative effects, can be implemented at little or no cost, and will likely save both lives and resources."[78]

WHAT STATES ARE DOING:

State laws have been necessary to overcome barriers that often prevent use of naloxone in emergency situations. Laws have been implemented to both encourage increased prescribing of such medication to those at risk of an overdose and to protect those who administer naloxone to an overdosing individual from civil or criminal repercussions. Some states may be able to accomplish this through regulations.

Seventeen states and D.C. currently have a law to help increase access and use of naloxone in emergency situations in order to reduce overdose deaths. A state received credit on this indicator if they possess any law that expands access to naloxone to lay administrators. These laws vary in their detail and scope. For instance, some of the laws include: 1) removing civil liability for prescribers (CA, CT, CO, NJ, NM, NC and VT); 2) removing civil liability for lay administration (CO, DC, KY, MA, NJ, NM, NY, NC, RI, and VA); 3) removing criminal liability for prescribers (CO, MA, NJ, NM, NC, RI, VT and WA); and 4) removing criminal liability for lay administration (CO, DC, KY, MA, NJ, NM, NC, RI, VA and WA). Illinois removes criminal liability for possession of naloxone without a prescription. Several state laws allow third-party prescription of naloxone to a family member, friend or other person in a position to assist a person at risk of experiencing an overdose, including Illinois, New York, Washington, Massachusetts, North Carolina, Virginia, Kentucky, New Jersey, Maryland and Vermont. Oregon's law allows those who have completed training to possess and administer naloxone.

Washington and Rhode Island are currently implementing collaborative practice agreements where naloxone is distributed by pharmacists.

It is important to note that having a law in place does not measure where the law is being implemented.

OHIO: PROJECT DAWN

In response to the growing problem of opioid overdose deaths in Ohio, the Ohio Department of Health implemented Project DAWN (Deaths Avoided With Naloxone) Overdose Reversal Project. Project DAWN is a community-based program that focuses on prevention and education and also distributes intranasal naloxone hydrochloride to those deemed at risk for an opioid overdose in Ohio.[80] There are currently three Project DAWN sites in Ohio where participants receive training on:

- Recognizing the signs and symptoms of an overdose;
- Distinguishing between different types of overdose;
- Rescue breathing and the rescue position;
- The importance of calling 911;
- Proper administration of naloxone; and
- Discussion of substance abuse treatment options.[81]

MASSACHUSETTS' NALOXONE DISTRIBUTION PILOT

Over the last six years, the Massachusetts Department of Public Health has implemented overdose education and naloxone distribution programs across the state in which they train drug users, family members and friends on how to reduce overdose risk, recognize signs of an overdose, access emergency medical services and administer naloxone. Since its inception in 2007, the program has trained more than 10,000 individuals and resulted in more than 2,000 prescription painkiller overdose reversals.[79] The Massachusetts' Department of Public Health has a system for distribution by approved trainers under a standing order by the Public Health Department's Medical Director.

8. PHYSICAL EXAM REQUIREMENT

FINDING: 44 states and D.C. require a healthcare provider to either conduct a physical exam of the patient, a screening for signs of substance abuse or have a bona fide patient-physician relationship that includes a physician examination prior to prescribing prescription medications.

44 states and D.C. require a healthcare provider to either conduct a physical exam of the patient, a screening for signs of substance abuse or have a bona fide patient-physician relationship that includes a physician examination prior to prescribing prescription medications.			6 states do not require a healthcare provider to either conduct a physical exam of the patient, a screening for signs of substance abuse or have a bona fide patient-physician relationship that includes a physician examination prior to prescribing prescription medications.
Alabama	Iowa	North Dakota	Maryland
Alaska	Kansas	Ohio	Michigan
Arizona	Kentucky	Oklahoma	Montana
Arkansas	Louisiana	Oregon	Nebraska
California	Maine	Pennsylvania	South Dakota
Colorado	Massachusetts	Rhode Island	Wyoming
Connecticut	Minnesota	South Carolina	
Delaware	Mississippi	Tennessee	
D.C.	Missouri	Texas	
Florida	Nevada	Utah	
Georgia	New Hampshire	Vermont	
Hawaii	New Jersey	Virginia	
Idaho	New Mexico	Washington	
Illinois	New York	West Virginia	
Indiana	North Carolina	Wisconsin	

WHAT THESE LAWS DO:

To prevent inappropriate prescribing of controlled substances, laws have been put in place requiring health practitioners to examine the patient or obtain a patient history and perform a "patient evaluation" prior to prescribing a controlled substance. CDC has reported that state policies requiring a physical exam before prescribing have shown promise in reducing prescription drug abuse while ensuring patients have access to safe, effective pain treatment.[82] The National Alliance for Model State Drug Laws has identified conducting a comprehensive patient examination, including a physical examination, and screening for signs of abuse and addiction, as a recommended prescribing practice for the treatment of pain involving controlled substance.[83]

WHAT STATES ARE DOING:

Forty-four states and D.C. received a point for this indicator for having a requirement that a patient receive a physical exam by a healthcare provider, a screening for signs of substance abuse and addiction, or a bona fide patient-physician relationship that includes a physician examination, prior to prescribing. The state laws vary in the circumstances under which an exam is required (for example, for all drugs or just specified prescriptions) and the consequences for prescribing without a required examination (whether there is criminal liability).

32 states have a law requiring or permitting a pharmacist to require an ID prior to dispensing a controlled substance.			18 states and D.C. do not have a law requiring or permitting a pharmacist to require an ID prior to dispensing a controlled substance.	
Connecticut	Massachusetts	Oregon	Alabama	Mississippi
Delaware	Michigan	South Carolina	Alaska	Missouri
Florida	Minnesota	Tennessee	Arizona	Nebraska
Georgia	Montana	Texas	Arkansas	New Jersey
Hawaii	Nevada	Utah	California	Ohio
Idaho	New Hampshire	Vermont	Colorado	Pennsylvania
Illinois	New Mexico	Virginia	D.C.	Rhode Island
Indiana	New York	Washington	Iowa	South Dakota
Kentucky	North Carolina	West Virginia	Kansas	Wisconsin
Louisiana	North Dakota	Wisconsin	Maryland	
Maine	Oklahoma			

9. ID REQUIREMENT

FINDING: 32 states have a law requiring or permitting a pharmacist to require an ID prior to dispensing a controlled substance.

WHAT THESE LAWS DO:

Pharmacists, as the dispensers of prescriptions drugs, have been targeted by some state laws in order to prevent prescription fraud and diversion by ensuring persons obtaining a prescription are who they claim to be. CDC has stated that state policies requiring patient identification before dispensing prescription drugs have shown promise in reducing prescription drug abuse while ensuring patients have access to safe, effective pain treatment.[84] The Council of State Governments has said that states can prevent the fraudulent use of Medicaid cards by requiring picture identification to pick up a prescription.[85]

WHAT STATES ARE DOING:

The 32 states that have a law requiring or permitting a pharmacist to request an ID prior to dispensing a controlled substance received a point for this indicator. These state laws vary by the circumstances under which an ID is required to be shown as well as the type of identification that must be used. Some states require presentation of an ID in all circumstances and some are limited to people unknown to the pharmacist. Some states require photo identification and others accept a broader range of government IDs.

THE ROLE OF PHARMACIES

Currently, under the Controlled Substances Act, pharmacists are required to evaluate the appropriateness of any controlled-substance prescription presented to them by patients. Unfortunately, it is often difficult for pharmacists to make an informed decision about whether or not to fill a prescription when a patient has a legal prescription from a licensed physician.

In an effort to limit inappropriate prescribing, CVS pharmacies used their aggregated data to analyze prescriber patterns to identify potential pill mill doctors. Through this program, CVS tracked data over a two-year period for specific prescriptions and prescribers were compared against each other on three parameters: the volume and proportion of prescriptions for high-risk drugs; the number of patients who paid cash for high-risk drugs as well percentage of patients receiving high-risk drugs between the ages of 18 to 35; and finally the prescriptions for noncontrolled substances compared to prescriptions for controlled substances within the prescriber's practice.[86] After analyzing the data, CVS contacted the potential pill mill doctors and decided on a case-by-case basis whether to continue filling these providers' prescriptions.

Access to information of prescriber and patient history helps improve the ability of pharmacies and pharmacists to prevent prescription drug abuse.

10. PHARMACY LOCK-IN PROGRAMS

FINDING: 46 states and D.C. have a pharmacy lock-in program under the state's Medicaid plan where individuals suspected of misusing controlled substances must use a single prescriber and pharmacy.

46 states and D.C. have a pharmacy lock-in program under the state's Medicaid plan where individuals suspected of misusing controlled substances must use a single prescriber and pharmacy.			4 states do not have a pharmacy lock-in program under the state's Medicaid plan where individuals suspected of misusing controlled substances must use a single prescriber and pharmacy.
Alabama	Kentucky	North Dakota	Arizona
Alaska	Louisiana	Ohio	Massachusetts
Arkansas	Maine	Oregon	Oklahoma
California	Maryland	Pennsylvania	South Dakota
Colorado	Michigan	Rhode Island	
Connecticut	Minnesota	South Carolina	
Delaware	Mississippi	Tennessee	
D.C.	Missouri	Texas	
Florida	Montana	Utah	
Georgia	Nebraska	Vermont	
Hawaii	Nevada	Virginia	
Idaho	New Hampshire	Washington	
Illinois	New Jersey	West Virginia	
Indiana	New Mexico	Wisconsin	
Iowa	New York	Wyoming	
Kansas	North Carolina		

WHAT THESE LAWS DO:

In order to help healthcare providers monitor potential abuse or inappropriate utilization of controlled prescription drugs, states have implemented programs requiring high users of certain drugs to use only one pharmacy and get prescriptions for controlled substances from only one medical office. Lock-in programs can help avoid doctor shopping while ensuring appropriate pain care for patients.

Lock-in programs can help avoid doctor shopping while ensuring appropriate pain care for patients.

- A 2009 analysis of the Oklahoma Pharmacy Lock-In Program found it resulted in a decrease in doctor shopping and in the use of prescription painkillers for emergency department visits among participants, while saving an average $600 in prescription painkiller costs for those enrolled in the program the first year. The analysis did not show any change in the use of maintenance medication, suggesting that the lock-in program did not affect therapies for chronic conditions.[87]
- A Washington State analysis of 20 Medicaid clients in the state's Medicaid "lock-in" program estimated that participation resulted in $6,000 savings per year per client.[88]

WHAT STATES ARE DOING:

Forty-six states and D.C. have pharmacy lock-in programs via the state's Medicaid plan where individuals suspected of misusing controlled substance must use a single prescriber and pharmacy and received a point for this indicator. The programs provide a way to detect potential abuse of prescription painkillers and other medications and a procedure to "lock in" the member to one pharmacy. Some other insurers and employers have also started lock-in programs for their beneficiaries.



National Issues & Recommendations

Prescription drug abuse has rapidly become a serious public health problem in the United States and a quick response is required to curb it before it gets even more out of control.

Effective solutions will require acting on the best available advice from public health, clinical and legal experts, and forging partnerships across federal, state and local governments along with healthcare providers, the healthcare and benefits industries, pharmacies, schools and universities, employers and others.

Federal, state and local governments have taken the problem seriously and have identified it as an important priority.

- In 2011, the federal government issued a plan, Epidemic: Responding to America's Prescription Drug Abuse Crisis, identifying four main priorities for a comprehensive approach to preventing prescription drug misuse and abuse, including education, implementing PDMPs in every state, proper medication disposal, and law enforcement.[89] ONDCP launched a Federal Council on Prescription Drug Abuse comprised of federal agencies to coordinate implementation of the prescription drug abuse prevention plan and engage a wide range of partners to reach the plan's goals.[90] ONDCP regularly convenes an Interagency Working Group with stakeholders from a host of Federal agencies, including the DOD, the Department of Justice (DOJ) (including Bureau of Prisons and Drug Enforcement Administration), the Department of Education, the Department of Health and Human Services (HHS) (including CDC, FDA, NIDA and SAMHSA) and the U.S. Department of Veterans' Affairs (VA). This group focuses on implementing the action items in the Prescription Drug Abuse Plan, as well as emerging issues related to prescription drug abuse.

- Each participating agency is taking a range of actions. For instance at CDC, the National Center for Injury Prevention and Control's (the Injury Center) primary strategy for addressing the prescription drug overdose epidemic is to conduct surveillance on prescription drug abuse and overdose trends, evaluate and identify effective interventions and policies for reducing overdoses and improve clinical practice to reduce prescription drug diversion and abuse. Instrumental to this approach is partnering with states to amplify, inform and strengthen their prevention efforts. As an example, CDC's Injury Center collaborates with DOJ's Bureau of Justice Assistance to better understand how PDMPs can be effectively used to curb abuse and overdose deaths.
- State leaders are also launching special initiatives to target the problem of prescription drug abuse. In a 2012 issue brief, the National Governors' Association (NGA) identified six strategies for reducing prescription drug abuse, including making better use of prescription drug monitoring programs, enhancing enforcement efforts, ensuring proper disposal of prescription drugs, leveraging the state's role as regulator and purchaser of services, building partnerships among key stake holders, and promoting public education about prescription drug abuse.[91] NGA is partnering with the National Safety Council and the Association of State and Territorial Health Officials (ASTHO), among others, on an initiative co-chaired by Governor Robert Bentley (R-AL) and Governor John Hickenlooper (D-CO) in which seven states (Alabama, Arkansas, Colorado, Kentucky, New Mexico, Oregon and Virginia) are participating in a year-long Prescription Drug Abuse Reduction Policy Academy.

In the following section of the report, TFAH provides an overview of some key aspects of addressing prescription drug abuse as a public health problem and recommendations for ways to speedily and effectively implement policies, including:

A. Improving Prescription Drug Monitoring Programs

B. Ensuring Access to Substance Abuse Treatment

C. Ensuring Responsible Prescribing Practices

D. Expanding Public Education & Building Community Partnerships

NATIONAL GOVERNORS' ASSOCIATION AND ASSOCIATION OF STATE AND TERRITORIAL HEALTH OFFICIALS: A COORDINATED, MULTI-SECTOR APPROACH

Strategies to reduce misuse and abuse of prescription painkillers require collaboration across a range of disciplines and fields. In 2012, ASTHO worked with five state teams (KY, OH, OK, TN and WV) to develop state action plans addressing several domains: prevention and education; monitoring and surveillance; diversion control, licensure, and enforcement; and treatment and recovery.[92]

The combined team approach brought together various efforts and state departments in the interest of building capacity for policy and programmatic approaches to prevent prescription opioid overdoses and treat addiction by moving toward a more coordinated, multi-sector system.

In 2013, in concert with NGA's State Policy Academy, ASTHO added four new state teams (AZ, CT, DE and IL) to this learning collaborative—which currently stands at 15 states total—to foster interstate collaboration, promote information exchange and sharing of best practices, and encourage strategic planning and leadership development, with the goal of creating a platform for ongoing dialogue between states.

A central principle of this work is to help governors' offices, state health officials, policymakers, and other state leaders identify effective policy and legal strategies that are successful in reducing overdose deaths through collaboration with a variety of partners. Providing a tool to help states visualize their current investments and identify areas for further work, ASTHO developed a gap assessment matrix containing recommendations from ONDCP's Prescription Drug Abuse Prevention Plan, and the CDC's Injury Center state teams used this tool to identify the scope of the issue, identify political and resource barriers, assess partnerships, and determine how various systems can fit together using a public health approach.

A. IMPROVING PRESCRIPTION DRUG MONITORING PROGRAMS

"State prescription drug monitoring programs (PDMPs) are an important component of government efforts to prevent and reduce controlled substance diversion and abuse. State PDMPs collect, monitor, and analyze scheduled or controlled prescription drugs, with the goal of preventing prescription drug misuse and abuse and illegal diversion."

– Westley Clark, M.D., J.D., M.P.H., CAS, FASAM, Director of the Substance Abuse and Mental Health Services' Center for Substance Abuse Treatment[93]

Nearly every expert group engaged in working to reduce prescription drug abuse considers PDMPs an essential tool to support the response to prescription drug abuse. They are designed to monitor suspected abuse and to identify doctors who issue excessive numbers of prescriptions and patients seeking excessive numbers of prescriptions. This not only helps prevent problem prescribing and "doctor shopping," but also helps doctors understand norms, allows doctors and patients to avoid unintended multiple prescriptions for similar medications by different prescribers, and helps identify and provide treatment for individuals at an early stage of a substance abuse disorder.

Currently, however, a limited number of officials have access to PDMPs, and who has access is different by state. Only between 5 percent and 39 percent of healthcare providers, varying by state, use PDMP data because of factors including low awareness, low registration, data that is not current or real-time, limitations on authorized users, reports and web portals that do not support clinical practices and workflows, low technical maturity to support interoperability and lack of business agreements to protect PDMP information.[95] A number of organizations identified improvements that could help PDMPs realize their full potential, including a set of goals laid out in the White House's 2011 Prescription Drug Abuse Prevention Plan, which included: 1) work with states to establish an effective PDMP in every state, and to require every prescriber and dispenser to be trained in their appropriate use; 2) encourage research on PDMPs to determine current effectiveness and ways to make them more effective; 3) support the National All Schedules



"What I would like is a good, efficient drug monitoring program. We have to stop doctor shopping and inappropriate prescriptions. Doctors should know whom else the patient is seeing. Building the database to prevent abuse is critical. It is not intended as a police mechanism—it is truly to enhance the public's health by being an informational tool."

– Paul Halverson, DrPH, MHSA, FACHE, Director of Health and State Health Officer, Arkansas[94]



Prescription Electronic Reporting Act (a formula grant program administered by SAMHSA that funds state PDMPs) reauthorization in Congress; 4) work with Congress to pass legislation to authorize the Secretary of Veterans Affairs and the Secretary of Defense to share patient information on controlled substance prescriptions with state PDMPs; 5) encourage federally funded healthcare programs to provide controlled substance prescription information electronically to the PDMPs in states in which they operate healthcare facilities or pharmacies; and encourage them to have their prescribers check PDMPs for patient histories before generating prescriptions; 6) explore the feasibility of reimbursing prescribers who check PDMPs before writing prescriptions for patients covered under insurance plans; and 7) expand on DOJ's pilot efforts to build PDMP interoperability across state lines and expand interstate data sharing among PDMPs through the Prescription Drug Information Exchange. One of these goals has made progress through language in the FY 2012 Appropriations bill that allows the VA to share information with state PDMPs. While the rule is being finalized, VA providers have been encouraged to check state PDMPs, as allowed by state laws, before issuing prescriptions.

Many prescription drug monitoring programs struggle to stay operational due to insufficient and uncertain funding.

TFAH supports the following recommendations to help PDMPs become a more effective tool in reducing prescription drug misuse and abuse:

▲ Provide Needed Resources:

Many PDMPs struggle to stay operational due to insufficient and uncertain funding. Some states prohibit using general state revenues for the programs, which means many PDMPs are supported only by federal grants, while others are forced to seek private funding.[96]

TFAH recommends that a sufficient level of state and federal resources should be devoted to PDMPs. This investment could yield a strong return through reducing misuse and overdoses. While states are responsible for their own PDMPs, the federal government has several programs in place to support them, including:

- **Harold Rogers PDMP Grant Program:** The Bureau of Justice Assistance, through its Harold Rogers PDMP grant program, makes grants to states seeking to develop or enhance PDMPs and has supported technical assistance for the grantees.
- **The National All Schedules Prescription Electronic Reporting Act (NASPER):** NASPER was signed into law in 2005 to assist states through grants in combating prescription drug abuse through PDMPs. NASPER is housed at the Department of Health and Human Services. The program has not been funded since FY 2010.

▲ Ensure Interstate Operability:

One key element for PDMPs to be effective for healthcare providers and law enforcement agencies is to be able to share information across state and jurisdictional boundaries. This would, for instance, enable prescribers to detect patients who may try doctor shopping in different states. The Prescription Drug Monitoring Program Center of Excellence at Brandeis University, the School of Medicine and Public Health at the University of Wisconsin-Madison, the National Alliance for Model State Drug Laws, the Alliance of States with Prescription Monitoring Programs, and the American Cancer Society all recommend that states should share PDMP information with other states. The Council of State Governments passed a resolution encouraging states to explore all methods of interstate cooperation that facilitate the sharing of prescription drug monitoring data between states.[97]

As of June 2013, 44 states allowed the sharing of PDMP information across state lines but they vary in the way they do so. Nineteen states (AL, AR, DE, HI, IL, KS, ME, MD, MA, MS, MT, NV, NH, NC, RI, SD UT, VA and WI) allow the sharing of information with PDMPs in other states, eight (AK, CA, CO, ID, IA, MN, TX and WY) allow them to share information with authorized PDMP users in other states; and 17 (AZ, CT, IN, KY, LA, MI, NJ, NM, NY, ND, OH, OR, SC, TN, VT, WA and WV) allow sharing with both.[98] For states that share with PDMPs in other states, a practitioner would have to request that his or her state PDMP request and gather the other state's information. For states that share with authorized users, an out-of-state practitioner could become a registered user of another state's PDMP and directly access the information.

While federal legislation has been introduced, there is currently no national standard for the exchange of such information across state lines. Congress has passed legislation that authorizes the HHS Secretary, in consultation with the Attorney General, to facilitate the development of recommendations on interoperability standards for interstate exchange of PDMP information by states receiving federal grants to support the PDMP.[99] The Bureau of Justice Assistance, the IJSI Institute and the Alliance of States with Prescription Monitoring Programs are working to establish a National Network of State PMPs that are interoperable through the Prescription Monitoring Information Exchange Hub (PMIX). A state can participate in the PMIX program if it has legislation allowing it to share information with other states in real time, identified at least one other state as a partner in the information exchange, and either established an memorandum of understanding (MOU) with the identified partner or ratified the Prescription Monitoring Interstate Compact. Another initiative that has been put in place to make interstate sharing of PDMP information more feasible is InterConnect, developed by the National Association of Boards of Pharmacy (NABP) with pharmaceutical industry support. This technology platform currently allows users in 16 participating states to securely exchange prescription data, and it is anticipated that by the end of this year, 30 states will be utilizing it.[100]

TFAH recommends that the federal government expeditiously follow through to set national standards and provide a framework to remove barriers to the sharing of information across state lines.

NATIONAL ASSOCIATION OF BOARDS OF PHARMACY PRESCRIPTION MONITORING PROGRAM (NABP PMP) INTERCONNECT

The NABP PMP InterConnect helps with the sharing of prescription drug abuse data across state lines. It allows participating state PDMPs to be linked, providing a more streamlined approach to limit prescription drug abuse nationwide.[101]

The NABP PMP InterConnect allows users of PDMPs in 16 states to securely exchange information. The states connecting include: Arizona, Colorado, Connecticut, Illinois, Indiana, Kansas, Kentucky, Louisiana, Michigan, New Mexico, North Dakota, Ohio, South Carolina, South Dakota, Tennessee and Virginia.[102] NABP continues to work with other state PDMPs to facilitate their participation in the NABP InterConnect, and it is expected that by the end of 2013 approximately 30 states will be sharing data using NABP PMP InterConnect.



Indiana pilot study, linking PDMPs to electronic health records: In one month, 58 percent of physicians indicated a reduction in prescriptions written or number of pills dispensed.

▲ Link PDMPs to Electronic Health Records

On June 3, 2011, the Obama Administration held a White House Roundtable on Health Information Technology and Prescription Drug Abuse which resulted in the Office of the National Coordinator for Health IT and SAMHSA asking the MITRE Corporation to identify ways to leverage health IT to expand and improve access to PDMPs. Since it is estimated that, as of 2010, more than 50 percent of providers in the United States adopted and use electronic health record (EHR) systems, health IT systems can be used to improve the workflow of accessing PDMP information.[103] Integrating data between electronic health records and PDMPs will foster the ability of states to improve the quality of prescription drug information available to healthcare providers and support real-time access to prescription drug information.[104]

Seven pilot studies were conducted in five states (IN, MI, ND, OH and WA) and they each found that once prescriber and dispenser communities were connected to the state's PDMP, immediate improvement to the patient care process was achieved. In a pilot study in Indiana, over a one-month time period, 58 percent of physicians indicated a reduction in prescriptions written or number of pills dispensed.[105]

The MITRE report made the following recommendations to increase use of PDMP data through electronic health records:[106]

- Require automatic or mandatory registration to access the PDMP data;
- Create a common application programming interface for PDMP system-level access to allow other systems to query and retrieve data;
- Integrate PDMP data in EHR and pharmacy systems to provide access to the data in clinical workflow;
- Define a standard set of data that should be available in PDMP reports;
- Adopt the National Information Exchange Model Prescription Monitoring Program specification as the standard for PDMP data exchange; and
- Implement an agreement framework and model business agreements with third-party intermediaries to facilitate PDMP data sharing.

In 2011, SAMHSA funded the Enhanced Access to PDMPs through Health IT project, which awarded grants to states to use health IT to increase timely access to PDMP data. In 2012, the agency funded the PDMP Electronic Health Record Integration and Interoperability Expansion Program to improve real-time access to PDMP data through the integration of PDMPs into existing technologies, including electronic health records.

TFAH recommends that states should work to integrate PDMPs with public and private electronic health records and e-Prescribing systems, and the federal government should provide the financial and technical support needed to support these systems and ensure that patient privacy is protected and access is properly restricted.

▲ Ensure PDMPs Operate Efficiently and Effectively

TFAH recommends that all states should pass laws to make sure that their PDMPs operate in the most efficient and effective manner, and that federal grants that help develop state's PDMPs should set minimal requirements for the PDMPs they will fund, including:

- **Requiring PDMPs to Utilize Real-Time Data Collection:** States vary in their time requirements for entering data. Currently, only New York and Oklahoma have a real-time requirement. The Prescription Drug Monitoring Program Center of Excellence at Brandeis University, the School of Medicine and Public Health at the University of Wisconsin-Madison, the National Alliance for Model State Drug Laws, the Alliance of States with Prescription Monitoring Programs, and the American Cancer Society recommend that states require the reporting of PDMP data within seven days of the date of dispensing the controlled substance, and the PDMP Center of Excellence, National Alliance of Model State Drug Laws and the AMA advocate that states move toward real-time data collection. Recognizing that there are technical and organizational barriers to real-time reporting, the PDMP Center of Excellence says prescription data should be available online as soon as possible after controlled substances have been dispensed and that, as the delay increases, the window of opportunity for prescription fraud widens.
- **Requiring Use of Unsolicited Reports:** According to the PDMP Center of Excellence at Brandeis University, experience indicates that when PDMPs proactively analyze their databases and send an unsolicited report to prescribers when they identify probable doctor shoppers, such reports result not only in reducing the subsequent prescriptions obtained by the doctor shoppers but also significantly increases the number of prescribers requesting data and leads to a general reduction in prescriptions to doctor shoppers.

▲ Encourage States to Utilize PDMPs to Improve Access to Substance Abuse Services

Identifying individuals who may have a substance abuse disorder or may be engaging in "doctor shopping" is only the first step in a comprehensive strategy — connecting individuals to effective treatment is also necessary.

Information collected by PDMPs may be used to identify prescription drug-addicted individuals and enable intervention and treatment.[107] The National Alliance for Model State Drug Laws recommends that "state officials, by statute, regulation, rule or policy, or in practice, should establish an appropriate linkage from the [Prescription Monitoring Program (PMP)] to addiction treatment professionals to help individuals identified through the PMP as potentially impaired or potentially addicted to a substance monitored by the PMP."[108]

TFAH recommends that states work to ensure that PDMPs include mechanisms for connecting individuals who may be abusing prescription drugs with substance abuse treatment and services. State should also work to ensure that when high-risk users are identified through "doctor shopping" laws or PDMPs policies should prioritize connecting those individuals with treatment – particularly for first offenders.

Information collected by PDMPs may be used to identify individuals with a prescription drug abuse addiction and help connect them with appropriate treatment and services.

B. ENSURING ACCESS TO SUBSTANCE ABUSE SERVICES

"Prescription medications are beneficial when used as prescribed to treat pain, anxiety, or ADHD, [h]owever, their abuse can have serious consequences, including addiction or even death from overdose. We are especially concerned about prescription drug abuse among teens, who are developmentally at an increased risk for addiction."

– Nora D. Volkow, M.D., National Institute on Drug Abuse Director [109]



An estimated 20.6 million Americans — 8 percent of the U.S. population ages 12 and older — were classified with substance dependence or abuse in 2011.[110]

Substance abuse disorder is defined as a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences. Researchers at NIDA and leading research organizations across the country have documented how drug use — including prescription drug abuse — changes the structure of the brain and how it works, which can be long lasting and lead to harmful behaviors.[111] In addition, according to SAMHSA, it is important to note that substance dependence rates are higher for adults who experience a mental illness or serious mental illness. Adults experiencing any mental illness were more than three times as likely to meet the criteria for substance abuse or dependence than adults who had not (20 percent compared to 6.1 percent).[112]

According to NIDA, addiction to any drug — prescribed or illicit — is a brain disease that can be effectively treated.[113]

Any strategies involving preventing and reducing prescription drug abuse must focus on providing treatment — otherwise they are inherently incomplete and ineffective. PDMPs, doctor shopping laws and a number of other strategies focus on identifying individuals who may be abusing prescription drugs, but these strategies must be combined with efforts to provide sufficient, quality affordable treatment to these individuals.

Types of treatment vary depending on the type of drug dependence:

- For addiction to prescription painkillers, the treatment typically involves counseling and building a stronger support network of friends, families and services for an individual, but also medications have been developed that can ease or eliminate withdrawal symptoms and relieve cravings.[114] Medication-Assisted Treatment combines use of medications under doctor supervision along with counseling, and according to SAMHSA is often the best choice for opioid addiction.[115] These medications include methadone, buprenorphine or naltrexone.
- For addiction to depressants and stimulants, the treatment typically involves counseling, building a support network and very carefully managed detoxification programs

because withdrawal symptoms can be severe and, particularly for withdrawal from depressants, even be fatal.[116, 117]

- Additional considerations are needed for individuals who may be dependent on multiple substances.

- There is increasing need for access to substance abuse treatment as there are growing accounts in many states and communities that the increase in prescription drug abuse may also be fueling a rise in heroin addiction. Since heroin is cheaper and often easier to buy, there are concerns that some prescription drug users are transitioning to heroin use.[118, 119] An analysis by the Center for Behavioral Health Statistics and Quality at SAMHSA pooled data from 2002 through 2011 from the National Survey on Drug Use and Health and found that among 12- to 49-year-olds recent (within the last 12 months) heroin use was 19 times higher among those who had previously used nonmedical painkillers compared to those who had not.[120] Almost 80 percent of new heroin users had previously used prescription painkillers, while only 1 percent of new nonmedical prescription painkiller users previously used heroin. Although the rates of prescription users starting heroin use are high, still only 3.6 percent of nonmedical prescription painkillers users initiated heroin use in the five years following first nonmedical prescription painkillers use.

Treatment is paid for through federal, state and local programs and services as well as through public and private health insurance. However, currently, only a fraction of individuals in need of treatment receive it.

Substance abuse treatment has been underfunded for decades, and the escalation of prescription drug abuse has created an additional urgency in the need to dramatically increase the availability and support for treatment.

- While there has been more than a five-fold increase in treatment admissions for prescription drug abuse in the past decade, millions more are still going untreated.[121]

- According to the National Center on Addiction and Substance Abuse (CASA) at Columbia University, only around one out of every 10 Americans who meet the diagnostic criteria for addition to alcohol or drugs (not including tobacco) receive treatment.[122]

- The country only spends approximately 1 percent of total health expenditures on substance abuse treatment — around $24 billion a year. Spending on substance abuse treatment grew slower than for all health spending from 1986 to 2009, at a rate of 4.4 percent annually on average, compared to 7.5 percent for all health spending.[123]

Almost 80 percent of new heroin users had previously used prescription painkillers.

- There is a severe shortage of professionals to provide substance abuse treatment services. According to SAMHSA's *Action Plan for Behavioral Workforce Development*, treatment services are often siloed from other aspects of the healthcare system, and there is relatively little training for other healthcare professionals in how to identify and learn the most effective ways to provide treatments.[124] Studies in 2003 and 1999 identified that there were only 67,000 counselors licensed or unlicensed to provide substance abuse treatment, and another 40,000 professionals licensed or credentialed to provide such care. In addition, there is a reported 50 percent turnover in directors and staff of frontline substance abuse agencies each year, and 70 percent of these frontline staff did not have access to basic information technology to support their work. The workforce shortages are particularly acute in rural areas — a reported 55 percent of rural counties in the United States do not have a single practicing psychiatrist, psychologist or social worker – and there is major underrepresentation of minority professionals.[125]

55 percent of rural counties in the United States do not have a single practicing psychiatrist, psychologist or social worker.

The "treatment gap" has been fueled by lack of funding, limits on insurance coverage, ongoing social stigma around substance abuse disorders and misperceptions about how effective treatment works. The 2012 *Addiction Medicine: Closing the Gap Between Science and Research* study by CASA Columbia outlines how research and science about how addiction works and what constitutes effective treatment has advanced, yet treatment practices and support have not kept pace.[126] Some major concerns raised included the limited training for health professionals on screening patients; the siloed nature of how treatment is provided; lack of modernization of many treatment programs to match current evidence-based best practices; limited standards and accountability for many treatment programs; limited numbers of providers trained and licensed to provide addiction treatment; and lack of understanding and support about the need for long-term disease management.

Given the rapid increase in prescription drug abuse in the past decade, major advances in brain and addiction research and changes sparked by health reform and parity legislation, TFAH recommends that strategies for substance abuse treatment be modernized. One large component of this will be to ensure a greatly expanded and sufficient level of funding for federal, state and local programs as well as expanding insurance coverage of substance abuse treatment services. Another major component must include expanding the workforce for substance abuse treatment, and improving training and standards for those directly providing treatment as well as other physicians and providers who provide general services across the spectrum of specialties to help identify when their patients may need help and how to best support them when they do.

SPENDING BY PAYER: LEVELS AND PERCENT DISTRIBUTION FOR SUBSTANCE ABUSE, 2009

Type of Payer	Millions ($)	Percent
Total	$24,339	100%
Private—Total	7,656	31%
Out-of-pocket	2,579	11%
Private insurance	3,852	16%
Other private	1,225	5%
Public—Total	16,682	69%
Medicare	1,197	5%
Medicaid	5,158	21%
Other Federal[a]	2,689	11%
Other State and local[a]	7,639	31%
All Federal[b]	7,292	30%
All State[c]	9,390	39%

Sources: SAMHSA Spending Estimates, 2013; Centers for Medicare & Medicaid Services, Office of the Actuary, National Health Expenditure Accounts

NOTES:

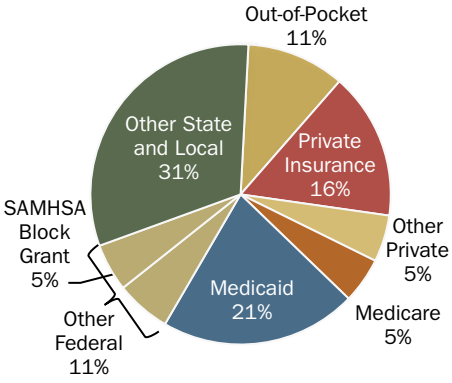
a. SAMHSA block grants to "State and local" agencies are part of the "other Federal" government spending. In 2009, block grants amounted to $1,251 million for substance abuse.

b. Includes Federal share of Medicaid.

c. Includes State and local share of Medicaid.

Other State and Local Payers Accounted for the Largest Share of Spending on Substance Abuse Treatment in 2009

Distribution of Spending on Substance Abuse Treatment by Payer, 2009

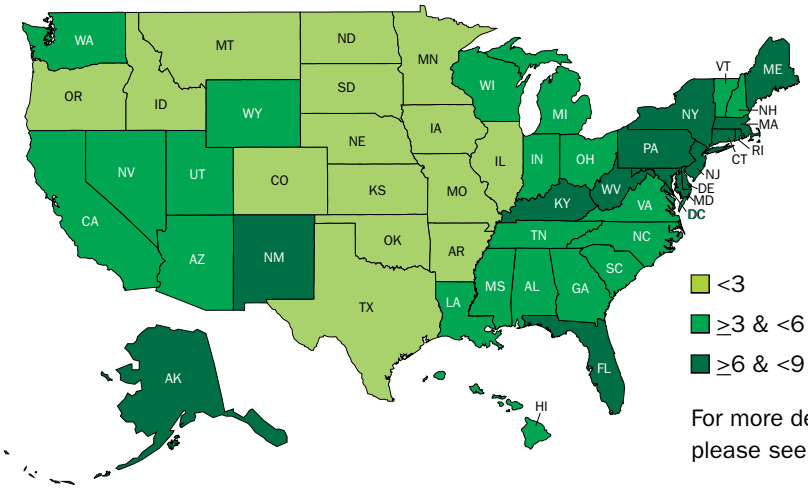


NUMBER OF PHYSICIANS AUTHORIZED TO TREAT PAINKILLER ADDICTION WITH BUPRENORPHINE BY STATE PER 100,000 PEOPLE

Physicians, other healthcare providers and treatment centers must receive special authorization under federal law to treat painkiller addiction with controlled substances, including methadone and buprenorphine so the number of providers and availability of medications for treatment is limited and often difficult for patients to access.

More than two-thirds of states have fewer than six medical professionals per every 100,000 people approved to treat patients with buprenorphine — Iowa has the fewest at 0.9 per 100,000 people and Washington, D.C. has the highest at 8.5 per 100,000 people.

Rate of Providers (per 100,000 people)



For more detail by state, please see Appendix A.

▲ Increasing Support for Federal, State and Local Programs and Services

Federal, state and local governments provide a number of programs that support treatment in communities around the country that are not a direct part of the insurance payment system.

State and local substance abuse treatment programs and services — not including the state share of Medicaid — are the largest source of support for substance abuse treatment spending, accounting for around 30 percent of total spending.[127] However, these programs are severely underfunded to meet the needs of the community.

At the federal level, the Substance Abuse Prevention and Treatment Block Grant from SAMHSA provides around 5 percent of the amount spent on substance abuse treatment annually. The block grants provide support to every state to:

- Fund priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time;
- Fund priority treatment and support services not covered by Medicaid, Medicare or private insurance for low-income individuals and that demonstrate success in improving outcomes and/or supporting recovery;
- Fund primary prevention — universal, selective and indicated prevention activities and services for persons not identified as needing treatment; and
- Collect performance and outcome data to determine the ongoing effectiveness of behavioral health promotion, treatment and recovery support services and plan the implementation of new services on a nationwide basis.[128]

In addition, NIDA engages in scientific and biomedical research to better understand and improve treatment of drug abuse and addiction.

FEDERAL APPROPRIATIONS AND REQUEST[129]
(Dollars in Millions)

	2009	2010	2011	2012	2013 Annualized CR	FY 2014 President's Budget
NIDA	$1,032.8	$1,066.9	$1,050.5	$1,051.4	$1,058.6	$1,071.6
SAMHSA Block Grant	$1,778.6	$,1,798.6	$1,800.2	$1,800.3	$1,811.3	$1,819.9

Source: Mental Health Liaison Group, http://www.mhlg.org/issue-statements/appropriations/.

TFAH recommends that there should be increased federal, state and local funding to support treatment programs and services, and that research should be increased to continue to inform and improve treatment approaches and better match the seriousness and scope of the problems. Spending should be used to support the strongest evidence-based and effective approaches to treatment, including for Medication-Assisted Treatment programs for prescription painkiller treatment.

▲ Expand Insurance Coverage of Substance Abuse Services

Private and public insurance support for substance abuse treatment varies dramatically. Coverage is often limited and does not match what is needed for effective treatment of prescription drug abuse. For instance, insurance plans often have a cap on how long or how many times a person can receive substance abuse disorder services, and one-third of Americans covered in the individual market have no coverage for substance abuse disorder services.[130]

The National Association of State Alcohol and Drug Abuse Directors (NASADAD) recommends that public and private health insurance plans should cover medications for the treatment of painkiller dependence.[131]

The Affordable Care Act attempts to expand the reach of coverage for substance abuse treatment in several ways, and will have a large impact on individuals who require treatment for prescription drug abuse, in terms of accessibility and affordability.

First, the federal health reform law creates a mandated benefit for coverage of substance abuse disorder services in three types of health plans: individual and small group market plans (both inside and outside of Health Insurance Marketplaces) and Medicaid non-managed care Alternative Benefit Programs.[132] It is estimated that this will benefit about 3.9 million people who are currently covered in the individual market and will gain mental health and/or substance use disorder coverage and 1.2 million individuals currently in small group plans who will receive substance use disorder benefits.[133]

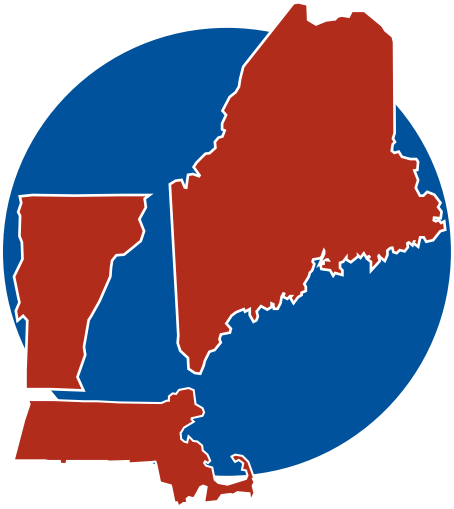
Second, the ACA applies federal parity protections to substance use disorder benefits in individual and small group markets. Currently, under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008, only group health plans and insurers that offer substance abuse disorder benefits are required to provide coverage that is comparable to general medical and surgical care.

Third, by ending discrimination against people with pre-existing conditions, insurers will no longer be allowed to deny coverage because of substance abuse disorders.

Fourth, by expanding coverage to uninsured Americans, substance use disorder services subject to parity requirements could be expanded to a projected 27 million additional Americans.

TFAH recommends that all states work to ensure that the coverage of the Essential Health Benefits packages in their respective Insurance Marketplaces, insurance plans outside the Marketplaces, and plans in traditional Medicaid programs offer benefits covering the full continuum of substance abuse disorder services. TFAH also recommends that all states should provide comprehensive coverage for all three FDA-approved medications for the treatment of painkiller addiction (methadone, buprenorphine/naloxone, and naltrexone (oral and injectable)).





EXPANDING SUBSTANCE ABUSE TREATMENT: MAINE, MASSACHUSETTS AND VERMONT[134]

A 2010 report by the National Association of State Alcohol and Drug Abuse Directors examined how health reform initiatives in three states have led to expanded substance abuse treatment services. The initiatives all included expansions of private and Medicaid coverage combined with state substance abuse agencies managing a statewide system of care for prevention, treatment and recovery, with support from state and local funding and the federal Substance Abuse Prevention and Treatment Block Grant.

The state substance abuse agencies plan and oversee a coordinated system of care composed of a variety of state and federal funding streams; ensure accountability and effectiveness through a range of mechanisms; assure quality by utilization standards of care, patient placement criteria, licensure and more. The three states reported using SAPT funds to support medically necessary services for those that remain uninsured or those that are not covered by other payers, particularly residential treatment; services not covered by public or private health insurers, including case management, recovery support services; and substance abuse prevention services.

Maine: The number of clients admitted to publicly funded substance abuse providers increased by 45 percent between 1999 and 2008. This increase was due to the expansion of substance abuse services covered under Medicaid (including medications), expansion of the population covered by MaineCare (Medicaid) and increased provider efficiencies through performance contracting and improved treatment admissions processes.

Massachusetts: Admissions to public substance abuse treatment rose nearly 20 percent in only two years between 2006 and 2008. Improvements in access, capacity and quality were achieved through MassHealth (Medicaid), expansions in covered populations (particularly "non categoricals," or adults with no dependent children); a process-improvement initiative; and efforts that address workforce development, as well as increased use of evidence-based practices.

Vermont: The state saw the number of persons treated in its public substance abuse treatment system double between 1998 and 2007. This was accomplished through strategic planning initiatives at the state and division levels; increased health insurance coverage for individuals through Green Mountain Care (Medicaid); expanded Medicaid coverage of treatment, including medication-assisted treatment (both methadone and buprenorphine); and a treatment admission process-improvement initiative funded with SAPT Block Grant monies.

Source: NASADAD, *Effects of State Health Reform on Substance Abuse Services in Maine, Massachusetts and Vermont.*

C. ENSURING RESPONSIBLE PRESCRIBING PRACTICES

▲ Provide Education for Healthcare Providers

In order to promote awareness of the growing problem with prescription drug misuse and abuse, healthcare providers must receive education and training on issues surrounding pain management and medications. Currently, the AMA[135] has called for positive incentives for increased education, and the federal government has laid out the goal of educating prescribers and dispensers on appropriate and safe use and proper storage and disposal of prescription drugs. ONDCP and NIDA have launched a free online training tool for providers on proper prescribing and patient management practices for patients taking prescription painkillers.[136]

TFAH recommends that all providers should receive education and continued training about appropriate prescribing of commonly abused medications. In addition, medical, nursing, dental and pharmacy schools and other healthcare training systems should improve their education on pain management issues, and state medical boards should be engaged on prescription drug issues. Education should be offered on a variety of prescription drug issues including the most current effective treatment practices for addiction and how to screen and manage mental health concerns as a form of prevention.

SCOTT COUNTY, INDIANA: CEASe

For the past three years, Scott County, Indiana has been ranked the least healthy county in the state, and also has the highest rate of prescription drug deaths in the surrounding six counties. In an effort to address poor health outcomes in Scott County, community members put together a 40 member group called the Coalition to Eliminate Abuse of Substances of Scott County (CEASe). CEASe includes law enforcement, healthcare, education, community leaders and others from the community to tackle prescription drug abuse in the county. The coalition has already changed local hospital and doctor prescribing practices with limited state and local funding. Prior to CEASe involvement, individuals visiting the emergency room could get pain medication prescriptions for 10 days; but now, narcotic prescriptions are only written for three days at a time, and practices are in place to ensure that doctors conduct blood level checks and review patients' prescription use histories.[137]



▲ Increase Regulation of Pill Mills

Rogue pain management clinics, known as "pill mills," are facilities that provide management services or employ a physician who is primarily engaged in the treatment of pain by prescribing or dispensing controlled substance medications. As of August 2013, 10 states have laws regulating pain clinics with the goal of targeting "pill mill" activities — AL, FL, GA, KY, LA, MS, OH, TN, TX and WV.

Each of the laws require pain clinics to meet certain registration or certification procedures, require clinic owners to be licensed or certified, establish training and reporting requirements, or place restrictions on the prescribing and dispensing of controlled substances in a pain clinic setting.

TFAH recommends that states should evaluate whether these facilities exist in their state and institute regulations to prevent these facilities from prescribing controlled substances indiscriminately or inappropriately. Regulations should include state oversight, registration, licensure and ownership requirements, and money from seized illicit operations should be used for drug treatment programs.

▲ Track Prescriber Patterns

The federal government and states have numerous tools at their disposal to track prescriber patterns with the goal of identifying and stopping doctor shoppers. For instance, states can use PDMP, Medicaid and workers' compensation data to identify doctor shoppers, and the federal government can do the same with Medicare data. While the data are often available, this type of tracking has not been a regular practice. A recent report by the Inspector General at HHS that reviewed more than 87,000 doctors who prescribe through the Medicare program identified 736 doctors as having prescribing practices that raised questions about whether their prescriptions were "legitimate or necessary." Within that study, in one case, 24 doctors signed more than 400 prescriptions for a single patient, while the average doctor issued 13 prescriptions per patient and, in another case, one doctor was flagged for having prescriptions he issued filled in 47 states and Guam. One of the report's recommendations was to send report cards generated by Medicare to doctors comparing their prescribing practices to their peers.[138]

Another law that is designed to promote the use of tamper-resistant prescription pads by prescribers. Such laws are intended to reduce forged and altered prescriptions and deter drug abuse. The Centers for Medicare and Medicaid Services (CMS) requires Medicaid programs to use tamper-resistant prescription pads in order to get reimbursed for outpatient prescription drugs. In order for a written prescription to be considered tamper resistant by CMS, the prescription paper must 1) prevent unauthorized copying of completed or blank prescription forms; 2) prevent erasure or modification of information written on the prescription form; and 3) prevent the use of counterfeit prescription forms. State laws vary in how extensive the requirement is and who it applies to, as well as what features the special pads are required to have. It should be noted that as more states and medical professionals increase their use of electronic medical records and electronically-generated prescriptions (e-prescribing), this requirement will be less critical for states to have in their toolkit of policy solutions.

E-prescribing holds the potential to curb inappropriate prescribing by physicians and other providers, and provide the means to electronically track controlled substance prescriptions in real time. Historically, there have been limits on e-prescribing for controlled substances, but it has been identified as a way to not only limit prescription tampering but also to help provide more real-time data for prescription monitoring and communication between doctors and pharmacies. The New York Legislature recently passed a new law, I-STOP (Internet System for Tracking Over-Prescribing) that establishes a real-time reporting system to help track patterns of abuse by patients, doctors and pharmacists.

TFAH recommends that strong oversight be provided to ensure healthcare providers are prescribing responsibly and are held accountable for their practices.

▲ Make Rescue Medicines More Widely Available

States are changing their laws to allow more people access to, and the ability to use, rescue medicines, like naloxone, to prevent a drug overdose. FDA is working to provide regulatory prioritization assistance to manufacturers who are working to develop easier ways to administer naloxone, such as auto-injectors or intranasal administration. In 2012, during the last Congressional session, bi-partisan legislation called the Stop Overdose Stat (S.O.S.) Act was introduced by Congresswomen Mary Bono Mack (R-CA) and Donna Edwards (D-MD), and co-sponsored by 31 others, to expand take-home naloxone prevention community programs through federal grants and cooperative agreements.

TFAH recommends that access to naloxone should be encouraged and expanded since it has the potential to dramatically reduce deaths from overdose. Prescribers should be encouraged to prescribe naloxone to at-risk individuals, states should support prescribing and liability protection for those using naloxone and FDA should continue the process toward making naloxone available over-the-counter.

NORTH CAROLINA: PROJECT LAZARUS

Project Lazarus is a secular public health non-profit organization that expanded to operate statewide, after being established in 2008 in response to extremely high drug overdose death rates in Wilkes County, North Carolina. The Project Lazarus public health model is based on the premise that drug overdose deaths are preventable and that all communities are ultimately responsible for their own health. The model components are: (1) community activation and coalition building, (2) monitoring and epidemiologic surveillance, (3) prevention of overdoses through medical education and other means, (4) use of rescue medication to reverse overdoses by community members, and (5) evaluation of project components. The last four steps operate in a cyclical manner, with community advisory boards playing the central role in developing and designing each aspect of the intervention. Project Lazarus enables overdose prevention by providing technical assistance to create and maintain community coalitions, helping them create locally tailored drug overdose prevention programs, and connecting them to state and national resources. The initiative works closely with North Carolina's non-profit Medicaid management entity — Community Care of North Carolina's (CCNC) — Chronic Pain Initiative and utilizes a broad partnership that includes the North Carolina Hospital Association, local hospitals and emergency departments, local health departments, primary care doctors, faith-based programs and law enforcement.[139] The program includes coalition-building, data collection and monitoring, education of medical care providers on safe prescribing, school-based drug education, and the distribution of naloxone to help prevent overdose fatalities.[140]

One of its initiatives is a community-based overdose prevention program in Wilkes County and western North Carolina that focuses on increasing access to naloxone for prescription opioid users. Naloxone distribution is done through several ways: encouraging physicians to prescribe the antidote to patients at highest risk of an overdose and allowing those entering drug treatment and anyone voluntarily requesting naloxone to receive naloxone for free — paid for by Project Lazarus, through grants from industry.[141] Another area of success has been its use of prescription history information collected by North Carolina's prescription drug monitoring program to motivate, guide and track its prevention efforts.[142]

The program has had dramatic success. In 2011, not a single Wilkes County resident died from a prescription opioid from a prescriber within the county, compared to 2008 when 82 percent of the unintentional overdose deaths in Wilkes County obtained their opioid prescriptions from doctors practicing there. In addition, between 2009 and 2010, hospital emergency department visits for overdose and substance abuse in the county were down 15 percent.[143] As of 2010, 70 percent of the county's prescribers were registered with the state's prescription drug monitoring program, compared to a statewide average of only 26 percent. Data from Wilkes County suggest that the Project Lazarus had an impact within two years of its initiation, and that strong effects were apparent by the third year.[144]

▲ Ensure Access to Safe and Effective Drugs

Recognizing its role in the development, review and approval of drugs, FDA is working towards a targeted, science-based, multi-pronged approach at critical points in the development of an opioid product and in its use throughout the healthcare system.

Their five-pronged approach includes: 1) encouraging scientific work into the development of safe and effective treatments for pain and into the most appropriate uses of pain medicines; 2) encouraging the development of abuse-deterrent drug formulations for opioids; 3) working to improve the appropriate use of opioids to treat pain through prescriber and patient education; 4) evaluating opioid labeling, and 5) improving the availability of products that treat abuse and overdose.[145] In Congress, bi-partisan legislation was introduced by Congressmen Harold Rogers (R-KY) and William Keating (D-MA) in March 2013 to require FDA to refuse to approve any new pharmaceuticals that did not use formulas resistant to tampering.[146]

TFAH recommends that tamper-resistant formulas be required to limit opportunities to make prescription drugs unsafe.

▲ Make Sure Patients Receive the Pain Medications They Need

As solutions are developed to combat prescription drug abuse, there must be a balance with any policy implementation to make sure that patients have the prescription drugs they need and that the pendulum does not swing too far the other way and make healthcare providers overly cautious of prescribing necessary pain medications for patients in need.

A number of groups are stressing policies and practices that help ensure providers and patients understand the importance of proper use of medications, such as stressing "medical adherence" so providers give clear information to patients on how to properly use medications as prescribed and patients clearly understand and have tools they need to help ensure they take their medications as prescribed; making sure that patients contact their doctor if they feel there needs to be a change in their medications; and instructing patients properly dispose of any unused medications.

- The Center for Lawful Access and Abuse Deterrence (CLAAD) and its partners issued a National Prescription Drug Abuse Prevention Strategy focused on five issue areas: 1) data collection and analysis; 2) new technologies; 3) mandatory prescriber education in the safe prescribing of controlled substances; 4) safe storage and responsible disposal; and 5) improved PDMPs.[147]
- A coalition of healthcare, consumer, patient, and industry organizations — Prescriptions for a Healthy America: A Partnership for Advancing Medication Adherence — is working towards the goal of bringing greater awareness to the value of medication adherence by supporting public policy solutions including: incentives for care coordination and comprehensive medication management; improved quality measurement and healthcare provider and plan performance improvement; better use of health information technology; robust patient/provider education and engagement; and additional research into which interventions work and which do not.

TFAH recommends ensuring that any policies targeting prescription drug misuse and abuse do not impose overly burdensome obstacles for needed pain management prescriptions.

D. EXPANDING PUBLIC EDUCATION & BUILDING COMMUNITY PARTNERSHIPS

▲ Increase Public Education Efforts

Often prescription drugs are misused because of lack of knowledge or awareness by users and their family members. Research has shown that preventive interventions can have an impact on prescription drug abuse. For example, research funded by the National Institutes of Health found that middle school students from small towns and rural communities who received any of three community-based prevention programs were less likely to abuse prescription medications in late adolescence and young adulthood.[148]

The Administration's 2011 Prescription Drug Abuse Prevention Plan focused on strategies to educate parents, youth and patients through 1) supporting and promoting evidence-based public education campaigns on the appropriate use, secure storage and disposal of prescription drugs; 2) requiring manufacturers, through the Opioid Risk Evaluation and Mitigation Strategy, to develop effective educational materials for patients on appropriate use and disposal of opioid painkillers; and 3) working with private-sector groups to develop an evidence based media campaign targeted to parents.[149] In the 2012 survey of state substance abuse agencies by NASADAD, 83 percent of respondents — 39 states — indicated that some efforts have taken place in their states to provide public education on prescription drug misuse and abuse. Education efforts include printed materials, radio and television ads, internet campaigns, and community forums and town hall meetings.[150]



"It's no coincidence that our strategy to address our nation's prescription drug abuse epidemic begins with education. All of us — parents, patients, and prescribers — have a shared responsibility to learn more about this challenge and act to save lives. Prescribers in particular play a critical role in this national effort and I strongly encourage them to take advantage of this training to ensure the safe and appropriate use of painkillers."

– R. Gil Kerlikowske, Director of the Office of National Drug Control Policy[151]

There are numerous efforts in place to make sure evidenced-based and effective public education is occurring. For example:

- **The Medicine Abuse Project** was launched in 2012 by The Partnership at Drugfree.org and a diverse group of committed partners. The Medicine Abuse Project aims to curb the abuse of medicine, the most significant drug problem in the United States today. The campaign encourages parents, stakeholders and the public to take action: first, by talking with their kids about the dangers of abusing prescription and over-the-counter medicines, and second, by safeguarding and properly disposing of unused medications. Together with 18 sponsors, seven federal partners and more than 70 strategic partners, The Partnership at Drugfree.org has made a five-year commitment to this effort, with the goal of preventing half a million teens from abusing prescription drugs by the year 2017, while advancing intervention and treatment resources to help those who have already begun to abuse these products. The Medicine Abuse Project enlists key constituents, including parents, healthcare professionals, educators and community leaders, enabling them to play a role in ending the epidemic of medicine abuse. The campaign's website, drugfree.org/MedicineAbuseProject, houses a suite of comprehensive, science-based resources tailored to each of these groups to help them learn about and address the problem. Website visitors are encouraged to take a pledge to end medicine abuse by learning about teen medicine abuse, safeguarding medicines at home and talking to teens about the issue.
- **Rx for Understanding** is a set of standards-based teaching resources for teachers of middle school and high school students available free of charge from the National Education Association Health Information Network.[152]
- **PEERx** is NIDA's program to discourage abuse of prescription drugs among teens. PEERx provides science-based information about prescription drug abuse prevention. Components of the on-line educational initiative include Choose Your Path videos, which allow teens to assume the role of the main character and make decisions about whether to abuse certain prescription drugs, an Activity Guide for planning events in schools and communities, a partner toolkit, fact sheets about prescription drugs, and other helpful resources.[153]

TFAH recommends that evidence-based public education campaigns be conducted by government and non-governmental actors to increase awareness of the risks associated with misusing prescription drugs — and that resources and support for these programs must be increased.

"These data make it very clear: the problem is real, the threat immediate and the situation is not poised to get better. Parents fear drugs like cocaine or heroin and want to protect their kids. But the truth is that when misused and abused, medicines — especially stimulants and opioids — can be every bit as dangerous and harmful as those illicit street drugs. Medicine abuse is one of the most significant and preventable adolescent health problems facing our families today. What's worse is that kids who begin using at an early age are more likely to struggle with substance use disorders when compared to those who might start using after the teenage years. As parents and caring adults, we need to take definitive action to address the risks that intentional medicine abuse poses to the lives and the long-term health of our teens."

– Steve Pasierb, MEd, President and CEO of The Partnership at Drugfree.org.[154]

UTAH: "USE ONLY AS DIRECTED" — http://www.useonlyasdirected.org

Utah's Use Only as Directed media and education campaign is designed to prevent and reduce the misuse and abuse of prescription drugs through safe use, safe storage and safe disposal. The initial campaign, funded by the state legislature, ran from 2008 to 2009 and targeted middle-aged adults through TV and radio ads. From 2011 to 2013, the campaign expanded under the leadership of the Utah Pharmaceutical Drug Crime Project — a multidisciplinary collaborative effort involving local, state and federal agencies — and was funded by federal grant dollars. The campaign includes a media campaign, community take-back events and education of healthcare professionals.[155]

"Somewhere around 2000, the medical examiners noticed a trend. Previously, there were about 30-40 deaths per year in prescription opioid use. That jumped to somewhere around 250."

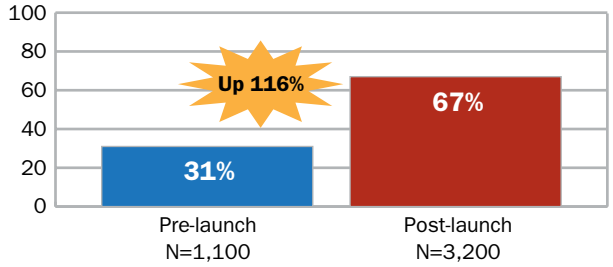
– Robert T. Rolfs, M.D., Deputy Director, Utah Department of Health[156]

PROMISING RESULTS: ONDCP NATIONAL YOUTH ANTI-DRUG MEDIA CAMPAIGN 2008

In the first half of 2008, ONDCP launched a media campaign to help educate youth and their parents about the risks of prescription drug misuse. The campaign budget was $28 million ($14 million plus a media match) and included TV advertising supplemented by print advertising, public relations activities, flyers stapled to prescription drugs at many chain store pharmacies and outreach to healthcare professionals, educators and community organizations. The campaign helped significantly increase awareness about the problem and the serious treat that it poses.

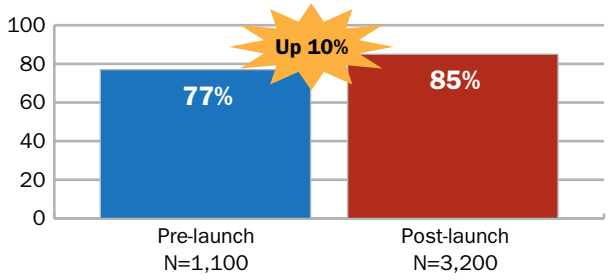
Parents' Awareness of Advertising – Teen Rx Abuse

Awareness levels from the pre- to post-launch periods more than doubled from the launch of the campaign



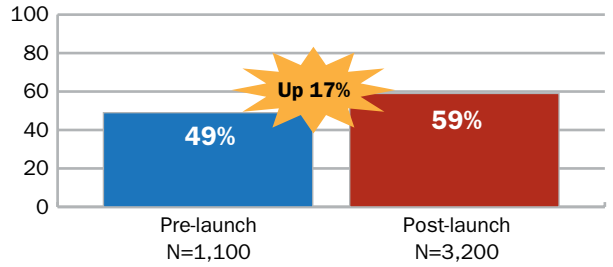
Parents' Perceptions – Prevalence of Teen Rx Abuse

Among those parents who are aware of advertising, perceptions of the prevalence of teen RX abuse increased significantly from the pre- to post-launch periods



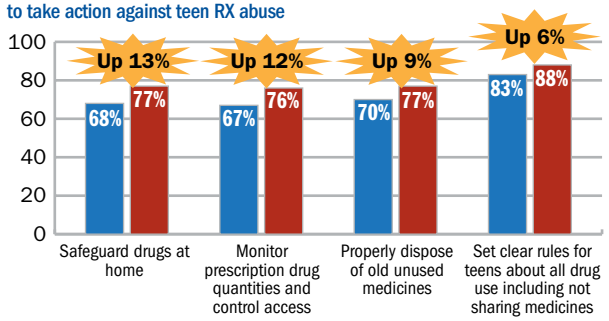
Parents' Beliefs – Rx Abuse is a Serious Problem Among Teens

There has been a significant jump among parents who viewed the campaign who now believe that prescription drug abuse is a serious problem among teens



Parents' Likelihood to Take Action

Among parents who saw the ads, a significant increase was also seen in intention to take action against teen RX abuse





▲ Build Community Partnerships

Community partnerships are a necessary component of any strategy to reduce prescription drug abuse and misuse. Recognizing that local drug problems require local solutions, the federal grant program Drug Free Communities Support Program (DFC) provides funding to community-based coalitions that organize to prevent youth substance use. The program is a match, meaning that all grantees must secure dollar-for-dollar non-federal funds, which demonstrates the community buy-in and participation necessary to be successful.[157]

Another support for community programs is the Community Anti-Drug Coalitions of America (CADCA), a national membership organization that works to strengthen the capacity of community coalitions to create and maintain drug-free communities. CADCA has engaged in on-going educational and communications efforts around prescription drug abuse including putting out publications to provide community anti-drug coalitions with the research and tools they need to implement effective prevention strategies and training community anti-drug coalitions in effective community problem-solving strategies using local data.[158]

KENTUCKY: OPERATION "UNITE"

The Unlawful Narcotics Investigations, Treatment and Education (UNITE) is a three-pronged, comprehensive approach created in 2003 by Congressman Hal Rogers (R-KY) to combat substance abuse in Kentucky. UNITE's goal is to educate and activate individuals by developing and empowering community coalitions to no longer accept or tolerate the drug culture. Tactics include undercover narcotics investigations, coordinating treatment for substance abusers, providing support to families and friends of substance abusers, and educating the public about the danger of using drugs. The organization funds the National Rx Drug Abuse Summit that brings together experts and leaders on prescription drug abuse issue areas. Operation UNITE's funding has come from federal grants, including a Community Transformation Grant (CTG), state dollars, and private sector donations.[159]

▲ Expand Programs to Enable Proper Disposal of Prescription Drugs

Since the majority of people who abuse or misuse prescription drugs get them from friends and family, there must be policies in place to promote safe and effective drug disposal methods. Since 2010, DEA has partnered with thousands of local law enforcement agencies and drug-free communities' coalitions to hold six national take-back days — safely disposing of more than 2.8 million pounds of unused medication.[160] Programs must factor in environmental safety and cost concerns for different methods of disposal.

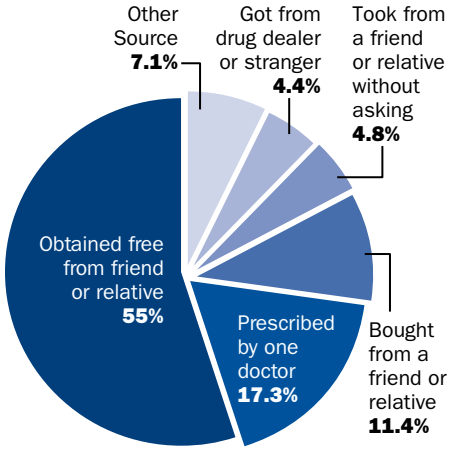
A number of states and communities have been creating additional sustainable take back models, such as drug drop boxes or mail-in programs.

- The 2011 Prescription Drug Abuse Prevention Plan included recommending that DEA and other federal agencies 1) conduct take-back events and distribute information to local anti-drug coalitions, pharmacies, environmental agencies, boards of medicine, and other organizations; 2) develop and execute a public education initiative on safe and effective drug return and disposal; and 3) engage PhRMA and the private sector to support community-based medication disposal programs. DEA has proposed a regulation that would expand take-back programs by allowing, for the first time, groups outside of law enforcement to collect unused drugs for disposal.[161] The final rule is expected by the end of 2013.
- Other community and industry associations are working to ensure the safe disposal of medications. Initiatives include:
  - The SMARxT Disposal Program: A partnership between PhRMA, the Department of Fish and Wildlife and the American Pharmacists Association designed to inform people how to promptly and safely dispose of medications.
  - Safeguard My Meds: A national educational program from the National Community Pharmacists Association, Purdue Pharma L.P., and the U.S. Conference of Mayors created to increase awareness about the importance of safe storage and disposal of prescription medicine.



TFAH recommends that take-back programs be continuously conducted through public-private partnerships. Federal and DEA support for take-back programs will cease once the new regulation rules are issued in 2013 which remove the requirement that law enforcement has to be present at these events, so state and local governments and local entities will be able to conduct their own take back days. Since there will no longer be federally-supported take back days, starting in 2014, it is imperative that states and local communities work with the medical, pharmaceutical, pharmacy and other industries and institutions to ensure these programs are continued and are supported, and any take-back programs should include innovative, sustainable approaches such as drug drop boxes and mail-in programs.

People who abuse prescription painkillers get drugs from a variety of sources



Prescription Drug Abuse
Appendix A

NUMBER OF PHYSICIANS AUTHORIZED TO TREAT PAINKILLER ADDICTION WITH BUPRENORPHINE BY STATE PER 100,000 PEOPLE		
	Number of Providers	**Rate of Providers (per 100,000)**
Alabama	242	5.0
Alaska	45	6.2
Arizona	220	3.4
Arkansas	49	1.7
California	1,485	3.9
Colorado	142	2.7
Connecticut	273	7.6
Delaware	56	6.1
D.C.	54	8.5
Florida	1,178	6.1
Georgia	416	4.2
Hawaii	59	4.2
Idaho	34	2.1
Illinois	338	2.6
Indiana	222	3.4
Iowa	29	0.9
Kansas	64	2.2
Kentucky	283	6.5
Louisiana	213	4.6
Maine	101	7.6
Maryland	463	7.9
Massachusetts	555	8.4
Michigan	479	4.8
Minnesota	87	1.6
Mississippi	119	4.0
Missouri	130	2.2
Montana	21	2.1
Nebraska	27	1.5
Nevada	98	3.6
New Hampshire	45	3.4
New Jersey	625	7.1
New Mexico	176	8.4
New York	1,649	8.4
North Carolina	316	3.2
North Dakota	12	1.7
Ohio	530	4.6
Oklahoma	94	2.5
Oregon	115	2.9
Pennsylvania	784	6.1
Rhode Island	84	8.0
South Carolina	156	3.3
South Dakota	9	1.1
Tennessee	339	5.3
Texas	680	2.6
Utah	147	5.1
Vermont	33	5.3
Virginia	252	3.1
Washington	249	3.6
West Virginia	135	7.3
Wisconsin	173	3.0
Wyoming	21	3.6

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