August 25, 2016

The Arizona Public Health Association (AzPHA) supports the adoption of the following APHA Policy Statement 20154 - Prevention and Intervention Strategies to Decrease Misuse of Prescription Pain Medication and its action step recommendations.

Policy Statement: 20154

Abstract
The United States is undergoing an epidemic of deaths caused by prescription drug overdoses. Every 19 minutes, someone in the United States dies from an unintentional prescription drug overdose. One major contributing factor to the rise in such deaths is the increased use of opioid analgesics. This policy statement recommends legislative and educational strategies to combat misuse of prescription pain medications. Legislation needs to address physical and mental status examination laws, doctor shopping laws, tamper-resistant prescription form requirements, regulation of pain management clinics, prescription drug monitoring laws, prescription drug overdose emergency response immunity, and access to naloxone. Education must be required for health care prescribers and for the general public. Community education efforts could focus on safe storage, use, and disposal of prescription medications. Pain medication prescription prescribers must be educated on identification and treatment of pain, alternative modalities, substance abuse screening, and mental illness assessments and treatment for vulnerable populations.

Relationship to Existing APHA Policy Statements
This policy has been identified as a policy statement gap for 2015 (a related policy is 20133, Reducing Opioid Overdose through Education and Naloxone Distribution). Existing policies focus predominantly on naloxone distribution programs. A more comprehensive policy statement with additional actions that should be taken at the local, state, and national levels was requested. These additional actions are included in this policy.

Problem Statement
According to a report released in 2013 by the Trust for America's Health, "prescription drug abuse has quickly become a top public health concern, as the number of drug overdose deaths—a majority of which are from prescription drugs—[has] doubled in 29 states since 1999. The rates [have] quadrupled in four of these states and tripled in 10 more of these states."[1] Enough prescription painkillers were prescribed in 2010 to medicate every American adult around the clock for 1 month. Although most of these pills were prescribed for a medical purpose, many ended up in the hands of people who abused them.[2]
According to the Centers for Disease Control and Prevention (CDC), prescription drug abuse was the fastest growing drug problem in the United States as of 2012.[3] Many people who use heroin in the United States today used prescription opioids first.[4] Although the number of drug deaths related to prescription opioids has stabilized,

mortality rates associated with heroin have increased over the last 3 years.[4] One major contributing factor to this growing drug problem in the United States is the increased use and prescribing of opioid analgesics, which, over the past decade, have caused more overdose deaths than heroin and cocaine combined.[3] One CDC report noted that, for every overdose death, there are 10 treatment admissions for abuse, 32 emergency department visits for misuse or abuse, 130 people who abuse or are dependent, and 825 people who take prescription painkillers for nonmedical use.[2] In that report, nonmedical use was defined as “use of a prescription pain reliever without a prescription belonging to the respondent or use for the experience or feeling the drug causes.”[2]

Not only are the morbidity and mortality rates associated with prescription drugs a top public health concern, but the costs imposed on the US economy are also substantial. A 2011 study estimated that, in 2006, nonmedical use of prescription painkillers imposed a cost of $53.4 billion on the US 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.[2]

As a result of the growing drug problem in the United States and the associated costs incurred by the US economy, the White House Office of National Drug Control Policy, the CDC, the Substance Abuse and Mental Health Services Administration (SAMHSA), and state and local public health agencies have made reducing prescription drug abuse a top priority to address associated rates of morbidity and mortality.[1] In addition, in 2014, the Association for State and Territorial Health Officials implemented the 15 by 15 challenge, intended to reduce prescription drug misuse and deaths by 15% by 2015.[5]

The Prescription Drug Monitoring Program (PDMP) Center of Excellence describes the prescription drug abuse epidemic as a factor of increased prescribing of prescription drugs: “The rise in the misuse and abuse of prescription drugs, opiates in particular, has been attributed to their increased availability over the last decade, a result of increased prescribing. Increased prescribing in turn has been driven by more aggressive treatment of pain in response to patient advocacy groups, the development of new formulations of opiate analgesics to meet this demand, and increased marketing of opiates by pharmaceutical companies. Hydrocodone-acetaminophen, sold under the brand name Vicodin™, is among the most widely prescribed medications in the US in any drug category. Synthetic opioids such as OxyContin™, oxycodone and methadone are more frequently prescribed to treat non-cancer pain than in prior decades. Because of their psychoactive and addictive properties, these drugs, along with tranquilizers (e.g., benzodiazepines such as Xanax, Klonopin, and Valium) and stimulants (Ritalin, Adderall) have high street value. They are diverted for illicit use by means of sharing among friends and family, doctor shopping, prescription fraud, and theft.”[6]

Opioid painkillers are only one group of prescription drugs that have potential for misuse or abuse. The National Institute on Drug Abuse (NIDA) has grouped the most commonly used addictive drugs into 13 different categories, one of which is prescription and over-

the-counter medications.[7] Although the prescription drug abuse epidemic may be commonly discussed in terms of opioid analgesics, there are several other groups of prescription and over-the-counter medications that may be subject to misuse and abuse. For example, stimulants such as amphetamines and methylphenidates are commonly prescribed to treat attention-deficit hyperactivity disorder and have the potential for abuse. In addition, depressants may be used to treat anxiety- or sleep-related disorders and contribute to the prescription drug abuse problem in the United States. Prescription-strength cold medicines may contain ingredients such as promethazine or codeine, both of which can illicit euphoric or sedative effects. Furthermore, common over-the-counter drugs that contain ingredients such as dextromethorphan and pseudoephedrine may be subject to misuse and abuse.[7] Thus, it is important for initiatives aimed at curbing the prescription drug abuse epidemic to address the abuse and misuse of all groups of prescription and over-the-counter medications that have the potential for abuse.

Policy efforts aimed at reducing the impact of morbidity and mortality related to prescription drug abuse commonly focus on the supply side of the “drug abuse supply-and-demand equation.”[8] However, there is some literature that questions the effectiveness of heavy supply-side-focused initiatives.[9] The concern is that these initiatives may limit access to medications for patients who have legitimate chronic pain. Some policy initiatives, however, may have the potential to reduce the supply of prescription drugs and thus reduce the potential for drug diversion that leads to misuse and abuse. According to Twillman et al., policy initiatives that focus on the supply of prescription drugs should consider (1) abuse-deterrent opioid formulations, (2) increased medication storage security at home, (3) drug take-back opportunities, (4) improved clinician education, and (5) improved effectiveness of prescription drug monitoring programs.[8] These five solutions strive to reduce access to prescription drugs that may be used for reasons other than their originally intended purpose. For example, improved clinician education aims to teach clinicians “to prescribe only the number of doses they expect patients to need in acute pain settings and the importance of avoiding excess prescribing.”[9] Similarly, PDMP electronic databases provide supplemental information on controlled substance prescriptions and allow for detection of and intervention among individuals attempting to fraudulently obtain such prescriptions. Although supply-side initiatives are a major focus in prescription drug abuse efforts, the demand side of the equation is equally important.

Policymakers and public health officials must also aim to reduce the demand for prescription drugs to prevent individuals from developing the disease of addiction. Primary drug abuse prevention efforts that aim to educate patients and their families form the foundation for reducing prescription drug demand. Research efforts must focus on understanding how to improve the effectiveness of primary drug abuse prevention programs.[9] Furthermore, these programs must become more prominent throughout the country to prevent the development of addiction. Although the goal is to completely prevent abuse of prescription drugs, treatment services must be available to those who

have abused or are currently abusing these drugs. Therefore, demand reduction strategies must ensure that there is an adequate supply of substance abuse treatment programs and mental health professionals to provide these services.

Prescription drug misuse and abuse disproportionately affect men as compared with women. According to SAMHSA, the rate of nonmedical use of prescription psychotherapeutic drugs is 2.6% among men and 2.3% among women.[10,11] SAMHSA also identifies young adults, veterans, and military service members, as well as older adults, as being disproportionately affected by prescription drug misuse and abuse.[11] In fact, many young people believe prescription drugs to be safer than illegal drugs. In 2014, youths 12 to 17 years of age and young adults 18 to 25 years of age were more likely to have misused prescription drugs in the past year than adults 26 years or older.[11]

On the other end of the spectrum, NIDA notes that prescription drug misuse and abuse are increasing among people in their 50s.[11] This population is at higher risk for medication misuse than the general population, largely as a result of increased rates of pain, sleep disorders/insomnia, and anxiety.[11] In addition, elderly individuals are typically more sensitive to medications because of their slower metabolism.[11] Furthermore, the elderly population may be more likely to take multiple medications concurrently for the treatment or management of several comorbidities, a practice referred to as polypharmacy. According to a systematic literature review conducted in 2005, polypharmacy is correlated with adverse health outcomes among elderly individuals.[12] These adverse outcomes are likely due to the increased risk of drug interactions between multiple medications and the complexity of the treatment and management of multiple comorbidities. Therefore, improved health outcomes in this population may depend on successful care coordination and reductions in cases of polypharmacy.

Intervention strategies that aim to curb the prescription drug abuse epidemic must (1) improve legislation and enforcement of existing laws, (2) improve medical practice with respect to prescribing opioids, (3) educate prescribers regarding the underappreciated risks and benefits of high-dose opioid therapy, and (4) include secondary and tertiary prevention measures to improve access to substance abuse services and overdose harm reduction programs.[3] In addition, policy initiatives must not focus solely on the supply side of the prescription drug abuse equation, which could reduce access to treatment among patients who have a legitimate need for medications to control chronic pain. As such, policy initiatives focused on demand must also be considered, with particular attention to populations disproportionately affected by prescription drug misuse and abuse.

Evidence-Based Strategies to Address the Problem

The prescription drug abuse injury policy report published by the Trust for America's Health in 2013 described several strategic interventions considered to be the most promising to fight prescription drug abuse.[1] Unfortunately, many of these intervention

strategies are relatively new, and therefore strong research and evidence are limited.[1] However, the Trust for America's Health convened a group of medical, law enforcement, and public health experts to identify the most promising policies and approaches to reducing prescription drug abuse on the basis of available research and data.[1] As a result, these strategies may be considered as informed by evidence. The strategies can be broken into two categories. The first category includes strategies aimed at prevention of drug misuse and abuse, such as implementation and mandatory use of PDMP initiatives, adoption of doctor shopping laws and medical provider education laws, and implementation of physical exam requirements. The second category of interventions aims to increase access to and support for substance abuse services. These strategies include adoption of good Samaritan laws, laws that support access to rescue drugs, and other overdose harm reduction programs. This category also recommends that resources be allocated for development and continued support of substance abuse services. Specifically, SAMHSA has reported a growing workforce crisis in the addictions field due to high turnover rates, worker shortages, an inadequately qualified and aging workforce, and stigma.[13]

In combination with counseling, medication-assisted treatment for opioid addiction in opioid treatment programs can reduce prescription overdose deaths. Best practice guidelines, available through SAMHSA, include individually designed programs with detoxification and medically supervised withdrawal and maintenance medications. Also recommended are psychosocial counseling and treatment for any co-occurring disorders, vocational and rehabilitation services, and case management services.[14] Other recommendations are listed below.

- Legislation requiring a practitioner to examine or evaluate the physical and mental status of a patient before prescribing or dispensing controlled substances. "Practitioner" broadly refers to physicians, dentists, pharmacists, physician assistants, nurse practitioners, or any other individuals permitted to prescribe, dispense, and distribute a controlled substance.[15]
- Legislation addressing doctor shopping to prevent patients from obtaining controlled substances from multiple providers. Although all states follow the Narcotic Drug Act of 1932 or the Uniform Controlled Substances Act of 1970, according to which no person "shall obtain or attempt to obtain a narcotic drug, or procure or attempt to procure the administration of a narcotic drug…by fraud, deceit, misrepresentation, or subterfuge," only 20 states have additional regulations to specifically prevent doctor shopping.[16] PDMPs are useful in allowing access to information across state lines, and prescribers should be required to check this information before the initial prescription is given and at least every 3 months thereafter.[17] Also, if patients are receiving multiple prescriptions, providers need to be knowledgeable regarding how to refer them for treatment.

- Legislation regulating “pill mills,” pain management clinics where large numbers of prescriptions are provided. Actions can include requiring clinics to register with the state or obtain a license or certificate. Also, owners can be required to be licensed prescribers and in good standing in the state, and unannounced inspections can be conducted as a means of verifying documentation and responding to complaints. Florida has experienced a decrease in overdose-related mortality as a result of its actions in this area.[18]
- Education for prescribers on appropriate diagnosis and treatment of chronic pain. One study of physicians revealed a knowledge gap related to abuse-deterrent formulations and the amount of recreational abuse stemming from diversions of legitimate prescriptions.[19]
- Education for providers on alternative modalities such as physical therapy, acupuncture, and nonnarcotic therapy. Providers who prescribe extended-release/long-acting opioid analgesics to treat chronic pain need to consider other drugs that can interact and cause respiratory depression.[20] A systematic review of randomized controlled trials of complementary and alternative medicines for cancer pain indicated some success with hypnosis, imagery, acupuncture, and healing touch.[21]
- Use of naloxone by first responders as well as family and friends of individuals addicted to opioids or other narcotics. Family and friends of those at risk of opioid overdose must be educated on the signs of overdose emergency and must be told to call 911 and administer naloxone. They and the naloxone prescriber need to be protected by immunity from prosecution.[22]
- Increased preparation of substance abuse treatment specialists and increased availability of treatment facilities. The National Association of Community Health Centers[23] found that 43% of physicians working in federally qualified health centers were interested in being trained to provide medication-assisted treatments for people with addictive disorders. SAMHSA workforce initiatives should be encouraged, including partnerships with community-based providers and organizations, efforts to increase the diversity of the behavioral health workforce, and initiatives to expand the numbers of on-site and distance education programs. Prescribers need to practice compassionate weaning if access to prescription drugs is restricted.[14]

The World Health Organization (WHO) has outlined several recommendations on treatment options and prevention of opioid overdose, including increasing the number of opioid dependency treatment programs. WHO also recommends reducing inappropriate opioid prescribing, making naloxone available to those who might witness an opioid overdose, and offering more psychosocial support to maintain treatment options. WHO’s suggested treatment options include methadone, buprenorphine, and

detoxification. Initial treatment would involve non-opioid medications, to be followed by weak opioids and, subsequently, stronger opioids.[24]

The Scottish government has funded a national take-home naloxone program since 2011 to educate families, friends, and caregivers on causes of overdose and administration of naloxone. All individuals released from prison who were on an opioid drug are given naloxone as they leave. This policy has led to a 20% to 30% reduction in opiate-related deaths among the prison release population.[25]

The International Narcotics Control Board has reported actions to overcome prescription drug abuse that include preventing forging of prescriptions and decreasing thefts from pharmacies, hospitals, and doctors' offices. The board also discourages doctor shopping and illegal Internet pharmacy operations.[26]

Opposing Arguments/Evidence

A 2011 Institute of Medicine report addressed relieving pain. Tens of millions of Americans are affected by pain, contributing to morbidity, mortality, disability, demands on the health care system, and economic costs. Disparities in the treatment of pain exist, and serious undertreatment of pain has been reported among children, the elderly, and racial and ethnic minority groups.[27] Restricting access to pain medications through legislative or criminal justice actions to prevent doctor shopping or close "pill mills" can further decrease legitimate pain medication access.[28]

Failure to adequately medicate a patient can place a physician at risk for malpractice. In addition to being charged with negligence, physicians have been sued as a result of complaints regarding both overtreatment and undertreatment of pain.[29]

Objections to distributing naloxone to nonmedical personnel also persist despite a lack of scientific evidence to support such objections. In fact, naloxone is safe, effective, and easy to administer via nasal spray or intramuscular injection. It has been argued that naloxone can encourage opiate users to increase their drug consumption, but the evidence contradicts this claim.[30–32] Legislators, police, and prosecutors still need to be convinced that naloxone programs are effective. Naloxone distribution has been an important step in harm reduction to help reach the goal of stopping dependence on and misuse of opiate substances. Syringe exchange programs and opiate substitution therapy are other examples of harm reduction strategies. Studies of naloxone distribution and overdose prevention programs report reductions in self-reported drug use. As noted in one report, "[i]t is unethical to allow a narrow focus on the harms of drug use to overshadow an opportunity to save human lives."[22]

Action Steps

Therefore, APHA:

- Urges public health and public policy education programs to prioritize and implement evidence-based community and provider training programs on mental health, nonpharmacological pain treatment alternatives, substance abuse, and overdose prevention. Among those with prescriptive authority, gaps in education can be assessed and continuing education provided at the time of licensing

renewal. States can use resources from the National Conference of State Legislatures to assess legislation addressing these actions and gaps.[33]

- Urges public education on nonsharing of prescription medications as well as safe storage, use, and disposal of medications. Messaging must come from multiple public health partners and resources, including public radio and television, billboards, and social media. Some states are using pledges to not share and website messaging (e.g., on state and local health department and public safety department sites).
- Urges pain prescription providers to become more knowledgeable on identifying and treating pain with alternative modalities and to coordinate pain management with complementary and integrative care providers.
- Urges providers to be educated on and require the use of PDMPs before prescribing pain medications and to increase integration of patients' information into their electronic health records. Prescribers need to be educated on referral and treatment options if concerns are identified on the PDMP assessment.
- Urges federal and state legislators to prioritize resources for development and continued support of evidence-based substance abuse treatment programs that include medication-assisted treatment and supportive counseling.
- Urges state legislation to require individuals to have physical and mental examinations before they are prescribed pain medications. Also, there is a need for legislation addressing doctor shopping, "pill mills," and use of tamper-resistant prescriptions. Plans to accommodate patients who need new providers must be coordinated with these actions.
- Urges state legislators to enact laws increasing distribution of and access to naloxone among first responders, family members, and friends of individuals who may be misusing opioids.

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