PREVENTION ALLIANCE of TENNESSEE
A STATE OF PREVENTION

White Paper on

Prescription Drug Abuse

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Introduction

Deaths from drug overdose have been rising steadily over the past two decades and have become the leading cause of injury death in the United States.[1] Every day in the United States, 114 people die as a result of drug overdose[1], and another 6,748 are treated in emergency departments (ED) for the misuse or abuse of drugs.[2] Nearly nine out of 10 poisoning deaths are caused by drugs.[1] Prescription drugs account for nearly 60 percent of all deaths from drug overdose, and pain relievers such as oxycodone, hydrocodone, and methadone are involved in three of every four prescription drug overdose fatalities.[2]

Americans, constituting only 4.6 percent of the world's population, have been consuming 80 percent of the global opioid supply, and 99 percent of the global hydrocodone supply, as well as two-thirds of the world's illegal drugs. Retail sales of commonly used opioid medications (including methadone, oxycodone, fentanyl base, hydromorphone, hydrocodone, morphine, meperidine, and codeine) have increased from a total of 50.7 million grams in 1997 to 126.5 million grams in 2007. This is an overall increase of 149 percent with increases ranging from 222 percent for morphine to up to 866 percent for oxycodone. Average sales of opioids per person have increased from 74 milligrams in 1997 to 368 milligrams in 2007, a 402 percent increase.[3]

Tennessee is one of the states being impacted, with the Eastern grand division experiencing the highest incidences of both overdose deaths and babies born diagnosed with Neonatal Abstinence Syndrome (NAS). In 2013, the Tennessee Department of Health established a reporting system for hospitals diagnosing newborns with NAS to more accurately track and monitor one of the most devastating outcomes of the prescription drug epidemic with 921 infant diagnoses being reported. Year-to-date, ending the week (42) of October 18, 2014, 766 cases were reported to the Department of Health. This is tracking higher than the numbers in 2013. Of those being reported, 52.61 percent were reported in East Tennessee, with another 11.66 percent in the Upper Cumberland region. Another 73.7 percent of birth mothers of NAS-diagnosed infants are receiving medications from medical providers for either supervised replacement therapy, for pain management, or for treatment of psychological disorders.[5]

Scope of the Problem

- Drug overdose was the leading cause of injury death in 2012. Among people 25 to 64 years old, drug overdose caused more deaths than motor vehicle traffic crashes.[5]

- Drug overdose death rates have been rising steadily since 1992 with a 117 percent increase from 1999 to 2012 alone.[5]
- In 2012, 33,175 (79.9 percent) of the 41,502 drug overdose deaths in the United States were unintentional, 5,465 (13.2 percent) were of suicidal intent, 80 (0.2 percent) were homicides, and 2,782 (6.7 percent) were of undetermined intent.[5]
- In 2011, drug misuse and abuse caused about 2.5 million emergency department (ED) visits. Of these, more than 1.4 million ED visits were related to pharmaceuticals.[6]
- Between 2004 and 2005, an estimated 71,000 children (18 or younger) were seen in EDs each year because of medication overdose (excluding self-harm, abuse and recreational drug use).[4]
- Among children under age 6, pharmaceuticals account for about 40percent of all exposures reported to poison centers.[6]
- In 2012, prescription opioids became the primary substance of abuse for people in TDMHSAS funded treatment, overtaking alcohol for the first time. [9]
- Tennesseans 18-25 years of age are using prescription opioids at a 30 percent higher rate than the national average.[9]
- There were 25 percent more controlled substances dispensed in Tennessee in 2012 than in 2010.[9]
- The number of emergency department visits in Tennessee for prescription drug poisoning has increased by approximately 40 percent from 2005 to 2010.[9]
- There has been a 220 percent increase in the number of drug overdose deaths since 1999, growing from 342 in 1999 to 1,094 in 2012.[9]

Most Common Drugs Involved in Overdoses

- In 2012, of the 41,502 drug overdose deaths in the United States, 22,114 (53 percent) were related to pharmaceuticals.[7]
- Of the 22,114 deaths relating to pharmaceutical overdose in 2012, 16,007 (72 percent) involved opioid analgesics (also called opioid pain relievers or prescription painkillers), and 6,524 (30 percent) involved benzodiazepines.[7] (Some deaths include more than one type of drug.)
- In 2011, about 1.4 million ED visits involved the nonmedical use of pharmaceuticals. Among those ED visits, 501,207 visits were related to anti-anxiety and insomnia medications, and 420,040 visits were related to opioid analgesics.[8]
- Benzodiazepines are frequently found among people treated in EDs for misusing or abusing drugs.[2] People who died of drug overdoses often had a combination of benzodiazepines and opioid analgesics in their bodies.[7]

Efforts in Tennessee

There are a number of efforts across the state being deployed to attack the prescription drug abuse epidemic, with prevention efforts being the most critical. At the community level, there are community prevention coalitions, prescription drug disposal take back events and placement of permanent drop boxes, as well as education, training and information dissemination. As well as prevention efforts, there are also early intervention initiatives such as Screening Brief Intervention Referral to Treatment (SBIRT). There are also enforcement, treatment and recovery services and programs. Together, these efforts are working to change current conditions, but more work is needed to move the numbers in Tennessee.[9]

Prescription for Success

In June of 2014, Governor Haslam revealed a three-year plan to reduce the impact of prescription drug abuse, *Prescription for Success*.

Goals of this plan are to:

1) Decrease the number of Tennesseans who abuse controlled substances

2) Decrease the number of Tennesseans who overdose on controlled substances

3) Decrease the amount of controlled substances dispensed in Tennessee

4) Increase access to drug disposal outlets in Tennessee

5) Increase access and quality of early intervention, treatment and recovery services

6) Expand collaborations and coordination among state agencies

7) Expand collaboration and coordination with other states

Under each of these goals is a set of strategies to achieve the desired outcome. Some of those efforts involve legislative actions such as strengthening pain management clinic regulations (goal 3, strategy 5), enacting a Good Samaritan law (goal 2, strategy 3), and repeal of the Intractable Pain Act (goal 3, strategy 4). [9]

Legislative Recommendations

The National Alliance of Model State Drug Laws has developed 10 laws designed to reduce the impact of prescription drug abuse in the United States.[10] Tennessee has now established nine out of 10 recommendations, with a Good Samaritan law being all that remains.[10] Although laws have been enacted, there are additional opportunities to strengthen those laws through closing loopholes and strengthening requirements. The National Alliance of Model State Drug Laws publishes laws from other states, which provides an opportunity for comparison.

There are three specific areas in the current Pain Management Clinic regulations that have been reviewed and compared with other states: ownership requirements, medical director qualifications and hours on site for the medical directors. Currently there are no restrictions for who can own a pain management clinic in Tennessee; therefore, many are owned by individuals who do not reside in the state of Tennessee or hold any type of medical licensure.[11] In Florida, Georgia, Kentucky, Louisiana and Ohio, clinics must be physician owned or be a licensed medical facility.[10] This provides an opportunity to uphold the greatest standards of practice when a medical license is held by the owner. When reviewing the medical director qualifications, since the other states require physician ownership, that requirement carries over into the medical director qualifications, with the medical director being a physician operating with an unrestricted medical license in that state. Tennessee currently requires that it be a physician licensed in Tennessee.[11] When the Tennessee Department of Health developed the chronic pain management guidelines, it is specifically recommended that patients who are on long-term opiate therapy of 120 medical morphine equivalent (MME) daily doses or above be evaluated by either board certified pain management specialists through the American Board of Medical Specialties or those who have had additional training and are American Board of Pain Medicine certified following and examination with a passing score.[12] Due to the comprehensive nature and inclusion of all seven licensure boards, the medical director requirements should mirror those recommendations. Those suffering from chronic non-cancer pain should be managed by those with specialized training in the management of pain. Pain management specialists should be used to consult with primary care physicians, who provide on-going care, a similar model used for all other specialty practices, such as cardiology or neurology.[12] Currently, a physician of any specialty can serve as the medical director of pain management clinics in Tennessee.[11] There are specialists in obstetrics, plastic surgery, and family practice serving as medical directors, who have limited training and no certification in the management of chronic pain. This should be treated like any other medical specialty and those who are board certified or had additional training should be recognized as experts in their field and serve to best manage those in need. These specialists are trained in alternative modalities for pain management and monitor patients who do need long-term opiate therapy carefully using pain management contracts and frequent urine testing to be sure patients are adhering to their prescribed regimen and not at risk for an unintentional drug overdose.[12] The final recommendation would be to require the medical director's to be on-site 50 percent of the

weekly clinic operating hours. The state with this requirement is Kentucky and since regulating their pain management clinics, they have gone from 44 clinics to 25 clinics.[13] The idea behind these regulations is to eliminate clinics who are operating to simply prescribe narcotics (pill mills), not to reduce legitimate clinics who are needed to help patients who are suffering from chronic pain.

In 2014, Tennessee passed a life-saving bill (§ 63-1-152) allowing for lay persons in this state to administer naloxone (an antidote to reverse the signs of a drug overdose). In this bill, we protected both the prescribers of naloxone and the lay person administering the drug through civil immunity. In order for this to be most effective, it is important that we also enact a Good Samaritan law that provides criminal immunity for those calling for help for someone experiencing a drug overdose.[10] This does not limit the ability to press charges if drug trafficking is occurring, but does allow for immunity from simple possession charges. In order for Tennessee to see the utilization of naloxone to become more widespread, criminal immunity should be considered under certain conditions.[10]

Physicians in Tennessee continue to express pressure under the Intractable Pain Treatment Act of 2001 to prescribe narcotic pain relievers when they believe narcotics are not necessary or would not provide relief that alternative therapies would provide. By repealing this act, it would leave the decision to be made by the physician in consultation with the patient. Medical providers believe this act is written in a way that undermines medical training and judgment and puts too much responsibility on patients who are not medically trained to determine the best and most appropriate treatment available. A bill repealing this act passed in the house in 2014, but did not pass in the Senate. This should be considered once again to reduce unnecessary opiate prescribing.[14]

Glossary

***Drug*:** Any chemical compound used for the diagnosis or treatment of disease or injury, for the relief of pain, or for the feeling it causes. A drug is either a pharmaceutical (including both prescription and over-the-counter products) or illicit.

Overdose: When a drug is eaten, inhaled, injected, or absorbed through the skin in excessive amounts and injures the body. Overdoses are either intentional or unintentional. If the person taking or giving a substance did not mean to cause harm, then it is unintentional.

Medical Morphine Equivalent (MME): Morphine is the precursor in the manufacture in a large number of opioids; therefore, medical morphine equivalent (MME) dose is calculated to determine the level of morphine being absorbed. MME calculators are available for physicians to calculate mg per day (or in the case of fentanyl transdermal patches is expressed as micrograms per hour).

***Misuse or abuse*:** The use of illicit or prescription or over-the-counter drugs in a manner other than as directed.

Neonatal Abstinence Syndrome (NAS): A set of drug withdrawal symptoms a newborn exhibits due to the Mother's prenatal substance use, requiring gradual detoxification to lesson painful symptoms.

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