



Preventing Prescription Drug Abuse

Nicholas Reuter

Center for Substance Abuse Treatment

Substance Abuse Mental Health Services Administration

U.S. Department of Health & Human Services

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Monitoring Program – National
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Overview



→ Substance Abuse Trends in the U.S.

- Illicit Drugs
- Prescription Drugs
 - Abuse
 - Diversion
 - Consequences, Mortality

→ Initiatives to Address Rx Drug Abuse

- Prescription Drug Monitoring Programs
- Prescriber/Consumer Education/Training
- SBIRT, PCSS
- Integrating PDMP and EHR

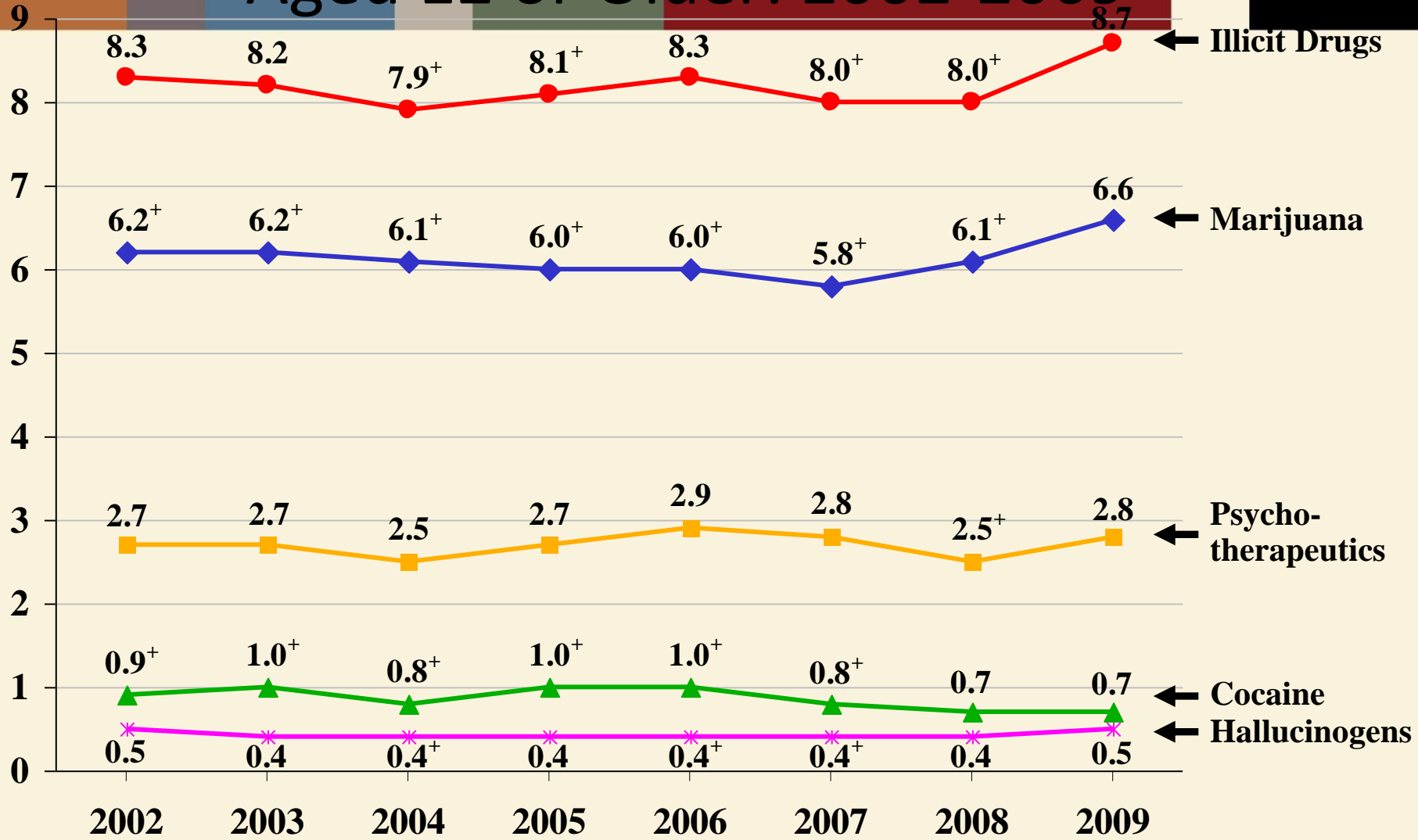
2009 NSDUH Highlights

- New National Survey Reveals shows the overall rate of current illicit drug use in the United States rose from 8.0 percent of the population aged 12 and older in 2008 to 8.7 percent in 2009. This rise in overall drug use was driven in large part by increases in marijuana use.
- The nonmedical use of prescription drugs rose from 2.5 percent of the population in 2008 to 2.8 percent in 2009,
- the number of methamphetamine users rose from 314,000 to 502,000 during that period
- estimated number of past-month ecstasy users rose from 555,000 in 2008 to 760,000 in 2009
- These results are a wake-up call to the nation,” said SAMHSA Administrator Pamela S. Hyde, J.D. “Our strategies of the past appear to have stalled out with generation ‘next.’ Parents and caregivers, teachers, coaches, faith and community leaders, must find credible new ways to communicate with our youth about the dangers of substance abuse.”

Fig 2.2

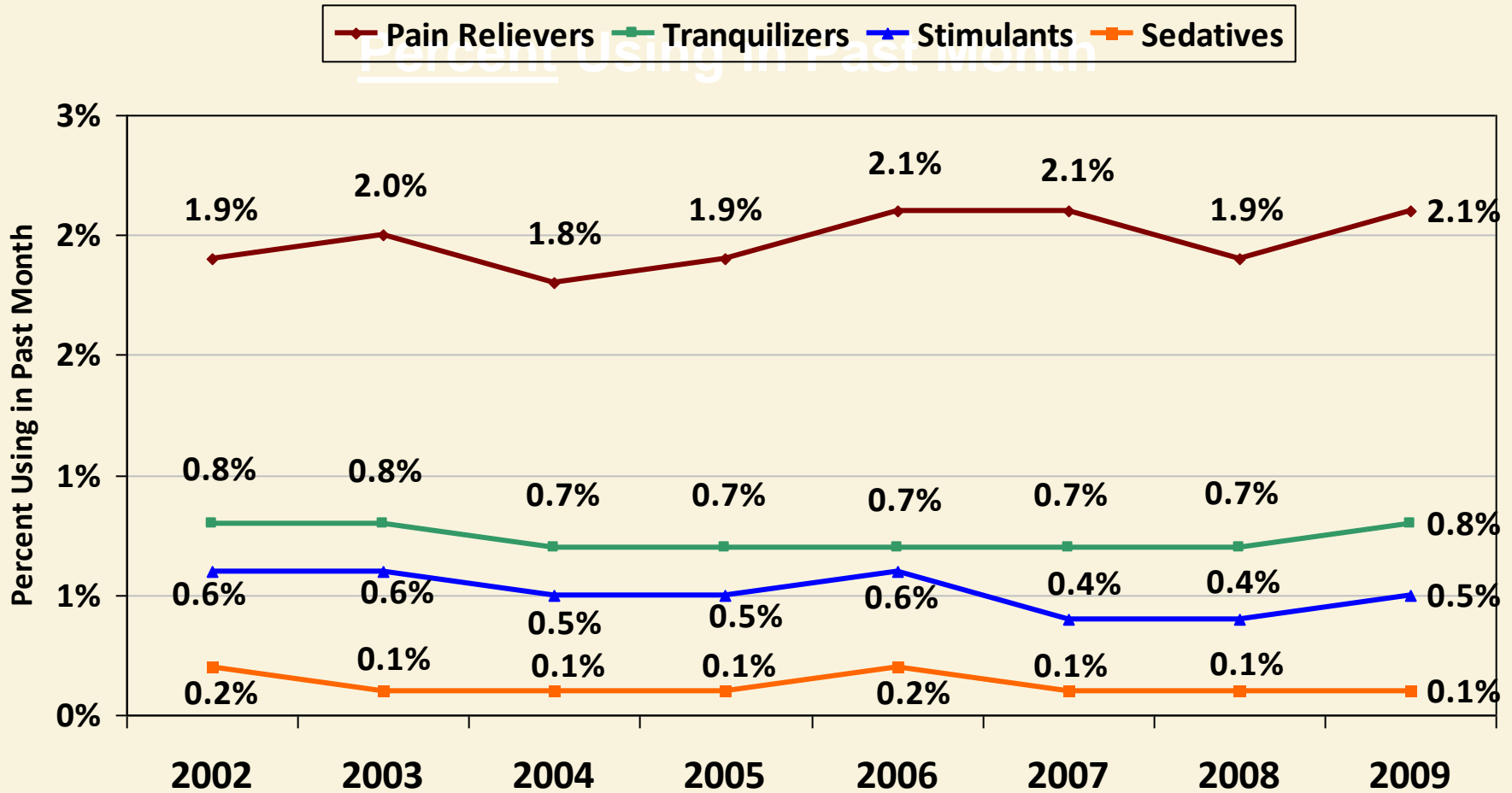
Past Month Use of Selected Illicit Drugs among Persons Aged 12 or Older: 2002-2009

Percent Using in Past Month



⁺ Difference between this estimate and the 2009 estimate is statistically significant at the .05 level.

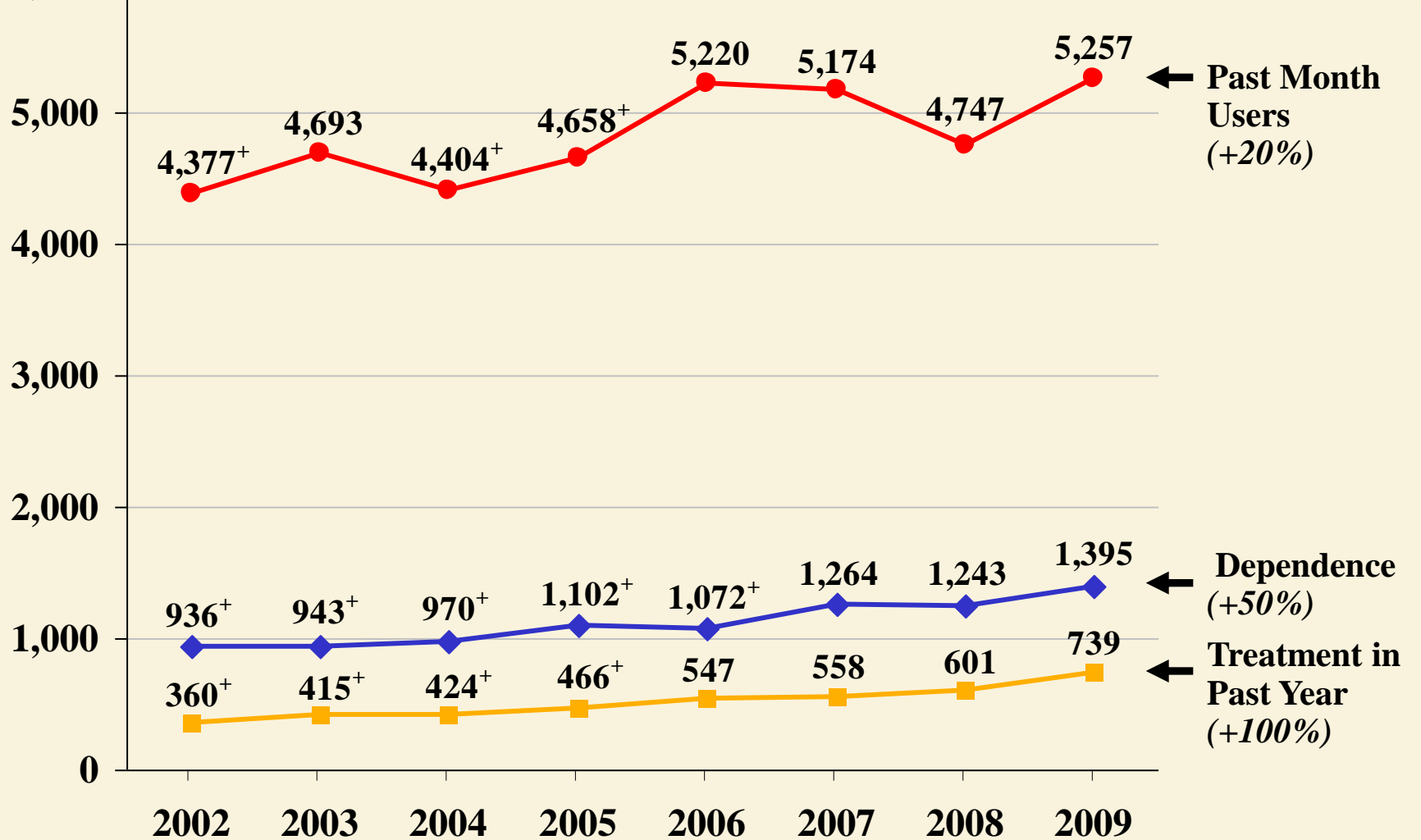
Past Month Nonmedical Use of Prescription Drugs (Psychotherapeutics) among Persons 12+:2002-2009



Pain Reliever Trends among Persons Aged 12 or Older: 2002 to 2009

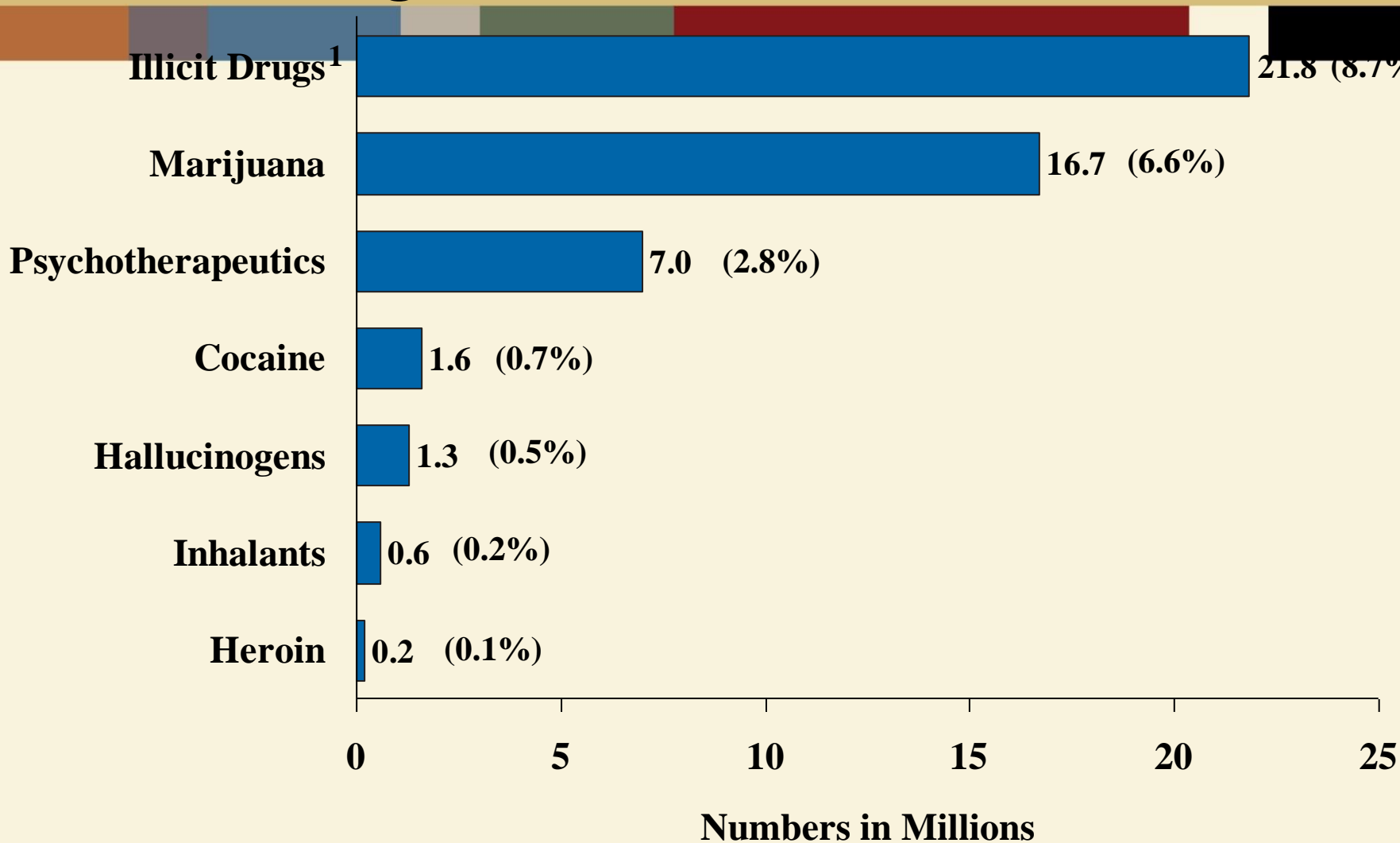
Numbers in Thousands

6,000



⁺ Difference between this estimate and the 2009 estimate is statistically significant at the .05 level.

Past Month Illicit Drug Use among Persons Aged 12 or Older: 2009

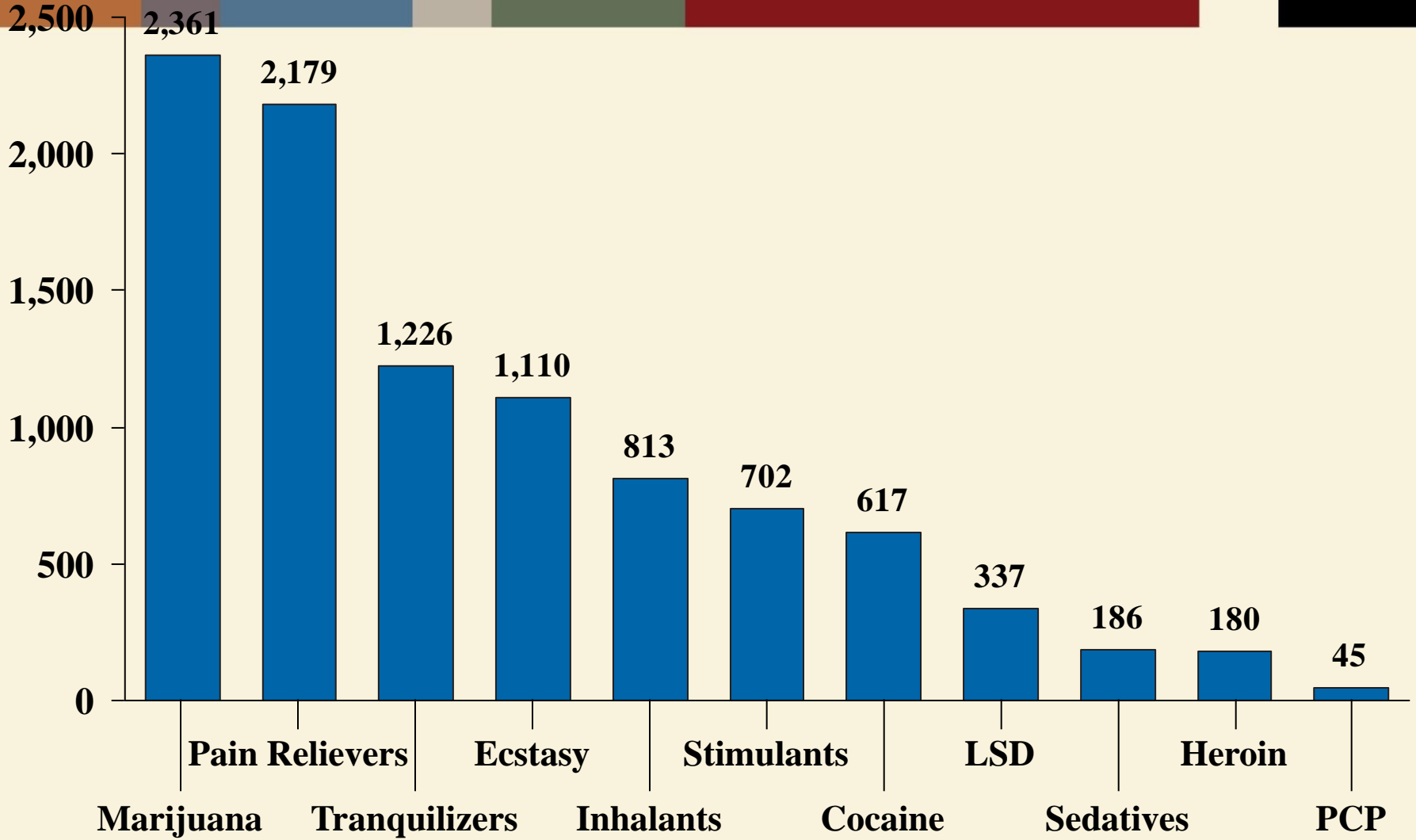


¹ Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.

Fig 5.2

Past Year Initiates of Specific Illicit Drugs among Persons Aged 12 or Older: 2009

Numbers in Thousands



Note: The specific drug refers to the one that was used for the first time, regardless of whether it was the first drug used or not.

Redesigning NSDUH



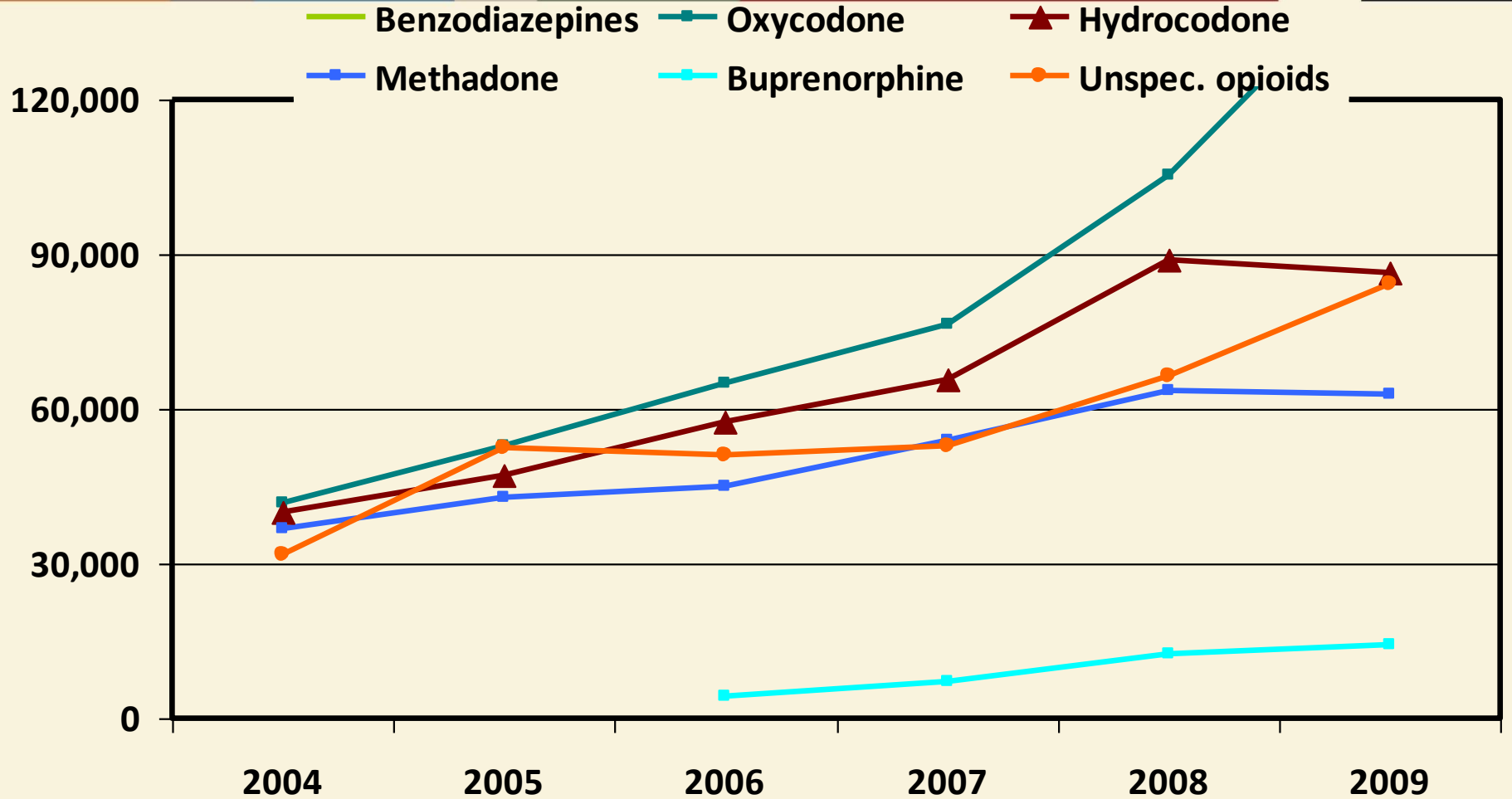
- NSDUH redesign is now expected to occur in 2015.
- The nonmedical use definition will be essentially the same, but different questions are being tested.
- The major shift is a focus on past year use of the **specific drugs**, instead of the current/lifetime approach,
- and a process to regularly update the drugs included.

DAWN ED 2009



- In 2009, there were nearly 4.6 million drug-related emergency department (ED) visits of which about one half (49.8 percent, or 2.3 million) were attributed to adverse reactions to pharmaceuticals and almost one half (45.1 percent, or 2.1 million) were attributed to drug misuse or abuse
- In 2009, ED visits resulting from the misuse or abuse of pharmaceuticals occurred at a rate of 405.4 visits per 100,000 population compared with a rate of 317.1 per 100,000 population for illicit drugs
- ED visits involving misuse or abuse of pharmaceuticals increased 98.4 percent between 2004 and 2009, from 627,291 visits in 2004 to 1,244,679 visits in 2009

Trends for Opioid Non-medical Use ED Visits – 2004 – 2009



TEDS Rx Pain Reliever Admissions 1998-2008

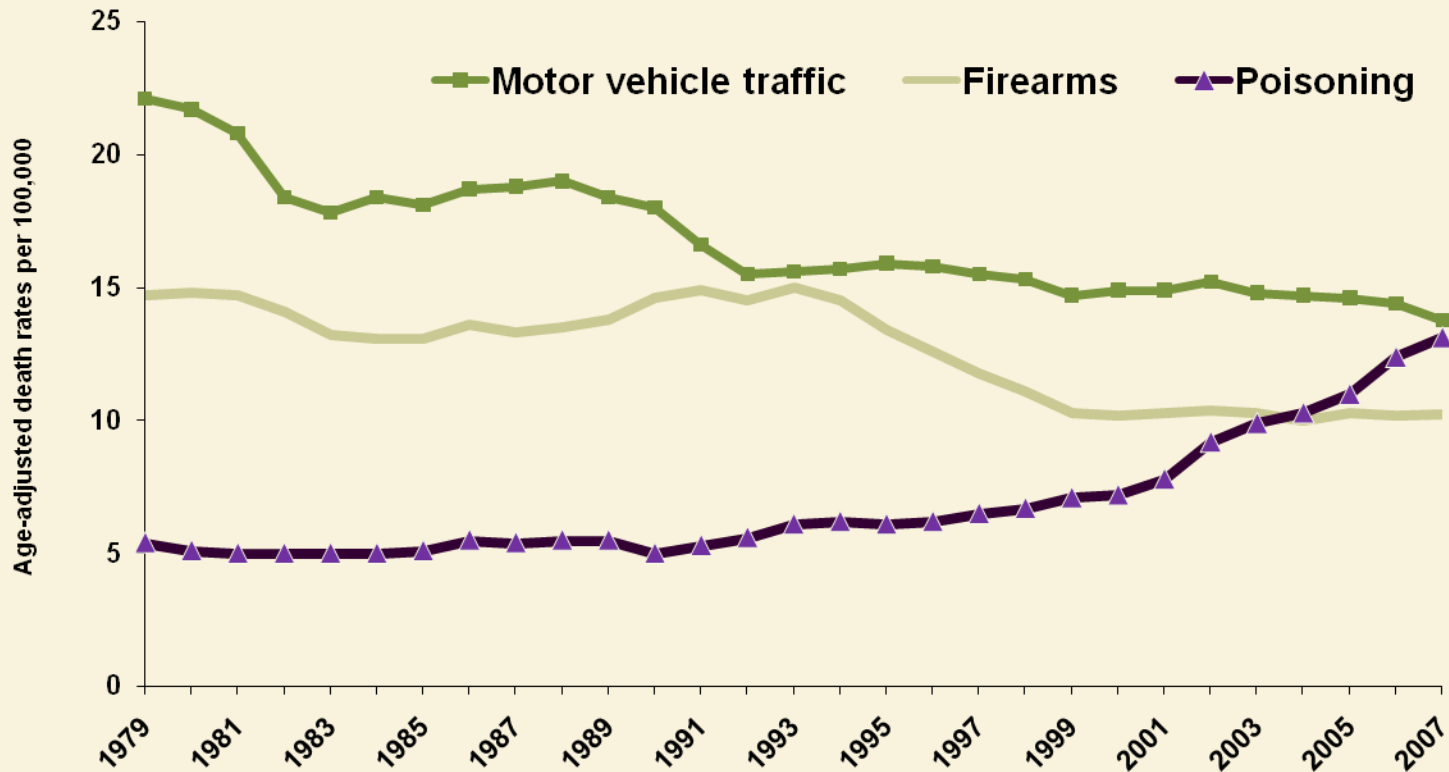


- Substance abuse treatment admissions reporting primary pain reliever abuse increased from 18,300 in 1998 (1.1 percent of all admissions) to approximately 105,680 (5.6 percent) in 2008
- Admissions for primary abuse of prescription pain relievers in 2008 were more than 3 times as likely as those in 1998 to be aged 18 to 24 (26.5 vs. 7.5 percent)
- Admissions for primary pain reliever abuse in 2008 were more likely than those in 1998 to be unemployed (41.1 vs. 28.6 percent)
- The percentage of primary pain reliever admissions with a co-occurring psychiatric disorder increased from 19.4 percent in 1998 to 38.6 percent in 2008

Prescription Drugs and Overdose Deaths

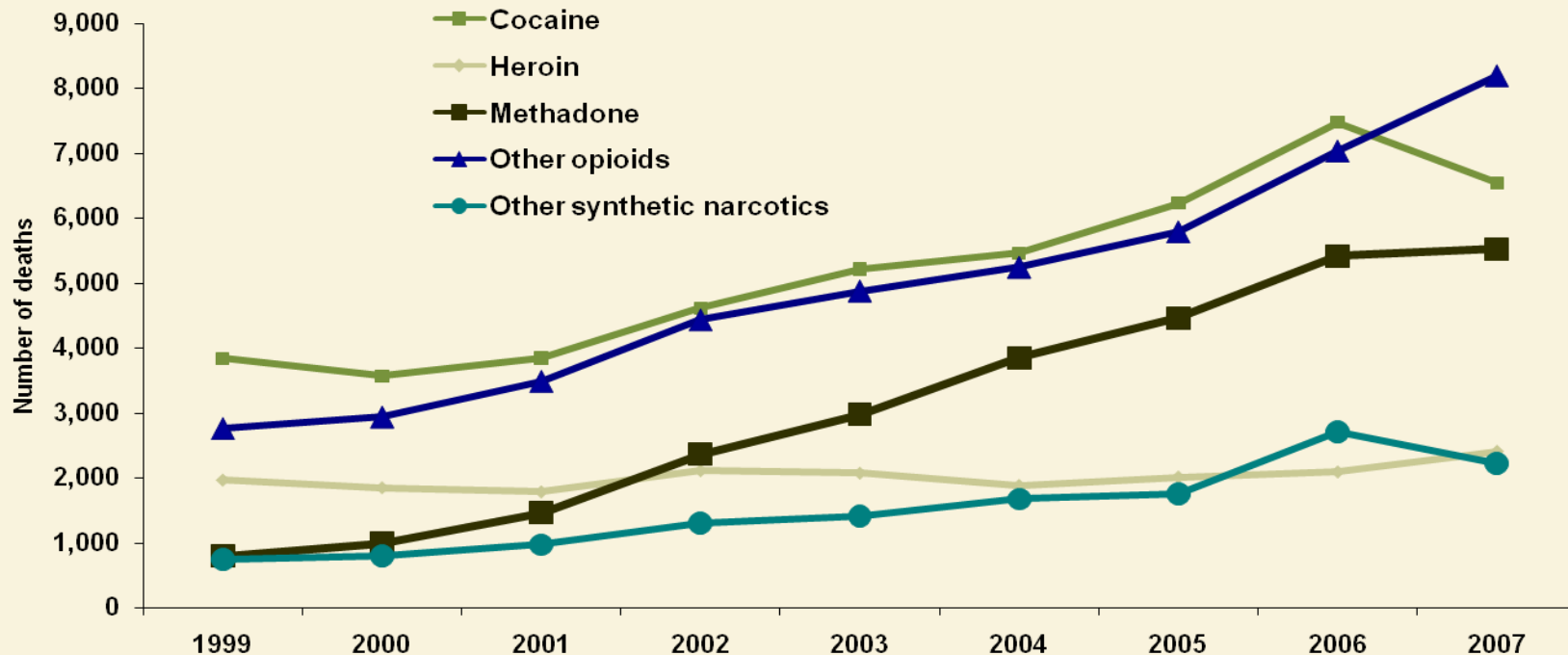


Three leading causes of injury death: United States, 1979--2007



Source: CDC/NCHS, National Vital Statistics System, Multiple Cause of Death

Poisoning deaths involving opioid analgesics, cocaine and heroin: United States, 1999–2007

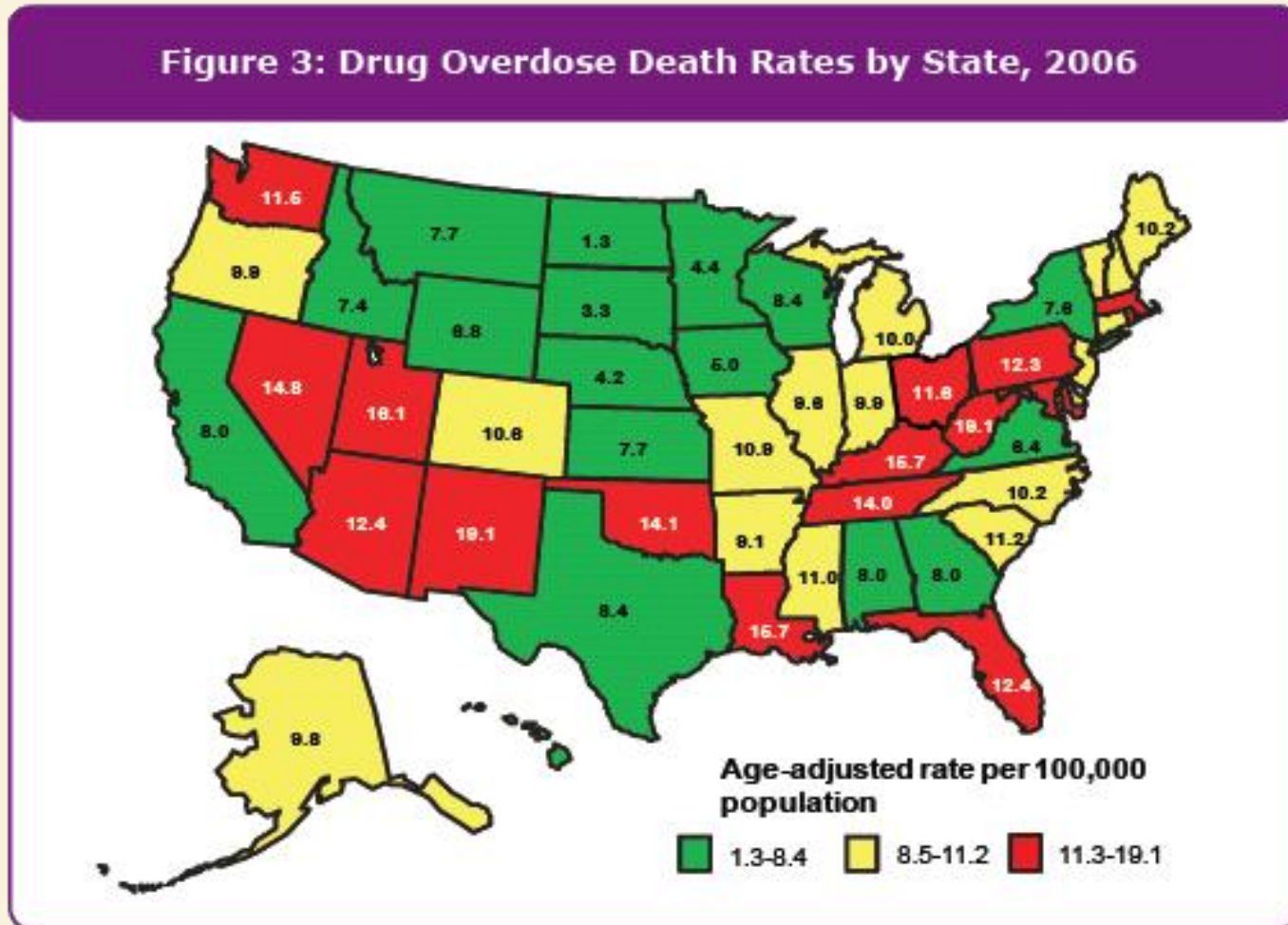


NOTE: Drug categories are not mutually exclusive. Deaths involving more than one drug category shown in this figure are counted multiple times.

Source: CDC/NCHS, National Vital Statistics System, Multiple Cause of Death file

Drug Overdose Deaths in the U.S.

- States in the Appalachian region and the Southwest have the highest overall drug overdose death rates.



Prevention of Substance Abuse and Mental Illness



Goal 1.4

Reduce prescription drug misuse and abuse.

Objective 1.4.1: Educate current and future prescribers regarding appropriate prescribing practices for pain and other medications subject to abuse and misuse.

Objective 1.4.2: Educate the public about the appropriate use of opioid pain medications, and encourage the safe and consistent collection and disposal of unused prescription drugs.

Objective 1.4.3: Support the establishment of State/Territory-administered controlled substance monitoring systems, and develop a set of best practices to guide the establishment of new State and Territorial programs and the improvement of existing programs.


Physician Education Opioid Prescribing

4-8 Hour CME

- **Problems we see with patients who are prescribed opioids for persistent pain**
- **Deciding whether or not to prescribe an opioid**
- **Pharmacology, emphasis on methadone**
- **Steps to take if you decide to use opioids in the treatment of persistent pain**
- **Steps to take if you decide NOT to use opioids in the treatment of persistent pain:**
- **The practical side of patient monitoring – PMP, screening, lost Rx, etc.**
- **When, why and how to stop prescribing opioids and manage the patient with another treatment approach**

Consumer Education

Not Worth the Risk: Even if it's legal.



→ Messages

- Prescription drugs are dangerous
- Prescription drugs should be secured
- Dispose of unused prescription drugs

→ Messengers

- Parents
- Health professionals
- Educators

NASPER



- SAMHSA grants to States to implement or improve prescription drug monitoring programs.
- Purpose
- “ensure that health care providers have access to accurate, timely prescription history information”
- Use as “tool for the early identification of individuals at risk for addiction to initiate early interventions”
- Establish best practices for the establishment of new State programs.

NASPER 2011



- RFA did not introduce new requirements.
- Increased flexibility for authenticating accounts.

Pending Federal Legislation

- H.R. 866: National All Schedules Prescription Electronic Reporting Reauthorization Act of 2011 Whitfield – maintain,
- H.R. 1065: Pill Mill Crackdown Act of 2011 – also reschedules vicodin
- H.R. 1266: Fraudulent Prescription Prevention Act of 2011 – (national prescription database for prescribers)
- H.R. 1316: The Stop Oxy Abuse Act of 2011 (oxycodone SR for severe-moderate pain)
- H.R. 1925: increases federal oversight of prescription opioid treatment and assistance to states in reducing opioid abuse, diversion, and deaths
- S. 507: Prescription Drug Abuse Prevention and Treatment Act of 2011

Enhancing PDMPs to Reduce Rx Drug Abuse



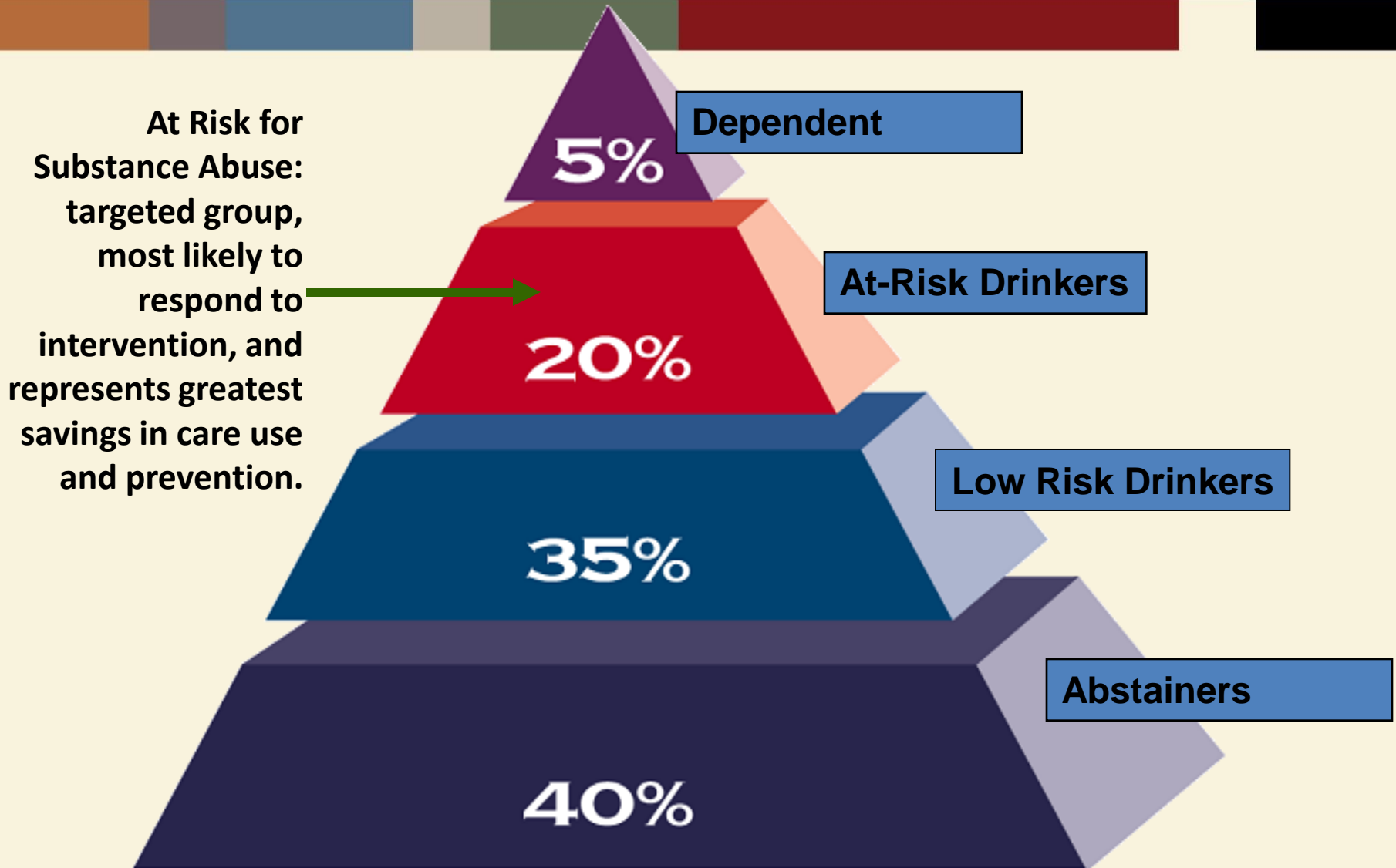
- Linkages to SBIRT
- Physician Clinical Support Systems
- Integration with Electronic Health Records
- Encouraging OTPs to access PDMPs

What is SBIRT



- Screening for individuals at risk of substance abuse in primary care settings.
- Identify patients who do not perceive a need for treatment.
- Provide a strategy to reduce or eliminate substance abuse.
- Transition into services.

Substance Abuse Pyramid



SBIRT Expands State Treatment Systems



- SBIRT expands and enhances State substance abuse treatment service systems.
- SBIRT services are offered in **over 135** general medical and other community settings in the U.S.
- There are currently 8 active SBIRT grants -- awarded to 7 states and 1 tribe.
- In FY 08, a new initiative was launched to train medical residents in SBIRT (11 five-year grants)
 - 6 additional grants were awarded in FY 09.

SBIRT Program Performance

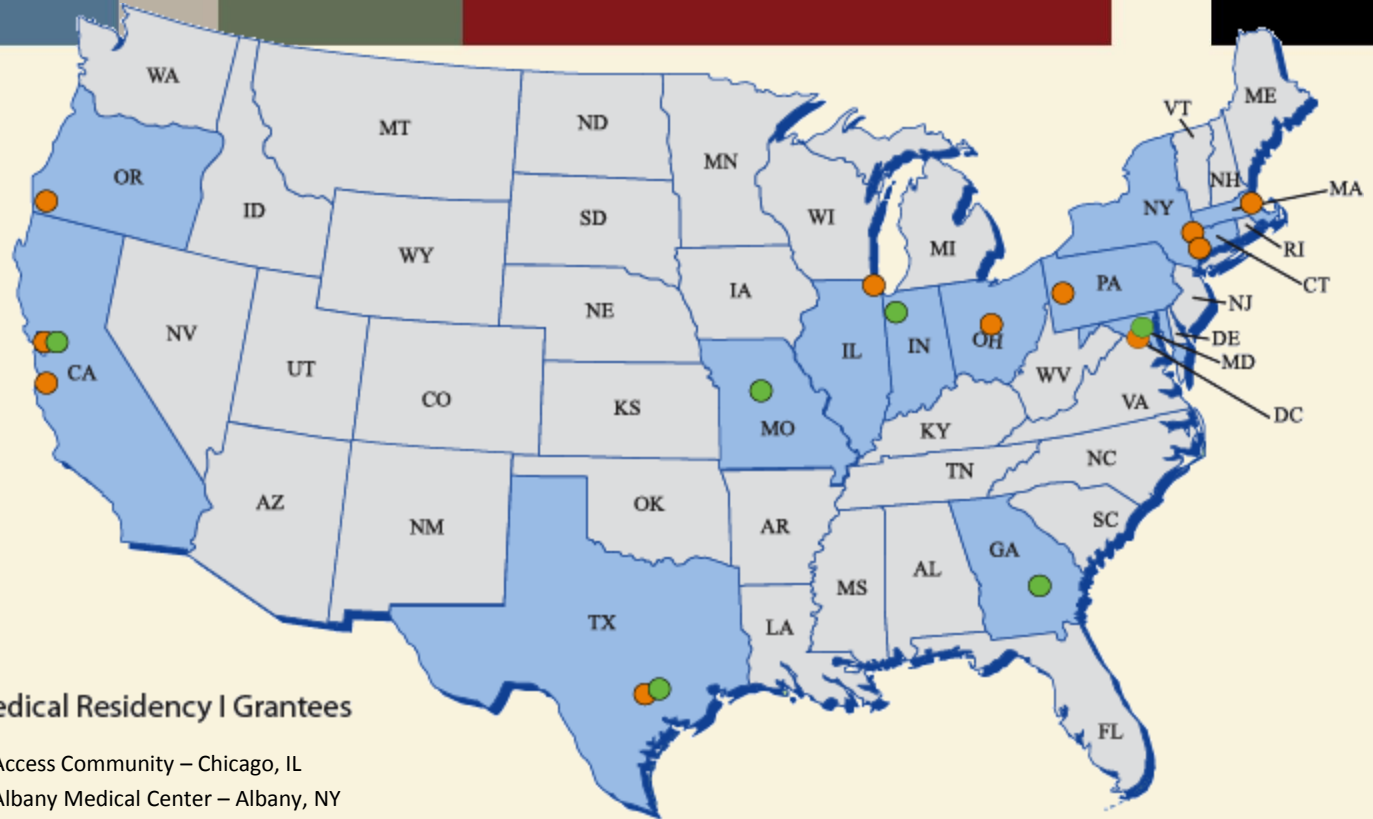
Of the 1 million clients served by SBIRT:	Percent
Intake	100.0%
Screening	78.3%
Brief Intervention	15.8%
Brief Treatment	2.7%
Referral to Treatment	3.3%

SBIRT Performance Outcomes

SBIRT services are offered in over 135 general medical and other community settings in the U.S.

Of Clients who screened positive...	At Intake	6-Month Follow-up	Difference
No substance use	11.6%	32.1%	↑ 177.8%
Being employed	41.8%	45.9%	↑ 9.8%
Being housed	56.2%	61.1%	↑ 8.6%
No arrests	82.4%	95.4%	↑ 15.7%
Being socially connected	68.9%	70.7%	↑ 2.6%

Medical Residency I and II Grantees



● Medical Residency I Grantees

- Access Community – Chicago, IL
- Albany Medical Center – Albany, NY
- Children’s Hospital Boston – Boston, MA
- Howard University – Washington, DC
- Kettering Medical Center – Kettering, OH
- Natividad Medical Center – Salinas, CA
- Oregon Health Services – Portland, OR
- San Francisco General Hospital – San Francisco, CA
- University of Pittsburgh – Pittsburgh, PA
- University of Texas Health Services - San Antonio, TX
- Yale University – New Haven, CT

● Medical Residency II Grantees

- Baylor College – Houston, TX
- Indiana University – Indianapolis, IN
- Mercer University – Macon, GA
- University of California SF – San Francisco, CA
- University of Maryland Baltimore – Baltimore, MD
- University of Missouri – Columbia, MO

Medical Residents Trained



- 675 new residents trained between October 2009 and May 2010
- 1,256 residents have been trained since September 2008
- Grantees also trained 1,021 non-residents (e.g., physician assistants, psychologists, social workers, other health care professionals)

Curriculum Components

- Medical Condition and Substance Abuse
- Screening Tools
- Brief Intervention
- Motivational Interviewing
- Referral to Treatment
- Detoxification
- Prescribing of Effective Medicines
- Prescribing Options for Pain Medications
- Medical Management
- Cultural Competency
- Others

Curriculum Components

Curriculum Components	n	%
Screening Tools - Include PMP Here????	17	100%
Brief Intervention	17	100%
Referral to Treatment	16	94%
Prescription of Effective Medicines	15	88%
Prescribing Options and Pain Meds	13	76%
Detoxification	13	76%
Motivational Interviewing	12	71%
Medical Condition and Substance Abuse	12	71%
Linkage to Specialty Treatment	11	65%
Oversight of SBIRT	10	59%
Cultural Competency	9	53%
Workforce Development	9	53%
Medical Management	9	53%
EHR Screening	9	53%
Implementation Issues	8	47%
Other	4	24%

Curriculum Focuses on Screenings

Screening instruments included as part of curricula:

- ASSIST
- DAST
- AUDIT
- CRAFFT
- CAGE
- TWEAK
- MAST

ASSIST - WHO

→ Question 1 (Question 2 – last three months)

- In your life, which of the following substances have you
- ever used? (*NON-MEDICAL USE ONLY*)
- No Yes
- a. Tobacco products (cigarettes, chewing tobacco, cigars, etc.) 0 3
- b. Alcoholic beverages (beer, wine, spirits, etc.) 0 3
- c. Cannabis (marijuana, pot, grass, hash, etc.) 0 3
- d. Cocaine (coke, crack, etc.) 0 3
- e. Amphetamine type stimulants (speed, diet pills, ecstasy, etc.) 0 3
- f. Inhalants (nitrous, glue, petrol, paint thinner, etc.) 0 3
- g. Sedatives or Sleeping Pills (Valium, Serepax, Rohypnol, etc.) 0 3
- h. Hallucinogens (LSD, acid, mushrooms, PCP, Special K, etc.) 0 3
- i. Opioids (heroin, morphine, methadone, codeine, etc.) 0 3
- j. Other - specify: 0 3

PCSS

- Physician Clinical Support System for mentoring and education – initially for methadone and buprenorphine used in SA treatment
- Expanded this year to include all opioid pain prescribers, including Dentists.
- Connect prescribing physician with expert in analyzing and addressing PDMP information?
- Develop guideline for prescribers in how to use PDMP information?

Integrating PDMPs and EHR

→ Can electronic PDMPs and Electronic Health Records be synchronized to:

- Reduce prescription drug abuse and overdose
- Increase prescriber utilization of both systems

→ ARRA

- Established Office of National Coordinator for Health Information Technology
- Established incentive to adopt EHR and E-prescribing
- Set 2014 for universal use of EHR

PDMPs and EHIEA

- Work with states to establish effective PDMPs in every state, including leveraging state electronic health information exchange activities
- Support the National All Schedules Prescription Electronic Reporting (NASPER) Act reauthorization in Congress
- Expand upon DOJ's pilot efforts to build PDMP interoperability across state lines, including leveraging state electronic health information exchange activities


ONDCP 2011 Prescription Drug Abuse Prevention Plan

EHR and NASPER



- NASPER Envisioned –
- “applications shall include... an agreement to adopt health information interoperability standards...”

Goals of Integration

- 
- Improve clinical outcomes for those at risk for prescription drug abuse by increasing access to PDMP data by clinicians (physicians, dentists, pharmacists and other treating clinicians) in a timely manner and across state boundaries.
 - How – Including patient prescription drug monitoring information in patient electronic health records.
 - Unsolicited reports, alert lists, from PDMP to EHR, including prescriber, pharmacy, and Emer. Dept.
 - Pilots being planned
 - Single log in for EHR and PDMP

Summary



- Drug Abuse and Rx drug abuse increased 2008-2009
- ED Data may reflect dynamic with methadone, hydrocodone
- Availability has been increasing commensurably
- Consequences of abuse - Prescription drug overdoses have increased with increasing abuse
- PMPs, dosing guidelines, prescriber/consumer educations programs in place to address prescription drug overdose problems
- Effective?