



# Insights from Early State Efforts to Address the Opioid Crisis

## Opioid Policymaking Insights and Experiences from the First Seven States Participating in the National Governors Association's Prescription Drug Abuse Reduction Policy Academy

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**Opioid overdose deaths appear to have accelerated faster than ever in the past three years. In 2015, 33,091 drug overdose deaths in the US involved an opioid (CDC, ASAM). Just one year later, opioid-related fatal overdoses increased by over 27 percent to 42,429 (CDC). Preliminary estimates indicate that “all evidence suggests the problem has continued to worsen in 2017.”**

The apparent acceleration of the opioid overdose rate has coincided with increased national attention to the problem. Over the past three years, the public has begun considering the problem an opioid overdose *crisis* and *epidemic*. However, the number of opioid-related deaths per 100,000 people in the United States has been a growing problem for much longer than the past two years, and state policymakers have been working to address the issue well before the general public considered it a “crisis” or “epidemic.”

As state policymakers attempt to govern during this crisis and explore the prospects of new interventions and possible federal resources, common elements of their efforts and experiences from before the public began to consider the opioid problem as a crisis, when options were more resource-constrained, offer a valuable reflection point. To that end, this brief summarizes common insights and experiences of state policymakers working to address opioid issues, collected in 2015 from the first seven states to participate in the National Governors Association's Prescription Drug Abuse Reduction Policy Academy. This brief is intended as a retrospective on states' efforts from 2012 through 2015.

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## BACKGROUND ON THE SOURCE OF THESE INSIGHTS

### What Is the NGA Prescription Drug Abuse Reduction Policy Academy?

Based on the recommendations of a diverse group of multidisciplinary representatives, the National Governors Association (NGA) created its Prescription Drug Abuse Reduction Policy Academy (the Policy Academy). In 2012, seven states (Oregon, Alabama, Arkansas, Virginia, Kentucky, Colorado, and New Mexico) were accepted into the first Policy Academy. Each state sent a team of four to seven high-level governmental representatives (including representatives of both health and public safety) to work with NGA during an initial two-day meeting focused on sharing current research, recommendations, and strategies each state was using to address the problem of prescription drug misuse, abuse, and overdose. NGA then led individual workshops in each state to further develop these recommendations into a strategic plan for implementation. Each state developed a strategy targeted to its prescription drug-abuse problem while incorporating ideas from other states, including legislation, trainings, public awareness campaigns, and cross-agency initiatives. In mid-2013, the state teams presented their plans to one another during a capstone meeting facilitated by NGA and ultimately submitted their plans to their governors for final approval and implementation.

### The Urban Institute's Research Purpose and Methods

NGA contracted with the Urban Institute to assess the value of the Policy Academy for the seven participant states' policymaking and implementation efforts, and to provide NGA with guidance on how states might benefit from improvements to the curriculum. Between May and July 2015, Urban Institute researchers conducted on-site interviews with a variety of stakeholders in each state, including leadership from state criminal justice and health agencies, governors' staff, epidemiologists, health licensing boards, medical professionals, pharmacists, substance abuse service providers, patient advocates, law enforcement, and community organizations. Some of these individuals participated in one or both Policy Academy meetings, but all were in some way involved with policy development or implementation efforts. Urban agreed not to identify the specific individuals interviewed as part of this project. **Importantly, this assessment was not designed to empirically evaluate** individual or combined policy efforts' effectiveness at producing their intended outcomes. Instead, the findings presented in this brief highlight consistent themes emerging from implementation efforts in multiple states for the benefit of policymakers and stakeholders working on this topic now and in the future.

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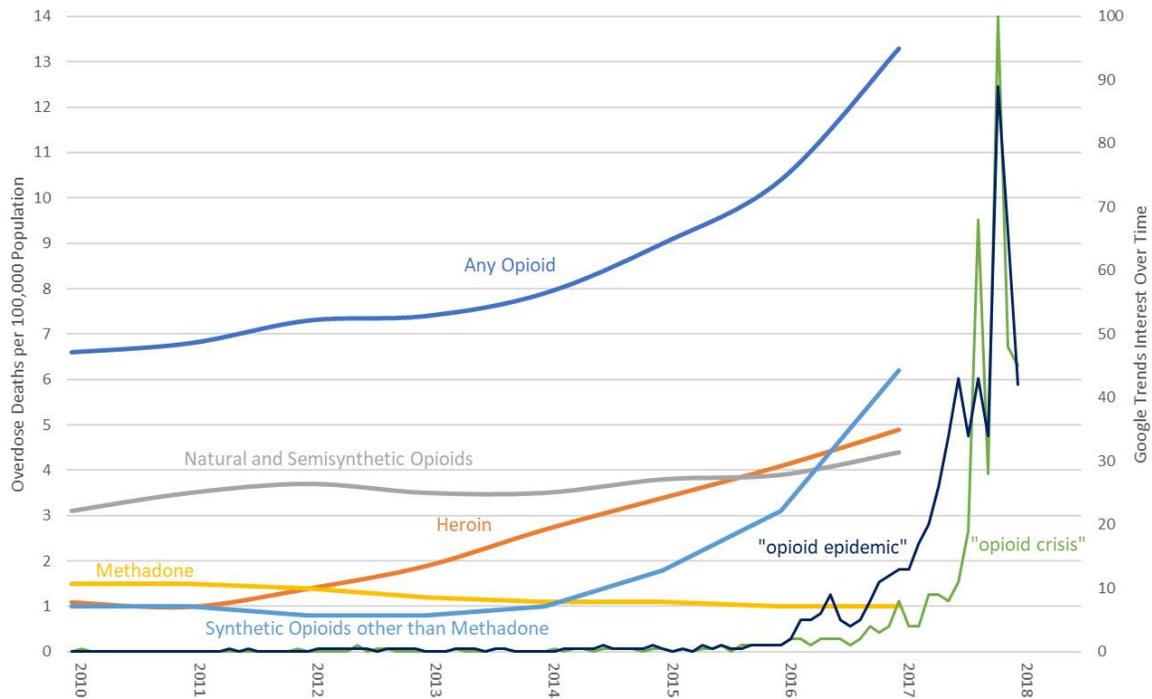
In the 17 years from 1999 to 2016, annual opioid overdose deaths in the United States have steadily increased from 2.9 to 13.3 deaths per 100,000 people. (CDC fatal overdose data are not currently available beyond 2016.) Though the CDC Director Frieden declared that “overdoses involving prescription painkillers are at epidemic levels” back in late 2011, significant public attention to this problem as the “opioid crisis” and “opioid epidemic” has primarily developed over the past three years.

Figure 1 presents combined CDC data on mortality attributed to opioids and Google Trends data on internet searches for these terms over the past five years as an indication of when the opioid problem started to be considered an “opioid crisis” or “opioid epidemic.” These data show that as opioid overdose deaths have been continuing to rise over the past five years, it was not until sometime in late 2015 that internet users began to increasingly use the terms “opioid crisis” and “opioid epidemic.”

FIGURE 1

### Opioid Overdose Deaths Began Increasing Long Before Widespread General Public Recognition of the Problem

National opioid overdose death rate and Google Trend results for interest over time in the “opioid crisis” and “opioid epidemic” in the United States



**Notes:** Google Trends explains that the Interest Over Time values “represent search interest relative to the highest point on the chart for the given region and time. A value of 100 is the peak popularity for the term. A value of 50 means that the term is half as popular. Likewise a score of 0 means the term was less than 1% as popular as the peak.”

Though this graph begins in 2010, the first wave of opioid overdose deaths is generally viewed as beginning in 1999. This graph should not be interpreted as suggesting that the first signs of an increase in opioid overdose deaths began in 2010. Instead, this graph is intended to convey that widespread public *recognition* of the significant increases in opioid overdose deaths began long after the increases in opioid overdoses had already begun.

This shift in language and increasing national attention to the opioid issue is not only a rhetorical change. Stakeholders have reported that such heightened public attention and a definitive designation of a public health issues as an epidemic has increased the public’s expectation that policymakers “do something” about the problem. Many state decisionmakers were already fully aware of the problem prior to the increase in national attention and had already been working on the problem for a long time. However, the complex and numerous consequences of the opioid crisis were already and remain very challenging for policymakers to address. Increasing public expectations and urgency make that task even more difficult as policymakers must govern within the context of a crisis.

However, growing public awareness and declaration of the “opioid overdose epidemic” also creates new opportunities for policymakers. In particular, the federal government has appropriated significant funding for addressing opioid issues. As concern about very limited state resources was the single most

common concern among the policymakers we spoke with in 2015, the appropriation of substantial federal resources offers new opportunities for policymakers to meet the unmet need for treatment, as well as leveraging additional policy options that were previously unavailable due to a lack of resources at the state level.<sup>1</sup>

Though states have certainly continued to develop and implement opioid-related policies since we spoke to them in the summer of 2015, the insights gained from those conversations provide important context for opioid-related policymaking in the current and future environment, where there are prospects for significant federal resources as well as intense public expectations for actions. Before describing several of the general policy approaches and experiences from across the seven states, the next section of this brief describes insights on the process of state opioid policymaking.

## Insights on the Process of State Opioid Policymaking

### Data Are Critical for Identifying and Targeting Specific Opioid Problems

Though the opioid crisis is often described as if it is a single national problem, the specific characteristics of the problem vary widely across states, and even within counties. As a result, state policymakers sought to develop responsive policy solutions that accounted for these characteristics and other state-specific conditions. (For more information on the role of data in policymaking, see [Using Data and Evaluation in Policy Development, Implementation, and Monitoring: Building Successful Policies to Reduce Prescription Opioid Misuse](#).)

Policymaking efforts in most states began with some form of problem identification and targeting. Some states had sufficient data infrastructure to proactively identify specific drivers of their opioid abuse problem and highly impacted subpopulations, while others relied more heavily on secondary data sources and limited analyses. Others saw the need to improve their capacity to access, share, connect, and analyze data before they could effectively identify and address their state's problems.

Among the seven states participating in the first NGA Policy Academy, state Prescription Drug Monitoring Programs (PDMPs) were the single most prominent source of data on prescription opioid abuse. Many states also used other data sources to monitor public health trends related to prescription drug abuse, including hospital emergency room data, Medicaid claims data, and state medical examiner or coroner records. The states found access to these data useful for understanding and monitoring their prescription opioid problem but also recognized that data are only as useful as how well prescribers and dispensers enter and access data in the system.

While each state's specific data experiences were different, several factors affected states' ability and capacity to use data to drive their efforts:

- Presence of a dedicated staff person (often the PDMP administrator or a public health official) whose job encompassed analyzing relevant data, which played a critical role in enabling more proactive and timely analysis

- Preexisting data infrastructure
  - » States with a longer history of collecting information through the prescription drug monitoring program had more information to draw on and, according to some stakeholders, a greater degree of buy-in from providers who had begun to see the utility of such data for their own job
- Ability to leverage existing health surveys to learn more about the nature and extent of opioid abuse

States where such factors were not present relied more heavily on reappropriated or secondary data sources and very limited analyses.

### State-Specific Characteristics Affect the Available Policy Options

Beyond the data for identifying specific forms of the problem in a state, other characteristics of each state's culture and composition affected the availability and viability of different policy response options. The following factors significantly influenced each state's efforts to address the prescription opioid abuse problem in their state:

- **Balance between privacy and access to information.** All states value privacy, especially concerning medical information. Some states were unable to utilize prescribing data due to state privacy concerns regarding access of PDMP data to understand and address the prescription drug abuse problems. Some states greatly benefited from analysis of these data, in several cases using deidentified data (e.g., prescription drug monitoring program or PDMP, Medicaid claims data) to identify which groups and areas are most at risk for abuse, while protecting individual patient privacy.
- **Degree of public acknowledgment of prescription opioid addiction.** There can be a stigma and general lack of awareness of prescription opioid abuse and addiction among the public. In some states, high-profile instances of opioid abuse, overdose, or high national fatality rankings created an acute public awareness of the opioid abuse problem in the state. Other states had to do more work to raise public awareness of the problem.
- **Urban versus rural composition.** The distance between individuals and potential treatment services can impact the feasibility of reforms that may change service delivery. For instance, in rural states where a nurse practitioner may be the only medical provider within 100 miles, regulations and training affecting a nurse practitioner's authority to prescribe opioids or medication-assisted treatment (MAT) will have different consequences than in more urban states.
- **Primary source of the prescription opioids being abused.** States differed both in how and what they identified as the primary sources of prescription drugs being abused. Stakeholders in some states perceived pill mills as a major source of illicit opioids, while others cited friends and family, providers in other states, and poor prescribing practices. All these different sources of

prescription drugs contribute to the same problem of opioid abuse, but each requires a different solution.

- » At the same time, stakeholders acknowledged the difficulty in ascertaining where illicitly-used drugs come from. Some states used surveys or other data to answer this question, while others appeared to rely more on the observational experiences of practitioners.
- **Available funding.**<sup>2</sup> Some states had more resources available to address prescription opioid abuse. States also found the levels of funding for existing programs were an important consideration, as some policy solutions effectively redistributed the demand for different services in a manner that agencies were not equipped to handle.
- **Medicaid expansion and treatment services capacity.**<sup>3</sup> Several states were working toward making Medicaid resources available for opioid addiction treatment services. This option was not as widely available in non-Medicaid expansion states. However, even in states which had expanded coverage, a shortage of doctors and clinics providing relevant services limited the availability of these services.

In short, while common problems and [policy solutions](#) do exist, they can also vary greatly due to the details of each state's specific opioid misuse patterns, overdose epidemic, and the conditions affecting viable solutions.

### *Reflection Point*

Before adopting solutions that have been applied in other states, it is useful to understand the state-specific nature of the opioid overdose epidemic and the conditions influencing potential reforms. Based on those understandings, states can develop or adapt more responsive solutions to their unique prescription opioid abuse conditions.

## **Policy Implementation Is an Iterative Process Requiring Continuity of Relationships and Resources**

As with any policy reform, successful implementation of policies to address opioid abuse can be affected by many factors. The seven states participating in the first NGA Policy Academy consistently identified three factors, both positive and negative, that impacted their ability to implement their policies: long-term sustainability through political transitions, informal relationships and information exchanges, and access to resources.

### **LONG-TERM SUSTAINABILITY AND CONSISTENCY**

Though addressing prescription opioid abuse is widely recognized as an important—and typically nonpartisan—issue, changing circumstances and political factors may cause specific initiatives or even the overall problem to lose priority in the transition from one governor's administration to the next. If the incoming administration comes from an opposing political party, it is possible that the next governor

may even be discouraged from prioritizing the issue if it was connected too strongly to their predecessor. In this case, it is incumbent upon the first administration to advance their policy efforts in a sufficiently robust manner that the policies can endure with minimal involvement of or attention from a subsequent administration.

Among the seven states, most had experienced or were anticipating such a transition in administrations. They described several approaches to sustain efforts through political turnover. Several states recognized the importance of statutorily establishing independent commissions to coordinate and prioritize reform efforts, whose members would remain in their positions through changes in administration. This approach was seen as more robust than a Governor's Task Force created by executive order, which could easily be rescinded by a subsequent administration. Others pointed to career staff in key roles (e.g., PDMP administrator) who served as important sources of continuity and expertise through the new administration.

### *Reflection Point*

Opioid-related policy efforts are rarely “quick fixes.” Specifically designing policy reforms to endure transitions in gubernatorial administrations helps increase the chances of long-term success. Likewise, stakeholders believed that while executive orders and Governor's Task Forces demonstrated significant commitment and prioritization of the issue, statutorily established commissions seemed better suited to drive sustainable policy efforts.

### INFORMAL RELATIONSHIPS AND INFORMATION EXCHANGES

As with any policy initiative, informal relationships and open channels of communication were often identified as critical to advancing efforts to combat prescription drug abuse. Though in many cases such relationships already existed, this area was one in which stakeholders pointed to the NGA Policy Academy as helpful in strengthening their efforts.

States entered the Policy Academy at varying stages in their efforts to develop and implement prescription drug abuse reduction policies. Some states had already adopted policies or even enacted extensive legislation. Others were at the beginning of their efforts. Among interviewed stakeholders who attended NGA's first Policy Academy, nearly all thought that it accelerated but did not initiate their efforts to address prescription drug abuse in their states by creating the conditions for progress. In particular, stakeholders found the following aspects of NGA's Policy Academy to have a positive impact on their ability to develop and implement key policies:

- **Having a trusted and neutral convener facilitate coalition building.** NGA's nonpartisan and trusted reputation allowed governors' administrations to more easily bring together different constituencies that could have otherwise been challenging to assemble. In at least one state, a university was also able to play this neutral third-party convening and coordinating role.

- **Creating an external accountability mechanism for ensuring progress in the face of competing priorities.** NGA’s role as a convener for internal state efforts provided an external accountability mechanism that kept the states working toward their goals. Organizing the Policy Academy as a *series* of meetings and technical assistance also introduced external deadlines for strategic planning, which helped prioritize the work.
- **Establishing and strengthening informal relationships within state teams.** Sharing the Policy Academy experience with others from within and across state teams helped build relationships that were useful in executing the policy strategies the team developed. The informal social bonds formed or strengthened between the states’ representatives helped lead to relationships in which individuals could “just pick up the phone” and resolve issues quickly by calling the right person.
- **Focusing discussions on a single issue in an out-of-town setting.** Bringing key stakeholders into a new environment allowed them to break from their normal routines and created a designated space and time for policymakers to sit down with their peers and focus on a single issue. This opportunity to concentrate stakeholders’ attention and brainstorm around a problem was seen as valuable and uncommon.
- **Existence of a strong “policy champion” to drive and coordinate efforts.** Addressing prescription drug abuse can require coordination across a wide range of government agencies, organizations, health care providers, and private companies. Having an in-state policy champion was key to bringing together various disconnected group and coordinating execution of states’ strategic plans. However, at least one state articulated the importance of not imposing a hierarchical leadership authority, but instead facilitating a sort of flat organization where everyone is equally accountable to everyone else.
- **Opportunity to share ideas and experiences with counterparts from other states.** Stakeholders consistently reported that the opportunity to learn from the experiences of other states was one of the most valuable elements of the Policy Academy. Cross-state conversations allowed stakeholders to exchange information about different tactics they had tried, what was successful and what failed, and how they handled problems that arose along the way. Stakeholders explained that they valued the information gained from other states above all other information presented during the Policy Academy, though many found other information (e.g., expert presentations) to be useful as well.

### *Reflection Point*

The problems connected to rising opioid overdose deaths are very broad and span the responsibilities for multiple state agencies and organizations. Coordination and good relationships are critical parts of successful policy efforts. The conditions created by process-oriented policy events, like the NGA Policy Academy, can accelerate progress by facilitating exchange of ideas and informal relationship-building among peers involved in implementing reforms.

#### **ACCESS TO RESOURCES<sup>4</sup>**

Available funding was the most commonly expressed limitation across the seven states. However, each state found several ways to address this challenge to some extent, either by making use of existing resources or developing new approaches with little or no new cost. Several states also found ways to make use of federally funded programs or were competing for federal grants to cover the costs of certain initiatives.

Addiction treatment services were the most widely recognized need across all seven states, but also the most expensive component of any state plan. For some states, the Affordable Care Act presented an opportunity to use Medicaid resources to partially cover these costs by expanding eligible diagnostic codes to include substance abuse, mental/behavioral health, and pain management services. Some states further expanded coverage to include services that had not traditionally been funded through Medicaid, such as peer support, wraparound substance abuse services, case management, and alternative forms of pain management, such as physical therapy.

However, even in states that expanded Medicaid, stakeholders reported that addiction treatment services remained out of reach to many of those in need of assistance. Several states reported that even if Medicaid would cover relevant services, they faced shortages of providers in key specialties such as addiction medicine, psychiatry, and medication-assisted treatment. Especially in rural areas, states reported that they lacked sufficient capacity even among private/non-Medicaid providers, let alone those that accept Medicaid. One state even considered funding loan forgiveness programs or working with medical schools to increase the number of doctors providing these services. At least one state reported that eligible substance abuse services were effectively inaccessible to a large portion of the state's population because the copays were too high for the lower-tier plans and the higher-tier plans were not affordable. As a result, stakeholders in several states reported that the criminal justice system was the only or primary source of treatment services.

Resources were also a major concern for ensuring safe drug disposal. Several states took advantage of prescription drug disposal events sponsored by the Drug Enforcement Administration (DEA) where people could dispose of their unwanted prescription drugs at a designated time and location, with no questions asked. However, these events were logistically burdensome and offered infrequently. All states either operated or explored the possibility of creating their own ongoing prescription drug

disposal programs, typically in the form of drop boxes located in police departments. However, stakeholders in some states reported delaying efforts to expand or establish these programs in anticipation of forthcoming DEA regulations on such programs; given the operating costs, states did not want to invest in drug disposal programs that may not comply with the new regulations. Once the DEA's new regulations were released in September 2015, stakeholders in several states described them as too long and complex to be easily understood or acted upon. For all forms of disposal, stakeholders noted that raising public awareness about how and where to dispose drugs was both a significant cost and important prerequisite to success.

Given their limited resources and competing priorities, stakeholders in several of the seven states explained that their teams were not able to spend enough time identifying and understanding, let alone responding to, the opportunities and resources available to help address prescription opioid abuse in their state (grants from federal agencies, foundations, corporations, etc.).

### *Reflection Point*

Some of the most desired policy solutions can be expensive and require a consistent flow of resources to be properly implemented. External resources from the federal government, foundations, and private businesses can be critical. However, in 2015, these resources could be prohibitively difficult to find and overly burdensome to use in some cases.

## Insights on Several Common Policy Approaches Explored across States

As described in the last section, treatment options were the most frequently sought solution across states, but they were also the most vulnerable to funding constraints. Alternatively, several different forms of prevention were often pursued for their potentially high value and lower costs.

### **The PDMP Is Most Useful When Used Routinely by Prescribers and Dispensers, and When Available for Multiple Purposes<sup>5</sup>**

In 2015, every state in the US but one had passed legislation authorizing the creation of a PDMP, which is an electronic database designed to capture information about the prescriptions and drugs dispensed to patients across the state.

For prescribers and pharmacists, the PDMP is intended to be a tool to ensure safe prescribing by providing access to patients' prescription histories across the state. The PDMP can also help prescribers recognize instances of potential "doctor shopping" or inappropriate drug use. For state officials, the PDMP can provide important data for monitoring public health trends. For law enforcement, the PDMP has the potential to provide key evidence in criminal investigations of diverted opioid supply chains.

The states found access to these data useful for understanding and monitoring their prescription opioid problem, but also recognized that data are only as useful as how well prescribers and dispensers enter and access data in the system.

### ENHANCING THE VALUE OF THE PDMP BY INCREASING ROUTINE USE BY PRESCRIBERS AND DISPENSERS

All seven states required dispensers (i.e., pharmacists) to enter information into the PDMP about the medications provided to patients, but requirements for prescribers (i.e., doctors) to use this information varied. Some states made it mandatory for prescribers to check the PDMP before prescribing certain medications perceived as more likely to be abused. Other states deliberately chose not to mandate prescriber behavior and focused instead on prescriber education and culture change as a potentially more effective strategy for changing behavior.

One way that states sought to encourage greater PDMP use was by making the system easier for prescribers to use. For example, based on discussions with prescribers, providers, health associations, and licensing boards, some states authorized providers to delegate PDMP data entry to assistants, instead of requiring (often very busy) doctors to enter the information themselves. Others streamlined or automated the prescriber registration process, or adjusted how frequently users must change their passwords. Additionally, several states sought to overcome resistance to PDMP use by emphasizing its value as a tool to help doctors track prescriptions and detect potential misuse or abuse in a clinical setting. One stakeholder reported that once doctors got over the initial hurdle of registering and using the system for the first few times, many began to see the PDMP as a valuable tool. Others reported that the PDMP could provide a seemingly objective tool or source of backup for doctors uncomfortable confronting patients about potential abuse.

While all the states recognized the value of the PDMP as a tool for prescribers to monitor a patient's prescriptions, there was also a common awareness that aspects of prescribing decisions should not be wholly automated (i.e., locking out a patient from receiving medications above a predetermined threshold). Rather, the system was viewed as a tool for raising awareness of a patient's potentially problematic prescription history so doctors could make more informed decisions. To increase the utility of this information, several states also authorized the use of alerts that would proactively inform doctors when patients met a predefined risk threshold for potential doctor shopping behavior (e.g., seeing more than five different doctors and/or five different pharmacists in a three-month period). However, the extent to which prescribers made use of those alerts varied, as did acceptance of using the system in this manner.

#### *Reflection Point*

Other stakeholders, in addition to prescribers, can benefit from prescribers regularly using their PDMP. To improve regular use, making the PDMP easier for prescribers to use can be a viable alternative to simply mandating they use the system.

## ACCESSING THE VALUE OF THE PDMP AS A COMPREHENSIVE DATA SOURCE ON PRESCRIPTION OPIOIDS

Beyond prescriber and dispenser use of a state's PDMP to monitor medications for individual patients, nearly all seven states resisted access by other stakeholders. Concerns largely centered around patient privacy, excessive government access to personal information, potential for abuse, and the possibility that excessive regulation of doctors might affect care or push providers out of the state. There was great variation across the states in terms of who had access to the PDMP data and for what purpose:

- **Systemwide monitoring of aggregated data to identify trends.** The data contained within the PDMP provide a valuable picture of prescription drug use in the state, but restrictions in some states limited or prevented this picture from being developed. One state was so restrictive as to limit even state health officials from examining the data in an aggregated form to find trends and patterns. In contrast, three states prioritized efforts to open forms of this information to the broader public by creating data dashboards for examining trends in a wide range of data.
- **Systemwide monitoring to identify problem prescribers.** In some states, review panels composed of policymakers and practitioners used PDMP and other data to regularly examine prescribing patterns within their state. From their review and interpretation of the data, these panels were able to identify potentially problematic prescribing behavior and respond accordingly. Responses included notifying doctors that they were among the most frequent opioid prescribers for their specialty; targeting outreach and education about appropriate opioid prescribing to the top tier of prescribers; and, in some cases, referring doctors to the state licensure board for further investigation. However, states were also wary of a “chilling effect” that might prevent doctors from prescribing *appropriate* medications and emphasized that cases should be reviewed by a doctor from the same specialty who could speak to whether the level of prescribing was appropriate in that context.
- **Deidentified data for research purposes.** States varied in whether they allowed PDMP data to be used for research. Several states had statutory limitations on the extent to which such research could be conducted within the state government; others lacked the resources or expertise to conduct such research even if it were permissible. Some regulations also restricted the extent to which state governments could partner with universities or other third-party organizations (e.g., national research centers, insurance companies, etc.) for research purposes.
- **Law enforcement investigations of criminal drug diversion.** Several states allowed law enforcement officials with training and credentials to access and review the data system to investigate suspected illegal behaviors, and another allowed its medical licensure board to proactively open investigations (as opposed to the majority, which required that a complaint be filed externally). In many states, law enforcement officers were able to request specific PDMP records with a warrant. However, other states completely prohibited the use of PDMP data for law enforcement purposes.

### *Reflection Point*

When using PDMP data for nonclinical purposes, policymakers should carefully consider the appropriate balance between data privacy and data utility. Policymakers should also make it clear how the information will and will not be used when it is collected.

## **Enhancing Options for Prescribers Is Critical for Properly Addressing Pain While Preventing and Treating Abuse<sup>6</sup>**

Opioids remain a powerful and immediate means of managing certain types of pain. Among stakeholders from the seven states participating in NGA's first Policy Academy, there was a shared understanding that a primary cause of the current opioid epidemic was a long-developing trend among prescribers to increasingly and regularly rely on these drugs for managing patients' pain. While several reasons were identified for this—from a focus in medical education on under-treatment of pain, to marketing by pharmaceutical companies, to limited research—the negative consequences of such routine use of prescription opioids have only become more widely recognized over the past several years. Changing prescribing behavior in response to this new realization has happened slowly, leading states to adopt different approaches for changing prescriber behavior:

- **Prescribing guidelines.** Several national and state-level organizations and agencies have developed safe opioid prescribing guidelines for doctors. Typically, these take the form of checklists or educational documents rather than enforceable rules, reserving the final prescribing decision to doctors' discretion. However, encouraging providers to learn and use these guidelines presented challenges: one stakeholder noted that unless prescribing guidelines are conveyed to staff, published widely in health care settings, and have clearly defined prescribing limits and thresholds (such as a recommended morphine-equivalent daily dosage limit), they will have limited utility.
  - » There was also a concern about a potential “chilling effect” that might occur from over-regulation and mandates. More specifically, policymakers were concerned that prescribers would begin to feel scrutinized by Big Brother examining their behaviors and potentially decide to withhold proper prescribing of medication to patients as a result. With these concerns in mind, some states deliberately adopted more informal and education-based approaches to influencing prescribers' behaviors, rather than mandating behaviors through regulations.
- **Education and training to raise awareness.<sup>7</sup>** Several states prioritized efforts to improve prescribing behavior by educating providers around several key topics, including addiction generally and to opioids specifically, safe opioid prescribing, pain management, and use of the PDMP. Many states attempted to incentivize training on these topics by leveraging continuing medical education (CME) requirements. While at least one state passed requirements that

prescribers devote a certain number of their CME hours to prescription drug abuse-related topics, others sought to encourage training by developing free courses and/or emphasizing that doctors could receive CME credit for participating. Several stakeholders also identified the need to educate the next generation of doctors through medical school curricula and residency programs to raise awareness and increase the number of treatment providers in the future.

- **Medication-assisted treatment and pain management facilities.**<sup>8</sup> In addition to addressing prescribing behaviors, several states reported that in order to effectively address the prescription drug abuse problem, they must build capacity to treat and prevent addiction and dependence. In particular, states emphasized the need to train and certify more doctors to provide MAT for opioid dependence. Despite indications that MAT can help reduce risk of relapse, few doctors are certified to provide this treatment, and several states noted that the required trainings are currently expensive, far away, and otherwise too burdensome to be a reasonable opportunity for interested doctors. Additionally, stakeholders in every state noted the importance of overcoming the substantial amount of stigma and skepticism about MAT, perceiving that many doctors preferred referring patients to abstinence-based treatment. Outside of MAT, stakeholders noted the need to train doctors in more comprehensive pain management that included a focus on treating underlying causes and promoting alternative forms of treatment besides prescription pain relievers.
- **Changing the culture around prescribing.** In some cases, states expanded educational efforts outside of the realm of formal education and introduced a number of initiatives designed to raise awareness and promote culture change around prescribing. In many cases, these efforts sought to engage licensed doctors and pharmacists as advocates who have credibility among other health professionals and who are able to make powerful “provider-to-provider” appeals for doctors and pharmacists to address prescription drug abuse.
- **Demonstrating the PDMP’s value to help doctors recognize and respond to “doctor shopping.”** Stakeholders in several states noted that health professionals often feel uncomfortable confronting a patient about potential drug-seeking behavior or denying them pain medication. They found that doctors appreciated the PDMP as a tool they could use to validate their own intuitions when they did suspect doctor shopping. The PDMP reports also gave prescribers evidence they could use to respond to a patient’s accusations of being harsh, cruel, or unfair. At the same time, encouraging doctors to consistently run searches for use of prescriptions was important as several stakeholders reported doctors being surprised by patients who contradicted their view of “typical drug abusers” but who PDMP data revealed to be misusing drugs.

Practicing medicine inherently requires a case-by-case approach and discretionary decisionmaking to respond appropriately in each individual case. Mandating how prescribers should behave in all cases limits that discretion and risks producing unintended consequences. While some states did make targeted restrictions on prescribing in certain types of cases, others preferred providing prescribers with resources to guide and inform their decisionmaking. For instance, several states sent proactive

reports to prescribers issuing the highest proportion of prescriptions for opioid pain medications within a given medical specialty to inform them of how their prescribing compared to their peers. Stakeholders explained that prescribers often may not know their prescribing was outside the norm. Intuitively, this information can encourage prescribers to change their behavior, and anecdotally some stakeholders perceived this was the case in their states. Balancing requirements and opportunities can create conditions that allow doctors to discover and solve the general problem of over-prescribing opioids without adversely impacting their ability to be responsive in specific cases.

### *Reflection Point*

The culture around prescribing opioids is a critical aspect of addressing prescription opioid abuse, but culture is difficult to change through legislation. Balancing requirements with useful resources that allow prescribers to better recognize and respond to the problem of prescription opioid abuse can be an effective strategy.

## **Law Enforcement Can Fulfill an Important and Unique Public Health Role**

Many states were first alerted to prescription drug abuse through law enforcement as officers responded to overdoses. However, all seven states took the perspective that prescription drug abuse is fundamentally a public health problem. Stakeholders from both public health and criminal justice agencies consistently explained that “we can’t arrest our way out of the problem.” In several states, this meant a much larger shift toward responding to addiction and substance dependency with treatment, as opposed to solely traditional criminal justice responses.

This perspective affected the role of law enforcement in several ways. While law enforcement continued to play an investigative role in combating deliberate and organized prescription drug diversion, they also operated as public health partners in many states. On the investigation side,<sup>9</sup> one ongoing debate in states was the degree to which law enforcement could access PDMP data. Generally, access was very limited across states: few states allowed law enforcement officials to have direct access to the PDMP, and the few that did allow access limited it to highly regulated applications. Other states required law enforcement to submit a warrant before accessing any PDMP data, and/or allowed them to access the data only through an intermediary such as the PDMP administrator.

On the public health side, several states described law enforcement responding to prescription drug abuse in ways outside their traditional enforcement role, playing an important part in efforts related to overdose response, diversion from the criminal justice system, and drug disposal.

- **Police are often first responders in cases of drug overdose and can channel such cases into the health system.** In cases of overdose, police are often first to the scene. Recognizing this, as of mid-2015 many states were developing programs to equip and train officers to perform emergency overdose reversals by administering naloxone. The programs were often accompanied by Good Samaritan reporting laws, whereby an individual can call the police or

other emergency responders for help when someone overdoses without fear of prosecution for their own drug use.<sup>10</sup> In some cases, states were also exploring crisis intervention training programs and establishing crisis triage centers for officers to quickly deliver someone to a health service provider and return to their duties, rather than arresting the person.

- **Prescription medication drop boxes seem convenient, but they have questionable utility and can be problematic for law enforcement.** Every state that participated in the NGA Policy Academy had, at least in some locations, established prescription drug drop boxes. Typically, drop boxes are operated out of police stations with a “no questions asked” policy to allay fears of potential consequences to individuals who dispose of their drugs. Though these boxes appear to be convenient and intuitive solutions, stakeholders raised several challenges:
  - » Drop boxes often collect a lot of trash and over-the-counter drugs that are not at risk of being abused.
  - » Drop boxes present significant targets for theft.
  - » Once drugs are collected, disposal can be costly. Regulations require that disposed drugs be accompanied by law enforcement officers at all times, yet in many states the closest drug incineration facilities were several hours away or in another state, requiring significant officer time to transport. Some states also noted that law enforcement departments were reluctant to operate drop box sites because they viewed them as outside the domain of their work.
  - » Stakeholders in five of the seven states expressed reluctance to invest in expanded or alternative disposal options as the DEA had repeatedly delayed the release of new regulations, which would determine what disposal options were legal and possible.
  
- **Other parts of the criminal justice system also play a role in handling opioid cases as more of a public health issue than a criminal justice issue.** For instance, some of the states specifically emphasized greater use of drug courts as a means of being more responsive to individuals’ medical needs in the course of delivering justice. Other states have included a focus on training Department of Corrections staff to make referrals to services and help increase Medicaid enrollment to facilitate access and use of treatment, especially MAT.

### *Reflection Point*

Law enforcement officers can provide a valuable point of public health engagement when they are given training and support to enable them to respond in more treatment-centric ways to situations involving drug abuse or overdose.

# Conclusion

Significant public attention to the escalating opioid problem in the United States is relatively recent. This new attention has raised important awareness, a sense of urgency for government officials to “do something” to address the problem, as well as the prospect of significant federal resources dedicated toward solutions. However, the opioid problem in the United States is complex, and the escalating pressures of more widespread public recognition of the worsening problem as a “crisis” or “epidemic” can both fuel continued efforts and further complicate the challenge for state policymakers.

While public attention to the issue may be relatively new, state policy-makers have been paying attention to the opioid problem and working on solutions long before it was described as a crisis or epidemic. They have been developing understandings of the many dimensions of the problem; attempting different solutions when significant federal resources were not a possibility; and learning about what does and does not work for implementation. Governing during a crisis is difficult and chaotic. State policy-makers can gain a better sense of direction for their policy efforts going forward by reflecting on the insights from early state efforts to address the opioid crisis.

## Notes

- <sup>1</sup> It is important to acknowledge that there has been a steep increase in federal funding to address the opioid crisis, and that the work of many stakeholders has continued and grown since this research was conducted in 2015.
- <sup>2</sup> These insights are meant as a retrospective on the perspective of stakeholders from around 2015. It is important to recognize that there have been significant new developments since then, including increases in funding availability and accessibility.
- <sup>3</sup> In late 2017, the Centers for Medicare & Medicaid Services (CMS) [announced](#) a new Medicaid policy that allows states “to pay for a fuller continuum of care to treat substance use disorders, including critical treatment in residential treatment facilities that Medicaid is unable to pay for without a waiver.
- <sup>4</sup> These insights are meant as a retrospective on the perspective of stakeholders from around 2015. It is important to recognize that there have been significant new developments since then, including increases in funding availability and accessibility.
- <sup>5</sup> Since these insights were collected from state stakeholders, additional federal resources and guidance have become available. For example, “[Prevention for States](#) is a program that helps states combat the ongoing prescription drug overdose epidemic. The purpose of Prevention for States is to provide state health departments with resources and support needed to advance interventions for preventing prescription drug overdoses.
- <sup>6</sup> Since these insights were collected from state stakeholders, the [CDC](#) has “developed and published the [CDC Guideline for Prescribing Opioids for Chronic Pain](#) to provide recommendations for the prescribing of opioid pain medication for patients 18 and older in primary care settings. Recommendations focus on the use of opioids in treating chronic pain (pain lasting longer than 3 months or past the time of normal tissue healing) outside of active cancer treatment, palliative care, and end-of-life care.”
- <sup>7</sup> In response to concerns and requests from the states at the time these insights were collected, new awareness and educational resources have been developed, such as the [Information for Providers](#) page of the CDC’s drug overdose website.
- <sup>8</sup> The Substance Abuse and Mental Health Services Administration (SAMHSA) currently offers a variety of [resources](#), including online trainings for MAT services. Additionally, in June, 2018, SAMHSA released a [call for](#)

applications from states and territories to receive federal funding “in support of their ongoing efforts to provide prevention, treatment and recovery support services to individuals with opioid use disorder.”

<sup>9</sup> It is also worth noting the PDMP is not the only significant source of information for law enforcement’s investigation activities. The DEA’s High Intensity Drug Trafficking Areas (HIDTAs) Program, and specifically the Heroin Response Strategy (HRS), have been organized to facilitate intelligence sharing across jurisdictions and agencies for the purposes of disrupting the supply of illegal opioids and reducing the number of opioid-related overdoses.

<sup>10</sup> For a review of the updated status of state Good Samaritan laws concerning naloxone, see the Network for Public Health Law’s brief on “[Legal Interventions to Reduce Overdose Mortality: Naloxone Access and Overdose Good Samaritan Laws.](#)”

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