

Reducing Prescription Drug Abuse: Lessons Learned from an NGA Policy Academy

Introduction

Prescription drug abuse is driving an epidemic of overdose deaths that increased for the 11th consecutive year in 2010.¹ 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

To help governors address that public health and safety crisis, the National Governors Association (NGA) launched the *Prescription Drug Abuse Reduction Policy Academy*, a year-long initiative led by Alabama Gov. Robert Bentley and Colorado Gov. John Hickenlooper. Through the policy academy, NGA worked with seven states—Alabama, Arkansas, Colorado, Kentucky, New Mexico, Oregon and Virginia—to develop comprehensive, coordinated strategic action plans for reducing prescription drug abuse.

This paper highlights lessons learned from the policy academy that can inform other states' efforts to combat the problem. Those lessons are:

- Leadership matters;
- Prescribing behavior needs to change;
- Disposal options should be convenient and cost-effective;
- Prescription drug monitoring programs (PDMPs) are underused;

- Public education is critical;
- Treatment is essential; and
- Data, metrics, and evaluation must drive policy and practice.

The paper also reviews the challenges policy academy states encountered in developing and implementing their plans, strategies they adopted to overcome those challenges, and outcomes they have achieved.

The NGA Prescription Drug Abuse Reduction Policy Academy

To assist state efforts in reducing prescription drug abuse, NGA launched the *Prescription Drug Abuse Reduction Policy Academy*.³ Over the course of a year, governor-appointed teams from the seven states participated in a strategic planning exercise with the goal of developing and taking the first steps toward implementing action plans tailored to address each state's challenges and priorities. Through the academy those teams had the opportunity to learn about best and promising practices from experts, practitioners, and researchers as well as their peers from around the country. (Additional information about the policy academy is included in the accompanying Appendix.) State teams were multidisciplinary and included cabinet secretaries of health and public safety agencies, governor's health and criminal justice policy advisors,

¹ Press Release, "Opioids drive continued increase in drug overdose deaths," Centers for Disease Control and Prevention, U.S. Department of Health and Human Services, Feb. 20, 2013, http://www.cdc.gov/media/releases/2013/p0220_drug_overdose_deaths.html

² C.M. Jones, K.A. Mack, L.J. Paulozzi, "Pharmaceutical Overdose Deaths," *The Journal of the American Medical Association*, February 20, 2013; 309(7): 657-9.

³ The work of the policy academy was originally designed around a series of recommendations including: 1) Make better use of prescription drug monitoring programs; 2) Enhance enforcement by coordinating operations, providing specialized training, and strengthening existing laws; 3) Ensure proper disposal of prescription drugs; 4) Leverage the state's role as regulator and purchaser of services; 5) Build partnerships among key stakeholders; 6) Use the bully pulpit to promote public education about prescription drug abuse.

Medicaid and public health officials, representatives from substance abuse and behavioral health agencies, treatment providers, law enforcement officials, legislators, physicians, researchers, and pharmacists. Participation by such a diverse group of stakeholders was important to developing a state response that was both comprehensive and coordinated.

Although states have only recently begun implementing their action plans, they have already taken a number of significant steps forward, including passing legislation, developing public awareness campaigns, conducting trainings for providers, launching cross-agency and regional initiatives, and forming partnerships with universities and the private sector. Governors' support of the policy academy process and the action plans that state teams developed has been key to realizing those achievements. Their buy-in helped create a sense of urgency and opportunity among stakeholders to reduce prescription drug abuse and, ultimately, save lives.

Lessons Learned

Over the course of the policy academy, a number of key insights emerged. Those lessons build upon recommendations NGA made in its 2012 issue brief, *Six Strategies for Reducing Prescription Drug Abuse*, and provide additional guidance to states seeking to reduce prescription drug abuse.

Leadership matters.

The response to prescription drug abuse is fragmented across different agencies and levels of government.⁴ Consequently, efforts to reduce the problem can be duplicative, result in conflicting guidance on recommended practice, and lead to inefficient use of resources.

However, through strong gubernatorial leadership, states can overcome those challenges. As the state's

chief executive, governors are responsible for setting public health priorities for their administration. With authority over state agencies that would implement a statewide plan to reduce prescription drug abuse, governors can help ensure accountability and see that objectives are achieved. As conveners, governors can bring together key stakeholders to promote collaboration and consensus that will be necessary to sustain efforts in the long-term. As leaders, they can serve the role of public champion, elevating the importance of reducing prescription drug abuse, securing buy-in among stakeholders, and creating momentum for change.

Alabama Gov. Robert Bentley and **Colorado** Gov. John Hickenlooper demonstrate the role governors can play in driving an effective statewide response. Gov. Bentley, a physician by training, helped spearhead passage of three bills that target prescription drug abuse and illicit prescribing by providers.⁵ Gov. Hickenlooper made reducing prescription drug abuse a key goal of his State of Health Initiative, a statewide effort that aims to improve the health of Coloradans.

As part of the initiative, Colorado set a goal of preventing 92,000 Coloradans from engaging in non-medical use of prescription pain medications by 2016, reducing current rates of misuse from 6 percent to 3.5 percent.⁶ In addition, the governor launched the Colorado Consortium to Reduce Prescription Drug Abuse at the Colorado School of Public Health. The consortium houses Colorado's plan to reduce prescription drug abuse, which will help coordinate implementation efforts and promote collaboration among the governor's office, the attorney general's office, state agencies, and other stakeholders.⁷

In 2012 **Kentucky** Gov. Steve Beshear led a bipartisan effort to pass HB1, which increased regulations of pain

⁴ "Prescription Drug Overdose: State Health Agencies Respond," Association of State and Territorial Health Officials, 2008, page 2.

⁵ Those laws are the Alabama Prescription Database and Advisory Committee Act, Act 2013-256, HB150; Alabama Pain Management Act, Act 2013-257, HB151; and the Alabama Doctor Shopping Act, Act 2013-258, HB152.

⁶ Colorado Plan to Reduce Prescription Drug Abuse, September 2013, page 7, available at http://www.cms.org/uploads/CO_Rx_Plan_FL-NAL_09.11.13.pdf

⁷ Colorado Plan to Reduce Prescription Drug Abuse, September 2013, page 9, available at http://www.cms.org/uploads/CO_Rx_Plan_FL-NAL_09.11.13.pdf

clinics to reduce the number operating as “pill mills” and required all providers of controlled substances to register with the state’s PDMP.⁸ In 2013, he signed a bill into law that clarified and strengthened HB1’s requirements, based on input from the medical community, law enforcement, licensing boards, and agency stakeholders.⁹ In summer 2013, the state reported that the number of prescription drug overdose deaths had declined for the first time in a decade.¹⁰

Prescribing behavior needs to change.

During the policy academy, agreement emerged among most state participants that controlled prescription drugs and opioid pain relievers in particular are being overprescribed. Nearly all prescription drugs involved in overdoses come originally from a prescription, rather than theft, and more than three out of four people who misuse prescription pain relievers use drugs prescribed for someone else.¹¹ Over the last decade, the increase in overdose deaths and treatment admissions has closely paralleled the increase in number of opioid pain relievers sold. In fact, opioid pain relievers are now the most widely prescribed class of medications in the United States.¹²

To change prescriber behavior, states primarily focused on educating providers about best practices. In addition, they adopted legal measures aimed at reducing the diversion of prescription drugs for illicit uses. **Arkansas** developed prescribing guidelines for emergency physicians and pain medicine specialists

and posted them in emergency departments across the state. The state is also working to incorporate education on prescription drug abuse and to integrate the state’s PDMP into the curricula of state medical schools. To educate providers on key provisions of HB1 and its accompanying regulations, **Kentucky** developed training courses that providers could take to meet Continuing Medical Education requirements.

Similarly, **Oregon** and the Oregon Medical Association partnered with Boston University School of Medicine and Case Western Reserve University to train prescribers on safely and effectively managing patients with chronic pain. Oregon has also directed state Medicaid providers to adopt evidence-based prescribing guidelines developed by the Opioid Prescribers Group, a group of 70 healthcare professionals from counties in Southern Oregon formed to establish community standards for chronic pain management and opioid prescribing.¹³

Alabama also developed trainings for providers, which includes a focus on treatment options for addicted patients. In addition, Alabama passed two bills in 2013 that targeted pain management services and doctor shopping. The Alabama Pain Management Act (Act 2013-257, HB151) increases regulations for pain clinics to reduce the number operating as pill mills.¹⁴ The Alabama Doctor Shopping Act (Act 2013-258, HB152) establishes criminal penalties for doctor shoppers, defined under the law as those who deceptively

⁸ HB1 was enacted in 2012 as the “Requires Use of Prescription Monitoring System by Physicians,” KRS § 218A. See also “Mandating PDMP participation by medical providers: current status and experience in Kentucky,” PDMP Center of Excellence, November 2013, <http://www.pdmpexcellence.org/sites/all/pdfs/COE%20briefing%20on%20mandates%2011%2014%2013.pdf>

⁹ H.R. 217, 2013 Gen. Assemb., Reg. Sess. § 1(4) (Ky. 2013)

¹⁰ Press Release, “One Year In, Landmark Prescription Drug Bill Shows Huge Impact,” Office of Kentucky Gov. Steve Beshear, July 25, 2013, <http://migration.kentucky.gov/newsroom/governor/20130725hb1.htm>

¹¹ “Policy Impact: Prescription Painkiller Overdoses,” National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention, Centers for Disease Control and Prevention, <http://www.cdc.gov/homeandrecreationalafety/rxbrief/>, accessed November 14, 2013.

¹² News Release, “Opioids Now Most Prescribed Class of Medications, Penn Researcher Finds,” Penn Medicine, April 5, 2011, http://www.uphs.upenn.edu/news/News_Releases/2011/04/opioid-prescriptions/. See also “Prescription Painkiller Overdoses in the US,” CDC Vital Signs, November 2011, <http://www.cdc.gov/vitalsigns/painkilleroverdoses/>

¹³ Southern Oregon Opioid Management website, <http://www.southernoregonopioidmanagement.org>

¹⁴ Pill mills are clinics that operate outside the scope of accepted medical practice, prescribing or dispensing narcotic painkillers inappropriately or for non-medical reasons, often in exchange for cash. Under Alabama’s law, pain clinics are required to have a medical care director who is a physician licensed to practice in Alabama. It requires that pain clinics be owned by doctors licensed to practice in Alabama or a business registered with the Secretary of State, and it gives the Alabama Board of Medical Examiners subpoena power to investigate pain clinics who may be operating as pill mills.

conceal from a doctor that they received the same or similar prescription drugs from another physician at the same time.

Disposal options should be convenient and cost-effective.

Reducing the oversupply of prescription drugs through proper disposal is an important component of an effective action plan. A challenge for states is changing consumer behavior to follow recommended disposal practices. Under the Drug Enforcement Administration's (DEA) current disposal guidelines, consumers are advised to dispose of controlled substances in drop boxes at police stations or during DEA take-back day events, which have been held seven times over the past three years.¹⁵ For many, those options may not be available or convenient, leading people to dispose of medicines in household trash or by flushing them down the toilet. Although the Federal Drug Administration does recommend flushing some prescription drugs,¹⁶ states expressed concerns that using that method for all drugs may pose risks to the public health and environment.¹⁷ Mail-in programs for controlled substances, which the DEA's proposed regulations to implement the Secure and Responsible Drug Disposal Act of 2010 would authorize if finalized, could offer a convenient way for consumers to get rid of leftover medications.¹⁸ But the cost of postage could potentially deter them from using that method, and city and county governments on limited budgets might not be able to cover the expense.

To encourage proper disposal of leftover medications, states can ensure that available disposal options are convenient for consumers and cost effective. Policy academy states focused on promoting take-back days and educating the public about safe storage and disposal, and several are working to increase the number of permanent drop boxes in their states. **Kentucky** has increased the number of its permanent drug take-back sites in the state to 170, and **Arkansas**, through the "MONITOR SECURE and DISPOSE" Drop Box Project, has awarded 60 new drug collection units to law enforcement agencies, with priority given to agencies from counties that currently lack them.¹⁹

Prescription drug monitoring programs are underused.

PDMPs are effective tools for collecting and analyzing prescription data,²⁰ but across the country they remain underused. Providers do not routinely check PDMP data to identify patients who are abusing or diverting prescription drugs, or to make clinical decisions about appropriate patient treatment.²¹ According to a report prepared for the Office of the National Coordinator for Health Information Technology in 2012, only 5 percent to 39 percent of providers use PDMP data, depending on the state.²² Providers do not use PDMPs for several reasons: they are not aware of the benefits or are not registered to use them; data is not current or real-time; there are limitations on authorized users; and processes for accessing the databases do not easily integrate into clinical workflows.²³ In many states,

¹⁵ See Title 21 Code of Federal Regulations, § 1307.21, Procedure for disposing of controlled substances, available at http://www.deadiversion.usdoj.gov/21cfr/cfr/1307/1307_21.htm, accessed November 14, 2013. Also see Press Release, "Americans Turn Out in Doves for DEA's Seventh National Prescription Drug Take-Back Day," Drug Enforcement Administration, November 6, 2013, <http://www.justice.gov/dea/divisions/hq/2013/hq110613.shtml>.

¹⁶ See "Disposal of Unused Medicines: What You Should Know," Federal Drug Administration, 2013, <http://www.fda.gov/drugs/resourcesforyou/consumers/buyingusingmedicinesafely/ensuringsafeuseofmedicine/safedisposalofmedicines/ucm186187.htm#MEDICINES>

¹⁷ See "Epidemic: Responding to America's Prescription Drug Abuse Crisis," White House Office of National Drug Control Policy, 2011, http://www.whitehouse.gov/sites/default/files/ondcp/issues-content/prescription-drugs/rx_abuse_plan_0.pdf

¹⁸ See Federal Register, Vol. 77, No. 246, Friday, December 21, 2012, available at <http://www.gpo.gov/fdsys/pkg/FR-2012-12-21/pdf/2012-30699.pdf>

¹⁹ "New prescription drug drop-boxes go out statewide," THV11, October 1, 2013, <http://www.thv11.com/news/article/281709/2/New-prescription-drug-drop-boxes-go-out-statewide>.

²⁰ See "Briefing on PDMP Effectiveness," PDMP Center of Excellence, http://www.pdmpexcellence.org/sites/all/pdfs/briefing_PDMP_effectiveness_april_2013.pdf

²¹ "Enhancing Access to Prescription Drug Monitoring Programs Using Health Information Technology: Workgroup Recommendations," The MITRE Corporation, August 17, 2012, page 6, available at http://www.healthit.gov/sites/default/files/pdmp_work_group_recommendations-1.pdf

²³ "Enhancing Access to Prescription Drug Monitoring Programs Using Health Information Technology: Workgroup Recommendations," The MITRE Corporation, August 17, 2012, page 7, available at http://www.healthit.gov/sites/default/files/pdmp_work_group_recommendations-1.pdf

privacy concerns also limit the extent to which PDMP data can be used for law enforcement, public health, and research purposes.

To improve clinical workflow and make it easier for providers to access PDMP data, **Arkansas** is working to integrate its PDMP with the state's electronic health records system. **Alabama** and **Colorado** are exploring the same option. **Virginia** is working to integrate its PDMP with ConnectVirginia, the Commonwealth's health information exchange, which electronically connects physicians and providers for sharing of patient health information. **Alabama** and **Oregon** passed legislation that allows physicians to delegate PDMP access to authorized employees.²⁴ Oregon's law authorizes physicians in **California**, **Idaho**, and **Washington** who treat Oregonians to access Oregon's PDMP, and it allows public health authorities to use PDMP data without patient identification for research and other purposes. **Alabama**, **Arkansas**, **Colorado**, **Kentucky**, **New Mexico**, **Virginia** and seventeen other states utilize three data sharing hubs to share data across state lines with each other and with authorized users; all three hubs are interoperable and will exchange data upon completion of MOUs.²⁵

Kentucky created a system that allows prescribers to run PDMP reports on their own practice to monitor for diversion of controlled substances. To increase physician registration with the state's PDMP, **Virginia's** Department of Health Professions will automate PDMP registration by tying to it to the license renewal process for providers.

Public education is critical.

To help people make informed decisions about using and storing prescription drugs, it is critical to educate them about the risks posed by prescription drugs. Prescription drugs are often assumed to be safe to take because a doctor prescribes them.²⁶ When appropriately prescribed and used, prescription pain medicines offer therapeutic benefits, but in some circumstances they have limited efficacy in treating chronic pain and, if misused, can lead to addiction, overdose, or death.²⁷

To promote greater awareness about the potential dangers of prescription drugs, **Alabama** launched a public education campaign designed to reach all age and socioeconomic groups through advertisements at gas stations, in movie theaters, on television, through social media, and in community magazines. As part of the campaign, the state also developed an online clearinghouse and education materials. **Arkansas** developed a toolkit for teachers, youth, and school counselors about prescription drug abuse, and **Kentucky** developed and distributed 20,000 brochures providing guidance on safe storage, safe disposal, and how to access substance abuse treatment.

Treatment is essential.

Treatment is critical to breaking the cycle of addiction and an essential component of a state action plan for reducing prescription drug abuse. Addiction is a chronic disease, and those who are addicted to prescription drugs are likely to need long-term care in order to achieve abstinence and recovery.²⁸ Indeed,

²⁴ Alabama Prescription Database and Advisory Committee Act, Act 2013-256, HB150; Oregon Legis 550 (2013), SB470.

²⁵ The three hubs are Rx Check, operated by the IJIS Institute, Rx Sentry, operated by Health Information Designs, and the National Association of Boards of Pharmacy's PMP InterConnect program. As of December 10, 2013, states in addition to Alabama, Arkansas, Colorado, Kentucky, New Mexico, and Virginia that are engaged in interstate data sharing include Arizona, Connecticut, Delaware, Florida, Illinois, Indiana, Kansas, Louisiana, Maine, Michigan, Minnesota, North Dakota, Ohio, South Carolina, South Dakota, Tennessee and Wisconsin. See Prescription Monitoring Program Training and Technical Assistance Center at Brandeis University, Prescription Drug Monitoring Programs (PDMPs) Interstate Data Sharing Status, December 12, 2013, http://pdmpassist.org/pdf/PDMP_interoperability_status_21031210.pdf. See also Prescription Monitoring Program Training and Technical Assistance Center at Brandeis University, Current sharing matrix 20131210-2, available upon request at: <http://pdmpassist.org/contact/>

²⁶ National Institute on Drug Abuse, "Topics in Brief: Prescription Drug Abuse (Revised December 2011)," <http://www.drugabuse.gov/publications/topics-in-brief/prescription-drug-abuse>; "Epidemic: Responding to America's Prescription Drug Abuse Crisis," White House Office of National Drug Control Policy, 2011, http://www.whitehouse.gov/sites/default/files/ondcp/issues-content/prescription-drugs/rx_abuse_plan_0.pdf

²⁷ See Andrea Trescot, et al., "Effectiveness of Opioids in the Treatment of Chronic Non-Cancer Pain," *Pain Physician 2008: Opioids Special Issue*, March 2008.

²⁸ *Principles of Drug Addiction Treatment: A Research-Based Guide, Third Edition*, National Institute on Drug Abuse, National Institutes of Health, U.S. Department of Health and Human Services, December 2012.

reducing the availability of potentially addictive prescription drugs without also providing effective treatment may drive those who are addicted to seek illegal narcotics. New research shows that a reduction in the opioid pill supply may lead to a rise in heroin use.²⁹ Heroin offers a potentially cheaper, more readily available alternative to opioid pain relievers. One study of heroin users in urban areas found that 86 percent had reported using opioid pain relievers before transitioning to heroin.³⁰ A consequence of that shift has been a new cohort of young heroin users in some parts of the country with Hepatitis C.³¹

Although treating substance abuse can be expensive, research suggests that it costs less than the health and social costs of untreated addiction.³² The National Institute on Drug Abuse reports that every dollar invested in addiction treatment programs yields a return of between \$4 and \$7 in reduced drug-related crime, criminal justice costs, and theft.³³ Other potential benefits include reduced morbidity and mortality, and greater productivity in the workplace.³⁴

States can use limited resources most effectively by targeting high-risk populations and taking advantage of expanded access to treatment under the Patient

Protection and Affordable Care Act (ACA). Under the ACA, primary care now includes treatment, and health plans will be required to cover it.³⁵ To take advantage of new eligibility provisions under the ACA, **New Mexico** is developing a plan to enroll inmates in Medicaid upon release from prison. Through Medicaid, that high-risk population will have access to treatment, which can help reduce drug use and recidivism due to drug-related behavior.³⁶ **Alabama** plans to survey resources available for treatment in the state in order to develop a plan for treatment programs in rural areas where current options and resources are limited.

Data, metrics, and evaluation must drive policy and practice.

To develop an effective response to prescription drug abuse, states need accurate and timely information about the incidence and scope of their problem. They need to know what is driving drug abuse rates in their state and which populations are at greatest risk of overdose. That way, interventions can be targeted for greatest effect. Many states, however, lack this information or do not use or analyze it to the extent they could to inform their decision-making processes. Consequently, solutions may be misguided or fail to achieve the return on investment that policymakers are seeking.³⁷

²⁹ C.M. Jones, "Heroin use and heroin use risk behaviors among nonmedical users of prescription opioid pain relievers – United States, 2002-2004 and 2008-2010," *Drug and Alcohol Dependence*, 2013, <http://dx.doi.org/10.1016/j.drugalcdep.2013.01.007>.

³⁰ S.E. Lankenau, et al., "Initiating into prescription opioid misuse amongst young injection drug users," *International Journal of Drug Policy*, Vol. 23, Issue 1, pp. 37-44, 2012.

³¹ R.M. Kleivins, et al., "Evolving epidemiology of hepatitis C virus in the United States," *Clinical Infection Diseases*, Vol. 55, Issue supplement, pp. S3-S9, 2012.

³² *Principles of Drug Addiction Treatment: A Research-Based Guide, Third Edition*, National Institute on Drug Abuse, National Institutes of Health, U.S. Department of Health and Human Services, December 2012. According to a new report from the RAND Corporation, leading studies on cost of opioid dependence tend to underestimate the welfare and intangible costs associated with the problem. Emma Disley, et al., "Development of a framework to estimate the cost of opioid dependence," RAND Europe, December 2013.

³³ *Principles of Drug Addiction Treatment: A Research-Based Guide, Third Edition*, National Institute on Drug Abuse, National Institutes of Health, U.S. Department of Health and Human Services, December 2012.

³⁴ Along with expanded access to treatment, increasing the availability of naloxone can be an important intervention to reduce the number of overdose fatalities. Naloxone is an opioid antagonist that can reverse the effects of an overdose. It is not addictive, cannot be used to get high, and is easily administered by laypeople. A recent case study reports that successful reversals were reported in 89 percent of overdose events where naloxone was used. See L. Enteen, et al., "Overdose Prevention and Naloxone Prescription for Opioid Users in San Francisco," *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, Vol. 87, No.6, 2010. Measures states can take include passing "good samaritan laws" that provide legal protection for those who administer naloxone in an emergency situation and encouraging providers to co-prescribe it with opioids drugs.

³⁵ HealthCare.gov, <https://www.healthcare.gov/do-marketplace-insurance-plans-cover-mental-health-and-substance-abuse-services/>, accessed November 14, 2013.

³⁶ Susan Phillips, "Implications for Public Safety and Corrections Populations," The Sentencing Project, September 2012, available at http://www.sentencingproject.org/doc/publications/inc_Affordable_Care_Act.pdf.

³⁷ A new report from the RAND Corporation proposes a framework states can use to calculate the costs of different types of opioid dependence in varying contexts. This tool can help states justify potential cost savings to policymakers through interventions shown to reduce opioid dependence. See Emma Disley, et al., "Development of a framework to estimate the cost of opioid dependence," RAND Europe, December 2013.

In addition to PDMPs, other sources include: morbidity and mortality data; patient, provider, and public surveys; Medicaid and other claims data; behavioral health data; and emergency department and hospitalization data.

To ensure that interventions have their intended effect, states should incorporate an evaluation component into their plans. The benefits include: demonstrating the impact and value of policy, accountability for resources invested, and informing the development of future policies and initiatives.³⁸

Arkansas established a multiagency working group tasked with identifying available data sources to help guide intervention efforts and evaluate outcomes. **Colorado** began an effort to map all sources of data within the state related to the scope and incidence of prescription drug abuse. To evaluate its efforts, **Kentucky** entered into an agreement with the University of Kentucky to conduct a study of the impact of HB1 on use of the state's PDMP, doctor shopping, prescribing rates, treatment admissions, overdose hospitalizations, overdose deaths, Neonatal Abstinence Syndrome, provider surveys, and potential unintended consequences.

Looking Ahead

As the public health and public safety crisis of prescription drug abuse evolves, policymakers will need to be mindful of potential unintended consequences of the policy solutions they adopt. Much like squeezing a balloon, interventions targeted at one problem may create new problems elsewhere. Reducing the opioid

pill supply, for example, can have the unintended consequence of increasing heroin use. Laws aimed at unscrupulous providers can make ethical providers less willing to prescribe out of fear of scrutiny from law enforcement, or simply because compliance with additional regulations is burdensome. And one state's successful efforts to reduce illicit sources of prescription drugs, such as pill mills, can shift illegal activities to neighboring states. Policymakers can learn from other states' efforts in order to prepare for and respond to these and other potential unintended consequences.

Although the knowledge base of best practices is growing, more research is needed to determine which interventions are effective at reducing prescription drug abuse. Specifically, more research is needed on which approaches are most effective for changing prescribing behavior and which public messaging campaigns change consumer behavior. By incorporating an evaluation component into their action plans, states can improve understanding of which interventions work.

Prescription drug abuse is a complex problem that requires a long-term commitment to action by state, federal, and local officials if it is to be solved. With leadership from governors and comprehensive statewide action plans, states can help lead the way in addressing this growing public health crisis.

The Prescription Drug Abuse Reduction Policy Academy is in partnership with the National Safety Council and supported by the Association of State and Territorial Health Officials, the Robert Wood Johnson Foundation, CVS Caremark Corporation, Rite Aid Corporation, Pharmaceutical Research and Manufacturers of America, the Healthcare Distribution Management Association, Association of Safe Online Pharmacies, and Magellan Health Services.

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³⁸ Chris Jones, Presentation, NGA Prescription Drug Abuse Reduction Policy Academy Meeting, Denver, CO, May 7, 2013.

Appendix

Policy Academy Process

An NGA policy academy is an intensive, 9-month to 18-month process designed to assist states in developing strategic action plans for addressing a particular policy challenge. Based on input from governors and their staff, NGA identifies issues of critical importance to states that could be addressed through the policy academy process. A primary benefit to states of participating is the opportunity to receive direct assistance from national experts in developing tailored policy solutions. In addition, they have the opportunity to work with and learn from other states dealing with similar policy challenges.

States are selected to participate through a competitive application process, and they are usually required to submit a letter of support from their governor indicating a commitment to project goals and objectives. State teams are governor-appointed and made up of four to seven high-level state representatives, including governors' cabinet secretaries and policy staff, state legislators, and agency directors.

In spring 2012, NGA convened a group of 25 health and law enforcement representatives with expertise on prescription drug abuse.* Through a facilitated process led by NGA staff, those experts helped identify key recommendations that governors could adopt to reduce prescription drug abuse. Subsequently, NGA published an issue brief, *Six Strategies for Reducing Prescription Drug Abuse*, which highlighted those recommendations and served as a framework for identifying policy academy objectives and developing state action plans.

In July 2012, NGA issued a solicitation inviting states to apply to join the policy academy. Seven states were selected by an independent panel of reviewers and announced in September. Those states include **Alabama, Arkansas, Colorado, Kentucky, New Mexico, Oregon, and Virginia**. In October 2012, Alabama Gov. Bentley hosted a two-day meeting in Montgomery to educate state teams about effective strategies for reducing prescription drug abuse and to develop a core set of recommendations for addressing the problem in their state. Between January and April of 2013, NGA led workshops in each state to solicit stakeholder feedback, refine the recommendations that teams made in Montgomery, and develop a strategic plan for implementing them. In May 2013, Colorado Gov. Hickenlooper hosted a capstone meeting in Denver for states to share lessons learned and further refine their strategic action plans. Afterward, state teams proposed their plans to their governors for final approval. NGA continues to provide technical assistance in order to support implementation efforts.

**Roundtable participants included representatives of governors' offices, the Centers for Disease Control and Prevention, the Association of State and Territorial Health Officials, the White House Office of National Drug Control Policy, the National Association of Attorneys General, Brandeis University, the Alliance of States with Prescription Monitoring Programs, the National Association of Medicaid Directors, the U.S. Department of Justice Bureau of Justice Assistance, the National Safety Council, the Substance Abuse and Mental Health Services Administration, the Drug Enforcement Administration, the National Association of Boards of Pharmacy, the American Medical Association, the National Center on Addiction and Substance Abuse at Columbia University, the Partnership at Drugfree.org, the*