Maine Center for Disease Control and Prevention

An Office of the Department of Health and Human Services

John E. Baldacci, Governor　　Brenda M. Harvey, Commissioner

Prescription Drug Misuse: A Community Challenge

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Good Group Decisions

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ACKNOWLEDGMENTS

The Maine Injury Prevention Program (MIPP) recognizes the funding support of the federal Centers for Disease Control and Prevention which enabled this symposium to be possible. In addition, the MIPP thanks the members of the symposium Planning Committee and symposium speakers for their hard work and participation in bringing the event together. Lastly, the MIPP thanks the individuals representing various memberships, agencies, implementing partners, and interested private parties who have given their time in attending this symposium and in their ongoing injury prevention efforts.

Additional thanks are due to the Maine Center for Disease Control and Prevention, the Office of Substance Abuse and the Northern New England Poison Center for hosting the symposium.

EXECUTIVE SUMMARY

In 2005 the Maine Injury Prevention Program (MIPP) was fortunate to receive five year funding to conduct an Integrated Core Injury Prevention and Control Project through a cooperative agreement with the Federal Centers for Disease Control and Prevention (CDC). This agreement directly improved the capacity of the MIPP to develop a coordinated, strategic approach to reducing injury morbidity and mortality in Maine.

The MIPP and the Integrated Core Injury Prevention and Control Project selected the injury priority area of *unintentional poisoning* as its symposium topic, with a specific focus on prescription drug misuse. The Northern New England Poison Center, Office of Substance Abuse and MIPP designed and planning the symposium.

Dr. Dora Anne Mills, Director, Maine Center for Disease Control and Prevention, Kim Johnson, Director, Office of Substance Abuse and Anne Jordan, Commissioner of Department of Public Safety provided opening remarks.

The afternoon portion was divided into two sections: Enforcement, Medical, and Community presentations and Small Group discussions.

I. The Enforcement, Medical and Community Presentations

The Enforcement, Medical, and Community presentations featured:

Roy McKinney - The Role of the MDEA: Enforcement Perspective and Approach to Prevention, *Director, Maine Drug Enforcement Agency, Maine Department of Public Safety*

Dr. Lenard Kaye - Implementing a Statewide Mail-Back Program for Expired and Unused Prescription Drugs, *Director of the University of Maine Center on Aging and Professor of Social Work in the College of Business, Public Policy, and Health.*

Dr. Karen Simone - Substance Abuse and Poisoning – Scope of the Problem in Northern New England, *Director, Northern New England Poison Center*

Dr. Peggy Greenwald - The Ultimate Consequence: Drug Deaths in Maine
Chief, State Medical Examiner, Office of the Attorney General

Daniel Eccher - Maine's Prescription Monitoring Program: An Overview
Project Coordinator, Prescription Monitoring Program, Office of Substance Abuse, Department of Health and Human Resources.

II. Small Group Discussions

The Small Group discussions allowed symposium attendees to self select into a Community group or the Medical/Enforcement group. Facilitators asked the following questions:

1. In this specific area (medical, enforcement, community), what are the major challenges/barriers/obstacles to reducing the inappropriate use of prescription drugs, particularly among 18-25 year olds?
2. What are the most effective, practical solutions? For example, what's working right now in your community?
3. How best should outside agencies (medical, enforcement, and community) approach and talk to each other? For example, what is the best message and what is the best method for delivering it?

OPENING REMARKS

Katharyn Zwicker – Welcome
Public Health Educator, Maine Injury Prevention Program

The Maine Injury Prevention Program serves as Maine's lead agency for intentional and unintentional injury prevention. The Program is located within the Division of Family Health under the Maine Center for Disease Control and Prevention in the Department of Health and Human Services.

The Mission of the Maine Injury Prevention Program is to provide leadership and coordination to agencies statewide in order to integrate effective injury and violence prevention into their organizational practices.

In 2005 the Maine Injury Prevention Program (MIPP) was fortunate to receive five year funding to conduct an Integrated Core Injury Prevention and Control Project through a cooperative agreement with the Federal Centers for Disease Control and Prevention (CDC). This agreement directly improved the capacity of the MIPP to develop a coordinated, strategic approach to reducing injury morbidity and mortality in Maine. Through working with key partners, MIPP utilizes a data driven approach and has shifted focus from children, teens, and young adults exclusively, to the prevention of leading injuries across the lifespan.

The four identified injury priority areas are:
1. Motor vehicle traffic crash injuries.
2. Suicide and self-inflicted injuries.
3. Falls among older adults.
4. Unintentional poisoning.

Craig Freshley - Facilitator
President, Good Group Decisions

Conference Overview
Craig introduced colleagues Amy Scott and Karen Tucker. He explained that in addition to serving the group by moving them through the day, he and his colleagues would provide a written report to the participants summarizing the day's activities. Craig then reviewed the Conference Purpose.

Conference Purpose
1. To increase participant knowledge of the health risks involving the misuse of prescription drugs.
2. To increase awareness of prevention and enforcement efforts.
3. Identify barriers, solutions, and partnering opportunities to address these issues.

Dr. Dora Anne Mills - Role of Maine CDC
Director, Maine Center for Disease Control and Prevention

The Center for Disease Control and Prevention recognizes the seriousness of prescription drug misuse as a public health issue and is pleased to host this symposium.

In August 2005 the Injury Prevention Program received funding from the Federal Centers for Disease Control and Prevention to develop a more coordinated and strategic approach to reduce the incidence, morbidity, and mortality of injury in Maine across all ages through surveillance and prevention efforts. An Injury Prevention Advisory Group was convened to review the injury data across the age groups and identified the following as the four priority issues:

1. Falls prevention among older adults
2. Motor vehicle crashes across the life span
3. Poison prevention across the life span – including prescription drugs
4. Suicide prevention across the life span

Kim Johnson - Approach to the Issue
Director, Office of Substance Abuse, Maine Department of Health and Human Services

Two major events have contributed to prescription drug misuse:

1. Ten years ago the Food and Drug Administration issued a letter to pharmaceutical companies allowing direct-to-consumer prescription drugs marketing. Globally this is only legal in the USA and New Zealand.

   People have become accustomed to treat not just disease, but their own lifestyles. Adolescents and young adults now have grown up in a time when everything is medicated, and these youth are comfortable with sharing medications. College students, for instance, share each other's medications for all kinds of uses.

2. Long acting narcotics were introduced 10 years ago. These drugs are great when used appropriately. For example, these have been extremely helpful in treating cancer patients. However, time-release drugs brought the onset of large doses in one pill.

   Opiate addiction has become a huge problem. We started treatment centers, but we did not realize that an epidemic was forming. We had primary prevention, which would not reach the issue in time, and we had treatment centers for people already addicted. There was nothing in between. We needed time to learn.

Anne Jordan
Commissioner, Maine Department of Public Safety

Commissioner Jordan shared with her son that she was attending today's symposium and a conversation ensued about prescription use and abuse. He asked if the problem of "Skittles Parties" would be discussed. She asked what a Skittles Party was and learned that they are parties where kids bring drugs taken from medicine cabinets or elsewhere. The drugs are then combined into a large bowl and when mixed resemble Skittles candy, hence the term – Skittles Party. Kids then take handfuls of the mixed drugs having no idea of what is being ingested or the potential consequences.

Commissioner Jordan suggested that participants ask teenagers questions relating to Skittles Parties when appropriate (i.e. either as a "Hot-line" question or Examiners question to friends and family).

ENFORCEMENT, MEDICAL, AND COMMUNITY PRESENTATIONS

Roy McKinney - The Role of the MDEA: Enforcement Perspective and Approach to Prevention
Director, Maine Drug Enforcement Agency, Maine Department of Public Safety

Mission
- The mission of the Drug Enforcement Agency is to reduce distribution, availability, and use of illicit drugs using a collaborative statewide approach.

Drug Deaths
- There were 178 drug overdose deaths in 2005.
- The rate of accidental overdose has gone up.
- 140 of those were accidental compared to 17 accidental in 1997.
- Suicide overdose has been steady over time.
- Methadone is the leading drug in deaths in New Hampshire and Maine.

Leading Drug Concerns
- Maine Drug Enforcement Agency Arrests in 2006:
  - Cocaine 43%.
  - Prescription drugs 26%.
  - Heroin is going down slowly.
- In 2006, we seized over 6,000 prescription drugs. Narcotics was a huge percentage of these.
- Prescription drugs of concern:
  - Alprazolam
  - Buprenorphine
  - Carisoprodol
  - Cyclobenzaprine
  - Diazepam
  - Fentanyl
  - Hydrocodone
  - Hydromorphone
  - Methamphetamine
  - Methlphenidate
  - Oxycodone
  - Tramadol

Drug Diverter
- The diverter is not necessarily what we think of as a typical drug dealer.
  - There is money to be made in diverting prescription drugs. People will compromise themselves and their families to make this money.
  - Pills are as common as marijuana and permeate every level of the drug market.
- Abusers shop for doctors to prescribe, and then they distribute on the street. They are acquiring drugs by deception, fraud, and theft.
- Street prices – a few examples:
  - Valium: $4 each.
  - Xanax: $5 each.

- Klonopin: $5 each.

- Recognizing the abuser:
  - Unusual behavior.
  - Assertive personality.
  - Unusual knowledge of controlled substances.
  - Very demanding and controlling.
  - Exaggerate medical problems.
  - Mood disturbances.
  - Want to be seen right away.
  - Want to be seen at end of office hours.
  - Traveling through towns.
  - Will often travel circuits and know where they can score most easily.
  - May claim that non-narcotics don't work for them.
  - Prescriptions lost or stolen.
  - More requests for refills.
  - May utilize other people.
- Examples of deception:
  - False name or address.

Dr. Lenard Kaye - Implementing a Statewide Mail-Back Program for Expired and Unused Prescription Drugs

Director of the University of Maine Center on Aging and Professor of Social Work in the College of Business, Public Policy, and Health.

Legislation

- Historic legislation: Public Law 2003, Chapter 679
  - Maine Unused Pharmaceutical Disposal Program is being administered by the Maine Drug Enforcement Agency's Maine Drug Return Implementation Group
  - LD 411 "An Act to Establish a Pilot Program for Return of Unused Prescription Drugs By Mail" has given support to Chapter 679

Pharmaceutical Mail-Back Project

- The unused pharmaceutical Mail-Back project background:
  - Maine has received an Environmental Protection Agency grant.
    - Maine and St. Louis were chosen.
    - Maine is a rural state, with a low population density. Also, Maine is the "oldest" state with a median age of 41.2 years, and because Americans over 65 account for over 1/3 of prescriptions dispensed and have the highest non-compliance rate.
  - The goal is to have full-scale establishment of a Maine Unused Pharmaceutical Disposal Program.
  - Project goals are to remove unneeded prescription drugs and create a system to dispose of drugs in compliance with the system and priorities of the Maine Drug Enforcement Agency, Maine Department of Environmental Protection and the US Postal Service. Incineration is shown to be the best way to destroy drugs.
  - Returned drugs will be classified by what kind of drug, weight, toxicity, amount, and disposal cost.

Timeline of the Two-Year Plan

- There will be two phases over 18-24 months.
  - Phase I: 1,200 (1,800 is our personal goal) mailers will be provided at 25 pharmacies in Aroostook, Cumberland, Kennebec and Penobscot counties.
  - Phase II: Revise our methods of operation according to what is learned before making 4,800 (6,200 is our personal goal) mailers available in all 16 counties.
    - There will be no formal campaign to drive individuals into pharmacies to return medications until Phase II. In Phase I communications will be directed to those coming into the pharmacy for their own purposes.
    - Our aim is to increase the number of mailers distributed in both phases by 50% to 9,000 pieces, increasing to 75 pharmacies throughout the state.

Pharmaceutical Mail-Back Project Benefits

- Our neutral position as an educational institution provides a group to facilitate the process, with the stakeholder groups as the content experts.
- Drug Collection:
  - Prevent environmental exposure.
  - Minimize accidental overdoses and poisonings.
  - Limit "pharming' and drug-related theft.
  - Provide alternative to drug stockpiling – i.e. hurricane and tsunami disasters becoming recipients of stockpiled drugs without monitoring properly.
  - Preclude bad drug donations.
  - Reduce inefficiency in the health care system.
- Project Data collection: Geographic and demographic patterns of prescription drug accumulation and pharmacoeconomic assessments of waste and implications for prescribing, insurance reimbursement, and dispensing policies.

Projected Outcomes

- Reduce improperly disposed drugs and heighten awareness of unused medications.
- Educate older adults concerning hazards of unused medications and improper disposal.
- Reduce incidence of accidental deaths, human and animal poisonings, and suicides caused by unused medications.

Dr. Karen Simone – Substance Abuse and Poisoning – Scope of the Problem in Northern New England

Director, Northern New England Poison Center

Poison Center Overview

- The information presented here is based on Poison Center Abuse Data for Maine.
- Certified by American Association of Poison Control Centers in November 2004.
  - Hotline - 1-800-222-1222.
- In 2006 the poison center had almost 82,000 calls. The majority of calls are questions. An example of a question:
  - I just bought a pill with these numbers on it. What did I just buy?
- The poison center focuses on harm reduction.

Reason for Poisonings by Age

- Among young children, most poisonings are unintentional.
- Among teenagers and twenties, about half are intentional, half unintentional.
- Of the unintentional poisonings, most have no effect.
- Of the intentional poisonings, most have serious outcomes – death or near-death.

Substance Abuse by Teens

- The greatest percentages of substance abuse questions by teens are about Opiods followed by benzodiazepines.
- The rest of the list includes a wide range of drugs – aspirin, Tylenol, antidepressants, heart drugs, muscle relaxants, etc.
  - Teens are not necessarily getting high off many of these drugs, but rather are using them after, or in conjunction with, other drugs. For example, a teen might take an antidepressant to take the edge off after taking ecstasy. This is a big concern.
  - Some of these drugs are not regulated at all, such as skeletal muscle relaxants. This is dangerous.
- When teens get sick and call us, the number one reason is drugs for asthma, colds, eye, ear, nose, and throat issues.
  - A large dose of these drugs give an out of body experience, and teens often do this in a group.
  - Teens abuse many other substances including anything that can be inhaled or that contain alcohol.

Drug Concerns

- The bottom line is that any type of drug can be, and is, abused by teens and young people.
  - Drug companies often claim that certain drugs cannot be abused, but our data tells us otherwise. People are abusing all kinds of drugs and will crush, snort, or shoot most anything.

Prescription Drug Abuse

- We've been seeing prescription drug abuse for 20 years, but it is getting worse.
  - Prescription drugs are desirable because you know what you are getting.
  - We are seeing more prescription drug abuse in teens; we used to see more in the 30's age group.
  - When adults get sick and call us, the number one reason is alcohol, followed by opioids.
  - Teens and young adults are getting the drugs from health care providers, and also giving them to each other.

Dr. Peggy Greenwald – The Ultimate Consequence: Drug Deaths in Maine
Chief, State Medical Examiner, Office of the Attorney General

Dr. Greenwald, in collaboration with Dr. Marcella Sorg, Director of the Rural Drug and Alcohol Research Program at the Margaret Chase Smith Policy Center of the University of Maine, started to collect the data on deaths related to drugs in 2001. It was noted drug deaths in Maine began to increase exponentially in 2002.

Drug Deaths in Maine

- 1997: 34 drug related deaths.
- 2005: 176 drug related deaths.
- Drug related deaths began to increase exponentially in 2002.
- From 2002-2005 there were 657 deaths total, 77% accidental over dose.
- Ninety-two percent of all drug deaths involved prescription drugs. Eight percent of drug deaths involved only illicit drugs. Approximately 60% of drug deaths involved more than one drug or one drug with alcohol.
- In our area it is the opiates that predominate rather than the amphetamines, which predominate in other areas of the United States.
  - Most of our drug deaths are late 20's to early 40's.

Drug Death Defined

- Drugs must be listed on the death certificate as the cause of death or as significantly contributing to the death.
- Types of poison deaths are specific drugs, "poly drug or multiple drug toxicity" and listed in Part 2 as a "significant condition contributing to the death."

Cause of Death Determination

- History: Scene investigation. We take a scene inventory; look for evidence for suicide (note, will, etc.). For this we rely on law enforcement. Some send drugs with the body. We talk to family and friends: How was this person acting lately? Review medical records, personal talks with primary care physician.
- A lot of detail and work goes into determining what happened

Drug Deaths

- Typical story: person comes home intoxicated; falls asleep, was snoring, and then could not be revived in the morning. Examples of medical history: Back pain, was a methadone clinic patient, mental illness (bipolar, schizophrenia), and chronic pain - multiple drugs and medical problems.

Physical Examination

- Approximately 70% were autopsied in 2005. If someone is older than 50, or has a known disease, we do not usually autopsy. We do a physical examination and look for injection sites, co-morbid diseases, evidence of aspiration, and evidence of prior suicide attempts. Microscopic examinations of tissues are done if drug levels are not significantly elevated.

Autopsy Goals

- Find or rule out natural disease that may have caused the death.
- Find or rule out trauma that has caused the death.
- Take samples for toxicology and histology.

Laboratory Tests

- Give specific drugs, electrolytes, and blood or tissue cultures.
    - Laboratory tests help us to know what drugs are in the community, and the drugs found at scenes help to inform for which drugs to test.

Case Examples From 2005

- 50-year old female had history of lower back pain and substance abuse, also multiple physical problems. Was found dead in bed. Had several drugs in her system within therapeutic range, but had huge amounts of oxycodone and morphine.
    - We looked at scene, no records of morphine prescribed. No container at scene. Her cause of death was undetermined. High levels indicate suicide, but could have been a gesture of frustration.

- 53-year old male prescribed with methadone, succeeded in getting a double prescription. Mom described him as very tired and he snored during the night. He was not responsive in the morning.
    - Autopsy performed, still young, want to determine if toxicology is due to over dose, or was prescribed amount. Analyze this through volume of distribution and weight.
        - Some problems are that we never know when or how frequently medication is taken or in what dosage.
        - Manner of death is accidental.

Daniel Eccher – Maine's Prescription Monitoring Program: An Overview

Project Coordinator, Prescription Monitoring Program, Office of Substance Abuse, Department of Health and Human Resources.

Development of Prescription Monitoring Program

- Legislation passed in 2003.
- Data collection began in July 2004.
- Data submitted twice a month from over 300 pharmacies.
- Scheduled drugs (II, III, and IV).
- All transactions saved in centralized relational database.
- Some drugs are being abused but are not scheduled.

Goals for Maine's Prescription Monitoring Program

- Improve patient care by giving health care providers comprehensive information.
- Curb prescription misuse.
- Get those who are addicted into appropriate treatment.
- Help stop prescription drug overdoses.
- Educate the public on the dangers of prescription drug misuse.
- Ensure that those who do need prescription medications still receive them.

Who has access to the data?

- Prescribers.
- Dispensers.
- Licensing boards.
- Patients.
- Office of Substance Abuse staff.
- Law enforcement (AG's office) – through the Office of Substance Abuse, by subpoena, for a case they are currently investigating, regarding a given suspect.
    - Note that in other states, law enforcement can "fish" through the data, while in Maine, a subpoena is needed to access the information.

Benefits for Prescribers

- Providing better care:

Patient Threshold Reports – the "red flag" of potential addiction and/or diversion.

- PMP: Giving clinicians the ability to coordinate care with other prescribers.
- Health care tool for new patients: allowing a background check on prescriptions of Schedule II, III, and IV drugs prior to a patient's first appointment.
    - Online data access.

Benefits for the Public

- More likely to get treatment.
- Licensing Boards and Law Enforcement: timely and complete information for investigations from one source.
- Prevention of "doctor-shopping", overdoses and accidents.
- Valuable aggregate data: available to inform policies and standards around prescription drugs and identify trends in particular regions of the state.

Recruitment Section

- I have been speaking at conventions, hospitals and clinics in an effort to recruit prescribers.
- Maine Medical Association is involved in recruitment.
- People are hearing about this by word of mouth, so I encourage all of you who have contact with pharmacists or doctors to help with recruitment.
- Some hospitals are requiring that the emergency room use the Prescription Monitoring Program data before prescribing.
- It is important to note that many prescribers in Maine (licensed by the Drug Enforcement Agency) are not primary care providers. Also, many of the prescribers licensed by the Drug Enforcement Agency are not prescribing controlled substances. This tells us that we need to focus recruitment on the emergency room doctors and primary care providers.

Report on Group Discussions

The purpose of the small group discussion was to begin to identify barriers, solutions and partnering opportunities to address prescription drug misuse. These discussions were a unique opportunity to gather information from three different perspectives dealing with prescription drug misuse.

Small Groups

The full group was divided into two smaller facilitated groups for the afternoon session:

1. Community group
2. Medical/Enforcement group

Small Group Discussion Questions

Each group was asked the following three questions by the facilitators:

1. In this specific area (medical, enforcement, community), what are the major challenges/barriers/obstacles to reducing the inappropriate use of prescription drugs, particularly among 18-25 year olds?
2. What are the most effective, practical solutions? For example, what's working right now in your community?
3. How best should outside agencies (medical, enforcement, and community) approach and talk to each other? For example, what is the best message and what is the best method for delivering it?

I. Community Organizations

About 18 people representing community-based organizations convened. The following are the written and verbal responses of the discussion.

A. Challenges

For community organizations, what are the major challenges/barriers/obstacles to reducing the inappropriate use of prescription drugs, particularly among 18-25 year olds?

Information

- Getting information to them.
- Information not enough to change behavior.
- Muddled/confusing information - lack of credibility.
- Demonize a substance – not effective.
  - Focus on behavior.
- How do you communicate to this age group? Information not enough to change behavior.
- Lack of communication infrastructure.

Culture

- Cultural pressure.
- Culture of immediate fix.
- Generation disconnect - parallel lives.
- We don't know them – different from previous generations.
- Messages are challenging – for young <u>and</u> old.
- Significant use of prescription drugs – culture of medication.
- Lack of community norms about proper use of prescription drugs.
- Expectations re: pain.

Developmental

- Misconceptions that prescription drugs are safe.
  - Magnitude of problem
  - Consequences
- Developmental issues – do not see consequences.
- Patterns established.
- 18-25: in between teens and adults.
- Continuing/Reinforcement of risky behavior.
- New freedom.
- Prolonged adolescence.

Medical

- No Primary Care Physician (PCP) and lack of credibility for PCPs.
- Opportunity for isolation and deception.
- Over (or under) prescribing.
- Some Emergency Rooms (ER) unaware of the non-obvious substances of abuse (i.e.: Neurontin education was helpful).
- Treating addicts with pain – few to no pain clinics willing to offer alternative pain management techniques and controlled narcotics use.

- Question the assumptions that young people are being over-prescribed drugs. It is social access.
- Prescription Monitoring Program (PMP) – difficult to log in – not user friendly.

Community
- Lack of social supports – in a new community.

Media
- Influenced by media.

The three major issues identified were:
1. Development issues (such as risk-taking). These are issues that cannot be addressed in this.
2. Information about prescription drugs. There is an abundance of information and it is complex and confusing.
3. Culture.

B. Solutions

What are the most effective, practical solutions? For example, what's working right now in your community?

Verbal responses were recorded on flip charts. Once the list was complete, each participant "voted" for the top three solutions that had the most chance of being effective and practical.

Below, the responses are arranged in order of priority.

1. Insurance company changes.
   - Broader coverage of services.
   - Currently biased toward prescriptions.
   - Report back to them regarding: returns.
2. Prescription monitoring.
3. Media literacy.
4. Parent education and support.
   - Reduce child abuse.
   - Extend regarding: ages.
5. Reach 18-25 year olds.
   - Web-based media.
   - Peer support.
   - Via the work place.
6. More responsible advertising.
7. Use of Eastern traditions.
   - Alternative pain management.
8. Develop public health system – helps change the culture.
9. Increased awareness of abuse.
   - Public
   - Medical
   - Enforcement
10. Mail-Back program for younger people.
11. Support non-users..

- Peer leadership programs
- Appropriate risk taking

12. Mail-Back program statewide.
13. Health insurance among 18-25 year olds.
14. Healthy activities for 18-25 year olds.

The two solutions receiving the most votes were discussed as follows:

1. How to Broaden Insurance Coverage.

- Change legislation.
    - o Mandatory coverage for 18-25 year olds and increased services.
    - o Bring insurance representatives to the table.
    - o Demonstrate return on investment and long-term costs of abuse.
    - o Engage business community.
        - ▪ Bangor Chamber as an example.
        - ▪ Focus on Chamber WELLCOA.
        - ▪ Partner with current advocacy organizations.

- Change rules to expand coverage.
    - o Department of Human Services committee.
- Advocate for universal health care.

2. Prescription Monitoring Program

- Provider awareness.
- Encourage registrations.
    - o Reach practice managers.
    - o Get youth involved?
- Social marketing
    - o Pilot project – make more user friendly.
- Prescription Monitoring Program better linked.
- Educate providers.
    - o In a partnership.
    - o What's in it for them?
    - o Show cost/benefit analysis.
- Make it mandatory.
- Training CEU's – web-based.

C. Communications

How best should outside agencies (medical, enforcement and community) approach and talk to each other? For example, what is the best message and what is the best method for delivering it?

- Web conferences.
- Need a high-level/high-profile advocate?
    - Insurance industry.
    - Youth
    - Education
- Always define: what's in it for them?
- Always keep in mind the goal: healthy people.
- Community level summits.
- More Forums, info sharing on the agenda.
    - Create public health infrastructure in Maine and communication issues will start to be addressed.

II. Medical and Enforcement Organizations

About 22 people representing medical and enforcement organizations convened. The following are the written and verbal responses of the discussion.

A. Challenges

In the medical and enforcement areas, what are the major challenges/barriers/obstacles to reducing the inappropriate use of prescription drugs, particularly among 18-25 year olds?

Communication

- Disconnect among providers. Patients' access drugs from different providers at the same time due to lack of communication.
- Lack of communication among providers.
- How do we deal with information about patients? Phone calls are not always accurate.
- Communication among providers, ER's, LE, etc.
- Lack of integrated communication between providers and law enforcement.

Societal Attitudes

- People's entitlement to pain management.
- Patients need to take responsibility, but they do not do it.
- Change in use of narcotics. Increase in use, maybe a shift, over the counter drugs has given a new starting point.
- Societal acceptance of medicating people for every little problem.

Education

- Unclear protocol, there is a need for education around this issue.
- Lack of real awareness among parents, especially since kids are starting young.
- Lack of education around the potential of abuse. People are not necessarily intending to abuse.
- Parents don't know how to help their kids. Can you report anonymously? What are the ramifications?
- Education – cautions regarding social use leading to addiction.

Availability

- Availability – in the home, medicine cabinet.
- Direct to consumer marketing – "pill for everything."
- Kids think drugs are normal. Parents pop pills…
- Availability of medications in society.

B. Solutions

What are the most effective, practical solutions? For example, what's working right now in your community?

Medical Records

- Shared electronic medical records.

Prescription Monitoring Program

- Pass legislation requiring law enforcement data be submitted to the Prescription Monitoring Program.
- Include narcotics contract information in Prescription Monitoring Program.
- Increase use of program.
- Add sign-up sheet in licensure renewal.

Education

- Education campaign for providers, consumers and pharmaceutical industry on the judicious use of narcotics.
  - Financial sponsorship by pharmaceutical industry?
- Public education around use, misuse, proper storage, proper disposal, etc.
- More education for providers
  - Screening Brief Intervention and Referral to Treatment (SBIRT) provides a good model.

Providers

- Best practices: Outline all communications within the narcotics agreement between the patient and provider, and provide patient with lots of education.
- Integrated clinics – treat the whole person.
- More opportunities for counseling.
  - Dedicate financial resources through legislation and the industry.
- Allocate last resort funding for adults (counseling). Already exists for youth.
- Alternative pain solutions.

Legislation

- Rollback direct-to-consumer marketing by drug companies. (Change federal law.)
- Funding for treatment.

Community

- Be more involved in your community.
  - Start to teach children at a very young age.
- Bring agencies/stakeholders together to understand each other.
- Focus on prevention.
- Change societal view of drugs on a big scale. Tobacco is a good example of a successful societal shift.

Communications

How best should outside agencies (medical, enforcement, and community) approach and talk to each other? For example, what is the best message and what is the best method for delivering it?

- Nonprofits providing various services, but not collaborating with each other. They are competing with each other. Get nonprofits to communicate and collaborate, not compete.
- Provider should/can call law enforcement if there is evidence that a patient is diverting narcotics.
  - Provider is covered if they've been deceived.
  - Need to educate providers on what constitutes deception.

- Better communication and coordination of care within medical community.
- Post information on web site that explains clearly to providers "when to report…"
  - A document exists that educates people on how to share information on the Prescription Monitoring Program.
- Create a central database so that the process is transparent from the outset: patients, prescribers, law enforcement are all clear when a patient gets a prescription.

Appendix A – Conference Agenda

Prescription Drug Misuse: A Community Challenge

Monday, July 30, 2007

Maple Hill Farm Conference Center – Hallowell, Maine

Time	Session	Speaker
8:00-8:30	**Arrival / Registration / Sign in** **Refreshments**	
8:30- 8:40	**Welcome/ Meeting Overview**	**Katharyn Zwicker,** Maine Injury Prevention Program, Maine Center for Disease Control and Prevention **Craig Freshly,** Facilitator, Good Group Decisions
8:40-8:55	**Approach to the Issue** **Office of Substance Abuse** **Maine CDCP**	**Kim Johnson,** Director, Office of Substance Abuse, ME DHHS **Dora Mills,** Director, Maine Center for Disease Control and Prevention, ME DHHS
8:55-9:35	**The Role of the MDEA** **Enforcement Perspective and Approach to Prevention**	**Roy McKinney,** Director, ME Drug Enforcement Agency, DPS
9:35- 10:15	**Implementing a Statewide Mail-Back Program for Expired and Unused Prescription Drugs**	**Lenard Kaye**, Director of the UMaine Center on Aging and professor of Social Work in the College of Business, Public Policy & Health
10:15-10:30	**Break**	
10:30- 11:15	**Substance Abuse and Poisoning-Scope of the Problem in Northern New England**	**Karen Simone,** Director, Northern New England Poison Center
11:15-12:00	**The Ultimate Consequence**	**Peggy Greenwald,** Chief, State Medical Examiner, AG's Office
12:00-12:45	**Lunch**	
12:45-1:15	**Maine's Prescription Monitoring Program: An Overview**	**Daniel Eccher,** Project Coordinator, Prescription Monitoring Program, Office of Substance Abuse
1:15-3:30	**Breakout Introduction and Sessions** Medical Personnel Enforcement Community Groups	**Craig Freshly,** Facilitator, Good Group Decisions
3:30-3:45	**Evaluation / Attendance Certificate**	**Katharyn Zwicker,** ME CDCP