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American Society of Addiction
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Statement on Measures to Counteract
Prescription Drug Diversion, Misuse
and Addiction



ASAM

American Society of Addiction Medicine

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Background

Diversion of prescription drugs and the non-medical, sometimes lethal use of these drugs are parts of society's overall drug problem that are of special concern to physicians. The last two decades have seen dramatic increases in the use of and addiction to potentially addictive pharmaceuticals. Although the non-medical use of prescription drugs is not a new phenomenon, increases in cases of diversion, misuse, and overdose deaths have been striking and have drawn the attention of public health officials, regulatory agencies, and public policy makers on the state and national level; notable among the proposed responses to these problems is the published strategy of the White House Office of National Drug Control Policy, addressing educational, rehabilitative and disciplinary approaches.

Two of the most commonly misused classes of prescription medications are opioid analgesics and sedative hypnotics, both of which are considered "controlled substances" in that they appear in schedules for pharmaceuticals under the federal Controlled Substance Act.

According to the Centers for Disease Control and Prevention, the number of opioid analgesic prescriptions filled at pharmacies has increased from 175 million in 2000 to 254 million in 2009. Prior to that, however, prescription levels of these same drugs were considered too low, based on evidence that physicians--fearful that they would face rebuke from their peers or sanctions from licensure bodies for being "too liberal" in the prescribing patterns--would decline to offer prescriptions for controlled substances even when patients were in significant pain. Well intentioned researchers demonstrated, in short term studies, that the benefit: risk ratio was positive when terminally ill patients with painful conditions were treated with what had heretofore been considered high-dose levels of opioid analgesics. This research was embraced by policy analysts who influenced bodies such as the Federation of State Medical Boards to issue "reformed" guidelines supporting the use of opioids, even in high doses, for palliative care, for oncology care, for acute injury care, and even for the treatment of chronic non-cancer pain. These guidelines assure practitioners that, when they act in good faith, conduct thorough evaluations, document their rationale well, and monitor their patients carefully, they will not be

sanctioned for providing appropriate medical care. Elements of the pharmaceutical industry engaged in well documented efforts to increase the utilization of large doses of opioid analgesic as the preferred, if not first-line treatment for chronic pain, including chronic non-cancer pain; and financial incentives from industry drove endorsements by recognized physicians and thought leaders of the use of high dose opioids as a treatment for non-malignant pain. The recommendation that physicians and other medical personnel probe for cases of pain and intervene lest pain go undertreated, culminated in accreditation requirements, such as the often-cited "Pain Standard" of the Joint Commission, which would find health care organizations to be sub-standard if, on accreditation site visits, they could not demonstrate that they had in place a formal process to proactively extract from patients comments about their perceived level of pain at essentially every clinical encounter.

Knowing that many patients with pain also experienced anxiety or sleep disturbances, clinicians would often add sedative hypnotics to a regimen of chronic opioid analgesic therapy, leading to instances of oversedation, chronic use of benzodiazepines, tolerance, withdrawal, and even addiction to benzodiazepines among some chronic pain patients. Physician familiarity with prescribing benzodiazepines (some of the most frequently prescribed of all medications in the 1980s) and patient liking for these agents made the co-prescribing of opioids and benzodiazepines a not uncommon clinical scenario.¹

Pain management is an important component of high-quality compassionate medical care. There remains great controversy about the place of opioid medications in the treatment of pain, and little education of the non-pain specialist related to the differences in various types of pain. The fact that acute pain from a fracture or surgery is different from "failed back syndrome," or from chronic stable pain of musculoskeletal origin, is infrequently stressed as physicians consider whether to prescribe opioids for complaints of back pain. Differences between nociceptive pain (the somatic pain commonly resultant from injury or surgery), neuropathic pain (injury to the nerve itself), and central pain (as seen in fibromyalgia, some cases of chronic headaches, or complex regional pain syndrome) and differences in recommended clinical and pharmacologic approaches for these different presentations, are appreciated by pain medicine specialists but rarely by other physicians. Furthermore, the understanding of iatrogenic injury that can arise from the prescription of scheduled medications to patients with chronic stable pain of musculoskeletal origin has been hampered by the exclusion of persons with drug misuse histories from research studies.

Similarly, studies have shown that physicians have not received adequate education about the potential psychiatric and addiction consequences of the use of scheduled medications. Most practicing physicians have had little if any formal training in addiction; few physicians demonstrate understanding of the etiology of addiction. Although issues of tolerance and withdrawal are understood to exist, most physicians are not aware of the mechanisms and the behavioral consequences of addiction. Confusion still exists whereby some clinicians mistake physical dependence (tolerance and withdrawal) for addiction. Rarely are craving and reward



seeking behaviors appreciated by prescribers as being potential consequences of their prescribing of opioid and sedative medications.

The evidence that physician education about addiction would modify prescribing practices is controversial. Different medical specialties have argued that the educational needs of physicians within a given specialty must be tailored to that specialty, and broad, all-licensee educational mandates would be a waste of educational resources and practicing physicians' time. Others have argued that basic concepts on how to recognize addiction, how to recognize physical dependence and withdrawal syndromes, and how to safely taper and discontinue opioid analgesics and sedative hypnotics are so misunderstood by physicians, dentists, and other licensed independent practitioners, that basic education for all persons granted a federal registration to prescribe controlled substances is necessary. It is possible that education that only addresses basic science aspects of pharmacology and neuroscience will not improve patient outcomes unless it is paired with clinical education that addresses strategies for the management of pain, withdrawal, and addiction; clinical drug testing and other diagnostic approaches; as well as functional assessment and basic concepts regarding occupational medicine and disability determination.

What is clear is that the current situation is untenable. Governmental agencies and the public expect the health system to be responsible, to respond to current clinical and epidemiological challenges, and to be "part of the solution" to reverse trends regarding prescription drug diversion, misuse, addiction, and overdose deaths. The "secondary use" of controlled substances in potentially lethal ways (e.g., by persons who obtain supplies of pharmaceuticals that originated from a legal prescription, but was written for someone else) must be addressed through improved education and practice. All health professionals who can prescribe scheduled medications must be included in any educational efforts to improve patient outcomes and public health.

Recommendations:

The American Society of Addiction Medicine recommends that the following components be included in any public policy response to the growing problem of prescription drug addiction, diversion, misuse and overdose deaths.

I. Mandatory Prescriber Education

1. Mandatory education of physicians and all other health professionals licensed to prescribe, dispense or administer prescription drugs is a key strategy in modifying the epidemic of misuse of and addiction to scheduled medications. The Controlled Substances Act should be amended to require all professionals with prescribing authority for controlled substances to receive periodic training on prescribing of all scheduled medication classes as part of their continuing professional development.

Education should include safe discontinuation and withdrawal management strategies, prescribing practices that address the number of doses and number of

refills authorized in various clinical situations, and functional assessments for persons with chronic conditions where treatment plans include the prescribing of scheduled medications (this would include general medical conditions as well as psychiatric conditions, tailored to the practices of the particular prescriber).

- a. Any required training should cover all “scheduled” drugs and not be limited to schedule II drugs or certain formulations of drugs.
2. Prescribers should be required to take additional prescription drug training specific to the medical conditions they are treating in their practices and to their individual learning needs. For example, an internist treating a chronic pain patient with long-acting opioids should be required to learn how to appropriately initiate and discontinue treatment plans that include that class of drugs; such training would differ from that required for a dentist prescribing opioids after oral surgery. Similarly, prescribers should not be required to learn about practices which are beyond the scope of their specialty. For example, a general surgeon should not be required to learn about the treatment of psychiatric disorders with stimulants, and an oral surgeon should not be required to learn about the treatment of low back pain with opioids.
 - a. Content for mandatory training should be evidence-based and focused on symptom reduction, functional impairment, and careful management of the risks associated with the controlled substances being prescribed. Physician education modules and patient education materials should be developed with input from professional societies; not only those that represent primary care and medical/dental/surgical prescribers, but also those that represent addiction medicine, addiction psychiatry, pain medicine, occupational medicine and physiatry. Modules completed by certified professionals as part of the requirements of Maintenance of Certification programs and Maintenance of Licensure programs would ideally be able to be applied to the mandates created for training of professionals with prescribing authority for controlled substances.
 - b. Professionals with significant pharmaceutical industry relationships (as defined by the AMA’s Council on Ethical and Judicial Affairs) should not be involved in developing educational content for mandated prescriber training.

II. Patient Education

Prescribers of controlled substances have a responsibility to educate the patient at the time of issuing a prescription, about safe drug storage and disposal practices by patients.

Practitioners need to be educated on how to inform patients about locking medication supplies in the home (akin to locking firearms and ammunition, and locking toxic chemical supplies in the home) as a means of prevention of unauthorized use, theft, or accidental

overdose by children. Physicians, dentists and others need to be part of the solution to the prescription drug overdose epidemic by helping patients (who may be parents or grandparents) become part of the solution to the public health crisis of prescription drug misuse and addiction.

III. Medical School and Residency Education

Training for the medical students and residents should include curriculum that focuses on pain medicine, addiction medicine, safe prescribing practices, safe medication storage and disposal practices, functional assessment of patients with chronic conditions, and the role of the prescriber in patient education.

IV. Prescription Drug Monitoring Programs

Prescription drug monitoring programs can be effective clinical tools in medication management involving controlled substances. In 2005, President Bush authorized the federal National All Schedules Prescription Electronic Reporting (NASPER) program to issue grants to state interested in establishing or enhancing prescription drug monitoring programs (PDMP). However, funding for NASPER has been inconsistent, not all states have an operational PDMP, and few state PDMPs are interconnected.

1. NASPER should be permanently authorized and adequately funded.
2. PDMPs developed by various states should be available for review by clinicians across state boundaries.
3. PDMP data should be available in real-time by clinicians considering a decision to authorize a prescription for a controlled substance.
4. PDMP data should be considered health information, and should be protected from release outside of the health care system (e.g., to law enforcement, the courts, employers, family members or others) unless there is a specific authorization from the individual patient to release personal health information (see ASAM Public Policy Statement on Confidentiality of Patient Records and Protections Against Discrimination).

V. Better Data Through Research

Epidemiological research conducted by the Centers for Disease Control and Prevention and others should be expanded to provide the best quality data on patterns of manufacture, distribution and sales of psychoactive drugs which have the potential for diversion and misuse. Better data is also needed on patterns of diversion and involvement of specific classes of scheduled drugs in being the direct and contributory causes of overdoses and drug-

related mortality. Health services research which profiles the prescribing patterns of individuals and classes of practitioners is an appropriate approach to learning more about how to reduce the incidence of prescription drug diversion, misuse, addiction, and overdose deaths.

¹ Ciccone DS, Just N, Bandilla EB et al. (2000), Psychological correlates of opioid use in patients with chronic nonmalignant pain: a preliminary test of the downhill spiral hypothesis. *J Pain Symptom Management* 20(3):180-192.