

Proceedings of the Summit:

# Tribal Prescription Drug Abuse Summit: Moving from Information Sharing to Action Plan



National American Indian & Alaska Native

**ATTC**

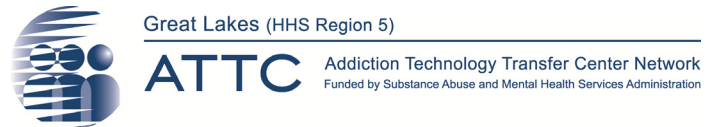
Addiction Technology Transfer Center Network  
Funded by Substance Abuse and Mental Health Services Administration



# Proceedings of the Tribal Prescription Drug Abuse Summit: Moving from Information Sharing to Action Plan

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In collaboration with the United States Department of Health and Human Services, Region V/Bemidji Area, Tribal Prescription Drug Abuse Workgroup, which includes representatives from the following operating divisions: Administration of Children and Families (ACF), Administration on Community Living (ACL), Centers for Medicare and Medicaid (CMS), Health Resources and Services Administration (HRSA), Indian Health Service (IHS), Office of Intergovernmental and External Affairs (IEA)



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To our regret, we were not able to contact all of the original presenters at the summit; this proceedings document does not include the materials of presenters whose transcripts could not be verified.

The content expressed herein is the work of the National American Indian and Alaska Native ATTC Network and does not necessarily reflect the official opinions or positions of the Department of Health and Human Services (DHHS), Substance and Mental Health Services Administration (SAMHSA) or the Center for Substance Abuse Treatment (CSAT).



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## Introduction to the Proceedings Document

Anne Helene Skinstad, Ph.D.,  
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On June 29<sup>th</sup> tribal leaders and representatives of the Health Resources and Services Administration (HRSA), Substance Abuse and Mental Health Services Administration (SAMHSA), Area Indian Health Service providers, Behavioral Health Directors, and representatives of two Addiction Technology Transfer Centers (ATTC) gathered in Bloomington, Minnesota, for the Summit: *Prescription Drug Meeting: Moving from Information Sharing to Action Plan Development*. The meeting was initiated by Dr. Jeffrey Coady, SAMHSA Region V Director. The need for such a meeting was identified by tribal leaders, who had expressed concerns about an increase in the use and abuse of prescription drugs in American Indian communities.

With limited data on prevalence of prescription drug abuse in American Indian communities, and much anecdotal information and stories from tribal leaders in both the Bemidji and Aberdeen area Indian Health Services (IHS), the focus of the day was on discussing the topic and trying to outline a course of action. The National Indian Health Boards have dedicated a specific part of their web/page to this topic:

[http://www.nihb.org/behavioral\\_health/prescription\\_drug\\_abuse\\_prevention.php](http://www.nihb.org/behavioral_health/prescription_drug_abuse_prevention.php)

The day started with an introduction to the day's topic by Dr. Coady, followed by a tribal blessing by Dr. Cecil White Hat.

Kenneth Munson then outlined federal initiatives and efforts to collaborate on prevention of prescription drug abuse across the country. In doing so, he reminded the audience of the Midwest Alliance of Sovereign Tribes/ HHS 2012 Tribal Consultations Session, where the issue of prescription drug abuse was discussed. He also referred to how the changes in the delivery of services outlined in the new Affordable Care Act might impact efforts to prevent prescription drug abuse.

Brooks Big John, who spoke next, related several stories told him by tribal members about prescription drug abuse. He then listed and discussed the pain killers/pain relievers that have been abused since 2000, raising the issue of the role of primary care physicians in reducing or enabling abuse of prescription pain killers: "Our primary care doctors may be enabling patients by knowingly and unknowingly prescribing pain medication to our tribal members."

David Bingman then summarized the Prescription Drug Abuse Prevention Plan and reminded us of the goals and objectives of the Summit. He reviewed the Public Health Plan for Action based upon four pillars. A crucial aspect of this action plan calls for tribal communities to create teams

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to work toward prevention and reduction of prescription drug use and abuse in order to create healthy tribal communities characterized by minimal abuse of prescription drugs.

Lawrence Scott reviewed the history of medication-assisted treatments (MAT) and reminded the audience of the dangers of overdosing on prescription drugs and pain medications. He focused on stories of teenagers who had overdosed on pain medications after having used opioid analgesics; some of these adolescents subsequently died from accidental poisoning. In this regard, Mr. Scott reminded the audience that data reported by the state of Michigan (MI) indicated that more than 60% of overdoses were those of young women between 14 and 25 years of age. This pattern of abuse has led to a substantial increase in the need for treatment for opioid addiction. In 2009 MI convened over 400 stakeholders to discuss this challenge. This work group developed a survey instrument to use as a community scanner among community coalitions and sovereign nations.

Denise E. Lindquist reviewed data from the State of Minnesota (MN) that showed an increase in opioid-related deaths in the state; she also highlighted data indicating that certain MN regions have the highest prevalence of deaths from overdose among American Indians. She outlined a pilot project that emphasizes positive community norms in an effort to counteract opioid abuse in American Indian communities in her state. Ms. Lindquist ended her presentation by stressing her experience in facilitating positive outcomes in American Indian communities in MN.

Gail Nahwahquaw described how Wisconsin (WI) has organized its tribal initiatives. She believes that the opiate addiction prevalence data presented for MN and MI are very similar to those for WI. However, the actual numbers are not yet available for the state since WI does not have a prescription monitoring system to track changes in use over time.

The next part of the day - and this document - included interviews with a number of tribal leaders on the matter of prescription drug abuse. Tribal leaders are very concerned about this trend, and they think it is important to go beyond education to develop an action plan, which would include concrete steps to tackle the problems of prescription drug abuse in tribal communities. Elders in American Indian communities have much of importance to say on this issue and ought to be included as partners in planning and implementing the action plans. Appropriate use of medication was also addressed in these interviews. The interviewees stressed the importance of a holistic approach to the care of patients on the part of tribal physicians. As well, they hoped that the tribal physicians integrated cultural values into their care of tribal members, both at tribal treatment agencies and urban Indian treatment programs.

Nicholas Reuter presented the **first pillar of the Action Plan: Education**. The audience was then divided into small groups to discuss the implications of what they had heard . The reader will

be introduced to the results of these small group discussions through the group leaders' presentations, and will be able to appreciate the rich conversation that followed the presentations.

Nicholas Reuter also presented the **second pillar in the Action Plan: The monitoring of prescription drugs**. Forty nine out of 50 states have instituted prescription drug monitoring systems. The speaker highlighted data on the effectiveness of the use of methadone maintenance in the treatment of clients with opioid addiction, reviewing briefly the Drug Addiction Treatment Act of 2000 that allows office-based physicians to prescribe buprenorphine (Subotex) to a limited number of patients. Currently, over 22,000 physicians in the US are authorized to prescribe buprenorphine, and some of them have registered their name and practice on the Buprenorphine Physician and Treatment Program Locator

Brian Garthwaite presented the **third pillar in the Action Plan: Safe Disposal Pillar**. Dr. Garthwaite is a compliance officer and represented the Food and Drug Administration (FDA), whose role it is to make sure that what firms have manufactured, such as food, drugs, cosmetics, medical devices, biological products, or veterinary products, are used as intended and disposed of in a safe manner. He also raised the issue of the accessibility of the family medicine cabinet to people visiting private homes. He observed that a great deal of medication is stolen in various ways by guests or family members from homes. Accordingly, it is important to find a safe way to dispose of unused medications in order to prevent their diversion from homes for inappropriate purposes.

Sergeant Matthew St. George then presented **the fourth pillar of the Action Plan: Enforcement**. Sergeant St. George has quite a varied background in law enforcement and has seen all sides of the drug trafficking problem as well as the abuse of prescription drugs. He reiterated data attesting to the steady increase in arrests for prescription drug abuse and pointed out that opiate-related deaths in two urban MN counties, Hennepin and Ramsey, now exceed the number of deaths from gunshot wounds. In a recent year, a 325% increase in the number of thefts related to prescription drugs was observed. These thefts were from drug stores and hospitals, which Sgt. St. George assumed meant that health care providers had stolen medication from their places of employment, or had diverted drugs. Sergeant St. George stressed the importance of inter-agency collaboration as a key to reducing the prescription drug epidemic. It is especially important, in his judgment, that local police departments, boards of medical practice, the state Department of Health, the state Board of Pharmacy and the state prescription drug monitoring program work together to enforce and monitor the problem.

Each presentation of one of the four pillars of the Action Plan was accompanied by energetic and informative discussions of the topic. Accordingly, this Summit touched on many important

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issues for consideration by tribal communities across the country in their efforts to find ways to handle the prescription drug epidemic.

The Summit has also led to a very important subsequent follow-up. Many representatives of tribal communities in Region V, since the Summit, have had regular conference calls to discuss plans and issues associated with the implementation of the Four Pillar program. I think we can expect to see the development of an effective plan against prescription drug abuse in the tribal programs in Region V and across the country in the future. Some tribal communities have through tribal resolutions and action plans, been able to work effectively on reducing number of suicides in their communities. It is my hope that this document will initiate the same type of tribal unity and initiatives, which I am confident will lead to a reduction in the use and abuse of prescription drugs in our tribal communities. A prime unresolved issue is how to assess the effectiveness of the four pillars of the Action Plan against prescription drug abuse.



***Opening Statement***

**JEFFREY COADY, Psy.D.:**

I'm the regional administrator for the Substance Abuse Mental Health Services Administration, also known as SAMHSA. We are pleased to support this event, the Tribal Prescription Drug Summit: Moving from Information Sharing to Action Plan. Now, before we get started with today's events, I'd like folks to know that there is audio and video equipment here. Our presenters – we would like the individuals who are going to be presenting some of the subject matter, we will video and audio tape them so we can preserve the presentations, and our hope is that we can have a webinar of the presentation that can be shared with everybody later for those who might not be in attendance, and nationally.

The second part of audio taping is that we would like to produce a summary document. The document will not have any individual names or tribal affiliations, but just the themes, the challenges, and the opportunities we come up with during this discussion. This will give folks the opportunity to review and to make comment on that document. We want this to be a shared document of our experience today, and something that together we can utilize to help strengthen and move forward, both within the Bemidji area as well as nationally. To the presenters, you should have a consent form you've all received. In addition, I would also like to let folks know that our Prairielands Addiction Technological Transfer, a SAMHSA grantee, is responsible for the AV portion of this, and we thank them for this support in that. One of their functions is to be able to disseminate information to tribes nationally. I will make the request that, if there are tribal members who would like to give testimony, then during the breaks or at lunch sometime, in terms of what they're experiencing on the tribes related to prescription drug abuse, they would be more than willing – happy, actually – to set up some time where you could speak and they could capture that narrative. Your voice is powerful, your stories are powerful, your message is powerful, and we need to hear that to inspire others to move forward nationally as we're doing today. I just wanted to let folks know a little bit about the process we're using.

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Before we get further along, I want to introduce Dr. Cecil White Hat. We are honored today that he is going to get the tribal blessing. He is from the Rosebud Sioux tribe. Cecil, please come on up.

### ***Tribal Blessing***

#### **CECIL WHITE HAT, Ph.D.:**

Good morning everyone. Jenny offered me some tobacco this morning, and it honored me certainly to offer a blessing. For the most part, I'm going to say the blessing in my language.

#### *(Blessing)*

When I greeted you in my Lakota (Sioux) language, I greeted you as relatives and with a good heart and a good handshake. I introduced myself as Cecil White Hat. I currently work with the Alcohol and Drug Abuse Division here in St. Paul, with the American Indian Section, and that's my Social Security name. My Indian name is Oyate Wayankapi, or "People See Him or Notice Him." So as we come together in these things, when we pray, certainly in my language, we ask for health and help for our people – that's the first thing we always ask for, so that's what we will pray for, and I certainly will pray for everyone here, with their family members, and ask for health and help for everybody here as well, and certainly safe travels home.

#### *(Prayer)*

**JEFFREY COADY:**

Thank you. I would like to introduce our Regional Director, and I'd like to say that following our tribal consultation, I think that in Petoskey in February, the tone that you set and our office set in terms of working with the tribes is something we hope to replicate today, and I want to thank you for your leadership in this effort. I'm glad you're able to come. Kenneth Munson.

***Tribal Consultation Follow-Up***

**KENNETH MUNSON, JD:**

Well thank you very much. I'm honored to be here with you this morning, and on behalf of the Obama Administration and on behalf of our Secretary Kathleen Sibelius and the President, I am honored to welcome you to today's summit. As you know by words and hopefully by deeds as well, the Administration is strongly committed to continuing the government-to-government relationship and improving the lives and safety of all our folks, to respect the tribal governments and sovereignty, and to work together to ensure that we don't just have great consultation or great communication or great relationships, but have great outcomes. So an event like today is really part of a journey, a walk down a road, and we continue to walk down that road together to make sure that people's lives are better. As Jeff said, today's direct summit is really a direct outcome of the Midwest Alliance of Sovereign Tribes/HHS 2012 Tribal Consultation Session, which was held in Petoskey earlier in the year and attended by many of the people and tribes represented here today. At that consultation session, as well as the sessions in other regions in the country, the issue of prescription drug abuse was identified again and again as a critical issue of utmost concern for our populations. To repeat, we heard really powerful stories of concern, and in talking to the other regional directors around the country, heard the same kind of story, so we certainly are working here in the Bemidji area, but we are also going to be working, and part of this work today is to connect with our other tribal governments and the other parts of HHS around the country to have that much more power in our efforts, to our work.

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But here in the Region 5 Bemidji area, in response to that discussion, the discussions and stories, those connections, a Tribal prescription Drug Taskforce was established. There will be more talk about that today. On behalf of our coordinated leadership, I wanted to thank Jeff for taking on that responsibility. As I said, this summer, there was a lot of highlighting of this critical effort and these critical needs, but it certainly is the case that this issue has been an issue of concern, certainly for our Administration since we've come into office. In April 2011, the White House identified prescription drug abuse as the nation's fastest growing drug problem and really set out kind of a road map with actions in four main areas: education, monitoring, proper disposal, and enforcement. I certainly know that the work we'll be doing as a Task Force will in many ways follow along and be parallel to some of the work being done there.

Let me just say for a second that we had some big news yesterday – this was big news to me – with the Affordable Care Act, and it's just important, I think, that it sounds good to me. It's important to recognize, as we know, that for folks who have mental health concerns, substance abuse issues, being able to find the resources, the help, the connections they need, is very difficult in any case, but is certainly made more challenging by the lack of health care options in our communities. So it's very important that in the Affordable Care Act there are some provisions that will go a long way toward addressing these issues. Individual tribal members and tribal governments will have many choices to make regarding the Affordable Care Act, but certainly knowing that within the act, the Medicaid expansion (which has been upheld) will have a floor basis for many more folks to be eligible for services that have not been eligible before to have that option in Medicaid. Also the coverage option of private insurance, where substance abuse and mental health services are covered as part of essential health benefits. I could spend a great deal of time and detail going through some of the really positive benefits for folks receiving their care either through Medicaid, Medicare, private insurance, Indian Health Services, and other ways. Let me just say, one of the great things about the court's decision is that it just provides more options, more possibilities, more ways for folks to be able to get and afford care, and I look forward to us working together and walking down this road together to make sure that people get the services and care than they need. To that end, we

will be having a great deal of discussion – not today, necessarily, but in the weeks and months ahead – about the scope and options in the Affordable Care Act for individual tribal members and governments. I wanted to make the offer here that, to the extent that our office and Region 5, based in Chicago, that the staff there and I can be helpful in answering questions for you and connecting people with information, we certainly want to do that and are offering to do that. It's also the case that the Administration will be having a number of consultation sessions regarding the next steps on the Affordable Care Act, and I ask you to look forward to the information that will be coming out in days and weeks about consultation sessions with the Indian Health Services as well as with the other regions around the next steps in the Affordable Care Act. Keep an eye out for that, and we will make sure to connect with you. I just want to thank you for allowing me to be here with you this morning. I look forward to a great day of meetings. So thank you very much.

**JEFFREY COADY:**

For the tribal leader perspective on prescription drug abuse, Brooks Big John, are you willing to come up and speak a little bit about your perspective on this and the challenges and opportunities ahead.

***Tribal Leader Perspective on Prescription Drug Abuse***

**COUNCILMAN BROOKS BIG JOHN:**

Thanks for giving me the opportunity to talk a little bit about some of the things that have been affecting our tribal members back home. We met over in Petoskey at the Indian Health Service consultation over the past winter and we were talking about different things on the agenda. I saw the prescription drug abuse stuff that was on there. I started reading about it a little bit and reflecting on what was going on back home, and probably in many of the tribes here, not only in Wisconsin but throughout the country – and probably throughout the country as a whole. I started thinking about some of our members and how they're affected, and I brought up a few questions to IHS, the SAMHSA guys, Jeff and Jenny Jenkins here. We kicked off probably about a two hour discussion on this prescription drug abuse and I started throwing out some facts and some things that I needed to share with the people so they would understand just how things are back on my reservation.

You know, back in the year 2000, one of my first terms on the Council, we started out with prescribing this Vicodin pill that we talk about – you all know about this. Our people prescribed around 5,000 pills that year. Seven years ago, when I was on my second term, in 2005, we prescribed about 66,000 Vicodin. Just using this one pill as an example, but you can imagine that the other drugs we're prescribing are also escalating, probably at an alarming rate. It puts a lot of things into perspective.

We talked about doctors enabling and a lot of different things. It kind of hit home, so I took it home and shared it with a lot of my counsel people who are here today. I'm glad they're here so they can see what's going on. I've been sending them emails and sharing stuff with them.

The reality of things really kind of hit home, and I need to tell you about some things so you get a good understanding. We had a tribal member whose head was crushed by a ball-peen hammer over a fight for this OxyContin. They were making runs from Oshkosh, when she was going to school, to Milwaukee. They were picking up this drug. She made a run, made another run. During one of these runs, this guy and his girlfriend weren't satisfied with what she had given them to pay them. They got in a big fight, and they ended up beating this girl up and crushing her head with a hammer. We had another person, a friend of mine whom I graduated from grade school and high school with. He ended up sucking out morphine patches, so the point where he eventually had too much and he overdosed and died. Two sisters that we grew up with on the reservation - mixing pills to the point where they pined for these things all day - they died. A brother and sister, relations to some of us here, they ended up overdosing on pills and dying. It got to the point where we had a guy who was sleeping in the ceiling of the tribal center building where the clinic was, six or seven hours until everything closed, so he could break into our clinic and steal these pills. Just recently we had a young lady and - the two sisters I mentioned, their brother robbed a pharmacy in St. Germaine, WI, for these pills.

The tribes are taking action. We have a pain agreement for our people, and when they violate this agreement they no longer get prescribed their medications at the Tribal Health facility. It doesn't seem to bother them, though, because they go right down the road 10 miles and see another doctor. They still get their pills. Or they hit the streets.

Our tribal government has initiated action that has zero tolerance for prescription drug abuse, and I challenge the other tribes and all the people here today to really take a thought for a moment and really think what that means: Zero tolerance. What does it mean? There are a lot of different ways you get there, but if we don't start doing some things today and start taking some action, we'll never get there.

## Introduction

Up by us they have established the Northwoods Coalition on Prescription Drug Abuse through Marshfield Clinic - it's been going for about a year. I've attended a few meetings and they're doing some near things up there. They've also created a Prescription Drug Abuse Task Force in Minocqua, our hometown, and we have a lot of members involved in that.

I was reading an article in USA Today – I don't know if anyone else caught it yesterday – about some people in Florida, where doctors were setting up shops illegally and prescribing pills. The numbers were alarming. I was multiplying the numbers times the street value and we could tell why good doctors are turning their backs on their livelihoods and their careers for the dollars. Astronomical.

The education and awareness that's happening, the conferences and meetings are all great, but like I said in Petoskey, it's time to take the next step. It's time to move beyond the awareness, and to go and start creating compliance plans. It's time for action. It's good to read and to share, like I have in emails with my members back home.

I've just touched on a few of the things that trouble me weekly and daily when I think about what's going on back home. I've seen grow men who have lost considerable weight. I've seen some beautiful women who used to walk in our community – they've kind of melted down their bodies.

It's time for action. It's time to go ahead and create a plan and to initiate and to take these things back to our community. Let's start moving. We've had enough talk. We've had too many deaths back home.

We'll talk about a lot of things happening in other communities today, but I had to share with you what's happening on my little bitty reservation back home.



**JEFFREY COADY:**

Thank you very much for sharing. You're encouraged to come forward and talk about stories. We talk about numbers and statistics, but the stories you share, on the personal level, the human toll of this crisis is meaningful. That's what we have to keep in mind. Much of the leadership you provided in willingness to step forward and talk about the next step we'll take today in terms of helping to develop the action plan. This will go past the talk and see what this looks like going forward together.

I'm going to ask David Bingaman, Administrator for HERSA, to come up and talk about the goals of the summit today. David, thanks so much for your help in getting this together and explaining the goals.

***Goals of the Summit***

**DAVID BINGAMAN, LCSW:**

Thank you Dr. Coady, and thank all of you for taking the time to be here with us today. As Jenny Jenkins mentioned, it is the Friday before a holiday weekend. We're thrilled with the turnout here on a Friday afternoon, so thank you very much for coming. I want to take just a few minutes to explain what we're planning to accomplish today and how we're going to do it.

As Director Munson said at our Region 5 Tribal Consultation, we heard Brooks Big John and other tribal leaders talk about the impacts that prescription drugs abuse and prescription drug abuse and diversion are having on their communities. I thank him again for sharing some of the impact it's having locally. We expect that it's one example of many that are occurring out there. He mentioned an article in USA Today. I wanted to add to what Brooks mentioned. One physician has prescribed 270,000 30-mg pills of oxycodone in one year. He will be charged with two counts of murder, as two of his patients died within just days of coming to his so-called pain clinic, which obviously was simply a prescription mill. This is happening nationwide. So as Brooks said, it's time for action. Today, that's what we're all about: moving to the action phase.

## Introduction

As Director Munson said at the Tribal Consultation Session, after we all heard the stories from Fond du Lac and other locations, Jenny Jenkins came around and asked several of us if we would be willing start to do something about it. Of course we said yes. As Director Munson said, we promptly established the Multi-Agency Prescription Drug Abuse and Diversion Task Force. Dr. Coady took the lead and we began holding conference calls every other week, and we shared a bunch of relevant information to help educate all of us on the key aspects of this issue. That's kind of how we got to deciding that a good start would be to bring people like you together and talk about how we move into an action step. As we were planning, we all read the National Prescription Drug Abuse Prevention Plan, and after hearing from Brooks that what he really felt he needed, and I think other people need as well, was a written action plan, a written plan of action to present to the tribal council to help focus the variety of activities that need to be approached in addressing this situation, so we've combined the four steps that are in the National Prevention Plan with the model of building an action plan. That's how we came to our agenda for today.

Sometimes we go to meetings and we all have been to meetings where we kind of sit there like a bump on a log. Oftentimes it's an uncomfortable log. We listen for a while, play with our PDAs and cell phones. We used to hold them under the table and make like nobody saw what we were doing; these days, however, we don't bother to put them under the table anymore. We go out in the hall and respond to phone calls, take phone calls, initiate phone calls. We're all very busy. We go home and then we feel like we've accomplished something. But that's not today. We've designed this as an actual working meeting, and previous speakers have mentioned, we're really responding to a crisis of epidemic proportion here. We all want to roll up our sleeves, turn off our cell phones – I know that's difficult for some people to do – but we want to listen carefully to each other, ask powerful questions, be creative, share our insights, start working on drafting out action plans, and most importantly make a commitment to go home, join with other people – we're not asking you to lead this effort individually or alone. We're going to be talking about some team effort here. Join with others to take some specific steps to reduce and minimize this diversion and abuse of prescription drugs.

So let's take a quick look at the agenda. Each of you should have an agenda in your folder. Maureen O'Connell is going to introduce Larry, Denise, and Gail – I hope they're all here – who will explain what's going on with prescription drug diversion and abuse in their three states. Then Nick, Brian, and Matthew will share information about those four components, or pillars, of a comprehensive public health strategy to combat prescription drug diversion and abuse. I should explain, after each topic is briefly presented for about 30 minutes, we will then have a 15-minute small group discussion at your existing tables. The purpose of the small group discussion is to identify, discuss, and document some specific activities that you and/or others will begin to work on when you get home. If you're not sitting by people from your home community, you might consider moving together, because talking about it together might facilitate your future work.

Next, we'll then have a 15-minute large group report to share ideas across groups so that all of us hear the good ideas that individuals come up with. That process will be repeated for each of the four pillars or areas that you see listed there. Since prescription drug diversion and abuse is a multifaceted community problem, we anticipate it will most likely take a group or team approach to be really successful. Peggy is going to speak with us about teamwork and how to recruit, build, and sustain an effective team. By 4:30 this afternoon, we will all be aware of how the states of Michigan, Minnesota, and Wisconsin are responding to prescription drug diversion and abuse. Secondly, we will know the four pillars of a comprehensive public health strategy to reduce prescription drug abuse. Three, we will be aware of some specific actions that can be taken in our communities to address this problem. Even if, in terms of roles, you don't personally expect to be in a role to implementing a plan locally, we really think that you should, for today's purposes, act as though someone will be proceeding with these activities, so think of it in terms of what you or other people can do, and the result of that is that by the time we're done we will be able to collect all of these great ideas and make a master plan, because every community is different. Every community response is going to be different. So we didn't make a plan and just pass it out, because each one is going to be unique, but one of the things

## Introduction

we will do after this is roll up all of your good ideas into a reference document that will have these activities, and then people in future meetings will be able to pick and choose from the great ideas that this initial, pioneering group came up with. Think of it in terms not necessarily of leading a group today, but for purposes of developing your draft action plan that you'll take home with you. The fourth pillar will be to understand how to create and develop a team approach to successful tribal and community actions. Brooks has given us a call to action, and I think we should honor him and the people both from his reservation and other reservations that we heard from at our meeting, of people that have died as a result of this problem. We will ask you to give us feedback on the degree to which these four goals have been met. You'll see in your folder this bright green evaluation form. We'll collect these and the end of the meeting, and we do really appreciate your feedback, because, as Jeff says, this is really the first meeting of this kind nationally and other areas may want to do the same and will want to incorporate your suggestions on what adjustments can be made for similar future activities.



We will all leave this afternoon knowing that no one will be alone in taking on this challenge. There will be a series of follow-up technical assistance conference calls to be held beginning in July. Jeff will talk more about this later. You'll be able to get both expert and peer support as we walk down this path together.

Thank you for coming today. The harsh realities of prescription drug abuse and diversion really do demand our collective action, and we greatly appreciate your involvement and commitment to this issue. We'll move on to the State panel.



**Prescription Drug Abuse Summit:**  
Moving From Information Sharing  
to Action Plan Development



June 29, 2012



**Goals of Prescription Drug Abuse Summit**

1. To become aware of how the States of Michigan, Minnesota, and Wisconsin are responding to the prescription drug abuse epidemic



1



**Goals of Prescription Drug Abuse Summit, cont.**

2. To learn the four pillars of a comprehensive public health strategy to reduce prescription drug diversion and abuse



2



**Goals of Prescription Drug Abuse Summit, cont.**

3. To identify and discuss specific actions that can be taken in tribal communities to address prescription drug abuse

3



**Goals of Prescription Drug Abuse Summit, cont.**

4. To understand how to create and develop a team approach to successful tribal/community action

4



***State Panel, Speaker 1***

**LAWRENCE SCOTT:**

Good morning. First I want to thank Dr. Coady, HHS and SAMHSA for inviting me to share Michigan's prescription and over-the-counter drug abuse plan with you. It was recently published and for those of you who wish to read it in its entirety, you will be able to find it at [www.michigan.gov/MDCH-BSAAS](http://www.michigan.gov/MDCH-BSAAS). When you click that, our website will come up. Click on "Prevention," and then you'll see a menu that will include our prescription drug abuse plan.

Jeff, had I known if this was going to be videotaped, I'd have worn my Michigan State colors. These are Michigan colors – trust me, it was totally coincidental that I have on Michigan colors today.

As I look around the room, I see some people I've known for years – Nick Reuter – and it brought me back to the days when I was a methadone authority. I'm sort of dating myself, because I don't think they use that type of terminology anymore. They call it medication assistance therapy or pharmacologic therapy. But as I was thinking about my term as a methadone authority, I was thinking about the people who were actually serving at that time, the age cohort. It was primarily an older group that was receiving public-funded treatment. The predominant age range was probably 35-45, maybe a little bit older. They had a myriad of health issues and health problems. They were receiving treatment because they were addicted to heroin – heroin addicts. We spent a great deal of money and effort trying to maintain people in treatment in their path and journey toward recovery.

Then, about four years ago, in Michigan we heard that about 10 teenagers in an affluent community right outside of Kalamazoo, MI overdosed on heroin. This was a new phenomenon for Michigan. We were able to investigate further and discovered that these individuals were abusing prescription drugs and couldn't find any more prescription drugs – access had been shut down and minimized. Therefore, they turned to a cheaper form of analgesic, which is

heroin. As we investigated further, we started to see our admissions for treatment for heroin, as well as prescription drugs, skyrocket. I'll get into that later.

And so it dawned on me that we're having a new generation of individuals, a younger population, if you will, becoming addicted to opioid analgesics. They are prescribed as hydrocodone. These individuals are getting younger and younger and coming into our treatment delivery system, and it's putting quite a strain on our system, but I'll share some of that with you later.

We were able to present our Prescription and Over-the-Counter Drug Abuse Strategic Plan about two weeks ago, so I'm more or less using that presentation today in a truncated version, so forgive me if you see the title that says "PHP" which stands for "Prepaid inpatient Health Plan," or "CMHSP" which stands for "Community Mental Health Service Providers."

Why do we need a strategic plan to reduce prescription and over-the-counter drug abuse in Michigan? Well, in 2008 unintentional poisoning was the second-leading cause of accidental death, after motor vehicle crashes. The increase in unintentional poisonings was driven by opioid analgesics, including oxycodone, hydrocodone, and methadone, that are usually prescribed. From 1999-2002, the number of unintentional drug poisoning deaths in the United States involving opioid analgesics increased by 91%, while death involving cocaine or heroin increased by 22.8% and 12%, respectively. In Michigan, however, unintentional poisonings became the leading cause of injury and death in 2009, and from 1999-2009, the unintentional drug poisoning drug rate for opioid analgesics in Michigan increased by 734%, while the death rate for heroin and cocaine increased by 487% and 203.9% respectively. This gives you an idea of this phenomenon being epidemic in Michigan.

*(Someone off-screen mentions that more persons died of accidental poisoning deaths attributable to prescription drug abuse than those who died in traffic accidents.)*



That is correct. Thank you, that is correct. Let me give you an idea. There was a 369% increase from 2000-2011 in the number of persons admitted to Michigan's public-funded treatment system for addiction to prescription drugs – again, primarily hydrocodone. The primary substance abuse was opioid-based synthetics.

Let me add here that in 2011, we had 603 persons between the ages of 14 and 25 admitted to drug treatment while stating that prescription drugs were their primary choice or primary drug of abuse. Again, this is primarily hydrocodone.

60% of those who were admitted between the ages of 14 and 25 were female. I don't know, are other places seeing that as well? In Michigan, it appears to be an issue among females in that age group.

The massive increase in the number of persons needing treatment due to their addiction to prescription drugs has placed a considerable strain on our public service delivery system. Last year, we spent about \$20 million for treating people for opioid analgesics, of which \$9 million was provided by Medicaid. Consider the Affordable Care Act kicking in in 2014, and you will have thousands entering into our drug treatment system. They are going to be paid for, in most cases, by Medicaid. So in Michigan, we will have to gear up our system of publically-funded health care to handle this massive increase. Cost per person is approximately \$2,000 per year if the person is receiving methadone treatment.

We treated 70,000 people last year, which is really the average number of people we treat in the publically-funded system, 44% of which were Medicaid-eligible, up from 29% in 2007. Again, that sort of gives you a snapshot of what it's going to be like in 2014.

How do we respond? In 2009, we convened a Prescription and over-the-Counter Summit in East Lansing, where over 400 key stakeholders were present, including and representing agencies such as law enforcement, the medical community (including pharmacists, treatment

and prevention organizations), community coalitions, tribal sovereign nations in Michigan, regional coordinating agencies, and education and local public health departments.

Coordinating agencies are the regional administrative entities in Michigan that are responsible for planning and funding local substance-abuse prevention treatment and recovery services.

The conference participants submitted recommendations to our agency, including what should be done to address this issue, how to remove the barriers and challenges to addressing the issue, appropriate goals for our agencies to address to combat the problem, and what measures to employ to determine if our agency piece has made an impact. In response to that, we require all of our 16 coordinating agencies, which serve all the 83 counties in Michigan, to address prescription and over-the-counter drug abuse in their action plans that they submitted for prevention – in other words, if they wanted our money, if they wanted block-grant funding or State funding, then the coordinating agencies had to have a prevention plan that included the strategic plan for addressing and over-the-counter drugs.

Keep in mind, the coordinating agencies are required to fund agencies serving the populations in our sovereign Indian nations. We also have two sovereign nations in our state that have the Strategic Prevention Framework Grant. This is a five-step process, starting with data-gathering whereby you study the severity of the problem, develop a capacity-building plan, build a strategic plan for implementation, and evaluate with cultural competency. That's the SPF process, and it's what I call a common-sense approach.

Utilizing the strategic planning framework, each coordinating agency developed and implemented a plan to prioritize needs within their region. In reaction to and progressing from that, in 2011 we established a Prescription and Over-the-Counter Drug Abuse Workgroup. The goal of the Workgroup was to develop a State strategic plan, including recommendations for reducing prescription and over-the-counter drug abuse. We wanted the Strategic Plan to serve as a template for community-level agencies, including sovereign nations in Michigan, to utilize when developing local action plans. Workgroup membership included representatives from

State and community-level agencies, including behavioral health, substance abuse disorder prevention, treatment, education, law enforcement, and environmental quality.

The Workgroup developed and distributed a Drug Abuse Community Scan Survey. We actually distributed a scan to community coalitions, sovereign nations, coordinating agencies, pharmacy retailers, local law enforcement, and local public health schools to discern their level of capacity to conduct education, law enforcement, and prescription drug storage and disposal programs in their respective communities. What we found from that survey was that the predominant feedback related to training. They wanted and needed more training in evidence-based practices that were effective in reducing prescription and over-the-counter drug abuse.

Based on the feedback from that scan, the Prescription and Over-the-Counter Drug Abuse Prevention Workgroup identified four overarching goals within a strategic plan framework: To increase multi-system collaboration, to broaden statewide media messages, to broaden the prescription and over-the-counter drug abuse education and use of brief screenings, and to increase access to and use of the Michigan Automated Prescription System.

Getting back to specifics related to recommendations of the group, regarding the increase in multi-system collaboration, the Workgroup recommended that we administer an additional community scan to some agencies who were in receipt of the scan earlier, as well as additional agencies that were not participating. For example, we didn't receive a great deal of feedback from the sovereign nations. It could have been the way we approached the dissemination plan. So we need to reissue the scan to the sovereign nations so we get a realistic and accurate look or snapshot of the epidemiology of prescription drug abuse in those communities.

We also didn't receive the feedback we were seeking from the pharmacy community. It's a very tight, close-knit group. The Michigan Pharmacy Association submitted some feedback, but we wanted considerably more than we received from the Association members. Therefore, we will be reissuing the scan to that particular group.

Let me just say that most doctors, physicians, doctors, dentists, and pharmacists in Michigan are complying with the law regarding issuing prescriptions, and they are cognizant of what they're doing. However, there is one key piece that's missing: doctors are not receiving considerable coursework in pharmacology during their training. Very little is done in terms of teaching pharmacology. To give you an anecdotal story, when I had some dental work done last summer, my dentist asked, "On a scale of 1 to 10, what's the level of your pain?" I said 6. He said he could write me a 30-day prescription for Vicodin. He was well-meaning, a great guy, but that gives you an idea of the extent of this. I don't think he'd ever had a course in pharmacology. Giving me a 30-day supply of Vicodin, I could have been someone who would have hit the street with that, divert that. So we need to increase multi-system collaboration.


We want to broaden state-wide media messages. We need a statewide media campaign that is culturally competent, so that it will be effective not only in targeting the sovereign nations in Michigan, but being relevant to the sovereign nations. We want to employ their assistance in developing a statewide media campaign. There is a media campaign that we want to model our campaign on, called "Prescription – Be the Solution." This was developed by the Northern Michigan Substance Abuse Agency Services.

Broadening prescription and over the counter drug abuse education and use of brief screenings is next. Physicians and dentists, etc. do not receive education during internship and residency on the use of brief screenings. That is an evidence-based practice known to be effective in referring people for appropriate treatment or referring people for the appropriate level of prevention. What we wish to do in Michigan is embark upon a very aggressive training program, bringing teaching universities onboard to be able to offer brief screenings to those physicians and residents, and interns. We also want to bring the medical societies onboard so they can also support that and offer brief screenings to physicians.

Let me give you an idea of the extent of prescriptions in Michigan. Just in 2010 alone, there were over 6,000,000 prescriptions written for hydrocodone alone. *Six million* prescriptions written for hydrocodone alone, a Schedule III drug. We're not talking about the other Schedule IIs and IIIs that we're writing for. Consider this: in Michigan, the population is 12,000,000, and yet our physicians and dentists wrote 6,000,000 legitimate prescriptions. So you see the potential for diversion is tremendous.

That being said, we do have a Michigan Automated Prescription System, which tracks the prescriptions written by physicians for Schedule II and Schedule III drugs. This system has been successful in identifying those physicians that have abused that privilege. What we would like to do, and what we are recommending, would be that MAPS be available not just to prescribing physicians, dentists, and other healthcare professionals, but also be available and accessible to those agencies that are providing treatment services. That information should also be available to our State Epidemiological Outcomes Workgroup, so that workgroup can actually look at the data and then form our planning system.

I'm available for any questions. Thank you.



**Michigan Department of Community Health**  
Director Olga Dazzo


**Prescription and Over-the-Counter  
Drug Abuse Strategic Plan**

**PIHP/CMHSP/CA Quarterly Meeting  
June 13, 2012**

Deborah J. Hollis, and Larry P. Scott  
Bureau of Substance Abuse and Addiction Services

**Why do we need a strategic plan to reduce prescription and over-the-counter (Rx/OTC) drug abuse?**


- In 2008, unintentional poisonings were the second leading cause of injury and death in the United States, followed by motor vehicle crashes.
- The increase in unintentional poisonings was driven by opioid analgesics including oxycodone, hydrocodone, and methadone that are usually prescribed to relieve pain.



2

**Why do we need a strategic plan to reduce prescription and over-the-counter (Rx/OTC) drug abuse?** (Continued)


- From 1999 to 2002, the number of unintentional drug poisoning deaths in the United States involving opioid analgesics increased by 91.2%, while deaths involving cocaine or heroin increased by 22.8% and 12.4%, respectively.
- In Michigan unintentional poisonings became the leading cause of injury and death in 2009.



3

**Why do we need a strategic plan to reduce prescription and over-the-counter (Rx/OTC) drug abuse?** (Continued)


- From 1999 to 2009 the unintentional drug poisoning death rate for opioid analgesics in Michigan increased by 734.6% during 1999-2009, while the death rate for heroin and cocaine increased by 487.8% and 203.9%, respectively.



4

**What is the impact of Rx/OTC drug abuse on our publically funded SUD services?**


- There was a 369% increase (1,189 to 5,581), from 2000 to 2011 in the number of persons admitted to Michigan's publicly-funded treatment system for addiction to prescription drugs. The primary substance of abuse was opioid based synthetics.
- This massive increase in the number of persons needing treatment due to their addiction to prescription drugs has placed a considerable strain on the public service delivery system.



5

**What is the impact of Rx/OTC drug abuse on our publically funded SUD services?** (Continued)


- The overall cost for publically funded treatment for addiction to prescription drugs and other opioid analgesics is just under \$20 million of which \$9 million is provided by Medicaid.
- Cost per person is approximately \$2,000 per year, if Methadone is the treatment regimen.
- Approximately 70,000 persons receive SUD treatment on a yearly basis of which 44 percent were Medicaid eligible in 2011, up from 29 percent in 2007.



6

**Rx/OTC Drug Abuse Summit**


- In 2009, in response to this widespread problem, the Bureau of Substance Abuse and Addiction Services (BSAAS) held a Rx/OTC Drug Abuse Summit.
- Over 400 key stakeholders were present at this summit, representing law enforcement, the medical community, including pharmacists; treatment and prevention organizations; community coalitions; regional coordinating agencies (CAs); education; and local public health departments



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**Rx/OTC Drug Abuse Summit (Continued)**


- The conference participants submitted recommendations to BSAAS including: what should be done to address the issue, how to remove the barriers and challenges to addressing the issue; appropriate goals for BSAAS to address to combat the problem, and what measures to employ to determine if BSAAS has made an impact.



8

**CA Action Plans**


- FY 2010, all 16 CAs were required to address Rx/OTC drug abuse in their Action Plan (AP) submissions for prevention.
- Utilizing a Strategic Planning Framework, each CA developed and implemented a plan to prioritize needs within their region.



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**Rx/OTC Drug Abuse Workgroup**


- In February 2011, BSAAS established an Rx/OTC Drug Abuse Workgroup. The goal of the workgroup was to develop a strategic plan, including recommendations, for reducing Rx/OTC drug abuse.
- The strategic plan is to serve as a template for community-level agencies committed to developing local-level action plans.
- The workgroup membership included representatives of the state- and community-level agencies responsible for behavioral health care, substance use disorder prevention, education, law enforcement, and environmental quality.



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**Rx/OTC Drug Abuse Community Scan Survey**

- In December 2011, the Rx/OTC Drug Abuse Workgroup distributed a *Community Scan Survey* to community coalitions, CAs, pharmacy retailers, local law enforcement, local public health departments, schools, and substance use disorder treatment and prevention providers.
- The purpose of the scan was to elicit feedback from community-level stakeholders on their level of capacity to conduct education, law enforcement and prescription drug storage or disposal programs in their respective communities.




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**Rx/OTC Drug Abuse Strategic Plan**

Based on feedback from over 400 stakeholders at the 2009 Rx/OTC Drug Abuse Summit and the recent *Community Scan Survey*, the BSAAS Rx/OTC Drug Abuse Prevention Workgroup identified four overarching goals to address in the strategic plan:

- 1. Increase Multi-System Collaboration**
- 2. Broaden Statewide Media Messages**
- 3. Broaden Rx/OTC Drug Abuse Education and Use of Brief Screenings**
- 4. Increase Access and Use Michigan Automated Prescription System (MAPS)**



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***State Panel, Speaker 2***

**JEFF COADY:**

Denise Lindquist, State of Minnesota. And after we do all the presentations, we can have a Q&A for the different state representatives.

**DENISE ESTEY LINDQUIST, MSE:**

Good morning. I'm Denise Estey Lindquist. I'm from the White Earth Reservation in Minnesota. Both my parents were members of the White Earth Reservation.

I work for the Department of Human Services, in the Chemical and Mental Health Services under the Chemical and Mental Health Services Alcohol and Drug Abuse Division, and we have an American Indian section. It's in legislation. First of all, under 254A, it talks about our Alcohol and Drug Abuse as being the State authority, with our Director as the single State authority in Minnesota. Right under that it talks about American Indian programs, my position and two assistants, and then it goes on from there to describe some other relevant information.

This presentation and the next few slides I have are from a presentation from Richard Muldenhauer, one of our State Planners. He was at the Indian Health Service Conference this week and gave this presentation, so some of you may have already seen this presentation. I picked out a few of his slides just to highlight some things going on in Minnesota. The numbers I picked out aren't for the State as a whole, but rather American Indian-specific. These numbers are also from 2000-2010. We already have some anecdotal information that we're going to surpass these numbers in the next reporting time period.

Here's where we're at. There were 1,986 death certificates issued with opiates as the primary or contributing cause of mortality, and of those, 94 – or 4.7% -- were identified as Native American or American Indian. In Minnesota, our American Indian population is 1.1% of the overall population. I was talking to Rick when he was putting his PowerPoint together, and I said, "You know, the tough part about this is what I hear from our Advisory Council members.

They will talk about what's going on in the state, what's going on in CD in their communities to the tribal councils, and oftentimes, it's really serious when they're talking about it, but then they have to move on and they go on to something else. They go off to their lives. When you can make this real to someone, when it is real to you in your community and your family, it makes a huge difference when there's a face attached. One of the things in my family is a cousin of mine, whom I worked with within the last 10 years, died from a heroin overdose last year. That really makes it real. I never would have expected that she would have gotten into heroin. She got divorced. Her husband was an alcoholic. She knew about addiction. She was a professional woman. When I saw that, I realized it would have been just as easy happened to me or my daughter, or to anyone in my family. This is just a reminder that when we look at statistics, those numbers really are about people.

What makes it really difficult is some of the things we hear about in our communities. We have the Native American culture, but we also have the culture of poverty. What we heard just a little bit ago was about diverted pharmaceuticals and how that happens. When it's your grandmother selling her pills, how do you report that? How do you deal with that when it's your cousin's family that's dealing the drugs? How do you deal with that? This is about real people in real situations.

In our Indian communities, we're so small in Minnesota that I go to meetings sometimes with Corrections and they're talking about a Native person and I know who they're talking about. They don't have to say the name. Maybe it's because I've been around a while, maybe because of my age, I don't know. But we're all affected by this. Some people have the luxury of not being affected by addiction, but when you're a Native in Minnesota, that is just not the case. You're affected. It's in your family. It's in your friends. It's right there.

We heard a legislator had said that it's such a small number, why even bother? We have more important things to do, more people to be concerned about. That's hard to hear.

The total American Indian opiate-related deaths in Minnesota are going up. As I mentioned, we believe they're continuing to rise. By gender, it's about equal across Minnesota population in general. Females are slightly less. But in the American Indian community, as you can see here, the females outweigh the males in deaths related to opiates.

Use of opiates 1-10 days prior to treatment shows non-prescribed methadone, opiates, and then heroin.

Primary use of opiates. Again, the non-prescription methadone, then heroin, then other opiates.

These are the counties where there is more American Indian mortality in Minnesota. Hennepin County has a large number of American Indians – it's our largest treatment admissions area. St. Louis County, the Duluth area, has a large American Indian population. Beltrami has Red Lake Nation, close to Leech Lake in Cass County. From 2000-2010, that's the report.

Opiate-related deaths in Minnesota by month. The reason I put this slide in is because, on the general opiate-related deaths in Minnesota, it was even all the way across. The month didn't matter. But as you can see, for American Indians, the time of year matters. Why is that? I don't know. I haven't figured that one out, but I thought it may be significant.

In this picture, we have three Advisory Council members, and I just want to point out that our Chairman, would you stand up Henry, from the White Earth Reservation is in the room. Henry Fox is our current Chairman. We have three Advisory Council members here, and one staff person, Betty Poitra. This picture was taken in Grand Portage. One of the things we do is that Advisory Councils are invited to different reservations to meet and spend time on yours of the different programs and hear more about what's going on in that specific reservation or community. Our Advisory Council is in legislation, which has been great for us to have

representatives from all the tribes and from our urban areas to work with and hear about what's going on first-hand.

The majority of our communities in Minnesota have prevention programs that we work with through grants or technical assistance and training. The prevention programs are to prevent, delay, or reduce alcohol and drug use by adolescents, with increased prevention resources and improved prevention resource coordination.

I wanted to say that with our Advisory Council, some of the things we're worked on – making sure we our providers are prevention specialists and treatment programs have support and help in addressing historical trauma. There has been research in Minnesota that shows that people think about loss of language, loss of land on a daily basis, on a weekly basis, on a monthly basis. How that impacts them on their daily lives is chronic bereavement. Our American Indian people don't get to resolve one loss before they have to cap that and deal with another death or another loss. There's a lot of grief work that needs to be done in our communities.

Biochemistry and prevention – we talk about a brain illness. We want to make sure people understand that. We want to make sure that they also understand the effect of diet and how we no longer have our traditional diet, which makes a huge difference in our lives.

The other thing that people have said is that if we add culture we don't get paid for it, so we wanted to make sure that culture is prevention and culture is treatment. Our culture is a way to prevent substance abuse. By putting that in a request for proposal, it's telling our tribes and our urban populations that we believe this is true, put this in, go ahead. We have tribal applications in Minnesota that are noncompetitive. We have federal and state funds, information, and training that we provide through our office. We have tribal and urban programs that implement the projects.

We have the American Indian Advisory Council, which is very involved in what we do, from participating in our strategic plan to meeting in committees to address different issues. They are quite involved in making decisions about where the money goes. Most of our programs have been implemented to include evidence-based programs and they include traditional cultural activities and activities designed to bring families together. Youth with strong cultural identification are less vulnerable to risk factors. Research and evidence-based practices are currently being implemented in the American Indian communities in Minnesota. In our state, our prevention programs, American Indian programs, have been using evidence-based programs for a long time. So it's not new for our programs.

These are some of the evidence-based practices, practice-based evidence that our prevention programs are using. I'm not going to read through them, I just want to highlight a couple of the more culturally-based ones. Storytelling is a huge thing in our community because of our oral traditions, so they have adapted that storytelling for empowerment. We have been doing more and more with motivational interviewing, not just with treatment but also for prevention. In our community we have used things like motivation enhancement or contingency management, not because we knew exactly what that was or how it worked, but because it's a good incentive for people to keep coming back, to stay for the entire group or stay for the entire program. Bizendadeda is a curriculum that was adopted from Iowa's Strengthening Families, so some of our programs in Minnesota are using that. Sons and Daughters of Tradition is the White Bison curriculum, and some of our tribes are using that with good success. Babes and Red Cliff are, I believe, used primarily in Red Lake. Those are programs that have been around a long time and they've found success with that program.

These are some other prevention activities in Minnesota that benefit American Indians. Minnesota has a State Prevention Framework State Incentive grant like was mentioned earlier. Those communities that have been recently funded were in Cohort IV or V. State Prevention Framework Tribal Incentive Grant – Leech Lake has one of those. They're pretty new as well in their SPF TIG rather than a SPF SIG. And then we have a State prevention Enhancement

## State Panel

Planning Grant through our office. Along with that we have a State Epidemiological Outcomes Workgroup I participate in. We have askMN.org, a website that has a lot of data and you can go in there and pull just American Indian-specific data, certain regions, so it's a good resource. Red Lake and Leech Lake have EPI work groups, so they have their own data. It's really helpful for them in writing grants, because they have data specific to their tribe.

The Tribal Summits. After the announcement for the state of emergency in White Earth, Leech Lake, and Red Lake, White Earth had a Tribal Summit last year. Leech Lake is working on one for this year.

There is a Minnesota Collaborative on Substance Abuse, and Carol Falkowski, who's in the room, convenes that group. It's with several State agencies including DPS – Department of Public Safety – the Minnesota Department of Health, Minnesota Department of Education, DUC, DHS, a lot of groups. Carol also has a drug trends report that she works on a couple times per year. She is one of the state people that do that around the country, and I believe there is a copy of the most recent one in the back of the room for the urban areas. Thanks, Carol.

We have an Annual Native American Prevention Program Sharing Conference. At that we have national speakers for keynotes that span the entire day and provide breakouts for us as well as keynote. We encourage evidence-based practices, and speakers are sought that can speak to the topic, so we always have somebody to speak to evidence-based practices or to provide something that's working in Indian Country. We have a youth track, and so two youths per chaperone are included in the adult registration. It's held with the Annual Minnesota American Indian Institute of Alcohol and Drugs. That happens every year.

Prevention and Treatment tracks: We have a newsletter than has a winter and spring issue. One of our staff is the primary on that newsletter, and he's in the room. Dr. Cecil White Hat, you met him. We produce that newsletter for prevention specialists and treatment providers who work with American Indian people. We use success stories from their programs. We love

putting in the work they do in their summer camps, their blueberry camp or their fishing camp or whatever, and the success that they have with the kids in those camps. Cultural stories and values events are included.

Just a little side about how, at the state, we have to have everything edited, and so we had a winter story put into our newsletter this past winter, and the state has a Communications Department, so the guy editing our story came back to Cecil and said, "You said this was a winter story, but there's nothing about winter in it." So there's a lot of opportunity for education all the time at the state. That's a lot of what our job is about, being in the meetings, making sure that our American Indian issues are raised and paid attention to.

We have a pilot program that we started this year. It's a Positive Community Norms. It's an environmental strategy at Red Lake, Fond du Lac, International Falls, Bois Fort, and the Minnesota Indian Woman's Resource Center located in Minneapolis. Our State has been using This Positive Community Norms project for about five years and it's been successful, so it's time for us to do some work with it as well and try it out with American Indians.

Because of the state of emergency, I was asked if we need - what we need to do, and what will help. I replied that really we need an army to address this. Our few staff are not going to do it; even if we worked around the clock we wouldn't make a dent in it. And then what do we do about all the other things that we do that we believe are helpful? So what we were given is another position. We'll take it. With that other position, what we hope to do is to have that person work primarily with White Earth, Leech Lake, and Red Lake around this issue.

Culturally specific treatment model – Dr. White Hat and the American Indian Advisory Council, some of the people met to work with that. We have a document that was approved by the Advisory Council and that a couple treatment programs in Minnesota have adopted. That's available for you to look at if you're interested. We have an American Indian Traditional Family Roles Assessment that Dr. White Hat has produced and several programs use, both for

prevention and treatment activity. Our Native American Curriculum for Prevention Specialists and Substance Abuse Providers, which we adapted from South Dakota's curriculum developed by Dr. Duane Mackey. We've trained, for the last several years, treatment counselors who work with American Indians, primarily non-Native people. Just this year we're starting to offer the training for tribes and our urban American Indians as well. It's a three-day, 22-hour curriculum. It's kind of American Indians 101, but we've had some really good responses and plan to continue to use that.

Outcomes. Meaningful and real-life outcomes is what we want. Abstinence. Resiliency in sustaining recovery prevention and treatment outcomes. Community wellness and better treatment outcomes. One of the things I wanted to say is in Minnesota we have a lot of Indian people who are in recovery, and I think that's important to remind people of. We have people who come to recovery or come to their sobriety or abstinence through religion. We have people who come to sobriety and abstinence through treatment and 12-steps. We have people who come to recovery through the culture. That's probably always been the case, but it's definitely the case today. A lot of people will say that the culture has been helpful in their staying sober and having a quality of life that is worth staying sober for. Even though we may have the highest rate for addiction, and I really think addiction is the issue, right now it's opiates, I always tell people that if you don't have an addiction or you haven't addressed an addiction in your life, try to stop drinking coffee or pop, caffeinated pop. Try doing that. Or quit smoking. Then you'll get a better understanding of what the addiction is about. Or give up sugar if you don't have caffeine or nicotine – or chocolate. That gives you a little bit of a sense about what addiction is and what people are experiencing, just a little taste of it. For some people it will be worse than others. That's what it is.

Thanks for being here.



**American Indian Substance Abuse Prevention Activity in Minnesota**

Department of Human Services  
Chemical and Mental Health Services  
Alcohol and Drug Abuse Division  
American Indian Section

**254A.03 STATE AUTHORITY ON ALCOHOL AND DRUG ABUSE.**

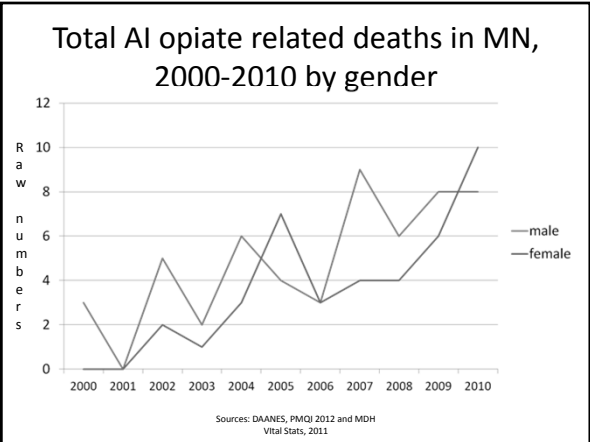
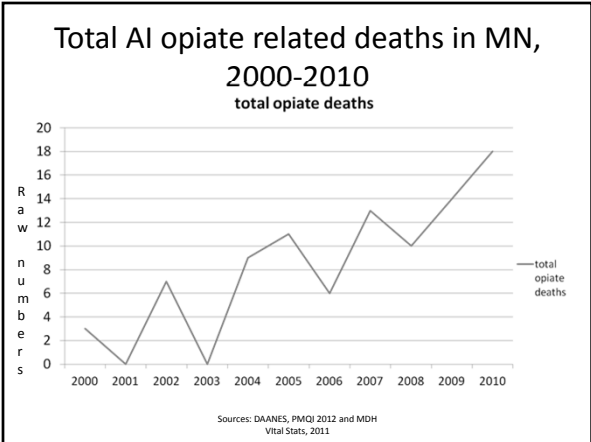
Subd. 2. **American Indian programs.**

- There is hereby created a section of American Indian programs, within the Alcohol and Drug Abuse Section of the Department of Human Services, to be headed by a special assistant for American Indian programs on alcoholism and drug abuse and two assistants to that position.

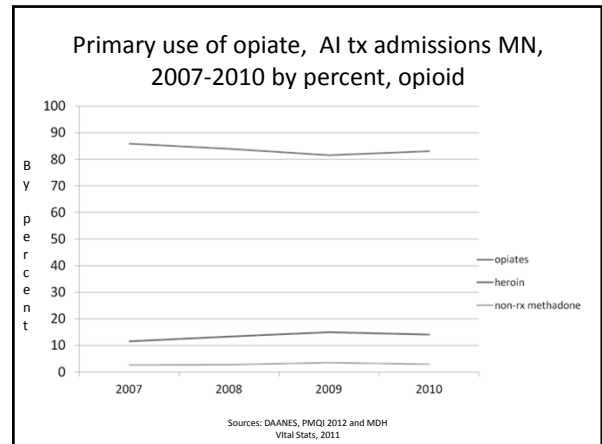
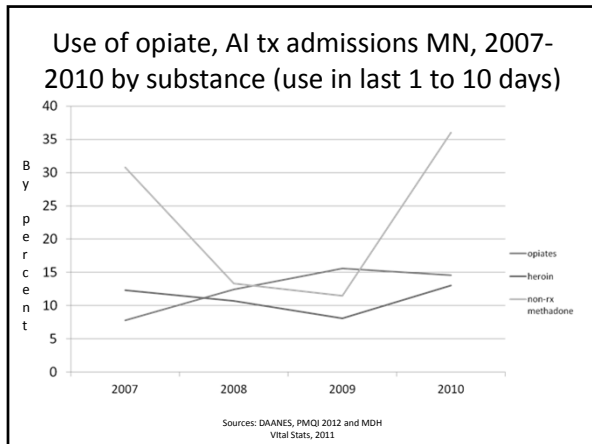
**Opioid**

- In MN, between CY 2000-2010 there were 1986 death certificates issued with opioid as a primary or contributing cause of mortality
- Of those, 94 (4.7%) were identified as Native American/American Indian

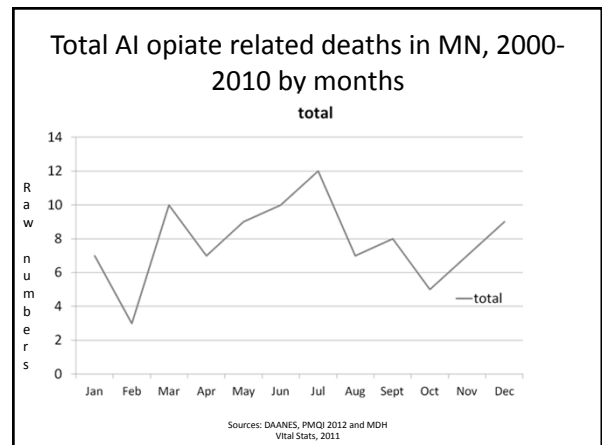
Richard Moldenhauer



State Panel




- ### Top counties for AI opioid mortality in MN, 2000-2010
- Hennepin..... 36
  - St Louis .....7
  - Beltrami.....6
  - Cass.....6
- Sources: DAANES, PMQJ 2012 and MDH Vital Stats, 2011



### 254A.035 AMERICAN INDIAN ADVISORY COUNCIL.

Subdivision 1. **Establishment.**

- There is created an American Indian Advisory Council to assist the state authority on alcohol and drug abuse in proposal review and formulating policies and procedures relating to chemical dependency and the abuse of alcohol and other drugs by American Indians.



**American  
Indian  
Community**

**Prevention Programs**  
Prevent/Delay/Reduce alcohol and drug use by adolescents  
Increased Prevention Resources  
Improved prevention resource coordination

Our culture is a way to prevent  
substance abuse



**CULTURE AND PREVENTION**

**Minnesota American Indian ATOD  
Prevention Programs**

- Tribal applications are non-competitive.
- State provides funds, information, and training.
- Tribal and Urban AI programs implement projects.
- American Indian Advisory Council is state legislated.
- Most programs implemented projects that include evidenced based programs and include traditional cultural activities and activities designed to bring families together.

Traditional/Cultural Activities

**Youth with strong cultural identification are less vulnerable to risk factors.**  
Evidence-Based Practices are currently being implemented in the  
American Indian Communities in Minnesota



**Evidence Based Practice  
and Practice Based Evidence**

- Storytelling for Empowerment
- Project Northland
- Project Venture
- Protecting You, Protecting Me
- Project Alert
- Guiding Good Choices
- Positive Action
- Motivational Interviewing
- Motivational Enhancement/contingency management
- Biizindadeda (Adapted from Iowa's Strengthening Families)
- Son's and Daughters of Tradition (White Bison)
- Babes & Red Cliff

**ADAD and other Prevention Activity  
that benefits American Indians in MN**

- State Prevention Framework - State Incentive Grant – ADAD
- State Prevention Framework – Tribal Incentive Grant – Leech Lake, MN
- State Prevention Enhancement – ADAD
- State Epidemiological Outcomes Workgroup (ADAD)
- EPI Workgroups (Red Lake, Leech Lake)
- Tribal Summits
- Minnesota Collaborative on Substance Abuse – DPS, MDH, MDE, DOC, DHS, HLB, HCMED

### Annual Native American Prevention Program Sharing Conference

- National speakers for keynotes that spend the entire day and provide breakouts as well as keynote.
- Evidence based practice is encouraged and speakers are sought that can speak to the topic.
- Youth track is included. Two youth per chaperone are included in adult registration.
- Held with the Annual Minnesota American Indian Institute of Alcohol and Drug Studies.

### Prevention and Treatment Tracks

- ADAD American Indian Section produces a newsletter for Prevention Specialists and Treatment Providers working with American Indian people.
- Winter and Spring issues.
- Success Stories from prevention programs are included.
- Cultural stories, values, events are included.

### Pilot Project

- Positive Community Norms
  - a. Red Lake
  - b. Fond du Lac
  - c. International Falls/Bois Forte
  - d. Minnesota Indian Women's Resource Center

### Technical Assistance and Training Projects

- State of Emergency concerning prescription drugs - White Earth, Leech Lake & Red Lake
- Culturally Specific Treatment Model – AIAC, lead staff Dr. Cecil White Hat
- American Indian Traditional Family Roles Assessment – Dr. Cecil White Hat
- Native American Curriculum for Prevention Specialists and Substance Abuse Providers – Adapted from South Dakota's curriculum developed by Dr. Duane Mackey



### Outcomes

Meaningful & real-life outcomes for people who are striving to attain and sustain recovery.

Abstinence

Resiliency & Sustaining Recovery – such as staying in school & getting and keeping a job  
Decreased involvement in the criminal justice system

Prevention and Treatment

Outcomes:

*Community Wellness*  
*Better Treatment Outcomes*



### Questions and Answers

- Denise Estey Lindquist
- [denise.estey.lindquist@state.mn.us](mailto:denise.estey.lindquist@state.mn.us)
- 651-431-2461
- 540 Cedar Street, St. Paul, MN 55155



***State Panel, Speaker 3***

**JEFF COADY:**

From the State of Wisconsin, Gail Nahwahquaw. Gail does not have a PowerPoint, which is OK.

**GAIL NAHWAHQUAW, BS:**

Good morning everyone. I'm Gail Nahwahquaw. I am with the Department of Health Services in the Division of Mental Health and Substance Abuse Services. I am a member of the Menomonee Nation in Wisconsin. I have been employed by the Department of Health Services in Wisconsin for the last 12 years, serving in both the Public Health Division and now the Division of Mental Health and Substance Abuse Services. My role in this Division is as our Intercultural Program Coordinator. What that means, essentially, is any of the substance abuse block grant dollars, mental health block grant dollars that come through our state and we contract out to the counties, community-based agencies, or the tribes, I help with the contract administration for those that go to the tribes and any of the agencies that serves our ethnic minority communities, which are primarily in Milwaukee for us in Wisconsin, serving African American and Hispanic communities. We are still working on growing better relationships with our Hmong community and refugee community in the state. I work probably the most with the tribal communities and I see many of my fellow Wisconsin tribal members here in the room and work fairly closely with them. I also wanted to acknowledge Ken Munson – he used to be our Deputy Secretary for the State so he is aware of many of the activities that have gone on in Wisconsin, and was very key to continuing the tribal consultation policy that we have at the Department of Health Services.

We maintain a tribal consultation policy in the State – I would say with each administration there is certainly a learning curve of what that means and the need to educate our administrators about the goals and the meaning of tribal consultation. We still maintain that the charge in our State for at least one tribal consultation per year. Our Department a few administrations ago...they meet every six months and have made it a biannual tribal consultation. I think it certainly is growing – the understanding of what that means for the

tribes to come to the table and let the Department know what the issues are within their tribal communities and helping to better shape what that consultation means, I think, is an ongoing process. However, it continues.

My instruction in coming here and talking to Jeff about what it was he wanted it was the strategies and initiatives that are happening with the Department of Health Services and the tribes, so that's part of what I've come here to talk about. Our state has a governor-appointed State Council on Alcohol and Other Drug Abuse – SCAODA is what's it's called – and it's made up of department heads, treatment providers, prevention providers, although it's probably heavily weighted on the treatment side. The current chair of SCAODA is a tribal member, although he serves in a provider capacity. He is a program manager of a local treatment agency in Madison. Their goal was to work on increasing the membership from tribal communities and put forth the recommendation to request more tribal membership. That also is ongoing. They work to continue to increase the number of tribal members at the table talking about the issues of drug abuse. So SCAODA recognized by any number of means – public forums, primarily tribal public forums, statistics, the need for really looking at the impacts of prescription drug abuse in our state. SCAODA requested that a task force be formed to study this issue in our state, so it came out of the Prevention Committee of SCAODA, a Controlled Substances Workgroup was formed in 2010 and studied the issue in our state for a year. The action plan was just released in January of this year and there are copies of it at the back table for any of you to take. That group was made up of local researchers, law enforcement, Pharmacy Examining Board, tribal communities represented by one of the – we have another group in the state, the Tribal-State Collaborative for Positive Change, which is a group made up of tribal behavioral health and substance abuse managers and staff. One of the members of that group sat on the Controlled Substances Workgroup as it looked at the issue of prescription drug abuse in our state. The Workgroup identified eight primary priority areas, with 34 recommendations under each of those priority areas.



That plan is what we're doing in the state around prescription drug abuse. You've seen lots of statistics from Michigan and Minnesota, and Wisconsin doesn't fall far outside of those numbers. I will say that Wisconsin does not have a prescription drug monitoring system currently, so we're unable to track, and out of this action plan, talk about the importance of being able to see what the problem really is in our state. Until we can do that, we can't see whether or not we're moving the needle in the right direction. That's a charge that's come out of this call to action.

We also know in Wisconsin that, while we hold our tribal consultation policies, we hold those meetings, we also note that we know that we don't track numbers in our health department of Native communities very well. We know that Natives are underreported in every health statistic that comes through our building. We know that. Again, there are many workgroups. Our tribal health directors meet regularly with our Department of Health Services, either with our Medicaid office or our tribal affairs office, and continually talk about how the tribes are underrepresented, how the numbers don't represent what is truly being seen at home and in their home communities, and trying to work on how do we better bolster the data that we collect and work together to make that happen. We have the Great Lakes Intertribal Epidemiological Center, and Kristin Hill, the director of that agency, also sits on many of our task forces, and she will always say that the number one health disparity for tribal communities is the lack of data. And again, until we can see what the numbers really are showing, tribes will continue to be at these disparity levels if we can't see the numbers. So she'll continually say that at our Task Force meetings.

I will just keep saying that it's through our tribal consultations, that's kind of our first area in working with the tribes through our Bureau, the number of task forces that we help staff, that we help coordinate, that we sit at the table with, and really want to hear from the tribes, what are the issues at home and know that is by their efforts, it is by discussions, they're the groups that can better describe what's going to work best for their communities. That's essentially what we try to work on in Wisconsin.

Again, the plan is in the back of the room.

**JEFF COADY:**

I'd like to thank all the state speakers who came to talk about their plans. In the interest of time, I would ask that we could take a 10-minute break now, and our state representatives are going to stay, and when we have a discussion on the actual pillars after the break, our state colleagues will be here to answer questions about how the state can help support some of the efforts in the Action Plan and we can start connecting some of the dots about where services exist and how we can fill some gaps.

***Interview 1***

**CECIL WHITE HAT, Ph.D.**

**INTERVIEWER:**

Would you like to introduce yourself?

**CECIL WHITE HAT:**

My name is Cecil White Hat. I'm from the Rosebud Sioux Tribe, and my clan is the Aske Gluwipi Tiospaye, the translation for our clan name is "People who wrap their braids." The question that I wanted to address was how to use the culture as a tool for addressing the rampant prescription drug abuse. I believe in using the culture. I believe that everything that we need to get well is in the culture. I think it's very important to differentiate with the people you work with in what are traditional family roles and the community roles as opposed to an alcohol and drug subculture, to make that distinction between those two lifestyles with the people you work with. I always make that distinction in my work with prevention and particularly with prescription drugs. I make sure that they understand that some of the behaviors are not cultural, and the best way to get that message across, of course, is an extensive use of our oral tradition. I believe that is a very important tool one can use to get that lesson across, because for millennia, that was our method of education – we would tell a story and then we would ask our listeners to respond to that story, is there a spiritual underpinning to the story? What was the lesson? Is there a moral lesson? Then we ask our listeners to make up their own mind as to how they can use that in their culture and in themselves as individuals to better their lives. I can't overstate the importance of oral tradition. This method of education created a people with strong identities, high self-esteem, honed critical thinking and developed excellent decision-making skills. Thank you very much.



***Interview 2***

**BROOKS BIG JOHN**

**INTERVIEWER:**

Please introduce yourself.

**BROOKS BIG JOHN:**

My name is Brooks Big John. I'm from Lac du Flambeau, WI. I'm a tribal councilmember. I've been the Tribal Chairman for a little while. My job is the tribal employment rights officer, and we're here today to learn more about the prescription drug abuse epidemic that has hit not only the nation, but tribes in general.

**INTERVIEWER:**

Prescription drug abuse is really important to you and you're passionate about people who are being harmed by prescription drug abuse in your community. Can you describe the impact of prescription drug abuse on your community?

**BROOKS BIG JOHN:**

Some of the impacts I've seen over the past couple of years have escalated to the point that there are now deaths. Not only as a person, but as a member of our Tribal Council, I think we need to be proactive instead of reactive, and really kill this pill, that's what I call this action that we're looking to put in place back home through our tribal government: I call it the Kill the Pill Plan. Some of the impact I've seen in the community has included deaths, but I've also seen grown men and women who used to be active in the community, in sports and other extracurricular activities, been laid off to the side. Their bodies have changed dramatically. I've seen some of our beautiful women kind of melt down to just skeletons, kind of scary people.

## Interviews

Some of the other impacts I've seen are some of the robberies that have taken place in our community, where people are stealing from other people, family and friends. That's where it really hits home, when they start robbing their own clinic. When people are robbing pharmacies in the nearby communities, you know something is wrong. That's not only in my eyes, but other people in our community see it too.

The impact on our kids – I run a baseball program, and I see these kids I have hope for and I know who their parents are. We have such a small community. But you want to have that hope, and you want to somehow inspire these kids to do better in their lives and make something of themselves; but you really feel hopeless for them at some point, because you know that their parents are involved with these things, they have been for years, and you really can't see a way out of it for them. As a tribal leader, I want to address that.

I talked to David Bingaman, Jeff Coady, and Jenny Jenkins, and I talked to Gail and some of the other people here. I tell them I'm tired of talking and being educated. Although that's all great stuff, at some point we need to go ahead and create a plan. That's why I call the plan I want to take back to my reservation the Kill the Pill Plan.

Today we're creating this plan. I see that there will be barriers to the plan once it's created, and we're going to have to have our hands out for this funding. We're going to have to be up to knocking on doors. I would like to see some inter-governmental or inter-tribal groups form from this where we have - instead of just our Lac du Flambeau tribe knocking on the door - we have a group of all 11 tribes from Wisconsin – or maybe with Minnesota and Michigan collectively – knocking on the door. We need to say we all have these problems, we see them, we have a plan we've created, now give us the money to help us through this. Tribal governments themselves, the ones that can go ahead and allocate money from their own budgets, need to start putting money aside and being players ourselves. This comes with educating my council, like I mentioned today. I asked the lady from the Division of Mental Health and Prescription Drug Abuse from Wisconsin, Gail, to come to our council, educate my

council and my colleagues there, get their support, and let's create a partnership that we can use to try to tackle some of these obstacles and barriers in front of us. Instead of talking about impact on my community, I hope to see in five years, ten years, I hope to be talking about positive outcomes that have come about through what's going on today at the SAMHSA Conference.

**INTERVIEWER:**

What can grandmas to do help this?

**BROOKS BIG JOHN:**

Grandmas? Well, the grandmas back home are our elders and our people need to listen to them. They do on other issues. I would like to see our grandmas maybe start working with kids in the schools. When they come before us as tribal leaders at the table, we give them our undivided attention. They talk about the cultural aspects and how we tie that into our plan. I think it's important. Years ago, these different types of herbs and different types of sweats and different types of things were all used, and I think we can be instilling that and weaving that into our plan. Whatever we can do to make that plan full is going to be a better plan in the long run. Of course this plan needs to be reassessed over time and we need to tweak it over time, make sure it's the right plan and it's working, lay aside some of the things that aren't working. I know that over time we'll develop a good, solid plan that will give the positive outcomes we're looking for.

**INTERVIEWER:**

Look into the future and describe, when this plan is in place and working well, what it will look like when you go back home. Take or give a few years from now, if everything was just great, describe what that would look like.

**BROOKS BIG JOHN:**

## Interviews

I don't think you're going to curtail this thing to a halt, but maybe accept that and really try to make the best and the most positive changes that you can. That gets back to the plan that you instill, the government that's there at the time. You have to go ahead and inform your community, and get them to show support, and back that plan. Without the community there, you're talking to deaf ears, and you're not going to see the rewards; so I think you have to talk about some of the success stories out there, not only in Indian Country but all throughout the nation, so our people can see that there's light at the end of the tunnel. Positive things can happen from that.

Thank you.



***Interview 3***

**DAWN WYLLIE, MD, MPH**

**INTERVIEWER:**

Please introduce yourself, your affiliations, however you feel comfortable.

**DAWN WYLLIE:**

I'm Captain Dawn Wyllie, I'm a family physician and the Chief Medical Officer and Deputy Area Director for the Bemidji Area. I'm of Sisseton Dakota American Indian heritage and I have been working in Indian health for the past 24 years.

**INTERVIEWER:**

Talk a little bit about what it looks like in your community, with prescription drug abuse.

**DAWN WYLLIE:**

I think what we're trying to do is a fair amount of provider/prescriber education on how to use medications appropriately, provide patient education, and have an impact in a way that will lead to the health of the individual in the best way possible. So if we have an individual coming in who needs a pain medication for an acute or chronic condition, it needs to be prescribed appropriately. If we find out they have issues of substance abuse or potential diversion, then we have to take the appropriate action with that patient and try to get them into the treatment, using a multidisciplinary way to approach the patient. Most patients come in with a pain issue, so we're using our policies and procedures to implement pain management teams, which are multidisciplinary, and patient/provider agreements that help and guide us in monitoring the best possible way to provide the care to the individual.

**INTERVIEWER:**

## Interviews

Describe the balance between traditional care and medication management for pain and prescription drug abuse?

### **DAWN WYLLIE:**

I think from the physician standpoint we need to use a holistic approach to the patient, and it's very important to use all different modalities of complimentary alternative medicine and traditional healing, long-term. Chronic pain medications, such as opioids, are really the last resort. It should proceed in a progressive way where you use physical therapy, use non-narcotic types of medications, biofeedback, and other kinds of disciplines – behavioral health, for instance, to look at your stress levels with your pain – and then you get to narcotics if you need them for unrelenting pain or if you have surgeries that have become infected. So there are a lot of things we can do first. I think there's a lot of education that needs to be done. We have contributed to the problem in that, as a clinical field, medicine today and as it's evolved over the last 30-40 years views a pill as the fix, but the pill is not the fix, it's only one of the options in our repertoire of treatments.

### **INTERVIEWER:**

How do you respond to medication management and medication treatment as just replacing the drug?

### **DAWN WYLLIE:**

I think that there's a place for medication management treatment, but it's in a very select group of patients and a very small percentage of patients. There are individuals who will need chronic narcotics and opioids for the rest of their lives because they have a condition where we're exhausted all the treatments and they still have their pain. They still need to be in an integrated care system when they're on that pain medicine, so they need to continue with their counseling, looking at family relationships, working in a job, having self-esteem, and the other things that make life manageable, to help them live their lives in a good way.

**INTERVIEWER:**

Is there anything else you'd like to say?

**DAWN WYLLIE:**

It's critically important that we approach pain management or any therapy we're doing in a multidisciplinary team way. We are mind, body, and spirit, and we should not have fragmented or siloed care.



***Pillar 1: Education***

**JEFFREY COADY:**

We're going to get started with the first pillar that we're going to discuss. Nick Reuter from SAMHSA is here. He's the lead for our strategic initiative in prevention for prescription drugs, and he's going to present on the first pillar, Education: What I'd like you to keep in mind, what he's talking about. David first presented the action plan template. The information he's going to share, begin to start thinking how this might be operationalized and implemented: What can be done in your particular tribe that you can take the information and move it to action. This won't necessarily be the final action plan – when you go home and build your team it will be massaged and refined – but begin to put the thoughts down. We'll have some table discussion and reports after he presents, but I think the important part is to take the information, put it together on paper as you develop your action plan.

I'm very happy to be here. Nick, you've been a source of information for me, and I know for the Nations, in terms of the efforts you've taken.

**NICHOLAS REUTER, MPH:**

Thank you. Good morning. We're going to start talking about pillars. Are there any pharmacists in the room right now? Wow, a lot. You know why pharmacists are held in such high regard? Because they're the PILLars of our community. So what better way to talk about...pills.

*(Laughter)*

We'll talk about that in a second, but I wanted to give you some background on what the Federal government is doing to prevent drug abuse, and some of the statistics we use to guide our interventions in this area. I'll go through this quickly.

## Pillar 1: Education

What I want to talk about is prescription drug abuse as a public health problem, preventing prescription drug abuse, a little bit about the pillars of the ONDCP White House drug control strategy for prescription drugs, focusing on the education pillar. Later this morning, we'll come back and talk a little bit about the monitoring part of that. This is one of SAMHSA's strategic initiatives – preventing substance abuse in mental illness, and preventing prescription drug abuse.

SAMHSA is guided in this by some statistics. We have a survey on drug use and health administered every year – it's a representative sample that interviews 67,000 people throughout the US -- to get an idea of the substance abuse problem in this country. Non-medical users of prescription drugs, as you see, are about 2.7% of the population over age 12. Notice it looks kind of steady from 2002 all the way to 2010; it doesn't look like a huge variation. It hovers around 2.5-2.8% of the population. You hear a lot of talk in the media about the epidemic of prescription drug abuse, but looking at that trend line, do you see anything that jumps out as a genuine epidemic or huge increase over the last eight years? This is an important distinction here – the number of people that currently have non-medication use of prescription drugs has stayed at that rate, and it's the same with prescription pain relievers at about 2% of the population.

Marijuana and illicit drugs have increased, and there have been some significant increases in the past two years. The substance abuse problem in the US is getting worse and a lot of what is driving it is marijuana; and a lot of what might be driving that is the perceived risk of drug use decreasing during this period of time. This puts those numbers in perspective, that 2.7% of the population is about seven million people in the US.

There are some nationwide trends you should be aware of. Cocaine use has decreased steadily and significantly since 2007. Methamphetamine use is trending down – it went up a little in 2009 but it's back down again. It's still a concern, but it's not what we're here to talk about.

The way we define non-medical use of prescription drugs is we ask them if they took a prescription drug that was not prescribed for you, or did you take it for the experience or feeling that it caused. I know a lot of people, and I won't ask for a show of hands who meets that first criterion. They may not necessarily think of themselves as drug abusers. A lot of people look at our estimate, therefore, and say it's an overestimate, but we think it's pretty accurate. The biggest problem we see with prescription drugs is pain relievers. Is that consistent with what you're seeing? The tranquilizers and benzodiazepine medications are trending up as well, but the biggest problem is prescription pain relievers. Stimulants and sedatives are much, much lower.

We also measure the initiates of specific drugs every year. This is changed. This is the number of people age 12 and over who initiated substance abuse in 2010. We see marijuana, pain relievers, and then other prescription drugs like tranquilizers and inhalants. This is going in the right direction. A couple of years ago, more people initiated substance abuse with prescription pain relievers than with marijuana in the US. Now we have fewer people who start to misuse and abuse drugs are abusing prescription pain relievers.

We can also measure how many people are dependent, and this shows you that prescription pain relievers have around 2,000,000 people in the US are currently dependent on prescription pain relievers. According to our survey, there are about 700,000 people dependent on heroin.

When it comes to prescription pain relievers, we ask where people who misuse prescription pain relievers actually obtain them. You would think -- at least what you hear on the media a lot -- is that people get them on the internet, shop doctors to get them or buy them from dealers. Things like that. But the biggest source is that people get them free from a friend or relative. Two years ago we added another question to follow up on that, asking where the friend or relative got the prescription pain reliever they use, and 80% of them said from just one doctor. So this guides us. We have a huge emphasis on preventing prescription pain reliever abuse by focusing on prescribers. This is important. Not so much on the internet.

## Pillar 1: Education

We talked about the straight line in the prevalence of prescription drug abuse, staying at around 2.7% and prescription pain relievers around 2.0% of the population – about 5,000,000 people are non-medical users.

The consequences of that use, there I'm confident in saying that is an epidemic in the US. Our Drug Abuse Warning Network, one of the other SAMHSA instruments, indicates that the emergency department visits involving pharmaceuticals almost doubled between 2004 and 2009. Three or four years ago, there was a tipping point and more people ended up in emergency departments for prescription drugs than for the traditional substances like marijuana, heroin, and cocaine. We passed that a long time ago. Prescription drugs are sending more people to emergency departments.

But there are some dynamics we'd like you to be aware of. Hydrocodone – Vicodin – we heard this morning is being a tremendous drug of abuse and I don't dispute that for a second. There's a lot of Vicodin prescribed in the US. But that's the red line we'd like you to be aware of, the hydrocodone combinations, have started to trend down in 2008 and 2009. Why? We're not exactly sure.

Methadone, another drug of abuse that gets a lot of attention, also decreased in 2008 and 2009. So there are some interesting trends going on when it comes to prescription pain relievers.

Another important consequence of prescription pain reliever abuse is that it's sending a lot of people into treatment facilities, which we can measure through our TEDS system. If you look at the overall bullet, there was a five-fold increase in the first bullet as treatment relievers driving them to inpatient treatment between 1998 and 2008.



I'd like to ask you to look at the very last bullet. There are some other demographics about people who do go into treatment. The percentage of prescription pain reliever admissions with comorbid psychiatric disorders increased from 19.4 to 38.36%. Is this what you're seeing? For four out of ten people seeking treatment for prescription pain reliever abuse, they have a co-occurring psychiatric disorder.

We have to factor that all into our education and other plans. There are a lot of things going on in this patient population.

I won't spend a lot of time on overdose deaths. There are a lot. The most recent Center for Disease Control mortality data indicate that 37,000 people died from overdose death, of which 21,000 died from prescription drugs. Opioids are part of that 21,000, almost 16,000 people died from them in 2009. That might be an underestimate as well.

This shows that more people are dying unintentional deaths due to opioid and prescription pain relievers. Drug poisoning deaths are up. Heroin is trickling up, just increasing gradually, and we will talk about that a little more in a second. Cocaine-related deaths are falling dramatically and significantly nationwide over the past several years.

To break down the opioids into different categories, hydrocodone, oxycodone, and morphine all grouped together are really driving the rate up. Methadone was always touted as the most toxic and lethal of all drugs, but methadone-associated mortality has decreased over each of the last two years, so something is going on there. We also have fentanyl and semi-synthetic opioids like propoxyphene and buprenorphine, which are narcotic addiction-treatment medications. That little blip in 2006 was from some heroin that was contaminated with fentanyl in the Midwest that caused a spate of overdose deaths.

The number of people in that 2% who use prescription pain relievers non-medically on a chronic basis is also increasing, so we have the factor that those who do abuse pain relievers

## Pillar 1: Education

are using them much more frequently. That little cohort is using them much more frequently and, as a matter of fact, the increase in the rate of chronic use parallels the rate of overdose deaths in the US.

So, later on when you sit and talk about how you want to target your prevention and intervention plans, you might want to look at these populations. There was a 75% increase in the past year in chronic non-medical use of pain reliever over 200 days during that year. The largest increase was in males, which doubled between years 2003 to 2010. There is a specific age group you want to factor into your efforts – that's the ages of 26-49. That's a big group, but the 35-49 increase in chronic use doubled over that period. So maybe you want to target your interventions to that particular age group – they're the chronic users of prescription pain relievers and they're the ones also most likely to overdose and die at some point.

The final consequence I'll discuss is neonatal withdrawal symptoms. Are you seeing women who come in to your treatment facilities and health centers who are dependent on pain relievers and other opioids during pregnancy? We're seeing quite a bit of that nationwide as well, and it's showing up in a lot of different areas. Neonatal abstinence syndrome is associated with prescription pain reliever abuse during pregnancy. That's something that has gathered a lot of attention since a JAMA article published earlier this year. Opioid exposures increased from 2000 to 2009 almost threefold. Hospitalization costs for treating neonatal abstinence syndrome – all infants treated in ICUs in the hospital – went from 39,000 to 53,000 during that period of time. 77% of that treatment was covered by Medicaid. I've talked to people in the field who said they're spending \$80,000 per neonatal abstinence treatment episode in private and community hospitals, so it's expensive and most of it is being funded by Medicaid. Average length of stay is 16 days for neonatal abstinence syndrome. This rise parallels the increase in prescription drug abuse. In Florida, from 2009-2010, there was a 42% increase in infants discharged with neonatal abstinence syndrome.

To sum up all the statistics on the scope of the problem we have with prescription drugs, many more men than women die of overdoses, which doesn't match exactly what we heard from Minnesota earlier. Middle-age adults have the highest prescription painkiller overdose rates. People in rural counties are about twice as likely to overdose on prescription painkillers as people in big cities. White and American Indian or Alaska Natives are more likely to overdose on prescription painkillers. Three Minnesota tribes declared prescription drug abuse a public health crisis in their Nations just this year.

So how does that factor into our plans? You've heard about the four pillars, and we at SAMHSA have incorporated these pillars into our plans. To address the education pillar, we will talk about that in groups in just a second. We have Screening Brief Intervention and Referral for Treatment – SBIRT – that showed up in a state plan. We're going out to medical school residency programs to teach them about SBIRT, and most of the focus has been on screening people or alcohol abuse and addiction, but what we're doing right now is teaching them to look out for prescription drug abuse. The two elements of SBIRT are trying to catch people early, upstream, before their problem becomes a severe addiction, and the second is focused in the primary setting where we're educating future primary care providers on how to screen people for prescription drug abuse. A description of SBIRT is we're targeting the 20% at risk. The 5% with severe problems are easy to identify, but we want to get at the 20% who are at risk and intervene now and use primary care providers who are the front line for that. There are some statistics I'd point out that, if you do screen people and refer them for treatment, SBIRT reduces substance abuse and unemployment, increases housing, decreases criminality, and increases social connectedness. Someone raised the issue that there's no training in medical schools and residency programs about this, but that's not true. We have grantees at 17 locations throughout the US, though I don't believe Minnesota is one of them. There will be another round of grants, however.

There are other screening instruments. So, if you develop your education and screening and go to the doctors in your tribes and regions to ask them to educate you on who's at risk for

## Pillar 1: Education

prescription drug abuse and dependence, we have these tools. They're tested and validated. This is one the World Health Organization developed a few years ago for screening people for all kinds of substance abuse issues. They just asked the patients questions and they added one for opioids – "In your life in the last three months, how many of these have you ever used?" In prescription drugs, they ask them non-medically. They did a score from 0-3. You can score this and get an assessment of how someone may be at risk and need of referral for treatment.

We also have a plan or program in place that targets existing prescribers, our Prescription Education CME Program for Opioid Prescribing. We've done it all over the US. As you think about your plans, if you want to have someone come in and provide your community with continuing education that focuses on appropriate opiate prescribing, let us know and we'll get someone out to you. We've talked to doctors who tell us they don't know what to do if they discover someone is a doctor-shopper or if they want to treat someone with methadone, which is complicated. We teach them the steps to take if they decide not to use opioids in the treatment of prescription pain. We teach them to use prescription monitoring programs. And, importantly, we teach when, why, and how to stop prescribing opioids and manage the patient with another treatment approach. In other words the patient comes in and the doctor checks the prescription drug monitoring program and realizes there's a problem – they can't risk their medical license by writing another prescription for an opioid because they patient has filled prescriptions from other providers and pharmacies but don't want to abandon the patient. There are other treatment opportunities they can offer, such as meeting at the emergency department, where the patient's withdrawal symptoms can be treated as a further plan is made.

We talk a little about consumer education, and you should have that as well. We have some features that address consumer education. We had one at SAMHSA called "Not Worth the Risk, Even If It's Legal." It gets at the issue of underestimation of risk, risk assessment in the population, especially adolescents. We teach them. The pamphlets we develop indicate that prescription drugs are dangerous, they should be secured, and unused drugs should be

disposed of. It targets the messages to the appropriate messengers. You want to include this, especially in how to get the storytelling and other elements involved to get the message across culturally and acceptably. We've identified parents, healthcare professionals, and educators – three different agents of change in the consumer education piece.

Dr. Coady asked me to talk a little bit about our Opioid Program Overdose Prevention Toolkit. Not everyone has to die from an opioid overdose, which is our theme. We developed a toolkit that we're going to distribute to the Nations – 1,200 opioid treatment programs that will compliment some of the work we've done in the past on methadone safety. We think this community is the right community to get this Overdose Prevention Toolkit out to the patients who are at risk of overdose and the patients in the community where they identify colleagues who do affect overdose, and we think they can get that message out. The Toolkit includes a lot of information on preventing overdoses, but it also talks about reversing overdoses.

How many of you have heard of the medication Narcan? It's a narcotic antagonist that can reverse overdose situations. When we had the fentanyl-contaminated heroin a few years ago, it developed a real understanding to have these Narcan distribution centers out there to reverse these overdoses. They reversed at least 2,000 people in overdose situations.

Out theory is that you'll distribute Narcan, but will that encourage future drug or opioid abuse? Our view is that we think we can actually use it to get people into treatment, and if someone has overdosed and died of an overdose, we certainly know they can't come into treatment. This quote from our ATIDE Conference last year was, "You can't recover if you're dead; you can't get into treatment if you're dead." That's what Narcan and overdose prevention does, and that's what we'll do with our toolkit.

Naloxone is a prescription medication, but still it can be developed into these toolkits and made available. Does anybody know if there is an overdose prevention activity component or outreach program in Minnesota? If at all, it would be in the Twin Cities area. There is one?

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We've found that most of these are located in major metropolitan areas, but the two states with the highest rates of opioid overdose in the country are two interesting, diverse states. Number one is New Mexico, driven by a heavy heroin contribution. Number two is West Virginia. There isn't a single overdose prevention program in the state of West Virginia right now. You have one western state and one Appalachian state with the highest rates.

The World Health Organization is developing guidance on using Naloxone, and finally just this week the American Medical Association developed a resolution encouraging the use of Narcan distribution to prevent overdoses. That resolution encourages more pilots, more education of healthcare providers. The big thing here is educating people who are abusing opioids on how to use Naloxone and preventing overdose fatalities.

Some subgroups and providers disagree. They think that Narcan, which is a safe medication with no side effects and risks much less than ibuprofen, should only be used by trained health professionals. So there's a bit of a dilemma there that needs to be resolved, whether bystanders can be trained to use Narcan, and that's what the FDA will be looking at, to see if it can be made available without a prescription, which would expand the use of that, save more lives, get more people into treatment, and reduce the toll of prescription drug abuse.

To sum things up, prescription drug abuse is stable at about 2.7% of the population. The consequences I've talked about – ER admissions, treatment admissions, chronic use, maternal exposure, and mortality -- are increasing significantly. That's why we're here this morning. There are prescriber and consumer educational resources available, like treatment improvement protocols we've developed, but I've talked about the resources we have right now when it comes to prescriber and consumer education material. They're there and if you ask us for them, we'll get them to you.

Heroin is increasing, prescription to heroin transmissions are increasing. We just had a briefing yesterday from our National Survey on Drug Use and Health, and 97% of the people who

initiate heroin abuse previously used prescription pain relievers non-medically – 97%. The reverse is not true – 3% of the nonmedical uses did not previously use heroin. So you might say the prescription pain relievers are a gateway to heroin abuse, as are other things. Marijuana has also shown up as a possible contributor to future heroin abuse; cocaine and other things as well.

So, for this morning, I was going to give you a little bit of guidance on what you might do on a successful pillar of education plan. What I've seen in going around the country and talking to groups like this about a successful for education intervention and the kind of tasks are first to identify your stakeholders; and here's my guidance: Be very comprehensive. Include community leaders, healthcare providers, treatment providers, and please don't exclude law enforcement when you do this. My experience is a lot of health professionals say they don't want the law enforcement people there. Don't think that way.

As an aside, I worked with a community in rural Pennsylvania, Lewistown. It's right on the Route 81 border, and drug rings from New York City were coming down and establishing heroin in that tiny rural Pennsylvania mining town. Half a dozen adolescents overdosed on heroin. Law enforcement got involved. They went and seized the assets of the people who were trafficking in heroin, which were substantial. The prosecutors and the US Attorneys in that area decided to take the asset forfeiture money and use it to train physicians on the use of buprenorphine. They immediately developed treatment intervention.

When I talk to law enforcement, they don't want to go out and arrest a lot of people who are showing up with prescription drug abuse problems. They really would rather see those people in treatment and interventions in that regard.

Identify your resources as part of your task. Now, I just talked about all the resources we can provide, but there are others in your areas.

## Pillar 1: Education

Identify your shortcomings. What additional resources can you use?

When it comes to prescriber education, what we've found helpful is engaging the State Boards of Medicine to "encourage" prescribers to come in and complete the training. So that's an important stakeholder as well.

These are all things that could go into an effective strategy when it comes to overdose prevention. It surprised me when the Department of Defense – incidentally, anyone know the rate of nonmedical prescription painkiller use in the active military, compared to the 2.7% in the active population? Ten percent. The Department of Defense was experiencing overdoses of people with prescription pain relievers, wounded veterans, returning soldiers, and they intervened. At Ft. Bragg they established a system for evaluation called a buddy system – anyone getting a prescription for an opioid pain reliever has a buddy in the barracks who keeps an eye on them. The US military was distributing Narcan at the same time they would distribute the prescription pain relievers to the soldiers and the soldiers' families, with instructions for use. And it turns out, once they went through that education, they didn't need to use the Narcan – not a single vial of it had to be used. The emphasis was on the education and preventing the overdose in the first place.

So I think if you want to educate people, education on preventing overdose should be a part of that, and all the resources we have available will help.

Thanks.



**Prescription Drug Abuse: Recognition, Intervention, and Prevention**

Nicholas Reuter  
Division of Pharmacologic Therapy  
Center for Substance Abuse Treatment  
Substance Abuse and Mental Health Services Administration  
U.S. Department of Health & Human Services

Tribal Prescription Drug Abuse Conference – June 29, 2012  
Bloomington, MN

**Behavioral Health is Essential To Health**

Prevention Works

Treatment is Effective

People Recover

**Substance Abuse and Mental Health Services Administration/CSAT**

**SAMHSA's Mission:**

- To reduce the impact of substance abuse and mental illness on America's communities

**Center for Substance Abuse Treatment (CSAT) Mission:**

- To improve the health of the nation by bringing effective alcohol and drug treatment to every community.

3

**Overview**

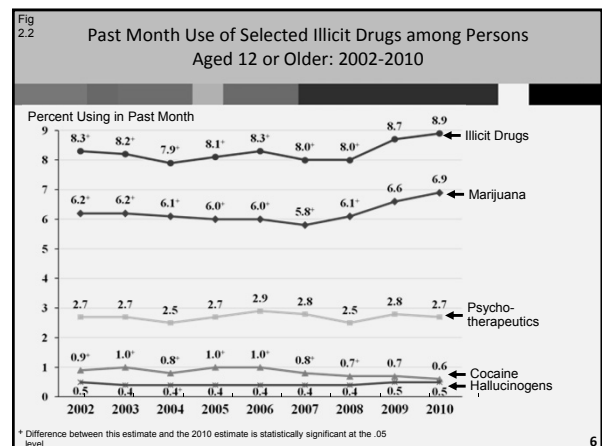
- Prescription Drug Abuse – Public Health Problem.
- Prevention of Prescription Drug Abuse
- Recovery and Treatment
- Medication Assisted Recovery
- Preventing Overdose and Reversal Toolkit
- Resources

4

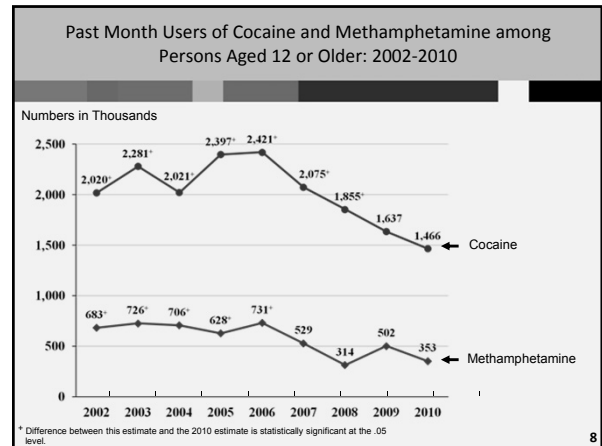
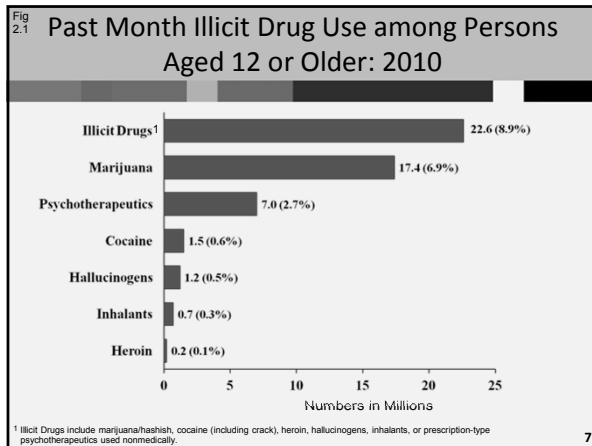
**SAMHSA's Strategic Initiatives**

- Prevention of Substance Abuse & Mental Illness
- Trauma and Justice
- Military Service Members, National Guard, Reserve, Veterans, and their families
- Health Insurance Reform Implementation
- Housing and Homelessness
- Health Information Technology, electronic health Records, and Behavioral Health
- Data, Outcomes, and Quality: Demonstrating Results
- Public Education and Support

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# Pillar 1: Education



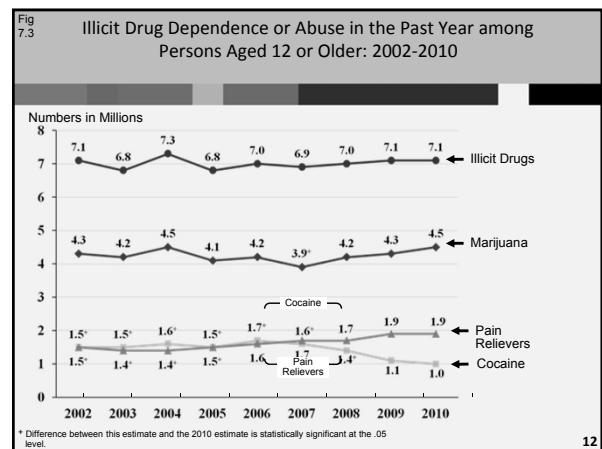
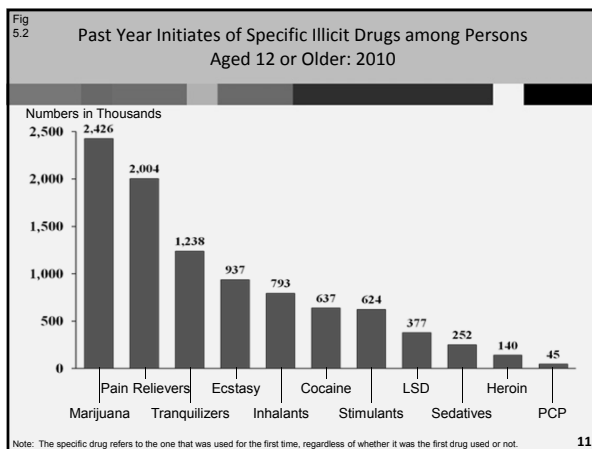
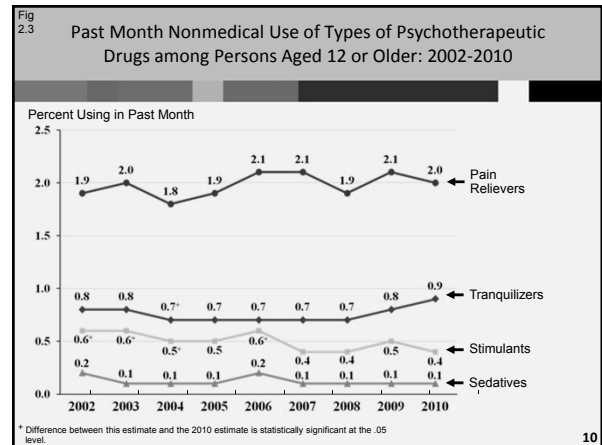
**Nonmedical Prescription Drug Use: NSDUH Definition**

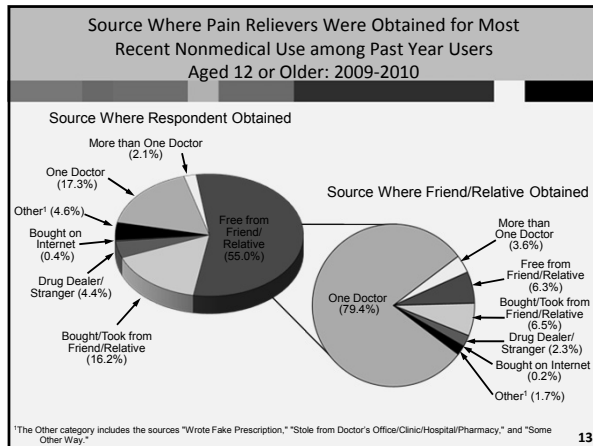
“Not prescribed for you”

OR

“You took the drug only for the experience or feeling it caused”

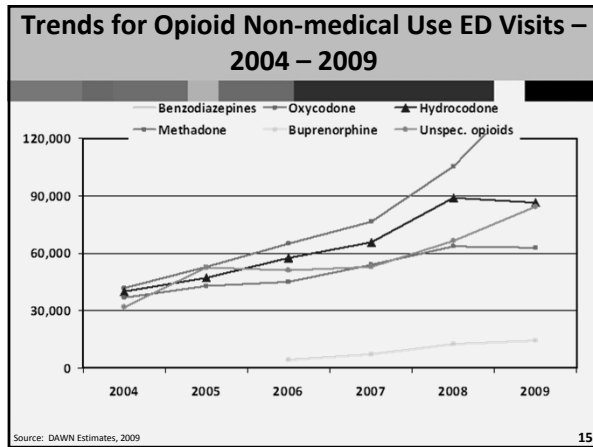
(Excludes OTC)





### DAWN ED 2009

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



### TEDS Rx Pain Reliever Admissions 1998-2008

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

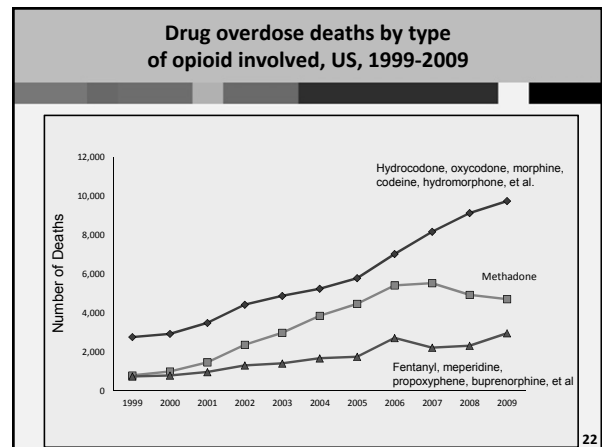
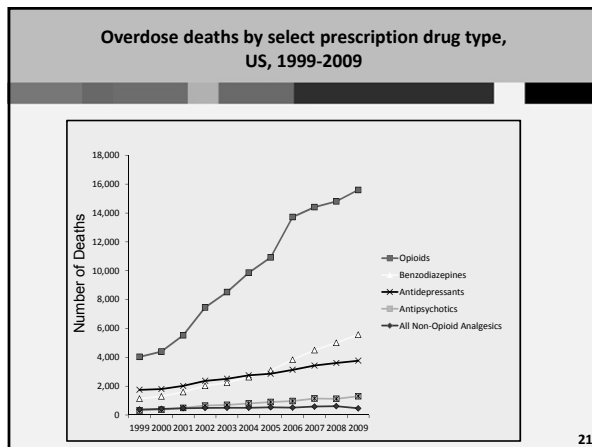
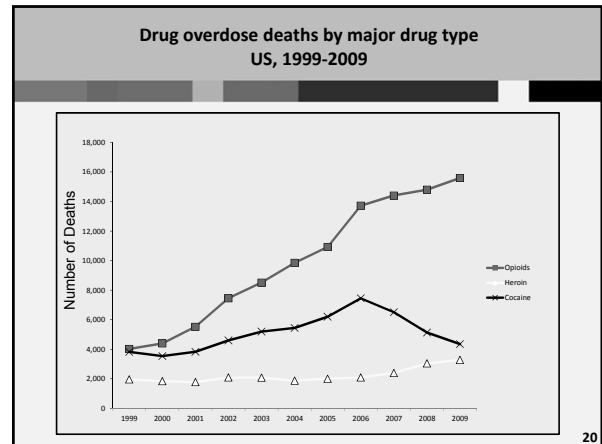
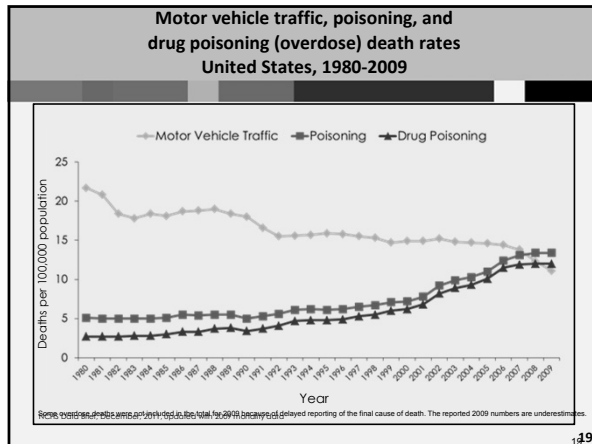
### Prescription Drugs and Overdose Deaths

### 2009 drug-related mortality data

- Drug Overdose Deaths – 37,004
- Prescription Drug Overdose Deaths – 20,848
- Opioid Overdose Deaths – 15,597
- The number of deaths for 2009 is an underestimate
  - Delayed reporting from OH, WV, NJ, DC

\* Overdose deaths includes all intents

## Pillar 1: Education



### Chronic non medical use of pain relievers has increased

- There was a significant increase in PYNMU of pain relievers of 200-365 days between 2002-2003 and 2009-2010
- Any PYNMU and PYNMU of 1-29 days, 30-99 days, or 100-199 days did not increase during the time period.
- The total number of person-days of PYNMU increased 35%, from 451,031,411 in 2002-2003 to 612,829,084 in 2009-2010
- Nearly 1 million people 12 and older used pain relievers nonmedically for 200 days or more in 2009-2010
- The 74.6% increase in PYNMU of 200-365 days parallels increases in overdose deaths, treatment admissions, and other negative effects associated with pain relievers in recent years
- Variation in annual average rates of PYNMU among age groups and sex were also found
  - Some of the largest increases in PYNMU of 200-365 days were among males (105.3%), and people aged 26-34 (81%) and 35-49 (134.6%) – Target interventions here?????
- Coupled with continued increases in pain reliever morbidity and mortality, these findings underscore the need for concerted public health and public safety action to prevent nonmedical use of these drugs

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### Neonate Withdrawal/Neonatal Abstinence Syndrome (NAS)

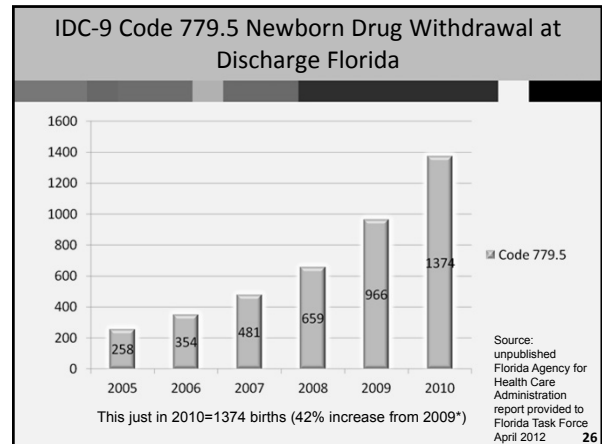
- In chronically opioid exposed newborns, norepinephrine “rebound” produces symptoms of gastrointestinal and motoric/nervous system hyperarousal after birth as opioids are no longer being administered through the umbilical connection to the mother and are metabolized
- 40-60% of exposed babies have NAS signs & researchers don’t know which babies will have it
- Timing of onset relates to characteristics of drug used by mother, time of last dose
- Generally treated in hospital via swaddling, low stimulation environment, extra feedings, narcotic weaning

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### Science Study of the Week: Patrick et al 2012 JAMA

- Opioid exposures from 1.2/1000 births in 2000 to 3.39/1000 births in 2009 in U.S.
- Hospitalization costs from average of \$39400 (95% CI \$33,400-\$45,400) to \$53,400 average (95% CI \$49,000-\$57,700)
- Opioid exposed = greater % of babies with low birthweight, feeding, respiratory and seizure problems
- 77.6% of opioid exposed infants were Medicaid payers
- NAS Mean Length of stay=16 days
- Presume this increase relates to Rx epidemic

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### Summary

- **Certain groups are more likely to abuse or overdose on prescription painkillers.**
- ∅∅ Many more men than women die of overdoses from prescription painkillers.
- ∅∅ Middle-aged adults have the highest prescription painkiller overdose rates.
- ∅∅ People in rural counties are about two times as likely to overdose on prescription painkillers as people in big cities.
- ∅∅ Whites and American Indian or Alaska Natives are more likely to overdose on prescription painkillers
- 3 Minnesota Tribes declared a Rx Drug Abuse public health crisis.
- Heroin/opioid admissions, overdose deaths, arrests increasing in twin cities.

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### Prevention of Substance Abuse and Mental Illness

**Goal 1.4**  
Reduce prescription drug misuse and abuse.

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

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

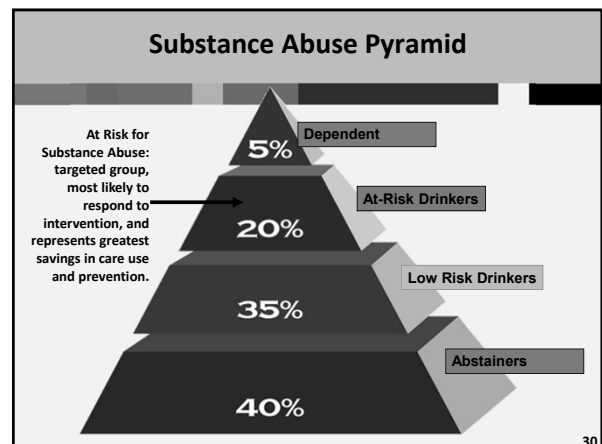
**Objective 1.4.3:** Support the establishment of State/Territory-administered controlled substance monitoring systems, and develop a set of best practices to guide the establishment of new State and Territorial programs and the improvement of existing programs.

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### Education and SBIRT What is SBIRT

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

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### Physician Education Opioid Prescribing 4-8 Hour CME

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

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### Consumer Education *Not Work the Risk: Even if it's legal.*

- Messages
  - Prescription drugs are dangerous
  - Prescription drugs should be secured
  - Dispose of unused prescription drugs
- Messengers
  - Parents
  - Health professionals
  - Educators

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### ASTHO-SAMHSA Opioid Treatment Program Opioid Overdose Toolkit

- Rationale:
- Opioid Treatment Programs – regulated by SAMHSA.
- Compliments DVD's on methadone safety
  - OTPs have experience with opioid overdoses
    - Patients
    - Community
  - Recovery – “You can't recover if you are dead.”  
William White, April 2012

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### OTP Overdose Prevention Toolkit

- Content
  - Providers
  - Patients
- Do's and Don'ts
- Recognizing overdose
- Rescue breathing
- Understanding how naloxone works
- How to administer naloxone

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### Future for Naloxone

- Nasal route of administration?
- Non-prescription status?
- FDA Public Meeting, April 12, 2012
  - Overwhelming support
  - Rx to OTC possible
  - Additional studies needed.
- International – programs in many countries
- WHO and UN considering
- AMA Endorsement? – HOD Resolution – Encourage new pilots,
- Educate Health workers and opioid users about naloxone in preventing overdose fatalities.

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### Summary

- Rx drug abuse stable 2.7% population
- Consequences – Emergency Dept, Treatment Admission, chronic use, mortality increasing significantly.
- Prescriber, consumer educational resources available.
- Comprehensive – integrated community, health care provider, law enforcement strategies have worked.
- Heroin increasing – Rx to heroin. (97% heroin initiates previously Rx opioid non medical use – 3% NMU previously used heroin.)

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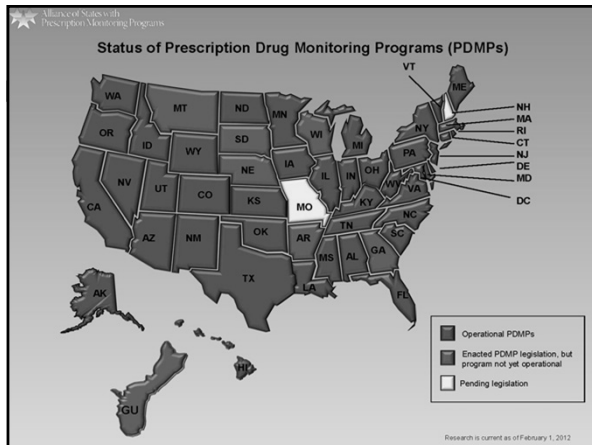
### Monitoring /Treatment

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### What is a PMP?

- Prescription Drug Monitoring Program
- Established by State Law
- Requires Prescription dispensers to report PHI to central State Database.
- Prescribers, dispensers, law enforcement (w/restrictions) can access
- State Medical Examiners, State Epidemiologists?
- Solicited request – from prescriber, etc.
- Unsolicited – from system to prescriber
- IHS is working on a system to connect to States

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### National All Schedules Prescription Electronic Reporting (NASPER)

- The intent of the National All Schedules Prescription Electronic Reporting Act of 2005 (NASPER) is to:
  - foster the establishment or enhancement of State-administered controlled substance monitoring systems in order to
  - ensure that health care providers have access to accurate, timely prescription history information,
  - and assist in the early identification of patients at risk for addiction. Early identification will lead to enhanced substance abuse treatment interventions.

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### SAMHSA's Formula Grant Program

- Under NASPER, SAMHSA established a formula grant program with first appropriation in FY 2009.
- FY 2009 appropriation: \$2.0 million – FY 2010 appropriation is also \$2.0 million
- Allocation formula distributes 1% of the appropriation to each eligible State – with additional amount distributed based on the ratio of the number of pharmacies in the State to the number of pharmacies in all States approved.
- In addition:
  - Justice program funds about \$7 million for 15 competitive PMP grants.

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### Unsolicited Reporting – Condition of Grant

- Any individual that has filled six or more controlled substance prescriptions from six different prescribers, or six different dispensers in the State, within a six month period shall be the subject of a report from the prescription drug monitoring program to each prescriber.
- Reports must be sent to at least ten percent of the registered prescribers in the State in one calendar year.

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### How Can PMPs Reduce Rx Drug Abuse

- Providers can have access to timely patient information on prescribed drugs
  - Use during visit
  - Build into treatment plan
  - Screen, refer to treatment – 17 Medical School SBIRT Residency Grants

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### PDMP – One State Experience (WVA 2006)

- Used ME and PDMP data to analyze all Rx drug abuse overdose deaths in 2006
- Of 295 decedents, 198 (67.1%) were men & 271 (91.9%) were aged 18 - 54 years.
- Pharmaceutical diversion was associated with 186 (63.1%) deaths while 63 (21.4%) were accompanied by evidence of doctor shopping.
- Prevalence of diversion was greatest among decedents aged 18 through 24 years and decreased across each successive age group.
- 56% of decedents had no registered prescription for an opioid
- 20% had misrepresented themselves to 5 or more physicians to receive opioid prescriptions ("doctor shopping").
- Substance abuse indicators were identified in 279 decedents (94.6%), with nonmedical routes of exposure and illicit contributory drugs particularly prevalent among drug diverters. Multiple contributory substances were implicated in 234 deaths (79.3%).
- Opioid analgesics were taken by 275 decedents (93.2%), of whom only 122 (44.4%) had ever been prescribed these drugs.
- Around one third had a prescription for at the time of death.
- **Conclusion** The majority of overdose deaths in West Virginia in 2006 were associated with nonmedical use and diversion of pharmaceuticals, primarily opioid analgesics

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### How can PDMPs Reduce Opioid Overdose Risk? – Dunn, et al, 2010, Annals of Internal Med

- 51 opioid-related overdoses were identified, including 6 deaths.
- Compared with patients receiving 1 to 20 mg/d of opioids (0.2% annual overdose rate),
- patients receiving 50 to 99 mg/d had a 3.7-fold increase in overdose risk (95% CI, 1.5 to 9.5) and a 0.7% annual overdose rate.
- Patients receiving 100 mg/d or more had an 8.9-fold increase in overdose risk (CI, 4.0 to 19.7) and a 1.8% annual overdose rate.




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### PDMPs: 2011-12 ONC-SAMHSA Project

- Issue: PDMPs collect a considerable amount of useful information but utilization of these programs by prescribers is unacceptably low.
- Project: Enhancing Access to Prescription Drug Monitoring Programs (PDMPs)
  - Use health IT to increase timely access to PDMP data in an effort to reduce prescription drug misuses and overdoses.
    - Develop the standards and policies necessary to connect existing health information technologies to increase timely use of PDMP data by providers, emergency department providers, and pharmacists.

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### Project Objectives

-  Connect PDMPs to health IT systems using existing technologies
-  Improve timely access to PDMP data
-  Establish standards for facilitating information exchange

Reduce prescription drug misuses and overdoses in the United States

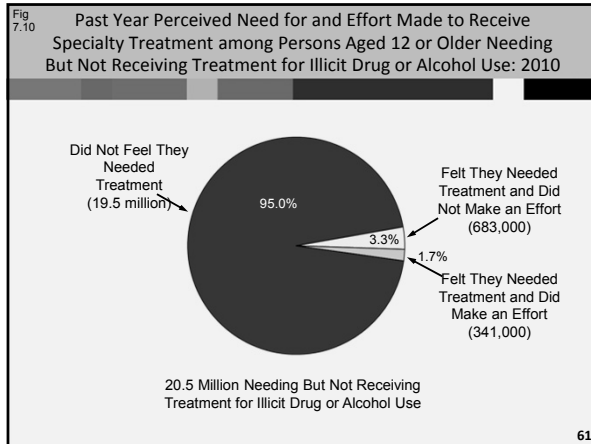
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### PMPs Part of Effort To Reduce Rx Drug Abuse

- Interoperable PMPs to enable cross State checks
- Prescriber education
  - Physician Clinical Support - Opioids
- Consumer Education
- Pain Clinic Regulation (3 States)
- Doctor Shopping Laws
- Community Initiatives
- Treatment Interventions

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### TEDS New Report - 2011

- On average, 15.6 years elapse between first use and first admission to treatment
- Males – 16.5 years
- Females – 13.8 years
- Alcohol, longest 20.2 years
- Prescription Pain relievers shortest, 7.8 years

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### TEDS Rx Pain Reliever Admissions 1998-2008

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

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### Types of Substance Abuse Treatment

- In patient, residential
- In patient detoxification
- Involuntary committment
- Drug free, 12-step
- Therapeutic communities
- Outpatient maintenance for opioids
  - Heroin
  - Prescription pain relievers

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### Treatment Interventions - Counseling

12 Step Oriented Treatment	Self-help Groups
Group Therapy	Supportive Psychotherapy
Cognitive Behavioral	Contingency Management
Cue Exposure	Psychodynamic
Network Therapy	Community-Based Model
Couple or Family	Vocational Training
Motivational Enhancement	Relapse Prevention



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### Historical Perspective

- 1974: first methadone maintenance programs for opioid addiction; currently serve approximately 260,000 patients
- Large increases in prescription opioid addiction starting in late 1990s to present
  - In May 2007, Purdue Frederick, a subsidiary of Norwalk, Conn.-based Purdue Pharma L.P., pleaded guilty to felony misbranding of Oxycontin related to its addictive risks as part of a settlement with federal prosecutors. \$634.5 million in fines paid by Purdue
  - Joint Commission: Pain Management Standards Jan 1, 2001
- U.S.: 4.6% of world's population; consumes 80% of world opioid supplies
- U.S.: consumes 99% of world's hydrocodone supply

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## Pillar 1: Education

### Why is MAT regulated

- 1933 - Maintaining an addict outside accepted medical practice and is not legal.
  - Addiction is not a medical condition or disease.
- 1970 - Permitted for programs only under special approval
- 1997 – NIH concludes methadone maintenance is the most effective treatment for opiate addiction
- 2000 - Office based treatment permitted with buprenorphine
- 2005 – Methadone and buprenorphine added to WHO list of essential medications for addiction tx.
- Substitution vs replacement treatment

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### Why Methadone?

- Orally active
- Slow onset
- Long duration of action
- Approved medical product
- Full opioid agonist
- Suppresses withdrawal
- Blocks heroin
- Reduces craving

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### Medication-Assisted Opioid Therapy—March 31, 2010

- Patients receiving methadone or buprenorphine in Opioid Treatment Programs (OTPs) accounted for 28 percent of all clients in treatment, although OTPs were available in only 1,166 (9 percent) of all substance abuse treatment facilities
- Private for-profit organizations operated 53 percent of OTPs compared to 30 percent of all substance abuse treatment facilities
- Of the 304,656 patients receiving medication-assisted opioid therapy in OTPs, 98 percent (298,170) received methadone. Of the 27,456 clients receiving buprenorphine, 76 percent received it in facilities that were not OTPs.

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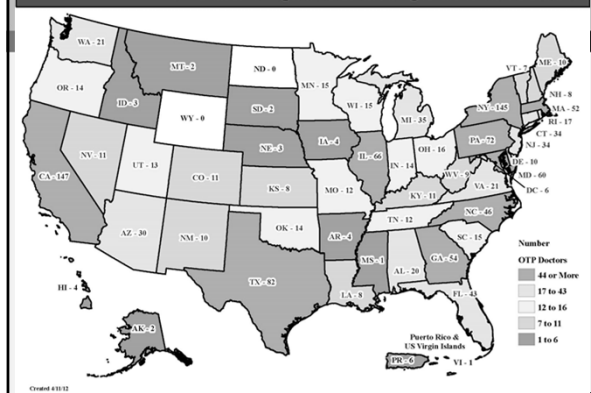
### Increase in Methadone Patients

Source NSSATS 2010

- US - 2005 – 2010 (298,608) – 21% increase
- Oklahoma – (450%)
- Vermont – (330%)
- New Hampshire (280%)
- Minnesota – (107%) ~ 3500 patients
- New York – (-3.2%)
- California – (1.4%)
- Texas – (4.5%)

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SAMHSA/Center for Substance Abuse Treatment  
Distribution of Opioid Treatment Programs in the United States



### Medication-Assisted Treatment Update OBOT Buprenorphine

- 2000 Law permits physicians to treat 30 or 100 patients.
- As of April 2012, over 30,000 physicians have been trained by a Drug Addiction Treatment Act of 2000 (DATA) recognized medical organization.
- Approximately 22,000 physicians have received a waiver to prescribe buprenorphine. MN-182
- 5900 physicians have indicated their intent to treat up to 100 patients.

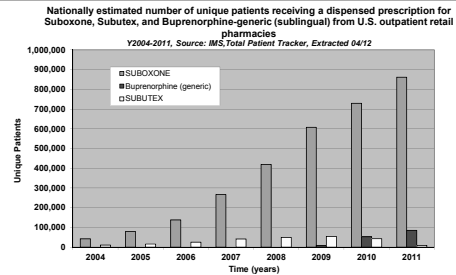
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### Why Buprenorphine

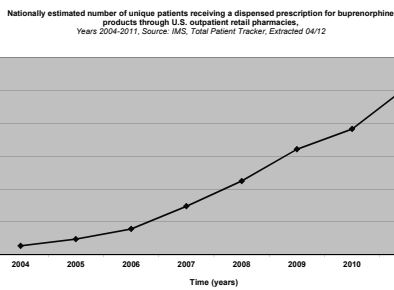
- Potent – 8-16 mg/day
- Eliminates withdrawal
- Long half life (72 hours)
- Relatively safe (overdose death rare)
- Partial opioid agonist – ceiling effect.
- Sublingual - Formulated to reduce IV abuse
- Schedule III – can be prescribed by physicians.

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### Buprenorphine Distribution



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### Buprenorphine Distribution DEA ARCOS-2010 (MN is 44<sup>th</sup>)

VERMONT	278,913
MAINE	230,525
RHODE ISLAND	169,490
MASSACHUSETTS	159,735
KENTUCKY	136,691
WEST VIRGINIA	127,903
CONNECTICUT	125,223
UTAH	115,125
TENNESSEE	114,298
MARYLAND	109,633

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### FDA Approval of Vivitrol for Opioid Treatment

- The Food and Drug Administration (FDA) has approved Vivitrol (injectable Naltrexone) for use as a monthly injection to treat opioid addiction. ("Prevention of relapse in combination with psychosocial services")
  - Vivitrol was previously approved to treat alcohol addiction.
- In 6-month long tests, 36% of Vivitrol-treated patients were able to stay in treatment for the full six months without using drugs, compared with 23% in the placebo group.
- Use of Vivitrol could help reduce stigma and increase access for certain MAT patients.

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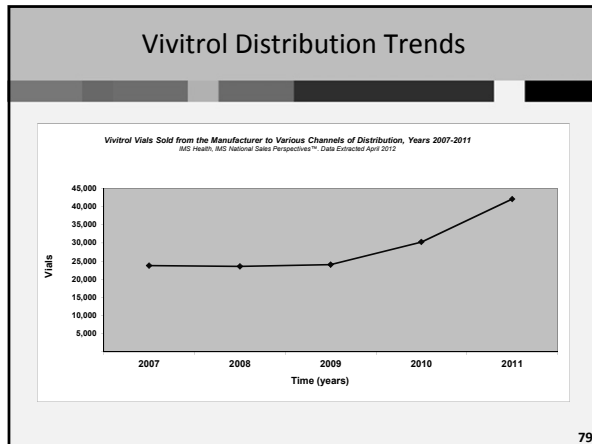
### FDA Approval of Vivitrol for Opioid Treatment (cont'd.)

- Opioid dependent patients must undergo detoxification treatment first, since there cannot be any opioids in their system when Vivitrol treatment is begun.
  - If there is, the patient may experience withdrawal symptoms from the opioids.
- Patients given Vivitrol may be more sensitive to opioids at the time their next scheduled dose is due.
  - This sensitivity can make patients more susceptible to an accidental overdose if they restart opioid use upon missing a dose of Vivitrol or after treatment with Vivitrol has ended.
- Need for protocols, Advisory

Source: Bates, R. MD (2010, October 13) Vivitrol approved by FDA for opioid dependency treatment. Retrieved from <http://www.emaxhealth.com/1024/vivitrol-approved-fda-opioid-dependency-treatment>

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## Pillar 1: Education



### Expect Treatment Success

- Treatment works, but not one size fits all
- When risky/inappropriate behaviors continue (drug use, diversion, non-adherence):
  - Reassess treatment plan & patient progress
  - Make changes
  - Reassess
- If treatment failing the patient – then assist with finding other treatment
- Maintain hope & keep treatment door open

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### Federal Initiatives Rx Opioid Overdoses (2)

- Opioid Surveillance
- Medical examiner case definition
- DEA – voluntary restrictions on methadone 40 mg diskette distribution
- Consumer Education – methadone safety pamphlets, video
- FDA Opioid REMS
- ONDCP Rx Drug Abuse Prevention Strategy

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### State OD Prevention Issues - 2010

- Continuing stigma against methadone treatment
- Funding and resource shortages
- Need to interface with criminal justice system
- Need to integrate treatment interventions/referrals into OD prevention
- Special attention to adolescents/young adults
- Lack of evidence and research to guide States on the effectiveness of strategies.

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### Utilize Physician Clinical Support System (PCSS-B)

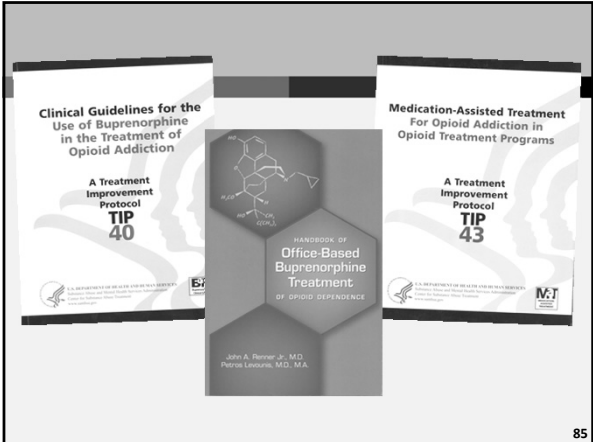
- National system of mentors with expertise in OBOT
- Free, on-line/phone mentoring
- Paired up based on your request: region, specialty
- Register @ [www.pcssbuprenorphine.org/pcss/about.php](http://www.pcssbuprenorphine.org/pcss/about.php)

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### Physician Clinical Support

- PCSS – O
  - Provides mentoring, guidelines for methadone in addiction and pain treatment
    - New Grant Cycle for FY-2011
    - Webinars, guidelines, includes Dentists
- PCSS – B – New grant award in 2010
  - Mentoring, guidelines (detox to Vivitrol?)
  - Monthly Webinars

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### Summary

- Prescription monitoring programs provide useful information to identify questionable behavior.
- Can be used to identify those at risk for addiction/dependence/overdose.
- Need to be integrated to expand and facilitate use.
- Many treatment options available
- Medication assisted treatment – methadone, buprenorphine, Vivitrol extensively studied, effective – considerable resources available.

**Questions & Discussion**





***Pillar 1 Discussion***

**JEFFREY COADY:**

Thank you for providing some information to think about next steps in our communities. At each table, take out your yellow piece of paper and begin to craft answers to the questions. What are some activities and who might be the responsible parties? Be thinking broadly of prevention treatment recovery. Be thinking about the different age groups you might want to target. Be thinking about some of the different resources you might be able to access, whether from the State or SAMHSA. And you'll come up with some questions during this, which is fine. That's part of the intent. We'll have some conversation afterwards and report out as a group that we can begin to capture.

Now while you're doing this, I'd say we have some Federal participation of people who've been on the Task Force, and we're going to walk around and assist you in moving things along. I'd also like some of the SAMHSA grantees who are here, our prevention folks – you want to stand up real quick? They're going to be walking around as well to talk a little bit. Start thinking about questions regarding prevention, they're sort of the experts on that, as well as the ATTCs, who are experts on the treatment and recovery systems. They have materials in the back. They're going to help participate and move this conversation along with any immediate questions for resources that exist, whether opportunities or ideas on exchange of information.

*[Break for group work]*

**JEFFREY COADY:**

Our plan is to go to each table and pass the microphone. Each table will take about a minute. I recognize that when we start, some tables will have ideas that you've had, so if you could add new ideas to that. In addition to ideas of how to implement this and operationalize elements we talked about, if there are challenges – “This is a great idea but I need resources or something's in the way.” We'll have some of the Federal agencies and representatives up here,

## Pillar 1: Education

so sometimes you'll get an answer immediately and some you won't. But we can begin to dialogue and talk as groups so we can have a summary of some next steps.

### **TABLE 1:**

I'm Capt. Dave Bell, the Acting Clinical Director at White Earth Health Center. We have a pretty diverse group here, primarily White Earth. We were talking about some of the problems, and one of the biggest things we noticed that has become more of an issue lately is that we used to take more drugs back through the pharmacy programs and we'd like to expand the drug takeback program. I think that's a good way to get some of these medications, once they've gotten out into the community. One of the things we've identified as a problem is that's not really a kosher thing to do anymore with the DEA. So one thing that we were thinking to do is have lockboxes like they do at Becker County – they have a drop box. We were thinking if we had something that was convenient to patients when they come in, a no-questions-asked kind of a thing where they can drop medications off and we can get them back, like a drug lockbox. We wouldn't have to do anything with it. It could be DEA or law enforcement, whoever, could own the lockbox. It would be a way to get the drugs back, and maybe we could get around the hurdle. I'm not exactly sure what the DEA hurdle is with the drug takeback.

### **JEFFREY COADY:**

We'll hear more from the DEA later today, but it sounds like education of providers as well as patients about the need to take back unused drugs.

### **TABLE 2:**

I'm Raymond Hawk, a physician's assistant, currently practicing, but also the clinic director at Bois Fort, MN, which most people probably know at Net Lake, an hour from International Falls. In talking about our educational process, I was quite shocked to see all the initials for the agencies doing these things, because my three providers and I have been unassisted in our struggles with opioid prescriptions. We spend about an hour and a half a day fending off prescription drug seekers, and that's not even the people we do give prescriptions to. So I

thought we'd start first with our own health division, our own health unit, because we have a lot of people working in the community in our health division. You know tribal units have CHR's, CD Departments, and all those places are close to us. We have a difficult time getting back and forth – what I mean by that is exchanging information. We get calls from CD people or Indian Child Welfare where they ask if a patient is in danger. I can look on the lists for people I prescribe for. They say they can't do that, but they can. So that's what I want to start with first, educating the health division, everybody in health and human services, about what a real problem it is for us. And then when the CHR's go inside the house, they're unsure what to do when the grandma is selling pills or the grandchildren are stealing the grandmother's pills. This would also include our clinicians.

Also, once we had a plan in the health division, we could take that education to the tribal leaders, because nothing's important on the reservation unless the tribal council thinks it is. And that's how you get your money. I've been with the tribal organization 31 years. With the tribal leaders, we can have the CD staff and the clinicians there to help present the thing so the tribal council knows what a problem it is, because the tribal attorney can help draw up some of the stuff. In particular we're struggling with patient pain contracts, patient management, and what all the terms are. Those are easy to do. But what do you do when they violate it?

Thirdly, we go to the local community, because we get a lot of reports – I can't even go into the clinic to see a patient without someone saying to me, "If you think the pill problem is bad, you have someone working here who's selling their pills." What do we do when someone tells you that? You go to the people and confront them, but they deny it. We drug screen them. All you have to do is drug screen one of them and find out they don't have the medications, and after that, everyone in the ring will take an opiate, so it's in their urine.

So our plan is to start small because we don't have a plan, but we want to get eventually to include the local communities, because no matter how hard we struggle in the tribal group, if

## Pillar 1: Education

we cut them off they will go somewhere else. We can see this in the prescription monitoring program.

### **JEFFREY COADY:**

Thank you, and I think you bring up some good points where it's education, internally in the clinic, as well as the leadership and the community, at different levels. SAMHSA has existing resources to educate providers and consumers as well as a wider community-based prevention effort. It sounds like it's a small but significantly meaningful step.

### **TABLE 3:**

One of the things we identified here at the table, where we're doing an excellent job projecting what we talked about, is how do you fill that gap of education? Where do we turn to go for the education for the person to come in when the system is ready? A general offer to everyone is the ATTC's Tiffany Kilpatrick is here and ready to talk, but every one of us in the system has SAMHSA resources to provide with that.

### **TABLE 4:**

We tried to take it from a tribal perspective, but most of the people at the table here are from oversight groups, and so we went through and decided that we'd go through what Nick suggested – identifying stakeholders. There would be certain people within the community that would be able to identify the stakeholders, such as, in our case, the health director, the tribal administrator, maybe somebody who has some data from Great Lakes Tribal Council, and then move from there. There could be somebody up at Great Lakes who might have information too. From there we could get the stakeholders and identify their education needs, what they know about the problem, what their interest is in the problem and then educate from there, identify shortcomings and resources through those stakeholders and branch out that way. It would be easy to get a process to educate our prescribers because they're employees and we can force them to be educated. The idea of educating consumers on overdose is kind of a new thing, and we thought that was kind of interesting. We could possibly

even supply them with naloxone to send a message of how dangerous the opiates are. Then to work with our resources to build our capacity to collect data on exactly what our problem is – we don't really know what the problem is yet. We know it is a problem but we don't know the dimensions, and we can't really follow the trends well. We can watch the number of prescriptions filled and doses given out, but we don't know outcomes. People who are dying from this probably aren't showing up anywhere as having been killed by prescription drug overdose because they're probably not getting autopsies.

One of our main missions at the Great Lakes Epidemiology Center, and one our goals, is to work with tribes to build capacity to collect and evaluate data. We have a cooperative agreement through the Indian Health Service. We're here to help all the tribes, centers, and service units. Just so everyone knows. If anyone wants help collecting or analyzing data, that's our main job.

**TABLE 5:**

We have two different communities here. My name is Gordon Fair. I served in leadership for many years at Lac Courte Oreilles Tribe. I served in leadership for many years at Lac Courte Oreilles years ago. I got out of tribal politics because I was tired of politics, wood ticks, and lunatics. I retired in 2007. My background has a lot to do with recovery. We have a treatment program under our ministry called First Nations Recovery Center in South Minneapolis, run by my wife Sheila. The corporation I founded many years ago ran detox for Hennepin County and 33% of our participants were Native people.

What I'm observing as a tribal leader is how we deal with prevention and overdose, but I've got to look at it from a broader standpoint, having been born and raised at Lac Courte Oreilles before we had electricity in a lot of our communities, I saw us as self-determined people: Hunters and gatherers and survivors. In the last 60 years, a lot has happened to deteriorate our communities. I think we have to look at how we ignite the spirit within our community to be self-determining once again. How do we ignite that? I gave a talk to our health department at the retreat. I said if we were to put a stethoscope at Lac Courte Oreilles, we would see that we

## Pillar 1: Education

have a very low heartbeat. We were not surviving. It has to do with a lot of things that I as a tribal leader back years ago, we have a spirit of entitlement and poverty in our thinking, and we don't have to be that. I see leadership who come into power and, because of the survivability of their term on council, have given a lot to feed into this entitlement mentality. It's something that hurts a lot of people. Maybe our tribes don't want to hear that, but I don't care. We have to look at what people have to do to change their thinking, because you're looking at the root of this, way down in the root of how our communities are. I see it up in Canada as well, where the epidemic is probably worse than it is here. The change has to happen in our own homes. I see some of our leadership here from our tribe who are giving in to the mentality of sustaining their jobs on the tribal council. I don't care what this costs me. I'm not looking for another term; I'm looking for some results in our tribe. We've had the US Attorney coming to us and confiscating 123 of our records in our clinic because of the over-prescription of drugs. This is sick. I really feel that there has to be more emphasis on tribal leadership to take an active role as tribal leaders, but we're not going to solve it ourselves. It has to be brought into the home. We talk about self-determination in Indian Country, but what does that mean? It goes down to every family and every household. Fathers need to be fathers to their children. This may not reach what we're talking about today, but it's something deeper that I see every day. But we need to look at the broader issues, so how do we begin to talk about that? There's no easy answer. I commend all of you today who are in the field working every day.

(Another speaker at the same table)

I know our chairman is supportive of me mentioning that we lost 12 tribal members last year to overdose, mostly women of childbearing age. We created a risk assessment to determine the common themes of the victims. We brought in a psychiatrist who's part Lakota and he's there two days a week. He uses that risk assessment too. He also works the other half time at a drug treatment center. It's a wonderful asset. We've started a provider task force group for all our prescribers, including dentists, pharmacists, doctors, and behavioral health directors. We sit down to look at cases that we know we can discuss because we can share information and

target and create plans for individuals without violating HIPAA. We also have a prescription review committee that looks at prescription practices. We're doing innovative things. We do a lot of education. We're looking at the transition from opiates to heroin, because heroin is easy to get. It comes from Minneapolis or Duluth. We know the distribution network. I think that's part of the education too. There's a lot of healing with all the losses and grief we've had.

(Return to initial speaker)

At Lac Courte Oreilles, we just had our grand opening for the On Eagle's Wings Safety Center. It's a 24/7 operation that we have in one of our high-risk communities. The purpose is to be a place open all the time where people can call in, they can come there if there's a domestic situation. We have our tribal police department right next door. There's a lighted basketball court adjacent. We have a volleyball and kickball room. But it has to have community ownership, and when we had the grand opening we had people from the community coming there. It's also gang prevention, and making the community responsible for that too. Our Director here is Jeff Crohn, who is also working for gang prevention. He's not a police officer, but he works for the tribal police department. We tell the police to come over there to have coffee, play basketball with the kids, whatever. It's eyes on the community. It's a pilot program we'd like to extend, and it requires community ownership and participation. Things like that are broader things that begin to address the issue.

(Third speaker at table)

For educational tasks, I would be the responsible party to send them to training. I don't look for the impacts on these, but consequences for the prescribers who overprescribe. I'd have the Health Board Chairman and team education the Health Board on this. The tribal council would be led by the tribal president. I've heard a lot today about the need to collect tribe-wide data, so I was looking to put together something to collect social and economic impacts on the community of this issue, and I'd look at the education support department, and overall to the

## Pillar 1: Education

Epi Center in Great Lakes to put things together in a way we can understand because we're not statisticians. And we need to educate everyone on provider and staff safety, because when you start resisting the people seeking these things, there can be some danger, so you need to put some systems in place to protect your staff so the providers don't feel that they have to write the prescription to get the miserable person out of their face.

Some of the things we need to educate ourselves on as clinics and tribes are alternative treatments. Should we start to use physical therapy more often? Chiropractery? Telepsychiatry is something I've been using, but the provider is a non-Indian from one of the healthcare factories in Wisconsin, and their primary purpose is production, so I want to get a psychiatrist who's an Indian. The only problem is if they're out of state I'll have a problem getting them licensed in Wisconsin. I may be able to get some help there.

Finally, once we put all this stuff together, we need to involve the communities. We need to get all the tribal programs and community members in it, the family elders everyone goes to when something horrible happens, and start educating them to help us with the rest of the people in the family. I see the children in the community raising themselves because mom and dad are numb, sitting home, watching TV. In 10 years these kids will come through my clinic as problems. They won't have healthy bodies or healthy minds. I worked 9 ½ years in the clinic, and 10 years as a community services director, then as a health director. I think I have a pretty good understanding of my community. Right now as health director, though, because of this problem, a lot of the people who used to visit me won't talk to me because they know I'm getting ready to do something about this. I served four terms on council and I figured out that the best way to do something for your tribe is to get out of politics and be a program director where you can effect change.

### **JEFFREY COADY:**

I think we've captured some good information and ideas with this conversation. The tables that we didn't get to will be able to access the flipcharts because we still want to capture these



information and ideas because they're valuable. We're learning from each other. So go ahead and write your information there. Right now we'll move on to the next pillar. Our presenter is Nick Reuter again, and we'll then go through the same process to report out and build the action plan. Nick stands between us and lunch, so be kind to him between now and then.



***Pillar 2: Monitoring***

**NICHOLAS REUTER:**

*(Microphone not on for initial portion of statement)*

The next pillar is monitoring, and I took it upon myself to add treatment. The National Drug Control Policy Plan for Preventing and Reducing Drug Abuse discusses treatment, and the recommendation is to increase treatment availability 10%. They provided no funding for that treatment availability, and it has not expanded 10%. However, there are some things available that I think will be helpful in this. Prescription drug monitoring programs is what the White House focused on when it came to monitoring. In addition, some increased epidemiological surveillance.

So what is a prescription drug monitoring program? It's established by state law. Pharmacists dispensing report patient prescription information into a centralized database, and providers, prevention, law enforcement (with restrictions) can access that. Also, State Medical Examiners can access the PDMPs, and a lot of very useful information is in there. Information can be requested by prescriber or dispenser, or the systems in many states can send the information directly from the system to those people without them asking for it – an unsolicited response. Indian Health Service –

(question from the audience)

That's IHS facilities submitting prescription information into the state databases.

Congratulations. As of a month ago, I thought it was actually happening. The Department of Defense is not sending in their patient health information, nor is the Veterans Administration from what I understand, so you're way ahead of those two Federal departments.

Prescription Drug Monitoring Programs are now approved in 49 states – New Hampshire just acted and passed their legislation, so Missouri right now is the only state without a PDMP authorized. SAMHSA has a program where we funded states to advance their PDMPs through a

## Pillar 2: Monitoring

formula grant program, but that was discontinued in 2011. What we tried to do with that is to advocate and advance unsolicited reporting. That's something you could factor into your initiatives here as well and into your plans – as a condition for a grant, a state had to send unsolicited reports to practitioners. The systems in the states are there, a lot of doctors have accounts but many don't and they aren't utilized much. Best-case utilization is, I would say, 20% -- 20% of the people who prescribe controlled substances actually access the system. That's too low, so we thought it would be better to make the system active and have the information sent from the PDMP to the prescriber and not wait for them to ask for it.

How can PDMPs reduce prescription drug abuse? The providers can have access to timely patient information on prescribed drugs, they can use it during patient visits, build it into their treatment plans, and use it as one of the screening tools under Screening Brief Intervention Referral to Treatment. In addition, questionnaires like the CAST, the ASSIST, etc. can be screened by contacting the PDMP and getting information from there as well.

PDMPs help us identify those at risk of overdose. The State of West Virginia used their system to evaluate every single person who died in 2006 from a drug overdose, and most of the overdose deaths in West Virginia were from prescription opioids. 56% of them did not have a prescription for an opioid, 20% had misrepresented themselves to 5 or more physicians in doctor shopping for the opioid they died from. The converse of that is that 2/3 of them did not have a prescription. They can be helpful for identifying how people are obtaining the drugs that are leading to their overdose deaths.

They can also help identify people at risk of overdose deaths, which is what the State of Washington did in evaluating overdose deaths in that state. They were able to look at a patient and see how many morphine-equivalents or opioid-equivalents they were getting. The larger the number of daily morphine-equivalent doses a person had, the higher the risk of overdose. If you're receiving more than 100 mg per day, you had almost a nine fold increase in overdose risk. That's kind of a no-brainer, but what you might want to do is identify low-hanging fruit.

Look at your systems to see how many people are getting even legitimate prescriptions for that much of an opioid and intervene. Discuss with their physicians that they are at a higher risk and perhaps reduce their risk.

Another thing we're trying to do to increase utilization is to link these systems with electronic health records. The idea here is prescribers and pharmacists don't access them because they don't have the time to. A physician who has 15 minutes to see a patient has to wait 10 minutes to access a prescription monitoring program and wait for the information come back. Doctors are telling us that won't work. So what we want to do is to link state PDMPs directly with the healthcare provider's electronic health records. When a doctor has a patient visit, the information on the prescription controlled substance history is right there before them and they don't have to ask for it, they can just factor it in.

The second part of that is to help doctors use the information. There are some things you can do are take data from a PDMP and determine whether or not a patient is high risk for being a doctor-shopper or things like that through a numeric score. It evaluates how often they refill prescriptions, whether they have gone to more doctors for the same prescription opioid or not, all factored into a formula that gives a prescriber an immediate assessment of that patient's risks.

PDMPs – the monitoring part – are an important part of reducing prescription drug abuse, but they aren't a panacea. At SAMHSA we would never say they would absolutely fix the prescription drug abuse problem in the US. Monitoring is important. It's truly got to be linked with other enforcement and monitoring-type activities. I talked about prescriber education. There's also a need to have the MDMPs interoperable. Consumer education is necessary. Pain clinic regulation is something else. You heard the story this morning about the physician in Florida who was probably a pain treatment physician. Now Florida requires the licensing of pain treatment clinics in an effort to close down those pill mills. We also have doctor-shopping laws in some states. There are laws that actually impose penalties on patients – the other end

## Pillar 2: Monitoring

of the spectrum – who do shop around for doctors. Some states have penalties for doctor-shoppers.

We'll talk a little later about drug takeback programs and DEA restrictions, and a law was enacted last year that would ease some of those restrictions.

There was an article in the New York Times last month about an emergency room physician who suggested the impracticality of consulting and acting upon the information from the PDMP, perhaps denying the patient a prescription for painkiller. The doctor said that patients so denied would complain and act out, which would not benefit the doctor, and therefore there was no incentive to do so. Patients receiving prescriptions for opioids will not complain, and the doctor would be rewarded through his employer. A month later New York passed a law saying that prescribers must check the New York PDMP for every controlled substance prescription issued, so they took his judgment out of it. He's forced to do that now. There are now five states that require prescribers, and in some cases pharmacists, to check the PDMPs every time they prescribe or periodically when they prescribe or fill a controlled substance prescription. That's the way the world is going in monitoring – really strictly taking judgment out, forcing prescribers to check these systems and making it a state law to do so. I know the alliance of states with PDMPs doesn't necessarily support that but that's how things are going. Ten years ago that kind of law was unheard of – a law that reaches that far into the practice of medicine.

There was another article in the Times by a prominent physician that described PDMPs as a powerful tool to identify doctor-shoppers, but “rather than using the databases as a way to kick patients out of doctors' offices, efforts must be made to link these individuals to addiction treatment. If we fail to do so, this epidemic will continue unabated.”

Addiction and dependence is a chronic relapsing disorder. It can't be cured just by identifying someone as a doctor-shopper and telling them to stop. I've been working with methadone for

years and talked to numerous patients who've said they don't want to go to the clinic every day, they don't want to go anymore, they don't want to be on methadone and demand to be detoxed. The programs usually give in. But the relapse rate on those cases is around 80%. There was a similar study using buprenorphine that showed the same thing. So treatment is part of recovery support. Recovery is important to SAMHSA. We define recovery as a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to achieve their full potential.

There are four different domains that are part of recovery: health, home, purpose, and community. I think these things are what you should factor into your plans. Recovery comes from all kinds of different angles. It can be person-centered, community-based and influenced, based on cultural issues, and emerges from hope.

What we're faced with when it comes to treatment is what a national survey showed. They asked people a series of questions. Is your drug problem interfering with your employment prospects? Yes. Is your drug problem interfering with your family and social commitments? Yes. Is your drug problem causing law enforcement and incarceration issues? Yes. Do you think you need treatment? 95% said no. So we're in this denial thing: Twenty and a half million people, of which nineteen and a half need treatment but don't believe it. This is something you'll need to factor into your deliberations. On average, 15.6 years elapse between someone's first use of an illicit substance and their first admission into treatment. Men take longer than women. Alcohol is at 20 years; prescription pain relievers are the shortest, at around eight years. So people are in denial and treatment is always the last resort.

There are many different types of places where people can receive substance abuse treatment. It can be inpatient, residential, detoxification, outpatient detox, therapeutic communities, etc. There are many different modalities out there and we can provide tons of information on all of them – group therapy, cognitive behavioral, cue exposure, motivational enhancement. We have information that can help you with each and every one of their treatment interventions.

## Pillar 2: Monitoring

A little bit about methadone. Why is it regulated? It is highly regulated at the Federal and, at many cases, the state level. This is because in 1933, when physicians were maintaining people with opioids, it was considered that maintaining an addict was outside acceptable medical practice. This was based on a determination that addiction was not a medical condition or disease, and therefore maintaining someone was not medical treatment. In the Michael Jackson case, he had a doctor looking after him and maintaining his addiction, and people said that wasn't what doctors should be doing – they should be treating people, and maintenance of addiction is not treatment. We disagree. We think methadone treatment is effective medical treatment, well established, very successful, with good outcomes.

(question from the audience)

Absolutely. I don't disagree that what you say happens, not just here and in the tribally-located programs, but also throughout the country. So we need to improve programs, which we're doing. We've got systems in place that can look into it. Not seeing a doctor for two years is a violation of our regulations and we can intervene in those cases.

But big-picture, in 1997, NIH – not us, not cities or states – concluded that methadone maintenance is the most effective treatment for opioid addiction. That's not to say there's no room for improvement, but it is out there and it is effective with many successful cases.

Office-based treatment was permitted in 2000, and methadone and buprenorphine were both added to WHO's list as essential medications for opioid addiction treatment. The same group that concluded that antimalarials and antibiotics were essential also determined the same thing about buprenorphine.

Methadone does have these advantages: it's orally active, it has a slow onset of activity, a long duration of action, it's an approved medical product, it's injectable, it's not at all like heroin,



which is a short-acting injectable, it's a full opioid agonist, and it's effective in that it suppresses and blocks heroin craving.

Just in the US there has been an increase in the number of patients who have been treated with methadone in opioid-treatment programs. Almost one of every three people in substance abuse treatment are in methadone maintenance treatment programs in the US, and those programs represent only about 9% of all providers. So there are around 300,000 patients currently in methadone treatment. In the last several years, in light of the prescription drug abuse problems, the number of patients in treatment has increased 21% in the US. In Minnesota, there was a 107% increase in the last six years, around 3,500 patients in Minnesota receiving methadone. There are programs in every state except North Dakota and Wyoming.

The other treatment option that you should factor in is something that's important to addressing prescription drug abuse, is the Drug Addiction Treatment Act of 2000, which allows office-based physicians to prescribe buprenorphine (Subutex) to a limited number of patients with certain controls. As of today there are 22,000 physicians in the US authorized buprenorphine for addiction treatment. Around 6,000 of them are authorized to treat up to 100 patients at any given time. Why is buprenorphine out there? It's an effective, potent medication. It's 8-16 mg per day, which is enough to suppress withdrawal symptoms. It lasts for 72 hours. Prescription opioids like Oxycodone and buprenorphine can suppress withdrawal symptoms much longer. It's safe – I will argue that there are more than 10 people across the US who have overdosed and died on buprenorphine despite it being prescribed to hundreds of thousands of people. Clearly the 35,000 who die every year from prescription opioids makes them a far, far more dangerous medication than buprenorphine. It's a very safe medication. It's a partial opioid agonist. It has a ceiling effect, which is why people don't overdose on it. It's a sublingual formulation, and one of the products has a naloxone component to prevent people from injecting it.

## Pillar 2: Monitoring

Buprenorphine use started at zero in 2003, and as of 2011, a million people were receiving buprenorphine prescriptions. So it is being used, and used in specific parts of the US more than elsewhere. New England has the highest per capita distribution, as well as Appalachian states. In Appalachia, the reason is that prescription opioid abuse is at its highest rate and those states have adopted buprenorphine as an intervention to reduce the problems there.

(question from audience)

I don't mean to convey that, and if I do, I'm sorry. What I'm trying to convey is that there are many different ways to treat this chronic relapsing condition. I showed the list of different therapies – therapeutic communities, drug-free outpatient, motivation enhancement, acupuncture, all these things are out there and they are effective in some people. But I'm telling you what the most evidence-supported and effective treatment is for someone who is truly dependent on opioids – and a lot of people in your communities are – is medication-assisted treatment. It's a chronic relapsing condition. Many people go through those other interventions and relapse. Drug-free detox may work in 20% of the people who try it, but that's a small portion of the people who become dependent. That's why I'm spending so much time talking about it. I'm not advocating it or saying it's the only thing, but it is the most evidentially supported. The value in buprenorphine is that a physician can prescribe it, which was a dramatic breakthrough in 2000. Up until that time, physicians couldn't prescribe a narcotic medication for narcotic dependence. Together with its safety profile, I think that indicates it's a relatively successful story when it comes to treating opioid dependence.

(question from audience)

Absolutely. Monitoring of the opioid treatment programs, the methadone programs, is extensive. They're inspected frequently by Federals and state authorities. With buprenorphine, Congress authorized physicians treating opioid addiction without restriction, without special monitoring.

(question from audience)

We know about buprenorphine diversion and we're taking steps to try to address that. Congress passed this with the idea of this new law that would allow doctors to prescribe as an experiment, and part of the experiment was they would only be able to treat 30 patients the first year, and then you could go up to 100. They also tasked us with assessing the effectiveness of it. We monitored and surveyed and found out it was effective in reducing opioid dependence. People who were on buprenorphine in 2006-2007 did not continue to abuse opiates. Diversion was not a significant issue and there were no negative public health consequences. We reported back to Congress, and to address some of the treatment shortages, they raised the limit from 30 to 100 for certain physicians – those who had treated patients for at least a year.

As far as how long people stay on treatment, I've talked to a lot of providers. Buprenorphine is an expensive medication that can be up to \$300 per month. Some people pay out of pocket for that. There is some insurance coverage because it is prescribed. Some state Medicaid funds cover it as well. A lot of people who need to pay that bill want to get people off it quickly. It's economics rather than making people drug free. NIH conducted a study with the object of seeing how well buprenorphine can be used to detox someone – give them the buprenorphine and see if it cures the addiction. It was a three-month trial, put on Subutex for three months, given counseling, they were tapered down after the three month period, and had a nine month follow up. The unfortunate news is that 94% of those subjects relapsed. So for 94% of the people, three months wasn't long enough. That's why the goal is not to set a time limit on being on methadone or buprenorphine. Our view is that you're on them for as long as it takes to sustain your recovery, and getting off the medication is not the primary goal. So it's a little hard to understand that it's not substitution, it's medication-assisted treatment. It's not a whole lot different than treating someone who's insulin-deficient. When it comes to methadone or buprenorphine, it's as long as it takes.

(question from audience)

Thanks. Just finishing up on the medications available, the FDA has approved another medication called Vivitrol. It's a one-month IM implant. Its indication is to prevent the relapse of opioid dependence. It completely blocks the opioid receptors – including opioids for pain relief. It costs around \$700 per monthly injection. It has a place, and that place is someone who is totally abstinent, hasn't used an opioid for a while, but who begins feeling the urges. This would completely block that. It has a lot of use in people who come out of correctional facilities who had opioid problems. It has its drawbacks. If you need an opioid for pain relief during that month, it's a complication. But it is getting a lot of attention in criminal justice settings.

Just to talk a little bit about some of the resources we have, the physician clinical support system for buprenorphine is available to connect you with a mentor right away. We also have a physician clinical support system for opioids, and important resource allowing anybody to connect with an experienced addictionologist to learn more about safe and effective prescribing of opioids. Those are free. We have several different guidelines as resources available for addiction treatment using different medications.

So just to summarize what I think you can do in developing your plans when it comes to monitoring and treatment. Try to integrate your PDMPs into your electronic health records. If you can do that, you'll get utilization up and see some immediate effects. Practitioners, prescribers and dispensers will utilize them much more frequently. You can identify diversion quickly with the use of PDMPs in the low-hanging fruit effect. You can find prescribers who are in need of attention by integrating PDMPs. You can do things to get more prescribers to use these systems. If you use the monitoring system and go out and train doctors and prescribers, you will increase utilization, which should be factored in. I believe the state PMDP administrators include training providers on using the monitoring system. It's not just the

simple task of checking the monitoring system, it's how to use that information and do the right thing with it. As far as treatment, there is a need to expand treatment availability. The quote from the physician in New York about the New York experience tells us that a lot of people treatment must be a part of what we're doing – it's not one of the pillars but it should be factored in. I think screening in brief intervention, if it can be used as a way to get more practitioners in primary care to start looking at this, and then use the referral to treatment part of it, should be something you factor into your monitoring and treatment interventions as well. We encourage the people who run the PDMPs in the states to establish linkages with the substance abuse treatment providers. That means that the physicians who identify someone in need of substance abuse treatment can immediately find the resources to get them into treatment. A few states have carried it further and allow licensed clinical social workers to access the state PDMP, which is the ultimate connection. You might want to look into that – substance abuse counselors accessing the PDMPs. All those things taken together should be a part of the monitoring programs you develop, but I'd also ask that you consider linkages and expanding treatment opportunities as part of your deliberations this morning.

(question from audience)

As far as I know, the material SAMHSA has on urine screening comes out of our workplace testing programs. I haven't seen that kind of finite information put into the guidance we have, but it's an interesting theory. It's off the subject, but there's something called ethylene glycol, which is supposed to be a very acute marker for past use of alcohol, and we did issue guidance on that because we can detect very, very low traces of past alcohol use – weeks ago – and people were losing their jobs if they tested positive for it. We issued guidance on that. To the best of my knowledge, that's the only thing we have so far. Thank you.

**JEFFREY COADY:**

Nick, it's good you expanded your talk to cover treatment, as treatment and recovery are both important concepts.



***Pillar 3: Disposal***

**JEFFREY COADY:**

For our next pillar, I'd like to introduce Dr. Brian Garthwaite, the compliance officer from the FDA, who will speak on the disposal pillar.

**BRIAN GARTHWAITE, Ph.D.:**

Thank you. I am very pleased to be here representing the FDA at this prescription drug abuse summit. My role as a compliance officer principally is to make sure that what the firms manufacture, i.e., the foods, drugs, cosmetics, medical devices, biologics, or veterinary products, are safe for the intended use. But I also have a component of my responsibilities that allows me to get to come out to conferences such as this and contribute back to the community.

I want to just highlight a little bit about what the Minneapolis District Office is. It's a smaller component of the Office of Regulatory Affairs. It's part of the FDA. We cover Minnesota, North Dakota, South Dakota, and Wisconsin, and on the diagram, each one of the little stars represents one of our resident posts. We have posts in Fargo, Pembina, Dunsieith, and Portal, ND, Sioux Falls, SD. We have a district office in Minneapolis. And we have resident posts in Green Bay, Milwaukee, Madison, Stevens Point, and Lacrosse, WI.

The subject of safe disposal is actually a question that I get in the office frequently from consumers. It's a question that had come up more frequently as the years have gone by.

I first wanted to highlight some of the risks of unused medication. And when I say unused, at least in this context, I will also reference "not yet used," because they're in our medicine cabinets. We spent most of the time talking about the potential for abuse so I won't reiterate many of the important things we've talked about. Sgt. St. George talked a little about theft, and I wanted to relate to you something from my home community, and actually on my block, that just recently happened. Sometimes maybe we aren't thinking about how, when we talk

about theft or diversion of the medications that we might have in our homes. There was a tree trimming service working up and down the blocks in my community that worked in teams of three. The first would come knock on your door and tell you that your trees needed to be trimmed and they provide the service. At that time, they're very good at doing a little social prospecting – who comes to the door, is it someone who might have some medical problem? Are they limping? Do they carry a cane? Are they elderly? They come in with their crew, and then an hour or so into their activities, one of them has to use the bathroom so they knock on the door and come in. And, of course, being kind people that we are, we would never tell someone they couldn't use our restroom. So they go in and do a survey of what's in your medicine cabinet but not take anything at that point. They'd go back out, and then when they would finish the job – and I'll point out that apparently they were doing a very good job of trimming the trees, which is how they would generate more business – but as the customers paid the bill, you'd have two of them in your house. One would be writing out the bill and you'd be writing out the check, and the other one would ask to use the restroom again, and that's when any of the medications that were in the medicine cabinet were taken. So that's something we need to be aware of. It's more than just what we would consider the common criminal that are diverting or taking the drugs.

Also, some of us take lots of medications, and there is the potential for medication mix-ups. We're creatures of habit, and we take the purple pill or the green pill or whatever, and we'll forget that maybe there's a change in the dose and maybe get those mixed up.

And the last one is accidental ingestion by children or pets. And I want to highlight that. In April this year, the FDA published a reminder to the public about the safe disposal of fentanyl patches – these are the little stickers you put on as a pain reliever. Reported to the FDA – these are just ones that were reported to the FDA – were 26 cases of pediatric accidental exposure in the last 15 years. Of those, there were 10 deaths and 12 hospitalizations that were represented by 16 children ages 2 or under. It's their innate curiosity. We're instructed to fold them up and



throw them away, but kids will pick them out of the garbage. They want to be like mom or dad so they'll put the patch on their wrist.

So I'm going to emphasize that safe and secure storage of the medications is just as important as safe disposal. There is probably no worse place to safely store your medicines than your medicine cabinet, because that's where everybody that comes into your house knows you're going to store medications. So, if it doesn't have a lock on it, that's something you can take back to your communities and tribes: Have your medications locked safe and secure. It's one of the best things you can do for visitors who come to your home, your children, or your grandchildren. They might ask if you don't trust them, and the answer is yes you do, but you don't trust everybody that comes to your house.

So I decided as I was putting together the presentation to outline three things we could take back to our communities and tribes. One we can do immediately, that costs nothing; another is something medium term, like every six months; and something that's a long-term program that maybe you can use in talks with your local law enforcements, your community hazardous waste disposal, or your pharmacy, to develop programs that long-term can serve you and your community.


The FDA has available on its website – just go to [FDA.gov](http://FDA.gov) and, in the search box in the upper right corner, put in “drug disposal” and hit Enter. Yes?

## Pillar 3: Disposal

FDA U.S. Food and Drug Administration  
Protecting and Promoting Public Health www.fda.gov

### Safe Disposal of Unused Medicine

Brian D. Garthwaite, Ph.D.  
Compliance Officer  
Food and Drug Administration  
Office of Regulatory Affairs  
Minneapolis District




Prescription Drug Abuse Summit:  
Moving from Information Sharing To Action Plan Development  
June 29, 2012

ORA Office of Regulatory Affairs

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### Risks of Unused Medication




- Potential for abuse
- Theft
- Medication mix-ups
- Accidental ingestion by children or pets

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### Risk: Accidental Ingestion

- On April 18, 2012, FDA published a reminder to the public about safe disposal of fentanyl patches
- 26 cases of pediatric accidental exposure over 15 years
- 10 deaths and 12 hospitalizations
- 16 in children 2 years old or less



Safe and secure storage of medications is as important as safe disposal!

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FDA U.S. Food and Drug Administration  
Protecting and Promoting Public Health www.fda.gov


### Options for Safe Drug Disposal

- At Home:
  - Flush down the toilet or sink
  - Municipal trash
- DEA National Prescription Drug Take-Back Day: September 29, 2012
- Local Medication Disposal Programs
  - Hazardous waste
  - Local law enforcement
  - Pharmacy take-back programs

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### At Home: Flush or Trash?



#### How to Dispose of Unused Medicines

Flush list


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### At Home: Flush or Trash?

#### Sources of disposal information

- Drug labeling
- Patient information
- Safety and handling instructions
- Medication Guides
- Pharmacist



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## At Home: Flush



FDA lists a small number of medicines recommended for disposal by flushing

Examples: fentanyl (Duragesic®), hydromorphone HCL (Dilaudid®), oxycodone HCL (Oxycontin®), acetaminophen + oxycodone HCL (Percocet®)

Flushing gets rid of them right away when other safe and secure options are not available

FDA does not advocate flushing of medicines that do not appear in the list

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## At Home: Trash

Most medicines can be disposed in household trash.



- Mix with inedible substance
- Place in a sealable container
- Dispose in trash
- Protect your identity


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## DEA National Drug Take-Back Day

**Got Drugs?**  
www.deadiversion.usdoj.gov



- September 29, 2012: 10:00 a.m. to 2:00 p.m.
- April 28, 2012: Collected 276 tons
- Four Take-Back Days Combined: 774 tons

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## DEA National Drug Take-Back Day

1-800-882-9539

- Site locations available in August
- Accept controlled substances (includes those on FDA's flush list), other prescription drugs, and nonprescription drugs
- DEA coordinates with local law enforcement and healthcare providers
- Law enforcement agent must be present if controlled substances are accepted at a take-back event

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## Local Medication Disposal Programs

www.co.countyname.mn.us

- Local hazardous waste disposal programs
- Local law enforcement coordinated with DEA
- Pharmacies or healthcare providers may offer take-back programs, but restricted by Federal laws

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## Local Medication Disposal Programs

- Free
- ID not required
- Self-operated
- Prescription
- Non-prescription
- Pet medicines
- Many dosage forms
- Safe and secure



<http://hennepin.us/medicine>

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## Pillar 3: Disposal

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### Environmental Concerns

- FDA recognizes the environmental concerns about flushing medicines
- Majority of medicines in the water system is from the body's natural route of drug elimination
- The known risk of harm from accidental exposure far outweighs potential risk to the environment from flushing of the selected list of medicines

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### Summary

- **Primary Focus:**  
Remove unused, expired, and unsafe medicines from the home
- **Method of Disposal:**
  - Quick
  - Complete
  - Safe
  - Secure

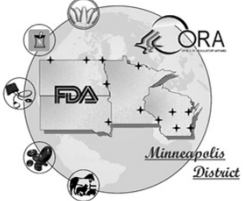
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### Safe Disposal of Unused Medicine

Brian D. Garthwaite, Ph.D.  
Compliance Officer  
Food and Drug Administration  
Office of Regulatory Affairs  
Minneapolis District



Prescription Drug Abuse Summit:  
Moving from Information Sharing To Action Plan Development  
June 29, 2012

ORA Office of Regulatory Affairs



***Pillar 3 Discussion***

**UNKNOWN SPEAKER:**

I work in Lac du Flambeau and people eat a lot of fish. We were told that you should not flush them down the toilet because it gets into the water system.

**BRIAN GARTHWAITE:**

I'll come back to that, so hold onto that thought.

So on FDA's website, we do have this information available, and as I said, if you go to FDA.gov and type in "drug disposal" in the search, there will be a number of options that come up for you to look at. Principally, at least in this case, is the decision of whether to flush some of our medications, or do we trash them. You'll find information about this, and I'll talk about each of these specifically. We have a limited list that the FDA suggests, at least as a short term in response to a lack of other disposal options, to flush. Yes?

**UNKNOWN SPEAKER:**

At the Behavioral Health Conference, I heard of a program in a troubled community where they were looking at doing safe burning of medications. Do you have that on your website? Which medications can be safely burned without causing toxic pollution in the home or burning facility?

**BRIAN GARTHWAITE:**

We don't have that information on the website.

If you go to the site and search "drugs at FDA," that will allow you to look up things such as the drug labeling that many firms are required now to consider as far as safe disposal of their medications and label their products with it. You can find patient information and safety and handling instructions for those medications, as well as medications guides.

### Pillar 3: Disposal

Consumers do call and I talk with them, and I always emphasize that it's important to engage the pharmacist, when you pick up the prescriptions, on how to dispose of leftover medications. It's a very simple question, but for whatever reason, it's not something we would intuitively think about.

Getting back to the issue of flushing, FDA does list on its website a small number of medicines that are recommended, in the absence of any other disposal method, to be flushed. You'll notice that this just some of the highlighted ones we've talked about today. They are the controlled substances. The real reason is that, if they are unused and in your home and you want to get rid of them right away, flushing is the way to get them out of your home right away. It's the method that we would suggest to do with, for example, the fentanyl patches – fold it and flush it so the little ones can't dig it out of the trash and nobody else gets exposed to it.

However, the FDA does not advocate flushing of medications that are not on that minimal list. There are better options for that. That is because most medicines can be safely disposed of in the trash. The FDA recommends that we mix them with inedible substances like coffee grounds, kitty litter – kitty litter soaks up liquids especially well – then put it in a sealable container and put it in the trash. And most importantly, because you are recycling the bottles it came in, conceal your identity: peel it off, black it out, whatever's necessary, because, again, people will go through garbage and they will look for that information and use it to their advantage.

Probably the most important and advocated method for safe and secure drug disposal is through DEA's National Drug Takeback Day. I have highlighted that the next one is on September 29, 2012, from 10 AM to 2 PM. Just as an idea of how well this is working, in April 2012, the most recent one, the DEA nationally collected over 276 tons of unused medications. That includes any prescription drug, veterinary medicines, it's not restricted just to the controlled substances. Altogether, the four takeback days that have been done have pulled 774 tons of unused medications off of the market. Now, what I don't know is if that number is just

by total weight and includes the bottle and caps and all, but I guess the bottom line is that it really doesn't matter. I've put the number from the DEA's website at the top that you can use to call to find out where, in your area, there would be any site locations. They won't be available, I guess, until August – at least according to the website – but something I would think about when you go back to your communities is maybe consider calling that number and asking if it's possible that you could coordinate with the DEA and local law enforcement to have a site location close to your community. It is something that's important to the tribes to do. The advantage of these programs is that they do accept, in addition to the controlled substances on FDA's flush list, other prescription drugs and non-prescription drugs, to include animal medications. The DEA does coordinate with local law enforcement and even healthcare providers to do that.

Something to think about, though, is that it's not as simple as saying you want to have a takeback day of your own and have everybody come in and turn in the unused medications for you to dispose of. That's not allowed by federal law. A law enforcement agent must be present if controlled substances are accepted at a takeback location, which is something you need to keep in mind if you're coming up with your own community or tribe's takeback program. Those are DEA laws that I'm not familiar with. It just basically comes down to each person being able to transport their own medications, but I can't give mine to you and then you take them in to return them. As I understand that law, there is some legislation being considered that may change that.

There are available some local disposal programs, and I've highlighted up at the top, somebody from Michigan and Wisconsin will have to help me out, but I know in Minnesota you can find your county's website just by [www.co.countyname.mn.us](http://www.co.countyname.mn.us). I think it's the same with the other states, but I'm not positive. It is? Ok, thank you. Again, if there is a local disposal program, it would need to be one that involved the controlled substances coordinated with DEA and your local law enforcement. Some counties have, as part of their local hazardous waste disposal programs, an allowance for the community to bring in medications that aren't on the controlled

### Pillar 3: Disposal

list. There are some pharmacies in Minnesota, including HealthPartners, that have some programs that encourage their customers to bring their expired or unused medications to their pharmacy, but again, it is restricted to non-controlled drugs because of Federal laws as mentioned before.

I'm going to highlight just one of the Minnesota counties, Hennepin. The county does have a medication disposal program that is free. It's located at the Sheriff's Office in downtown Minneapolis. There's one at the Water Control District and another at the Hennepin County Hazardous Waste Disposal site. Several of the advantages of these types of programs are that they are free and identification isn't required, so it's not like they're standing there waiting for someone to get rid of illicit drugs and then pouncing on them. I know that can be sensitive in a community when law enforcement is involved. They're self-operated, so it's as simple as opening the drawer, putting your medications in, and closing it so it drops in. And they will accept non-prescription medications, patent medicines, any forms (pills, liquids in bottles, blister packs), and most importantly it's safe and secure. Since these are located in police facilities or law enforcement facilities, you can feel assured that you're safe and that you don't have to worry about the drugs being diverted elsewhere. These are all maintained under law enforcement control until they're taken to an incinerator for disposal.

To get back to your question about the environmental concerns, the FDA does recognize that there are environmental concerns around flushing. However, something that gets lost in the conversation is that the majority of the medications found in the water supplies are actually through the body's own natural routes of drug elimination – the urine and feces, which end up in the sewage system. So the known risk of harm that can happen from an accidental exposure will far outweigh any potential risk to the environment from flushing just those selected list of medications. It gets it out of the home, it gets it out of circulation quickly and securely.

So in summary, the take-home points that I would like to make is that the primary focus is to remove the unused, expired, and unsafe medicines from the home. We can, in our



communities and tribes, assure that by doing this, the opportunity for theft or accidental exposure is marginalized. In our development of our programs, we want to make sure that our method of disposal is quick, complete, and safe and secure.

**JEFFREY COADY:**

Each table can go to talking about their action plan to implement some disposal methods.

*(Discussion)*

**JEFF COADY:**

If we can report out on the disposal pillar, then we can take a break. I'm going to offer any tribe or member participating here who would like to discuss some aspects of their plan to raise your hand.

**UNKNOWN SPEAKER:**

We recently had had a conversation with the Red Cliff Police Department. We had a meeting one day, and during the meeting, a suggestion was made to the Police Department to perhaps go around to the elders in the community who are maybe either shut in or would have a very difficult time leaving their homes to drop off their unused medications to the Police Department. Perhaps we could make a list of those people who are shut in or have difficulty getting out and give that to the police departments and allow them to stop at the person's home to pick them up for them. Of course, that would entail the health care center calling each of the people and ask them if they would like that service, because we couldn't just hand out names. We're looking at doing that, and we're taking steps to working toward that and we want that to actually happen before the first powwow, where we have a lot of people coming into the community. By doing this, it would help protect our elders from maybe somebody breaking into their home. Hopefully, that would help protect them a little bit.

**UNKNOWN SPEAKER:**

I think I heard a challenge being identified as a challenge of calling all these people. Why not just send out a mailing and announce that this is a project or a program? Would that make it easier? In other words, if you send it to everybody rather than worry about a specific group of patients?

**UNKNOWN SPEAKER:**

The reason this was brought up was because the Police Department does have a disposal in the Department, so people who are capable of picking their medicines up and leaving home and going to the Police Department would not have the same difficulty as an elder, perhaps. In mailing to everybody, then the Police Department could get pretty inundated, I think, because the idea is for the police officers to go to the certain homes to pick up that medication. We don't have a huge community, so would help things there, but the other difficulty is, if you mail things out to just, say, perhaps the elders, you might not get a response. So it would be a challenge to call each of these people, but because the community is small, right now we only have a list of about 15 names, and of those 15, we might only have five people who will say they would like to do that. If we do it time after time, perhaps it will get to be more popular and more people will use the service, but we're just testing the waters right now.

**UNKNOWN SPEAKER:**

This is a question and a comment. Instead of just sending it to the elders, what if you engaged the elders to help you get it out to everyone else that you want to attract to be a part of this? The reason I say that is because in Chicago there's a lot of violence going on, and the community and church leaders work with the police to have a gun turn-in day, and local leaders work with the police to reach out to the folks in the community, usually through letters or community forums to say it's going on, a turn-in day with no questions asked. I recently heard on the radio that they got four or five thousand guns turned in, and people brought them to the designated locations. I think the key in that whole piece was the police engaging the community leaders first to then reach out to the community.

**JEFFREY COADY:**

In full disclosure, I believe there was a hundred dollar gift certificate given, so there was incentive. If there's no other particular feedback for this, we can take a break for 15 minutes...oh...

**UNKNOWN SPEAKER:**

What about the drug turn-in boxes? Do they have to be in the police departments? Why not in a clinic? You only need a police officer if you need controlled substances being dropped off.

**UNKNOWN SPEAKER:**

I just talked to Sgt. St. George outside about this issue, because I thought it would be great to have some of these boxes in our facilities. He said that currently, because of DEA restrictions, it has to be local law enforcement. So it can't even be run by law enforcement at our facility. It has to be at a local law enforcement site. So I would assume that turn-in boxes would be dispensed through the DEA to local law enforcement. I'm hopeful that maybe this forum here that we're in can push something up to a level that, instead of running upstream this way, we can cross stream. This group is a group of a lot of people who have more clout than just individuals talking locally. Hopefully we can do that so that we can make some changes that really need to be made.

**UNKNOWN SPEAKER:**

I have a comment on disposal. I was in contact with a company that provides disposal containers, and they charge by the size of the container. They are 20, 40, and 80 gallons, or something like that. But like everyone is saying, you can't use it for controlled substances. What they did tell me, I trust that it's true because I guess he would know, is that the DEA is looking at the regulations so it could be kept outside of a law enforcement site. So if that regulation changes, then we could keep those in the clinics and then ship them out through that company.

**BRIAN GARTHWAITE:**

Part of the reason for having them at law enforcement facilities is that it is in a secure location. We heard this morning about the man who slept in the ceiling tiles and then broke into the pharmacy. That's exactly what we'd want to avoid.

And one other thing I forgot to mention is that one of the drop boxes in Minneapolis – this was told to me by Sgt. St. George – was sponsored by Target. So, maybe as you go back to your communities, you can engage your local pharmacies or businesses in helping sponsor those at your law enforcement sites through those agencies.

**UNKNOWN SPEAKER:**

I just wanted to add one comment to the drug disposal method that you demonstrated from the FDA about mixing it with something unpalatable like coffee grounds. I recommend that you crush the tablets or dissolve them in water first so they aren't identifiable, because a drug abuser might pick them out anyway. But if you're going to advertise the method, I would recommend crushing the tablet or dissolving the capsules in liquid first. They'd be more difficult to extract that way.

**BRIAN GARTHWAITE:**

That's a good point. There is some debate about whether crushing is a good idea because it's just another opportunity for exposure. I have observed some websites that say to do that and some that say don't. The FDA would prefer that you don't because it's one extra opportunity for exposure, but your point is taken.

***Pillar 4: Enforcement***

**MATTHEW ST. GEORGE, MA:**

My name is Matt St. George. I'm with the Minneapolis Police Department, currently on loan to the DEA as a Task Force Officer. Specifically what I'm working on is pharmaceutical drug-related crimes, dealing almost exclusively with overdose deaths and/or healthcare professionals who have been diverting controlled substances. Recently we've been dealing with a lot of issues related to certain communities, specifically the Native American community, and I want to talk a little bit about what we're doing as partners in some of these areas.

To give you a little bit of background on me, I've been with the Minneapolis Police Department for 17 years. During that time I've had the opportunity to work in a lot of different areas. I've worked in 911 Response, both in the 1<sup>st</sup> and 5<sup>th</sup> Precincts. The 1<sup>st</sup> Precinct has some very traditional drug crime issues going on downtown, with people loitering, drug use among some of the homeless population downtown; and 5<sup>th</sup> Precinct has the Uptown neighborhood, which perennially has been a place where we deal with heroin and other opiates. I've also had some opportunity to work in our Gang Unit and our Narcotics Unit. One of the things that I point out with my background is that I have been fortunate enough to have the experiences I've had, and the amount of experience, in dealing with drugs and gangs in Minneapolis. But what you need to understand is that when I was promoted in Sergeant in 2008, it was the only time in 17 years that I received any training dealing with pharmaceutical drugs. I think that is standard across the board for local law enforcement in Minnesota. The amount of training that we had received up until this point is minimal. If you were to stop someone and they had an illegal prescription for Vicodin in their pocket, nobody knew what to do with it, they didn't know where to go with it, they didn't know how to treat it, and they didn't know that can be looked at in the same way as a pocket full of crack cocaine. So we started doing some different things related to that.

In 2008, I was put in charge of what was, at the time, called the Prescription Forgery Unit for Minneapolis. All we did was take those people who walked into a pharmacy in Minneapolis

#### Pillar 4: Enforcement

with a forged prescription, and when they were arrested by the officers after the pharmacists alerted us and called 911, they would be arrested and put in jail. I would go out and interview and attempt to get those people charged out with what Minnesota calls a 5<sup>th</sup> degree controlled substance crime. That was all we did. We didn't do any follow-up investigation, we didn't do anything else. But what I started to see in Minnesota, and in Minneapolis, thanks in a large part to Carol Falkowski, and the Drug Trends Report, as well as other tools we have out there, is a rise in the amount of abuse of prescription drugs as well as the number of overdose deaths related to prescription drugs in Minneapolis, Ramsey County, and outstate as well, and on the reservations.

In 2009 I was transferred out of our Narcotics Unit into our Financial Crimes Unit, where I started working with people like Gary Nelson from HHS, and others, in dealing with health care fraud issues related to pharmaceutical drugs. That's a whole different issue that kind of goes untouched – what type of healthcare fraud is going on against Medicare and Medicaid for drugs that are being received for illegitimate purposes, and how do we address that? There are some astounding numbers; hundreds of billions of dollars of fraud going on annually.

Just a couple months ago I was transferred from the Financial Crimes Unit to our Violent Offender Task Force and placed as a task force officer with the DEA to continue my work. What we have seen across the board is that there is this issue with Minnesota's other drug problem. This is out of Minnesota's Drug Trend Report, which Carol Falkowski puts together every year, and these are some quotes from the 2011-2012 issue that recently came out. "In 2011, steady increased arrests over the last three years related to prescription drugs." What we're seeing right now in Minnesota, which Carol has talked about, is the use of opiates, whether it is heroin or other opiates, or prescription opiates, dominates the drug market across the board in the metro area, as well as the reservations. That's what we're dealing with: Prescription drug use. My job at DEA right now, as we're beginning to spool up, including chasing the prescription drug issues, hand in hand with that, is the heroin. So I'm working on heroin cases a lot as well. They drive each other. So if you get hooked on oxycodone, it may be cheaper or easier for you

to buy heroin on the street, and now we've got all the other issues with needle use and everything else that goes along with heroin addiction. They drive each other back and forth. When heroin is either not high in purity, or very expensive on the street, it's easier to have your insurance or medical assistance pay for your drugs that you'll obtain from a doctor illegally, either through some sort of doctor shopping scheme or some sort of drug scam that you can pull in order to obtain those controlled substances.

The other thing that we saw, was that admission to treatment centers for prescription medication ranks third after alcohol and marijuana. Those are some big numbers. If you look at, statistically, the things we have going on as far as alcohol -- the crimes related to alcohol in our communities, whether it's drunk driving, domestic assault, all the other things that go on with alcohol -- and our other issues with marijuana, which is pretty much endemic across every community, the next level is prescription drugs. That number alone is pretty astounding to me.

The next one is opiate-related deaths in Hennepin and Ramsey Counties, and I would update this slide if I had the opportunity, but opiate-related deaths outstrip gun violence deaths in Hennepin and Ramsey Counties. We put our resources into violent crime, and rightfully so -- we have some tragic, tragic things going on with gun violence in Minneapolis, Hennepin County, St. Paul, and Ramsey County. But we can't forget about the number of lives affected because of our overdose deaths related to pharmaceutical drugs and opiates.

Now over the last four years, in partnership with some of the other agencies I've been working with, we've realized that there is a deficiency in the quality of training for pharmaceutical drug crimes. As I said, up until 2008, a veteran police officer working in gangs and drugs, the only training I had received was when I started specifically working on prescription forgery -- and I had to seek that training out myself and go out of state to get that training.

What we began to see, along with the DEA, Minneapolis Police, the Food & Drug Administration, and the Minnesota BCA, we saw that deficiency in training. In 2012, we

#### Pillar 4: Enforcement

initiated a training course for tribal and local law enforcement. Back last year, the ASAC for DEA, Daniel Moren, was at an event similar to this at White Earth Indian Reservation, and he said that the DEA would assist with training tribal law enforcement as well as local law enforcement in getting people up to speed. So we sat down and put together an eight-hour training course specifically on this issue to train people up. Recently, this year, we've gone back to White Earth and trained tribal police there. Red Earth also sent some of their tribal officers, as well as other tribal officers from across the state. We've also done that training state-wide in Rochester, and we'll be doing another one in Grand Forks in the next month. After that we'll be going to Bismarck and Fargo to do the exact same training. The idea is to push that training out everywhere and do the training on every level that we possibly can.

The other issue we're dealing with, in pharmaceutical drugs, is an issue that we began to see as a real problem, which is that there was a 325% increase in the number of theft loss reports from Minnesota hospitals related to those drugs stored at or kept at hospitals. Meaning, essentially, that the health care professionals were the ones stealing these drugs. We have seen a major increase in the number of investigations we do out of the DEA office, the Diversion Office. So what ended up happening in 2011 was that there was a call by the Minnesota Department of Health as well as the Minnesota Hospital Association to begin addressing this issue. There have been several high-profile cases of healthcare workers diverting those drugs, and they said they wanted to address that issue proactively and come up with best practices on how to deal with it. We know this can lead to potential patient harm, and we also know that if we have addicted medical personnel – people within the medical community who are addicts themselves – they become targets of really bad guys in our society. They know that if they push the right buttons with the healthcare professionals to extort them with the threat of losing their jobs, going to treatment, or whatever – we're seeing that type of thing. I recently did a case on a pharmacy technician where that's exactly what happened: she was compromised, she was forced to give up patient data including names, SSI numbers, and insurance information, and then that was used to create fraudulent scripts passed all over the metro area. Those are the types of things we're seeing among the healthcare community.



Imagine the same type of problems with our nurses and MDs. Those are the types of issues we're dealing with.

What we came up with in this Commission, and what we saw as a real benefit, is that we all communicate and work together. That means that the Minneapolis Police Department talks with the Minnesota Board of Medical Practice, the Minnesota Department of Health, the Board of Pharmacy and the Prescription Monitoring Program. We have to lead with education and train all these people so we're all on the same page. We recognize we have a problem in this state that we need to address, and if we don't, we will end up with more overdose deaths on the street and more patient harm across the board. That transfers really well to a group like this. If we can't get everybody on the same page, we all have to work in that same direction.

Sometimes law enforcement doesn't do a really good job of communicating outside of the law enforcement arena. So working with healthcare professionals isn't really a good fit, or a comfortable fit, for people who have worked narcotics cases for a long time.

That being said, it's the same thing for healthcare providers. Every time I begin an investigation, I walk into a hospital and the first thing that's quoted to me is HIPAA. "I can't release that data to you because it would violate HIPAA." The reality is that when we have a criminal investigation, HIPAA is not a barrier for us to do those investigations, to get that evidence out of the medical record, and be able to use it for our investigations. It's a matter of training people up to get there.

It does not require a subpoena, but I will tell you to consult with your hospital staff first. The worst-case scenario when I do an investigation is that I meet with someone within the medical records department who is cooperative with me, understands that we have a crime that occurred, and wants to assist me, or a nurse or a doctor who wants to assist me in the investigation, and they give me the data. It wasn't a violation of HIPAA, but it was a violation of policy in the hospital and they get disciplined for assisting me. I don't ever want to see that

#### Pillar 4: Enforcement

happen. That is the worst-case scenario. What I would say is, before you give any data to law enforcement, consult your attorneys. If the attorney wants a subpoena – a Grand Jury subpoena federally, or a search warrant locally – we will get you what we need to get so we're not crossing those boundaries and hurting the professionals we're working with.

This my contact information, if you have any questions about any of this. One of the things I will leave you with, and one of the things I think is really important to understand: Pharmaceutical drugs have a purpose in our society. They're there for legitimate reasons. My own mother wouldn't have been able to make it to my wedding had she not had Percocet after a surgery. However, that being said, when there are people within our communities who abuse the ability to obtain these controlled substances, it makes it harder for doctors to prescribe in the way they need to, to treat people appropriately for the pain they need to. Legitimate, chronically, across the nation, legitimate patients who would need pain management are underprescribed for the medication, while those who are illegitimate patients – criminals – are overprescribed. We need to make that clear.

The other part about this is this: groups like this are fantastic to have, because you guys are spreading the knowledge about these problems across the state to address this issue. Local law enforcement can be a partner in dealing with that. I am speaking personally here, not as a representative of the Minneapolis Police Department or the DEA. Local law enforcement is community-oriented, and community-oriented policing has been the model for the 17 years I've been a law enforcement officer. When the community comes back to their police agencies and asks what we're doing about heroin in the community, or prescription drugs, local law enforcement has to respond. Groups like this can make that difference. Groups like this can make that change.

Any questions?

## Prescription Drug Abuse

A Law Enforcement collaborative perspective

Sgt. Matthew St. George  
Minneapolis Police Department  
DEA/TFO

## Sgt. St. George

- -17 Years with Minneapolis Police
  - 911 response 1<sup>st</sup> pct and 5<sup>th</sup> Pct
  - Minneapolis Gang Unit (1997-99)
  - 5<sup>th</sup> pct CRT
  - Minneapolis Narcotics
  - Promoted to Sgt. 2008
  - Financial Crimes 2009
  - DEA/Task Force 2012



## Minnesota's other drug problem

- ◎ MN drug trend report
  - Steady increase in arrests over last three years
  - Admissions to treatment centers for prescription pills ranks third after alcohol and marijuana.
  - Opiate related deaths have surpassed homicides in Hennepin county



## Law Enforcement Training Initiative



- DEA
- Minneapolis Police
- FDA
- MN BCA
- Recognized a deficiency in quality training on pharmaceutical drug crimes
- 2012: Initiated a training course for Tribal and Local Law Enforcement

## A Call to Action

- Prescription drug abuse is a national epidemic. As long as there is drug addiction, there will be thefts to obtain these drugs for personal use or sale.
- There have been high-profile cases of health care workers diverting drugs in Minnesota hospitals.
- From 2005-2011, there were 250 reports of theft/loss of controlled substances associated with health care workers.
  - Reports increased from 16 in 2006 to 52 in 2010, a 325% increase.
- Increased availability of these drugs

## MHA/MDH Commission Diversion Prevention Coalition

- Drug diversion is a serious issue that can lead to potential patient harm and/or patient safety issues, thus MHA and MDH commissioned a coalition May 2011.
- Coalition Participants: local law enforcement, DEA, FDA, licensing boards, hospitals, long-term care facilities, home care and hospice, and pharmacy associations.

Pillar 4: Enforcement

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***Pillar 4 Discussion***

**JEFFREY COADY:**

What we've usually done after the presentations is that each table takes a few minutes to write down an action plan of what they might do in their communities, the tribal nations, to take the next steps to implement and engage law enforcement. Then we report out and we may have some additional questions.

**JEFFREY COADY:**

We're going to start with our first report.

**UNKNOWN SPEAKER:**

Here we talked about the challenges of enforcement and some of the tribal law enforcement that are members of their local coalitions. So having those discussions and creating those relationships, but just the challenges of pleading cases down and people still getting let off pretty easy, once they are caught with any issues around drugs. That's the primary challenge discussed at this table.

**UNKNOWN SPEAKER:**

Lac du Flambeau question: how did they get your council involved? We've gone to council and told them that there's a prescription drug problem, but they don't see it as a big problem. I wish they were all here like you guys are. What happened? What were the first steps?

**UNKNOWN SPEAKER:**

When you're hit hard, when you see a death in the family or in the community, it really hits you hard. The Council was approached by different people, and I was glad our Council came down here today. The reality of the subject really hit home. The discussion around the table about being more proactive than reactive – let's stop a death, let's prevent one today and tomorrow, instead of reacting once a death has happened. That's some of what government has done there. The education needs to be ramped up, probably. I say, don't ever stop the education.

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We have our plates full, a lot of times, as a tribal government with a lot of different issues. We're much different than a city councilman who only has specific duties. We're into everything with our noses and our hands. We're involved in a lot of different things. There needs to be a constant there with the education. You can never have enough. So I've asked Gail here to present at our Council, and Pat, one of our Council is here. We were talking about different people who should be at this meeting. Let's go ahead and make it a constant. Don't just talk about it one day at a meeting and then it goes under the carpet because you're so busy. What we talked about earlier too is developing an intertribal task force. When Flambeau knocks by itself, the knock falls on deaf ears, but if all the tribes from Wisconsin knocking on the same door at once, they'll listen.

#### **UNKNOWN SPEAKER:**

If I could reiterate, the reason why I'm here today is, as a leader, we try to provide the best for the generations before us. We come here to get the education and take it back to our community to create a task force or give our task forces different ideas that we share with you guys. That's what I think it's all about. We're here to protect our children, grandchildren, and so forth. We can't do it sitting at home – and I don't mean to point a finger – but someone who isn't able to ask the questions. We need to bring it back and say "This is what the medical director has to do; this is what the health board has to do." That's why I'm here today.

#### **BECKY TUSSING, RN:**

Hi, my name is Becky Tussing, I'm a member of the Keweenaw Bay Indian Community and I'm also the Associate Health Director for our Department of Health and Human Services. Our tribe came up with a couple of ideas for enforcement activities, but first I'd like to share some things that you had mentioned in talking about in getting tribal support.

Several years ago, I obtained a report from the Michigan Department of Community Health to see the rates of Controlled Substances by county. I just assumed that all of the surrounding counties around the reservation had similar rates. I had worked with Stephanie Pinnow, our

contract epidemiologist, and we were shocked to find out that our rates were about five times that of Marquette County, which is considerably larger. With having that information, we presented it to the tribal council, and received strong support. We also submitted that information to local physicians' offices, because one thing we've noticed is that patients weren't just coming to our health department for health care. Since that time, the tribe has supported developing a drug task force committee. The drug task force committee is comprised of all major stakeholders from the community – the chief of police, the chief judge, I sit on there from the health department, the director of social services, council members – because in the beginning we found that there was a lot of finger-pointing, in particular with the medical community and law enforcement. Law enforcement asking why prescribers were prescribing, while prescribers would be asking why the criminals weren't in jail. When you get those groups together to talk about the problem and work on it, it's much more beneficial.

Some of the things we talked about were revising our prescription drug abuse policy to see how it's enforced. Perhaps we should implement some peer review into this? We also talked about tribal code and degrees to which patients are prosecuted. We talked about our tribal drug court. We have a drug tip line, and we talked about maybe having another law enforcement agency to assist with that, to help with compliance or maybe instilling confidence in community members in calling and reporting crimes. We talked about increasing education on what a reportable crime or suspicious activity may be.

**JEFFREY COADY:**

Another other suggestions anyone would like to make? Once again, we are also going to have the board you can write stuff on.

**UNKNOWN SPEAKER:**

I have a kind of a practical question. I'm a pharmacist at our clinic, Stockbridge-Munsee. Right now, we allow anybody. We don't have restrictions on who can pick up medicines for

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somebody else unless there's a specific request by that patient that other people don't pick it up. I'm wondering how other communities are dealing with that.

#### **UNKNOWN SPEAKER:**

In the Bemidji area, there is a policy we have in place that we use: Unless a patient assigns a proxy, only that patient can pick up the medication. Some facilities are a little stricter with it, but that has definitely reduced the diversion in the community. We use a signed form we keep on file.

#### **UNKNOWN SPEAKER:**

We also will use two patient identifiers, like if someone is picking it up they need to know their name and date of birth, and we're in the process of implementing IDs – they'll need to have an ID. I just moved here from Anchorage, and there we would write down the driver's license number on that prescription so you could check who had picked up the medication.

#### **MATTHEW ST. GEORGE:**

In my function, I deal with pharmacists almost on a daily basis, and one of the things we tell pharmacists is to make sure we're getting picture IDs. From a law enforcement perspective, if they can get a picture ID when someone is picking up drugs – not just the Schedule 2s, but any drugs – and make a photocopy of that to keep on file, we're rock solid on being able to then charge that person if it turns out they picked it up illegally. If they match the photo up with that person there and make a photocopy of it, it's in the file. HIPAA doesn't protect it because it is crime committed on the premises, so they can hand it over and we can charge the person with obtaining by fraud.

#### **UNKNOWN SPEAKER:**

One risk we realized with doing that in Anchorage is that we didn't have private consultation areas, just open windows, and it was really apparent to everyone in the waiting room when someone was digging in their pocket and getting their wallet out to show their ID, that they're



getting narcotic prescriptions. So there would be a trail of people following them to the parking lot.

So what our discussions have been at White Earth (and I've just been there a short time) is that will probably just ask for IDs for all prescriptions so it wouldn't be so obvious to anyone who's trying to look for narcotics. But that would take a lot of education within our community to get people used to that change.

**UNKNOWN SPEAKER:**

I was just going to say, this is a discussion about enforcement, and there are a lot of things you can do to enforce rules and regulations for prescribers and doctor shoppers. What a few states have done is going halfway to this enforcement. They've established prescribing guidelines, which really apply to pain treatment. Any patient who's above a certain dose triggers an event such as a consult with a pain treatment specialist. So it's not telling the doctors they can't prescribe, it's telling prescribers that they've reached a threshold that requires an extra level of scrutiny. They're trying this in Washington State and Utah, and it works. The only down side is that there aren't enough pain treatment specialists to refer people to for counsel and information. But you might want to look at that as a quasi-enforcement mechanism.

**JEFFREY COADY:**

So you're talking about a system of checks and balances, a colleague, a review, something that could be instituted.

**UNKNOWN SPEAKER:**

One thing is, it appears to me that we make it too easy to get prescriptions and want to make it easy. In Bad River, we built a new clinic and a drive-in pharmacy. We should make it more difficult. But at all the pharmacies I'm seeing, they're a moneymaker for the tribe. That's the direction we're pushed in, to get all the money we can. Why not? If people need a

prescription, why not make money off it. The dollar precedes and overrides our sense of responsibility. I think we need to look at that.

**UNKNOWN SPEAKER:**

Another thing that's really helpful is that there was a tribal summit at White Earth, and one of the things that was helpful was the extent to which the drug abuse was tied into other medical consequences and harm the community was suffering – and in this case it was hepatitis C. That really helped to open up the discussion about the linkage with drug use as well.

**UNKNOWN SPEAKER:**

I just have a comment on that about – you know we talk about the epidemic of drug abuse. We talk about making it more difficult. And I've been sitting here looking at our enforcement and plans. And we're not just making it more difficult for the person who's abusing or diverting the drugs – we're making it more difficult for people who need it. Going back to the statistic, only 2.6% of people divert it.

Secondly, say you go through all of this ID-ing people, signing in and signing out, picture IDs, and you say that's helped. How do you know that? How do you know it's cut down on diversion? The reason I ask that is that anything I've done, I haven't been able to tell if I've cut down on diversion because I find out those people have gone somewhere else.

**UNKNOWN SPEAKER:**

When you ask, sometimes they get kind of nervous and walk away. That's just anecdotal, but it has been perceived, at least, as being a deterrent to people who might have a guilty conscience. But there's no data that I'm aware of.

**UNKNOWN SPEAKER:**

And Sgt. St. George brought up the point that what's helped is the enforcement part of it, and that's a deterrent, that we haven't been part of the problem. We've been part of the solution. We haven't instituted the photo ID part, but that's coming down the road. It's something we'll do. But the big piece is that our patients are used to, like Judy had mentioned, they're used to picking up medications the way they are, and it's going to be a new educational piece. They're going to have something additional we'll be asking. So that will be something we'll have to implement. That will have to be done tactfully.

**JEFFREY COADY:**

I know the sergeant has to leave, so are there any other specific questions for him? I know he provided his contact information.

**MATTHEW ST. GEORGE:**

One last thing. Pharmaceutical drug abuse is crossing all demographics. This is a statewide issue. It's specific to the tribal areas we're talking about today, but statewide, Minnesota and Wisconsin are dealing with this issue. We're seeing it in healthcare providers, in the people we typically see as drug addicts on the street, and we're seeing it across all lines. And so it's not specific to any one community, but it is an issue that we all need to address in every part of our states. We need to understand that – it's the doctors who may have an issue on this, but it's also the law enforcement officers and the police. Within my own police department we've had issues with police officers addicted to controlled substances and have diverted. These are issues that cross all lines. It is number one drug problem in the US by far.