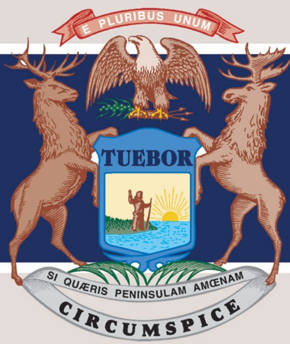

Michigan Prescription Drug and Opioid Abuse Task Force

REPORT OF FINDINGS AND RECOMMENDATIONS FOR ACTION

Governor Rick Snyder
Lt. Governor Brian Calley
REINVENTING MICHIGAN
Getting It Right. Getting It Done.

STATE OF MICHIGAN
EXECUTIVE OFFICE
LANSING

RICK SNYDER
GOVERNOR

BRIAN CALLEY
LT. GOVERNOR

Oct. 26, 2015

Governor Snyder,

Pain killers are powerful opioids that are highly addictive and opioid dependence affects millions of people in the United States. Prescribed opioids can lead to the use of highly addictive and dangerous illegal substances, especially heroin. As you know, the abuse of prescription drugs and opioids are a serious problem in Michigan.

In your 2015 State of the State Address, you called for a comprehensive plan to address prescription drug and opioid abuse in Michigan. In mid-June 2015, you formed a bipartisan Task Force to "examine the recent trends, evaluate strategic options, and develop a statewide action plan by fall 2015."

The members of the Michigan Prescription Drug & Opioid Abuse Task Force have been working diligently to provide recommendations on how best to address this burgeoning problem in Michigan.

The entire membership deserves thanks and applause for the professional manner in which they tackled this large undertaking together and in the full spirit of cooperation despite their varied professional and political backgrounds. I would like to call special attention to the leadership of Attorney General Bill Schuette and Department of Health and Human Services Director Nick Lyon for their oversight of the subcommittees that contributed greatly to the outcome of this report.

The Task Force has completed its work but there is still much to be done. All of us on the Task Force look forward to working with you, members of the state Legislature, the law enforcement and medical communities, the insurance and prescription drug industries and many other stakeholders as we seek to ensure that appropriate pain management is provided for our citizens.

Thank you for your leadership in forming this Task Force and your commitment to protecting the people of Michigan.

Brian Calley

Brian Calley
Lt. Governor
Chair, Michigan Prescription Drug & Opioid Abuse Task Force

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II. Executive Summary

In June 2015, Gov. Rick Snyder announced the creation of a task force focused on addressing the growing prescription drug and opioid problem in Michigan. The Michigan Prescription Drug & Opioid Abuse Task Force was chaired by Lt. Governor Brian Calley and was composed of 21 members, including state lawmakers, government officials, court officials, law enforcement personnel, medical professionals, and other stakeholders. Its mission was to examine recent trends in prescription drug and opioid abuse, evaluate strategic options, and develop a statewide action plan by fall 2015.

Attorney General Bill Schuette played a leadership role by chairing the Regulation, Enforcement, and Policy Subcommittee. Michigan Department of Health and Human Services Director Nick Lyon played a leadership role by chairing the Prevention, Treatment, and Outcomes Subcommittee.

Over the next several months, the two subcommittees met separately to devise their respective action plans and the Task Force met as a whole to review progress and discuss issues. Attorney General Schuette's Regulation, Enforcement, and Policy Subcommittee heard reports from various presenters on topics such as Michigan's prescription drug monitoring system, drug addiction, pain clinic regulation, drug disposal, public awareness and law enforcement. Director Lyon's Prevention, Treatment, and Outcomes Subcommittee also heard reports from numerous stakeholders, particularly in the treatment and prevention areas. Following these meetings, the entire Task Force met to develop recommendations with as much consensus as possible considering the complexity of the challenges facing Michigan with this issue.

Prescription drug abuse has reached epidemic proportions. The increased availability of prescription drugs, coupled with general misperceptions regarding the safety of physician-prescribed medications, has led to exponential growth of drug users and drug abusers. In Michigan, the number of drug overdose deaths – a majority of which are from prescription drugs – has tripled since 1999.[1] Moreover, recreational use of prescription drugs is a serious growing problem with teens and young adults. National studies show that many teens are more likely to abuse a prescription drug than illegal street drugs, with the exception of marijuana.[2]

The rise in heroin use is closely related to the prescription drug epidemic. As efforts to address prescription drug abuse increase, addicts often turn to illicit drugs. The

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[1] *Prescription Drug Abuse: Strategies to Stop the Epidemic*, TR. FOR AM. HEALTH (OCT. 2013), http://healthyamericans.org/reports/drugabuse2013/.
[2] DRUG ENF'T ADMIN., PRESCRIPTION FOR DISASTER: HOW TEENS ABUSE MEDICINE 8 (2nd ed. 2012), http://www.dea.gov/pr/multimedia-library/publications/prescription_for_disaster_english.pdf.

increased attention paid by law enforcement to combatting this problem, as well as the expansion of Drug Courts and the focus on diversion for treatment instead of incarceration when appropriate have helped but are not enough to bring the problem under control.

As we move forward, we must consider the legitimate needs of patients who require pain medication and recognize that the vast majority of health professionals provide appropriate treatment. The Task Force is cognizant that chronic pain continues to be a serious issue for millions of Americans. Any comprehensive approach to the prescription drug abuse problem and death rate must consider all stakeholders.

III. Background

To fully appreciate the issues considered by the Task Force, it is essential to understand the severity and complexity of the prescription drug abuse epidemic facing our nation and state today.

The Prescription Drug Abuse Epidemic in America

Prescription drug abuse has reached epidemic proportions in the United States.[3] Prescription drugs are abused more often than any other drug, except marijuana and alcohol.[4] A recent study indicated that more than 54 million people aged 12 and older had abused prescription drugs at some point in their lives and nearly 15 million people had done so in 2014. [5] More than 6.5 million people had abused prescription drugs in the month preceding the study and would qualify as current abusers. That is more than 2.5% of the U.S. population aged 12 and older.

According to data from the National Survey on Drug Use and Health (NSDUH), "nearly one-third of people aged 12 and over who used drugs for the first time in 2009 began by using a prescription drug non-medically, *i.e.*, without a prescription."[6] Importantly, the survey also found that more than 70% of people

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[3] *Prescription Drug Abuse*, OFFICE OF NAT'L DRUG CONTROL POLICY, https://www.whitehouse.gov/ondcp/prescription-drug-abuse (last visited Sept. 25, 2015).

[4] *Prescription Drug Misuse and Abuse*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., http://www.samhsa.gov/prescription-drug-misuse-abuse (last updated Sept. 29, 2014).

[5] CTR. FOR BEHAVIORAL HEALTH STATISTICS & QUALITY, SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMINISTRATION & RTI INTERNATIONAL, RESULTS FROM THE 2014 NATIONAL SURVEY ON DRUG USE AND HEALTH: DETAILED TABLES, http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH-DetTabs2014.htm#tab1-1a (last visited Sept. 25, 2015).

[6] OFFICE OF NAT'L DRUG CONTROL POLICY, 2011 PRESCRIPTION DRUG ABUSE PREVENTION PLAN (2011), https://www.whitehouse.gov/sites/default/files/ondcp/issues-content/prescription-drugs/rx_abuse_plan.pdf (citing SUBSTANCE ABUSE & MENTAL

who abused prescription painkillers obtained them from friends or relatives, while only approximately 5% got them from a drug dealer or from the Internet.[7] This growing form of drug abuse presents a daunting new set of challenges as we seek to curb the epidemic.

The Human Toll

Prescription drug abuse has led to health problems, addiction and death. Statistics show that 44 people die in the United States every day from an overdose of prescription painkillers,[8] more than cocaine and heroin combined.[9] In 2014, prescription drug abuse accounted for nearly 22,000 drug overdose deaths (half of all drug overdoses).[10] Two types of prescription drugs are largely responsible: painkillers (opioid analgesics) and tranquilizers (benzodiazepines). More than 16,000 of the prescription drug overdose deaths were related to the painkillers, while nearly 7,000 deaths were related to tranquilizers.[11]

Opioid painkillers such as oxycodone, hydrocodone, and methadone have been identified as one of the primary reasons for the tragic increase in prescription drug overdose deaths,[12] and they are being prescribed in the United States at an unprecedented rate. While U.S. residents constitute less than 5% of the world population, they consume 80% of the global opioid supply and 99% of the global hydrocodone supply.[13]

HEALTH SERVS. ADMIN., RESULTS FROM THE 2009 NATIONAL SURVEY ON DRUG USE AND HEALTH (NSDUH): NATIONAL FINDINGS (2010)).

[7] *Id.*

[8] *What the Public Needs to Know About the Epidemic*, CTR. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/drugoverdose/epidemic/public.html (last updated May 5, 2015).

[9] Ctrs. for Disease Control & Prevention, *CDC Grand Rounds: Prescription Drug Overdoses — A U.S. Epidemic*, 61 MORBIDITY AND MORTALITY WKLY. REP. 10 (2012), http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6101a3.htm.

[10] JEFFREY LEVI ET AL., TR. FOR AM.'S HEALTH & ROBERT WOOD JOHNSON FOUND., THE FACTS HURT: A STATE-BY-STATE INJURY PREVENTION POLICY REPORT 2015 63 (June 2015), http://www.healthyamericans.org/assets/files/TFAH-2015-InjuryRpt-final6.18.pdf.

[11] *Id.* at 64.

[12] BUREAU OF SUBSTANCE ABUSE & ADDICTION SERVICES, MICHIGAN DEPARTMENT OF COMMUNITY HEALTH, PRESCRIPTION AND OVER-THE-COUNTER DRUG ABUSE STRATEGIC PLAN 5 (May 2012), http://www.michigan.gov/documents/mdch/RxOTC_Drug_Abuse_Strategic_Plan_Final_389362_7.pdf.

[13] Laxmaiah Manchikanti et al., *Therapeutic Use, Abuse, and Nonmedical Use of Opioids: A Ten-Year Perspective*, 13 PAIN PHYSICIAN 401, 401 (2010), http://www.painphysicianjournal.com/current/pdf?article=MTM4Mg%3D%3D&journal=57.

Data compiled by the U.S. Centers for Disease Control (CDC) shows that most of the deaths from prescription opioid overdose involve people between the ages of 25 and 54.[14] Although most overdoses involve men, the gap between men and women is quickly closing.[15] Between 1999 and 2010, opioid overdose deaths increased by 265% among men and 400% among women.[16]

Heroin use among women has increased 100% in the past 10 years.[17] Many of these women are in their prime child bearing ages. This dramatic increase in the use of heroin has led to a significant increase in the number of children being born with neo-natal abstinence syndrome (NAS). NAS is a group of problems associated with drug withdrawal that occur in a newborn who was exposed to addictive opiate drugs while in the mother's womb.[18] Babies suffering from NAS tend to cry inconsolably, endure diarrhea and vomiting, have low-grade fevers and light sensitivity, and have seizures.[19] In 2012, 21,732 babies born in the United States suffered from NAS. This is a five-fold increase from 2000.[20] The average hospital costs for an infant born with NAS is $66,700 compared to $3,500 for an infant born without NAS.[21]

The Financial Toll

When a patient or a prescriber participates in the diversion of prescription drugs (using a prescription drug without a prescription), insurance companies or public health programs such as Medicare or Medicaid often end up footing the bill. The

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[14] *Prescription Drug Overdose Data: Deaths from Prescription Opioid Overdose*, CTRS. FOR DISEASE CONTROL & PREVENTION, http://www.cdc.gov/drugoverdose/data/overdose.html (last updated Apr. 30, 2015).

[15] *Id.*

[16] *Prescription Painkiller Overdoses: A Growing Epidemic, Especially Among Women*, CTRS. FOR DISEASE CONTROL & PREVENTION (July, 2013), http://www.cdc.gov/vitalsigns/prescriptionpainkilleroverdoses/index.html. Centers for

[17] *Today's Heroin Epidemic*, CTRS. FOR DISEASE CONTROL AND PREVENTION, http://www.cdc.gov/vitalsigns/heroin/ (last updated July 7, 2015).

[18] *Neonatal Abstinence Syndrome*, MEDLINEPLUS, https://www.nlm.nih.gov/medlineplus/ency/article/007313.htm (last updated Jan. 1, 2014).

[19] *Id.*

[20] *Dramatic Increases in Maternal Opioid Use and Neonatal Abstinence Syndrome*, NAT'L INST. ON DRUG ABUSE, http://www.drugabuse.gov/related-topics/trends-statistics/infographics/dramatic-increases-in-maternal-opioid-use-neonatal-abstinence-syndrome (last updated Sept. 2015).

[21] *Id*.

Coalition Against Insurance Fraud has estimated the cost to the healthcare industry from prescription drug diversion to be over $70 billion dollars annually.[22]

A study published in the *Journal of Managed Care Pharmacy* found that opioid abusers generate direct health care costs that are nearly nine times higher than those for non-abusers.[23] For each opioid overdose death, there are 11 abuse-treatment admissions and 33 emergency room visits.[24]

Financial consequences of prescription drug abuse go beyond increased healthcare costs. Individuals who abuse pain medication are less productive at work, thus increasing workplace costs.[25] Abusers also generate increased criminal justice costs.[26] A 2011 *Journal of Managed Care Pharmacy* study found that the

> …total U.S. societal costs of prescription opioid abuse were estimated at $55.7 billion in 2007… Workplace costs accounted for $25.6 billion (46%), healthcare costs accounted for $25 billion (45%), and criminal justice costs accounted for $5.1 billion (9%). Workplace costs were driven by lost earnings from premature death ($11.2 billion) and reduced compensation/lost employment ($7.9 billion). Healthcare costs consisted primarily of excess medical and prescription costs ($23.7 billion). Criminal justice costs were largely comprised of correctional facility ($2.3 billion) and police costs ($1.5 billion).[27]

Recent Trends

The prescription drug abuse epidemic is evolving. The success of efforts to reduce the supply of prescription opioids available for abuse has unfortunately resulted in an increase in heroin use and the diversion and misuse of buprenorphine, a medication used to treat opioid addiction.[28]

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[22] COALITION AGAINST INSURANCE FRAUD, PRESCRIPTION FOR PERIL: HOW INSURANCE FRAUD FINANCES THEFT AND ABUSE OF ADDICTIVE PRESCRIPTION DRUGS 4 (Dec. 2007), http://www.insurancefraud.org/downloads/drugDiversion.pdf.

[23] Alan G. White et al., *Direct Costs of Opioid Abuse in an Insured Population in the United States* 11 J. MANAGED CARE PHARMACY 469, 479 (2005), http://www.amcp.org/data/jmcp/3.pdf.

[24] LAURA K. Howard, SUBSTANCE ABUSE & MENTAL HEALTH SERVICES ADMINISTRATION, THE IMPORTANCE OF TREATMENT FOR OPIOID USE DISORDERS (2014), http://www.deadiversion.usdoj.gov/mtgs/drug_chemical/2014/howard.pdf.

[25] Howard G. Birnbaum et al., *Societal Costs of Prescription Opioid Abuse, Dependence, and Misuse in the United States*, 12 PAIN MEDICINE 657, 657 (2011), http://onlinelibrary.wiley.com/doi/10.1111/j.1526-4637.2011.01075.x/pdf.

[26] *Id.*

[27] *Id.*

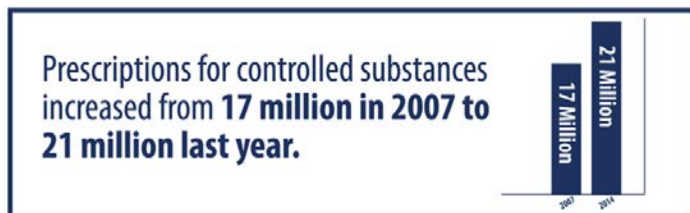
[28] Bridget M. Kuehn, *Driven by Prescription Drug Abuse, Heroin Use Increases Among Suburban and Rural Whites*, 312 [J]AMA 118 (2014); *From Pill-Mill Pariah to Paragon*, HERALD TRIBUNE (July 8, 2014),

In addition to opioids, an estimated 1.7 million Americans use tranquilizers, such as benzodiazepines, without a prescription.[29] The number of emergency room visits between 2005 and 2010 involving abuse of alprazolam, a type of benzodiazepine, more than doubled from 57,419 to 124,902.[30]

The abuse of prescription stimulants also is increasing dramatically. A recent study reported that 20 percent of college students misused or abused prescription stimulants at least once in their lives – to study, stay awake, or improve their academic or work performance.[31] This trend has led to a drastic rise in the number of emergency room visits related to stimulant use among people ages 18 to 34 from 5,600 in 2005 to 23,000 in 2011—a 292 percent increase.[32]

IV. Michigan's Problem with Prescription Drugs

Number of Prescriptions and Dosage Units



According to published raw data from the Michigan Automated Prescription System (MAPS), more than 21 million prescriptions for controlled substances were written in 2014.[33] This is roughly four million more prescriptions than were written in 2007, despite the fact that Michigan's population slightly decreased over the same time period.[34]

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http://www.heraldtribune.com/article/20140708/OPINION/307089999/-1/HEALTHMATTERS?Title=From-pill-mill-pariah-to-paragon.
[29] *Id.* at 16.
[30] *Press Release: Emergency Departments See Increased Visits Involving the Nonmedical Sedative Alprazolam*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (May 22, 2014), http://www.samhsa.gov/newsroom/press-announcements/201405220400.
[31] Josie Feliz, *New Survey: Misuse and Abuse of Prescription Stimulants Becoming Normalized Behavior Among College Students, Young Adults*, P'SHIP FOR DRUG FREE KIDS (Nov. 13, 2014), http://www.drugfree.org/newsroom/adhd-survey-2014.
[32] SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., EMERGENCY DEPARTMENT VISITS INVOLVING NONMEDICAL USE OF CENTRAL NERVOUS SYSTEM STIMULANTS (Aug. 8, 2013), http://www.samhsa.gov/data/sites/default/files/spot103-cns-stimulants-adults/spot103-cns-stimulants-adults.pdf; Charles Corra, *Abusing Prescription Adderall Hurts Those with ADHD*, DAILY ANTHENAEUM (Mar. 24, 2010), http://www.thedaonline.com/article_5a527a21-9605-5538-86b8-654b3c047a29.html.
[33] *MAPS Statistics*, MICH. DEP'T OF LICENSING & REGULATORY AFFAIRS, http://www.michigan.gov/lara/0,4601,7-154-63294_63303_55478_55484---,00.html (last visited Sept. 25, 2015)..
[34] *Id.*

Of the 21 million controlled substance prescriptions written last year, nearly 11 million (over half) were for schedule II drugs.[35] Schedule II drugs are classified by the U.S. Drug Enforcement Agency (DEA) as having a high potential for abuse and dependence.[36] This compares with just three million schedule II prescriptions in 2007.[37] Thus, schedule II prescriptions have nearly quadrupled in Michigan over the past seven years. Since the creation of MAPS, hydrocodone has been the most prescribed drug, accounting for 32.2% of all prescriptions written in Michigan in 2012.[38]

MAPS also tracks dosage units, or pill counts, of controlled substances. In 2007, prescribers wrote nearly 180 million individual dosage units of schedule II drugs.[39] In 2014, this number was an astonishing 745 million. This represents a quadrupling of pill counts in just seven years.[40]

Overdose Deaths and Emergency Room Visits

According to a 2014 report from the Michigan Department of Community Health, Michigan has experienced a four-fold increase in unintentional fatal drug poisonings since 1999.[41] Overall, 4,772 Michigan residents died from 2009 to 2012 due to unintentional or undetermined intent poisonings.[42] This equates to a rate of 12.3 deaths per 100,000 residents.[43] Of these overdose deaths, 19.4% were definitively opioid-related, more than any other category of drugs.[44] Additionally, of the 35.9% of drug overdose deaths that were a result of an unspecified drug, 83% of the overdosed individuals had filled a prescription for an opioid in the past 30 days.[45] Therefore, opioids likely caused an even higher percentage of overdose deaths.

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[35] *Id.*
[36] *Drug Schedules*, DRUG ENF'T ADMIN., http://www.dea.gov/druginfo/ds.shtml.
[37] MICH. DEP'T OF LICENSING & REGULATORY AFFAIRS, *supra* note 29.
[38] MICH. DEP'T OF CMTY. HEALTH, A PROFILE OF DRUG OVERDOSE DEATHS USING THE MICHIGAN AUTOMATED PRESCRIPTION SYSTEM (MAPS) 5 (2014), https://www.michigan.gov/documents/mdch/MAPS_Report_2014_-_FINAL_464112_7.pdf.
[39] MICH. DEP'T OF LICENSING & REGULATORY AFFAIRS, *supra* note 29.
[40] *Id.*
[41] MICH. DEP'T OF CMTY. HEALTH, *supra* note 29, at 5.
[42] *Id.* at 7.
[43] *Id.*
[44] *Id.* at 9.
[45] *Poisoning Deaths Due to Unspecified Drugs in Michigan, 2009-2012*, OFFICE OF RECOVERY ORIENTED SYS. OF CARE,

Of course, not every overdose results in a death. Thus, the number of emergency room visits also is an important measure of opioid abuse. Michigan hospitalizations involving opioids more than doubled from 2000 to 2011 from 9.2 to 20.4 per 10,000 population.[46]

Who it Affects

Of the 4,772 Michigan deaths noted above, 60.3% were men, and 39.7% were women.[47] The age of overdose victims ranged from less than 15 to over 65, but the highest percentage was between 45 to 55 years of age (29.3%).[48] More than 83% of the overdose death victims were white, 13.6% were black, 1.4% were Native American, and 0.1% were Asian or Pacific Islander.[49] Although Native Americans made up a small percentage of overall deaths, the death rate for Native Americans was 20.2 per 100,000, compared to 12.7 for whites and 10.9 for blacks.[50]

In 2012, of all unintentional or undetermined intent drug-poisoning deaths, 59% had received a prescription in the past 30 days and 80% had received a prescription in the past year.[51] Thus, the majority of victims seemingly did not receive their drugs through illegal means but by prescription.

Michigan's Rank

While effectively measuring one state against another is difficult, several statistics can help compare the extent of the problem in Michigan to that in other states.

According to a study published in the *Morbidity and Mortality Weekly Report* in 2014, Michigan ranked 10th among all states in per capita prescribing rates of opioid pain relievers in 2012.[52] In that year, providers wrote 107 prescriptions for

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http://www.michigan.gov/documents/mdch/Poisoning_Deaths_due_to_Unspecified_Drugs_in_MI_2009-2012_Fact_Sheet_-_FINAL_464113_7.pdf.

[46] *Hospitalizations involving Opioids, Cocaine, and Amphetamines, Michigan Residents, 2000-2011*, OFFICE OF RECOVERY ORIENTED SYS. OF CARE, http://www.michigan.gov/documents/mdch/Opioid-Related_Hospit_2000-2011_05-31-13_427136_7.pdf..

[47] MICH. DEP'T OF CMTY. HEALTH, *supra* note 34, at 8.

[48] *Id.*

[49] *Id.*

[50] *Id.*

[51] *Id.* at 12.

[52] Leonard J. Paulozzi et al., *Vital Signs: Variation Among States in Prescribing of Opioid Pain Relievers and Benzodiazepines — United States, 2012*, 63 MORBIDITY AND MORTALITY WKLY. REP. 563 (2014), http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6326a2.htm?s_cid=mm6326a2_w.

opioid drugs and benzodiazepines per 100 Michigan residents.[53] According to data compiled by Trust for America's Health for the years 2011-2013, Michigan ranked 18th in the nation based upon number of all overdose deaths.[54]

V. The Heroin Surge

National Trends

The surge of heroin use and addiction is closely related to the growing prescription drug epidemic.[55] Like prescription painkillers, heroin is an opioid.[56] However, heroin is an illegal opioid and is classified as a Schedule I drug by the DEA, meaning it has no recognized therapeutic value and presents a high risk of abuse.[57] A recent report reveals that 2.6 out of every 1,000 U.S. residents 12 and older used heroin between 2011 and 2013, a 63% increase since 2002-2004.[58] Heroin-related deaths have also increased dramatically. According to the CDC's 2013 drug overdose mortality data, the age-adjusted rate for drug overdose deaths involving heroin has increased across all regions of the country, with the greatest increase seen in the Midwest.[59] From 2000 to 2013, heroin-related overdose deaths in the Midwest increased 11-fold.[60]

According to the DEA, the increase in heroin use and overdoses is attributable to several factors: an increase in the average purity of retail heroin, a decrease in its - price,[61] and an increase in its availability, especially in the Northeast and the

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[53] *Id.*
[54] JEFFREY LEVI ET AL., *supra* note 10, at 14.
[55] *See Abuse of Prescription Pain Medications Risks Heroin Use*, NAT'L INST. ON DRUG ABUSE (2014), http://www.drugabuse.gov/related-topics/trends-statistics/infographics/abuse-prescription-pain-medications-risks-heroin-use (last updated Jan., 2014).
[56] *Drug Facts: Heroin*, NAT'L INST. ON DRUG ABUSE, http://www.drugabuse.gov/publications/drugfacts/heroin (last updated Oct. 2014).
[57] *Drug Scheduling*, DRUG ENF'T ADMIN., http://www.dea.gov/druginfo/ds.shtml (last visited Sept. 25, 2015).
[58] Christopher M. Jones et al., *Vital Signs: Demographic and Substance Use Trends Among Heroin Users — United States, 2002–2013*, 64 MORBIDITY AND MORTALITY WKLY. REP. 719 (2015), http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6426a3.htm?s_cid=mm6426a3_w.
[59] HOLLY HEDEGAARD, ET AL., NATIONAL CENTER FOR HEALTH STATISTICS, DRUG-POISONING DEATHS INVOLVING HEROIN: UNITED STATES, 2000–2013 5 (2015), http://www.cdc.gov/nchs/data/databriefs/db190.pdf.
[60] *Id.*
[61] DRUG ENF'T ADMIN., NATIONAL HEROIN THREAT ASSESSMENT SUMMARY 2 (2015), http://www.dea.gov/divisions/hq/2015/hq052215_National_Heroin_Threat_Assessment_Summary.pdf.

Midwest.[62] Additionally, heroin is a far deadlier drug than comparable drugs.[63] While cocaine prevalence is five times higher than heroin, heroin deaths rates are nearly twice as high as those for cocaine.[64]

Increases in heroin usage can also be directly linked to prescription drug abusers transitioning to heroin.[65] For example, the DEA found that when OxyContin was reformulated to make it less susceptible to abuse, more prescription drug abusers started turning to heroin as an alternative.[66] According to a 2014 CDC study, among heroin users who began their use after 2000, more than 75% reported that a prescription drug was the first opioid they had abused.[67] Respondents reported that they found heroin more readily accessible, less expensive, and more potent.[68] According to similar reports compiled by the National Institute on Drug Abuse (NIDA), almost half of young people who use heroin also started out by abusing prescription drugs.[69]

Abuse and Overdose Numbers in Michigan

Like the rest of the country, Michigan is experiencing a heroin crisis that must be addressed in coordination with the response to prescription drug abuse. The Michigan Department of Community Health documented 826 heroin-related deaths between 2009 and 2012.[70] During this time period, the heroin-related overdose death rate doubled – from 4.9 deaths per 100,000 residents in 2009 to 9.8 in 2013.[71] According to a recent statement from the West Michigan Enforcement Team (WEMET), heroin overdoses in Muskegon County have reached an average of one per day.[72] WEMET emphasized that this spike in heroin use is “absolutely” related to

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[62] *Id.* at 4.
[63] *Id.* at 8.
[64] *Id.*
[65] *Id.* at 2.
[66] NAT'L INST. ON DRUG ABUSE, *supra* note 51.
[67] Rose A. Rudd et al., *Increases in Heroin Overdose Deaths - 28 States, 2010-2012*, 63 Morbidity and Mortality Wkly. Rep. 849 (2014), http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6339a1.htm.
[68] *Id.* The DEA confirms this finding. *See* DRUG ENF'T ADMIN *supra* note 57, at 2 (finding that prescription drug abusers are turning to heroin because of the cheaper price and greater availability).
[69] *How is Heroin Linked to Prescription Drug Abuse?*, NAT'L INST. ON DRUG ABUSE, http://www.drugabuse.gov/publications/research-reports/heroin/how-heroin-linked-to-prescription-drug-abuse (last updated Nov. 2014).
[70] MICH. DEP'T OF CMTY. HEALTH, *supra* note 34, at 21.
[71] *Heroin-Related Mortality Among Michigan Residents*, MICH. DEP'T OF CMTY. HEALTH, http://www.michigan.gov/documents/mdch/Heroin-Related_Mortality_Fact_Sheet_Age_Group_2_483955_7.pdf (last visited Sept. 25, 2015).
[72] Heather Lynn Peters, *Heroin Overdoses Averaging 1 a Day in Muskegon County, Linked to Prescription Drug Use*, MLIVE.COM (May 26, 2015),

the increase of prescription drug abuse and the use of heroin as cheaper substitute.[73]

VI. Prescribing Controlled Substances

In 1970, the U.S. Congress passed the Controlled Substance Act (CSA) to regulate drugs based on their medical value and potential for abuse or dependence.[74] The CSA has been amended several times to keep up with issues related to new drugs, drug abuse and the movement of drugs around the world.[75] The CSA created a closed system of prescription drug distribution – requiring reporting and monitoring checks and balances at every step.

A prescription is required to get a drug designated as a controlled substance.[76] The CSA divides controlled substances into five schedules, ranging from those with a high potential for abuse and no currently accepted medical use (Schedule I) to low potential for abuse and a currently accepted medical use for treatment (Schedule V).[77]

It is important to note that federal laws and regulations set the floor, or minimum requirements, for the regulation of controlled substances. States are free to enact more restrictive laws or regulations. Michigan's controlled substance schedules are set by the state Legislature and listed in Michigan's Public Health Code.[78]

The U.S. DEA is responsible for enforcing the Controlled Substance Act – including the manufacture, distribution, and dispensing of legally produced controlled substances.[79] Manufacturers and distributors of controlled substances must report

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http://www.mlive.com/news/muskegon/index.ssf/2015/05/heroin_overdoses_averaging_1_a_1.html.

[73] *Id.*

[74] Comprehensive Drug Abuse Prevention and Control Act of 1970, Pub. L. No. 91-513, 84 Stat. 1236.

[75] Major amendments to the Controlled Substance Act include: Psychotropic Substances Act of 1987, Pub. L. No. 95-633, 92 Stat. 3768; Controlled Substances Penalties Amendments Act of 1984, Pub. L. No. 98-473, sec. 501 et seq., 98 Stat. 2068; Chemical Diversion and Trafficking Act of 1988, Pub. L. No. 100-690, sec. 6041, 102 Stat. 4312; Domestic Chemical Diversion Control Act of 1993, Pub. L. No. 103-200, 107 Stat. 2333; and Controlled Substance Analogue Enforcement Act of 1986, Pub. L. No. 99-570, sec. 1201, 100 Stat. 3207. For an overview of these amendments, see *Amendments to the 1970 Controlled Substances Act*, National Substance Abuse Index, http://nationalsubstanceabuseindex.org/amendments.htm (last visited Oct 1, 2015).

[76] 21 U.S.C. § 829 (2009).

[77] 21 U.S.C. § 812 (2012); *Drug Scheduling*, DRUG ENF'T ADMIN., http://www.dea.gov/druginfo/ds.shtml (last visited Oct 1, 2015).

[78] MICH. COMP. LAWS § 333.7212 (2013).

[79] Exec. Order No. 11,727, 3 C.F.R. § 785 (1971-1975).

to the DEA's Automation of Reports and Consolidated Orders System (ARCOS).[80] ARCOS then monitors controlled substances from manufacture through distribution to point of sale.[81] Information from ARCOS is given to federal and state agency investigators to identify possible illegal diversion of controlled substance.[82]

Prescriptions

The framework of prescribing controlled substances is a complex one, requiring an interplay between state and federal authorities. Physicians, dentists, and veterinarians are able to prescribe controlled substances in Michigan, so long as they meet a number of additional requirements.

1. Must be licensed with the appropriate licensing board (Board of Medicine, Board of Osteopathic Medicine and Surgery, Board of Dentistry, and Board of Veterinary Medicine).
2. Must have a Michigan Controlled Substance License from the Board of Pharmacy.[83]
3. Must have a DEA registration[84]

A prescriber must have ALL of the above. If the prescriber's license to practice is suspended or revoked, his or her Michigan controlled substance license is suspended by operation of law.[85] If the prescriber's federal registration is surrendered, suspended, or revoked, the state may suspend or revoke the Michigan controlled substance license.[86] Under the CSA, the DEA has the authority to suspend or revoke a registration if a state license has been suspended, revoked, or denied.[87]

If a physician wishes to prescribe a controlled substance to treat narcotic addiction, he or she also must have a Michigan Substance Abuse License[88] and a DEA Registration for Narcotic Treatment Programs.[89]

In Michigan, it is possible for a physician to delegate their prescribing authority to a physician assistant, nurse practitioner, or nurse midwife (mid-level practitioners).[90]

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[80] *Automation of Reports and Consolidated Orders System (ARCOS)*, DRUG ENF'T ADMIN, http://www.deadiversion.usdoj.gov/arcos/ (last visited Oct. 1, 2015).
[81] *Id.*
[82] *Id.*
[83] MICH. COMP. LAWS § 333.7303(1) (2013); Mich. Admin Code r. 338.3132 (2015).
[84] 21 C.F.R. § 1301.11 (2009).
[85] *See* MCL 333.7311(6)
[86] *See* MCL 333.7311(1)(b).
[87] *See* 21 U.S.C. § 824(a) (2000).
[88] MICH. ADMIN. CODE. r. 325.14921 (2015).
[89] 21 U.S.C. § 823(g) (2009); 21 C.F.R. § 1306.07(d) (2005).
[90] *MAPS Information for Prescribers and Dispensing Practitioners*

The mid-level practitioner uses the supervising doctor's controlled substance license as the basis for such a prescription.[91] However, the DEA does not allow the delegation of a DEA registration from a practitioner to a mid-level practitioner. Instead, the mid-level practitioner must obtain a DEA mid-level controlled substance registration.[92]

Dispensing

Like prescribing controlled substances, the system for dispensing controlled substances is equally complex and also requires an interplay between state and federal regulations and agencies.

A physician must meet all of the requirements necessary to prescribe controlled substances, but must also have a Michigan Drug Control License.[93] A pharmacist must also have a Michigan Drug Control License issued by the Michigan Board of Pharmacy.

As with prescribers, if a pharmacist (or pharmacy) or dispensing physician has one of the above licenses or registrations revoked, the others will automatically be revoked.

VII. Recommendations

A. Prevention

1. The Task Force has determined that medical professionals would benefit from additional training on how to treat patients using opioids and how to treat addiction to opioids and other controlled substances. Both subcommittees arrived at this conclusion separately. **The Task Force recommends requiring additional training for all professionals who will be prescribing controlled substances.**

   The Task Force believes the State needs to increase education and training requirements in the area of appropriate prescription of opiates. In addition, the state should encourage additional continuing education requirements for medical professionals regarding opioid use and addiction. This will help

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Reporting Requirements, MICH. DEP'T OF LICENSING AND REGULATORY AFFAIRS, http://www.michigan.gov/lara/0,4601,7-154-72600_72603_55478_55485---,00.html (last visited Oct. 1, 2015).

[91] *Id.*

[92] *DEA Registration Requirements for Physician's Assistance, Nurse Practitioners and Nurse Midwives*, MICH. BUREAU OF HEALTH SERVS., https://www.michigan.gov/documents/cis_fhs_bhser_Alert012403dearequirements_58938_7.pdf (last visited Oct. 1, 2015).

[93] *See* MCL § 333.17745(1) (2015).

medical professionals to properly prescribe controlled substances and be able to recognize when a patient may be abusing their prescribed medication.

2. Reducing opioid and prescription drug abuse will require a collaborative effort between external stakeholders and state government. **The Task Force recommends encouraging the development and maintenance of relationships among state and local agencies to provide necessary information regarding prescription drug abuse, prevention, and treatment.**

3. One way to reduce opioid and prescription drug abuse is to reduce the supply of unused medication. Drop-off bins are a secure and convenient way for individuals to dispose of their used prescription medications. In addition, developing effective take-back programs and increasing state partnerships with existing collectors and other appropriate entities would increase public awareness of such programs. **The Task Force recommends collaboration among local coalitions, pharmacies, health profession boards, state agencies and the DEA to increase the availability of prescription drop-off bins. The Task Force also recommends a review of successful state and local collection programs for possible replication and expansion.**

4. Those who are addicted or seeking prescription drugs for nonmedical purposes often go from doctor to doctor and pharmacy to pharmacy to try to get multiple prescriptions written and filled. This is known as doctor and pharmacy shopping. Reducing doctor and pharmacy shopping is a priority. One way to address this problem is to only allow prescriptions to be written by one doctor and filled at one pharmacy. This is known as being locked-in, and it helps to reduce doctor and pharmacy shopping. **The Task Force recommends reviewing programs and parameters established within the Medicaid system as well as actions taken by other states to determine the best route forward to eliminate doctor and pharmacy shopping.**

   The Task Force believes there may be appropriate conditions under which limiting patients to a certain doctor or pharmacy may have merit. Nevertheless, parameters would need to be established to help prevent prescription drug abuse without interfering with access to necessary medications by residents who are not trying to obtain controlled substances for illegal activities. **The Task Force recommends the state specifically review programs already in use in Tennessee and Washington to determine how their systems operate and if any of those systems would work in Michigan.**

5. Public awareness of opioid and prescription drug abuse is low. The magnitude of the problem is far too great to only have limited public awareness. Both subcommittees arrived at this conclusion separately. The Task Force believes raising public awareness in a broad manner is a priority. **The Task Force recommends a multifaceted public awareness campaign be undertaken to inform the public of the dangers of abuse, how to safeguard and properly dispose of medicines, publicize improper prescribing practices, and reduce the stigma of addiction.**

   There are many local entities that are already doing a good job in this arena and the Task Force believes the state should evaluate those programs for possible replication. In particular, the state should look for programs that treat opioid addiction as a disease, that reach children to help them understand the dangers of prescription drug abuse and the growing trend of such abuse leading to heroin addiction. **In addition, the Task Force recommends the State should inquire of pharmaceutical companies whether they would be willing to collaborate on a public relations awareness campaign in Michigan.**

B. Treatment

1. Naloxone is a drug that reduces the effects of an opioid overdose. Naloxone is a safe and life-saving drug that that should be more accessible. Both subcommittees arrived at this conclusion separately. Currently, Naloxone is not widely accessible. It is currently available for prescription only to public safety and emergency personnel or to a family member, friend or other individual in a position to assist a person at risk of experiencing an opioid-related overdose[94]. **The Task Force recommends pharmacists be allowed to dispense Naloxone to the public in similar fashion to how pseudoephedrine is currently dispensed.** The Task Force recognizes this may require a change in federal law, as well.

   The Task Force also suggests the State evaluate recent EpiPen laws in Michigan as well as laws passed in Ohio that address dispensing of Naloxone to learn from that state's research into the issue as well as the implementation of the law.

2. Responding to an emergency should be the priority when administering Naloxone. It is essential that anyone administering Naloxone should not be hesitant to do so because of criminal and civil liabilities. **The Task Force recommends pursuing increased public awareness regarding**

[94] *See* MCL § 333.17744b

the laws[95] that limit civil and criminal liabilities for administering Naloxone.

3. The saving of life must be given priority over other considerations. However, sometimes people do not call to report an overdose because of the fear that they may be arrested for their own criminal actions. People should be encouraged to call for assistance without the fear of criminal justice consequences. Both subcommittees arrived at this conclusion separately. **The Task Force recommends exploring the possibility of limited statutory immunity for low-level offenses involved in reporting an overdose and seeking medical assistance.**

4. Substance Use Disorder patients need adequate treatment, particularly Medication Assisted Treatment (MAT). MAT is the use of drugs that help reduce the desire for opioids in a patient and is essential to most patients' recovery from opioid addiction. Studies indicate that without MAT, patients are highly likely to relapse. An evidenced-based, recovery-oriented system of care is generally preferred by those who have successfully treated Substance Use Disorder.

   In a Presidential Memorandum dated Oct. 21, 2015, President Barack Obama – to improve access to treatment for prescription drug abuse and heroin use – directs federal departments and agencies that directly provide, contract to provide, reimburse for, or otherwise facilitate access to health benefits, to conduct a review to identify barriers to medication-assisted treatment for opioid use disorders and develop action plans to address these barriers. The White House also noted that under the Affordable Care Act, Substance Use Disorder treatments are "essential health benefits" to be covered by health plans in the federal exchange.

   The Task Force recommends exploring ways for the State to increase access to care, including wraparound services and MAT, as indicated by national and state guidelines for treatment. In addition, the Task Force recommends that insurance companies consider providing health plans that cover the costs of MAT with reasonable quantity limits on medication used.

5. There is a growing need for more physicians, pharmacists, therapists, counselors and caseworkers to be involved with treating addiction. The current level of professionals available for this work has prevented the growing number of substance use disorder patients from receiving the

[95] *See* MCL § 333.17744c and 691.1503

necessary care. **The Task Force recommends exploring ways to increase the number of addiction specialists practicing in Michigan.**

6. The Task Force recognizes that many of the individuals arrested on opioid and prescription drug-related charges are in need of treatment. **The Task Force recommends additional training for law enforcement in the area of recognizing and dealing with addiction for those officers who do not deal directly with narcotics regularly. The Task Force also recommends expansion of treatment courts as called for by Gov. Rick Snyder in his 2015 Criminal Justice Message, as well as expanding the courts' ability to create pilot programs for the use of Medication Assisted Treatment.**

   The ability of courts to use diversion for treatment instead of incarceration should be applauded and encouraged. The State should examine roadblocks to treatment currently being experienced by specialty treatment courts. Law enforcement also should be encouraged to work with local advocacy organizations and people with Substance Use Disorder to ensure that abusers receive access to the necessary treatment.

7. The over-prescribing of controlled substances often occurs when there is not a bona-fide physician-patient relationship. **The Task Force recommends requiring a bona-fide physician-patient relationship as defined in Michigan law prior to prescribing controlled substances.**

8. A dramatic increase in the use of heroin has led to a significant increase in the number of children being born with neo-natal abstinence syndrome (NAS). **The Task Force recommends the State review current best practice guidelines for reducing the development of NAS and consider pilot programs for the development of testing of pregnant women to reduce the risk of NAS caused by prescription drug and opioid abuse.**

C. Regulation

1. Pain management clinics have a role to play in the treatment of chronic pain for Michigan residents, but enforcement of how these clinics operate is sometimes called into question. **The Task Force recommends considering legislation to better define and identify pain management practice for the purposes of licensing.**

2. Methadone clinics have a role to play in ending Substance Use Disorder, but may require a different licensure than other types of treatment

facilities. The licensing regulations related to methadone and similar clinics have not been updated since 1978. **The Task Force recommends updating regulations to delineate licensing for clinics based on the population being treated and that the State consider a tiered system of licensing that regulates the functions and prescription capabilities of the clinics and their staff.**

3. Pharmacists may sometimes refrain from challenging the dispensing of a prescription due to possible civil liability. **The Task Force recommends the establishment of an exemption from civil liability when a pharmacist is acting in good faith and has reasonable doubt regarding the authenticity of the prescription or believes the prescription is being filled for non-medical purposes.**

The exemption should require consultation with the prescribing physician before the pharmacist can decide to deny filling the prescription.

4. Misuse of prescription drugs has led to an increase in emergency room visits, in some areas surpassing the use of illicit drugs as a reason for an ER visit. The Michigan College of Emergency Physicians has developed recommendations regarding the use of opioid analgesics with a focus on providing pain relief that is appropriate and safe for the illness being treated.

The Task Force recommends the State review the Michigan College of Emergency Physicians policy and then endorse a best practices policy that hospitals and doctors could use as a model.

5. The state has taken considerable steps in recent years to fight a growing methamphetamine production and abuse problem. **The Task Force recommends reviewing the limitation of the sale of pseudoephedrine by pharmacies only.**

Limiting the availability of pseudoephedrine – a major component in the production of methamphetamine – may reduce the use of pseudoephedrine for illegal purposes and assist with limited law enforcement resources.

D. Policy and Outcomes

1. In order to track the success of the Task Force's recommendations, the Task Force must be an ongoing part of the state's initiatives. Both subcommittees arrived at this conclusion separately. The ongoing Task

Force (or a permanent commission) could evaluate the success of current recommendations as well as make new recommendations to manage long-term elements of a comprehensive plan to prevent prescription drug abuse in Michigan. **The Task Force recommends creating an ongoing Prescription Drug and Opioid Task Force or Commission to evaluate the efficacy of current proposals and continually develop new solutions to address societal changes.**

Members should include representatives from the boards of medicine and could incorporate other existing commissions to streamline this effort.

2. As part of improving transparency, all measurements to success should be publicly accessible on the State Dashboard. **The Task Force recommends adding outcomes to the State Dashboard to track success.**

Performance measures that can be used to measure success could include a reduction in overdose deaths, MAPS utilization rates, and any other relevant trackable data.

3. When legal or business problems consume a medical practice, the patients often are left without a "medical home" at a most vulnerable time of their lives. **The Task Force recommends the State consider mechanisms to ensure patient continuity of care during an abrupt closure of a medical practice to ensure that necessary treatments can continue without interruption.**

4. By working together closely, local law enforcement and stakeholder coalitions have had some success in the reduction of overdose deaths for Substance Use Disorder patients. **The Task Force recommends the State document law enforcement efforts with local coalitions and focus groups that have resulted in a reduction of prescription overdose deaths to determine if replication and expansion are possible and warranted.**

E. Enforcement

1. Every state except Missouri has a prescription drug-monitoring program to scrutinize the movement of controlled substances. Michigan's program (the Michigan Automated Prescription System or "MAPS") is an electronic database of schedule II, III, IV, and V controlled substances dispensed in

Michigan. MAPS was created by statute in 2002 as part of a nationwide effort to curb prescription drug abuse, and is housed within the Department of Licensing and Regulatory Affairs (LARA). Registration with the system is required for those who *dispense* controlled substances but not for those who *prescribe* controlled substances. A modernization of MAPS is necessary for the following series of secondary recommendations to be fully implemented. **The Task Force recommends a review of the budgetary requirements for updating or replacing MAPS.**

While the MAPS update or replacement is being completed, **the Task Force recommends that mandatory registration in MAPS by all licensed prescribers should be implemented to ensure all are registered when the updated or new system is brought online.**

The Task Force recommends the following actions, understanding that updating or replacing MAPS would be necessary to complete these actions:

a) More rigorously enforce the requirement that dispensing health professionals report to MAPS.
b) Require pharmacists to review MAPS before dispensing new prescriptions for Schedule II-V drugs. Also require pharmacists to check MAPS quarterly for refills of controlled substances prescriptions.
c) Require prescribers to perform a quarterly review of MAPS for patients receiving opioid analgesics.
d) Improve coordination of care among providers and within health plans, as well as leveraging Health Information Technology including the Michigan Health Information Network.
e) Increase potential sanctions for covered professionals that demonstrate an intentional pattern of failing to consult MAPS while providing exceptions for good-faith errors.
f) Allow MAPS to generate a morphine equivalency rate or similar risk assessment scale.

2. Law enforcement professionals already have access to information contained within MAPS, however, the existing system of operation precludes them from obtaining information on nights, weekends and holidays. **The Task Force recommends allowing broader access to MAPS for law enforcement purposes when investigating questionable business practices by prescribers.** This increased access should be focused on making the information law enforcement already has access to being available 24 hours per day, 7 days per week, 365 days per year.

3. Enhanced licensing sanctions under the Public Health Code and enhanced criminal sanctions for licensed health care professionals convicted of delivery of controlled substances would help address abuse through the prescription pad. **The Task Force recommends requiring enhanced licensing sanctions for health professionals that violate proper prescribing and dispensing practices**.

   The Task Force recognizes that some of this may be possible through administration actions, but would support legislative action when necessary.

VIII. Acknowledgments

The Task Force wishes to acknowledge the countless hours of work provided to it by key staff members in the Office of the Governor, Office of the Attorney General and the Michigan Department of Health and Human Services, as well as the invaluable testimony and submissions of information provided by various individuals, associations and companies.

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