

The Language of Liberty Series



The Failure of the Prescription Drug Monitoring Program

By Dr. John D. Lilly, CSG Student

Deaths in the U.S. due to prescription drug overdose are reaching crisis proportions. The increase in the death rate due to all prescription drugs has been primarily due to the increase in prescription opioid pain medications. State governments are looking for a solution to the problem. Historically, it has been very easy for people to obtain opioid prescriptions from multiple doctors; therefore, an obvious solution is to monitor who is receiving all opioid prescriptions. States enacted Prescription Drug Monitoring Programs (PDMP) which record who is filling opioid prescription medications at every pharmacy in the state. The information goes into a database that can be accessed by doctors and pharmacists. The assumption was that having access to this information would stop individuals from obtaining medication from multiple providers, commonly known as “doctor shopping.” However, the death rate due to opioids continues to rise despite the fact that every state except Missouri has a PDMP.

Prescription medications that are controlled by the Food and Drug Administration (FDA) are classified on five different [schedules](#) from I to V. Schedule II through V drugs are prescribed by physicians. Schedule II drugs are the most addictive and are the most controlled. They include opioid pain medicines like hydrocodone (Lortab[®], Vicodin[®]), oxycodone (OxyContin[®], Percocet[®]), morphine (Roxanol[®], MS Contin[®]), and methadone (Dolophine[®]). Schedule IV drugs include benzodiazepines like alprazolam (Xanax[®]) and diazepam (Valium[®]). They are less addictive, but more habit forming.

A National Institute on Drug Abuse [report](#) shows the number of deaths caused by all prescription drugs for the entire country has increased from 7,885 in 2000 to 25,760 in 2014, and the number of deaths per 100,000 population, age adjusted, has increased from 2.81 in 2000 to 8.00 in 2014. That is a 226% increase over 15 years or 15% per year. A subset of that number is the deaths caused by opioid medication, which has increased per 100,000 population from 1.54 in 2000 to 5.91 in 2014. That is a 329% increase over 15 years or 22% per year. Another subset is the number of deaths caused by benzodiazepine medication, which has increased per 100,000 population from 0.46 in 2000 to 2.49 in 2014. That is a 512% increase over 15 years or 34% per year. The increase in all prescription drug deaths is primarily due to the increase in opioid pain medicine deaths with a smaller proportion due to benzodiazepines. Those two classes account for almost all of the increase.

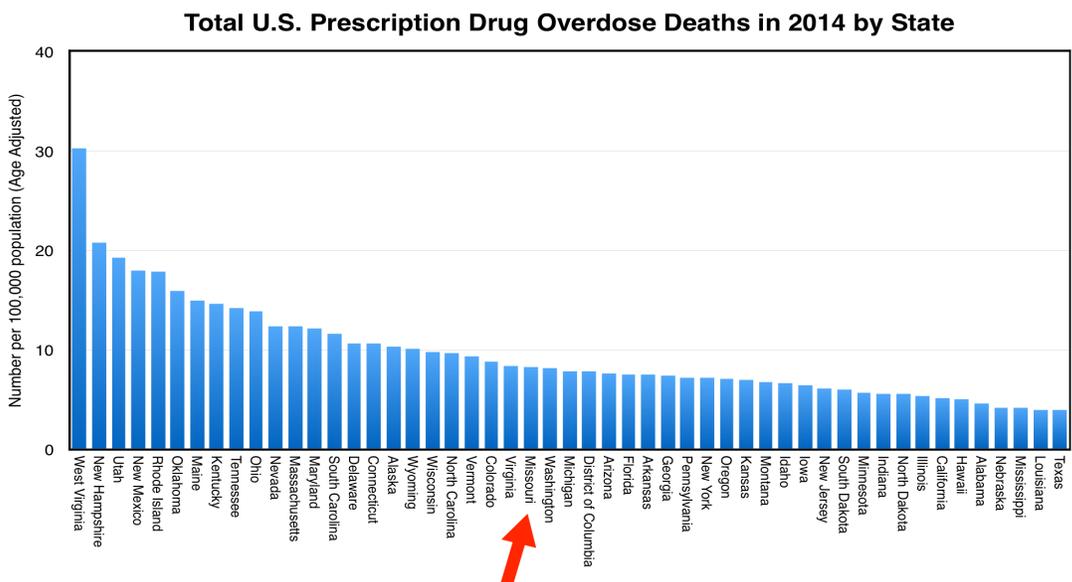
How did opioid pain medication become such a large problem? Before 1990, physicians were reluctant to prescribe opioid pain medication. It was only prescribed for a limited time for broken bones and after surgeries. Chronic use was limited to terminal cancer patients. During the 1990s, federal and state agencies started encouraging physicians to treat chronic pain with opioid pain medicine.

On the national level, the President’s Commission on Model State Drug Laws was formed in 1993. A bipartisan commission went on a fact-finding mission to obtain information at the local level about drug and alcohol abuse problems. The commission then created a nonprofit [organization](#): the National Alliance for Model State Drug Laws (NAMSDL), to help disseminate information and be a resource for state legislatures. Initially, NAMSDL worked to curb illegal drug and alcohol abuse. Later it took on the task of curbing prescription drug abuse. Its solution was to push to enact PDMPs in every state. The drug crisis was used to implement yet another government program to control individuals.

A PDMP is a statewide electronic database which collects designated data on specific medication dispensed in the state. The program is housed within a specified statewide regulatory, administrative, or law enforcement agency. The purpose of the program is to eliminate “doctor shopping” which is the practice of one patient going to two or more physicians to obtain prescription pain medication and having the prescriptions filled at two or more pharmacies in order to sell the medication.

Since Missouri is the only state without a program, it should be at the top of the list of deaths by prescription drug overdoses if these programs actually work. Looking at the number of deaths in 2014 due to all prescription drug overdoses, per 100,000 population, Missouri (see arrow) is 24th.

Limiting the deaths to those caused by prescription opioid pain medication, Missouri is 22nd. The deaths from prescription drugs since 2000 has been getting worse in every state. If the goal of the PDMPs is reducing the death rate, then every PDMP is a failure.

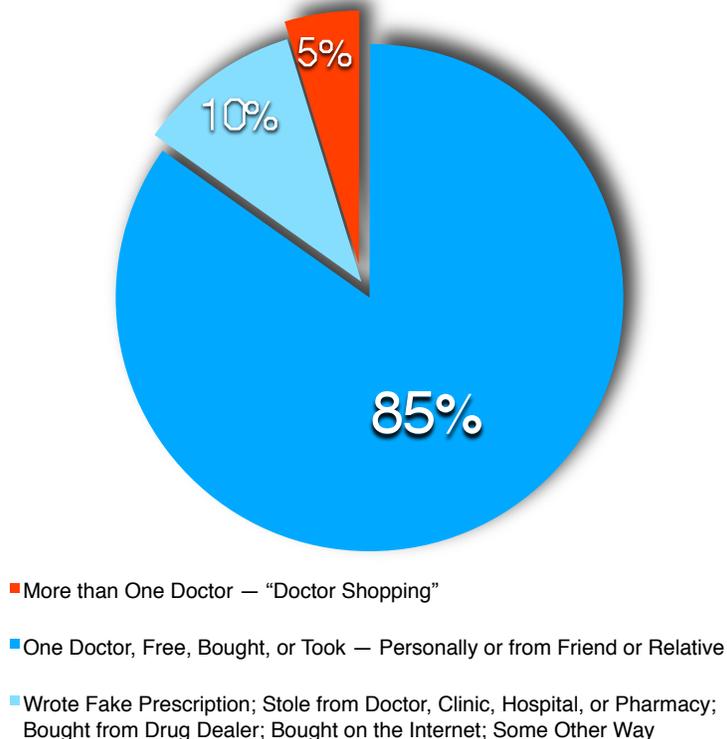


Proponents claim that a PDMP is required to catch all of the “doctor shopping” that makes opioid medications readily available to the public. According to the 2014 National Survey on Drug Use and Health, obtaining pain relievers (opioids) from more than one doctor is minimal. In this [survey](#), the total percentage of users aged 12 and older who obtained pain relievers for

non-medical use from more than one doctor was 5%. 85% got pain medicine from one doctor themselves, got it free from a friend or relative, or bought or took it from a friend or relative who obtained it themselves by one of these four methods. Clearly, doctor shopping is not the massive problem the proponents of PDMPs would have us believe.

Is there any research indicating that PDMPs are effective? The proponents will show small studies that show a limited effectiveness in a few programs (one in Tennessee and one in Florida). Both states have a worse problem than Missouri. A 2011 original research [article](#) in *Pain Medicine* that evaluated prescription drug deaths from 1999 to 2005 found that, “PDMPs were not associated with lower drug overdose mortality rates for any of the study years or

Sources of Diverted Pain Medicine



with decreases (or even with lesser increases) in the rates of death resulting from drug overdoses.”

There are specific scenarios that will not be flagged by a PDMP: When one patient consistently gets the same pain medication from the same physician every month. That is not doctor shopping. But that is how the 85% get their medications. In these instances, there is no PDMP that will catch this type of diversion.

If the PDMPs are ineffective, why do they continue and even expand? The National Alliance for Model State Drug Laws is the organization that is behind the expansion. It believes the PDMP should proactively provide data to every profession and governmental agency who could have access to the database to look for potential signs of misuse or diversion. Proponents argue that if it saves just one life it is worth it. The liberty of millions of citizens must not be infringed because someone else makes a poor decision.

The solution to the problem of prescription drug overdose deaths will not be found in one program or project. The burden of catching diversion of prescription medication mainly falls to the physician. The two primary methods to identify individuals who divert prescription medications are random urine drug screens and pill count visits. There are several sophisticated urine drug tests that will tell the physician if the patient is taking the medication properly by checking for the actual drug and its metabolites in the urine. Doing these tests at random times helps ensure that patients are taking the medication consistently. The second method is a pill count visit. Someone who sells or misuses their medication after getting the prescription filled at a pharmacy generally will do so within the first two weeks of obtaining the medication. In a pill count visit, the physician contacts the patient three to four weeks after writing the prescription and tells them to come in for an office visit and to bring their prescription medication in the bottle dispensed by the pharmacy. If they refuse to make an appointment or if they do not show up for the appointment, that is a good indicator that they did not have any pills left because they had already sold or used their monthly amount. Does government have a role in this solution? The Centers for Disease Control and Prevention (CDC) released a [Guideline](#) for Prescribing Opioids for Chronic Pain. It has finally admitted that it should not be encouraging physicians to prescribe opioids for chronic pain patients.

The Prescription Drug Monitoring Programs are another way for centralized government to collect information and maintain control over citizens without ever solving a problem - which ensures its perpetual existence. This can only be reversed if citizens use their civic authority to control the proper boundaries of centralized government.

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