Testimony of Kimberly Johnson, Director, Maine Office of Substance Abuse to the Senate Committee on Governmental Affairs Regarding Prescription Drug Abuse August 6, 2003

Senator Collins, my name is Kimberly Johnson, and I am the Director of the Maine Office of Substance Abuse. I am pleased to present information to you today regarding the problem of prescription drug abuse in Maine and across the country.

The Office of Substance Abuse is responsible for creating an integrated approach to the problem of alcohol and drug abuse in Maine, and is the state's single administrative unit for "planning, developing, implementing, coordinating, and evaluating all prevention and treatment activities and services."

Our office became aware of growth in prescription drug abuse early in the year 2000. At about the same time law enforcement, particularly in Washington County, began noticing growth in trafficking across the Canadian border and experienced a growth in property crime due to abuse of Oxycontin.

One of the early problems Maine faced was a lack of communication between systems. If the medical community (particularly emergency rooms), law enforcement, poison control, and the treatment field had been collecting and sharing data at the time, we probably could have caught the problem at an earlier stage and addressed it more effectively. As it was, there was not a comprehensive review of the data that existed until the Substance Abuse Services Commission released its report Oxycontin: Maine's Newest Epidemic in January of 2002. This report collated local medical and law enforcement data and reviewed national data to gain a sense of the scope of the problem. The results were alarming.

In FY 1995, fewer than 100 people were admitted to substance abuse treatment in Maine for prescription narcotic abuse. In FY 2000, the last year of data available for the 2001 report, nearly 800 people were admitted for abuse of prescription narcotics. That represented 8% of the treatment population and surpassed all other categories of drug except alcohol and marijuana. That growth trend continued until this year. While all of the data for fiscal year 2003, which ended June 30, is not yet in, the growth in treatment admissions for prescription drug abuse seems to have leveled off. Unfortunately, it has been replaced by growth in admissions due to heroin abuse.

Growth in arrests for prescription drug related crimes also increased dramatically from FY 1997 to 2001. UCR reports indicated that these arrests doubled in the five year period. At that time the problem was localized to primarily Washington and Cumberland counties. Since the Oxycontin report, the problem has leveled off in those two counties, but has grown in other counties, particularly Waldo, Knox and Hancock.

Every other year, OSA performs a school survey regarding drug and alcohol use for students in 6th – 12th grade. In the 2002 administration of the survey, we asked about

abuse of prescription drugs. The results were startling. Twenty-five percent of high school seniors had abused prescription drugs at some point in their lives and 10% had done so within 30 days of administration of the survey.

In the summer of 2002, it became clear that there was a dramatic increase in drug overdose deaths in the city of Portland. The medical examiner's office began a review of five years worth of overdose death data that will be presented to you later today. At the same time, a research team from Yale University, headed by Robert Heimer, PhD, began a naturalistic study of drug users in Portland and in Washington County. While they have not yet published their data, preliminary data that the team has shared with us indicates that of the 238 opiate users interviewed in Portland, 25% used heroin the most and the remainder used prescription narcotics the most. At the time of the study, summer 2002, most of the interviewees were not yet regular injection drug users, and only half of them had ever injected. This research drew a picture for us of a young, relatively inexperienced drug using population. Maine still has very few of the hardened drug addicts that are so often portrayed. Rather, we have a population of young, new users that should be responsive to treatment if it is offered.

Interestingly, despite the attention that has been drawn to Methadone, it did not appear to be a very popular drug among interviewees in the Yale study. Twenty-five percent of the sample had used it at some point, but it was not a preferred drug for most, and was used primarily to stave off withdrawal symptoms. Of the Methadone used, half was reported to be pills obtained for the treatment of pain, and half had come from substance abuse treatment clinics. Most of the Methadone from clinics had been shared by legitimate Methadone patients rather than obtained off the street.

Because historically there has been very little opiate abuse in Maine, there has been very little Methadone treatment. In 1995, two programs opened the first Methadone treatment programs in Maine. The client population was not large enough to support two clinics at the time, and one closed. By 2001, there was a strong demand for more treatment, and the client population at the existing programs had grown dramatically. OSA funded a new program at Acadia Hospital in Bangor and a second Portland area program opened. In the span of two years, the total Methadone treatment population went from a stable population of 300 hundred people to the current 1600, and there is still unmet demand, particularly in Washington County where people are driving to Portland in order to receive their daily dose.

We believe that the recent problems with diversion and abuse of Methadone have to do with the rapid growth in the treatment population as well as the relative naiveté of the drug using population in Maine.

Drug users did not seem to be aware of the pharmaceutical qualities of Methadone and did not distinguish it from the other opiates that they were abusing. They did not understand that it was slow acting as well as long acting and that unlike most drugs of abuse that have a very short action period, Methadone reaches peak blood levels 2 – 4 hours after administration. They attempted to inject it and took repeated doses in order to

get high. We believe that many of the decedents died because while they used the drug with other people, they were alone when peak levels were reached.

Because the two Portland clinics were only opened six days a week, everyone had at least one take home dose a week. This probably increased the availability of Methadone to the non-patient drug users and was a factor in some of the overdose cases, both fatal and non-fatal. OSA chose to exceed the federal regulations and require all clinics to remain open seven days a week.

In August, we reported the concerns with Methadone abuse to the Center for Substance Abuse Treatment, one of the centers in the Substance Abuse, Mental Health Services Authority under the Department of Health and Human Services. CSAT offered technical assistance and help developing and funding public education efforts. We have found CSAT to be very responsive to state needs, and particularly helpful regarding this issue. As CSAT heard from other states that Methadone was being abused, they called together a working group of national experts and people from the various HHS offices to look at the etiology of the growth in Methadone abuse and develop a response.

The meetings, which took place this Spring brought together data from a variety of sources including the CDC, DAWN, ARCOS, TEDS and others. What is clear is that the overdose death issue is more complicated than the press reports. First of all, there has been a large increase in the use of Methadone to treat pain, while the growth of Methadone substance abuse treatment nationally has been moderate. The locales that seem to have developed Methadone abuse problems are places where Methadone is a relatively unknown drug, and there is an inexperienced drug using population, just as we have seen in Maine. In my opinion, the switch of oversight of Methadone treatment from the FDA to SAMHSA is coincidental to the growth in misuse of Methadone. Growth of misuse of Methadone has come from increased availability as it grows as a pain treatment, and out of the desperation of drug addicts that cannot obtain their drug of choice or access appropriate treatment.

Given our experience over the past three years, I would make a number of recommendations for addressing the problem of prescription drug abuse and preventing or providing early intervention to other emerging drug problems. I believe that having the ability to share data across the various systems that deal with drug abuse is critical. I still believe that if OSA had had better data sooner, we could have stopped this problem before it became epidemic. We have begun working with the state Bureau of Health to follow a NIDA created protocol for regular data sharing across systems. We will meet quarterly to share information on trends and emerging issues so that the state health care system, law enforcement, and others can develop a comprehensive plan to address problems as early as we can identify them. Nationally, the DAWN network provides a similar tool, but it is only available for urban areas. CSAT's response to the Methadone overdose issue is another good example of data sharing that could and should happen on a regular basis.

Maine finally passed a bill creating an Electronic Prescription Monitoring Program last session. While these programs remain controversial, I believe it is critical to track the prescribing of scheduled drugs in order to address the prescription drug abuse problem. All states should have these systems, and there ought to be a way to share information across states when it seems relevant. PMP programs raise significant privacy and civil rights issues and must be implemented carefully, but I know of no other way to catch "doctor shoppers" and bad doctors. Maine's program was authorized with no funding, and we are relying on a federal DOJ grant to get started.

I also think that medical providers (physicians, nurse practitioners, physician assistants, and pharmacists) must receive better training in addictions. Most providers don't even ask questions about alcohol consumption, let alone drug use. They are not adept at recognizing the signs of substance abuse and do not know what to do when they have a patient with addictive disorders. Many are very misinformed about appropriate treatment protocols. I also believe that as more primary care providers provide more treatment that was once provided by specialists (for example pain treatment and mental health treatment) the need for knowledge about dealing with addictive disorders and substance abuse becomes more critical.

Providers that treat pain should learn how to appropriately withdraw a person who has become physically dependent on prescription narcotics. Many of the people now treated in addiction clinics began as legitimate pain patients. For some, their experiences with medical practitioners led to their addiction. First of all, medical personnel rarely screen for susceptibility to addictive disorders prior to prescribing potentially addictive medications. Secondly, they often do not handle a patient's growing tolerance to a medication well, interpreting their tolerance as drug seeking or addictive behavior. Finally, medical staff need to learn how to appropriately withdraw patients from medications to which they have developed tolerance and physical dependence, which is not necessarily addiction. For many patients, their addictive behavior began when their need for pain medication was over, but their uncomfortable, even painful withdrawal from their prescribed medication led them to seek other sources of relief, which eventually led to the cycle of addiction that we all know.

Lastly, I am concerned with current marketing practices. While Purdue Pharma has been chastised for its aggressive marketing practices, I am less concerned about marketing to prescribers who should know better through training and experience, and more concerned about direct to consumer marketing. Scheduled drugs are not marketed directly to consumers, but everything else is. When I sit and watch tv with my teenage daughter, I am amazed to see the quantity of ads for prescription drugs. They all have a particular format, which is to make you believe that your mild symptoms of indigestion, PMS, or sadness may in fact be a serious disease for which prescription medication is necessary. In my opinion, these ads have created a sense of urgency about every medical symptom, and have presented the solution as taking a pill. The pills are attractive, the side effects are always described as mild, and the need as serious. The current generation of adolescents was raised watching these ads at the same time they have been watching ads about the dangers of illegal drugs. It should be no surprise to us that they perceive

pharmaceuticals as a safe and effective high. This industry practice is relatively new, and only predates the growth in abuse of prescription drugs by a few years, which helps to confirm the connection in my mind. We restrict type and placement of much commercial speech, and I believe we should address this new practice by pharmaceutical companies as it has created the social climate that has made prescription drug abuse inevitable.

I'd be happy to answer any questions.