Prescription drug abuse is a significant problem in America. One way states are attempting to address this problem is through prescription drug monitoring programs — government-run databases designed to track how doctors and pharmacists in a state prescribe and dispense controlled substances. The goal of these programs is to help identify who is prescribing and being prescribed controlled substances, and to take steps to combat abuse and misuse. Unfortunately, some state lawmakers have either dragged their feet on implementing these programs or have created policies that limit their effectiveness under the guise of protecting privacy.

Prescription drug monitoring programs have a long history. California launched the first continuously running program in 1939 when it began requiring doctors to send carbon copies of handwritten prescriptions to the state’s Department of Justice. In the intervening years, states began to do this electronically, and almost all states adopted some variation of this program, with the vast majority doing this after 2002 when Congress began providing grants to help pay for them.

And by most accounts they have largely been successful. For example, a year after implementing its program, New York had a 75 percent drop in patients going to multiple doctors for the same drug.
These programs have become especially vital with rising concerns about opioid addiction — **every day 44 people die** in the U.S. as a result of overdosing on prescription painkillers. But here too prescription drug monitoring programs have been effective. Florida, for example, reported a **50 percent drop in oxycodone deaths** two years after establishing its prescription drug monitoring program. And the Centers for Disease Control and Prevention call prescription drug monitoring programs **“among the most promising state-level interventions”** to combat the abuse of prescription opioids.

Yet for all their successes, progress has been an uphill struggle. Consider recent events in Missouri. In April, the **Missouri Senate** approved legislation to create its own prescription drug monitoring program, putting it on track to becoming the **final state** in the country to implement such a program. This was a long overdue reform, but they have run into constant roadblocks from those who view any effort at using data-driven interventions as too privacy intrusive. For example, in the recently passed Missouri bill, one legislator limited the amount of time the government could keep records to **180 days**. While **many states** limit how long the government can keep the data, such a short retention period is counterproductive. This means that doctors would have no information about treating a patient who has relapsed after as little as six months.

Other states have imposed restrictions that limit the effectiveness of their databases. For example, some states **do not require** providers to report data immediately. Alaska only requires pharmacies to report data monthly, and a handful of states, such as Texas, Georgia and Florida, only require weekly reporting. Other states limit how data can be shared, such as by not allowing **interstate data sharing**, or permitting it in their statutes, but then not implementing **data-sharing agreements** with other states. The result is that a patient can get a prescription in one state and drive across the border to get it filled without anyone being the wiser.

Finally, while many states produce de-identified data for research purposes, some states **only allow government employees** to do this analysis. So after investing millions into building these databases and producing anonymized data, these states are limiting public health researchers at top universities from using this de-identified data to study prescription drug addiction. These arbitrary limits on using de-identified data simply make no sense.

Prescription drug monitoring programs are not a silver bullet, but they create much of the data that health-care workers, law enforcement officials and public health experts will need to address this problem. As the **opiod epidemic** continues to escalate, hopefully state policymakers will stop resisting efforts to use data in the fight against addiction and pay more attention to questions about whether prescription drug monitoring programs have everything they need to be maximally effective.