EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
Washington, D.C. 20503

"Attacking America's Epidemic of Heroin and Prescription Drug Abuse"

Committee on the Judiciary
United States Senate

Wednesday, January 27, 2016
10:00 a.m.
226 Dirksen Senate Office Building

Statement of
Michael P. Botticelli
Director of National Drug Control Policy

Chairman Grassley, Ranking Member Leahy, and members of the Committee, thank you for this opportunity to address the issues surrounding opioid drugs, including heroin and fentanyl in the United States, and the Federal response. As you know, this is an important concern for President Obama, who traveled to West Virginia in October to highlight this public health and public safety challenge. During his State of the Union address earlier this month, the President specifically mentioned addressing prescription drug and heroin abuse as a priority – and an opportunity to work with Congress in a bipartisan manner on this issue that transcends political party, income level, gender, and race.

The Office of National Drug Control Policy (ONDCP) was established by Congress in 1988 with the principal purpose of reducing illicit drug use, manufacturing, and trafficking; drug-related crime and violence; and drug-related health consequences. As a component of the Executive Office of the President, ONDCP establishes policies, priorities, and objectives for the Nation's drug control programs and ensures that adequate resources are provided to implement them. We also develop, evaluate, coordinate, and oversee the international and domestic anti-drug efforts of Executive Branch agencies and ensure such efforts sustain and complement state and local drug policy activities.

At ONDCP, we are charged with producing the *National Drug Control Strategy* (*Strategy*), the Administration's primary blueprint for drug policy, along with a national drug control budget. The *Strategy* is a 21st century plan that outlines a series of evidence-based reforms that treat our Nation's drug problem as a public health challenge, not just a criminal justice issue. It is guided by what science, experience, and compassion demonstrate about the true nature of drug use in America. We recognize that any policies to limit the prescribing of opioids need to take into account patients' legitimate need for pain medications.

The considerable public health and safety consequences of nonmedical prescription opioid, heroin, and illicit fentanyl use underscore the need for action. Since the Administration's inaugural 2010 *Strategy*, we have deployed a comprehensive and evidence-based strategy to address opioid use disorders and opioid induced overdose deaths. The Administration has increased access to treatment for substance use disorders, expanded efforts to prevent overdose, and coordinated a Government-wide response to address the consequences of opioid misuse. We also have continued to pursue actions against criminal organizations trafficking in opioid drugs.

This statement focuses largely on the Administration's interventions to address opioid drug misuse, as well as those of our Federal, state, and local partners that are involved with opioid prescribing or the prevention and treatment of opioid misuse.

Opioid Use Trends and Consequences

Opioids – a category of drugs that includes heroin and prescription pain medicines like oxycodone, oxymorphone, and hydrocodone – are having a considerable impact on public health and safety in communities across the United States. According to the Centers for Disease Control and Prevention (CDC), approximately 129 Americans on average died from a drug overdose

every day in 2014.[1] Of the 47,055 drug overdose deaths in 2014, heroin was involved in 10,574 drug overdose deaths, while opioid analgesics were involved in 20,808 drug overdose deaths. Among the opioid analgesic category, there were more than 5,544 drug overdose deaths involving synthetic narcotics other than methadone, which includes fentanyl. This number has more than doubled from two years earlier (2,628 in 2012). Moreover, overdose deaths involving opioids are likely undercounted. Of deaths where drug overdose is cited as the underlying cause of death, approximately one-fifth of the death certificates do not list the drug responsible for the fatal overdose.[2]

The Administration continues to focus on vulnerable populations affected by opioids, including pregnant women and their newborns. When used chronically by pregnant women, both prescription opioids and heroin can cause withdrawal symptoms in newborns at birth; if these opioids were withdrawn during pregnancy, fetal harm could result. From 2000 to 2009 the number of infants displaying symptoms of drug withdrawal after birth, known as neonatal abstinence syndrome (NAS), increased approximately threefold nationwide.[3] Newborns with NAS have more complicated and longer initial hospitalizations than other newborns.[4] Newly published data show the rate of NAS incidence per 1,000 births increased 40 percent, from 3.4 in 2009 to 5.8 in 2012.[5]

Overdose rates are still too high; however, the Nation is making some progress in addressing prescription opioid misuse. In 2014, more than 4.3 million Americans ages 12 and older reported using prescription pain relievers non-medically within the past month, down from 4.5 million in 2013 and as high as 5.3 million in 2009.[6] The number of Americans 12 and older initiating the nonmedical use of prescription pain relievers in the past year also has decreased from 2009 to 2014, from 2.2 million to 1.4 million.[7] Additionally, according to the latest Monitoring the Future survey, the rate of past-year use among high school seniors of narcotics other than heroin, including OxyContin or Vicodin, in 2015 is its lowest since 2002.[8]

While progress has been made in reducing nonmedical use of prescription opioids, it has been counteracted by a rise in availability and use of heroin, although nonmedical prescription

---

[1] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death, 1999-2014 on CDC WONDER Online Database, released 2015. Extracted by ONDCP from http://wonder.cdc.gov/mcd-icd10.html on December 9, 2015.

[2] Rudd, RA, Aleshire, N, Zibbell, JE, and Gladden, RM. Increases in Drug and Opioid Overdose Deaths – 2000-2014. Centers for Disease Control and Prevention: Mortality and Morbidity Weekly Report. Jan. 1, 2016. 64(50);1378-82. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm?s_cid=mm6450a3_w

[3] Patrick, Stephen W., et al. Neonatal Abstinence Syndrome and Associated Health Care Expenditures: United States, 2000-2009 (2012). Journal of the American Medical Association. 2012 May 9;307(18):1934-40. doi:10.1001/jama.2012.3951. Epub 2012 Apr 30. Available at: http://www.ncbi.nlm.nih.gov/pubmed/22546608.

[4] Patrick, SW, Schumacher, RE, Benneyworth, BD, Krans, EE, McAllister, JM, & Davis, MM. (2012). Neonatal abstinence syndrome and associated health care expenditures: United States, 2000-2009. Journal of the American Medical Association, 307(18): 1934-40. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/22546608.

[5] Patrick, SW, Davis, MM, Lehman, CU, and Cooper, WO. Increasing incidence and geographic distribution of neonatal abstinence syndrome: United States 2009-2012. Journal of Perinatology (2015): 1-6 online publication, April 30, 2015; doi:10.1038/jp.2015.36

[6] Substance Abuse and Mental Health Services Administration. Results from the 2014 National Survey on Drug Use and Health: Detailed Tables. Department of Health and Human Services. [September 2015] *Table 7.3A – Types of Illicit Drug Use in the Past Month among Persons Aged 12 or Older: Numbers in Thousands, 2002-2014* Available at: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH-DetTabs2014.htm#tab7-3a

[7] Substance Abuse and Mental Health Services Administration. *Results from the 2014 National Survey on Drug Use and Health: Detailed Tables*. Department of Health and Human Services. [September 2015] *Table 7.44A – Past Year Initiation of Substance Use among Persons Aged 12 or Older: Numbers in Thousands, 2002-2014* Available at: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH-DetTabs2014.htm#tab7-44a

[8] The Monitoring the Future study. *Narcotics other than Heroin: Trends in Annual Use and Availability – Grades 8, 10, and 12*. University of Michigan. [December 2015]. Available: http://www.monitoringthefuture.org/data/15data/15drfig8.pdf

opioid use continues to far surpass heroin use. The number of past-year heroin users increased from 373,000 in 2007 to 914,000 in 2014,[9] and approximately 435,000 Americans reported past-month use of heroin in 2014.[10] These figures likely undercount the number of users, as national household surveys do not track all heroin-using populations, such as homeless users.

Heroin use and deaths involving heroin use are rising significantly throughout the United States among men and women, in most age groups, and regardless of income level. [11] Since 2007, there has been a 340 percent increase in heroin-involved overdose deaths, from 2,402 in 2007 to 10,574 in 2014.[12] Additionally, heroin purity has been rising since 2010, while prices have remained low.[13] This increase in purity permits heroin use by snorting or smoking, which broadens the drug's appeal to a population that previously was disinclined to inject the drug intravenously.

Similar trends concerning growth in heroin use are reflected in the country's substance use disorder treatment system. Data show a near tripling in the past 10 years of treatment admissions for individuals primarily seeking treatment for non-heroin opiate use disorder, from 52,768 in 2003 to 154,778 in 2013. During the same period, the number of admissions for primary heroin abuse increased by 15 percent (from 274,459 to 316,797).[14] Although all states have not yet reported specialty treatment admission data for 2013 and 2014, the states that have reported show an increase in the proportion of primary treatment admissions that are for heroin use.[15]

The heroin crisis is being compounded by the reemergence of illicit fentanyl, a powerful Schedule II synthetic opioid analgesic more potent than morphine or heroin.[16] Fentanyl is sometimes added to heroin to increase the product's potency, or mixed with adulterants and sold as heroin with or without the buyer's knowledge. Since fentanyl is more potent than heroin, its use increases risks for overdose death, even among individuals who are chronic opioid users.[17]

Some states are being hit especially hard by fentanyl-related overdoses. For example, Ohio state medical authorities report there were 514 fentanyl-related overdose deaths in Ohio in

---

[9] Substance Abuse and Mental Health Services Administration. Results from the 2014 National Survey on Drug Use and Health: Detailed Tables. Department of Health and Human Services. [September 2015] *Table 7.2A – Types of Illicit Drug Use in the Past Year among Persons Aged 12 or Older: Numbers in Thousands, 2002-2014.* Available at: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH-DetTabs2014.htm#tab7-2a.

[10] Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, *National Survey on Drug Use and Health, 2013 and 2014: Table 1.1A Types of Illicit Drug Use in Lifetime, Past Year, and Past Month among Persons Aged 12 or Older: Numbers in Thousands, 2013 and 2014.*

[11] Jones et. al., Vital Signs: Demographic and Substance Use Trends Among Heroin Users – United States, 2002-2013, Morbidity and Mortality Weekly Report (July 2015) 64(26); 719-725.

[12] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death, 1999-2014 on CDC WONDER Online Database, released 2015. Extracted by ONDCP from http://wonder.cdc.gov/mcd-icd10.html on December 9, 2015.

[13] Drug Enforcement Administration, El Paso Intelligence Center, National Seizure System, 2008-2014; and Drug Enforcement Administration. Strategic Intelligence Section. 2015 National Heroin Threat Assessment. DEA-DCT-DIR-039-15.

[14] Substance Abuse and Mental Health Services Administration, *Treatment Episode Data Set (TEDS): 2003-2013. National Admissions to Substance Abuse Treatment Services.* [*Table 1.1a. Admissions aged 12 and older, by primary substance of abuse: Number, 2003-2013*]. U.S. Department of Health and Human Services. [December 2015]. Available: http://www.samhsa.gov/data/sites/default/files/2003_2013_TEDS_National/2003_2013_Treatment_Episode_Data_Set_National.pdf.

[15] Substance Abuse and Mental Health Services Administration. *Treatment Episode Data Set (TEDS) Substance Abuse Treatment extracted 6/2/2015* http://wwwdasis.samhsa.gov/webt/newmapv1.htm

[16] Zuurmond WW, Meert TF, and Noorduin H. (2002). Partial versus full agonists for opioid-mediated analgesia--focus on fentanyl and buprenorphine. Acta Anaesthesiol Belg, 53(3):193-201.

[17] U.S. Department of Justice, Drug Enforcement Administration, *DEA Issues Nationwide Alert on Fentanyl as Threat to Health and Public Safety*, 2015. http://www.dea.gov/divisions/hq/2015/hq031815.shtml

2014 alone – up from 92 in the previous year.[18] And in New Hampshire, the Office of the Chief Medical Examiner reports that out of 385 drug deaths in 2015 (an additional 45 are pending toxicology results), 351 involved opioids. Of those deaths involving opioids, 253 involved fentanyl and 74 involved heroin.[19]

It is important to note the complex relationship that exists between nonmedical prescription opioid use and heroin use. A report from the Substance Abuse and Mental Health Services Administration (SAMHSA) found that the majority of current heroin users report nonmedical prescription opioid use prior to initiating heroin use, but heroin use among nonmedical prescription opioid users is rare, and the transition to heroin occurs at a low rate.[20] However, a review article in the New England Journal of Medicine concluded that the transition from nonmedical prescription opioid use to heroin use appears to be part of the progression of the substance use disorder in a subgroup of nonmedical users of prescription opioids, primarily among persons with frequent nonmedical use and those with prescription opioid abuse or dependence.[21] This indicates that a certain segment of the population is at higher risk of developing an opioid use disorder and transitioning from nonmedical prescription opioid use to heroin use. This behavior dramatically increases their risk of exposure to blood-borne infections from injection drug use, including human immunodeficiency virus (HIV) and hepatitis C. Intravenous use of the prescription opioid oxymorphone recently spurred an HIV outbreak in southeast Indiana. Since the first patient in the outbreak was identified in January 2015, 184 people have tested positive for HIV.[22]

Additionally, an evaluation of recent healthcare claims data found that a majority of non-fatal opioid overdose victims were receiving an opioid from a prescriber at the time of their overdose and that 91 percent of victims received an opioid prescription again from a prescriber following their overdose.[23] This includes overdose due to a prescription opioid or heroin. This study also found that the percentage of people who overdosed a second time was double among those with an active prescription compared to those without one, and those on the highest doses of opioids were at significantly greater risk of overdosing.

This interrelationship between prescription opioids and heroin indicates that we must continue to push for mandatory education and training of opioid prescribers to alleviate the circumstances discussed above.

Mexico is a primary supplier of heroin to the United States, with Mexican drug traffickers producing heroin in Mexico and smuggling the finished product into the United States

---

[18] 2014 Ohio Drug Overdose Preliminary Data: General Findings, Ohio Department of Health, Office of Vital Statistics; Analysis Conducted by Injury Prevention Program. Available at: http://www.healthy.ohio.gov/~/media/HealthyOhio/ASSETS/Files/injury%20prevention/2014%20Ohio%20Preliminary%20Overdose%20Report.pdf. Accessed 11-24-15.

[19] Personal Communication. January 14, 2016. New Hampshire Office of the Chief Medical Examiner.

[20] Muhuri, P.K., Gfroerer, J.C., Davies, MC. SAMHSA CBHSQ Data Review. Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States. August 2013. Available at: http://archive.samhsa.gov/data/2k13/DataReview/DR006/nonmedical-pain-reliever-use-2013.pdf.

[21] Compton, W.M., Jones, C.M., and Baldwin, G.T.. *Relationship Between Nonmedical Prescription Opioid Use and Heroin Use*. N Engl J Med 2016; 374:154-163. January 14, 2016. DOI: 10.1056/NEJMra1508490. Available at: http://www.nejm.org/doi/full/10.1056/NEJMra1508490

[22] Morbidity and Mortality Weekly Report (MMWR), Community Outbreak of HIV Infection Linked to Injection Drug Use of Oxymorphone — Indiana, 2015, 64 (16); p 443-444, May 1, 2015. Data from State of Indiana https://secure.in.gov/isdh/26649.htm

[23] Larochelle, Mark R., et al. *Opioid Prescribing After Nonfatal Overdose and Association with Repeated Overdose*. Annals of Internal Medicine. doi: 10.7326/M15-0038. Published: December 29, 2015.

through a variety of means.[24] Opium poppy cultivation in Mexico has increased substantially in recent years, rising from 11,000 hectares in 2013, with an estimated potential pure heroin production of 26 metric tons, to 17,000 hectares in 2014 with potential production of 42 metric tons of pure heroin.[25] Illicit fentanyl, which is sometimes used as an adulterant and mixed with lower grade heroin or sold as "synthetic heroin," comes from several sources including pharmaceutical fentanyl diverted from legal medical use and clandestine fentanyl that is manufactured, usually in Mexico using precursor chemicals, often from China.[26]

The Administration's Response

President Obama's inaugural *National Drug Control Strategy*, released in May 2010, labeled opioid overdose a "growing national crisis" and laid out specific actions and goals for reducing nonmedical prescription opioid and heroin use.[27] In April 2011, the Administration released a comprehensive *Prescription Drug Abuse Prevention Plan (Plan)*,[28] which created a national framework for reducing prescription drug diversion and misuse. The *Plan* focuses on: improving education for patients and healthcare providers; supporting the expansion of state-based prescription drug monitoring programs; developing more convenient and environmentally responsible disposal methods to remove unused and unneeded medications from the home; and reducing the prevalence of pill mills and doctor shopping through targeted enforcement efforts.

Graduate medical education programs may not provide a comprehensive focus on the identification or treatment of substance use disorders, and since the opioid drug epidemic is connected to overprescribing of prescription opioid drugs in the United States, the first pillar of the *Plan* focuses on ensuring that prescribers are better trained on the dangers of misuse and abuse of prescription drugs. Much progress has been made in expanding available continuing education for prescribers. At least ten states (Connecticut,[29] Delaware,[30] Iowa,[31] Kentucky,[32] Massachusetts,[33] Nevada,[34] New Mexico,[35] Tennessee,[36] Utah,[37] and West Virginia[38]) have passed legislation mandating education for prescribers.

At the Federal level, in West Virginia President Obama announced a Presidential Memorandum requiring all Federal agencies, to the extent permitted by law, to provide training on the appropriate and effective prescribing of opioid medications to all employees and certain

---

[24] Drug Enforcement Administration. Strategic Intelligence Section. 2015 National Heroin Threat Assessment. DEA-DCT-DIR-039-15.

[25] US Department of State, Bureau of International Narcotics and Law Enforcement Affairs. International Narcotics Control Strategy Report - 2015 [INCSR] (March 2015) for data from 2013 - 2014 and unpublished U.S. Government Estimates.

[26] Drug Enforcement Administration. Strategic Intelligence Section. 2015 National Heroin Threat Assessment. DEA-DCT-DIR-039-15.

[27] Office of National Drug Control Policy. *2010 National Drug Control Strategy*. Executive Office of the President. [2010]. Available: http://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/ndcs2010.pdf#page=49

[28] Office of National Drug Control Policy. *Epidemic: Responding to America's Prescription Drug Abuse Crisis* [2011] Available: http://www.whitehouse.gov/sites/default/files/ondcp/issues-content/prescription-drugs/rx_abuse_plan.pdf

[29] CONN. GEN. STAT. § 20-10b (2015), *available at* http://www.cga.ct.gov/2015/ACT/PA/2015PA-00198-R00HB-06856-PA.htm

[30] 24 DEL. CODE ANN. § 3.1.1, *available at* http://regulations.delaware.gov/AdminCode/title24/Uniform%20Controlled%20Substances%20Act%20Regulations.pdf.

[31] IOWA ADMIN. CODE r. 253-11.4 (2011), *available at* https://www.legis.iowa.gov/docs/ACO/chapter/07-22-2015.653.11.pdf.

[32] 201 Ky. Admin. Reg. 9:250 (2013), *available at* http://www.lrc.ky.gov/kar/201/009/250.htm.

[33] MASS. GEN. LAWS ch. 94C, § 18(e) (2011), *available at* https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXV/Chapter94c/Section18.

[34] NV. SB 459 (2015), *available at* https://www.leg.state.nv.us/Session/78th2015/Reports/history.cfm?BillName=SB459

[35] N.M. ADMIN. CODE § 16-10-14 (2012), *available at* http://164.64.110.239/nmac/parts/title16/16.010.0014.htm.

[36] TENN. CODE ANN. § 63-1-402 (2013), *available at* http://www.tn.gov/sos/acts/108/pub/pc0430.pdf.

[37] UTAH ADMIN. CODE r. 58-37-6.5 (2012), *available at* http://le.utah.gov/xcode/Title58/Chapter37/58-37-S6.5.html?v=C58-37-S6.5_1800010118000101.

[38] W. VA. CODE § 30-1-7A (2011), *available at* http://www.legis.state.wv.us/wvcode/ChapterEntire.cfm?chap=30&art=1&section=7A.

contractors who are health care professionals and who prescribe controlled substances as part of their Federal responsibilities and duties.[39] Additionally, the Administration has developed and made available free and low-cost training options for prescribers and dispensers of opioid medications via several sources, including SAMHSA and the National Institute on Drug Abuse at the National Institutes of Health. Also, the Food and Drug Administration (FDA) now requires manufacturers of extended-release and long-acting opioid pain relievers to make available free or low-cost continuing education to prescribers under the Risk Evaluation and Mitigation Strategy for these drugs. And recently, CDC has issued a draft guideline to provide recommendations for the prescribing of opioid pain medication for patients 18 and older in primary care settings, focusing on the use of opioids in treating chronic pain outside of active cancer treatment, palliative care, and end-of-life care. Comments to the draft guidelines are currently being reviewed.

In order to help prescribers and pharmacists identify patients who may be at risk for substance use disorders, overdose, or other significant health consequences of misusing prescription opioids, the second area of the Administration's *Plan* focuses on improving the operation and functionality of state-administered prescription drug monitoring programs (PDMP). PDMPs provide prescribers with information on the types and frequency of prescribed controlled substances. State regulatory and law enforcement agencies may also use this information to identify and prevent unsafe prescribing, doctor shopping, and other methods of diverting controlled substances. Research also shows that PDMPs may have a role in reducing the rates of prescribing for opioid analgesics.[40]

In 2006, only 20 states had PDMPs. Today, the District of Columbia has a law authorizing a PDMP, and 49 states have operational programs.[41] At least Kentucky,[42] New Jersey,[43] New Mexico,[44] New York,[45] Oklahoma,[46] and Tennessee[47] require their prescribers to use the state's PDMP prior to prescribing a controlled substance in, which can have very beneficial results. For example, in Tennessee, there has been a 38 percent decrease in the number of high-utilizing patients of opioid pain relievers since the mandatory requirement to check the PDMP went into effect on January 1, 2013.[48]

The Department of Justice's (DOJ) Bureau of Justice Assistance (BJA) is supporting expanded interstate sharing of PDMP data. Currently, due to efforts of BJA, the Department of Health and Human Services (HHS), ONDCP, and stakeholders such as National Association of Boards of Pharmacies, at least 34 states have some ability to request and share data across state

---

[39] Presidential Memorandum -- Addressing Prescription Drug Abuse and Heroin Use (October 21, 2015). Available at: https://www.whitehouse.gov/the-press-office/2015/10/21/presidential-memorandum-addressing-prescription-drug-abuse-and-heroin.
[40] Brady, JE, Wunsch, H, Dimaggio, C, Lang, BH, Giglio, J, and Li, G. Prescription drug monitoring and dispensing of prescription opioids. Public Health Reports 2014, 129 (2): 139-47. http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3904893/pdf/phr129000139.pdf
[41] National Alliance of Model State Drug Laws. (2014). Status of State Prescription Drug Monitoring Programs (PDMPs). Retrieved from http://www.namsdl.org/library/16666FCC-65BE-F4BB-A2BBAD44E1BC7031/.
[42] Kentucky 201 KAR 9:260. 2012. Available at http://www.lrc.ky.gov/kar/201/009/260.htm
[43] P.L. 2015, c.74 (N.J. 2015), *available at* http://www.njleg.state.nj.us/2014/Bills/AL15/74_.PDF
[44] New Mexico Register. 16.12.9.9. November 15, 2012. Available at http://www.nmcpr.state.nm.us/new-mexico-register/prev_issues/prev_issuesxxiii/xxiii21/16.12.9amend
[45] New York 3343-A. 2012. Available at http://law.justia.com/codes/new-york/2012/pbh/article-33/title-4/3343-a
[46] Oklahoma 3251. 2010. Available at http://www.oklegislature.gov/cf_pdf/2009-10%20FLR/hflr/HB3251%20hflr.pdf
[47] Tennessee 2253. 53-10-310. 2012. Available at http://www.tn.gov/sos/acts/107/pub/pc0880.pdf
[48] Tennessee Department of Health Controlled Substance Monitoring Database Committee. Controlled Substance Monitoring Database 2015 Report to the 109th Tennessee General Assembly, February 1, 2015. Page 10. Available at https://www.tn.gov/assets/entities/health/attachments/CSMD_AnnualReport_2015.pdf

lines.[49] HHS has invested significant resources to make PDMPs more user-friendly, so healthcare providers can access them quickly and easily as part of their clinical workflow. Since the inception of BJA's grant program in Fiscal Year (FY) 2002, grants have been awarded to 49 states and 1 U.S. territory. In recent years, the grant program has been expanded to include tribal participation and to give support to states and localities to expand collaborative efforts between public health and public safety professionals.

In addition, the Consolidated Appropriations Act, 2016 (Pub. L. 114-113) includes a total of $70 million (an increase of $50 million) to scale up CDC's *Prescription Drug Overdose Prevention for States* program. This program provides grants to states to help implement tailored, state-based prevention strategies such as maximizing PDMPs, enhancing public insurer mechanisms to prevent overdoses, and evaluating state policies and programs aimed at addressing the opioid epidemic.

Data show that approximately 66 percent of past-year nonmedical users of prescription pain relievers report getting them from a friend or relative the last time they used them, and approximately 84 percent of the time, that friend or relative obtained the pain relievers from one doctor.[50] Therefore, the third area of the *Plan* focuses on safely removing millions of pounds of expired and unneeded prescription medications from circulation. Since September 2010, the Drug Enforcement Administration (DEA) has partnered with hundreds of state and local law enforcement agencies and community coalitions, as well as other Federal agencies, to hold 10 National Prescription Take-Back Days. Cumulatively, these events allowed DEA to collect and safely dispose of more than 5.5 million pounds of unneeded or expired medications.[51] In addition, DEA published a Final Rule for the Disposal of Controlled Substances, which took effect October 9, 2014.[52] This regulation expands the options available to securely and safely dispose of unneeded prescription medications. ONDCP and DEA have engaged with Federal, state, and local agencies, and other stakeholders to educate the public about the new rule and expand local drug disposal programs.

The final part of the *Plan* focuses on improving law enforcement capabilities to reduce the diversion of prescription opioids. Federal law enforcement, including our partners at DEA, are working with state and local agencies to reduce pill mills, and prosecute and eradicate unscrupulous registrants or anyone engaging in illegal prescribing practices.

Additionally, the Administration has focused on several key areas to reduce and prevent opioid overdoses from prescription opioids and heroin, including educating the public about overdose risk and interventions; increasing third-party and first responder access to the opioid overdose reversal medication naloxone; working with states to promote Good Samaritan laws; and connecting overdose victims and persons with an opioid use disorder to treatment.

---

[49] Association of Boards of Pharmacy. Three Additional States Sign Agreement to Participate in NABP PMP Interconnect. (December 24, 2015). Available at: https://www.nabp.net/news/three-additional-states-sign-agreement-to-participate-in-nabp-pmp-interconnect

[50] Substance Abuse and Mental Health Services Administration. *Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings*. Department of Health and Human Services. [September 2014]. Available: http://www.samhsa.gov/data/sites/default/files/NSDUHresultsPDFWHTML2013/Web/NSDUHresults2013.htm#2.16

[51] Drug Enforcement Administration. "DEA's Prescription Drug Take-Back Effort - A Big Success." Department of Justice. [October 1, 2015]. Available: http://www.dea.gov/divisions/hq/2015/hq100115.shtml

[52] Disposal of Controlled Substances, 79 Fed. Reg. 53519 (Sep. 9, 2014). Available: https://www.federalregister.gov/articles/2014/09/09/2014-20926/disposal-of-controlled-substances

The Administration continues to promote the use of naloxone by those likely to encounter overdose victims, especially first responders and caregivers. Prior to 2012, just six states had any laws that expanded access to naloxone or limited criminal liability for persons that took steps to assist an overdose victim. Today, 46 states and the District of Columbia have enacted statutes that expand access to naloxone or provide "Good Samaritan" protections for possession of a controlled substance if emergency assistance is sought for a victim of an opioid overdose.[53] In addition, in 2014, FDA approved a naloxone auto-injector, Evzio, and in 2015, a nasal formulation of naloxone, Narcan. These two delivery methods should facilitate administration of naloxone by third parties who would be hesitant to administer the drug via injection when they encounter an overdose.

The expansion of treatment services for persons with opioid and other substance use disorders has been a key focus of the Administration. The Affordable Care Act and Federal parity laws are extending access to mental health benefits and substance use disorder services for an estimated 62 million Americans.[54] This represents the largest expansion of treatment access in a generation, and could help guide millions into successful recovery.

The FY 2016 appropriations act provides more than $400 million in funding specifically to address the opioid epidemic, an increase of more than $100 million over the previous year. It includes a $35 million increase for SAMHSA to expand medication-assisted treatment for opioid use disorders in high-risk communities, increase the use of the overdose-reversal drug naloxone, and improve prevention efforts, as well as a $38 million increase in SAMHSA Block Grant funding, which is distributed among all 50 states to prevent substance use and treat substance use disorders. It also includes $7 million in funding for the DOJ Community Oriented Policing Services' Anti-Heroin Task Force grants to help communities form innovative partnerships that address the opioid epidemic, and $116 million for the Bureau of Prisons to provide appropriate substance use disorder treatment for eligible inmates. The act also allows high-risk communities to use Federal funds for services associated with syringe service programs and increases funding for general drug prevention, anti-trafficking and treatment programs.

To address the emerging rise in heroin and illicit fentanyl use and availability, the *National Drug Control Strategy* focuses on identifying, disrupting and dismantling criminal organizations trafficking in opioid drugs; working with the international community to reduce cultivation of poppy; identifying labs creating dangerous synthetic opioids like fentanyl and acetyl-fentanyl; and enhancing efforts along the Nation's borders to decrease the flow of these drugs into our country.

Expanding on these efforts, in October, ONDCP created the National Heroin Coordination Group, a multi-disciplinary team of subject matter experts to lead Federal efforts to reduce the availability of heroin and fentanyl in the United States. This hub of interagency partners will leverage their home agency authorities and resources to disrupt the heroin and illicit

[53] Only IA, KS, MT and WY do not have such laws.
[54] Berino, K., Rosa, P., Skopec, L. & Glied, S. (2013). Affordable Care Act Will Expand Mental Health and Substance Use Disorder Benefits and Parity Protections for 62 Million Americans. *Research Brief.* Assistant Secretary for Planning and Evaluation (ASPE). Washington, DC (Citation: Abstract of the Brief found at http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.cfm)

fentanyl supply chain coming into the U.S. and will establish mechanisms for interagency collaboration and information-sharing focused on heroin and fentanyl.

And at the end of last year, the Administration released the report of the Congressionally-mandated interagency Heroin Task Force co-chaired by ONDCP and DOJ. The report includes recommendations of Federal agency experts in law enforcement, medicine, public health and education, providing emerging evidence-based public health and public safety models for Federal agency engagement in activities that promote solutions to reduce demand or decrease spread of disease.

In addition, this past summer, ONDCP committed $2.5 million in High Intensity Drug Trafficking Areas (HIDTA) Program funds to develop a strategy to respond to the Nation's heroin epidemic. This unprecedented project by ONDCP combines prevention, education, intelligence, and enforcement resources to address the heroin threat across 15 states and the District of Columbia. The effort will be carried out through a unique partnership of five regional HIDTAs – Appalachia, New England, New York/New Jersey, Philadelphia/Camden, and Washington/Baltimore. The HIDTA Program is a locally-based program that responds to the drug trafficking issues facing specific areas of the country. Law enforcement agencies at all levels of government share information and implement coordinated enforcement activities; enhance intelligence sharing among Federal, state, local, and tribal law enforcement agencies; provide reliable intelligence to law enforcement agencies to develop effective enforcement strategies and operations; and support coordinated law enforcement strategies to maximize available resources and reduce the supply of illegal drugs in designated areas. The HIDTA heroin response strategy will foster a collaborative network of public health-public safety partnerships, sharing best practices, innovative pilots, and identifying new opportunities to leverage resources.

Our Federal law enforcement agencies are aggressively addressing the heroin and fentanyl issue here and abroad through a variety of means. The DEA and other U.S. Federal law enforcement agencies have co-located Special Agents with international partners such as Mexico, in South America, and in other parts of the world to assist in criminal investigations targeting drug trafficking organizations, and to help develop their capacity to conduct the full range of narcotics interdiction activities within their countries to target both heroin and fentanyl. Our Federal law enforcement agencies, in conjunction with the Department of State, are working with the countries who supply fentanyl and the precursor chemicals used in its manufacture to stem the flow of these dangerous chemicals to the Western Hemisphere. And along our southwest border, U.S. Customs and Border Protection continues to detect and interdict heroin and illicit fentanyl entering the United States, and to apprehend those attempting to bring these dangerous drugs into our communities.

Conclusion

The Administration continues to work with our Federal, state, local, and tribal partners to reduce and prevent the health and safety consequences of nonmedical prescription opioid, heroin, and fentanyl use. Together with all of you, we are committed partners, working to reduce the prevalence of substance use disorders through prevention, increasing access to treatment, and

helping individuals recover from the disease of addiction. Thank you for the opportunity to testify here today, and for your ongoing commitment to these issues. I look forward to continuing to work with you on these pressing public health matters.