Responses to Questions for the Record
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following hearing entitled,
"Defeating Fentanyl: Addressing the Deadliest Drugs Fueling the Opioid Crisis"
April 11, 2018

Questions from Senator Christopher Coons

1. Wilmington's *News Journal*, reported that between Friday, April 6, 2018, and Monday, April 9, 2018, 36 Delawareans overdosed statewide. In 2016 alone, 154 Delawareans died from opioid-related overdoses, which is a rate of 16.9 deaths per 100,000 persons and higher than the national rate. Delaware is not alone in facing this epidemic. Based on your experience with the opioid epidemic, what are some best practices Delaware should consider implementing?

RESPONSE: The Office of National Drug Control Policy (ONDCP) recommends Delaware implement best practices that align with the three focus areas of President Trump's Initiative to Stop Opioid Abuse and Reduce Drug Supply and Demand.[1] Delaware can reduce demand and over-prescription through public awareness about the dangers of prescription and illicit opioid abuse. Recently, the ONDCP, the Ad Council, and the Truth Initiative launched a campaign to stop youth opioid abuse that focuses on preventing and reducing the misuse of opioids among youth and young adults. Delaware could begin working with media outlets in the state to show these important public service announcements. To further reduce demand, ONDCP recommends that Delaware work with treatment providers to ensure they are aware about the Centers for Disease Control and Prevention's Guideline for Prescribing Opioids for Chronic Pain and to ensure they are using the state's Prescription Drug Monitoring Program. Delaware's public safety officials can work with each other, other states and federal authorities to crack down on international and domestic illicit drug supply chains that are devastating your communities. For example, Delaware officials can work with federal official to help secure ports of entry and waterways against illegal smuggling. Finally, Delaware should ensure access to available Federal funding to help those struggling with addiction through evidence-based treatment and recovery support services. For example, Delaware received $2 million in each of Fiscal Years (FY) 2017 and 2018 through the Substance Abuse and Mental Health Services Administration's (SAMHSA) State Targeted Response to the Opioid Crisis grant program, which it is utilizing to develop three new recovery support centers and for the strategic deployment of newly trained recovery coaches. In FY18, Delaware is also eligible for more than $12.5 million in additional funds through SAMHSA's State Opioid Response grant program, which the state may want to utilize to support best practices such as ensuring first responders are supplied with naloxone and individuals with opioid use disorder have access to evidence-based treatment, particularly medication-assisted treatment. To cut off the flow of illicit drugs, ONDCP recommends Delaware aggressively deploy appropriate criminal and civil actions to hold opioid manufactures and traffickers accountable and continue to work with ONDCP-funded High Intensity Drug Trafficking Areas (HIDTAs). And to save

[1] https://www.whitehouse.gov/briefings-statements/president-donald-j-trumps-initiative-stop-opioid-abuse-reduce-drug-supply-demand/ pulled on July 17, 2018.

lives by expanding opportunities for proven treatment, ONDCP recommends Delaware equip all first responders with naloxone, a lifesaving medication to reverse opioid overdoses and ensure those struggling with addiction have access to evidence-based treatment, including medication-assisted treatment, and recovery support services. In addition to ensuring that first responders have access to naloxone, the state should consider whether their law enforcement officials have adequate personal protective equipment to safely follow the Fentanyl Safety Recommendations for First Responders[2] resulting from a Federal interagency working group coordinated by the White House National Security Council.

2. According to a report on alcohol, drugs, and health by the Surgeon General, "[i]mplementation of evidence-based interventions . . . can have a benefit of more than $58 for every dollar spent; and studies show that every dollar spent on substance use disorder treatment saves $4 in health care costs and $7 in criminal justice costs." How would you recommend allocating funding to best combat the scourge of opioids and specifically fentanyl?

RESPONSE: Addressing an epidemic requires not only treating those affected, but also preventing new occurrences of the disease. ONDCP recommends that states develop a comprehensive, well-coordinated, evidence-based approach to preventing, treating, and supporting sustained recovery, from substance use disorder (SUD). To protect future generations from substance use generally and to help stem the opioid epidemic, evidence-based programs to encourage the prevention of illicit drug use should be delivered in schools and communities across the state. Evidence-based prevention has the greatest long-term cost-offset. The Surgeon General's report to which you refer, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*,[3] provides information on evidence-based prevention, as does the National Institute on Drug Abuse's *Preventing Drug Use among Children and Adolescents: A Research-Based Guide for Parents, Educators, and Community Leaders, Second Edition*.[4] The following areas of focus should be considered:

- Educating the public on the dangers of opioids, including fentanyl and its analogues;
- Expanding effective, evidence-based prevention programs in schools and communities;
- Expanding access to and use of all FDA-approved medications for medication-assisted treatment (MAT) in treatment and recovery services;
- Expanding peer recovery support services;
- Expanding access to recovery housing;
- Expanding engagement with first responders to enhance their engagement with community prevention resources and connecting individuals with SUD to treatment;
- Expanding the number and capacity of drug courts, ensuring that they incorporate MAT for opioid use disorder (OUD);
- Ensuring access to SUD treatment in state and local detention facilities and incorporating MAT into treatment, especially among individuals with OUD who are being released from incarceration; and
- Ensuring ample co-occurring disorder treatment services.

[2] https://www.whitehouse.gov/ondcp/key-issues/fentanyl/
[3] https://addiction.surgeongeneral.gov/sites/default/files/surgeon-generals-report.pdf
[4] https://www.drugabuse.gov/sites/default/files/preventingdruguse_2.pdf

3. In 1997, Delaware Superior Court introduced the first statewide drug court in the United States. Before that, the Drug Court Program started in New Castle County. Defendants began to enter the program in April 1994. Now, in part because of successes in states like Delaware, there are over 3,000 drug courts nationwide.
    a. In your experience, how do drug courts help to address the opioid crisis?

RESPONSE: Drug courts have proven to be a highly effective intervention—an intervention that already has transformed hundreds of thousands of American lives. Today, drug courts use that intervention to respond to the opioid crisis now devastating our Nation's communities. With over 3,000 drug courts operating around the country today, serving more than 125,000 participants a year, drug courts are uniquely positioned to support President Trump's commitment to stop opioid abuse, in line with the work of the Trump Administration's Commission on Combating Drug Addiction and the Opioid Crisis, and the Initiative to Stop Opioid Abuse and Reduce Drug Supply and Demand.

    b. What are some best practices for drug courts that you would recommend replicating?

RESPONSE: As the drug court movement has flourished and expanded, a set of Adult Drug Court Best Practice Standards has been identified and refined through the National Association of Drug Court Professionals (NADCP), ONDCP's grantee on drug court training and technical assistance, and its National Drug Court Institute (NDCI).[5] ONDCP recommends Delaware implement the Adult Drug Court Best Practice Standards to eliminate the most challenging issues facing drug courts today. In addition, ONDCP recommends Delaware look for opportunities to implement new variants of the drug court model, such as Veterans Courts, which have been adapted to create a range of other problem-solving courts and programs. Federal agencies are working to further strengthen and refine drug courts.

    c. What unique challenges does fentanyl present for a drug court?

RESPONSE: An Opioid Rapid Response strategy incorporated in drug courts, which is designed to rapidly initiate evidence-based treatment prior to adjudication of charges, shows great promise and deserves further study. For example, opioid treatment programs recently established in New York – Buffalo Rapid Integration Team and the Bronx Overdose Avoidance and Recovery – are best viewed as enhancements of the traditional drug court model. Because of the dangers of opioid abuse, and in particular, fentanyl use, rapid responses are often needed to save defendants' lives, and the treatment court model can allow courts to move swiftly, ultimately saving lives. However, a challenge to replicating this model in jurisdictions across the country is ensuring there is enough treatment infrastructure to handle the offenders who seek help.

4. In the 1980s, in response to the crack epidemic, Congress enacted legislation that created harsher penalties for crack cocaine use, including mandatory minimum sentences. These new penalties for drug use disproportionally affected the African-American community. In addition, according to a 2014 report for the National Academy of Sciences, "[t]he best empirical evidence suggests that the successive iterations of the war on drugs – through a substantial public policy effort – are unlikely to have markedly or clearly reduced drug crime over the past three decades."

[5] http://www.nadcp.org/Standards/.

a. Please distinguish why increasing the use of mandatory minimum sentences would be the same as or different from the response to the crack cocaine epidemic.
b. Please explain whether you believe increasing the use of mandatory minimum sentences would effectively stop the spread of fentanyl use, as opposed to the impact achieved for crack cocaine.

RESPONSE: The recommended sentencing changes for fentanyl and its analogues are based on their demonstrated lethality and the comparatively minute amount required to cause significant harm. The substantial increased harm caused by fentanyl and its analogues in such small quantities relative to other illicit opioids bears on the sentencing discussion in a different way than the response to the emergence of crack cocaine in the 1980s. The sentencing disparity between crack and powder cocaine created 30 years ago was based, in part, on the belief that crack is more addictive than powder cocaine when, in fact, they are two formulations of the same compound and affect the brain in the same manner.

We are in the midst of a devastating crisis with new opioid analogues produced and sold to knowing and unknowing buyers on a regular basis. In 2016, there were 19,413 deaths in the United States due to synthetic opioids other than methadone, a medical coding dominated by fentanyl, a 103 percent increase over the previous year.[6] Since 2010, United States forensic laboratories detected 28 unique fentanyl analogues. Canadian laboratories detected four additional fentanyl analogues that were not observed in the United States. The structural modifications observed in these 32 fentanyl analogues potentially could translate into 1,920 unique fentanyl-related analogues.[7] Currently, most states in the Northeast and Midwest are experiencing fentanyl cross over, seeing more overdose deaths related to fentanyl and its analogues than heroin.[8]

While we cannot state categorically how much fentanyl or heroin it would take to cause an overdose, since a number of variables play into whether an overdose will occur, such as the relative amount of drug consumed versus an individual's weight, that individual's opioid tolerance, or their experience in consuming opioids, as little as two milligrams of fentanyl is considered a lethal dosage in most people.[9] In contrast, the average lethal dose for heroin is approximately 200 milligrams.[10] Currently, mandatory minimum penalties based on drug weight in simple distribution cases are triggered at 40 grams of fentanyl. Mathematically, that results in a five-year mandatory minimum sentence for an amount of fentanyl containing up to 20,000 potentially lethal doses.

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[6] Seth P, Scholl L, Rudd RA, Bacon S. Overdose Deaths Involving Opioids, Cocaine, and Psychostimulants — United States, 2015–2016. MMWR Morb Mortal Wkly Rep 2018;67:349–358. DOI: http://dx.doi.org/10.15585/mmwr.mm6712a1.

[7] From U.S. Customs and Border Protection correspondence dated May 14, 2018.

[8] See Seth P, Scholl L, Rudd RA, Bacon S. Overdose Deaths Involving Opioids, Cocaine, and Psychostimulants — United States, 2015–2016. MMWR Morb Mortal Wkly Rep 2018; 67:349–358. DOI: http://dx.doi.org/10.15585/mmwr.mm6712a1.

[9] Drug Enforcement Administration, Fentanyl FAQs. Available at: https://www.dea.gov/druginfo/fentanyl-faq.shtml; European Monitoring Centre for Drugs and Drug Addiction, Fentanyl Drug Profile, available at: http://www.emcdda.europa.eu/publications/drug-profiles/fentanyl; *see also* Ellenhorn, M.J. & D.G. Barceloux, Medical Toxicology - Diagnosis and Treatment of Human Poisoning, New York, NY:. Elsevier Science Publishing Co., Inc. 45 (1988) (.25 milligrams, reported in micrograms).

[10] European Monitoring Centre for Drugs and Drug Addiction, Heroin Drug Profile, Pharmacology, available at: http://www.emcdda.europa.eu/publications/drug-profiles/heroin.

We need to strengthen our criminal statutes and guidelines for drug traffickers to match the new reality of drugs like fentanyl, which are lethal, even in extremely small doses. We support changes that will provide law enforcement the necessary tools needed to hold traffickers accountable, while providing resources to those suffering from an OUD.

5. A 2011 congressional report by the Unites States Sentencing Commission found that mandatory minimum sentences were often applied too broadly, were set too high, and were unevenly applied. If Congress enacts legislation that reduces the threshold required to impose mandatory minimum sentences on people trafficking or distributing fentanyl, how would you recommend that we ensure that the problems identified by the United States Sentencing Commission do not persist?

RESPONSE: As stated in question (4) above, the Administration supports guidelines that not only provide law enforcement the tools necessary to hold drug traffickers accountable in an environment reflective of the modern realities of the comparatively small amount of some drugs needed to cause significant harm, but also provide necessary resources to those suffering with an OUD. We defer to the Department of Justice to ensure that charging is appropriate and fair.

6. Senator Hoeven and I introduced the Illegal Synthetic Drug Safety Act (S.658) to stop synthetic drugs from being sold in the United States. The legislation amends the Controlled Substances Act in order to close a loophole that enables companies to circumvent the law. Currently, some producers alter the molecular structure of fentanyl and other controlled drugs to create analogues, which are technically different but have the same dangerous risks as the original drug. Under the current law, analogues of controlled substances that are "intended for human consumption" are to be considered Schedule I substances. However, companies that produce analogue substances label their products as "not for human consumption," even though the drugs are purchased for that exact purpose, and as such, exploit a loophole in current law. Our bill would close this loophole by removing the "intended for human consumption" language from the Controlled Substance Act. If enacted, do you believe that this law would help combat the opioid epidemic?

RESPONSE: It is apparent that drug distributors today are attempting to avoid prosecution under the Controlled Substances Act (CSA) by labelling substances as "not for human consumption," even if they are fully intended to be consumed as a drug by humans. We believe that providing prosecutors with the necessary tools to prosecute these drug distributors under the CSA, such as the modification of this criterion, would be beneficial. Although the Administration has not taken a position on this bill, we would be happy to work with your staff to provide technical assistance.

7. How effective is naloxone in treating opioid overdoses when administered by a layperson, and would training on the use of naloxone increase its effectiveness?

RESPONSE: Results from an evaluation of naloxone training and distribution programs showed trained laypersons were as adept as medical experts in

recognizing an opioid overdose and knowing when naloxone use was necessary.[11]

Administering naloxone during an opioid overdose reverses the overdose and can prevent death. While many users of naloxone obtain the drug through a formal training program, a study has shown that people who obtain naloxone through other means (e.g., their social networks) can and do use it successfully to reverse overdoses, nor do their responses to overdose differ significantly from those of people who have been trained in the provision of naloxone.[12] Increased provider awareness of the benefits of community-use naloxone and the availability of easy-to-use naloxone formulations will hopefully lead to increases in naloxone prescription rates.[13] It could, therefore, be anticipated that wider use of naloxone offers the opportunity to decrease the mortality associated with the current opioid epidemic. Finally, it is important to note that across all products and access points, instructions stress that training a family member, friend, or caregiver to use naloxone is recommended.[14]

In fact, to demonstrate the utility of training laypersons in naloxone administration, ONDCP Deputy Director Carroll spearheaded providing naloxone training for all ONDCP staff.

8. Would you recommend making naloxone more readily available, for example, over-the-counter at pharmacies?

RESPONSE: Currently, naloxone is a prescription medicine. However, states may enact legislation or in some cases use regulatory mechanisms to make it available through a standing order from the health department director to pharmacies, so that patients do not need to see a provider first. Delaware should be commended for enacting a law that expanded community access to naloxone by making it possible for pharmacists to dispense the antidote without an individual prescription under the same legal protections afforded to doctors, peace officers, and people who participate in the Community-Based Naloxone Access Program.

9. In President Trump's proposed budget, he suggests drastic cuts to the Office of National Drug Control Policy.
   a. How would such a cut affect your work?
   b. Do you know whether the President plans to move the High Intensity Drug Trafficking Areas grant program to the Department of Justice?
   c. How would this change impact the effective collaboration among federal, state and

[11] Kim, D., Irwin, K. S., & Khoshnood, K. (2009). Expanded Access to Naloxone: Options for Critical Response to the Epidemic of Opioid Overdose Mortality. *American Journal of Public Health, 99*(3), 402–407. Retrieved May 23, 2018, from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2661437/.
[12] Doe-Simkins M, Quinn E, Xuan Z, Sorensen-Alawad A, Hackman H, Ozonoff A, Walley AY. Overdose rescues by trained and untrained participants and change in opioid use among substance-using participants in overdose education and naloxone distribution programs: A retrospective cohort study. BMC Public Health. 2014;14:297. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4004504/.
[13] Dunne, R. B. (2018). Prescribing naloxone for opioid overdose intervention. Pain Management, 8(3), 197-208. doi:10.2217/pmt-2017-0065. Available at: https://www.ncbi.nlm.nih.gov/pubmed/29667859/.
[14] Bonnie, R. J., Ford, M. A., & Phillips, J. (2017). *Pain management and the opioid epidemic: Balancing societal and individual benefits and risks of prescription opioid use*. Washington, DC: The National Academies Press. Retrieved July 13, 2017, from https://www.ncbi.nlm.nih.gov/books/NBK458653/.

local law enforcement to track and seize fentanyl?

RESPONSE: The Administration's proposed FY 2019 budget request for ONDCP is $29.2 million, a reduction of $386.3 million (or 93%) from the FY 2018 enacted level. The main reason for the decrease is a proposed transfer of the High Intensity Drug Trafficking Areas (HIDTA) program from ONDCP to the Department of Justice (DOJ) and the Drug-Free Communities (DFC) Support Program from ONDCP to SAMHSA. We note that both the Senate- and House-passed bills for ONDCP's FY 2019 budget keep the programs at ONDCP and that the HIDTA and DFC programs both were reauthorized as part of ONDCP activities in Pub. L. 115-271, the Substance Use–Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act. The White House has heard the concerns of Congress and the American people and will revisit the issue in the FY 2020 Budget.

10. Congress recently passed and the President signed into law the INTERDICT Act, which authorizes funding for U.S. Customs and Border Protection for detection devices and personnel that can assist with halting the flow of illicit fentanyl into the United States. How will the INTERDICT Act impact the flow of these dangerous drugs into the United States?

RESPONSE: The detection of high-purity fentanyl directly shipped into the United States via the U.S. Postal Service or express consignment presents a unique challenge. The U.S. Customs and Border Protection (CBP) operates within nine major United States Postal Service (USPS) International Mail Facilities inspecting international mail and parcels arriving from more than 180 countries. When advance targeting is not used, international mail processing can include manual, operations, which require CBP officers to sort through large volumes of parcels to identify potential shipments of concern. CBP screens all international mail parcels for radiological threats, x-rays all international mail packages presented by USPS, and physically examines those deemed high-risk. The sheer volume of international mail and the International Mail Facilities (IMF) infrastructure makes interdiction efforts focused on illicit opioids and other drugs a challenge.

The incredibly high volume of mail combined with fentanyl's ability to be shipped in very small quantities, along with the relative lack of robust screening and detection capabilities, make detecting and seizing these drugs as they move through the mail system difficult. Each day a number of packages from China move through the International Screening Center at JFK airport.

The Federal Government, including CBP and the USPS, are collaborating and building layers of detection to help address this problem. First, because of the increased threat of fentanyl and the interagency focus on disrupting the fentanyl supply chain, in the past year the CBP focused on enhancing and expanding their detection technology and capabilities at all IMFs and Ports of Entry.

The INTERDICT Act authorizes $9,000,000 for CBP to ensure chemical screening devices, personnel, and scientists are available during all operational hours to detect, prevent, and interdict the unlawful importation of fentanyl, fentanyl analogues, and other synthetic opioids. Expanding CBP's resources in combination with improved canine detection, the

Department of Justice's Joint Criminal Opioid Darknet Enforcement (J-CODE) team, and efforts by the USPS to increase their collection of Advance Electronic Data (AED) will help to eliminate the seams that synthetic opioid users and traffickers continue to exploit.

Tackling this complex threat involves a united, comprehensive strategy and an aggressive approach by multiple entities across all levels of government. With continued support from Congress, CBP, in coordination with the interagency, will continue to refine and further enhance the effectiveness of our detection and interdiction capabilities to the entry of dangerous illicit drugs into the United States. The INTERDICT ACT will improve CBP's detection capabilities to identify and analyze substances with greater speed to alert of potential outbreaks and trends, as well as identify new and emerging deadly synthetic drugs more quickly.

11. GAO recently looked into federal agencies ongoing efforts to limit the domestic availability of and enhance their response to illicit **synthetic** opioids. GAO made six recommendations, including that agencies develop performance metrics. ONDCP did not state whether they agreed or disagreed. What are your thoughts on GAO's findings?

RESPONSE: In regard to the two recommendations in GAO's report that were directed at ONDCP, the agency did indicate in its response letter to GAO that we took issue with their recommendations, in that the report discounted the existing performance measures in an area that is multi-faceted and does not easily lend itself to the type of metrics that GAO recommended. Nonetheless, subsequent to the report, we provided GAO with additional information on how the Administration is addressing these two recommendations.

The first recommendation from GAO to ONDCP was that the agency should lead a review on ways to improve the timeliness, accuracy, and accessibility of fatal and non-fatal overdose data from law enforcement and public health sources that provide critical information to understand and respond to the opioid epidemic. Such a review should expand on and leverage the findings from previous Federal studies. It should also assess the benefits and scalability of ongoing efforts to leverage data systems, such as the Washington-Baltimore HIDTA's ODMAP [High Intensity Drug Trafficking Area Overdose Mapping Application Program], and examine ways in which laws that restrict access to public health data to protect patient privacy, have exemptions for law enforcement entities that could be more widely leveraged, while protecting patient privacy.

As GAO observed, there are ongoing efforts to track overdoses. For instance, in March 2017, the Washington-Baltimore HIDTA launched the ODMAP to track the geospatial location of fatal and non-fatal overdoses and the administration of naloxone by first responders. ODMAP is being used by first responders in over 500 communities. However, use of ODMAP data is restricted to the community at hand and has not been scaled up more broadly.

Federal agencies have a stake in expanding near real-time data collection and analysis related to fatal and non-fatal overdoses to support effective public health, behavioral health, and public safety responses in partnership with state and local governments. To that end, the National Security Council convened an Interagency Working Group (IWG), of which ONDCP is an active participant, to consider the implementation of an expanded overdose tracking and analytic capability. The IWG is reviewing various approaches to expand the deployment of

ODMAP and evaluating the appropriate role for Federal departments and agencies to engage in this initiative.

The Federal Government is undertaking several other steps to improve the timeliness, accuracy, and accessibility of fatal and non-fatal overdose data. An initial obstacle is that, although information on fatal drug overdoses is derived from death certificates collected by the 50 states and the District of Columbia, each state and locality has its own format, method, and process for documenting mortality information based on their death certificates. And in instances of drug overdose deaths, there are significant delays in the development of death certificates by local medical examiners or coroners due to the need for toxicology tests to identify the drugs involved. The National Center for Health Statistics (NCHS) at the Centers for Disease Control and Prevention obtains death certificates from the states and converts their information into a standardized international format based on the International Classification of Diseases (ICD) codes, which promotes international comparability in the collection, processing, classification, and presentation of mortality statistics. Prior to 2014, the NCHS ICD coding process took several years for one year's worth of death certificates. NCHS has been making progress at expediting this process.

In the past year, NCHS commenced publicly reporting provisional mortality counts and, at ONDCP's request, included drug overdose death statistics based on a current flow of mortality data in the National Vital Statistics System. National provisional counts include deaths occurring within the 50 states and the District of Columbia. The counts represent the number of reported deaths due to drug overdose occurring in the 12-month period ending in the month indicated (i.e., these are rolling 12-month periods rather than a calendar year). These counts include all seasons of the year and thus are insensitive to variations by seasonality. Deaths are reported by the jurisdiction in which the death occurred. Beginning in 2018, the provisional numbers of deaths due to any opioid are included.

In addition to efforts to address fatal overdoses, there are initiatives to facilitate the collection of information on non-fatal drug overdoses. These initiatives rely on public health systems, through either emergency medical services (EMS) or hospital emergency departments.

The Department of Transportation's National Highway Traffic Safety Administration (NHTSA) has developed the National EMS Information System (NEMSIS), which collects EMS patient care data using a national standard, making the data easy to aggregate and analyze. NHTSA supports the use of EMS data in public health activities by educating and partnering with researchers and public health officials. For opioid overdoses, communities across the United States are using EMS data to help understand and address the opioid overdose crisis. NHTSA has worked with local and State partners to educate colleagues around the country about how EMS data can be used to identify trends, assist with law enforcement activities, allocate resources and more. In addition, information on non-fatal overdose information is being collected from patients entering hospital emergency departments. SAMHSA's Drug Abuse Warning Network (DAWN) collected drug-related information through 2011, when funding was terminated. In Fiscal Year 2018, SAMHSA was appropriated $10 million to reestablish DAWN, and SAMHSA is currently developing the procurement package.

The second recommendation was that ONDCP should work with the HIDTAs participating in

the Heroin Response Strategy (HRS) to establish outcome-oriented performance measures for the four main goals set out in the strategy. The leaders of High Intensity Drug Trafficking Areas (HIDTAs) participating in the Heroin Response Strategy (HRS) have also been actively engaged in developing more specific performance measures. As of early May 2018, nine core (mandatory) and two optional performance measures have been established for all HIDTAs participating in the HRS.