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Testimony
Of
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Senate Committee on the Judiciary

"Effective Community Efforts to Counter Drug-Related Crime in Rural America"

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Senate Committee on the Judiciary
Field Hearing
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Thank you very much Chairman Leahy and Senator Whitehouse for the opportunity to testify on this important subject. I look forward to today's discussion and also working closely with both of you on drug issues both here in the Northeastern United States and across the country.

The Obama Administration understands that addiction is a disease, and that prevention, treatment, and law enforcement must all be included as part of a comprehensive strategy to stop drug use, get help to those who need it, and ensure public safety. In the coming days, we will release the 2010 National Drug Control Strategy. This inaugural Strategy commits the Obama Administration to reduce drug use and its consequences. It reflects a nine-month consultative effort with Congress, Federal agencies, State, local, and tribal partners, and hundreds of concerned citizens. It serves as a bold call to action for all Americans who share in the desire and the responsibility to keep our citizens, especially our youth, safe, healthy and protected from the terrible costs of substance abuse.

This Strategy sets specific goals by which we will measure the progress we are making. Over the next five years, working with dozens of agencies, departments, Members of Congress, State and local organizations, Indian tribes, and the American people, we intend to make significant reductions in drug use and its consequences.

Our efforts are balanced and incorporate new research and smarter strategies to better align policy with the realities of drug use in communities throughout this country. Research shows addiction is a complex, biological, and psychological disorder. It is chronic and progressive, and negatively affects individuals, families, communities, and our society as a whole. In 2008, over 23 million Americans ages 12 or older needed treatment for an illicit drug or alcohol use problem. However, less than 10% received the necessary treatment for their disorders.[1]

Treatment is effective and recovery is possible. Three decades of scientific research and clinical practice have proven that treatment for drug addiction is as effective as treatment for most other chronic medical conditions, such as diabetes, hypertension, and asthma. We need to change the conversation in this country to emphasize the importance and effectiveness of treatment and recovery in overcoming this disease, and each of us must take personal responsibility for not using drugs, for seeking treatment if we have a problem, and for committing to recovery from substance abuse.

[1] Results from the 2008 National Survey on Drug Use and Health: National Findings, Substance Abuse and Mental Health Services Administration (SAMHSA), 2008, http://www.oas.samhsa.gov/nsduh/2k8nsduh/2k8Results.cfm

Thousands of Americans lose their lives each year because of illicit drug use. I am deeply troubled by the recent sharp increases in drug-related deaths. In 2006, the latest year for which data are available, drug-induced deaths surpassed gun-shot wounds and now rank second only to motor vehicle crashes as a cause of injury deaths in our country. Reducing fatal drug overdoses – particularly deaths involving controlled, prescription drugs – is an urgent challenge, and one that we all recognize requires the attention of leaders at all levels of our government.

Drug Use in Rural America

Drug use and addiction affects millions of Americans, many living in rural communities across the Nation. Rural Americans are confronted with a host of challenges related to drug use and addiction. Some of these challenges are shared by urban and suburban communities and many others are unique to rural communities. The latest research into drug use patterns and demographics presents a complex picture of these challenges. In 2008, Americans living in rural areas used illicit drugs at lower overall levels of current use (approximately 6%) than their counterparts in suburban and metropolitan areas (8-9%). Rural Americans also show lower rates of diagnosable drug abuse and dependence.[2] However, closer inspection of the data reveals some concerns about rural drug use.

Youth in rural America show higher rates of use, particularly for methamphetamines, prescription pain killers, and alcohol.[3] Data show that 2.9% of young adults, ages of 18 to 25, use methamphetamine in the most rural areas. That rate is nearly double the 1.5% of young adults using meth in urban areas.[4] This pattern is similar for OxyContin, with 2.8% of young adults in the most rural areas abusing these drugs, compared to 1.7% of urban young adults. The latest data also show that youth in the smallest rural areas binge drink at higher rates than their peers in suburban and metropolitan areas. Additionally, children aged 12 to 17 from the most rural areas are more likely to have used alcohol, engaged in heavy drinking, and driven under the influence (DUI).[5] These differences are significant and pose unique challenges to rural communities.

Among American Indians and Alaskan Natives (AI/ANs) data show the urgency of their alcohol and drug problems. Although these data do not separate out the problems in rural areas, many AI/ANs live on rural reservations or in rural states. The alcohol-related age-adjusted mortality for AI/ANs in service areas of the Indian Health Service was over six times higher than the rates for all other U.S. races for the year 2003. For the same year, the drug-related death rate was 50% percent greater for AI/ANs than for all races in the U.S.

One of the most alarming issues in rural areas is the rate of overdose deaths. Rural communities have experienced significant increases in overdose death rates, rapidly outpacing the rate increases in urban and suburban communities. These deaths are largely attributed to the rise in

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[2] SAMHSA, "Results from the 2008 National Survey on Drug Use and Health: National Findings." U.S. Department of Health and Human Services. [2009] Available http://oas.samhsa.gov/nsduh/2k8nsduh/2k8Results.cfm

[3] SAMHSA, "Study Helps Dispel Substance Use Myth: Rural Communities at Risk." U.S. Department of Health and Human Services. [March/April 2008] Available http://www.samhsa.gov/SAMHSA_News/VolumeXVI_2/article17.htm

[4] Muskie School of Public Service, "Substance Abuse Among Rural Youth: A Little Meth and a Lot of Booze." Maine Rural Health Research Center/University of Southern Maine. [June 2007] Available http://muskie.usm.maine.edu/Publications/rural/pb35a.pdf

[5] Muskie School of Public Service, "Substance Abuse Among Rural Youth: A Little Meth and a Lot of Booze." Maine Rural Health Research Center/University of Southern Maine. [June 2007] Available http://muskie.usm.maine.edu/Publications/rural/pb35a.pdf

misuse of prescription painkillers. The latest study available from the Centers for Disease Control and Prevention (CDC) examining data from 1999-2004 shows that overdose death rates in predominantly rural States are higher than in more metropolitan States. Vermont, Maine and West Virginia all experienced significant increases in overdose death rates during this time: 164%, 210%, and 550% respectively. Increases of 100% or more occurred in 23 States, the vast majority of which are highly rural. These figures paint a picture of the human costs of drug use in rural communities across the Nation.[6]

The Administration recognizes the need to address these issues as rapidly and effectively as possible, and has taken a number of steps to do so. We emphasize proven prevention methods, treatment expansion, and smart enforcement strategies, for maximum impact in rural communities.

Prevention in Rural Communities

A number of prevention tools have demonstrated remarkable effectiveness in reducing youth drug and alcohol use. This Administration recognizes the unique ability of community-based efforts to identify the local substance use problems and implement evidence-based solutions best suited to address their local challenges. ONDCP's Drug Free Communities Support Program (DFC), created by the Drug Free Communities Act of 1997 (P.L. 105-20), is one of the leading community prevention efforts. Based on the understanding that local problems need local solutions, DFC-funded coalitions involve multiple sectors of the community to implement proven strategies to address their specific local drug problems. Coalition volunteers work together across service and professional disciplines to determine which drug problems should be priorities for short-term and long-term efforts in their community and then work to involve the community in implementing the planned strategies. With a focus on comprehensive prevention strategies, DFC coalitions are designed to reach youth, parents, teachers, law enforcement, and other leaders to improve the environments within these communities. This broad approach reduces collective risk, making these coalitions one of the most effective and efficient prevention efforts in our Nation. This comprehensive approach makes DFC-funded communities well-suited for rural, suburban, and metropolitan communities.

Currently, the DFC Program supports 14 coalitions in Vermont, totaling nearly $1.3 million in Fiscal Year 2009 funds. These Vermont coalitions typically work in rural communities, often reaching out to cover several towns in wide geographical areas. By collaborating with a broad cross-section of sectors within their community, including law enforcement, health care, education, the media, youth, and others, the coalitions are implementing a number of prevention and early intervention efforts.

Vermont's DFC grantees have been using survey data to plan and implement prevention efforts since approximately 2005, and are working to improve parent attitudes, young people's perceptions of the risks of substance use, and lower alcohol and drug use rates. These surveys also enable the grantees to target the most current, relevant challenges facing the members of their communities. These coalitions cite alcohol and binge drinking, marijuana, tobacco,

[6] Morbidity and Mortality Weekly Report: "Unintentional Poisoning Deaths – United States, 1999-2004." Centers for Disease Control and Prevention. [February 2007] Available http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5605a1.htm

prescription drugs, and cocaine as their main concerns, and are tailoring their prevention and intervention tools to address these challenges. The DFC Program continues to support the efforts of coalitions in Vermont and in rural communities nationwide, as these coalitions represent one of the most effective prevention strategies available today. I'd like to acknowledge Senator Leahy's strong support of this Program for so long, as well as the work of so many participating in these anti-drug coalitions.

Improving Treatment Delivery in Rural Areas

High rates of alcohol, prescription drug, and methamphetamine abuse and dependence in rural areas necessitate a well-developed treatment infrastructure. While treatment availability is a challenge facing much of the country, it is particularly pronounced in rural regions, further intensifying the substance use problems in these areas.

The geographic dispersion of rural populations poses a unique challenge to treatment providers. The most recent study on rural substance abuse treatment availability was completed in 2004 and found that, of more than 13,000 treatment facilities across the United States, 91.1% were located in either metropolitan or metro-adjacent counties, leaving a very small number of providers for very large areas of rural America. While rural facilities typically have much smaller populations to serve, these populations are highly dispersed, hindering easy access to treatment services and dramatically hindering treatment initiation and outcomes.[7]

Intensive treatment services are particularly scarce in rural areas. A recent survey of rural treatment availability found that there are only 28 beds per 100,000 people in non-metropolitan areas, compared to approximately 43 in metropolitan areas. The same study found that opioid treatment programs (OTPs), which use methadone and other medications to treat severe heroin and other addictions, are extremely rare in rural settings. Of the over 1,000 facilities offering OTPs nationwide, only about 5.0% are located in non-metropolitan counties.[8]

Combining state funds with nearly $6 million in Federal resources for treatment in FY 2009 and 2010, approximately 40 treatment programs in Vermont are providing critical intervention, treatment, and recovery services to patients in need.[9] This funding enables State leadership to enhance performance standards and improve treatment outcomes for these patients.[10] However, difficult State budget cuts pose a challenge for treatment providers in Vermont. At the Federal level, we are exploring ways to support state leadership in Vermont and other states with large rural populations, to ensure that critical treatment services are available for those in need.

The Administration is taking a number of steps to improve access to substance abuse treatment in rural areas. To quickly improve intervention and treatment services, the Administration is exploring ways to enhance services delivered by primary health care providers in rural areas.

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[7] Jennifer Lenardson and John Gale, "Distribution of Substance Abuse Treatment Facilities Across the Rural-Urban Continuum." Maine Rural Health Research Center/University of Southern Maine. [February 2008] Available http://muskie.usm.maine.edu/Publications/rural/pb35bSubstAbuseTreatmentFacilities.pdf

[8] Lenardson and Gale, "Distribution of Substance Abuse Treatment Facilities Across the Rural-Urban Continuum."

[9] SAMHSA. "Grant Awards by State: State Summaries FY 2009/2010: Vermont." U.S. Department of Health and Human Services. [October 2009]. Available: http://www.samhsa.gov/Statesummaries/StateSummaries.aspx

[10] Division of Alcohol and Drug Abuse Programs. "Treatment Goals and Key Activities." Vermont Department of Health. [2010]. Available: http://healthvermont.gov/adap/treatment/treatment.aspx

One current efforts involve improving and expanding addiction care in two systems receiving Federal support: community health centers supported by the Health Resources and Services Administration (HRSA), along with centers supported by the Indian Health Service (IHS). Upgrading these systems will improve substance abuse intervention and treatment services and attract currently un-served or under-served rural populations, including American Indian/Alaska Native populations. Key to this effort will be training of physicians, nurses and social workers, and the hiring and training of new behavioral health counselors. In addition, it will be important to modernize clinical information systems, and increase the availability of evidence-based medications, therapies, and other interventions in both of these healthcare systems.[11]

Ongoing treatment and recovery support is critical to assist patients in maintaining sobriety upon completion of a treatment program. The Substance Abuse and Mental Health Services' Administration's Access to Recovery (ATR) program is a voucher-based system that provides patients with access to a large pool of service providers, including mental health clinics, social services, and housing agencies, as well as faith-based and community organizations. By providing additional options for treatment and recovery support, these vouchers enable individuals to obtain care that is convenient and effective for them, helping address some of the obstacles of limited rural treatment availability. Already implemented in 24 States and tribal organizations, many ATR grantees have focused on methamphetamine and prescription drug addiction in rural areas, and are providing critical support services for those in recovery.[12]

The Administration is committed to increasing treatment capacity and improving access for those in need of substance abuse services. We will continue to seek out and support the development of promising new models and technologies with potential to improve the care available to citizens in rural areas of the Nation.

Improving the Effectiveness of Rural Drug Enforcement

Rural law enforcement organizations are often under-resourced when tasked with addressing methamphetamine production and prescription drug diversion. State task forces and High Intensity Drug Trafficking Areas (HIDTAs) augment rural agencies' capabilities, and have demonstrated success. Across the country, the HIDTA program is also assisting small cities and rural areas affected by methamphetamine production and abuse. In particular, HIDTAs in California, Florida and Michigan are focused on fighting methamphetamine production in rural areas through the task force approach. Nationwide, methamphetamine supplies continue to depend on local production by small clandestine laboratories, facilitated by precursor chemical dealers, and pseudoephedrine smurfing operations[13]. HIDTAs provide funding to rural law enforcement agencies to support multi-agency task forces. In addition to critical financial resources, HIDTAs also provide training, intelligence, and investigative support. Partnerships between Federal and State task forces and rural agencies must continue to ensure recent reductions in rural methamphetamine lab production persist and effectively target sophisticated prescription drug diversion networks.

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[11] Lenardson and Gale, "Distribution of Substance Abuse Treatment Facilities Across the Rural-Urban Continuum."
[12] SAMHSA, "State ATR Program Descriptions." U.S. Department of Health and Human Services. [September 2007]. Available: http://atr.samhsa.gov/stateprograms.aspx
13 "smurfing": numerous individuals going from store to store purchasing the maximum limit of pseudoephedrine and ephedrine products at each store and then pooling their purchases.

The task force approach is working well in Vermont. We are well aware of Chairman Leahy's support of the Vermont Drug Task Force, as evidenced by its consistent funding levels of approximately $1 million per year in recent years. Similarly, we appreciate Chairman Leahy's consistent support of the New England HIDTA and its efforts to combat drug trafficking, especially across state lines. The Vermont Drug Task Force, consisting of State, county, and local law enforcement, under the direction of the Vermont State Police, works closely with the New England HIDTA. Uniformed State and local law enforcement agencies can target resources to high threat areas as identified by intelligence from the HIDTA. New England HIDTA funding also provides drug intelligence and investigative training to Vermont State and local officers, ensuring the most effective use of resources to identify and disrupt drug trafficking in the State. The New England HIDTA also provides continuous support to drug enforcement operations in rural Vermont by funding year round State police patrols. These patrols are instrumental in interdicting drugs as they are transported into Vermont, and gathering intelligence on drug, cash, and weapons couriers for follow-up investigation by the Vermont Task Force and HIDTA Task Force personnel. Additionally, the HIDTA and Vermont Task Force are supporting prevention and treatment efforts in the State by collaborating with leaders in these areas and ensuring individuals entering the criminal justice system can access needed treatment services, when appropriate.

Prescription Drug Monitoring Programs (PDMPs) have the potential to enable health care providers and law enforcement to more effectively track prescriptions within their States and identify patients who may be abusing their medications. PDMPs can also help State medical leadership examine prescribing practices and aid in law enforcement investigations into prescription drug diversion.[14] As of February 2009, 33 States, including Vermont and Rhode Island, have operational PDMPs, with five more States in the planning stages.[15] The Administration seeks to ensure new and existing PDMPs are effectively utilizing the data they acquire, and are bridging the gap between law enforcement and health care providers to utilize accurate data and patient tracking to reduce diversion of prescription drugs.

Expanding Alternatives to Incarceration

In addition to identifying ways to improve law enforcement operations in rural areas, the Administration is exploring and expanding alternatives to incarceration, such as drug courts and probationary programs like Hawaii's Opportunity Probation with Enforcement (HOPE). HOPE and other programs that emphasize testing and swift sanctions have received considerable attention for their effectiveness in reducing recidivism and substance use for drug offenders. While treatment-focused programs like drug courts require training, technical assistance, and support from local treatment providers, studies have demonstrated they are cost effective, when compared to traditional incarceration of non-violent drug offenders.[16]

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[14] Nathaniel Katz, "U.S. Strategy to Prevent and Manage Prescription Opioid Abuse." Analgesic Research. [2009]. Memorandum.
[15] "Status of State Prescription Drug Monitoring Programs." National Alliance for Model State Drug Laws. [February 2010]. Available: http://www.namsdl.org/documents/StatusofStates2-17-10.pdf
[16] U.S. Government Accountability Office, "Adult Drug Courts: Evidence Indicates Recidivism Reductions and Mixed Results for Other Outcomes." GAO. [February 2005]. Available http://www.gao.gov/new.items/d05219.pdf

There are three drug courts for adults and one for juveniles currently operating in Vermont, and they have demonstrated remarkable results in reducing incarceration for drug offenders and improving treatment outcomes for their clients.[17] Rhode Island's four adult and four juvenile courts have shown similar success.[18] HOPE has also demonstrated success in reducing jail time and recidivism, and significant improvements in abstinence rates, and has shown significant promise in methamphetamine-using populations, a traditionally difficult to treat population.[19] These probation programs have displayed significant cost-offsets compared to jail and prison systems, and demonstrate positive outcomes with reduced need for intensive treatment services, which are frequently lacking in rural areas. The Administration is committed to supporting and expanding drug courts and is currently supporting research into probation programs like HOPE to ensure these promising alternatives are available to break the cycle of incarceration for drug offenders.

Improving Collaboration at the Federal Level

To better ensure collaboration with our Federal partners, ONDCP recently re-established the Drug Demand Reduction Interagency Working Group (IWG). This Working Group is tasked with clarifying Federal programs and strategies, and informing our priorities moving forward. The Working Group has established several subgroups focused around the most critical drug issues in the country today. These groups, consisting of representatives from over 30 Federal agencies, play a critical role in coordinating Federal drug prevention and treatment strategies. The IWG ensures particularly challenging issue areas receive the attention of Federal stakeholders. The members of this Working Group are well aware of the unique challenges facing rural communities, and are currently examining ways to utilize Federal resources and capabilities to identify and implement solutions.

Conclusion

Rural America is facing a number of unique challenges related to the use and abuse of alcohol and drugs. The Obama Administration is dedicated to identifying those problems, and working closely with other Federal, State, local, and tribal leaders to identify and implement the best solutions as quickly and effectively as possible. We know substance abuse and addiction are in the background of so many other negative social consequences, but no single approach will be effective alone. Instead, we must focus on prevention, treatment, enforcement, interdiction, and international partnerships as essential priorities in an overall strategy. Policies and strategies that augment existing infrastructures, which are cost-effective and can be rapidly implemented, are best suited for this task.

I look forward to working closely with you and the other Committee members to address these important issues in our rural communities. I fully recognize the critical role of Congress and the many other leaders and stakeholders here today, and I look forward to future opportunities to partner with all of you. Thank you again for the opportunity to testify here today and for your support on this vital issue.

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[17] Karen Gennette. "State Drug Coordinator's Meeting: Vermont." Vermont Judiciary. [October 2009]. Memorandum.
[18] Matthew Weldon. "State Drug Coordinator's Meeting: Rhode Island." Rhode Island Superior Court. [October 2009]. Memorandum.
[19] Mark Kleiman, "Managing Substance Abuse Disorders In Criminally-Active Populations." [*Presentation delivered November 2009*].