

## WRITTEN TESTIMONY

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Subcommittee on Criminal Justice, Drug Policy, and Human Resources  
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**“Prescription Drug Abuse: What is Being Done to Address this New Drug Epidemic?”**

### **I. INTRODUCTION**

Chairman Souder, Ranking Member Cummings, and distinguished members of the Subcommittee. I appreciate the opportunity to appear before you today to discuss the Federal response to Prescription Drug Abuse.

Abuse or non-medical use of prescription drugs can be defined as use of drugs not prescribed for an individual, use of drugs solely for the experience or feelings they cause, or use of drugs by a person who has made false or inaccurate claims to obtain the drugs. Several classes of controlled prescription drugs, prescribed by physicians for legitimate medical purposes, have abuse and addiction potential: narcotic opioid analgesics (for management of pain, cough and other indications), stimulant drugs (to treat attentional disorders, narcolepsy and, less frequently, depression), tranquilizing drugs (to treat anxiety) and sedative drugs (to promote sleep) are of particular concern. These drugs are safe, effective and necessary when used according to doctors' prescriptions and advice.

Last year, the National Survey on Drug Use and Health (NSDUH) uncovered a higher number of new initiates into non-medical prescription drug use than initiates into marijuana use. Data described below (Sec. II) indicate that misuse and abuse of controlled and certain over-the-counter prescription drugs is a significant national problem. Notwithstanding the abuse of a range of controlled and over-the-counter prescription drugs, more attention has focused on opioid analgesic drugs, because of the higher absolute number of users, escalating rates of abuse, high addictive potential, and the potential to induce overdose crises or death due to respiratory failure.

**Potential causes.** Among the factors postulated to fuel increased diversion of legitimate prescription drugs are: 1) public perception that prescription drugs are safer than illicit street drugs; 2) easier availability via web-based sources or theft of legitimate prescriptions; 3) increased direct-to-consumer advertising, which fosters the view that prescription drugs are integral to our lives; 4) increased prescriptions for chronic pain, sleeping and attentional

problems, with increased potential for diversion; 5). inadequate public perception on guarding prescription medications; 6) increased web-based sources on how to tamper with medications; and 7) the aging of the US population, which requires an increased level of medications to sustain good health.

**Potential profiles of abusers and sources of drugs.** Different cohorts of users require different strategies to prevent non-medical use of prescription drugs. Intended populations include patients who suffer pain, but misuse drugs, or are co-morbid for opioid abuse, or opioid abusers who acquire prescription drugs by doctor shopping, pill mills, or by other means. Unintended populations of users include children, teens, adults and high risk populations who can become abusers by acquiring prescription medications by forgery, internet purchases, robberies, buying from patients, stealing from home medical sources, and access to illegal drug rings.

**Response of various sectors:** ONDCP, FDA, DEA, DOJ, SAMHSA, NIDA, pharmaceutical companies, medical associations, pain management specialists, medical schools and communities, are developing strategies in response to this mounting problem, with the ultimate goal of attenuating diversion of effective medications with abuse potential, while not compromising the health, comfort and well-being of intended patient populations. The core problem -- misuse and abuse of legitimate medications by unintended populations -- is complex. This emerging challenge requires surveillance, distribution chain integrity, interventions, and more research by private and public sectors. Coordinated responses that include federal, medical partners, public health administrators, state legislators (e.g. Alliance of States with Prescription Monitoring), and international organizations are needed to implement educational outreach and other strategies targeted to a wide swath of distinct populations, including physicians, pharmacists, intended patient populations, educators, unintended populations, parents, high school and college students, high risk adults, the elderly, and many others. Effective risk management plans developed by pharmaceutical companies in collaboration with the FDA, as well as outreach to physicians and their patients and pharmacists, need to be complemented by education, screening, intervention and treatment for those misusing or abusing prescription drugs. ONDCP is a key contributor to devising policies and funding demonstration programs that can survey, detect, intervene and treat unintended populations that use prescription drugs.

## II. MAGNITUDE OF THE PROBLEM

**Data.** Several Federal agencies generated the data cited below, including the National Survey on Drug Use and Health (NSDUH) which monitored 67,760 persons aged 12 or older; treatment episode data sets (TEDS); Monitoring the Future (MTF); and Drug Abuse Warning Network (DAWN).

In 2004, an estimated 2.8 million persons used psychotherapeutics non-medically for the first time within the past year. The number of new users of psychotherapeutics in 2004 was 2.4 million for pain relievers; 1.2 million for tranquilizers; and 793,000 for stimulants. An estimated 19.4 percent of past-year users of prescription drugs were new users—a statistically significant increase of 13 percent over 2003's 17.2 percent.

The 2004 NSDUH data estimated that 48 million people ages 12 and older had used prescription drugs for non-medical purposes in their lifetimes. Of these, 2.5% (6 million people) were current users. These estimates are unchanged from 2002 and 2003. Among young adults (aged 18 to 25), non-medical use of prescription drugs was significantly higher in 2004 compared with 2002 for lifetime use (an increase from 27.7% to 29.2%) and for past month use (from 5.4% to 6.1%).

The mean age of first use of the various types of prescription drugs is among the highest for any class of drug, equaled only by heroin at 24.4 years. The mean age for first illicit use of pain relievers is 23.3 years; 24.5 years for Oxycontin®; 25.2 years for tranquilizers; 24.1 years for stimulants; and 29.3 years for sedatives. Only the mean age of first use for tranquilizers showed any change from 2003, increasing from 22.9 years.

**Non-medical prescription drug use: opioids.** Narcotic analgesic drugs are a type of pain reliever derived from natural or synthetic opioids. Examples of these in common brand names include Vicodin®, Percocet®, OxyContin®, and Darvon®. Pain relievers are the most commonly abused prescription drugs, representing 75% of non-medical use for the past month and past year (2004 data). While the numbers of current (4.4 million) and past year (11.3 million) users of pain relievers in 2004 are unchanged from 2002 and 2003, the estimates for lifetime users increased 7 percent between 2002 and 2004 (from 29.6 million to 31.8 million). Specifically, lifetime use of pain relievers increased (22.1% to 24.3%), as did past month use of pain relievers (4.1% to 4.7%).

The type of drug for new initiates is an important parameter of current and possibly future trends. Of the 2.8 million past year initiates into non-medical use of prescription drugs, 2.4 million (85%) were pain reliever initiates. Equally concerning is that new users represented 21.5% of past year pain reliever users. Focusing on specific opioids, 1.2 million Americans used Oxycontin® non-medically in the past year, and of these, 50.7% were new users.

Monitoring the Future (MTF) data also may portend future drug trends. MTF reports that past year use of Oxycontin® among 12th graders increased 39.2 percent over three years - from 4.0% in 2002 (the first year for which data on Oxycontin® were collected) to 5.5% in 2005. Past year use of Vicodin remained stable, averaging 10% among 12th graders.

**Non-medical prescription drug use: other drug classes.** Of the other classes of prescription drugs, only sedatives showed any change in 2004 – a 39 percent decrease in the number of current users compared with 2002 (from 436,000 to 265,000 people) was observed in the general household population. However, among high school seniors, lifetime and past year use of sedatives increased 21.5 percent and 25.2 percent, respectively, since 2001 (from 8.7% to 10.5% and from 5.7% to 7.2%, respectively).

Use of tranquilizers decreased among 8<sup>th</sup> and 10<sup>th</sup> graders. Lifetime use of tranquilizers among 8<sup>th</sup> graders decreased 18.8% (from 5.0% to 4.1%), and 22.9% among 10<sup>th</sup> graders (from 9.2% to 7.1%). Past year use decreased 34.8% among 10<sup>th</sup> graders (from 7.3% to 4.8%).

**Non-medical prescription drug use: treatment consequences.** The Treatment Episode Data Set (TEDS) compiles admission to facilities that are licensed by State substance abuse agencies to provide substance abuse treatment and are collected by SAMHSA. Although most admissions for opioid addiction in 2004 were for heroin, TEDS admissions for primary abuse of opioids other than heroin increased from **2.8 percent** of all admissions in 2003 to 3.4 percent in 2004, and increased from 53,730 to 63,853 individuals.

**Non-medical prescription drug use: emergency room consequences.** Emergency department reports of opioid pain relievers and other prescription drug abuse are increasing. According to SAMHSA's Drug Abuse Warning Network (DAWN) data system, drug abuse related emergency department visits involving narcotic analgesics/combinations increased 163 percent in the nation (from 45,254 visits to 119,185 emergency department visits) between 1995 to 2002. The greatest increases during this period occurred for oxycodone/combinations (512%), methadone (176%), hydrocodone/combinations (159%), and morphine/combinations (116%).

Dependence was the most frequently mentioned motive underlying drug abuse related emergency department visits involving narcotic analgesics (47%), followed by suicide (22%), and psychic effects (15%). The drug abuse motive was unknown for 14% of the analgesic related emergency department visits. Disposition of emergency department patients involving narcotic analgesics was as follows: 53% were admitted for treatment, 44% were treated and released from the hospital, and 3% that either left against medical advice, died, or had an unknown outcome.

Other potential secondary consequences to intended patients include reduced confidence in essential medications, increased physician reluctance to prescribe pain medications and reduced patient access to needed analgesic medications.

### **III. POSITIVE PROGRESS**

These data emerge simultaneously with very encouraging reductions in use of other drugs. Cooperative efforts of the Administration and Congress have led to a historic 19% reduction in teenage illicit drug use over the last 4 years. This reduction means that there are approximately 691,000 fewer 8<sup>th</sup>, 10<sup>th</sup>, and 12<sup>th</sup> graders using illicit drugs than in 2001.

- This includes a 30% reduction in the number of methamphetamine lab incidents, in methamphetamine-positive workplace tests, in lifetime methamphetamine use among youths over the past two years. Furthermore, there is a significant increase in 12<sup>th</sup> graders who disapprove of using amphetamines (MTF). Details for each drug are presented below:
- Marijuana is the most commonly used illicit drug among this population. Lifetime, past year, and past 30 day marijuana use decreased 12.9 percent, 15.0 percent, and 19.4 percent.
- Reductions in use of the hallucinogens LSD and MDMA (ecstasy) since 2001 have been dramatic, declining as much as a half to nearly two-thirds. Declines in LSD use in all three prevalence categories are nearly two-thirds and declines in the use of ecstasy among these categories range from almost half to nearly two-thirds.

- There were also decreases in some categories of other club drugs, including rohypnol, GHB, and ketamine.
- Use of amphetamines in all three prevalence categories dropped by more than one-quarter: 25.7 percent (from 13.9% to 10.3%), 27.2 percent (from 9.6% to 7.0%), and 30.7 percent (from 4.7% to 3.3%).
- The use of steroids was down 38.2 percent, 36.7 percent, and 29.8 percent for lifetime, past year, and past month use, respectively.
- Lifetime use of heroin and inhalants for all three grades combined declined 13 percent.

#### **IV. SYNTHETIC DRUG CONTROL STRATEGY: INTRODUCTION**

The Administration is concerned about the increase in the abuse of controlled substance prescription drugs. In response to the data described above, the Administration released its first-ever *Synthetic Drug Control Strategy* in June 2006, which focuses on methamphetamine and prescription drug abuse. With respect to prescription drug abuse, the *Synthetics Strategy* calls for a 15% reduction in the illicit use of prescription drugs over three years.

The unique nature of this problem, non-medical use of medically approved prescription drugs, requires a creative balance between aggressively reducing abuse of controlled prescription drugs while simultaneously permitting lawful acquisition of controlled prescription drugs in the practice of medicine. To develop an effective equilibrium between the two general policy concerns, the Administration is committed to prevention, education, and enforcement of non-medical, unlawful use of controlled substances while recognizing the need for legitimate access to controlled substance prescription drugs.

#### **V. OVERVIEW OF SUPPLY REDUCTION**

A significant challenge in developing a strategy to reduce the non-medical use of controlled substance prescription drugs involves understanding how the prescription drugs are diverted for illicit use, and which of those methods are most commonly used. Unlike drugs such as heroin or marijuana which are presumptively illegal and often obtained through clandestine, secretive transactions, controlled substance prescription drugs are available for legitimate purposes through one's physician and pharmacy. For this reason, mechanisms that are otherwise legal are often manipulated to acquire controlled substance prescription drugs for illegal purposes.

The Administration's strategy to reduce opportunities for the diversion of controlled substance prescription drugs seeks to address each method of diversion. Because reliable data ranking each of these methods of diversion by prevalence does not exist, for the first time in 2005, the NSDUH incorporated questions into the *Survey* to identify sources of diverted prescription drugs. These data are expected to be released in September 2006. The 2006 *Survey* will seek even more detailed data from respondents as to methods of diversion.

Although there are no firm data that rank methods of acquisition of prescription drugs for non-medical purposes by frequency, specific methods of diversion have been identified. The

Administration's *Synthetics Strategy* seeks to address each specific method: doctor shopping or other prescription fraud, shipping illegal prescriptions from online pharmacies, over-prescribing, theft and burglary (from residences, pharmacies, etc.), selling pills to others, receiving at little or no cost, from friends or family.

**Strategy to Reduce Doctor Shopping or Other Prescription Fraud: Prescription Drug Monitoring Programs.** The *2004, 2005, and 2006 National Strategies* recognized the problem of prescription drug diversion via “doctor shopping.” Generally, this term refers to the visit by an individual—who may or may not have legitimate medical needs—to several doctors, each of whom writes a prescription for a controlled substance. The abuser or addict will visit several pharmacies, receiving more of the drug than intended by any single physician, typically for the purpose of using the drug for psychoactive effects. Associated illegal activities may include the forgery of prescriptions, further multiplying the extent of diversion, or the sale or transfer of the drug to others. In many states, physicians and pharmacists have not been able to automatically cross-check other prescriptions given to the same patient.

In 2004, the Administration announced its intent to respond to this problem by supporting Prescription Drug Monitoring Programs (PDMPs). These programs are designed to reduce prescription fraud and doctor shopping by giving physicians and pharmacists more complete information about a patient's controlled substance prescriptions. These programs vary by State, but generally share the characteristic of allowing prescribers (e.g., a physician) and dispensers (e.g., a pharmacist) to input and receive accurate and timely controlled substance prescription history information, while ensuring patient access to needed treatment. Most States also have some mechanism for law enforcement to receive this information in cases where criminal activity is suspected. Health care providers can use this information as a tool for early identification of patients at risk for addiction and initiate appropriate medical interventions. The justice system can use this information to assist in the enforcement of laws controlling the sale and use of controlled substance prescription medication.

At the beginning of this Administration, approximately 15 PDMPs were in existence in the Nation. The program has expanded to 33 States with active or planned PDMPs—more than double the number in existence in 2001.

A critical avenue of Federal support for States is through the Harold Rogers Prescription Drug Monitoring Grants Program at the Department of Justice. These grants can be used to implement or enhance PDMPs at the State level. The 2007 Budget continues funding for the Rogers Program at the Justice Department, following the funding stream approved by the Congress since 2003. The President has requested that Congress provide \$9.9 million for the program in fiscal year 2007 in order to expand the program to new States and enhance the program where it already exists. Officials at ONDCP, the Department of Health and Human Services, and the Department of Justice work with state policymakers to better understand best practices where the programs already exist.

**Strategy to Reduce Illegal Access to Controlled Prescription Medications: Internet pharmacies.** As the number of Americans with Internet access has increased, so too have opportunities for individuals to acquire controlled substance prescription drugs over the Internet.

The benefits of allowing individuals with a valid prescription to get their prescriptions over the Internet, from a legitimate pharmacy are acknowledged, particularly for people living in rural areas or individuals who are homebound due to illness, disability or other factors. There are legitimate pharmacies that provide services over the Internet and that operate well within the bounds of both the law and sound medical practice. The National Association of Boards of Pharmacy has established a registry of pharmacies that operate online and meet certain criteria, including compliance with licensing and inspection requirements of their State and each State to which they dispense pharmaceuticals.

However, the anonymity of the Internet has enabled proliferation of Web sites that facilitate illicit transactions for controlled substance prescription drugs. These rogue online pharmacy Web sites and links to those sites enable controlled substances to be ordered without a valid prescription. The sites have given drug abusers/ drug addicts and illegal providers a venue to circumvent the law and medically approved prescribing practices by physicians.

Also in existence are Web sites that advertise themselves as pharmacies, but do not operate in the same manner as legitimate pharmacies. Many of these Web sites advertise the sale of controlled substances without a prescription. Such online Web sites usually act as a facilitator, or link, between an individual seeking controlled substance prescription drugs and a doctor and a pharmacy willing to provide these drugs without determining whether the individual has a legitimate medical need. Of particular concern is the “pseudoexam”, a cursory, abbreviated medical interaction provided by the Internet site to facilitate a cursory consultation by a doctor via computer or telephone for customers. This consultation is unable to elicit meaningful health information, because the doctor writing the prescription does not see the patient to verify the information provided by the individual. For example, Web sites have no independent means to verify the age of the recipient, enabling a minor to log onto a Web site and claim an inaccurate age. Doctors, frequently paid by the number of prescriptions they sign in this system, have no incentive to spend time seeking additional patient information. Law enforcement has discovered Web site-affiliated doctors who sign hundreds or thousands of prescriptions a day. After receiving the prescription from the doctor, the facilitator will then submit the prescription to a cooperating pharmacy. Because there is no identifying information on the Web site, it is difficult for law enforcement to track the individuals supervising the Web site.

The Administration is using available tools to conduct investigations of rogue Internet-facilitator Web sites, with the purpose of intercepting controlled substance prescriptions illegally sent into the United States through the mail system. For example, the DEA’s Internet investigation unit at its Special Operations Division coordinates Internet cases. The DEA has issued immediate suspensions of numerous Internet pharmacies. DOJ has prosecuted doctors and pharmacies who illegally distribute via the Internet. States can also play a significant role in addressing the problem of online facilitators, particularly through PDMPs.

As part of the Administration’s work with States regarding PDMPs over the next three years, States will be encouraged to consider addressing, either by statute, regulation, or interstate agreement, situations in which:

- Pharmacies in the State dispense or deliver controlled substance prescription drugs to an address of a patient in another State;

- Pharmacies or other dispensers located in another State dispense or deliver controlled substance prescription drugs to an address of a patient in their own State; and
- Pharmacies or other dispensers in another State that dispense or deliver controlled substance prescription drugs to a patient with an official address in their own State.

The Administration will continue to use the tools at its disposal to target, investigate, prosecute, and dismantle illicit online pharmacies.

**Strategy to Reduce Improper Prescribing.** The overwhelming majority of prescriptions written in America are responsibly issued on the basis of legitimate medical reasons. A small number of physicians over-prescribe controlled substances, either carelessly, or deliberately. This source of prescriptions drugs facilitates drug addiction. The number of physicians responsible for this problem is a very small fraction of those licensed to dispense controlled substances in the United States. Law enforcement conducts investigations to establish whether the prescribing practice is consistent with sound medical judgment and prevailing medical standards. As part of the Administration's strategy to reduce opportunities to divert controlled substance prescriptions, law enforcement will continue to examine situations where prescriptions for controlled substances are unusually and obviously high, in the absence of legitimate circumstances.

## **VI. OVERVIEW OF PREVENTION AND TREATMENT**

Approximately 35% of the Federal drug budget is targeted to prevention and treatment of drug abuse and addiction. These programs give states and local authorities flexibility in meeting drug-related challenges their communities face, including the mounting problem of prescription drug abuse. Our strategies in prevention and treatment of prescription drugs are both targeted specifically to prescription drugs and to programs that enable prevention, intervention and treatment of addictions, which can have a significant impact on prescription drug abuse.

Preliminary data suggests that the most common way in which controlled substance prescriptions are diverted may be through friends and family.<sup>1</sup> A person with a lawful and medical need for a certain amount of a controlled substance may use only a portion of the prescribed amount and responds to a family member's complaint of pain, by sharing excess medication. Alternatively, for a family member addicted to controlled substance prescription drugs, the mere availability of unused controlled substance prescriptions in the house may prove to be an irresistible temptation. The solution to this problem lies with the medical community and the intended recipient of prescription medications: medical education programs that inform the physician on how to identify the opioid-seeker, counsel patients from losing control of their prescription medications, reducing the number of doses, if feasible, refer pain patients to specialists, and monitor opioid use, by biometric analysis. Patients require information on strategies to retain control of their medications.

**Strategies Specific for Physicians Prescribing Controlled Prescription Drugs: Medical Education.** The Medical Profession has been alerted through a number of organizations,

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<sup>1</sup> Special data run for ONDCP, Preliminary data from the 2005 *National Survey on Drug Use and Health*; data are for the first half of the year and are unweighted.

meetings, medical journals, and medical associations and via pharmaceutical companies of the mounting problem of prescription drug abuse. Notwithstanding the responsible and considered response of the medical community, current statistics indicate that a more concerted effort is required to diminish this escalating public health problem in our society. The administration recognizes the need for a closer partnership between the general medical community, and pain and addiction specialists. To this end, we are organizing several events later this year to facilitate the dissemination of pain and addiction information to the general medical community. Representatives of the medical and pharmaceutical communities will be called together to develop an concerted, effective strategy of change to address this public health problem. It will encourages medical professionals, pharmacists and pharmaceutical companies to take a leading role in educating physicians and patients as to the importance of retaining control of prescriptions medications with abuse liability. ONDCP is also convening a medical conference to assemble leading medical professional associations to focus on medical education on addictions, and specifically on prescription medications.

**Multi-Disciplinary Dissemination of Prescription Drug Strategies: Fentanyl.** In response to deaths reported in eight states to be associated with fentanyl-laced heroin and cognizant of the view that illegal manufacture and distribution of fentanyl poses unique challenges, ONDCP is convening a Demand Reduction Forum in Philadelphia this Friday, July 28/2006. The forum brings together law enforcement and public health officials, treatment providers, and prevention specialists from Federal, State, and local government to discuss response mechanisms and techniques and the threat to public health arising from abuse of fentanyl. By Friday July 21, 2006, over 100 professionals have registered to attend this important conference.

Other recent outreach efforts include two meetings in Chicago convened by the Chicago Police Department, the Drug Enforcement Agency, and the Chicago High Intensity Drug Trafficking Area, a weekly inter-agency telephone conference initially convened by CDC and SAMHSA to share information on recent developments, and warning alerts sent out by SAMHSA to treatment providers and CDC to public healthcare professionals, including state and local health departments and poison control centers.

**Prevention Strategies Specific for People with Access to Controlled Prescription Drugs: Media Campaign.** Reductions in prescription drug abuse also require the dissemination of information to various sectors of our society that encounter this class of drugs. Foremost, patients in possession of controlled prescription drugs need to be educated about the legal, social, medical and behavioral consequences of providing a controlled substance to a friend or family member. Patient-parents also need to become aware of the need to restrict access to their drugs. Finally, youth and adults need to become aware of the potentially severe adverse consequences of drugs. ONDCP's National Youth Anti-Drug Media Campaign is addressing the rise in prescription drug abuse by teens. Prescription Drug Use is featured on the Youth and Parents Websites visited by almost two million people a month. The Parent Website has extensive information on the dangers of prescription drugs, ways to prevent this drug use, and resources for parents to help teens who have a problem. All of the parenting resources (handbooks, CD-ROMs, brochures, websites, advertisements, press messages) have solid information on monitoring techniques that are effective against prescription drug use, along with other risky behaviors. The Media

Campaign recently added a specific advice page on how to deal with prescription drug use into their interactive parenting guide.

The Media Campaign is also reaching parents with press outreach; for example, on July 18th Director Walters held a press conference that focused on the need for parents to monitor their teens internet usage to avoid the drug threat. Starting last Friday, a new open letter ad from ONDCP's National Youth Anti-Drug Media Campaign will run in *People* magazine, alerting parents to the pro-drug influences to which young people are exposed by technologies like the Internet, text messaging, and social networking sites. The ad specifically addresses the risk of prescription and over-the-counter drug abuse by young people. The E-Monitoring Open Letter to Parents also appeared in Sunday's *New York Times*, as well as top newspapers in 27 media markets across the country and consumer publications like *Newsweek*. Seven health, parenting, and media education organizations signed the E-Monitoring Open Letter to Parents, including the PTA and the American Academy of Pediatrics.

**Established Programs: Community Coalitions.** Communities across the country have formed local anti-drug community coalitions that coordinate prevention and intervention efforts. These coalitions bring together community leaders and professionals in health care, law enforcement, and education to provide local, grassroots solutions to the challenges drug and alcohol abuse pose to their neighborhoods. Coalitions work to develop a model for all sectors to work together to change community norms and send the same no-use messages to young people. The Administration supports the efforts of many of these coalitions by providing \$79.2 million in the President's FY 2007 Budget through the Drug-Free Communities (DFC) Support Program. Through the establishment of community coalitions, the DFC program is designed to complement the development and implementation of the Strategic Prevention Framework in communities across America.

**Community Coalitions: Prescription Drug Tracking.** Currently, there are over 700 funded DFC coalitions, which exist in every state and form the backbone of the Nation's community prevention system. Under this program, each grantee receives up to \$100,000 annually for up to five years to develop a comprehensive community plan to address substance abuse problems. Of the over 700 DCF grantees, 365 work on prescription drug abuse, including education efforts to prevent abuse and the tracking of amphetamines, barbiturates, and oxycodone.

**Established Programs: Prevention and Intervention by Biometric Identification: Student Drug Testing.** The President stated in his 2004 State of the Union Address that drug testing is an effective part of a community-based strategy to reduce the demand for illicit substances. When implemented in combination with other drug abuse prevention measures, this non-punitive public health tool can reduce the number of youth using drugs illicitly and, by preventing or deterring early-initiation, can also decrease the likelihood of adult drug use. Testing can be used to screen for the abuse of prescription drugs. If a student tests positive, the parents can be notified of the result and can take action if they determine the student should not be taking the drug.

Student drug testing is also an important screening tool that can identify youth who have initiated prescription substance use so that parents and counselors can intervene at an early stage as well as those with a drug dependency so that they can be referred to appropriate treatment. The Office

of National Drug Control Policy works closely with the Department of Education to help interested schools and communities learn more about how to develop and implement a comprehensive, considerate, and safe random student drug testing policy. Regional and State summits with experts in the field and other outreach activities help spread model program elements and increase awareness about this prevention program.

Grants from the Department of Education in 2003 and 2004 in the amount of \$2 million and in 2005 in the amount of \$9.9 million have afforded 373 schools around the nation the opportunity to enhance and implement student drug testing programs. All grantees screen for opioids and amphetamines. Once a screen shows an opioid positive, the screen is broken down to determine which drug is present. If it is determined to be a prescription drug, then the parent is notified to verify that the student has been prescribed that particular drug. Many more schools have added this strategy to their existing drug prevention programs. These schools recognize the benefits of stopping drug use before it starts and in promoting a safe and drug-free community.

**Established Programs: Screening, Brief Intervention, Referral and Treatment (SBIRT).** A key component of expanding the Nation's treatment capacity lies in early detection and engaging health professionals in the identification, counseling, referral, and ongoing medical management of persons with substance use disorders. The Department of Health and Human Services offers grants through the Screening, Brief Intervention, Referral and Treatment (SBIRT) program to States, territories, and tribal organizations to provide effective early identification and intervention in general medical settings. This program is based on research showing that by simply asking questions regarding unhealthy behaviors and conducting brief interventions, patients are more likely to avoid the behavior in the future and seek help if they believe they have problem. The programs are based in clinical settings, a location that has a high propensity to attract higher-risk populations, who through violence, accidents or health-related problems, are seen by medical professionals.

SBIRT expands the continuum of care available for treatment of substance use disorders by matching an individual's stage of illness to the initial treatment experience and improves linkages among general community-health related services and specialized substance abuse treatment agencies. Universal screening of patients in a general medical setting can significantly reduce drug and alcohol use among non-dependent users, even without accompanying intervention.

SBIRT could help identify a cohort of prescription drug abusers who enter hospital or clinical environments seeking treatment for reasons other than for prescription drug abuse. This cohort would have the opportunity to be shepherded into interventions or treatment programs.

Awards for the program were made in September 2003 to six States and one Tribal Council. In addition to these grants, 12 universities and colleges have received funding to develop a screening and intervention model to be used on campuses. These programs will identify drug problems at an early stage and help reduce drug dependency and addiction in this vulnerable age cohort. The Office of National Drug Control Policy works closely with the Substance Abuse and Mental Health Administration to monitor the success of these programs and to highlight the

benefits of early screening and intervention. As part of the FY07 budget, approximately \$31.2 million is requested for this initiative.

**Established Treatment Programs.** Stopping use before it starts is a priority of the Office of National Drug Control Policy, but treating drug users is critical to demand reduction efforts. From extensive work in the field of addiction science, we know that treatment for drug dependency and addiction – including to methamphetamine – can be effective. The programs we support make significant contributions to closing the treatment gap. At present 8.1 million of the 34.8 million past year drug users in the United States meet the clinical definition of abuse or dependency. Of these, 1.4 million received treatment at a specialty treatment facility. Continued success in healing America’s drug users is predicated on the availability of treatment for the remaining 6.6 million.

Treatment for prescription drug abuse is available. For example, for those who abuse methamphetamine, the Matrix Model is an evidence-based intensive outpatient treatment program created by The Matrix Institute in Los Angeles. It has been tested through research, showing favorable outcomes. It is a manual-based treatment that uses cognitive behavioral therapy, relapse prevention and skill training, all presented in Motivational Interviewing style. Treatment includes educational sessions for client families and other support people. Skill training groups focus on recovery and relapse prevention. The main objective of the program is to provide clients with a behavioral structure and daily skills enabling the eventual development of a clean and sober lifestyle.

Matrix clients were 38 percent more likely to stay in treatment compared with other treatment modalities and were 27 percent more likely to complete treatment. In some sites of the research clinical trial (total of 8 sites), the Matrix condition was associated with significantly longer periods of abstinence. Treatment completion was about 41 percent.

Specific to opioid addiction, SAMHSA’s Center for Substance Abuse and Treatment has Opioid Treatment Program (OT) accreditation grants to: (1) reduce the costs of basic accreditation education and accreditation surveys and ongoing reaccreditation for OTPs; (2) ensure that new OTPs and OTPs that did not become fully accredited before the May 19, 2004, regulatory date become fully accredited under 42 CFR Part 8; and (3) ensure that OTPs maintain their accreditation by undergoing the reaccreditation process every three years.

The President’s FY 2007 budget request includes \$1.76 billion for the Substance Abuse Prevention and Treatment Block grant, of which 20 percent is set-aside for substance abuse prevention. These funds are directed to specialty treatment providers, many of whom provide treatment for abuse and dependence of prescription drugs. The President’s budget also includes nearly \$556 million in prevention and treatment discretionary grants (Programs of Regional and National Significance), including *Access to Recovery*.

Administered by SAMHSA, the President’s *Access to Recovery* (ATR) program is now in 14 States and one Native American organization. Over the three year grant cycle, ATR will provide services to an estimated 125,000 people who seek treatment, but are not able to obtain it, in part, because they cannot afford it. To close the treatment gap, ATR also funds essential recovery

support services not generally provided through conventional Federal treatment resources, such as comprehensive relapse prevention services, transportation, or child-care. Many providers are unable to offer “wrap-around” services, even though they are less costly than services required in the initial stages of recovery, and are of paramount significance to those in recovery

The President’s FY07 request for ATR is \$98.2 million, which includes \$24.8 million for an ATR-Methamphetamine initiative. Both the House and Senate appropriations bills eliminated funding for ATR I’d like to take this opportunity to encourage the Committee to look more closely at ATR, and data on outcome measures.

**Established Treatment Program: Drug Courts.** There are currently in excess of 1,750 drug courts in operation and another 400 in development. Using the coercive power of the courts to alter behavior through a combination of escalating sanctions, mandatory drug sentencing, and rigorous case management to address the individual’s overall needs, drug courts divert non-violent, low-level offenders whose underlying problem is drug use away from prison and into supervised treatment. The National Center on Addiction and Substance Abuse (CASA) at Columbia University reviewed and synthesized over 120 evaluations and determined that drug courts provide the most comprehensive and effective control of drug-using offenders criminality and drug usage while under the courts supervision. A National Institute of Justice report demonstrated that, within the first year of release, 43.5 percent of drug offenders are rearrested, whereas only 16.4 percent of drug court graduates are re-arrested. This ratio of re-arrest rates persists in year two following graduation from drug court. Drug courts have not traditionally focused on prescription drug abusers. ONDCP will be working with HHS and DOJ to assess the current status of prescription drug abuse in drug courts and will make recommendations based on our findings. There is strong administration support for drug courts. The President’s FY 2007 budget requests a funding level of \$69.2 million for drug courts programs – an increase of \$59.3 million over the 2006 enacted level. This increase reflects a commitment to this program.

## VII. CONCLUSION

Scheduled prescription drugs are safe, effective, and necessary for intended patients, when prescribed for legitimate medical purposes. The diversion of prescription drugs for unintended, non-medical purposes is a national public health challenge. We are encouraged by increasing collaboration and cooperation between pharmaceutical companies and federal agencies, the medical community, and state regulators, which have instituted surveillance, pharmaceutical tracking, legal strategies, educational programs, risk management plans, tamper-free formulations and other procedures and policies to attenuate this escalating problem.

ONDCP is committed to eliminate diversion and abuse of potentially addictive prescription medications, by engaging Federal, private, legal and medical sectors in the creation of effective strategies and policies. The Synthetic Strategy focuses on methamphetamine with relevant programs applicable to prescription drug abuse. Screening, brief intervention and referral to treatment (SBIRT), Student Drug Testing and Drug Courts identify and steer methamphetamine or prescription drug abusers/addicts into intervention and treatment programs. Access to recovery (ATR) and State Block grants provide the necessary treatment.

The President's Drug Control Policy is characterized by vigilance, flexibility, adaptability and innovative strategies to address emerging drug threats. The Administration is committed to developing an effective public health strategy that balances the legitimate medical use of prescription drugs by intended populations, while eliminating diversion and abuse of these medications by unintended populations. Multidisciplinary programs that provide surveillance, legal strategies, identification of prescription drug abusers and treatment capacity are major components of the Synthetic Strategy.

Thank you. I welcome questions from the Subcommittee.