MAY 17, 2016

AMERICA'S INSATIABLE DEMAND FOR DRUGS: ASSESSING THE FEDERAL RESPONSE

UNITED STATES SENATE COMMITTEE ON HOMELAND SECURITY & GOVERNMENTAL AFFAIRS

ONE HUNDRED FOURTEENTH CONGRESS, SECOND SESSION

HEARING CONTENTS:

MEMBER STATEMENTS

WITNESS STATEMENTS

AVAILABLE WEBCAST(S):*

COMPILED FROM:

- *http://www.hsgac.senate.gov/hearings/americas-insatiable-demand-for-drugs-assessing-the-federal-response*

** Please note: Any external links included in this compilation were functional at its creation but are not maintained thereafter.*

Chairman Johnson Opening Statement
"America's Insatiable Demand for Drugs: Assessing the Federal Response"

Tuesday, May 17, 2016

As submitted for the record:

As chairman of this committee, I have made addressing border security a top priority. We have held 18 hearings on the topic and released a 100-page report, "The State of America's Border Security." The clear finding is that America's borders are not secure. Over the course of the committee's extensive work on this issue, it also has become clear that America's insatiable demand for drugs is the root cause of our insecure border. Today, we will examine the federal government's response to this demand.

At the federal level, we spend approximately $31 billion per year on our war on drugs. According to testimony before this committee, we interdict less than 10 percent of illegal drugs coming across our southwest border and somewhere between 11 and 18 percent coming in through our maritime borders.

As a result, heroin entering the United States today is significantly higher in purity and lower in price than it was in the past. According to Wisconsin Attorney General Brad Schimel, heroin sold on the street has increased from five percent in purity to now between 20 and 80 percent. Meanwhile, the price of heroin has decreased from a nationwide average of $3,260 per gram of pure heroin in 1981 to $100 to $150 per gram in Wisconsin today. That can translate into as little as $10 for one hit.

The ease with which an addict can access heroin has led to an alarming rise in overdoses across the country. In Milwaukee County alone, 109 heroin-related overdose deaths were reported in 2015. In 2014, there were more than 47,000 drug overdoses in the United States, meaning that every day an average of 129 Americans die of overdose. One of those senseless losses was Lauri Badura's son, Archie. During a field hearing in Wisconsin last month, I had the opportunity to meet with Lauri and learn about her son and his tragic death from a heroin overdose. During her courageous testimony, she stated that she did not understand the lack of outrage and attention being paid to this killer.

We are not winning the war on drugs. I share Lauri Badura's frustration that we are not effectively addressing this problem, and I believe we owe it to our nation's families to reassess our current strategies. To that end, today's hearing will examine how the United States is allocating funds to fight the war on drugs. In particular, we will explore how resources are currently directed, what is working, and what should be done differently.

I thank our witnesses for providing the attention to this issue that it deserves and I look forward to your testimony.

Statement of Ranking Member Tom Carper
"America's Insatiable Demand for Drugs: Assessing the Federal Response"

Tuesday, May 17, 2016

As prepared for delivery:

Thank you, Mr. Chairman, for holding this hearing today to examine the federal government's efforts to stem the demand for illegal drugs and treat the substance abuse disorders that fuel it. I look forward to hearing from our witnesses on this difficult issue that has developed into a health emergency across the country and to learning more about what the federal government is doing and should be doing to address the root causes of this complex challenge.

As we all know, substance abuse, particularly prescription opioid and heroin abuse, has been a growing problem in our country for a number of years now. According to the Centers for Disease Control, there has been a dramatic increase in opioid-related overdoses in recent years with the number of incidents actually quadrupling since 2000. And opioids, primarily prescription pain relievers and heroin, are the main cause of overdose deaths. All told, there were just over 47,000 drug overdose deaths in 2014 in our country, up from just under 44,000 in 2013, a more than six percent increase in just one year. Even when drug abuse is not deadly, it inflicts other damage, not just on those doing the drugs, but also their families and communities. And we must also be honest about how our country's demand for drugs has fueled violence and disorder in Mexico and much of Central America, breaking down communities and touching families throughout the region.

This committee is familiar with the work the Department of Homeland Security and others do at and around our borders to stop the supply of illicit drugs coming into our country. But as former SouthCOMM Commander General Kelly has told us, we cannot intercept our way out of this problem. We must do more to address the demand for drugs. That means looking at the challenge we face as a public health crisis, not just a law enforcement issue.

Simply put, substance abuse issues are complex and require a robust and comprehensive response. We of course need to make sure that our law enforcement agencies have the tools and resources they need to combat drug traffickers and reduce the supply drugs available in our country. But we also need to make sure we're investing in public health and funding treatment and other initiatives that can reduce the demand for drugs. We also need to ensure that these efforts are well coordinated, and that the agencies involved are working effectively with states and localities.

That's why I'm pleased to see that the individual responsible for our national drug control efforts, the Director of the Office of National Drug Control Policy, Michael Botticelli, is here to provide insight into what the Obama Administration has done in the last several years to address these issues. I'm also pleased to see that the Principal Deputy Administrator at the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA), Ms. Kana Enomoto, is here to provide us with information on the government's efforts to prevent and treat substance abuse disorders, as we all know that treatment and prevention are crucial if we want to reduce the

demand for drugs. Additionally, Ms. Diana Maurer, Director of Homeland Security and Justice at the GAO, will provide us with an overview of the progress made toward our national drug control strategy goals and the work that remains to be done in this area.

In sum, this problem we're facing is complex, and the potential solutions are neither quick nor easy. Getting a handle on drug abuse and substance abuse disorders and the tragic problems that stem from them both in our communities, and in neighboring countries, will require an all-hands-on-deck effort. Again, my thanks to our Chairman for holding this hearing and to our witnesses for their contributions. I look forward to reviewing our federal efforts to reduce the supply and demand for illegal drugs.

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

Assessing the Federal Response to Drug and Opioid Use

Homeland Security and Government Affairs Committee
United States Senate

Tuesday, May 17, 2016
2:30 p.m.

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

Overview

Chairman Johnson, Ranking Member Carper, and members of the Committee, thank you for this opportunity to discuss the Office of National Drug Control Policy's authorities and efforts to collaboratively carry out President Obama's drug control priorities.

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

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

Status of Drug Use and Availability

The *Strategy* takes a thorough and comprehensive approach to addressing .drug use and availability. With its inaugural 2010 *Strategy,* the Administration stressed a public health and public safety approach that recognized substance use disorder is a disease of the brain that can be prevented, treated, and from which people can recover. It also recognized the continued importance of law enforcement efforts, including interdiction and cooperation with international partners to reduce the supply of illicit drugs.

The *Strategies* have produced results. In 2012, the Nation saw the first decline in the rate of deaths involving opioid medications. From 1999 to 2011, these death rates increased each year, rising from 2.4 deaths per 100,000 population to 6.2. In 2012, they dipped to 5.8 and remained there in 2013 before rising again to 6.5 in 2014.[1] This rise in 2014 may likely be attributed to fentanyl. The rate of overdose deaths involving synthetic opioids nearly doubled between 2013 and 2014; it includes prescription opioids and non-pharmaceutical fentanyl manufactured in illegal laboratories, and toxicology tests used by medical examiners and coroners are unable to distinguish between the two.[2] With the continued implementation of the various elements of the Administration's plan for addressing this crisis, including increasing access to treatment for opioid use disorders, improving prescription drug monitoring programs and their interoperability, expanding distribution of the opioid overdose antidote naloxone to all first responders, prescriber education, expanding local prescription medication disposal

[1] Centers for Disease Control and Prevention (CDC), National Center for Health Statistics. Multiple Case of Death, 1999-2014 on CDC WONDER Online Database, released 2015. Extracted by ONDCP from http://wonder.cdc.gov/mcd-icd10.html on December 9, 2015.
[2] Rose A. Rudd, MSPH; Noah Aleshire, JD; Jon E. Zibbell, PhD; R. Matthew Gladden, PhD Centers for Disease Control and Prevention (CDC). Morbidity and Mortality Weekly Report. Increases in Drug and Opioid Overdose Deaths – United States 2000-2014. Weekly. January 1, 2016. 64(50); 1378-82. Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm.

programs, and continuing law enforcement actions against pill-mill operators and suppliers and traffickers of heroin and illicit fentanyl, we are hopeful that the Nation will see renewed declines in deaths involving all opioids.

Our hope is fueled by recent reductions in the non-medical use of these powerful drugs. Among youth age 12 to 17, current non-medical use of these drugs declined 29 percent from 2009 to 2014, and 39 percent among young adults age 18 to 29. Perhaps most importantly, initiation of nonmedical use of opioid medications is down 35 percent over this same period, from 2.2 million in 2009 to 1.4 million in 2014. These significant declines in the number of non-medical prescription opioid use by youth and young adults, and in the number of new initiates, demonstrate the effectiveness of this Administration's policies, including education and prevention efforts on the harms of prescription opioid misuse.

From 2009 to 2014, there have been reductions in the use of illicit drugs other than marijuana, dropping 21 percent among youth age 12 to 17, and 20 percent among young adults age 18 to 29. The declines have been driven by decreases in the non-medical use of prescription drugs, ecstasy, hallucinogens, and inhalants.[3] Substantial progress also has been achieved in reducing alcohol and tobacco use among youth, the two most frequently used substances at this age. Among 8th grade students, the rate of lifetime use of these substances declined 28 percent for alcohol (from 36.6 percent in 2009 to 26.1 percent in 2015) and 34 percent for cigarettes (from 20.1 percent to 13.3 percent in 2015).[4] These declines exceeded the targets established for them in the 2010 *Strategy*.

Substantial progress also has been achieved in reducing the number of HIV infections attributable to intravenous drug use. Such infections fell from 5,799 in 2009 to 4,366 in 2013, exceeding the 2015 Strategy target of 4,929.[5] Nonetheless, only certain parts of the country have benefitted from policies to reduce the risk of exposure to blood-borne infections. For example, in rural southeastern Indiana, intravenous use of prescription oxymorphone caused an HIV outbreak where 191 persons have tested positive since January 2015.[6] This outbreak reminds us that more work remains.

Despite these achievements, much remains to be done. The past five years have seen an alarming increase in deaths involving heroin, rising from 3,038 in 2010 to 10,574 in 2014.[7] This increase has been accompanied by a sharp rise in the availability of purer forms of heroin that allow for non-intravenous use,[8] and at a relatively lower price,[9] and an increase in the initiation of heroin use (from 116,000 people in 2008 to 212,000 in 2014).[10] Drugged driving continues to be of great concern. In 2007, the National Highway Traffic Safety Administration estimated that 16.3 percent of the Nation's weekend nighttime drivers tested positive for an illicit drug or

[3] Center for Behavioral Health Statistics and Quality (CBHSQ). 2015. *2014 National Survey on Drug Use and Health (NSDUH): Detailed Tables.* Substance Abuse and Mental Health Services Administration, Rockville, MD
[4] Johnston, L.D.; O'Malley, P.M.; Miech, R.A.; Bachman, J.G.; and Schulenberg, J.E. 2015.D.; 2015. *Monitoring the Future. National Survey Results on Drug Use. 2015 Overview: Key Findings on Adolescent Drug Use*. The University of Michigan, Institute for Social Research, Ann Arbor, MI
[5] Centers for Disease Control and Prevention. February 2015. HIV Surveillance Report-Diagnoses of HIV Infection in the United States, 2013. Vol. 25. Department of Health and human Services, Washington, DC
[6] Morbidity and Mortality Weekly Report (MMWR), Community Outbreak of HIV Infection Linked to Injection Drug Use of Oxymorphone — Indiana, 2015, 64 (16); p 443-444, May 1, 2015. Data from State of Indiana, available at https://secure.in.gov/isdh/26649.htm.
[7] Op cit., CDC WONDER 2015.
[8] Drug Enforcement Administration. Strategic Intelligence Section. 2015 National Heroin Threat Assessment. DEA-DCT-DIR-039-15.
[9] Drug Enforcement Administration. System to Retrieve Information from Drug Evidence (STRIDE), Price and Purity Data, 2015.
[10] Op cit., CBHSQ NSDUH 2015.

medication capable of impairing driving skills. Unfortunately, by 2013/2014 that estimate had risen to 20.0 percent.[11]

Drug Policy Priorities and *Strategy* Goals

ONDCP produces the *Strategy* each year in partnership with our fellow Federal agencies and with extensive feedback and input from stakeholders across the country and around the world. The *Strategy* establishes the framework for the Nation's drug control efforts, focusing on prevention, early intervention, treatment and recovery support, criminal justice reform, law enforcement efforts, and international partnerships. The *Strategy* also reviews the results of current data and research efforts that inform our policies, and identifies areas where more information is needed.

To assist in establishing policy and evaluating the success of our efforts, the *Strategy* includes two broad policy goals accompanied by performance measures and targets. The *Strategy* seeks to: (1) Curtail illicit drug consumption in America, and (2) Improve the public health and public safety of the American people by reducing the consequences of drug use. There are 15 data items that inform seven Strategy Measures in support of the two goals. In addition, for the past six years, each chapter of the *Strategy* has included action items assigned to Federal agencies. Each action item addresses an area of policy critical to improving the health and safety of our Nation. Completion of these action items supports the Administration's efforts to meet the goals of the *Strategy*.

Overview of 2015 *Strategy*

President Obama's inaugural *Strategy*, released in May 2010, labeled opioid overdose a "growing national crisis" and laid out specific actions and goals for reducing nonmedical prescription opioid and heroin use.[12]

Building on this, the Administration released a comprehensive *Prescription Drug Abuse Prevention Plan (Plan)*[13] in 2011, which created a national framework for reducing prescription drug diversion and misuse. The *Plan* focuses on: improving education for patients and healthcare providers; supporting the expansion of state-based prescription drug monitoring programs; developing more convenient and environmentally responsible disposal methods to remove unused and unneeded medications from the home; and reducing the prevalence of pill mills and diversion through targeted enforcement efforts.

Success in each of these efforts has been the result of concerted collaboration among Federal agencies and coordination by ONDCP. Since the release of this plan, our efforts have built upon this foundation and have expanded to respond more comprehensively to the growing crisis.

---

[11] National Highway Traffic Safety Administration. 2015. Traffic Safety Facts. Research Note. Results of the 2013-2014 National Roadside Survey of Alcohol and Drug Use by Drivers. Department of Transportation (DOT HS 812 118).
[12] Office of National Drug Control Policy. *2010 National Drug Control Strategy*. Executive Office of the President. [2010]. Available: http://www.whitehouse.gov/sites/default/files/ondcp/policy-and-research/ndcs2010.pdf#page=49
[13] Office of National Drug Control Policy. *Epidemic: Responding to America's Prescription Drug Abuse Crisis* [2011] Available: http://www.whitehouse.gov/sites/default/files/ondcp/issues-content/prescription-drugs/rx_abuse_plan.pdf

The Administration has increased access to treatment for substance use disorders, expanded efforts to prevent overdose, and coordinated a Government-wide response to address the consequences of opioid misuse. We have worked to educate prescribers and the public on the risks associated with misusing prescription opioids. We have worked with state and local governments to improve legislative and policy responses to opioid use in their communities. We have also continued to pursue actions against criminal organizations trafficking in opioid drugs and we continue our close cooperation with the Government of Mexico to disrupt criminal networks and reduce the flow of heroin from Mexico into the United State.

Mexico is currently the primary supplier of heroin to the United States, with Mexican drug traffickers producing heroin in Mexico and smuggling the finished product into the United States.[14] Opium poppy cultivation in Mexico has increased substantially in recent years, rising from 17,000 hectares in 2014, with an estimated potential pure heroin production of 42 metric tons, to 28,000 hectares in 2015 with potential production of 70 metric tons of pure heroin.[15] Additionally, we are working with several states to obtain better reporting on the use and abuse of fentanyl to help us better understand the increased availability of fentanyl in the United States. This not only includes reporting on fentanyl seizures by law enforcement agencies but also post-mortem detection of fentanyl in suspected overdose cases that may not be attributed to heroin alone.

At the same time, we have focused on addressing Neonatal Abstinence Syndrome and opioid use disorder among pregnant women; worked with Congress to revise the ban against federal funds for syringe service programs; expanded the availability of medication assisted treatment for opioid use disorder, including increasing the number of trained and waivered healthcare providers that can prescribe buprenorphine; and taken budget and policy actions that have expanded the availability and use of the opioid overdose reversal medication naloxone, including by law enforcement and other first responders. In each of these areas, multiple agencies have come together to leverage resources and policy expertise toward a common goal.

How the Drug Budget is Aligned with Policy Priorities

ONDCP's authorities allow it to engage in a policy and budget development process that is dynamic, nimble, and responsive to the needs of communities and which allow us to collaborate effectively with Congress, state and local governments, community organizations, individual citizens, and other stakeholders.

Nowhere is this more evident than in the Federal response to the prescription drug and heroin epidemic currently facing our Nation. ONDCP's oversight of the National Drug Control Budget ensures the Federal Government's drug control efforts are well coordinated and support the objectives of the *Strategy*. Since the Administration's inaugural 2010 *Strategy*, we have deployed a comprehensive and evidence-based strategy to address opioid use disorders and opioid induced overdose deaths. ONDCP's annual funding guidance to Drug Control Program agencies emphasized the need for increased access to treatment for substance use disorders, expanded efforts to prevent overdose, and a coordinated Government-wide response to address the public health and public safety consequences of substance use—particularly heroin use and

[14] Drug Enforcement Administration. Strategic Intelligence Section. 2015 National Heroin Threat Assessment. DEA-DCT-DIR-039-15.
[15] US Department of State, Bureau of International Narcotics and Law Enforcement Affairs. International Narcotics Control Strategy Report - 2015 [INCSR] (March 2015) for data from 2013 - 2014 and unpublished U.S. Government Estimates.

the non-medical use of opioid medications. The guidance also recognizes the need for continued interdiction and enforcement actions against criminal drug trafficking organizations.

The funding guidance provides Drug Control Program agencies notification of the budget priorities needed to support the objectives of the *Strategy*. ONDCP reviews and makes funding recommendations on the budget submissions of Drug Control Program agencies twice during each budget cycle. The budgets are first reviewed in the summer when bureaus submit budget data to their respective Departments for review. They are reviewed a second time in the fall when Departments submit their budgets to the Office of Management and Budget. ONDCP coordinates closely with policy and budget officials to ensure that ONDCP funding priorities are supported as much as possible in the President's Budget.

ONDCP's efforts have helped to secure necessary resources for the Administration's priorities, and align overall funding to reflect a balanced demand reduction and supply reduction approach to drug control efforts.

When the Administration took office, 37 percent of Federal drug control resources were devoted to demand reduction efforts such as preventing and treating substance use disorders. In FY 2017, 51 percent of Federal drug control resources are requested for demand reduction and 49 percent of Federal drug control resources are requested for supply reduction. This is the first time that more Federal funding has been requested to support drug treatment and prevention than for supply -reduction efforts.

The total national drug control policy budget request in FY 2017 is $31.1 billion. This is half-a-billion dollars more than the FY 2016 enacted level and represents an increase of $6.2 billion (+25 percent) in drug control funding since the beginning of the Administration. Since the Administration took office in 2009, the policy guidance and the drug control funding levels supporting those policies show that ONDCP's efforts have contributed to a change in how the Federal government approaches substance use and its consequences. The FY 2017 Administration's request of $15.8 billion for drug treatment and prevention includes an increase of $6.7 billion since the beginning of the Administration, increasing the amount of funding available for demand reduction programs by more than 70 percent. In FY 2017, the Administration requests more than $15.2 billion for supply reduction programs. Since 2009, the funding request for supply reduction efforts has provided increases for domestic law enforcement (+$63 million) and interdiction (+$439 million), but a reduction in funding for international drug control (-$952 million).

The FY 2017 drug control budget matches the seriousness of the situation we face as a nation. The President's FY 2017 Budget takes a two-pronged approach to address the opioid epidemic. First, it includes $1 billion in new mandatory funding over two years to expand access to treatment and recovery support services for those suffering from opioid use disorder. This funding will boost efforts to help individuals seek and complete treatment, and sustain recovery. This funding includes:

- $920 million to support cooperative agreements with States to expand access to treatment for opioid use disorders. States will receive funds based on the severity of the epidemic and on the strength of their strategy to respond to it. States can use these funds to expand treatment capacity and make services more affordable.

- $50 million to the National Health Service Corps to expand access to substance use disorder treatment providers. This funding will support approximately 700 substance use disorder treatment providers in areas most in need of these services.

- $30 million to evaluate the effectiveness of treatment programs employing medication-assisted treatment and to improve treatment for patients with opioid use disorder.

This investment, combined with efforts to reduce barriers to treatment for substance use disorders, is a critical step in helping every American who wants treatment access it and get the help they need.

In addition to the request for new mandatory funding, the President's FY 2017 Budget request includes an increase of more than $90 million for the Departments of Justice and Health and Human Services to continue expanding state-level prescription drug overdose prevention strategies, increase the availability of medication-assisted treatment programs, improve access to the overdose-reversal drug naloxone, and support targeted enforcement activities. A portion of this funding is directed to rural areas, where rates of opioid use and overdose are high and access to resources is limited.

Evaluating the Effectiveness of Drug Policy Programs.

As for so many of the issues facing our Nation, we must continue seeking new and effective solutions to reduce drug use and its consequences. As policy develops in response to the changes in drug trafficking and use, ONDCP has been able to work in partnership with the Federal Drug Control agencies to develop new programs and expand successful ones.

Measuring performance is a key tool for ONDCP in its oversight of National Drug Control Program agencies – it enables ONDCP to assess the extent to which the *Strategy* is achieving its goals, and accounts for the contributions of individual drug control agencies. ONDCP's approach to performance evaluation includes several elements.

The first element is implementation of the *Strategy*. The *Strategy* identifies Action Items that are essential to achieving the *Strategy's* Goals and Objectives. The implementation of these action items by interagency partners is monitored by ONDCP's Delivery Unit, which works with ONDCP components to coordinate and track progress. When progress is not being achieved, relevant agency partners are convened to assess challenges and implement corrective actions. Additionally, once funds are appropriated by Congress, Drug Control Program agencies submit financial plans to ONDCP with account-level detail that links the drug budget to the operating budget, and provides policy officials with the information to make resource allocation decisions. Occasionally, an agency may seek to reprogram funding to address an unanticipated need. Drug Control Program agencies that seek to reprogram or transfer appropriated Drug Control Program funds exceeding one million dollars must have the request approved by ONDCP.

The second element is the Performance Reporting System (PRS). As noted above, the *Strategy* has two overarching goals: (1) curtailing illicit drug consumption in the United States;

and (2) improving the public health and public safety of the American people by reducing the consequences of drug use. ONDCP and its Federal partners use the PRS to assess progress toward meeting specific quantitative targets of the *Strategy's* Goals and Objectives. The *Strategy's* overarching goals call for reductions in the rate of young adult drug use, chronic drug use, and drug-related consequences, such as drug-related morbidity and drugged driving. The PRS' seven objectives focus on prevention, early intervention, treatment & recovery support, breaking the cycle of drug use and crime, drug trafficking and production, international partnerships, and enhancing data sources to inform policies, programs, and practices.

Data from the Substance Abuse and Mental Health Services Administration (SAMHSA), National Institute on Drug Abuse (NIDA), Centers for Disease Control and Prevention (CDC), Health Resources and Services Administration (HRSA), Department of Justice, Department of State, and ONDCP are used to track 32 measures. These data are used to track progress-to-date compared to the baseline for each measure. In reviewing these data, ONDCP and its Federal partners look at trends and shifts in trends that may be a sign of an emerging issue. An example would include monitoring trends of drug-induced deaths. In 2009, there were 39,147 drug-induced deaths; 37,004 of these were drug poisoning deaths and 20,848 of those were reported to involve prescription drugs. In 2013, there were 46,471 drug-induced deaths, an increase of 19 percent compared to 2009. These data, among other data and information, prompted a more extensive review that was used to inform ONDCP's response to shifts in prescription drug misuse and heroin use.

A third element of ONDCP's approach to performance is the Performance Summary Report (PSR). Individual agency performance summary reports are a component of ONDCP's assessment of agency performance. These reports provide the Administration and Congress with independent assessments of agency accountability systems – the measures, the process of developing targets, the quality of data systems, and the use of performance information.

Progress on *Strategy* Goals

A suite of seven measures, informed by 15 data items, was developed to assess the Nation's progress toward achieving the *Strategy's* goals. The 2015 PRS Report found good progress in a number of areas, including a decrease in 30-day prevalence of drug use among 12-17 year olds, a decrease in lifetime prevalence of 8th graders using alcohol and tobacco, a reduction in HIV infections attributable to drug use, and reduction in the number of chronic cocaine and methamphetamine users.

However, challenges remain. We have not achieved reduction targets for lifetime prevalence of 8th graders using illicit drugs and have not made progress on reducing drug use among 18-25 year olds. The primary reason for this lack of success is the continued and unchanging high prevalence of past month marijuana use among young adults—nearly 20 percent since 2009. However, when marijuana is excluded from the estimation of illicit drug use, the Nation has actually already doubled the targeted reduction—a 20 percent decline from 2009 to 2013. This decline has been driven by a 25 percent decline in past month non-medical use of prescription drugs overall, which in turn was driven by a 31 percent decline in past month non-medical use of prescription opioid medications.

The heroin crisis is being compounded by the emergence of illicit fentanyl, a powerful opioid more potent than morphine or heroin.[16] Fentanyl is sometimes added to heroin to increase potency, or mixed with adulterants and sold as heroin with or without the buyer's knowledge. Some states are being hit especially hard by fentanyl-related overdoses. For example, Ohio med ical authorities reported 514 fentanyl-related overdose deaths in Ohio in 2014 alone – up from 92 in the previous year.[17] And in New Hampshire, the Office of the Chief Medical Examiner reports that out of 433 drug deaths in 2015, 396 involved opioids. Of those deaths involving opioids, 281 involved fentanyl and 88 involved heroin.[18]

In response, and per the *Strategy*, ONDCP coordinates with Federal partners to identify, disrupt and dismantle criminal organizations trafficking in opioid drugs; works with the international community to reduce the cultivation of poppy; identifies labs creating dangerous synthetic opioids like fentanyl and acetyl-fentanyl; and enhances efforts along the Nation's borders to decrease the flow of these drugs into our country. Expanding on these efforts, in October, ONDCP created the National Heroin Coordination Group, a multi-disciplinary team of subject matter experts to lead Federal efforts to reduce the availability of heroin and fentanyl in the United States. This hub of interagency partners will leverage their home agency authorities and resources to disrupt the heroin and illicit fentanyl supply chain coming into the U.S. and will establish mechanisms for interagency collaboration and information-sharing focused on heroin and fentanyl.

With regard to drugged driving, the data are mixed. As noted above, data from the National Highway Traffic Safety Administration's National Roadside Survey show the Nation moving in the wrong direction on drug-involved driving. Results from the 2013/2014 survey indicated that driving after consuming drugs on weekend nights was 20 percent, up from 16.3 percent in 2009. ONDCP also is tracking the prevalence of drugged driving with self-report data from the National Survey on Drug Use and Health (NSDUH). According to data from the 2014 NSDUH, the United States is almost at its target of reducing drugged driving by 10 percent by 2015. The baseline rate of drugged driving for drivers 16 and older in 2009 was 4.4 percent; the target rate by 2015 is 4.0 percent; and in 2014 at the rate achieved was 4.1 percent.

Coordinating Drug Control Efforts to Eliminate Duplication

ONDCP coordinates drug control efforts and eliminates duplication through a variety of mechanisms. ONDCP works closely with all Federal drug control agencies to develop the President's *National Drug Control Strategy*, and the drug control budget. Additionally, ONDCP leads a broad range of interagency groups that support the *Strategy's* initiatives. Examples include interagency working groups on treatment, prevention, and data, the Interdiction Committee, the National Heroin Task Force, and the National Heroin Coordination Group.

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

[17] 2014 Ohio Drug Overdose Preliminary Data: General Findings, Ohio Department of Health, Office of Vital Statistics; Analysis Conducted by Injury Prevention Program. Available at: http://www.healthy.ohio.gov/~/media/HealthyOhio/ASSETS/Files/injury%20prevention/2014%20Ohio%20Preliminary%20Overdose%20Report.pdf. Accessed 11-24-15.

[18] Personal E-mail Communication. April 28, 2016. New Hampshire Office of the Chief Medical Examiner. 2015 Current Drug Data as of April 14, 2016.

In 2013, the General Accountability Office (GAO) released a report indicating overlapping services in substance use prevention and treatment, which could increase the risk of duplication. As a follow up to this report, ONDCP undertook an assessment of the extent of overlap, duplication, and coordination. ONDCP found that nearly all of the identified programs serve distinct beneficiaries in distinct settings. In a few cases where overlap could occur, a review of the grantees found duplication did not occur. Further, ONDCP found that the agencies managing these programs have coordinated their programs to achieve the best results. In a few cases, ONDCP found a limited number of programs that would benefit from greater coordination and worked with the programs to enhance it.

ONDCP continues to coordinate with Federal agency partners and lead interagency working groups to prevent program overlap. We appreciate GAO's recognition that ONDCP's actions mean ONDCP "will be better positioned to help ensure that federal agencies undertaking similar drug abuse prevention and treatment efforts better leverage and more efficiently use limited resources."

Conclusion

Achieving the *Strategy's* goals takes extensive effort at the federal, state and local level. ONDCP will continue to lead the Federal Government in addressing drug use and its public health and public safety consequences, including the opioid epidemic. ONDCP's guidance and coordination with our Federal partners maintains focus on the President's policy and funding priorities, and helps states and communities address illicit substance use. Together, we are committed partners, working to reduce the prevalence of substance use disorders through prevention, increasing access to treatment, and helping individuals recover from the disease of addiction. These efforts are also accompanied by a focus on effective law enforcement and supply reduction strategies to interrupt drug trafficking networks. Thank you for the opportunity to testify and for your ongoing commitment to these issues. I look forward to continuing to work with you on these pressing matters.

Substance Abuse and Mental Health Services Administration
SAMHSA
1 Choke Cherry Road • Rockville, MD 20857
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

Testimony Before the

U.S. Senate Committee on Homeland Security and Governmental Affairs

Hearing to Examine "America's Insatiable Demand for Drugs: Assessing the Federal Response"

May 17, 2016

Statement of Kana Enomoto

Principal Deputy Administrator

Substance Abuse and Mental Health Services Administration

U.S. Department of Health and Human Services

Good morning Chairman Johnson, Ranking Member Carper, and distinguished members of the Committee. My name is Kana Enomoto, and I am the Principal Deputy Administrator of the Substance Abuse and Mental Health Services Administration (SAMHSA), an agency of the Department of Health and Human Services (HHS). I am pleased to be here, along with my colleagues from the Office of National Drug Control Policy (ONDCP), to discuss the importance of preventing substance misuse and ensuring appropriate treatment and recovery support services for individuals with substance use disorders in America.

The problems of prescription misuse, illicit drug use, and substance use disorders are complex and require epidemiological surveillance, prevention, interventions, policy changes and further research. No organization or agency can address these problems alone; a coordinated response is required. The Federal Government, medical and other health partners, public health officials, state governments, and community organizations all are needed to implement educational outreach and intervention strategies targeted to a range of discrete audiences, including physicians, pharmacists, patients, educators, parents, students, adults at high risk, older adults, and many others.

SAMHSA

SAMHSA's mission is to reduce the impact of substance misuse and mental illness on America's communities. SAMHSA was established in 1992 and directed by the Congress to target substance use prevention and treatment and mental health services to people most in need of them and to enhance the delivery of behavioral health services to all. Substance misuse, substance use disorders, poor emotional health, and mental illnesses take a toll on individuals, families, and communities. These conditions cost lives and productivity, and strain families and resources in the same way as untreated physical illnesses, yet the majority of those who need treatment do not receive it. SAMHSA strives to close this gap by raising awareness that:

- Behavioral health is essential to health;
- Prevention works;
- Treatment is effective; and
- People recover.

SAMHSA is working with its partners across the Administration to implement the *National Drug Control Strategy*. SAMHSA is participating in various cross-departmental and intra-departmental workgroups to ensure coordination of policy and programs.

SAMHSA also works across HHS through the Behavioral Health Coordinating Council. As a result, SAMHSA has partnerships with the Centers for Disease Control and Prevention (CDC), the Food and Drug Administration (FDA), the National Institutes of Health (NIH), the Centers for Medicare & Medicaid Services (CMS), the Office of the National Coordinator for Health Information Technology (ONC), the Office of the Assistant Secretary for Health (OASH), the Office of the Surgeon General (SG), and the Office of the Assistant Secretary for Planning and Evaluation (ASPE) working to prevent substance misuse and treat substance use disorders.

As you may know, in October, the Surgeon General announced that he would be developing a

report on substance use, addiction and health. SAMHSA is providing technical assistance with the development of this report and we look forward to its release.

SAMHSA's Role in the *National Drug Control Strategy (Strategy)*

In fiscal year (FY) 2017, a total of $31.1 billion, an increase of more than $500 million over FY 2016 enacted, was requested by the President to support National Drug Control Strategy (Strategy) efforts to reduce drug use. The Administration's 21st century approach to drug policy works to reduce illicit drug use and its consequences in the United States. This evidence-based plan balances public health and public safety efforts to prevent, treat and provide recovery from the disease of addiction. In FY 2017, for the first time, the Administration proposes more funding for demand reduction than supply reduction. SAMHSA plays a key role in the prevention and treatment aspects of the Strategy, many of which also support HHS Secretary Burwell's initiative to address opioid misuse, abuse, and overdose.

SAMHSA's Role in the Secretary's Evidence-Based Opioid Initiative

SAMHSA is a key player in Secretary Burwell's initiative to address opioid misuse, abuse, and overdose. This initiative focuses on three specific areas targeted for their potential to produce the most impact:

(1) Improving opioid prescribing practices;
(2) Increasing the use of naloxone; and
(3) Expanding use of medication-assisted treatment (MAT) and recovery support services for individuals with an opioid use disorder.

According to the 2014 National Survey on Drug Use and Health (NSDUH), which SAMHSA conducts annually, 4.3 million individuals (aged 12 and older) reported non-medical use of prescription pain relievers during the past month and 435,000 reported using heroin.[1] That equals 1.6 percent of the population non-medically using prescription pain relievers and 0.2 percent of the population using heroin. Although reports of heroin use are significantly lower than reported prescription opioid non-medical use, the numbers have been increasing fairly steadily since 2007. In fact, reported heroin use more than doubled in seven years from 161,000 individuals in 2007 to 435,000 in 2014.

Of the 47,055 drug overdose deaths in 2014, heroin was involved in 10,574 drug overdose deaths, while opioid analgesics were involved in 20,808 drug overdose deaths. Among the opioid analgesic category, there were more than 5,544 drug overdose deaths involving synthetic narcotics other than methadone, which includes fentanyl. The number of opioid overdose deaths involving synthetic narcotics more than doubled from two years earlier (2,628 in 2012).[1]

Of the individuals admitted to treatment in 2013, 18.8 percent of admissions were for heroin.

[1] Centers for Disease Control and Prevention, National Center for Health Statistics. *Multiple Cause of Death 1999-2014* on CDC WONDER Online Database, released 2015. Data are from the Multiple Cause of Death Files, 1999-2014, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at http://wonder.cdc.gov/mcd-icd10.html, December 2015.

Another 9.2 percent of admissions were for other opioids.[2] What these data do not fully reflect is the pain felt at losing a job, a home, or a cherished family member. Opioid and heroin use destabilizes families, disrupts the health care system, and imposes enormous financial and human costs on American society.

SAMHSA's Opioid Proposals in the President's FY17 Budget

Addressing the crisis of opioid overdose from prescription pain relievers, heroin, and illicit fentanyl is a major priority for SAMHSA. The President's Budget recognizes the need for immediate action and proposes to address the opioid epidemic with a $1 billion two-year investment in new mandatory funding. This investment of mandatory funds makes a bold commitment to build the addictions workforce and bolster the continuum of services for prevention, treatment, and recovery.

Of the $1 billion in new mandatory funding, SAMHSA proposes $920 million over two years to support cooperative agreements with states to expand access to treatment for opioid use disorders. In each of FYs 2017 and 2018, SAMHSA would provide $460 million in new mandatory funding toward State Targeted Response Cooperative Agreements for states to help individuals seek and successfully complete treatment and sustain recovery from opioid use disorders. Evidence-based strategies that states might consider include training and certifying opioid use disorder treatment providers and supporting delivery of MAT. Program goals include: reducing the cost of care, expanding access, engaging patients, and addressing the negative attitudes associated with accessing opioid use disorder treatment.

Another component of the Administration's two-year initiative includes $30 million in new mandatory funding for SAMHSA to implement Cohort Monitoring and Evaluation of MAT, to evaluate the effectiveness of treatment programs employing medication-assisted treatment under real-world conditions. This program will help identify opportunities to improve treatment for patients with opioid use disorders.

In addition to the new mandatory investments, SAMHSA continues and expands existing strategies to address opioid use disorders. SAMHSA is requesting $50.1 million to double the size of the Medication Assisted Treatment – Prescription Drug and Opioid Addiction (MAT-PDOA) program. The funding will support 23 new MAT-PDOA state grants in providing FDA-approved MAT in conjunction with psychosocial interventions to those living with opioid use disorders.

[1] Center for Behavioral Health Statistics and Quality. (2015). *Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health* (HHS Publication No. SMA 15-4927, NSDUH Series H-50). Retrieved from http://www.samhsa.gov/data/

[2] Center for Behavioral Health Statistics and Quality. (2015). *Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health* (HHS Publication No. SMA 15-4927, NSDUH Series H-50). Retrieved from http://www.samhsa.gov/data/

To help further expand access to treatment, SAMHSA's Budget Request includes a $10 million pilot project, the Buprenorphine-Prescribing Authority Demonstration, aimed at increasing the types of practitioners able to prescribe buprenorphine, a medication for opioid use disorder treatment, where allowed by state law. This demonstration will test the safety and effectiveness of allowing prescribing buprenorphine by non-physician advance practice providers.

In conjunction with these treatment efforts, SAMHSA is also proposing continued investments to prevent the misuse and overdose deaths related to prescription drugs, heroin, and fentanyl. The FY 2017 Budget maintains investments in the Prevention of Prescription Drug and Opioid Overdose Related Deaths program at $12 million. This program focuses on overdose death prevention strategies such as naloxone distribution and education of first responders on its use along with other prevention strategies. Additionally, SAMHSA requests continued support ($10 million) of the Strategic Prevention Framework-Rx program which enables states to enhance, implement, and evaluate strategies to prevent prescription drug misuse. These continued and expanded efforts build upon SAMHSA's numerous activities geared toward preventing prescription drug and opioid misuse and treating opioid use disorders, including: courses for healthcare professionals on prescribing opioids for pain, prescription drug monitoring program interoperability enhancement, development and implementation of the Opioid Overdose Prevention Toolkit, and clarification on the allowable use of SABG funds to support equipping first responders with naloxone.

SAMHSA's Ongoing Work to Address the Opioids Epidemic

Improving Prescriber Practices

SAMHSA understands the importance of modifying prescribing behavior and providing prescribers with the information and the tools that are needed to appropriately treat patients with chronic pain.

Since 2007, over 72,000 prescribing primary care physicians and other healthcare professionals have received continuing education credits from SAMHSA's courses on prescribing opioids for chronic pain. This technical assistance is provided through SAMHSA's Providers' Clinical Support System for Opioid Therapies, a free national training and mentoring network that provides clinical support to physicians, dentists, and other medical professionals in the appropriate use of opioids for the treatment of chronic pain and screening and treating opioid use disorder.

SAMHSA has also addressed the issue of prescribing practices through various efforts related to increasing Prescription Drug Monitoring Program (PDMP) interoperability among states and intra-operability among the PDMP, electronic health records (EHR), health information exchanges and pharmacies. The Enhancing Access to PMDPs Project was funded by SAMHSA and managed by ONC in collaboration with SAMHSA, CDC, and ONDCP. SAMHSA also funded the PDMP EHR Integration and Interoperability Cooperative Agreement program in Fiscal Year (FY) 2012 and the Electronic Health Record and PDMP Data Integration Cooperative Agreement in FY 2013. These programs bring funding directly to states to complete integration projects.

Congress recently provided the additional funding SAMHSA requested for opioid misuse prevention that will allow PDMPs to be utilized to target localities where states should focus their prevention efforts. In FY 2016, the Congress appropriated $10 million for a new initiative, the "Strategic Prevention Framework Rx" (SPF Rx), which will allow states to enhance the use of data from PDMPs by identifying communities by geography and high-risk populations (e.g., age group), including those in need of prevention programs, connect patients to treatment resources, and complement CDC's Prescription Drug Overdose: Prevention for States program, which includes a component focused on enhancing prescription drug monitoring programs and leveraging them as public health tools.

SAMHSA expects grantees to continue to use the Strategic Prevention Framework (SPF) process at both the State/tribal and community levels to meet the goals of the SPF Partnerships for Success (PFS) Program. There are five steps in this process: (1) assess needs; (2) build capacity; (3) plan; (4) implement; and (5) evaluate. Using the SPF process is critical to ensuring that states/tribes and their communities work together to use data driven decision making processes to develop effective prevention strategies and sustainable prevention infrastructures. The SPF PFS grantees are using these funds to target two priorities: (1) underage drinking among persons aged 12-20; and (2) prescription drug misuse among persons aged 12-25. At their discretion, states/tribes may also use their SPF PFS funds to target an additional data driven priority (e.g., heroin, marijuana use). States and tribes developed an approach to funding communities of high need that ensures all funded communities will receive ongoing guidance and support from the state/tribe, including technical assistance and training for the duration of the SPF PFS project.

Another core aspect of the Secretary's initiative is to provide guidance on opioid prescribing practices focusing on inappropriate or excessive prescribing. Recently, CDC released the *Guideline for Prescribing Opioids for Chronic Pain*, to guide primary care providers in appropriate prescribing of opioids to improve pain management and patient safety. SAMHSA supports CDC in this effort and will help disseminate and encourage uptake of the new guideline.

Opioid Overdose Prevention – Expanding the Use of Naloxone

SAMHSA is also working to carry out a significant portion of the Opioid Initiative's second priority area – preventing opioid overdoses by expanding the use and distribution of naloxone. When administered in a timely manner, naloxone rapidly restores breathing to a victim in the throes of an opioid overdose. Because police are often the first on the scene of an overdose, local law enforcement agencies can train their personnel on overdose prevention and equip them with naloxone as a means of improving response.

In 2014, SAMHSA clarified that at the state's discretion its Substance Abuse Prevention and Treatment Block Grant (SABG) funds may be used to support first-responder naloxone initiatives. For example, SABG primary prevention set-aside funds may be utilized to support overdose prevention education and training. Additionally, SABG funds other than primary prevention set-aside funds may be used to purchase naloxone and materials to assemble overdose kits as well as to cover the dissemination of such kits. However, SAMHSA encourages public and private insurers to pay for this medication for those at risk or for those living with people at risk.

SAMHSA also published an Opioid Overdose Prevention Toolkit to educate individuals, families, first responders, prescribing providers, persons in recovery from substance use disorders (SUD), and community members about steps to take to prevent opioid overdose and respond to overdoses (including the use of naloxone). The toolkit is the most downloaded document on the SAMHSA website, and SAMHSA continues to promote its availability through various social media outlets to reach a wide range of populations. SAMHSA also offers a naloxone and overdose prevention course for prescribers and pharmacists.

The Congress provided SAMHSA an additional $12 million in FY 2016 to initiate a Prevention of Prescription Drug/Opioid Overdose-Related Deaths grant program, which will provide funds to states for the purchase of naloxone and for training first responders in communities of high need.

Expanding MAT and Recovery Services

MAT is an evidence-based approach which combines behavioral therapy with medications to treat SUDs, including opioid use disorders. Research shows that medications are effective for decreasing opioid craving and withdrawal symptoms, blocking euphoria if relapse occurs, and augmenting the effect of counseling.[3]

SAMHSA has a key role in ensuring access to MAT for opioid use. In FY2016, Congress appropriated $12 million for a new initiative at SAMHSA, the "Grants to Prevent Prescription Drug/Opioid Overdose Related Deaths" (PDO), which allows states to reduce the number of prescription drug/opioid overdose-related deaths and adverse events among individuals 18 years of age and older by training first responders and other key community sectors on the prevention of prescription drug/opioid overdose-related deaths and implementing secondary prevention strategies, including the purchase and distribution of naloxone to first responders and others in high-need communities.

In FY 2016, Congress appropriated $25 million for MAT-PDOA, an increase of $13 million over FY 2015. The FY 2016 funding will increase the number of states receiving funding from 11 to 22, and will serve an additional 24 high-risk communities.

The President's FY 2017 budget requests $1 billion in mandatory funding over two years to expand access to treatment, and requests more than $90 million in additional discretionary funds that will support targeted enforcement activities and help the federal government to continue and expand current efforts across the Departments of Justice (DOJ) and HHS to expand state-level prescription drug overdose prevention strategies, increase the availability of medication-assisted treatment programs, improve access to the overdose-reversal drug naloxone, and support targeted enforcement activities. As stated above, this epidemic requires a comprehensive approach, which includes funding to expand access to treatment and help individuals who seek treatment to successfully complete it and sustain recovery. We look forward to working with Congress to make the much needed investments to tackle this crisis.

A number of other SAMHSA programs enhance access to opioid use disorder treatment, including MAT. Through the Pregnant and Postpartum Women's (PPW) initiative, SAMHSA encourages grantees to accept pregnant women with opioid use disorders into residential treatment settings, and in recent years many of the PPW treatment providers have begun administering MAT onsite

to the women admitted to their programs due to an opioid use disorder. As a result, pregnant women recovering from opioid use disorders are remaining in treatment longer, resulting in healthier births.[4]

SAMHSA's budget request for FY 2017 includes innovation grants through the PPW program, which will test different models for family-centered treatment programs, including outpatient treatment programs. Outpatient services are not currently an allowable use of funds, and would offer substance use disorder treatment for pregnant and postpartum women, without separating them from their minor children and other family members in the home.

SAMHSA has also worked with ONDCP and DOJ to expand access to MAT for justice-involved individuals with opioid use disorders by adding language to our drug court grant applications ensuring clinically beneficial MAT with FDA-approved medications is not denied or restricted. However, a judge retains judicial discretion to mitigate/reduce the risk of misuse or diversion of these medications. These Drug Court program grantees are encouraged to use up to 20 percent of their grant awards for MAT.

SAMHSA also funds the Providers' Clinical Support System for Medication Assisted Treatment which provides technical assistance on proper dispensing and prescribing of FDA-approved medications for opioid use disorders. Recognizing that there is a need to further educate providers regarding the use of injectable extended-release naltrexone in addition to the more heavily regulated opioid agonist therapies, methadone and buprenorphine, SAMHSA has developed a wide variety of guidelines. These include "Clinical Use of Extended-Release Injectable Naltrexone in the Treatment of Opioid Use Disorders: A Brief Guide" released in January 2015. SAMHSA also plans to convene a meeting on the use of opioid antagonist therapies, like naltrexone, in May to bring together researchers, clinicians, and others specifically to review the literature and clinical experiences with naltrexone.

SAMHSA also has primary responsibility for regulating Opioid Treatment Programs (OTPs). OTPs provide all three FDA-approved opioid use disorder medications (methadone, buprenorphine and naltrexone) and counseling services for opioid use disorders directly to their respective patients. OTPs must maintain certification with SAMHSA in order to operate. SAMHSA cooperates with state agencies, the Drug Enforcement Administration (DEA) and approved accrediting organizations to accomplish this. Currently there are 1,402 OTPs in operation, with an additional 51 pending SAMHSA certification.

[3] Catherine Anne Fullerton, M.D., M.P.H.; Meelee Kim, M.A.; Cindy Parks Thomas, Ph.D.; D. Russell Lyman, Ph.D.; Leslie B. Montejano, M.A., C.C.R.P.; Richard H. Dougherty, Ph.D.; Allen S. Daniels, Ed.D.; Sushmita Shoma Ghose, Ph.D.; Miriam E. Delphin-Rittmon, Ph.D. (2/1/2014), Medication-Assisted Treatment With Methadone: Assessing the Evidence, Psychiatric Services 2014 Vol 65, No. 2; and Catherine Anne Fullerton, M.D., M.P.H.; Meelee Kim, M.A.; Cindy Parks Thomas, Ph.D.; D. Russell Lyman, Ph.D.; Leslie B. Montejano, M.A., C.C.R.P.; Richard H. Dougherty, Ph.D.; Allen S. Daniels, Ed.D.; Sushmita Shoma Ghose, Ph.D.; Miriam E. Delphin-Rittmon, Ph.D. (2/1/2014), Medication-Assisted Treatment With Buprenorphine: Assessing the Evidence, Psychiatric Services 2014 Vol 65, No. 2. & Kraus et al., 2011; NIDA, 2012.

[4] Substance Abuse and Mental Health Services Administration (2014) *Preliminary Cross-site Data Analysis*

Consistent with the Controlled Substances Act, as amended by the Drug Addiction Treatment Act of 2000 (DATA 2000), physicians wishing to treat opioid use disorders with buprenorphine in a practice setting not subject to OTP regulations, such as a private practice or non-OTP treatment program, must submit a notice of intent to SAMHSA. Initially physicians in these settings are restricted to treating a maximum of 30 patients at a time. After one year of experience, physicians desiring to increase their patient limit to 100 may submit a second notification to SAMHSA of the need and intent to treat up to 100 patients. SAMHSA coordinates processing of these notifications with DEA. Of the approximately 1,189,000 physicians registered with DEA to prescribe controlled substances, there are currently 32,243 physicians with a waiver to prescribe buprenorphine for opioid dependence.[5] Of these, 10,473 are authorized to treat up to 100 patients.

SAMHSA is working to find other ways to expand access to MAT. On March 30, 2016, we released a Notice of Proposed Rulemaking (NPRM) that would increase the patient limit for certain qualified physicians that have a waiver to prescribe buprenorphine. The NPRM would allow a waivered practitioner to increase their patient base from 100 to 200 if they request approval for the higher patient limit and fulfill several additional requirements. We believe the NPRM will achieve the goals of expanding access to buprenorphine, increasing the quality of treatment for opioid use disorders, and limiting the diversion of buprenorphine. In addition, to ascertain if allowing additional categories of prescribers to obtain DATA 2000 waivers would help address provider shortage while maintaining safety and quality of care, the President's FY 2017 Budget is proposing a pilot study in states where practice laws already provide advanced practice registered nurses and physician's assistants the necessary practice scope and prescribing authority to provide office-based opioid treatment.

Finally, SAMHSA has done significant work to ensure that behavioral health treatment is appropriately financed and implemented to support integrated care across an array of health systems and programs. SAMHSA's report, "Medicaid Coverage and Financing of Medications to Treat Alcohol and Opioid Use Disorders," provides clinicians and policy makers a resource guide for developing beneficial medication coverage and financing policies. The report presents innovative coverage and financing approaches that are being used to ensure cost-effective and treatment-effective outcomes. To complement this effort, SAMHSA engaged with its Federal partners (CMS, CDC, NIDA, and the National Institute on Alcohol Abuse and Alcoholism) to issue a CMS Informational Bulletin on MAT to inform states and other stakeholders about effective practices for identifying and treating mental and substance use disorders covered under Medicaid. Additionally, CMS and SAMHSA jointly issued an Informational Bulletin on coverage of behavioral health services for youth with substance use disorders to assist states in designing a benefit that meets the needs of youth with substance use disorders and their families and to help states comply with their obligations under Medicaid's Early and Periodic Screening, Diagnostic, and Treatment requirements. The services described were designed to enable youth to address their substance use disorders, to receive treatment and continuing care, and participate in recovery services and supports.

[5] SAMHSA, Retrieved March 21, 2016, from http://www.samhsa.gov/programs-campaigns/medication-assisted-treatment/physician-program-data

Criminal Justice Activities

A public health approach to addressing substance use disorders is vital. At the same time, public health agencies and organizations understand the importance of working with our public safety colleagues in the criminal justice field. SAMHSA's criminal justice portfolio includes several grant programs that focus on diversion, alternatives to incarceration, drug courts, and re-entry from incarceration for adolescents and adults with substance use disorders, and/or co-occurring substance use and mental disorders.

Drug Courts

SAMHSA's adult drug court programs support a variety of services, including treatment for diverse populations at risk; wraparound/recovery support services designed to improve access and retention; drug testing for illicit substances required for supervision, treatment adherence, and therapeutic intervention; education support; relapse prevention and long-term management; MAT; and HIV testing conducted in accordance with state and local requirements.

SAMHSA's treatment drug court grant programs focus on Tribal Healing to Wellness Courts, Juvenile Treatment Drug Courts, and SAMHSA's collaboration with DOJ's Bureau of Justice Assistance. In FY 2015, SAMHSA supported the continuation of 103 drug court grants, and provided funding to 35 new adult and family drug court grants and 10 new BJA jointly funded drug court grants. Congress expanded this provision – new in FY 2015 – from $50 million for Drug Courts to a new total of $60 million in FY 2016.

Offender Reentry Program

In addition to SAMHSA's drug court portfolio, criminal justice funds also support Offender Reentry Program (ORP) grants, which provide screening, assessment, comprehensive treatment, and recovery support services to offenders reentering the community, as well as offenders who are currently on or being released from probation or parole. Funding for ORP may be used for a variety of services, including but not limited to screening, comprehensive individual assessment for substance use and/or co-occurring mental disorders, case management, referrals related to substance abuse treatment for clients, alcohol and drug treatment, wrap-around services, drug testing, and relapse prevention and long-term management support.

In FY 2015, SAMHSA supported 30 three-year ORP grant continuations, and up to 18 new ORP grants, which will have a particular emphasis on opioid overdose prevention.

Conclusion

On behalf of SAMHSA, I appreciate the opportunity to testify today and share with you our prevention, treatment and recovery support strategies. We look forward to partnering with you as well and thank you for your leadership on this issue.

I welcome any questions that you may have.

United States Government Accountability Office

Testimony

Before the Committee on Homeland Security and Governmental Affairs, U. S. Senate

For Release on Delivery
2:30 p.m ET
Tuesday, May 17, 2016

OFFICE OF NATIONAL DRUG CONTROL POLICY

Progress toward Some National Drug Control Strategy Goals, but None Have Been Fully Achieved

Statement of Diana C. Maurer, Director, Homeland Security and Justice

May 17, 2016

OFFICE OF NATIONAL DRUG CONTROL POLICY

Progress toward Some National Drug Control Strategy Goals, but None Have Been Fully Achieved

GAO Highlights

Highlights of GAO-16-660T, a testimony before the Committee on Homeland Security and Governmental Affairs, U.S. Senate

Why GAO Did This Study

Policymakers, health care providers, and the public are concerned about the nation's current drug epidemic and its effects, as drug overdose deaths surpassed auto accidents as the leading cause of death or injury in recent years. To help address national drug control policy efforts, ONDCP coordinates and oversees implementation of a National Drug Control Strategy to reduce illicit drug use, among other things.

This statement addresses (1) what progress has been made toward achieving National Drug Control Strategy goals and how ONDCP monitors progress and (2) trends in federal drug control spending.

This statement is based upon findings GAO reported in March 2013 and December 2015, analysis of ONDCP's Budget and Performance Summaries and selected updates in 2016. For the updates, GAO analyzed publically available data sources that ONDCP uses to assess progress on Strategy goals, reviewed ONDCP Performance Reporting System reports, and interviewed ONCDP officials.

What GAO Recommends

GAO made a prior recommendation to ONDCP to assess overlap in drug prevention and treatment programs. ONDCP concurred and has implemented it. GAO is not making new recommendations in this testimony.

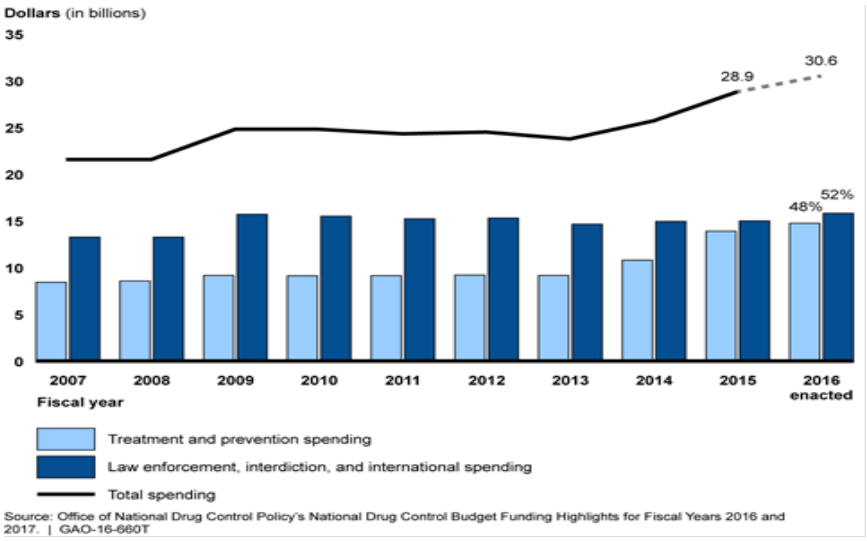
View GAO-16-660T. For more information, contact Diana Maurer at (202) 512-8777 or maurerd@gao.gov

What GAO Found

The Office of National Drug Control Policy (ONDCP) and federal agencies have made mixed progress toward achieving the goals articulated in the 2010 National Drug Control Strategy (Strategy) and ONDCP has established a mechanism to monitor and assess progress. In the Strategy, ONDCP established seven goals related to reducing illicit drug use and its consequences by 2015. As of May 2016, our analysis indicates that ONDCP and federal agencies have made moderate progress toward achieving one goal, limited progress on three goals, and no progress on the three other three goals. Overall, none of the goals in the Strategy have been fully achieved. In March 2013, GAO reported that ONDCP established the Performance Reporting System to monitor and assess progress toward meeting Strategy goals and objectives. GAO reported that the system's 26 new performance measures were generally consistent with attributes of effective performance management. A 2015 ONDCP report on progress towards these measures similarly identified some progress towards overall achievements—some of the measures had met or exceeded targets, some had significant progress underway, and some had limited or no progress.

Federal drug control spending increased from $21.7 billion in fiscal year (FY) 2007 to approximately $30.6 billion in allocated funding in FY 2016 as shown in figure 1. Although total federal drug control spending increased from FY 2007 through FY 2016, spending on supply reduction programs, such as domestic law enforcement, interdiction, and international programs remained relatively constant at $13.3 billion in FY 2007 and $15.8 billion allocated in FY 2016. However, federal spending for—treatment and prevention has steadily increased from FY 2007 through FY 2016 and spending in these two programs went from $8.4 billion in FY 2007 to $14.7 billion allocated in FY 2016.

Figure 1: Federal Drug Control Spending for Fiscal Years 2007 through 2016



Source: Office of National Drug Control Policy's National Drug Control Budget Funding Highlights for Fiscal Years 2016 and 2017. | GAO-16-660T

Chairman Johnson, Ranking Member Carper, and Members of the Committee:

I am pleased to be here today to discuss the Office of National Drug Control Policy's (ONDCP) efforts to implement the National Drug Control Strategy. In recent years, policy makers, health care providers, and the public at large are turning their attention to the current drug epidemic and its impact on our nation. Deaths from drug overdose rose steadily over the past two decades to become the leading cause of injury or death in the United States, surpassing the annual number of traffic crash fatalities in recent years. In 2013, approximately 120 people died every day from drug overdoses. ONDCP is responsible for, among other things, overseeing and coordinating the implementation of national drug control policy across the federal government to address illicit drug use.[1] In this role, the Director of ONDCP is required annually to develop a National Drug Control Strategy (the Strategy), which is to set forth a comprehensive plan to reduce illicit drug use through programs intended to prevent or treat drug use or reduce the availability of illegal drugs.[2] ONDCP is also responsible for developing a National Drug Control Program Budget proposal for implementing the Strategy.[3] In fiscal year 2017, a total of $31.1 billion was requested to support the Strategy. This represents an increase of more than $500 million over the enacted fiscal year 2016 level of $30.6 billion.

Today, I will discuss (1) what progress has been made toward achieving National Drug Control Strategy goals and how ONDCP monitors progress and (2) trends in federal drug control spending. My remarks today are based on findings from our March 2013 report on progress toward Strategy goals and ONDCP mechanisms to monitor progress, our December 2015 testimony statement on these areas, updates to our analysis and findings in the report and testimony statement, and our analysis of ONDCP's Budget and Performance summaries.[4]

---

[1]Illicit drug use includes the use of marijuana (including hashish), cocaine (including crack), heroin, hallucinogens, and inhalants, as well as the nonmedical use of prescription drugs, such as pain relievers and sedatives.

[2]For the purposes of this statement we refer to the National Drug Control Strategy as 'the Strategy' mirroring the reference commonly used by ONDCP.

[3]21 U.S.C. §§ 1703(b)-(c), 1705(a). Under 21 U.S.C. § 1701(7), the term "National Drug Control Program agency" means any agency that is responsible for implementing any aspect of the National Drug Control Strategy, including any agency that receives federal funds to implement any aspect of the National Drug Control Strategy, subject to certain exceptions regarding intelligence agencies.

[4]See GAO, *Office of National Drug Control Policy: Office Could Better Identify Opportunities to Increase Program Coordination*, GAO-13-333 (Washington, D.C.: Mar. 26, 2013) and *Office of National Drug Control Policy: Lack of Progress on Achieving National Strategy Goals*, GAO-16-257T (Washington, D.C.: Dec. 2, 2015).

In performing the work for our March 2013 report, we analyzed the 2010 National Drug Control Strategy; available data on progress toward achieving Strategy goals, and documents about ONDCP's monitoring mechanisms. In March 2013 we made a recommendation to ONDCP to assess overlap in drug prevention and treatment programs. ONDCP concurred and has implemented it. For our December 2015 testimony statement, we analyzed ONDCP's reported progress on Strategy goals in its 2015 Strategy and performance report. More detail on our scope and methodologies can be found in our March 2013 report and December 2015 statement. For updates to these reports, we analyzed publically available data sources, ONDCP reports on progress toward the Strategy's goals and objectives, and reviewed ONDCP's Fiscal Year 2015 and Fiscal Year 2016 Budget and Performance reports, and interviewed ONDCP officials.[5] We previously reported on progress toward meeting Strategy goals in our December 2015 testimony based on results provided in ONDCP's 2015 Strategy and performance report, which were issued in November 2015. To assess progress on Strategy goals, we updated results for the goals using publically available data sources as of May 2016. The data sources for the goals were determined by ONDCP when developing the 2010 Strategy, based on their availability and quality. We used the same data sources that ONDCP uses to assess progress on Strategy goals to update results and did not independently assess the reliability of these data.

This statement is based on our prior work issued from July 2012 through December 2015, with select updates as of May 2016. The work upon which this testimony is based was conducted in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

[5]Office of National Drug Control Policy *FY 2015 and FY 2016 Budget and Performance Summaries Companion to the National Drug Control Strategy,* July 2014 and November 2015; and *National Drug Control Budget FY 2017 Funding Highlights*, February 2016.

Background

ONDCP was established by the Anti-Drug Abuse Act of 1988 to, among other things, enhance national drug control planning and coordination and represent the drug policies of the executive branch before Congress.[6] In this role, the office is responsible for (1) developing a national drug control policy, (2) developing and applying specific goals and performance measurements to evaluate the effectiveness of national drug control policy and National Drug Control Program agencies' programs,[7] (3) overseeing and coordinating the implementation of the national drug control policy, and (4) assessing and certifying the adequacy of the budget for National Drug Control Programs.

The 2010 National Drug Control Strategy is the inaugural strategy guiding drug policy under President Obama's administration. According to ONDCP officials, it sought a comprehensive approach to drug policy, including an emphasis on drug abuse prevention and treatment efforts and the use of evidence-based practices—approaches to prevention or treatments that are based in theory and have undergone scientific evaluation. Drug abuse prevention includes activities focused on discouraging the first-time use of controlled substances and efforts to encourage those who have begun to use illicit drugs to cease their use. Treatment includes activities focused on assisting regular users of controlled substances to become drug free through such means as counseling services, inpatient and outpatient care, and the demonstration and provision of effective treatment methods.

ONDCP established two overarching policy goals in the 2010 Strategy for (1) curtailing illicit drug consumption and (2) improving public health by reducing the consequences of drug abuse, and seven subgoals under them that delineate specific quantitative outcomes to be achieved by 2015, such as reducing drug-induced deaths by 15 percent. To support the achievement of these two policy goals and seven subgoals (collectively referred to as goals), the Strategy

[6]See 21 U.S.C. § 1702. ONDCP was created and authorized through January 21, 1994, by the National Narcotics Leadership Act of 1988, which was enacted as title 1 of the Anti-Drug Abuse Act of 1988. Pub. L. No. 100-690, 102 Stat. 4181 (1988). ONDCP has continued to operate since the conclusion of its first authorization through multiple reauthorizations or as a result of legislation providing continued funding.

[7]Department of Agriculture; Court Services and Offender Supervision Agency for the District of Columbia; Department of Defense; Department of Education; Federal Judiciary; Department of Health and Human Services; Department of Homeland Security; Department of Housing and Urban Development; Department of the Interior; Department of Justice; Department of Labor; Office of National Drug Control Policy; Department of State; Department of Transportation; Department of the Treasury; and Department of Veterans Affairs.

included seven strategic objectives and multiple action items under each objective, with lead and participating agencies designated for each action item. Strategy objectives include, for example, Strengthen Efforts to Prevent Drug Use in Communities and Disrupt Domestic Drug Trafficking and Production. Subsequent annual Strategies provided updates on the implementation of action items, included new action items intended to help address emerging drug-related problems, and highlighted initiatives and efforts that support the Strategy's objectives.

ONDCP is required annually to develop the National Drug Control Strategy, which sets forth a plan to reduce illicit drug use through prevention, treatment, and law enforcement programs, and to develop a Drug Control Budget for implementing the strategy.[8] National Drug Control Program agencies follow a detailed process in developing their annual budget submissions for inclusion in the Drug Control Budget, which provides information on the funding that the executive branch requested for drug control to implement the strategy.[9] Agencies submit to ONDCP the portion of their annual budget requests dedicated to drug control, which they prepare as part of their overall budget submission to the Office of Management and Budget for inclusion in the President's annual budget request. ONDCP reviews the budget requests of the drug control agencies to determine if the agencies have acceptable methodologies for estimating their drug control budgets, and includes those that do in the Drug Control Budget.[10] In FY 2016, the budget contains 38 federal agencies or programs.

There are five priorities for which resources are requested across agencies: substance abuse prevention and substance abuse treatment (both of which are considered demand-reduction areas), and drug interdiction, domestic law enforcement, and international partnerships (the

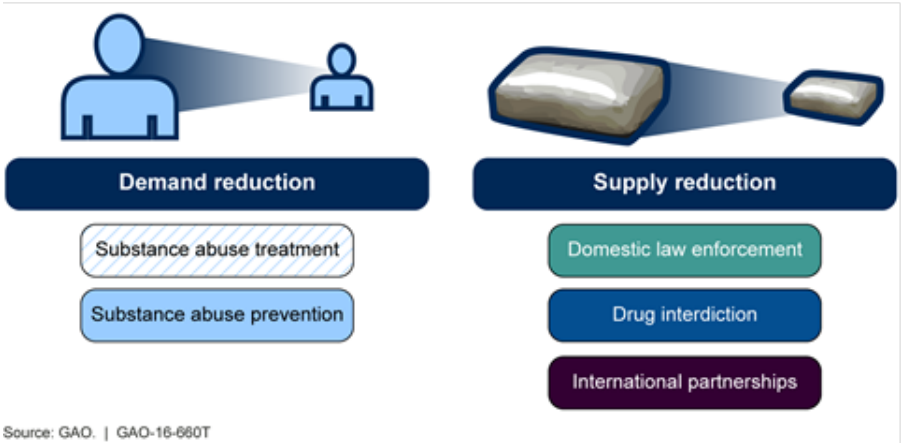
[8]In 2008, the National Academy of Public Administration's report entitled *Building the Capacity to Address the Nation's Drug Problem* recommended that ONDCP develop a comprehensive budget to ensure policymakers and the public have a full understanding of the federal drug control expenditures. In response to this recommendation, ONDCP undertook a review of the National Drug Control Budget to determine which agencies and programs should constitute the National Drug Control Budget. As a result, it decided to restructure the budget.

[9]*See* 21 U.S.C. § 1703(c).

[10]An acceptable methodology relies on availability of empirical data at the agencies for estimating their drug control budgets. These data include determining which portion of an agency's funding is for drug control programs or activities versus non-drug control programs. See GAO, *Office of National Drug Control Policy: Agencies View the Budget Process as Useful for Identifying Priorities, but Challenges Exist*, GAO-11-261R (Washington, D.C.: May 2, 2011). Agencies may administer programs that include drug abuse prevention and treatment activities but do not meet ONDCP's standards for having an acceptable budget estimation methodology. Such programs are not represented in the Drug Control Budget.

three of which are considered supply-reduction areas) as shown in figure 1. ONDCP manages and oversees two primary program accounts: the High Intensity Drug Trafficking Areas (HIDTA) Program and the Other Federal Drug Control Programs. ONDCP previously managed the National Youth Anti-Drug Media Campaign which last received appropriations in fiscal year 2011.

Figure 1: Federal Drug Control Program Priority Areas



ONDCP and Other Federal Agencies Have Not Fully Achieved 2010 Strategy Goals; ONDCP Has Established a Mechanism to Monitor Progress

Although Limited Progress Has Been Made for Some Goals, None of the National Drug Control Strategy Goals Have Been Fully Achieved

In the 2010 National Drug Control Strategy, ONDCP established seven goals related to reducing illicit drug use and its consequences to be achieved by 2015. As of May 2016, our analysis indicates that ONDCP and federal agencies have made moderate progress toward achieving one goal, limited progress on three goals, and no demonstrated progress on the remaining three goals.[11] ONDCP officials stated that they intend to report on updated progress

[11]Three of the Strategy's goals have multiple sub-measures. Limited progress indicates that progress has been made toward goals on at least one of these measures but not all. We previously reported on progress toward meeting Strategy goals in our December 2016 testimony based on results provided in ONDCP's 2015 Strategy and performance system report, which were issued in November 2015. See GAO-16-257T. We updated results for five of the seven goals based on available data sources as of May 2016.

toward meeting the strategic goals in summer 2016. As of May 2016, overall, none of the goals in the Strategy have been fully achieved. Table 1 shows the 2010 Strategy goals and progress toward meeting them.

Table 1: 2010 National Drug Control Strategy Goals and Progress toward Meeting Them, as of May 2016

2010 Strategy goals	2009 (baseline)	Progress to date[a]	2015 (goal)
Curtail illicit drug consumption in America			
1. Decrease the 30-day prevalence of drug use among 12- to 17-year-olds by 15 percent[b]	10.1 percent	9.4 percent (2014)	8.6 percent
2. Decrease the lifetime prevalence of eighth graders who have used drugs, alcohol, or tobacco by 15 percent			
Illicit drugs[c]	19.9 percent	20.5 percent(2015)	16.9 percent
Alcohol	36.6 percent	26.1 percent (2015)	31.1 percent
Tobacco	20.1 percent	13.3 percent (2015)	17.1 percent
3. Decrease the 30-day prevalence of drug use among young adults aged 18-25 by 10 percent[d]	21.4 percent	22.0 percent (2014)	19.3 percent
4. Reduce the number of chronic drug users by 15 percent[e]			
Cocaine	2.7 million	2.5 million (2010)	2.3 million
Heroin	1.5 million	1.5 million (2010)	1.3 million
Marijuana	16.2 million	17.6 million (2010)	13.8 million
Methamphetamine	1.8 million	1.6 million (2010)	1.5 million
Improve the public health and public safety of the American people by reducing the consequences of drug abuse			
5. Reduce drug-induced deaths by 15 percent	39,147	49,714 (2014)	33,275
6. Reduce drug-related morbidity by 15 percent			
Emergency room visits for drug misuse and abuse[f]	2,070,452	2,462,948 (2011)	1,759,884
HIV infections attributable to drug use	5,799	3,852 (2014)	4,929
7. Reduce the prevalence of drugged driving by 10 percent[g]	16.3 percent (2007)	20.0 percent (2013)	14.7 percent

Source: GAO analysis of ONDCP's 2015 Performance Reporting System report and data from (1) Substance Abuse and Mental Health Services Administration's (SAMHSA) National Survey on Drug Use and Health (NSDUH); (2) National Institute on Drug Abuse's Monitoring the Future; (3) *What America's Users Spend on Illegal Drugs*; (4) Centers for Disease Control and Prevention's (CDC) National Vital Statistics System; (5) SAMHSA's Drug Abuse Warning Network drug-related emergency room visits; (6) CDC's HIV Surveillance Report-Diagnoses of HIV Infection in the United States; and (7) National Highway Traffic Safety Administration's National Roadside Survey. | GAO-16-660T

[a]Year for which the most recent data were available is in parenthesis.

[b]According to the 2014 NSDUH, 7.4 percent of 12- to 17-year-olds reporting having used marijuana in the past month and 3.6 percent reported having used illicit drugs other than marijuana.

[c]According to the 2015 Monitoring the Future survey, 15.5 percent of eighth graders reported having used marijuana in their lifetimes and 10.3 percent reported having used any illicit drug other than marijuana.

[d]According to the 2014 NSDUH, 19.6 percent of 18- to 25-year-olds reported having used marijuana in the past month and 6.4 percent reported having used illicit drugs other than marijuana.

[e]The data source for this measure is a report entitled *What America's Users Spend on Illegal Drugs*, which is sponsored by ONDCP and prepared by RAND Corporation. As of May 2016, the most recent report had been released in February 2014 and provided data from 2000 through 2010.

[f]According to ONDCP's 2015 Performance Reporting System report, the data source for this measure—the Drug Abuse Warning System—was discontinued by SAMHSA in 2011, and SAMHSA and CDC are currently working to implement a replacement system to provide data on drug-related emergency department visits.

[g]The primary data source for this measure is the National Roadside Survey conducted by the National Highway Traffic Safety Administration. The baseline survey was conducted in 2007. The NSDUH, which also measures the prevalence of drugged driving, serves as a secondary data source to the National Roadside Survey. ONDCP reported that the drugged driving goal was met when 2013 data from the NSDUH source is used.

ONDCP and federal drug control agencies have made mixed progress but have not fully achieved any of the four Strategy goals associated with curtailing illicit drug consumption. For example, progress has been made on the goal to decrease the 30-day prevalence of drug use among 12- to 17-year-olds by 15 percent. The data source for this measure—SAMHSA's National Survey on Drug Use and Health (NSDUH)—indicates that in 2014, 9.4 percent of 12- to 17-year-olds reported having used illicit drugs in the past month. This represents a 7 percent decrease from the 2009 baseline for this measure. However, progress has not been made on the goal to decrease the 30-day prevalence of drug use among young adults aged 18 to 25 by 10 percent. Specifically, the rate of drug use for young adults increased from 21.4 percent in 2009 to 22 percent in 2014, moving in the opposite direction of the goal. This increase was primarily driven by marijuana use. According to the 2014 NSDUH, 19.6 percent of young adults reported having used marijuana in the past month and 6.4 percent reported having used illicit drugs other than marijuana.[12] The rates of reported marijuana use for this measure increased by 8 percent from 2009 to 2014 while the rates of reported use of illicit drugs other than marijuana decreased by 24 percent.

Progress has also been mixed on the remaining three Strategy goals associated with reducing the consequences of drug use. For example, the goal to reduce drug-related morbidity by 15 percent has two measures, and progress has been made on one but not the other. Specifically, HIV infections attributable to drug use decreased by 34 percent from 2009 to 2014, exceeding the established target. However, the number of emergency room visits for substance use disorders increased by 19 percent from 2009 to 2011. The data source for this measure—SAMHSA's Drug Abuse Warning Network—indicates that pharmaceuticals alone were involved in 34 percent of these visits and illicit drugs alone were involved in 27 percent of them.[13] According to the 2013 Drug Abuse Warning Network report, the increase in emergency room visits for drug misuse and abuse from 2009 to 2011 was largely driven by a 38 percent increase in visits involving illicit drugs only. In addition, progress has not been made on the goal to reduce drug-induced deaths by 15 percent. According to the CDC's National Vital Statistics System, 49,714 deaths were from drug-induced causes in 2014, an increase of 27 percent

[12]Marijuana includes marijuana and hashish. Illicit drugs other than marijuana include cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.

[13]These numbers do not include visits that involved a combination of illicit drugs, pharmaceuticals, and/or alcohol, which accounted for 35 percent of emergency room visits for substance use disorders.

compared to 2009. This represents a significant departure from the 2015 goal. The CDC's January 2016 Morbidity and Mortality Weekly Report stated that 47,055 of these deaths were from drug overdoses, the majority of which (61 percent) involved opioids.

ONDCP Established a System to Monitor Progress toward Strategy Goals

In March 2013, we reported that ONDCP established the Performance Reporting System (PRS) to monitor and assess progress toward meeting Strategy goals and objectives and issued a report describing the system with its 2012 Strategy.[14] The PRS includes interagency performance measures and targets under each of the Strategy's seven objectives, which collectively support the overarching goals discussed above. For example, one of the six performance measures under the Strategy's first objective—Strengthen Efforts to Prevent Drug Use in Our Communities—is the average age of initiation for all illicit drug use, which has a 2009 baseline of 17.6 years of age and a 2015 target of 19.5 years of age. These PRS measures were established to help assess progress towards each objective. According to ONDCP, they are a tool to help indicate where the Strategy is on track, and when and where further attention, assessment, evaluation, and problem-solving are needed.

As part of our review for our March 2013 report, we assessed the PRS measures for the Strategy's seven objectives and found them to be generally consistent with attributes of effective performance management identified in our prior work as important for ensuring performance measures demonstrate results and are useful for decision making.[15] For example, we found that the PRS measures for the objectives were clearly stated, with descriptions included in the 2012 PRS report, and all 26 of them had or were to have measurable numerical targets. In addition, the measures were developed with input from stakeholders through an interagency working group process, which included participation by the Departments of Education, Justice, and Health and Human Services, among others. The groups assessed the validity of the measures and evaluated data sources, among other things. At the time of our review, the PRS was in its early stages and ONDCP had not issued its first report on the results of the system's performance measures.

[14]See GAO-13-333.

[15]See GAO, *Tax Administration: IRS Needs to Further Refine Its Tax Season Performance Measures*, GAO-03-143 (Washington, D.C.: Nov. 22, 2002).

ONDCP released its most recent annual PRS report in November 2015. The 2015 report assesses progress on the Strategy's goals and the 28 performance measures and submeasures related to each of the Strategy's seven objectives, which support the achievement of the goals.[16] For each objective, the report classifies results on performance measures into five categories and identifies areas of progress on and challenges with achieving objectives.[17] For example:

- *Objective 1—Strengthen Efforts to Prevent Drug Use in Our Communities.* The report indicates that sufficient progress has been made on reducing the average age of initiation for all illicit drugs to enable meeting the 2015 target. However, it notes that accelerated effort is needed to prevent youth marijuana use and counter youth perceptions that marijuana (including synthetic marijuana) use is not harmful. The report shows that the percent of respondents aged 12 to 17 who perceive a great risk in smoking marijuana once or twice a week decreased from 2009 to 2013, moving in the opposite direction of the 2015 target.
- *Objective 3—Integrate Treatment for Substance Use Disorders into Health Care and Expand Support for Recovery.* The report shows that the percent of treatment facilities offering at least four specified recovery support services, such as child care, employment assistance, and housing assistance, increased from 2008 to 2013 and exceeded the 2015 target. However, the report states that challenges persist in the integration of substance abuse treatment services into mainstream health care. For instance, the percent of the Health Resources and Services Administration's Health Center Program grantees providing substance use counseling and treatment services decreased from 2009 to 2013. According to the report, implementation of the Affordable Care Act presents opportunities to provide greater access to treatment for substance use disorders by, for example, efficiently integrating such treatment into the health care system and providing non-discrimination for coverage for preexisting conditions.
- *Objective 5—Disrupt Domestic Drug Trafficking and Production.* According to the report, progress is being achieved in domestic law enforcement and efforts to disrupt or dismantle

[16]ONDCP included new submeasures for one of the performance measures in the 2015 PRS report, which accounts for the difference in the number of measures between the 2012 and 2015 reports.

[17]The categories are (1) target met or exceeded, progress should be maintained through 2015; (2) progress sufficient to enable meeting 2015 target; (3) progressing, accelerated progress required to meet 2015 target; (4) no progress to date, accelerated progress required to meet 2015 target; and (5) significant (or considerable) progress required to meet 2015 target.

domestic drug trafficking organizations. The 2015 targets for both measures related to these efforts have been exceeded. The report also indicates that progress has been made on reducing the number of methamphetamine lab seizure incidents (a proxy for lab activity) from 2009 to 2013 but accelerated progress is needed to meet the 2015 target.

- *Objective 6—Strengthen International Partnerships and Reduce the Availability of Foreign Produced Drugs in the United States.* According to the report, key source and transit countries continue to demonstrate increased commitment to reducing drug trafficking and use through demand and supply reduction efforts. The targets for the two measures related to such commitments have both been met. However, the report states that accelerated progress is needed in working with partner countries to reduce the cultivation of drugs and their production potential in Afghanistan, Burma, Laos, Mexico, and Peru.

See attachment I for performance measures under each Strategy objective, progress toward 2015 targets, and ONDCP's assessment categorizations. ONDCP officials stated that actions taken in response to PRS results include Department of Education grants for school-based prevention activities to help educate students on the risks of using marijuana and increased funding to expand access to treatment to help address the rise in drug-induced deaths from opioid use, as discussed below.

Total Federal Spending for Drug Control Programs Has Increased since FY 2007

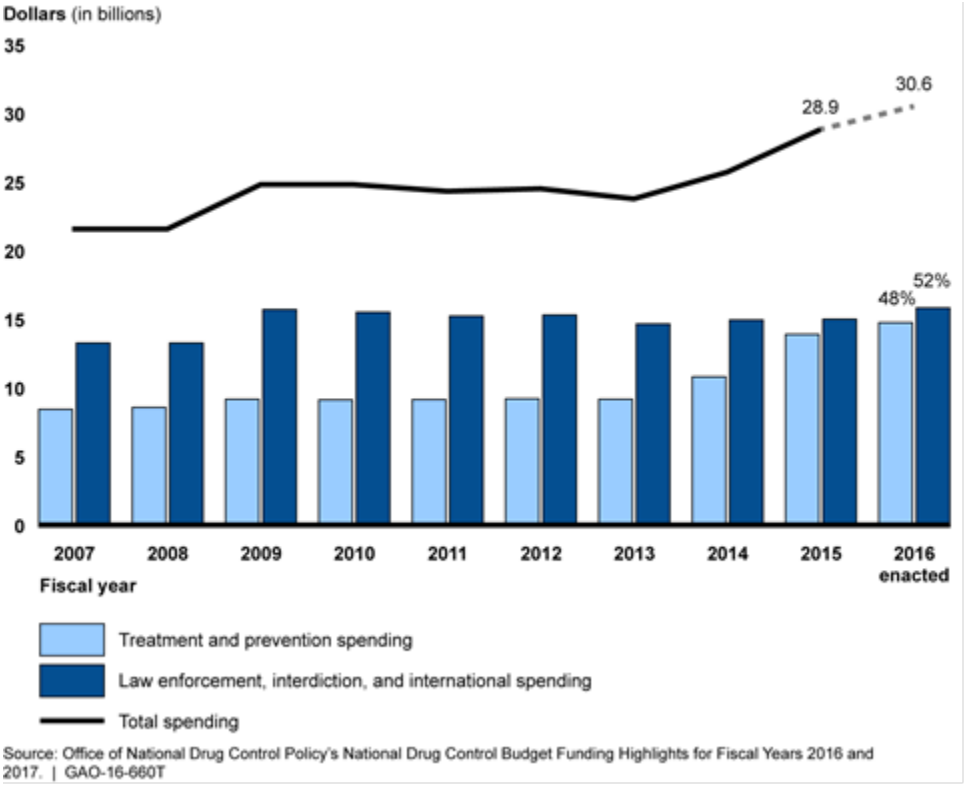
Federal Drug Control Spending on Treatment and Prevention Increased, While Law Enforcement and Interdiction Spending Remain Relatively Constant

According to ONDCP, federal drug control spending increased from $21.7 billion in FY 2007 to approximately $30.6 billion that was allocated for drug control programs in FY 2016 as shown in figure 2.[18] Though, total federal drug control spending increased from FY 2007 through FY

[18]We reviewed the fiscal year 2017 National Drug Control Budget Funding Highlights that describes fiscal year 2016 allocations. ONDCP refers to these funds as enacted in the National Drug Control Budget, while we use the term allocated funding. All FY 2016 funding is considered allocated funding for purposes of this statement. At the beginning of a fiscal year, agencies may allocate certain amounts from available appropriations for specific programs. However, to the extent that an appropriation has not identified a particular amount for a specific program, an agency may reallocate unobligated funds from that program to another during the course of a fiscal year. To the extent other statutory authority results in making mandatory funding for programs that may include drug abuse prevention and treatment, such as Medicare and Medicaid, we also include these as allocated funds.

2016, spending on supply reduction programs, such as domestic law enforcement, interdiction, and international programs remained relatively constant at $13.3 billion in FY 2007 and $15.8 billion in FY 2016.[19] However, federal spending for demand programs—treatment and prevention steadily increased from FY 2007 through FY 2016 and spending in these two programs went from $8.4 billion in FY 2007 to $14.7 billion in FY 2016. As a result, the proportion of funds spent on demand programs increased from 39 percent of total spending in FY 2007 to 48 percent in FY 2016.

Figure 2: Federal Drug Control Spending for Fiscal Years 2007 through 2016



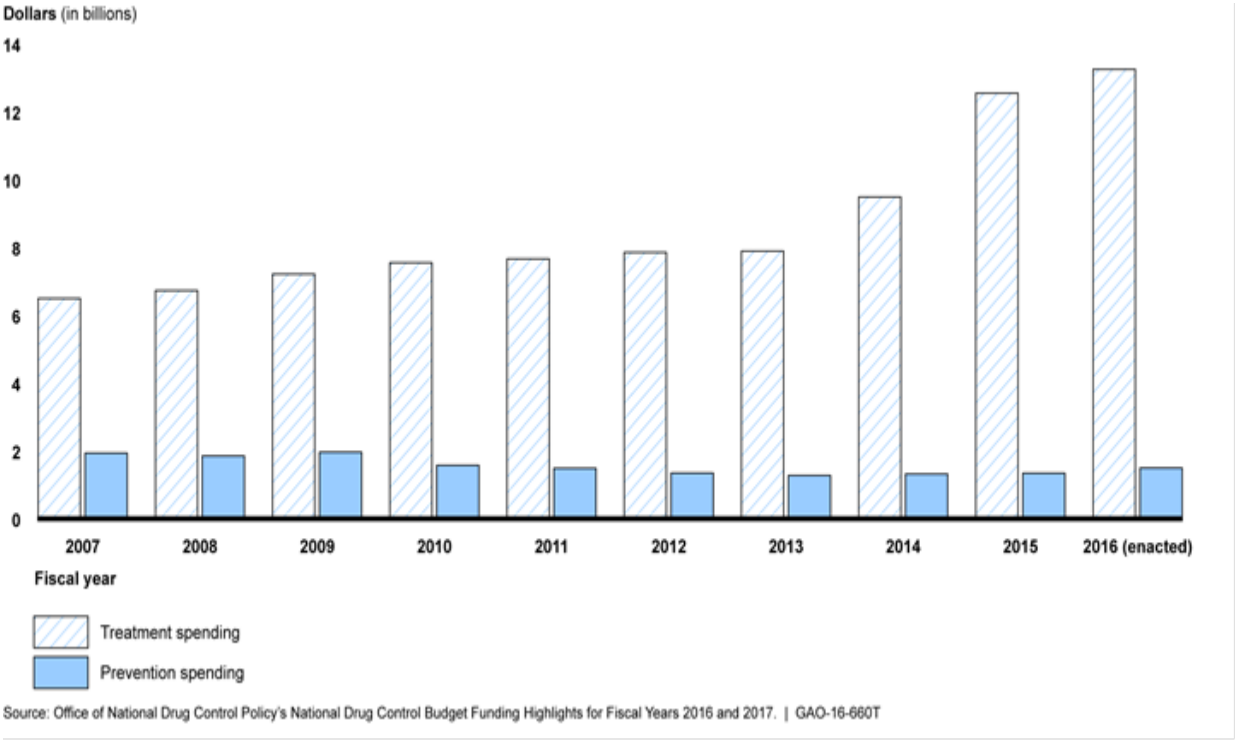
Source: Office of National Drug Control Policy's National Drug Control Budget Funding Highlights for Fiscal Years 2016 and 2017. | GAO-16-660T

According to ONDCP's *Fiscal Year 2016 Budget and Performance Summary*, ONDCP has prioritized treatment and recovery support services stating that they are essential elements of the Strategy's efforts to support long-term recovery among people with substance use disorders. Allocated funding for treatment increased in FY 2016 to approximately $13 billion, a 5 percent increase over FY 2015. These funds are used for early intervention programs, treatment programs, and recovery services. For example, according to ONDCP, approximately $8.8 billion

[19]All FY 2016 funding is considered allocated funding for purposes of this statement.

was the amount estimated for benefit outlays by the Department of Health and Human Services' (HHS) Centers for Medicare and Medicaid Services for substance use disorder treatment in both inpatient and outpatient settings for FY 2016. ONDCP also stated that preventing drug use before it starts is a fundamental element of the Strategy. Funding for prevention increased in FY 2016 to about $1.5 billion, a 10 percent increase from FY 2015, as shown in figure 3. Funding for treatment also increased from $12.5 billion in FY 2015 to $13.2 billion in FY 2016 in allocated funding. Figure 3 shows the increase in treatment and prevention spending for fiscal years 2007 through 2016.

Figure 3: Federal Spending for Drug Treatment and Prevention for Fiscal Years 2007 through 2016



Source: Office of National Drug Control Policy's National Drug Control Budget Funding Highlights for Fiscal Years 2016 and 2017. | GAO-16-660T

Additionally, in FY 2017, HHS' Substance Abuse and Mental Health Services Administration (SAMHSA) requested $460 million for a new program (State Targeted Response Cooperative Agreements) to help expand access to treatment for opioid use disorders, as well as $15 million for evaluating the effectiveness of medication-assisted treatment programs to improve service delivery and decrease the incident of opioid-related overdose and death (Cohort Monitoring and

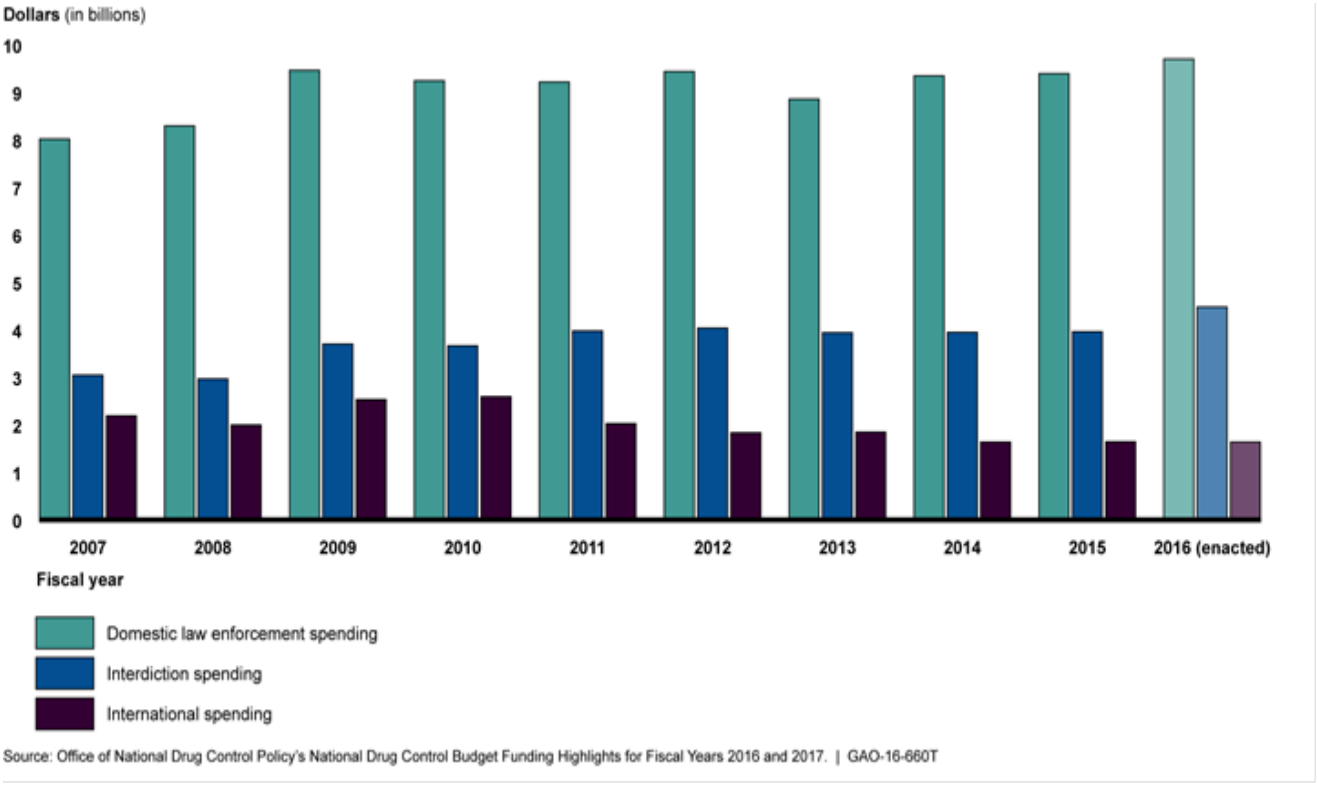
Evaluation of Medication Assisted Treatment Outcomes).[20] These programs could result in increasing SAMHSA's budget request for treatment programs to approximately $3 billion in FY 2017 from $2.5 billion enacted in FY 2016.

Addressing the drug supply is categorized by three main functions, which are Domestic Law Enforcement, Interdiction, and International. For Domestic Law Enforcement, ONDCP noted that federal, state, local, and tribal law enforcement agencies play a key role in the Administration's approach to reduce drug use and its associate consequences. ONDCP also stated that interagency drug task forces, such as the High Intensity Drug Trafficking Areas (HIDTA) program, are critical to leveraging limited resources among agencies. Allocated funding for domestic law enforcement in FY 2016 is approximately $9.7 billion, a 4 percent increase from FY 2015 funding. Regarding Interdiction, the United States continues to face a serious challenge from the large scale smuggling of drugs from abroad which are distributed to every region in the Nation. These funds support collaborative activities between federal law enforcement agencies, the military, the intelligence community, and international allies to interdict or disrupt shipments of illegal drugs, their precursors, and their illicit proceeds.

Allocated funding in support of Interdiction for FY 2016 is approximately $4.5 billion, an increase of 12 percent from FY 2015. International functions place focus on collaborative efforts between the U.S. Government and its international partners around the globe. According to ONDCP, illicit drug production and trafficking generate huge profits and are responsible for the establishment of criminal networks that are powerful, corrosive forces that destroy the lives of individuals, tear at the social fabric, and weaken the rule of law in affected countries. In FY 2016, approximately $1.6 billion was enacted, a 0.4 percent decrease from FY 2015. Figure 4 shows federal drug spending for Domestic Law Enforcement, Interdiction, and International activities.

[20]SAMHSA's FY 2017 request proposed a 2-year $920 million support cooperative agreements with states to expand access to treatment for opioid use disorders. In each of FY 2017 and 2018, SAMHSA would provide $460 million in new mandatory funding toward State Targeted Response Cooperative Agreements.

Figure 4: Federal Spending for Drug related Domestic Law enforcement, Interdiction, and International Activities for Fiscal Years 2007 through 2016

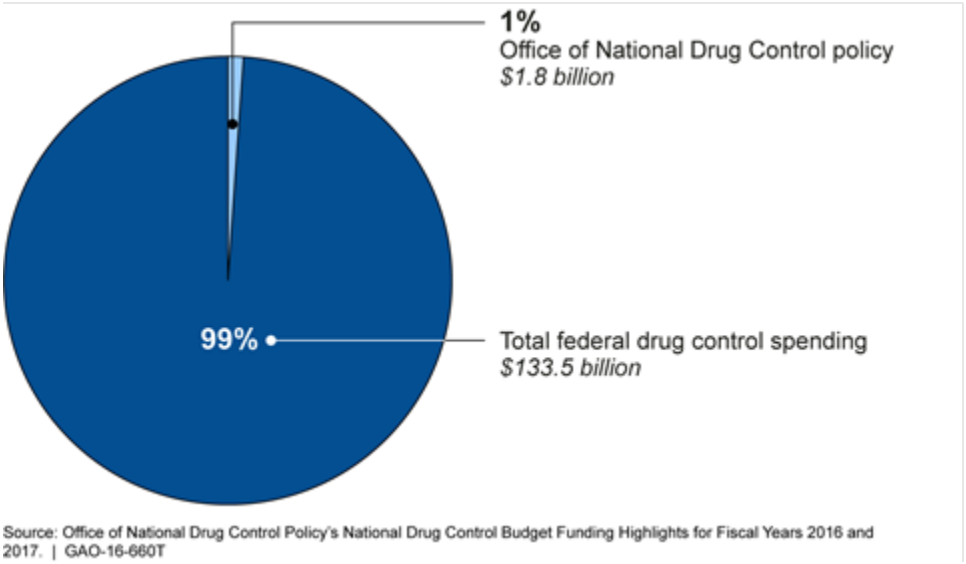


Source: Office of National Drug Control Policy's National Drug Control Budget Funding Highlights for Fiscal Years 2016 and 2017. | GAO-16-660T

ONDCP Spending Account For One Percent of Total Federal Drug Control Spending

In addition to advising the President on drug-control issues and coordinating drug-control activities and related funding across the Federal government, ONDCP also directly oversees two drug-related functions for which it receives federal drug control funding —HITDAs and other federal drug control programs, such as the Drug Free Community (DFC) coalition grant program. Based on ONDCP's spending in FY 2012 through its allocated funding in FY 2016 for these two functions, ONDCP's drug-related spending account for 1 percent of the total federal drug control spending in the federal government. ONDCP's requested funding for FY 2017 is 1 percent of the total federal drug control request. See figure 5 for allocated percentages.

Figure 5: ONDCP Spending Fiscal Years 2012 through 2016



Source: Office of National Drug Control Policy's National Drug Control Budget Funding Highlights for Fiscal Years 2016 and 2017. | GAO-16-660T

Chairman Johnson, Ranking Member Carper, and Committee members, this concludes my prepared statement. I would be happy to respond to any questions you may have.

Attachment I: ONDCP 2015 Performance Reporting System Report—Performance Measures for Strategy Objectives, Progress toward 2015 Targets, and Assessment Categorizations

Measure	Baseline	Progress to date	2015 Target	ONDCP assessment
Objective 1—Strengthen Efforts to Prevent Drug Use in Our Communities				
Measure 1.1: Percent of respondents, ages 12–17, who perceive a great risk in smoking marijuana once or twice a week.	49.0 percent (2009)	39.5 percent (2013)	51.2 percent	Significant progress required to meet 2015 target
Measure 1.2: Percent of respondents, ages 12–17, who perceive a great risk in consumption of one or more packs of cigarettes per day	65.5 percent (2009)	64.3 percent (2013)	68.0 percent	No progress to date, accelerated progress required to meet 2015 target
Measure 1.3: Percent of respondents ,ages 12–17, who perceive a great risk in consuming four or five drinks once or twice a week	39.6 percent (2009)	39.0 percent (2013)	41.4 percent	No progress to date, accelerated progress required to meet 2015 target
Measure 1.4: Average age of initiation for all illicit drugs	17.6 years (2009)	19.0 (2013)	19.5 years	Progress sufficient to enable meeting 2015 target
Measure 1.5: Average age of initiation for alcohol use	16.9 years (2009)	17.3 (2013)	21.0 years	Progressing, accelerated progress required to meet 2015 target
Measure 1.6: Average age of initiation for tobacco use				
- Cigarettes	17.5 years (2009)	17.8 (2013)	18.0 years	Progressing, accelerated progress required to meet 2015 target
- Cigars	20.7 years (2009)	21.6 (2013)	18.0 years	Target met or exceeded, progress should be maintained through 2015
- Smokeless tobacco	18.9 years (2009)	18.4 (2013)	18.0 years	Target met or exceeded, progress should be maintained through 2015
Objective 2—Seek Early Intervention Opportunities in Health Care				
Measure 2.1: Percent of Health Center Program grantees providing SBIRT services	10.3 percent (2009)	16.9 percent (2013)	15.0 percent	Target met or exceeded, progress should be maintained through 2015
Measure 2.2: Percent of respondents in the past year using prescription-type drugs non-medically, age 12–17	7.7 percent (2009)	5.8 percent (2013)	6.5 percent	Target met or exceeded, progress should be maintained through 2015
Measure 2.3: Percent of respondents in the past year using prescription-type drugs non-medically, age 18–25	15 percent (2009)	12.2 percent (2013)	12.8 percent	Target met or exceeded, progress should be maintained through 2015
Measure 2.4: Percent of respondents in the past year using prescription-type drugs non-medically, age 26+	4.7 percent (2009)	4.8 percent (2013)	4.0 percent	No progress to date, accelerated progress required to meet 2015 target
Objective 3—Integrate Treatment for Substance Use Disorders into Health Care and Expand Support for Recovery				

Measure	Baseline	Progress to date	2015 Target	ONDCP assessment
Measure 3.1: Percent of treatment plans completed	45.1 percent (2007)	43.7 percent (2011)	50.0 percent	Significant progress required to meet 2015 target
Measure 3.2: Percent of Health Center Program grantees providing substance use counseling and treatment services	21.6 percent (2009)	20.0 percent (2013)	23.0 percent	Significant progress required to meet 2015 target
Measure 3.3: Percent of treatment facilities offering at least 4 of the standard spectrum of recovery services (child care, transportation assistance, employment assistance, housing assistance, discharge planning, and after-care counseling)	35.5 percent (2008)	41.0 percent (2013)	39.0 percent	Target met or exceeded, progress should be maintained through 2015
Objective 4—Break the Cycle of Drug Use, Crime, Delinquency, and Incarceration				
Measure 4.1: Percent of residential facilities in the juvenile justice system offering substance abuse treatment	38.8 percent (2008)	45.3 percent (2012)	42.7 percent	Target met or exceeded, progress should be maintained
Measure 4.2: Percent of treatment plans completed by those referred by the criminal justice system	48.8 percent (2007)	47.5 percent (2011)	51.0 percent	Progressing, accelerated progress required to meet 2015 target
Objective 5—Disrupt Domestic Drug Trafficking and Production				
Measure 5.1: Number of domestic Consolidated Priority Organization Targets linked organizations disrupted or dismantled*	296 (2009)	473 (2013)	380	Target met or exceeded, progress should be maintained through 2015
Measure 5.2: Number of Regional Priority Organization Targets linked organizations disrupted or dismantled	119 (2009)	153 (2014)	120	Target met or exceeded, progress should be maintained through 2015
Measure 5.3: Methamphetamine lab activity (as measured by number of methamphetamine lab seizure incidents)	12,852 (2009)	11,329 (2013)	9,639	Progressing, accelerated progress required to meet 2015 target
Objective 6—Strengthen International Partnerships and Reduce the Availability of Foreign Produced Drugs in the United States				
Measure 6.1: Percent of selected countries that increased their commitment to supply reduction	2009 or earliest available [Baseline not provided in PRS report]	100 percent (progress to date)	100 percent	Target met or exceeded, progress should be maintained through 2015
Measure 6.2: Percent of selected countries that increased their commitment to demand reduction	2009 [Baseline not provided in PRS report]	100 percent (progress to date)	100 percent	Target met or exceeded, progress should be maintained through 2015
Measure 6.3: Percent of selected countries showing progress since 2009 in reducing either cultivation or drug production potential	2009 [Baseline not provided	29 percent (progress to date)	100 percent	No progress to date, accelerated progress required to meet 2015 target

Measure	Baseline	Progress to date	2015 Target	ONDCP assessment
	in PRS report]			
Measure 6.4: Number of international Consolidated Priority Organization Targets linked organizations disrupted or dismantled	65 (2009)	72 (2014)	60	Target met or exceeded, progress should be maintained through 2015
Objective 7—Improve Information Systems for Analysis, Assessment, and Local Management				
Measure 7.1: Increase timeliness (year-end to date-of-release) of select Federal data sets above their baseline by 10percent—Treatment Episode Data Set(TEDS)	17.5 Months	23.5 (2011)	16 Months	Significant progress required to meet 2015 target
Measure 7.2: Increase the utilization (number of annual web hits, or number of documents referencing the source) of select Federal data sets by 10percent from the baseline				
- Substance Abuse and Mental Health Data Archive (SAMHDA)	200,000 web hits/year	937,643 (2014)	220,000 web hits/ year	Target met or exceeded, progress should be maintained through 2015
- National Survey of Drug Use and Health (NSDUH) (Journal articles referencing NSDUH)	37 per year	113 (2014)	41 per year	Target met or exceeded, progress should be maintained through 2015
Measure 7.3: Increase Federal data sets that establish feedback mechanisms to measure usefulness (surveys, focus groups, etc.)—SAMHSA Funded Data Sets	0	1 (progress to date)	1	Target met or exceeded, progress should be maintained through 2015

Source: ONDCP 2015 Performance Reporting System report.

GAO Contact and Staff Acknowledgements

If you or your staff members have any questions about this testimony, please contact Diana Maurer at (202) 512-8777 or maurerd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Other contributors included Kevin Heinz, Assistant Director, Aditi Archer, Lyle Brittan, Eric Hauswirth, Justin Snover, and Johanna Wong.

(100835)