EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
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"What is the Federal Government Doing to Combat the Opioid Abuse Epidemic?"

Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
United States House of Representatives

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

Chairman Murphy, Ranking Member DeGette, and members of the Subcommittee, thank you for this opportunity to address the public health and safety issues surrounding the diversion and non-medical use of opioid drugs – including prescription painkillers and heroin - in the United States.

As you know, the Office of National Drug Control Policy (ONDCP) was established in 1988 by Congress 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, our office 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 It moves beyond an outdated "war on drugs" approach, and is guided by what science, experience, and compassion demonstrate about the true nature of drug use in America.

The considerable public health and safety consequences of nonmedical prescription opioid and heroin use underscore the need for action. Since the Administration's inaugural *2010 National Drug Control Strategy*, we have deployed a comprehensive and evidence-based strategy to address overdose deaths and opioid use disorders. The Administration has significantly bolstered support for substance use disorder treatment and overdose prevention; coordinated a government-wide response to the epidemic consequences from nonmedical prescription drug use; and pursued action against criminal organizations trafficking in opioid drugs.

Trends and Consequences of Opioid Use

The nonmedical use of opioids – a category of drugs which include heroin and prescription pain relievers like oxycodone and hydrocodone – is having a considerable impact on public health and safety in communities across the United States. According to the Centers for Disease Control and Prevention (CDC), approximately 120 Americans on average died from a drug overdose every day in 2013. Of the nearly 44,000 drug overdose deaths in 2013, opioid pain relievers were involved in over 16,200, while heroin was involved in over 8,200. Overall, drug overdose deaths now outnumber deaths from gunshot wounds (over 33,600) or motor vehicle accidents (over 35,400) in the United States. [1]

[1] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death, 1999-2013 on CDC WONDER Online Database, released 2015. Extracted by ONDCP from http://wonder.cdc.gov/mcd-icd10.html on January 30, 2015.

As this Subcommittee knows, the diversion and nonmedical use of prescription opioid medications has been of serious concern at the national, state, and local levels. Increases in admissions to treatment for substance use disorders,[2] drug-related emergency department visits,[3] and, most disturbingly, overdose deaths[4] attributable to nonmedical prescription drug use place enormous burdens upon communities across the country.

In 2013, over 4.5 million Americans ages 12 and older reported using prescription pain relievers non-medically within the past month.[5] This makes nonmedical prescription pain reliever use more common than use of any category of illicit drug in the United States except for marijuana. By comparison, approximately 289,000 Americans reported past month use of heroin.[6] Heroin use remains relatively low in the United States when compared to other drugs; however, there has been a troubling increase in the number of people using the drug in recent years – from 373,000 past year users in 2007 to 681,000 in 2013.[7] This trend comports with other indicators, including recent reporting from the National Institute on Drug Abuse's (NIDA) Community Epidemiology Work Group, which found that several U.S. cities, including Atlanta, Baltimore, Boston, Chicago, Cincinnati, Denver, Miami, Minneapolis, San Diego, Seattle, and St. Louis, indicated increases in heroin use. In addition, heroin remained at relatively stable but high levels in Detroit, New York City, and Philadelphia.[8] The Drug Enforcement Administration (DEA) also reports an over 300 percent increase of heroin seizures at the Southwest border from 2008 to 2013.[9]

The nonmedical use of these opioids translates into serious health consequences. In 2013 alone, approximately 1.9 million Americans met the diagnostic criteria for abuse or dependence on prescription pain relievers, while heroin accounted for approximately 517,000 people with

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[2] Substance Abuse and Mental Health Services Administration. *Treatment Episode Data Set (TEDS) 2001-2011, National Admissions to Substance Abuse Treatment Services*. U.S. Department of Health and Human Services. [2013]. Extracted April 2013.

[3] Substance Abuse and Mental Health Services Administration. *Drug Abuse Warning Network, 2011: National Estimates of Drug-Related Emergency Department Visits*. U.S. Department of Health and Human Services. [May 2013]. Available: http://www.samhsa.gov/data/2k13/DAWN2k11ED/DAWN2k11ED.htm#5.2

[4] Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death, 1999-2013 on CDC WONDER Online Database, released 2015.

[5] Substance Abuse and Mental Health Services Administration. *Results from the 2013 National Survey on Drug Use and Health: Detailed Tables*. Department of Health and Human Services. [November 2014]. Available: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabsPDFWHTML2013/Web/HTML/NSDUH-DetTabsSect7peTabs1to45-2013.htm#tab7.3b

[6] Substance Abuse and Mental Health Services Administration. *Results from the 2013 National Survey on Drug Use and Health: Detailed Tables*. Department of Health and Human Services. [November 2014]. Available: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabsPDFWHTML2013/Web/HTML/NSDUH-DetTabsSect7peTabs1to45-2013.htm#tab7.3A

[7] Substance Abuse and Mental Health Services Administration. *Results from the 2013 National Survey on Drug Use and Health: Detailed Tables*. Department of Health and Human Services. [November 2014]. Available: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabsPDFWHTML2013/Web/HTML/NSDUH-DetTabsSect7peTabs1to45-2013.htm#tab7.2A

[8] National Institute on Drug Abuse. Highlights and Summaries from January 2014 Reports. Available: http://www.drugabuse.gov/about-nida/organization/workgroups-interest-groups-consortia/community-epidemiology-work-group-cewg/highlights-summaries-january-2014-reports

[9] National Seizure System, El Paso Intelligence Center, extracted January 25, 2014.

past year use or dependence. Both of these figures represent significant increases from just a decade earlier.[10]

Beyond the many lives taken by overdoses involving these medications, prescription opioids are also associated with significant consequences for our health care system. In 2011 alone, 1.2 million emergency department (ED) visits involved the non-medical use of all prescription drugs.[11] Of these 1.2 million ED visits, opioid pain relievers accounted for the single largest drug class, accounting for approximately 488,000 visits. This is nearly triple (2.8 times) the number of ED visits involving opioid pain relievers just 7 years earlier in 2004 (173,000). Among specific opioid drugs in 2011, oxycodone accounted for the largest share (31 percent) of ED visits; there were 100,000 more visits involving oxycodone in 2011 than in 2004; this is an increase of 263 percent in the number of such visits from 2004 to 2011. While ED admissions involving heroin have remained relatively flat over the past several years, the drug was still involved in nearly 260,000 visits in 2011.

Similar trends are reflected in the country's substance use disorder treatment system. Data show a nearly four-fold increase in the past ten years of treatment admissions for individuals primarily abusing prescription pain relievers, from 43,000 in 2002 to 164,000 in 2012. Heroin treatment admissions remained flat over the same time period, but still accounted for 285,000 admissions in 2012.[12]

There has been considerable discussion around potential connections between the non-medical use of prescription opioids and heroin use. There is evidence to suggest that some users, specifically those with chronic opioid addictions, will substitute heroin for prescription opioids, since heroin is often cheaper than prescription drugs. A recent report from the Substance Abuse and Mental Health Services Administration (SAMHSA) found that four out of five recent heroin initiates had previously used prescription pain relievers non-medically. However, only a very small proportion (3.6%) of those who recently had started using prescription drugs non-medically initiated heroin use in the following five-year period.[13] Therefore, focusing our efforts to prevent first-time nonmedical opioid pain reliever use can help reduce heroin initiation.

We also know that substance use disorders, including those driven by opioids, are a progressive disease. We know from survey data that as an individual's non-medical use of

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[10] Substance Abuse and Mental Health Services Administration. *Results from the 2013 National Survey on Drug Use and Health: Detailed Tables*. Department of Health and Human Services. [November 2014]. Available: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabsPDFWHTML2013/Web/HTML/NSDUH-DetTabsSect7peTabs1to45-2013.htm#tab7.40A

[11] Substance Abuse and Mental Health Services Administration. *Drug Abuse Warning Network, 2011: National Estimates of Drug-Related Emergency Department Visits*. U.S. Department of Health and Human Services. [May 2013]. Available: http://www.samhsa.gov/data/2k13/DAWN2k11ED/DAWN2k11ED.htm#5.2

[12] Substance Abuse and Mental Health Services Administration. *Treatment Episode Data Set (TEDS) Substance Abuse Treatment Admissions by Primary Substance of Abuse, United States* [2002 through 2012 – Table 1.1a]. U.S. Department of Health and Human Services. [July 2014]. Available: http://www.samhsa.gov/data/sites/default/files/2002_2012_TEDS_National/2002_2012_Treatment_Episode_Data_Set_National_Tables.htm

[13] Substance Abuse and Mental Health Services Administration. *Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States*. Department of Health and Human Services. [August 2013]. Available: http://www.samhsa.gov/data/2k13/DataReview/DR006/nonmedical-pain-reliever-use-2013.pdf

prescription opioids becomes more frequent or chronic, that person is more inclined to purchase the drugs from dealers/prescriptions from multiple doctors, rather than simply getting them for free from a friend or relative.[14] Qualitative data indicates as tolerance, dependence or craving increases, users tend to obtain more opioid sources and at times will select lower cost alternatives such as heroin as a way to meet and afford escalating opioid needs.[15,16,17]

The Administration's Response

Since 2009, the Obama Administration has deployed a comprehensive and evidence-based strategy to address opioid drug misuse and its consequences. The Administration has coordinated a Government-wide response to this epidemic, significantly bolstered support for medication-assisted opioid treatment and overdose prevention, and pursued action against criminal organizations trafficking in opioid drugs. President Obama's inaugural *National Drug Control Strategy*, released in May 2010, labeled opioid overdose a "growing national crisis" and laid out specific actions and goals for reducing nonmedical prescription opioid and heroin use.[18]

Nonmedical use of prescription drugs represents the bulk of illicit opioid use in America, and our response to this public health emergency focuses not only on preventing the diversion and abuse of prescription drugs, but also decreasing the number of Americans dying from opioid overdose every day. In April 2011, the Administration released a comprehensive *Prescription Drug Abuse Prevention Plan (Plan),*[19] which created a national framework for reducing prescription drug diversion and misuse. This *Plan* built upon the goal identified in the *National Drug Control Strategy* to reduce drug-induced deaths by 15 percent by 2015 and augmented that goal with a distinct goal to reduce unintentional overdose deaths related to opioids by 15 percent within 5 years. The *Plan* focuses on improving education for patients and healthcare providers, supporting the expansion of state-based prescription drug monitoring programs, developing more convenient and environmentally responsible disposal methods to remove unused and unneeded medications from the home, and reducing the prevalence of pill mills and doctor shopping through targeted enforcement efforts.

The Administration has made considerable progress in all four areas of the *Plan*. To start, much progress has been made in expanding available continuing education for prescribers.

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[14] Unpublished estimates from Substance Abuse and Mental Health Services Administration, *National Survey on Drug Use and Health*. 2009-2012, March 2014.

[15] Lankenau SE, Teti M, Silva K, Jackson Bloom J, Harocopos A, Treese M. Initiation into prescription opioid misuse amongst young injection drug users. Int J Drug Policy. 2012 Jan;23(1):37-44. doi: 10.1016/j.drugpo.2011.05.014. Epub 2011 Jun 20. PMID: 21689917 available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3196821/

[16] Lankenau SE1, Teti M, Silva K, Bloom JJ, Harocopos A, Treese M.J Patterns of prescription drug misuse among young injection drug users.Urban Health. 2012 Dec;89(6):1004-16. doi: 10.1007/s11524-012-9691-9. Available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3531346/

[17] Sarah G. Mars, Philippe Bourgois, George Karandinos, Fernando Montero, Daniel Ciccarone. "Every 'Never' I Ever Said Came True": Transitions from opioid pills to heroin injecting Int J Drug Policy. Author manuscript; available in PMC 2015 March 1.Published in final edited form as: Int J Drug Policy. 2014 March; 25(2): 257–266. Published online 2013 October 19. doi: 10.1016/j.drugpo.2013.10.004 available at http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3961517/pdf/nihms533727.pdf

[18] 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

[19] 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

Managing patients' pain is a crucial area of clinical practice, but research indicates that health care practitioners receive little training on pain management, safe opioid prescribing, or recognizing and treating substance use disorders.[20,21] Several states, including Iowa,[22] Kentucky,[23] Massachusetts,[24] Ohio,[25] Tennessee,[26] New Mexico,[27] and Utah,[28] have passed legislation mandating education for prescribers, and we strongly encourage other states to explore this as an option.

The Administration developed and has made available free and low-cost training options available for prescribers and dispensers of opioid medications via several sources. SAMHSA provides such training. In addition, ONDCP worked with NIDA to develop "NIDAMED," two free, online training tools on safe prescribing for pain and on managing pain patients who use prescription opioids non-medically. Since its launch in late 2012 through February 2015, 58,166 clinicians completed the first NIDAMED course, and 48,189 clinicians completed the second course for continuing medical education credit. In total, 115,116 clinicians viewed part or all of the first course, and 89,654 viewed part or all of the second course. Pharmacists can also access these courses, and as of March 2014, members of the American Association of Nurse Practitioners and the American Academy of Physician Assistants were able to take these courses for credit.

The Food and Drug Administration (FDA) now requires manufacturers of extended-release and long-acting (ER/LA) opioid pain relievers to make available free or low-cost continuing education to prescribers under the Risk Evaluation and Mitigation Strategy (REMS) for these drugs. This program is arguably the most ambitious as FDA expects to train at least 60 percent of the approximately 320,000 prescribers of these medications within the first four years of the program.[29]

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[20] Mezei, L., et al. Pain Education in North American Medical Schools. *The Journal of Pain*. 12(12):1199-1208. 2011.
[21] U.S. Government Accountability Office. *Prescription Pain Reliever Abuse*. [December 2011]. Available: http://www.gao.gov/assets/590/587301.pdf
[22] Iowa Board of Medicine. "New rules require physicians to complete training on chronic pain, end-of-life care." State of Iowa. [August 2011]. Available: http://medicalboard.iowa.gov/Board%20News/2011/New%20rules%20physicians%20to%20complete%20training%20chronic%20pain_08182011.pdf
[23] Kentucky Board of Medical Licensure. "House Bill 1." Commonwealth of Kentucky. [2012]. Available: http://kbml.ky.gov/hb1/Pages/default.aspx
[24] Executive Office of Health and Human Services. "PMP and Mandatory Educational Requirements for Prescribers." Commonwealth of Massachusetts. [October 2011]. Available: http://www.mass.gov/eohhs/provider/licensing/occupational/dentist/pmp-and-mandatory-educational-requirements-for-pre.html
[25] General Assembly of the State of Ohio. "129th General Assembly – Amended Substitute Senate Bill Number 83." [2012]. Available: http://www.legislature.state.oh.us/bills.cfm?ID=129_SB_83
[26] State of Tennessee. "Public Chapter No. 430 – Senate Bill 676." [April 18, 2013]. Available: http://www.tn.gov/sos/acts/108/pub/pc0430.pdf
[27] New Mexico Medical Board. "Title 16 Chapter 10 Part 14 Section 11 – "Pain Management Continuing Education." [effective November 2012]. Available at: http://www.nmmb.state.nm.us/pdffiles/Rules/NMAC16.10.14_PainManagement.pdf
[28] Utah Division of Occupational and Professional Licensing. *Utah Controlled Substances Act, 58-37-6.5*. State of Utah. [May 2012]. Available: http://www.dopl.utah.gov/laws/58-37.pdf#page=24
[29] Food and Drug Administration. "Questions and Answers: FDA approves a Risk Evaluation and Mitigation Strategy (REMS) for Extended-Release and Long-Acting (ER/LA) Opioid Analgesics." Department of Health and Human Services. [updated March 2013]. Available: http://www.fda.gov/Drugs/DrugSafety/InformationbyDrugClass/ucm309742.htm#Q8

The Department of Health and Human Services (HHS) has implemented education requirements for its agency health care personnel, including professionals serving tribal communities through the Indian Health Service (IHS), those working with underserved populations through the Health Resources and Services Administration (HRSA), and personnel attending to biomedical research trial participants at the Clinical Center of the National Institutes of Health (NIH). Similar efforts have been implemented by the Bureau of Prisons, Department of Defense (DoD), and the Department of Veterans Affairs (VA).

Although FDA has made excellent progress with the REMS, it alone cannot address the dearth of critical and necessary opioid prescriber training. For one thing, REMS only covers ER/LA opioids. Also, while there are around one million physicians eligible to prescribe controlled substances, FDA estimates that fewer than 100,000 prescribers will have completed REMS continuing education by July 2015. While educating this number of prescribers is valuable, it is unrealistic to think that prescribing culture will change substantially without training a majority of subscribers. From 2010 to 2013, prescription opioid overdose deaths have decreased – but only by 2 percent. We must do more to ensure all prescribers have the knowledge and tools they need to prevent non-medical prescription drug use. That is why we, like FDA, continue to recommend a mandatory continuing education requirement tied to controlled substance licensure.

In March, HHS announced a comprehensive, evidence-based initiative aimed at reducing opioid dependence and overdose. Among the three priority areas of the initiative are efforts to train and educate health professionals on safe opioid prescribing, including the development of prescribing guidelines for chronic pain by the CDC.

The FDA has also taken a number of steps to help safeguard access to opioid pain relievers while reducing risks of non-medical use and overdose. In September 2013, ONDCP joined the FDA to announce significant new measures to enhance the safe and appropriate use of ER/LA opioid analgesics.[30] FDA required class-wide labeling changes for these medications, including modifications to the products' indication for severe pain, warnings around use during pregnancy, as well as post-market research requirements. FDA also announced that manufacturers of ER/LA opioids must conduct further studies and clinical trials to better assess risks of misuse, addiction, overdose, and death. In April 2013, FDA approved updated labeling for reformulated OxyContin that describes the medication's abuse-deterrent properties. These properties make the drug more difficult to inject or use nasally.[31] And in December 2013, FDA announced its recommendation that DEA reschedule hydrocodone combination products from Schedule III to Schedule II of the Controlled Substances Act, which requires more stringent standards for storage, record keeping, and prescribing. In August 2014, DEA issued a Final Rule:

[30] Food and Drug Administration. "ER/LA Opioid Analgesic Class Labeling Changes and Postmarket Requirements – Letter to ER/LA opioid application holders." Department of Health and Human Services. [September 2013]. Available: http://www.fda.gov/downloads/Drugs/DrugSafety/InformationbyDrugClass/UCM367697.pdf

[31] "Determination That the OXYCONTIN (Oxycodone Hydrochloride) Drug Products Covered by New Drug Application 20–553 Were Withdrawn From Sale for Reasons of Safety or Effectiveness." Federal Register 78:75 (April 18, 2013) p. 23273. Available: http://www.gpo.gov/fdsys/pkg/FR-2013-04-18/pdf/2013-09092.pdf

Schedules of Controlled Substances: Rescheduling of Hydrocodone Combination Products From Schedule III to Schedule II, which became effective in October 2014.[32]

The Administration is also educating the general public around opioid use. ONDCP's Drug-Free Communities (DFC) Support Program currently funds 680 community coalitions to work with local youth, parent, business, religious, civic, and other groups to help prevent youth substance use. Grants awarded through the DFC program are intended to support established community-based coalitions capable of effecting community-level change. All DFC-funded grantees are required to collect and report data on past 30-day use; perception of risk or harm of use; perception of parental disapproval of use; and perception of peer disapproval of use for four substances, including prescription drugs.

The second pillar of the Administration's *Plan* focuses on improving the operations and functionality of state-administered Prescription Drug Monitoring Programs (PDMPs). PDMP data can help prescribers and pharmacists identify patients who may be at-risk for substance use disorders, overdose, or other significant health consequences of misusing prescription opioids. State regulatory and law enforcement agencies may also use this information to identify and prevent unsafe prescribing, doctor shopping, and other methods of diverting controlled substances. Aggregate data from PDMPs can also be used to track the impact of policy changes on prescribing rates. The Prescription Behavior Surveillance System, funded by CDC and FDA, is developing this surveillance capacity for PDMPs. Research also shows that PDMPs may have a role in reducing the rates of prescribing for opioid analgesics. For example, states where PDMPs are administered by a state health department showed especially positive results.[33]

In 2006, only twenty states had PDMPs. Today, the District of Columbia has a law authorizing a PDMP, and forty-nine states have operational programs.[34] The state of Missouri stands alone in not authorizing a PDMP. However, its state Senate and state House have passed separate bills authorizing a state PDMP. We are cautiously optimistic that this means 2015 will be the year we can finally say we have a PDMP in every state. Today, Kentucky, New York, Tennessee, New Mexico, and Oklahoma all require prescribers to use their state's PDMP prior to prescribing in certain circumstances.[35] In Tennessee, where the requirement to check the PDMP went into effect in 2013, there was a drop in the rate of high utilizers of opioid pain relievers from the fourth quarter of 2011 to the fourth quarter of 2013.

Building upon this progress, the HHS Office of the National Coordinator for Health Information Technology (ONC) and SAMHSA are working with state governments and private sector technology experts to integrate PDMPs with health information technology (health IT)

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[32] 21 CFR Part 1308 Schedules of Controlled Substances: Rescheduling of Hydrocondone Combination Products from Schedule III to Schedule II. DEA. Final Rule. Available at http://www.gpo.gov/fdsys/pkg/FR-2014-08-22/pdf/2014-19922.pdf

[33] Brady, JE, Wunsch, H, Dimaggio, C, Lang, BH, Giglio, J, and Li, G. Prescription drug monitoring and dispensing of prescription opioids. Public Health Reports 2014, 129 (2): 139-47.

[34] National Alliance of Model State Drug Laws. (2014). Status of State Prescription Drug Monitoring Programs (PDMPs). Retrieved from http://www.namsdl.org/library/16666FCC-65BE-F4BB-A2BBAD44E1BC7031/.

[35] Tennessee Department of Health Controlled Substance Monitoring Database Committee. Controlled Substance Monitoring Database 2014 Report to the 108th Tennessee General Assembly, February 1, 2014. Page 5. Available at http://health.tn.gov/statistics/Legislative_Reports_PDF/CSMD_AnnualReport_2014.pdf Linked to 9-04-2014

systems such as electronic health records. Health IT integration will enable authorized healthcare providers to access PDMP data quickly and easily at the point of care. To date, SAMHSA has provided funding to sixteen states, and ONC has conducted thirteen pilots focused on integrating health IT systems with PDMPs. CDC is currently evaluating the 2012 SAMHSA grantees to identify best practices and determine the impact of the integration efforts.

The Department of Justice's (DOJ) Bureau of Justice Assistance (BJA) is also supporting expanded interstate sharing of PDMP data. Data sharing between states is especially important. Currently, at least thirty states have some ability to share data. In 2010, no states had any capacity for interstate data sharing. PDMP administrators are working to better integrate these systems into other health IT programs.

In FY 2014, BJA made fifteen site-based awards for states to implement or enhance a PDMP program or strategy to address non-medical prescription drug use, misuse and diversion within their communities. Since inception of the grant program in FY 2002, grants have been awarded to forty-nine different states and one U.S. territory. The program allows for state discretion to accommodate local decision-making based on state laws and preference, while encouraging the replication of demonstrated best practices. In recent years, the grant program included tribal participation, and gave support to states and localities to expand collaborative efforts between public health and public safety professionals. For example, Maryland used the funding to form overdose fatality review (OFR) teams comprised of multi-agency, multi-disciplinary stakeholders who review information on individuals who died from drug and alcohol related overdose. The OFR teams meet monthly to review medical examiner and other data. They identify overdose risk factors, missed opportunities for prevention/intervention, and make policy recommendations.[36]

In February 2013, the Department of Veterans Affairs (VA) issued an Interim Final Rule authorizing VA physicians to access state PDMPs in accordance with state laws and to develop mechanisms to begin sharing VA prescribing data with state PDMPs. The interim rule became final on March 14, 2014.[37] Since then, the VA has developed and installed software to enable VA pharmacies to transmit their data to PDMPs. As of April 2015, 67 VA facilities were sharing information with PDMPs in their respective states. VA providers have also begun registering and checking the state databases. However, VA's Veterans Health Administration (VHA) does not currently require prescribers to check the PDMP prior to prescribing. Investment in the VHA Electronic Health Record System is needed to expand PDMP integration.

While PDMP reporting is not required by IHS facilities, many tribes have declared a public health emergency and have elected to participate with the PDMP reporting initiative. Currently, IHS is sharing its pharmacy data with PDMPs in 18 states,[38] and IHS is in the process

[36] Maryland Department of Health & Mental Hygiene. (2014). Overdose Fatality Review in Maryland. Harold Rogers PDMP National Meeting. Retrieved from http://www.pdmpassist.org/pdf/PPTs/National2014/2-04_Baier.pdf. Linked to on 4-22-2015
[37] Disclosures to Participate in State Prescription Drug Monitoring Programs, 78 Fed. Reg. 9589 (Feb. 11, 2013); 79 Fed. Reg. 14400 (Mar. 14, 2014).
[38] Indian Health Service. (2014). Prescription Drug Monitoring Programs: Indian Health Service Update. Harold Rogers PDMP Annual Meeting. Retrieved from http://www.pdmpassist.org/pdf/PPTs/National2014/2-14_Tuttle.pdf.

of negotiating data-sharing with more states.[39] As these systems continue to mature, PDMPs can enable health care providers and law enforcement agencies to prevent the non-medical use and diversion of prescription opioids.

The third pillar of our *Plan* focuses on safely removing millions of pounds of expired and unneeded medications from circulation. Research shows that approximately 70 percent of past year nonmedical users of prescription pain relievers report getting them from a friend or relative the last time they used them, and approximately 84 percent of the time, that friend or relative obtained the pain relievers from one doctor.[40] Safe and proper disposal programs allow individuals to dispose of unneeded or expired medications in a safe, timely, and environmentally responsible manner.

From September 2010 through September 2014, the DEA partnered with hundreds of state and local law enforcement agencies and community coalitions, as well as other Federal agencies, to hold nine National Take-Back Days. Through these events, DEA collected and safely disposed of more than 4.8 million pounds of unneeded or expired medications.[41] The final National Take-Back Day took place on September 27, 2014. However, in September 2014, DEA published its Final Rule for the Disposal of Controlled Substances, which took effect October 9, 2014. These new regulations expand the options available to securely and safely dispose of unneeded prescription medications. They authorize certain DEA registrants (manufacturers, distributors, reverse distributors, narcotic treatment programs, retail pharmacies, and hospitals/clinics with an on-site pharmacy) to modify their registration with the DEA to become authorized collectors. Collectors may operate a collection receptacle at their registered location, and anyone can distribute pre-printed/pre-addressed mail-back packages that go to mail-back program operators. Retail pharmacies and hospitals/clinics with on-site pharmacies may operate their own disposal collection receptacles. In addition, long-term care facilities that offer disposal collection receptacles must partner with either a retail pharmacy or a hospital/clinic with an on-site pharmacy to operate collection receptacles in their facilities. Any person or entity may partner with law enforcement to conduct take-back events. Additionally, VHA has agreed to offer drug take back at VA facilities for patients and those accompanying them to appointments.[42]

ONDCP and DEA have engaged with Federal, state, and local agencies, and other stakeholders to increase awareness and educate the public about the new rule. In November 2014, ONDCP, DEA and the Alameda County California Superintendent's office hosted a webinar for community agencies to explain the new rule and discuss how local ordinances might

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[39] Cynthia Gunderson, Prescription Drug Monitoring Programs & Indian Health Service, Barriers, Participation, and Future Initiatives, Presentation at Third Party Payer Meeting, December 2012. http://www.pdmpexcellence.org/sites/all/pdfs/Gunderson.pdf.

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

[41] Drug Enforcement Administration. "DEA and Partners Collect 309 Tons of Polls on Ninth Prescription Drug Take-Back Day." Department of Justice. [November 5, 2014]. Available: http://www.dea.gov/divisions/hq/2014/hq110514.shtml

[42] Veterans Health Administration. "Joint Fact Sheet: DoD and VA Take New Steps to Support the Mental Health Needs of Service Members and Veterans." [August 26, 2014]. Available at: http://www.va.gov/opa/docs/26-AUG-JOINT-FACT-SHEET-FINAL.pdf linked to on 12-01-2014.

define or fund disposal programs. Over 800 people registered for the program, and 436 viewed it live.[43] ONDCP, the Environmental Protection Agency, DEA, and HHS will continue to develop and implement a plan for engaging communities to increase safe disposal.

The *Plan's* fourth pillar focuses on improving law enforcement capabilities to reduce diversion of prescription opioids. Federal law enforcement is partnering with state and local agencies across the country to reduce pill mills and prosecute those responsible for improper or illegal prescribing practices. The National Methamphetamine and Pharmaceuticals Initiative (NMPI), funded through ONDCP's High Intensity Drug Trafficking Areas (HIDTA) program, provides critical training on pharmaceutical crime investigations to law enforcement agencies across the country.

U.S. Customs and Border Protection, through its Laboratories and Scientific Service Directorate, routinely evaluates the type, volume, and quality of declared pharmaceutical products being shipped in international mail packages to guard against trafficking through the mail and parcel services. "Operation Safeguard" includes participation from numerous agencies, including the U.S. Postal Inspection Service, FDA, and DEA, and operates at international mail facilities.

All of these efforts under the *Prescription Drug Abuse Prevention Plan* are intended to reduce the diversion, non-medical use, and health and safety consequences of prescription opioids. The Administration has worked tirelessly to address the problem at the source and at an array of intervention points. This work has been paralleled by efforts to address heroin trafficking and use, as well as the larger opioid overdose problem facing this country. Just this week the Administration held its inaugural meeting of the Congressionally-mandated interagency Heroin Task Force. This Task Force is co-chaired by ONDCP Deputy Director for State, Local and Tribal Affairs Mary Lou Leary and U.S. Attorney for the Western District of Pennsylvania David Hickton, and includes Federal agency experts from law enforcement, medicine, public health and education. The Task Force will take an evidence-based approach to reducing heroin use and the public safety and public health consequences caused by heroin and prescription opioids.

The Administration continues to focus on vulnerable populations affected by opioids, including pregnant women and their newborns. Research suggests that over the last decade the prevalence of pregnant women using prescription medications may have increased.[44] From 2000 to 2009 the number of infants displaying symptoms of drug withdrawal after birth, known as neonatal abstinence syndrome (NAS), increased approximately threefold nationwide.[45]

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[43] Office of National Drug Control Policy. "Website Blog Watch: Webinar DEA Final Rule on Disposal of Controlled Substances." Available at: https://www.whitehouse.gov/blog/2014/11/17/watch-webinar-dea-s-final-rule-disposal-control-substances. Linked to on 4-15-2015

[44] Creanga, A.A., Sabel, J.C., Ko, J.Y., Wasserman, C.R., Shapiro-Mendoza, C.K., Taylor, P., Barfield, W., Cawthon, L., & Paulozzi, L.J. (2012). Maternal drug use and its effect on neonates: A population-based study in Washington State. Obstetric Gynecology, 119(5): 924-33. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/22525903.

[45] Epstein, R.A., Bobo, W.V., Martin, P.R., Morrow, J.A., Wang, W., Chandrasekhar, R., & Cooper, W.O. (2013). Increasing pregnancy-related use of prescribed opioid analgesics. Annals of Epidemiology, 23(8): 498-503. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/23889859.

Newborns with NAS have more complicated and longer initial hospitalizations than other newborns.[46] Newly published data shows the problem nearly doubled from 2009 to 2012.[47] Moreover, 80 percent of the cost for caring for these infants was the responsibility of state Medicaid programs during this time.

In 2012, the Administration held a symposium of key stakeholders and researchers aimed at improving outcomes for opioid dependent women and their newborns. From this symposium, partnerships developed around the country focused on this emerging issue, including partnerships with the National Governor's Association and the Association of State and Territorial Health Officials. In 2013, ONDCP worked with the Vermont Oxford Network to improve care for mothers and infants affected by opioid dependence. The Network's multidisciplinary effort involves teams from 205 hospitals from 42 states, Canada, Ireland, and the United Kingdom. This ambitious project aims to improve every aspect of care delivered to families – from standardizing newborn treatment, to engaging community partners at the local level. ONDCP and its interagency partners have identified five action items to address NAS that HHS and ONDCP intend to work on in the final years of the Administration.

The Administration is focusing on several key areas to reduce and prevent opioid overdoses, including educating the public about overdose risks and interventions; increasing access to naloxone, an emergency opioid overdose reversal medication; and working with states to promote Good Samaritan laws and other measures that can help save lives. With the recent rise in overdose deaths across the country, it is increasingly important to prevent overdoses and make antidotes available.

The Administration is providing tools to local communities to empower them to save lives. In August 2013, SAMHSA released the *Opioid Overdose Prevention Toolkit.*[48] This toolkit provides communities and local governments with material to develop policies and practices to help prevent opioid-related overdoses and deaths. It contains information for first responders, treatment providers, and those recovering from opioid overdose. This kit will enable state and community leaders to implement effective overdose prevention initiatives and connect people to the treatment they need.

In July 2014, the Attorney General issued a Memorandum urging Federal law enforcement agencies to identify, train and equip personnel who may interact with victims of an opioid overdose.[49] In October 2014, Attorney General Holder announced the launch of the

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[46] Patrick, S., Schumacher, R.E., Benneyworth, B.D., Krans, E.E., McAllister, J.M., & Davis, M.M. (2012). Neonatal abstinence syndrome and associated health care expenditures: United States, 2000-2009. Journal of the American Medical Association, 307(18): 1934-40. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/22546608.

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

[48] Substance Abuse and Mental Health Services Administration. Opioid Overdose Prevention Toolkit. Department of Health and Human Services. [August 2013]. Available: http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit/SMA13-4742

[49] Department of Justice, Office of Public Affairs. "Attorney General Holder Announces Plans for Federal Law Enforcement Personnel to Begin Carrying Naloxone." [July 31, 2014]. Available at http://www.justice.gov/opa/pr/attorney-general-holder-announces-plans-federal-law-enforcement-personnel-begin-carrying linked to 10-18-2014

Department of Justice's *Naloxone Toolkit* for law enforcement.[50] This toolkit is an online clearinghouse of more than 80 resources, such as sample policies and training materials designed to support law enforcement agencies in establishing a naloxone program. Training and technical assistance may also be requested through the toolkit. And in August 2014, the Administration announced that DoD was making a new commitment to ensure that opiate overdose reversal kits and training are available to every first responder on military bases or other areas under DoD's control.[51]

The Administration continues to promote the use of naloxone by those likely to encounter overdose victims and be in the position to reverse the overdose, especially first responders and caregivers. Increasing access to naloxone is one of the priority areas of HHS opioid initiative, and the Administration's FY 2016 Budget requests $12 million in grants to be issued by SAMHSA to states to purchase naloxone, equip first responders in high-risk communities, and provide education and the necessary materials to assemble overdose kits, as well as cover expenses incurred from dissemination efforts. Profiled in the 2013 *National Drug Control Strategy*, the Police Department in Quincy, Massachusetts, has partnered with the State health department to train and equip police officers to resuscitate overdose victims using naloxone. The Department reports that since October 2010, officers in Quincy have administered naloxone in more than 382 overdose events, resulting in 360 successful overdose reversals.[52] In the past year, we have witnessed an exponential expansion in the number of police departments that are training and equipping their police officers with naloxone. They now number in the hundreds.

There is extraordinary collaboration taking place in rural and suburban communities such as Lake County, Illinois. As part of the Lake County Heroin/Opioid Prevention Taskforce, the Lake County State's Attorney has partnered with various county agencies, including the Lake County Health Department; drug courts; police and fire departments; health, advocacy and prevention organizations; and local pharmacies to develop and implement an opioid overdose prevention plan.[53] Since July 2014, the Lake County Health Department has trained more than 34 police departments, 27 of which are carrying naloxone. As of February 2015, the Lake County Health Department had trained 828 police officers and 200 sheriff's deputies to carry and administer naloxone, and more departments have requested this training.[54]

Prior to 2012, just six states had any laws which expanded access to naloxone or limited criminal liability. Today, 35 states[55] and the District of Columbia have passed laws that offer criminal and/or civil liability protections to lay persons or first responders who administer naloxone. Twenty-four states[56] have passed laws that offer criminal and/or civil liability

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[50] Department of Justice, Office of Public Affairs. "Remarks by Attorney General Holder at the International Association of Chiefs of Police Annual Conference." [October 27, 2014]. Available at: http://www.justice.gov/opa/speech/remarks-attorney-general-holder-international-association-chiefs-police-annual-conference

[51] http://www.va.gov/opa/docs/26-AUG-JOINT-FACT-SHEET-FINAL.pdf

[52] Quincy (Massachusetts) Police Department Reporting. Email received 3/15/15.

[53] Office of the State's Attorney, Lake County, Illinois, Michael G. Nerheim. "Call to Action Lake County Opioid Prevention Initiative." [May 29, 2013]. Available at: http://lcsao.org/news/press-releases

[54] Lake County Health Department Reporting. Email 2/19/15.

[55] CA, CO, ID, OR, UT, WA, AZ, NM, OK, GA, KY, LA, MS, NC, TN, VA, WV, CT, DE, MA, MD, ME, NJ, NY, PA, RI, VT, IL, IN, MI, MN, MO, OH, SD, and WI.

[56] CA, CO, ID, UT, AZ, NM, GA, MS, NC, TN, VA, WV, CT, MA, NJ, NY, PA, VT, IN, MI, MN, OH, SD, and WI.

protections for prescribing or distributing naloxone. Thirty-three states[57] have passed laws allowing naloxone distribution to third-parties or first responders via direct prescription or standing order. ONDCP is collaborating with state health and law enforcement officials to promote best practices and connect officials interested in starting their own naloxone programs. The odds of surviving an overdose, much like the odds of surviving a heart attack, depend on how quickly the victim receives treatment. Twenty-five states[58] and the District of Columbia have passed laws which offer protections from charge or prosecution for possession of a controlled substance and/or paraphernalia if the person seeks emergency assistance for someone that is experiencing an opioid induced overdose. As these laws are implemented, the Administration will carefully monitor their effect on public health and public safety.

The Affordable Care Act and Federal parity laws are extending access to mental health and substance use disorder benefits for an estimated 62 million Americans.[59] This represents the largest expansion of treatment access in a generation and could help guide millions into successful recovery. The President's FY 2016 budget request includes $11 billion for treatment, a nearly seven percent increase over the FY 2015 funding level.

We are also seeking to ensure that the treatment people receive for their opioid use disorder is evidence-based. When combined with other supports, under the care of a physician, medication-assisted treatment (MAT) has been shown to be the best course of treatment for persons with an opioid use disorder. Several FDA-approved medications, including methadone, buprenorphine, and naltrexone, are proven treatment tools that are helping thousands of people maintain long-term recovery and lead healthy, productive lives. Additionally, medication assisted treatment may help reduce deaths from opioid drugs; a study found, for example, that increased access to medication-assisted treatment in Baltimore, Maryland, was associated with a reduction in heroin deaths.[60]

It is essential to identify and engage people who use prescription opioids non-medically early because the risks of being infected with HIV or hepatitis C increases dramatically once someone transitions to injection drug use. In fact, just a few weeks ago, the state of Indiana and the CDC identified over 130 people in a small county in Indiana who tested positive for HIV.[61] Many of these people had a history of injecting extended release oxymorhone. It is much less expensive to treat a person for just a substance use disorder early using evidence-based treatment, rather than to treat a person with a substance use disorder and provide lifetime treatment for HIV or a cure for hepatitis C.

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[57] CA, CO, ID, OR, UT, WA, AZ, OK, GA, KY, LA, MS, NC, TN, VA, WV, CT, DE, MA, MD, ME, NJ, NY, PA, VT, IL, IN, MI, MN, MO, OH, SD, and WI.

[58] AK, CA, CO, UT, WA, NM, FL, GA, KY, LA, NC, WV, CT, DE, MA, MD, NJ, NY, PA, RI, VT, IL, IN, MN, and WI.

[59] Berino, K., Rosa, P., Skopec, L. & Glied, S. (2013). Affordable Care Act Will Expand Mental Health and Substance Use Disorder Benefits and Parity Protections for 62 Million Americans. *Research Brief.* Assistant Secretary for Planning and Evaluation (ASPE). Washington, DC (Citation: Abstract of the Brief found at http://aspe.hhs.gov/health/reports/2013/mental/rb_mental.cfm)

[60] Schwartz, RP, Gryczynski, J, O'Grady, KE, Scharfstein, JM, Warren, G, Olsen, Y, Mitchell, SG, and Jaffe, JH. Opioid Agonist Treatments and Heroin Overdose Deaths in Baltimore, Maryland, 1995–2009 *Am J Public Health*. 2013;103:917–922.

[61] http://www.in.gov/isdh/files/April_17_MORE_HIV_CASES_REPORTED_IN_SOUTHEASTERN_INDIANA_AS_TESTING_RAMPS_UP.pdf

Medication-assisted treatment should be the recognized standard of care for opioid use disorders. Research shows that even heroin users can sustain recovery if treated with evidence-based methods. Studies have shown that individuals with opioid use disorders have better outcomes with maintenance MAT.[62] Yet for too many people, it is out of reach. For instance, in 2012 only 8 percent (1,167) of treatment facilities certified by SAMHSA provided treatment with methadone and/or buprenorphine (Opioid Treatment Programs).[63] Treatment programs are too often unable to provide this standard of care, and there is a significant need for medical professionals who can provide MAT in an integrated health care setting**.**

Medicines for opioid use disorder containing buprenorphine are an important advance that have only been available since Congress passed the Drug Addiction Treatment Act of 2000. They expand the reach of treatment beyond the limited number of heavily regulated Opioid Treatment Programs. Also because physicians who have taken the training to administer the medicines are allowed to treat patients in an office-based setting, it allows patient care to be integrated with mainstream medicine. Injectable naltrexone offers similar advantages but only to patients who have been abstinent for 7-10 days. Special training is not required for injectable naltrexone and its use is not limited to physicians.

We need to increase the number of physicians who can prescribe buprenorphine, when appropriate and the numbers of providers offering injectable naltrexone. Of the more than 877,000 physicians who can write controlled substance prescriptions, only about 29,194 have received a waiver to prescribe office-based buprenorphine. Of those, 9,011 had completed the requirements to serve up to 100 patients. The remainder can serve up to 30. Although they were augmented by an additional 1,372 narcotic treatment programs, far too few providers elect to use any form of medication-assisted treatment for their patients.[64] Injectable naltrexone was only approved for use with opioid use disorders in 2012, and little is known about its adoption outside specialty substance use treatment programs but use in primary care and other settings are possible. To date only about 3% of U.S. treatment programs offer this medicine for opioid use disorder.[65] Education on the etiology of opioid abuse and clinician interventions is critical to increasing access to treatments that will stem the tide of abuse and overdose.

The Administration is committed to promoting MAT in treatment systems at the Federal, state, and local levels. Increasing access to MAT is another one of the priority areas of the HHS opioid initiative. The President's FY 2016 budget request includes: an additional $26 million ($60 million total) within the total for the Second Chance Act grant for substance use treatment to help reduce re-offending and violations of probation and parole; an additional $13.1 million ($25.1 million total) for SAMHSA to expand MAT for its Prescription Drug and Opioid Addiction program; $5 million for the Agency for Healthcare Research and Quality to provide a

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[62] Weiss RD, Potter JS, Griffin ML, McHugh RK, Haller D, Jacobs P, Gardin J 2nd, Fischer D, Rosen KD. Adjunctive Counseling During Brief and Extended Buprenorphine-Naloxone Treatment for Prescription Opioid Dependence: A 2-Phase Randomized Controlled Trial Published in final edited form as: Arch Gen Psychiatry. 2011 December; 68(12): 1238–1246.

[63] SAMHSA. *National Survey of Substance Abuse Treatment Services (N-SSATS): 2012 -- Data on Substance Abuse Treatment Facilities* (December 2013).

[64] Personal communication (email) from Robert Hill (DEA).

[65] Aletraris L1, Bond Edmond M1, Roman PM1., Adoption of injectable naltrexone in U.S. substance use disorder treatment programs. J Stud Alcohol Drugs. 2015 Jan;76(1):143-51.

more robust review of evidence and evaluation regarding MAT in primary care settings as well as grants to develop and test new methods, processes, and tools for better implementing these treatment strategies; and an additional $1.2 million ($116.6 million total) for the Bureau of Prisons' substance use disorder treatment program and $1 million to expand its MAT field trial.

Reducing and preventing opioid diversion, abuse, overdose, and the array of public health and safety consequences requires collaboration with a broad range of stakeholders. The Administration has worked closely with a number of associations and groups, including the National Governors Association, the National Association of Attorneys General, the American Medical Association, the American Dental Association, the American College of Emergency Physicians, the National Safety Council, the National Conference of State Legislatures, the National Association of Boards of Pharmacy, the Association of State and Territorial Health Officials, state medical boards, and countless community groups in states, localities, and tribes across the country. All of these groups and the constituencies they represent have recognized the urgency of this national problem and are helping to bring about the changes we need to prevent negative health consequences like transmission of infection, and more deaths as well as to protect the public safety through targeted enforcement and smart on crime approaches that decrease diversion of prescription opioids and reduce the supply of heroin.

And there are some signs that these national efforts are working. The number of Americans 12 and older initiating the nonmedical use of prescription opioids in the past year has decreased significantly since 2009, from 2.2 million in that year to 1.5 million in 2013.[66] Additionally, according to the latest Monitoring the Future survey, the rate of past year use among high school seniors of OxyContin or Vicodin in 2014 is its lowest since 2002.[67]

However, while all of these trends are promising, the national data cited earlier concerning increases in emergency department visits, treatment admissions, and overdoses involving opioids bring the task ahead of us into stark focus. Continuing challenges with prescription opioids, and concerns about a reemergence of heroin use, particularly among young adults, underscore the need for leadership at all levels of government.

Conclusion

We continue to work with our Federal, state, local, and tribal partners to continue to reduce and prevent the health and safety consequences of nonmedical prescription opioid and heroin use. Together with all of you, we are committed partners, working to reduce the prevalence of substance use disorders through prevention, increasing access to treatment, and helping individuals recover from the disease of addiction. Thank you for the opportunity to testify here today, and for your ongoing commitment to this issue. I look forward to continuing to work with you on this pressing public health matter.

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[66] Substance Abuse and Mental Health Services Administration. *Results from the 2013 National Survey on Drug Use and Health: Detailed Tables*. Department of Health and Human Services. [November 2014]. Available: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabsPDFWHTML2013/Web/HTML/NSDUH-DetTabsSect7peTabs1to45-2013.htm#tab7.36A

[67] The Monitoring the Future study. *Narcotics other than Heroin: Trends in Annual Use and Availability – Grades 8, 10, and 12*. University of Michigan. [December 2014]. Available: http://www.monitoringthefuture.org/data/14data/14drfig11.pdf