



EXECUTIVE OFFICE OF THE PRESIDENT
OFFICE OF NATIONAL DRUG CONTROL POLICY
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**“All Hands on Deck: Working Together to
End the Trafficking and Abuse of
Prescription Opioids, Heroin, and Fentanyl”**

Field Hearing
of the
Committee on Homeland Security and Governmental Affairs
United States Senate

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New Hampshire Institute of Politics
Manchester, New Hampshire

Statement of
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Director of National Drug Control Policy

Senator Ayotte, Senator Shaheen, and members of the Committee, thank you for this opportunity to address the issues surrounding opioids, including heroin, in the United States and in New Hampshire in particular, and the Federal response.

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 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 opioid use disorders and overdose deaths due to heroin use and prescription opioid misuse. The Administration has increased access to treatment for substance use disorders, expanded efforts to prevent overdose and has coordinated a Government-wide response to the consequences of nonmedical prescription drug use. We also have continued to pursue actions against criminal organizations trafficking in opioid drugs. This statement focuses largely on the Administration's public health policy interventions to address opioid drug abuse, as well as those of our Federal, state and local partners, including professional associations that are involved with opioid prescribing or the prevention and treatment of opioid misuse. The statement of the Drug Enforcement Administration (DEA) for this hearing will discuss supply and law enforcement approaches.

Trends and Consequences of Opioid Use

Opioids – a category of drugs that includes heroin and prescription pain medicines like oxycodone, oxymorphone and hydrocodone – are 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 crashes (over

32,700)¹ in the United States.² Moreover, overdose deaths related to opioid pain relievers and heroin are undercounted as around one quarter of death certificates do not list the drug responsible for the fatal drug overdose,³ and until recently standards did not exist for death investigation reporting, and adoption of these standard is not universally practiced.⁴

The diversion and nonmedical use of prescription opioid medications has been of serious concern at the national, state, and local levels for over a decade. Increases in admissions to treatment for substance use disorders,⁵ drug-related emergency department visits,⁶ and, most disturbingly, overdose deaths⁷ attributable to nonmedical prescription drug use place enormous burdens upon communities across the country. Heroin, in contrast, until very recently has been used at much lower rates, possibly because historically its use was generally via injection, which often was necessitated by its low purity. As heroin purity increases, heroin can be smoked or snorted.⁸ Research shows that price reductions (resulting from greater availability) are closely related to overdose hospitalization rates; every \$100 decrease in the price of heroin per pure gram results in a 2.9 percent increase in the number of overdose hospitalizations.⁹

In 2014, over 4.3 million Americans ages 12 and older reported using prescription pain relievers non-medically within the past month.¹⁰ This makes nonmedical prescription pain reliever use more common than use of any category of illicit drug in the United States except for marijuana. Approximately 435,000 Americans reported past month use of heroin in 2014.¹¹ Heroin use remains relatively low in the United States when compared to other drugs; however, the increase in the number of people using the drug in recent years – from 373,000 past year users in 2007 to 914,000 in 2014 – is troubling.¹² These figures likely undercount the number of users, as national household surveys do not track all heroin-using populations such as homeless users. At least one community with a high level of chronic drug users among its homeless

¹ Fatality Analysis Reporting System (FARS) Encyclopedia Available at: <http://www-fars.nhtsa.dot.gov/Main/index.aspx>

² 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.

³ See <http://s3.documentcloud.org/documents/1151267/heroin-project-2014-study-on-overdose-deaths.pdf>

⁴ Goldberger BA1, Maxwell JC, Campbell A, Wilford BB. Uniform standards and case definitions for classifying opioid-related deaths: recommendations by a SAMHSA consensus panel. *J Addict Dis.* 2013;32(3):231-43. doi: 10.1080/10550887.2013.824334.

⁵ 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.

⁶ 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>

⁷ Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death, 1999-2013 on CDC WONDER Online Database, released 2015.

⁸ Stöver HJ1, Schäffer D. SMOKE IT! Promoting a change of opiate consumption pattern - from injecting to inhaling. *Harm Reduct J.* 2014 Jun 27;11:18. doi: 10.1186/1477-7517-11-18. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4094754/>

⁹ Unick G1, Rosenblum D, Mars S, Ciccarone D. Addiction. The relationship between US heroin market dynamics and heroin-related overdose, 1992-2008. *2014 Nov*;109(11):1889-98. doi: 10.1111/add.12664. Epub 2014 Aug 4.

¹⁰ Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, *National Survey on Drug Use and Health, 2013 and 2014. Table 1.1A Types of Illicit Drug Use in Lifetime, Past Year, and Past Month among Persons Aged 12 or Older: Numbers in Thousands, 2013 and 2014.*

¹¹ [Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2013 and 2014: Table 1.1A Types of Illicit Drug Use in Lifetime, Past Year, and Past Month among Persons Aged 12 or Older: Numbers in Thousands, 2013 and 2014.](http://www.samhsa.gov/data/2k13/DAWN2k11ED/DAWN2k11ED.htm#5.2)

¹² Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, *National Survey on Drug Use and Health, 2013 and 2014: Table 1.1A Types of Illicit Drug Use in Lifetime, Past Year, and Past Month among Persons Aged 12 or Older: Numbers in Thousands, 2013 and 2014.*

population, Baltimore, revises their heroin count by 10 percent to adjust for heroin use among its homeless population.¹³

Nonetheless, the trend for increases in heroin users shown in the National Survey on Drug Use and Health (NSDUH), a household-based survey from the Substance Abuse and Mental Health Services Administration (SAMHSA), comports with other indicators, including recent reporting from the National Institute on Drug Abuse's (NIDA) Community Epidemiology Work Group, which found that a number of 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.¹⁴ DEA also reports an over 300 percent increase of heroin seizures at the Southwest border from 2008 to 2013.¹⁵

A recent report from CDC and FDA using NSDUH public-use data¹⁶ shows a significant increase in heroin use from 2002 to 2004 and from 2011 to 2013. Rates remained highest among males, persons aged 18 to 25 years, persons with annual household incomes below \$20,000, persons living in urban areas, and persons with no health insurance or with Medicaid; however, rates increased significantly across almost all study groups. Moreover, the greatest increases in heroin use occurred in demographic groups that historically have had lower rates of heroin use, doubling among women and more than doubling among non-Hispanic whites. The rates of individuals who developed abuse or dependence on heroin, a near doubling during the decade-long study period, with a 35.7 percent increase during 2008–2010 alone, emphasize the addictive nature of this drug. This increase parallels the sharp increase in heroin-related overdose deaths reported since 2010.

This report also indicates that individuals who use heroin also use other drugs. People with past year abuse of or dependence on alcohol, marijuana, cocaine, or opioid pain relievers were at increased risk for past year heroin abuse or dependence. In 2013, 59 percent of the 8,257 heroin-related overdose deaths in the United States involved at least one other drug.¹⁷ Data presented in this report indicate the relationship between heroin and opioid pain relievers, as well as the relationship between heroin and cocaine, are particularly strong. In fact, past year abuse or dependence on opioid pain relievers was the strongest risk factor for past year heroin abuse or dependence. These results, coupled with prior research on heroin use trajectories, underscore that heroin use has its roots in, and often exists alongside, other forms of substance misuse.

Research illustrates that heroin use today is one of the later steps in most personal drug use trajectories. An analysis of NSDUH data shows that 21,000 people nationally began using

¹³ Baltimore Mayor's Heroin Treatment & Prevention Task Force Report <http://health.baltimorecity.gov/sites/default/files/Mayor%20Heroin%20Treatment%20Prevention%20Task%20Force%20Final%20Report%20July%202013%202015.pdf>

¹⁴ 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>

¹⁵ National Seizure System, El Paso Intelligence Center, extracted January 25, 2014.

¹⁶ Jones CM, Logan J, Gladden RM, Bohm MK. Vital Signs: Demographic and Substance Use Trends Among Heroin Users - United States, 2002-2013. MMWR Morb Mortal Wkly Rep. 2015 Jul 10;64(26):719-25 Available at: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6426a3.htm?s_cid=mm6426a3_w

¹⁷ CDC. Wide-ranging online data for epidemiologic research (WONDER). Atlanta, GA: CDC, National Center for Health Statistics; 2014. Available at <http://wonder.cdc.gov>.

heroin when 12 to 17 years old, 66,000 people began using when 18 to 25 years old, and 82,000 began when 26 years and older.¹⁸ Past-year heroin users were most likely to be in the 26 and older demographic. A second study of treatment seekers found the average age of treatment seekers to be around 23, and 75 percent of these began by using prescription opioids first.¹⁹ While the increases in overdose deaths among young people is disturbing, and pediatricians and doctors caring for people under the age of 25 need to be engaged on this issue, practitioners who treat adults normally past the typical age for developing substance use disorders need to monitor their patients for possible heroin use.

We are also concerned about the rise in reports by law enforcement about heroin that is cut with fentanyl. Fentanyl, a Schedule II substance under the Controlled Substances Act, is an opioid drug that is estimated to be 80 times as potent as morphine and hundreds of times more potent than heroin.²⁰ Fentanyl can serve as a direct substitute for heroin in opioid dependent individuals. However, fentanyl is a dangerous substitute for heroin because its increased potency results in frequent overdoses that can lead to respiratory depression and death.²¹ On July 17, 2015, DEA issued a Final Rule using its emergency scheduling authority to place acetyl fentanyl, a fentanyl analogue, in Schedule I of the Controlled Substances Act.²²

The nonmedical use of opioids translates into serious health consequences. In 2014 alone, approximately 1.9 million Americans met the diagnostic criteria for abuse of or dependence on prescription pain relievers, with heroin accounting for approximately 586,000 people with past-year abuse or dependence; both figures represent significant increases from just eleven years earlier.²³ For the duration of this statement, the terms “opioid use disorder” and “heroin use disorder” will be used to describe people who meet the criteria for abuse and dependence, since the terminology in the Diagnostic and Statistical Manual, Fifth Edition (DSM 5), the U.S. standard for classifying mental health disorders, no longer makes a distinction between abuse and dependence.

Beyond the many lives taken by fatal overdoses involving these medications, prescription opioids are associated with significant burden on our healthcare system. In 2011 alone, the last year for which these data are available, 1.2 million emergency department (ED) visits involved the nonmedical use of prescription drugs.²⁴ 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

¹⁸ R.N. Lipari and A. Hughes. The NSDUH Report: Trends in Heroin Use in the United States: 2002 to 2013. (2015). Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. Rockville, MD. http://www.samhsa.gov/data/sites/default/files/report_1943/ShortReport-1943.html Available at linked to on 7-19-2015.

¹⁹ Cicero TJ, Ellis MS, Surratt HL, Kurtz SP. The changing face of heroin use in the United States: a retrospective analysis of the past 50 years. *JAMA Psychiatry*. 2014 Jul 1;71(7):821-6. doi: 10.1001/jamapsychiatry.2014.366.

PMID: 24871348 available at <http://archpsyc.jamanetwork.com/article.aspx?articleid=1874575>

²⁰ National Institute for Occupational Safety and Health, Emergency Response Safety and Health Database, Fentanyl, Incapacitating Agent. Available at: http://www.cdc.gov/niosh/ershdb/emergencypersoncard_29750022.html

²¹ Drug Enforcement Administration, Office of Diversion Control. Fentanyl Fact Sheet. Available at: http://www.deadiversion.usdoj.gov/drug_chem_info/fentanyl.pdf.

²² Schedules of Controlled Substances: Temporary Placement of Acetyl Fentanyl Into Schedule I, 80 FR 42381 (July 17, 2015).

²³ Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality, *National Survey on Drug Use and Health, 2013 and 2014. Table 5.2A Substance Dependence or Abuse for Specific Substances in the Past Year, by Age Group: Numbers in Thousands, 2013 and 2014*

²⁴ 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>

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%) of ED visits; there were 100,000 more visits involving oxycodone in 2011 than in 2004, an increase of 263 percent. Heroin was involved in nearly 258,000 visits in 2011. Increases in hospitalizations for prescription opioid overdose within a community actually predicts subsequent year heroin overdose,²⁵ indicating that not only do some people tend to migrate to heroin if it is available, but also entire communities may shift usage habits. Although conventional theory suggests demand influences supply, it may also be the case that ample supply, especially pure and low priced product, can shift usage patterns and stoke demand.

Similar trends concerning growth in heroin use are reflected in the country's specialty substance use disorder treatment system. Data show a more than double increase in the past ten years of treatment admissions for individuals primarily seeking treatment for prescription opioid use disorder, from 53,000 in 2003 to 127,000 in 2011. Heroin treatment admissions remained flat over the same time period, yet accounted for 285,451 admissions in 2012.²⁶ Although all states have not yet reported specialty treatment admission data for 2013 and 2014, the trend in those states that have is that many more people are seeking treatment for heroin use than in the past.²⁷ In contrast, the percentage of people seeking treatment for prescription opioid use disorder has declined. Not every state, however, has experienced this decline. In some states with particularly intransigent prescription opioid misuse problems (for example, Tennessee), treatment admissions remain higher. In some states with historically high heroin treatment admissions (for example, New York), prescription opioid treatment admissions began an upward climb only in the late 1990s and at much lower levels.

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 a serious prescription opioid use disorder, will substitute heroin for prescription opioids. Heroin is cheaper than prescription opioids. A SAMHSA report found that four out of five recent heroin initiates had previously used prescription pain relievers nonmedically. However, only a very small proportion (3.6%) of those who recently had started using prescription drugs nonmedically initiated heroin use in the following five-year period.²⁸ Preventing the initiation of nonmedical opioid use nevertheless can help reduce the pool of people who may resort to heroin initiation later on because a large proportion of heroin users begin with abusing opioid pain relievers, even if this is a small subset of overall nonmedical opioid users.

²⁵ Unick GJ, Rosenblum D, Mars S, Ciccarone D. Intertwined epidemics: national demographic trends in hospitalizations for heroin- and opioid-related overdoses, 1993-2009. *PLoS One*. 2013;8(2):e54496. doi: 10.1371/journal.pone.0054496. Epub 2013 Feb 6. PMID: 23405084.

²⁶ 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

²⁷ Substance Abuse and Mental Health Services Administration. *Treatment Episode Data Set (TEDS) Substance Abuse Treatment extracted 6/2/2015 (Source: CAL TIC Presentation Primary Drug Treatment Admissions)*.

²⁸ 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>

We also know that substance use is often progressive, with some users rapidly escalating their use frequency, dosing, potency of drug and using through routes other than oral administration (e.g., sniffing, smoking or injecting) to achieve greater euphoria. Because the body rapidly develops tolerance to most effects of opioids and because withdrawal from opioids exerts the opposite effect (e.g., severe pain and gastrointestinal distress) regardless of whether the drug used is a relatively weak opioid like codeine or a stronger one like heroin, a vicious cycle can develop, where a user must keep using to avoid the severe flu-like and depressive symptoms associated with withdrawal. We know from survey data that as an individual's nonmedical use of 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.²⁹ 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.^{30,31,32} Research also suggests that the same dealers who deal in illicit pills often also supply heroin.³³

The Problem in New Hampshire

Overdose and non-medical prescription opioid use is a concern in New Hampshire, just as it is in other parts of the United States, and certain demographic groups have been affected greatly. For example:

- In 2013, New Hampshire had the 22nd highest drug poisoning rate (per 100,000 population) in the Nation. More New Hampshire residents died from drug poisonings (203) than motor vehicle crashes (138) or firearms (93).
- In New Hampshire during the 2012-2013 time period, the rate of prevalence of nonmedical use of prescription pain medication was more than 10 percent above the national average for persons age 18 to 25.
- The rate of drug poisoning deaths involving heroin increased in New Hampshire to surpass the national rate. In 2013, that rate reached 5.5 per 100,000 population.
- The rate of opioid analgesic-involved deaths in New Hampshire in 2013 (6.7 per 100,000 population) remained above the national rate (5.1 per 100,000 population).
- Eight of New Hampshire's 10 counties have a drug poisoning death rate above the national rate (12.9 per 100,000 population). The two counties with the highest rates are

²⁹ Unpublished estimates from Substance Abuse and Mental Health Services Administration, *National Survey on Drug Use and Health*. 2009-2012, March 2014.

³⁰ 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/>

³¹ 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/>

³² 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>

³³ 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>

Cheshire County (16.9 per 100,000 population) and Belknap County (16.3 per 100,000 population).

- Although its death rate is not as high because the population is so large, from 2009 to 2013 Hillsborough County lost the most people to overdose. In this time period 214 people died from drug poisonings involving opioids.

Drug treatment admissions can reflect a location's primary drug problem but can also reflect its treatment system infrastructure and workforce. The per capita rate of drug treatment admissions for other opiates besides heroin peaked in 2010 in New Hampshire at 102 per 100,000 population. That rate has declined slightly since then; however, in 2013 the rate was still above the national average, placing New Hampshire in the top 20 states (79 per 100,000 population). In 2012 heroin surpassed other opioids in treatment admissions. By 2014, heroin was the most common drug for which New Hampshire residents sought treatment; 1,508 primary drug treatment admissions were for heroin. Overall in New Hampshire, more than five times as many people in 2014 sought treatment for an opioid use issue (as their primary drug) than sought treatment for using marijuana, the most commonly used drug. Although New Hampshire has the lowest overall rate of drug treatment admissions in New England, opioid treatment has grown from 2009 to 2013 from a single-day count of 1763 people receiving methadone to 2,340 people receiving methadone in outpatient treatment programs and from 124 to 311 people receiving buprenorphine over those same dates.³⁴ Using the single-day count as a measure of capacity, as of 2013 New Hampshire ranked behind Connecticut, Massachusetts, Maine, and Rhode Island and only ahead of Vermont in the number of available treatment slots for treatment with either of these medications.^{35,36,37,38,39}

Injection drug users are at high risk for acquiring HIV because they may exchange syringes and equipment with others who are living with HIV. Among those living with HIV/AIDS in New Hampshire as of December 2013, 12.4 percent of persons living with AIDS contracted HIV through IDU.⁴⁰

The Administration's Response

³⁴ Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: New Hampshire, 2014. HHS Publication No. SMA-15-4895NH. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. Available at http://www.samhsa.gov/data/sites/default/files/State_BHBarometers_2014_2/BHBarometer-NH.pdf linked to on 9-1-2014. (7 Single-day counts reflect the number of persons who were enrolled in substance use treatment on March 31, 2009; March 31, 2010; March 31, 2011; March 30, 2012; and March 29, 2013).

³⁵ Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Connecticut, 2014. HHS Publication No. SMA-15-4895CT. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. Available at http://www.samhsa.gov/data/sites/default/files/State_BHBarometers_2014_1/BHBarometer-CT.pdf Linked to on 9-1-2015.

³⁶ Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Massachusetts, 2014. HHS Publication No. SMA-15-4895MA. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. http://www.samhsa.gov/data/sites/default/files/State_BHBarometers_2014_1/BHBarometer-MA.pdf.

³⁷ Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Maine, 2014. HHS Publication No. SMA-15-4895ME. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. http://www.samhsa.gov/data/sites/default/files/State_BHBarometers_2014_1/BHBarometer-ME.pdf.

³⁸ Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Rhode Island, 2014. HHS Publication No. SMA-15-4895RI. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. http://www.samhsa.gov/data/sites/default/files/State_BHBarometers_2014_2/BHBarometer-RI.pdf.

³⁹ Substance Abuse and Mental Health Services Administration. Behavioral Health Barometer: Vermont, 2014. HHS Publication No. SMA-15-4895VT. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2015. http://www.samhsa.gov/data/sites/default/files/State_BHBarometers_2014_2/BHBarometer-VT.pdf.

⁴⁰ New Hampshire Division of Public Health Services. Department of Health and Human Services, Epidemiologic Profile for HIV/AIDS Prevention and Care Planning 2013 available at <http://www.dhhs.nh.gov/data/index.htm> linked to on 08/28/2015.

Since 2009, the Obama Administration has deployed a comprehensive and evidence-based strategy to address: (1) excessive and dangerous opioid prescribing for pain and its consequences; and (2) illegal importation and sales of heroin. These efforts have expanded as surveillance has revealed an uptick in deaths related to the laboratory-created synthetic drug fentanyl and its analogs.

The following discussion identifies the efforts in each of these areas as experts believe they are all important for addressing heroin and the public health of people and communities heroin impacts.

Efforts to Stem the Prescription Opioid Crisis

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.⁴¹

Nonmedical use of prescription drugs still represents the bulk of illicit opioid use in America, and pharmaceutical opioids are responsible for the majority of opioid-related deaths. Our response to this public health emergency focuses on preventing the diversion and nonmedical use of prescription drugs, decreasing the number of Americans dying from opioid overdose every day, and expanding access to effective treatment, health care, and services for people with opioid use disorders.

In April 2011, the Administration released a comprehensive *Prescription Drug Abuse Prevention Plan (Plan)*,⁴² 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 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. Managing patients’ pain is a crucial area of clinical practice, but research indicates that health care practitioners receive little training on pain management or, safe opioid prescribing.^{43,44} Ten

⁴¹ 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>

⁴² 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

⁴³ Mezei, L., et al. Pain Education in North American Medical Schools. *The Journal of Pain*. 12(12):1199-1208. 2011.

⁴⁴ U.S. Government Accountability Office. *Prescription Pain Reliever Abuse*. [December 2011]. Available: <http://www.gao.gov/assets/590/587301.pdf>

states (Connecticut,⁴⁵ Delaware,⁴⁶ Iowa,⁴⁷ Kentucky,⁴⁸ Massachusetts,⁴⁹ New Mexico,⁵⁰ Ohio,⁵¹ Tennessee,⁵² Utah,⁵³ and West Virginia⁵⁴) have passed legislation mandating education for prescribers, and we strongly encourage other states to explore this as an option.

At the Federal level, 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 and the Department of Defense (DoD).

The Administration developed and has made available free and low-cost training options available for prescribers and dispensers of opioid medications via several sources, including SAMHSA and NIDA. 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.

These efforts alone, however, cannot address the dearth of critical and necessary opioid prescriber training as it is an optional program. From 2010 to 2013, overdose deaths involving prescription opioids have decreased – but only by 2 percent.⁵⁵ We must do more to ensure all prescribers have the tools they need to prevent nonmedical prescription drug use. The Administration continues to support policies that mandate a continuing education requirement for prescribers, as outlined in the *Plan*, potentially linked to their registration to prescribe with the DEA.

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.

FDA has also taken a number of steps to help safeguard access to opioid analgesics while reducing risks of non-medical use and overdose. In April 2013, FDA approved updated labeling for reformulated OxyContin that describes the medication's abuse-deterrent properties. These

⁴⁵ CONN. GEN. STAT. § 20-10b (2015), available at <http://www.cga.ct.gov/2015/ACT/PA/2015PA-00198-R00HB-06856-PA.htm>

⁴⁶ 24 DEL. CODE ANN. § 3.1.1, available at

<http://regulations.delaware.gov/AdminCode/title24/Uniform%20Controlled%20Substances%20Act%20Regulations.pdf>.

⁴⁷ IOWA ADMIN. CODE r. 253-11.4 (2011), available at <https://www.legis.iowa.gov/docs/ACO/chapter/07-22-2015.653.11.pdf>.

⁴⁸ 201 Ky. Admin. Reg. 9:250 (2013), available at <http://www.lrc.ky.gov/kar/201/009/250.htm>.

⁴⁹ MASS. GEN. LAWS ch. 94C, § 18(e) (2011), available at <https://malegislature.gov/Laws/GeneralLaws/PartI/TitleXV/Chapter94c/Section18>.

⁵⁰ N.M. ADMIN. CODE § 16-10-14 (2012), available at <http://164.64.110.239/nmac/parts/title16/16.010.0014.htm>.

⁵¹ OHIO REV. CODE ANN. § 4723.482

⁵² TENN. CODE ANN. § 63-1-402 (2013), available at <http://www.tn.gov/sos/acts/108/pub/pc0430.pdf>.

⁵³ UTAH ADMIN. CODE r. 58-37-6.5 (2012), available at http://le.utah.gov/xcode/Title58/Chapter37/58-37-S6.5.html?v=C58-37-S6.5_1800010118000101.

⁵⁴ W. VA. CODE § 30-1-7A (2011), available at <http://www.legis.state.wv.us/wvcode/ChapterEntire.cfm?chap=30&art=1§ion=7A>.

⁵⁵ 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.

properties are expected to make the drug more difficult to inject or abuse nasally.⁵⁶ In September 2013, ONDCP joined the FDA to announce significant new measures to enhance the safe and appropriate use of ER/LA opioid analgesics.⁵⁷ FDA required class-wide labeling changes for these medications, including modifications to the products' indication for pain severe enough to require daily, around-the clock, long-term opioid treatment and for which alternative treatment options are inadequate, 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. And in December 2013, following a congressionally-mandated public hearing, FDA announced that it agreed with the DEA recommendation that hydrocodone combination products be rescheduled from Schedule III to Schedule II of the Controlled Substances Act; in August 2014, DEA issued a Final Rule rescheduling hydrocodone combination products, which became effective in October 2014.⁵⁸

The Administration is also educating the general public about the dangers of 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 area 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.⁵⁹

In 2006, only twenty states had PDMPs. Today, the District of Columbia has a law authorizing a PDMP, and forty-nine states, including New Hampshire, have operational

⁵⁶ "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>

⁵⁷ 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>

⁵⁸ 21 CFR Part 1308 Schedules of Controlled Substances: Rescheduling of Hydrocodone 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>

⁵⁹ 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. <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3904893/pdf/phr129000139.pdf>

programs.⁶⁰ The state of Missouri stands alone in not authorizing a PDMP. Kentucky⁶¹, New Jersey,⁶² New Mexico⁶³, New York⁶⁴, Oklahoma⁶⁵, and Tennessee⁶⁶ all require their prescribers to use their state's PDMP prior to prescribing in certain circumstances. In Tennessee, where the requirement to check the PDMP went into effect in 2013, there was a drop in the number of high utilizers of opioid pain relievers from the fourth quarter of 2011 to the fourth quarter of 2013.⁶⁷

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) 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. CDC is evaluating the 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, which is especially important. Currently, at least thirty states have some ability to share data. 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 states and one U.S. territory. 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, according to Maryland's Department of Health and Mental Hygiene,⁶⁸ the state used its grant funding to form local 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 to identify overdose risk factors, missed opportunities for prevention/intervention, and make policy recommendations. These teams work on both prescription opioid and heroin overdose deaths. Currently the PDMP cannot disclose its information directly to the fatality review teams but there is a proposal to change this law so the review team can request data directly. This is an excellent example of how the PDMP expansion can be useful in understanding and addressing what for some can be the second stage of opioid use disorders, heroin use.

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

⁶⁰ 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/>.

⁶¹ Kentucky 201 KAR 9:260. 2012. Available at <http://www.lrc.ky.gov/kar/201/009/260.htm>

⁶² P.L. 2015, c.74 (N.J. 2015), available at http://www.njleg.state.nj.us/2014/Bills/AL15/74_.PDF

⁶³ New Mexico Register. 16.12.9.9. November 15, 2012. Available at http://www.nmcpr.state.nm.us/new-mexico-register/prev_issues/prev_issuesxxiii/xxiii21/16.12.9amend

⁶⁴ New York 3343-A. 2012. Available at <http://law.justia.com/codes/new-york/2012/pbh/article-33/title-4/3343-a>

⁶⁵ Oklahoma 3251. 2010. Available at http://www.oklegislature.gov/cf_pdf/2009-10%20FLR/hflr/HB3251%20hflr.pdf

⁶⁶ Tennessee 2253. 53-10-310. 2012. Available at <http://www.tn.gov/sos/acts/107/pub/pc0880.pdf>

⁶⁷ 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

⁶⁸ 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. Accessed on 4-22-2015.

mechanisms to begin sharing VA prescribing data with state PDMPs. The interim rule became final on March 14, 2014.⁶⁹ 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, the VA does not currently require prescribers to check the PDMP prior to prescribing.

While PDMP reporting is not required by IHS facilities, many tribes have declared public health emergencies and have elected to participate with the PDMP reporting initiative. Currently, IHS is sharing its pharmacy data with PDMPs in 18 states,⁷⁰ and IHS is in the process of negotiating data-sharing with more states.⁷¹ 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 53 percent of past year nonmedical users of prescription pain relievers report getting them for free from a friend or relative the last time they used them, and for approximately 84 percent of these, that friend or relative obtained the pain relievers from one doctor. An additional 15 percent bought or took them from a friend or relative.⁷² 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.⁷³ DEA has scheduled its next National Take-Back Day for September 26, 2015.

In addition, DEA published a Final Rule for the Disposal of Controlled Substances, which took effect October 9, 2014.⁷⁴ 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. Collectors that are retail pharmacies and hospitals/clinics

⁶⁹ Disclosures to Participate in State Prescription Drug Monitoring Programs, 78 Fed. Reg. 9589 (Feb. 11, 2013); 79 Fed. Reg. 14400 (Mar. 14, 2014).

⁷⁰ 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.

⁷¹ 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>.

⁷² 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>

⁷³ Drug Enforcement Administration. "DEA and Partners Collect 309 Tons of Pills on Ninth Prescription Drug Take-Back Day." Department of Justice. [November 5, 2014]. Available: <http://www.dea.gov/divisions/hq/2014/hq110514.shtml>

⁷⁴ Disposal of Controlled Substances, 79 Fed. Reg. 53519 (Sep. 9, 2014). Available: <https://www.federalregister.gov/articles/2014/09/09/2014-20926/disposal-of-controlled-substances>

with on-site pharmacies and law enforcement to include Veterans Health Administration (VHA) and DoD police officers 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 is offering drug take back options to Veterans.⁷⁵

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 define or fund disposal programs. Over 800 people registered for the program, and 436 viewed it live.⁷⁶ ONDCP and DEA will engage with Federal partners as well as with state and local entities to develop and implement a plan to develop disposal programs nationwide.

The *Plan's* fourth pillar focuses on improving law enforcement capabilities to reduce the diversion of prescription opioids. Federal law enforcement, to include our partners at DEA, is working with state and local agencies across the country to reduce pill mills, prosecute those responsible for improper or illegal prescribing practices, and make it harder for unscrupulous registrants including pharmacies to remain in business.

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.

Efforts to Stem the Heroin Crisis:

Heroin was added to Schedule I of the controlled substances list in 1914, and efforts to address heroin use and trafficking have been reflected annually in our *National Drug Control Strategy*. Opium poppy, from which heroin is derived, is not grown in the United States, and manufacturing is based outside of the country, primarily in Mexico for U.S. sales. Drug seizure data suggest a great deal of heroin has been flowing into the United States in recent years, primarily from Mexico but also from South America.

Pharmaceutical opioids activate the same receptors in the brain as heroin, a reason why users can switch from one to the other and avoid withdrawal. Approximately 18 billion opioid pills were dispensed in 2012,⁷⁷ enough to give every American 18 years or older 75 pills.⁷⁸ Plentiful access to opioid drugs via medical prescribing and easy access to diverted opioids for

⁷⁵ 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>. Accessed on 12-01-2014.

⁷⁶ 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>. Accessed on 4-15-2015

⁷⁷ IMS Health, National Prescription Audit, 2012

⁷⁸ Estimate presented by Thomas Frieden during oral presentation at Preventing Prescription Drug Overdose: New Challenges, New Opportunities. National RX Drug Abuse Summit, Operation Unite. Atlanta GA. April 8, 2014.

nonmedical use help feed our opioid crisis. In fact, as discussed above, the majority of new users come to heroin with experience as nonmedical prescription drug users.⁷⁹ Prior to today's opioid epidemic, heroin largely had been confined to urban centers with larger heroin using populations. Many communities and states that have never had a heroin use problem are now dealing with this epidemic, as Vermont Governor Shumlin discussed in his 2014 *State of the State* address.

In 2012 ONDCP held an interagency meeting focused on heroin, as many agencies were concerned that prescription opioid users might migrate to heroin. The interagency prescription drug working group formed a research group to examine the nature of the transition from prescription opioids to heroin, and CDC and SAMHSA have increased their focus on this issue, developing additional analyses to help track and publicize the issue.^{80,81}

In May 2015, 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 report will highlight emerging evidence-based public health and public safety models for Federal agency engagement in activities that promote solutions to reduce demand or decrease spread of disease.

The *National Drug Control Strategy's* efforts also include pursuing action against criminal organizations trafficking in opioid drugs, working with the international community to reduce cultivation of poppy, identifying labs creating dangerous synthetic opioids like fentanyl and acetyl-fentanyl and enhancing border efforts to decrease the flow of these drugs into the country.

Administration Support of State and Local Efforts

The Administration is funding numerous efforts to reduce opioid misuse and abuse in the states. In July, HHS announced an additional \$11 million in to states to expand the use of medication-assisted treatment (MAT) and an additional \$100 million to improve and expand substance use disorder services at community health centers, with a focus on MAT. In response to a number of requests from states and stakeholders, the Centers for Medicare & Medicaid Services is offering state Medicaid programs a new opportunity to receive Federal funding through a Social Security Act section 1115 demonstration project to support the design of service delivery systems to effectively treat individuals with substance use disorder, including by providing care in residential settings that would not ordinarily be covered.

The President's FY 2016 Budget proposal also includes critical investments to intensify efforts to reduce opioid misuse and abuse, including \$133 million overall in new funding. This

⁷⁹ Muhuri, P.K., Gfroerer, J.C., Davies, MC. SAMHSA CBHSQ Data Review. Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States. August 2013.

⁸⁰ R.N. Lipari and A. Hughes. The NSDUH Report: Trends in Heroin Use in the United States: 2002 to 2013. (2015). Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. Rockville, MD. http://www.samhsa.gov/data/sites/default/files/report_1943/ShortReport-1943.html Available at linked to on 7-19-2015

⁸¹ Jones CM, Logan J, Gladden RM, Bohm MK. Vital Signs: Demographic and Substance Use Trends Among Heroin Users - United States, 2002-2013. MMWR Morb Mortal Wkly Rep. 2015 Jul 10;64(26):719-25. PMID: 26158353

overall amount includes \$48 million in new funding to strengthen and evaluate state-level prescription drug overdose prevention, including a major expansion of CDC's Prescription Drug Overdose Prevention for States program to support efforts to reduce overdoses from opioids and other drugs. This investment would leverage existing PDMP activities and bring total CDC funding for this state prevention program to \$65 million. These funds would support grants to all 50 states and Washington, DC, for improvements to prescription drug monitoring programs, such as interstate interoperability and improved proactive reporting. Grants would also support national-level activities, including patient safety improvements and enhancements in data quality and monitoring with an emphasis on real-time mortality data. The FY 2016 Budget also includes \$5.6 million in new funding to address the rising rate of heroin-related overdose deaths by working to collect near real-time emergency department data and higher quality and timely mortality data by rapidly integrating death certificate and toxicology information, and \$5 million in increased funding for electronic death reporting to provide faster, better quality data, including on opioid overdose deaths.

The FY 2016 Budget for SAMHSA includes \$12 million for a new program to provide grants to 10 states to significantly reduce the number of opioid overdose-related deaths and help states purchase naloxone, equip and train first responders in high-risk communities on its use, support education on the use of naloxone and other overdose death prevention strategies, and support dissemination efforts. The Budget also includes \$10 million in new funding for SAMHSA's Strategic Prevention Framework to help states incorporate substance abuse prevention into state strategic planning efforts, including implementation of evidence-based practices aimed at reducing prescription drug abuse and misuse.

The Budget also proposes to establish a program in Medicare Part D to prevent prescription drug abuse by requiring that beneficiaries at risk for prescription drug misuse obtain controlled substances only from specified providers and pharmacies, similar to many state Medicaid programs. And the Budget requests \$5 million in new funding for ONC to improve the integration of Prescription Drug Monitoring Programs with electronic health records.

The FY 2016 Budget includes \$13 million in new resources for SAMHSA to expand or enhance MAT and other clinically appropriate services for persons with opioid use disorders through grants to states. This program will fund technical assistance and treatment services to communities with the greatest need. It also includes \$5 million in new funding for HHS's Agency for Healthcare Research and Quality to conduct a 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.

HIDTA Program Support to Respond to the Heroin Epidemic

ONDCP has committed \$2.5 million in FY 2015 funds for its High Intensity Drug Trafficking Areas (HIDTA) Program to develop a strategy to respond to the Nation's heroin epidemic.⁸² This project will combine prevention, education, intelligence, and enforcement

⁸² The Organized Crime and Drug Enforcement Task Forces (OCDETF) announced its National Heroin Initiative in December 2014, which outlines a similar strategy to respond to the national heroin epidemic, and appointed a National Coordinator in May 2015. Throughout the development of this program, HIDTA has been partnering with OCDETF in multiple regions across the country by participating in multiple

resources to address this drug threat across 15 states, including New Hampshire (Connecticut, Delaware, Kentucky, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Tennessee, Vermont, Virginia, and West Virginia), and the District of Columbia. The effort will be carried out through a unique partnership of five HIDTAs – Appalachia, New England, New York/New Jersey, Philadelphia/Camden, and Washington/Baltimore. The Heroin Response Strategy incorporates three key components:

1. Enhancement of the Drug Intelligence Officer Network

The Heroin Response Strategy will foster a collaborative network of public health-public safety partnerships to address the heroin/opioid epidemic from multiple perspectives. The Strategy will enhance the efficacy and efficiency of the criminal intelligence process in support of cooperative law enforcement operations. The five HIDTAs will create a multistate network of experienced, connected law enforcement contacts and leverage these connections and information-gathering capabilities with a strong, complementary, analytical capacity.

The five HIDTAs will select two centrally located Regional Coordinators, one with a public health focus and the other with a public safety focus, who will manage and oversee implementation and operation of the Heroin Response Teams. The Public Health Coordinator will oversee regional reporting of fatal and non-fatal overdose information and issuing of relevant alerts regarding dangerous batches of heroin and other heroin-related threats to health authorities. This will mobilize a rapid public health response to distribute naloxone or expand resources in the affected areas, helping to mitigate the number of overdoses and prevent deaths. The Public Safety Coordinator will oversee execution of public safety goals by ensuring case support is provided where needed and intelligence is being disseminated to relevant law enforcement authorities to enable disruption of the heroin supply.

2. Education and Training for Public Safety First Responders

A heroin and prescription opioid training curriculum will be developed and used to prepare rural and municipal officers and first responders who are inexperienced in responding to heroin and prescription opioid-related incidents. To assist communities in coping with this escalating problem, the HIDTAs will develop education and training strategies that will increase awareness of heroin and opiate addiction, create linkages to available prevention and treatment resources in the respective regions, and enable first-responders to know how to report all pertinent information developed from seizures and overdose responses.

3. State of the Region Public Health-Public Safety Symposia

strategic initiatives developed by OCDETF on the district and regional level, through its member agencies and their collaboration with state and local law enforcement partners.

The Heroin Response Strategy will build on the successes of the 2014 symposium hosted by the Washington/Baltimore HIDTA. The five HIDTAs will host two, 2-day State of the Region symposia at a jointly nominated HIDTA. These symposia will build additional structure within each respective HIDTA by allowing attendees to maintain regular contact and continue their public health-public safety partnerships between symposia. The aim will be to facilitate collaboration between public health and public safety partners within and across jurisdictions, sharing best practices, innovative pilots, and identifying new opportunities to leverage resources.

The HIDTA Program is funding two additional discretionary projects in FY 2015 that will benefit New Hampshire. The Southern New Hampshire Drug Task Force will be receiving \$90,000 to support Safe and Competent Opioid Prescribing Education (SCOPE) of Pain continuing medical education (CME) training. And the New England HIDTA received \$125,000 to support efforts throughout the HIDTA region. We anticipate that New Hampshire will receive a portion of that funding, although specific amounts are not yet available.

Treatment, Overdose Prevention, and Other Public Health Efforts

The public health consequences of nonmedical opioid and heroin use are often similar if not identical. Most notably, in both cases, some proportion of individuals escalate use and eventually develop a chronic opioid use disorder requiring treatment. The low rate of cases referred to treatment by medical personnel in the face of such a dangerous epidemic suggests that providers may ignore or miss the problems of nonmedical prescription opioid use and heroin use among their patients. The extent of the opioid use problem requires that health care providers work in tandem with law enforcement to address the issue.

People who escalate use are vulnerable to begin injecting, and this behavior dramatically increases their risk of exposure to blood-borne infections, including human immunodeficiency virus (HIV) and hepatitis C. It is noteworthy that in the latest HIV outbreak in rural Indiana, it was intravenous use of the strong prescription opioid oxycodone, not heroin, which accounted for most of the cases. Since the first patient in the outbreak was identified in January 2015, 174 people have tested positive for HIV. To combat the spread of HIV, Indiana instituted an emergency syringe services program, among other efforts to expand treatment for HIV and opioid use disorders. The Administration continues to support a consistent policy that would allow Federal funds to be used in locations where local authorities deem syringe services programs to be effective and appropriate. Studies show that comprehensive prevention and drug treatment programs, including syringe services program, have dramatically cut the number of new HIV infections among people who inject drugs.

Nonmedical use of prescription opioids and use of heroin can produce overdose including fatal overdose especially when used in conjunction with other sedatives including alcohol and anti-anxiety medicines. People who have stopped using for a period of time, such as those who were in treatment, have been medically withdrawn, or have been incarcerated, are especially at risk of overdose because their tolerance has worn off but they use amounts similar to those prior to cessation. When used chronically by pregnant women, both prescription opioids and heroin

can cause withdrawal symptoms in newborns upon birth, and if these opioids are withdrawn during pregnancy, fetal harm may result.

For these reasons, it is important to identify and treat people with prescription opioid use disorder quickly, ensure they are engaged in the most effective forms of evidence-based treatment, and make lifesaving tools like the overdose reversal antidote naloxone widely available. Fortunately, the treatments for heroin and prescription opioid use disorder are the same. The standard of care is behavioral treatment plus stabilization on one of three FDA-approved medicines, often called medication-assisted treatment. MAT may be tapered in time to produce abstinence, but a health care provider must make the decision that is right for his or her patient regarding whether to cease a medication.

The Administration continues to focus on vulnerable populations affected by opioids, including pregnant women and their newborns. 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.⁸³ Newborns with NAS have more complicated and longer initial hospitalizations than other newborns.⁸⁴ Newly published data shows the problem nearly doubled from 2009 to 2012.⁸⁵ Additionally, the study showed that 80 percent of the cost for caring for these infants was the responsibility of state Medicaid programs during this time.

The Administration is focusing on several key areas to reduce and prevent opioid overdoses from prescription opioids and heroin, 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 opioid-involved overdose deaths across the country, it is increasingly important to prevent overdoses and make antidotes available.

It is important to note in some cases traffickers are combining heroin with the synthetic lab-produced opioid fentanyl or an analog, presumably as a way to increase user perception of product strength and thus user experience.⁸⁶ Fentanyl can produce overdose rapidly in naïve users and in such cases naloxone may be insufficient remedy for fentanyl or its analogs.⁸⁷

The Administration is providing tools to local communities to deal with the opioid drug epidemic. In August 2013, SAMHSA released the *Opioid Overdose Prevention Toolkit*.⁸⁸ This

⁸³ 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>.

⁸⁴ 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>.

⁸⁵ Patrick, SW, Davis, MM, Lehman, CU, Cooper, WO. Increasing 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

⁸⁶ Notes from the field: increase in fentanyl-related overdose deaths - Rhode Island, November 2013-March 2014.

Mercado-Crespo MC, Sumner SA, Spelke MB, Sugerma DE, Stanley C; EIS officer, CDC.

MMWR Morb Mortal Wkly Rep. 2014 Jun 20;63(24):531. <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6324a3.htm>

⁸⁷ Zuckerman M, Weisberg SN, Boyer EW. Pitfalls of intranasal naloxone. *Prehosp Emerg Care*. 2014 Oct-Dec;18(4):550-4. doi: 10.3109/10903127.2014.896961. Epub 2014 May 15..

⁸⁸ 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>

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. In July 2014, Attorney General Holder issued a Memorandum urging Federal law enforcement agencies to identify, train and equip personnel who may interact with victims of an opioid overdose,⁸⁹ and in October 2014, the Attorney General announced the launch of the Department of Justice's *Naloxone Toolkit* to support law enforcement agencies in establishing a naloxone program.⁹⁰ 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.⁹¹ And earlier this month, the Indian Health Service announced its own toolkit for use with American Indian and Alaskan Natives a population who has disparate rates of past year non-medical prescription pain reliever use (6.9 percent vs. 4.2 percent in the rest of the population).⁹²

The Administration continues to promote the use of naloxone by those likely to encounter overdose victims and for them to be in the position to reverse the overdose, especially first responders and caregivers. 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 Quincy Massachusetts Police Department 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.⁹³ 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.

Extraordinary collaboration is 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.⁹⁴ 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

⁸⁹ 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>

⁹⁰ 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>

⁹¹ <http://www.va.gov/opa/docs/26-AUG-JOINT-FACT-SHEET-FINAL.pdf>

⁹² SAMHSA. National Survey on Drug Use and Health. The CBHSQ Report, June 2015. Nonmedical use of prescription pain relievers varies by race. http://www.samhsa.gov/data/sites/default/files/report_1972/Spotlight-1972.html linked to on 7-19-2015.

⁹³ Quincy (Massachusetts) Police Department Reporting. Email received 3/15/15.

⁹⁴ 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>

Department had trained 828 police officers and 200 sheriff's deputies to carry and administer naloxone, and more departments have requested this training.⁹⁵

Prior to 2012, just six states had any laws which expanded access to naloxone or limited criminal liability. Today, 36 states⁹⁶ 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-five states⁹⁷ have passed laws that offer criminal and/or civil liability protections for prescribing or distributing naloxone. Thirty-four states⁹⁸ 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 states⁹⁹ 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.¹⁰⁰ 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.

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. 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 pharmaceuticals to treat and cure hepatitis C.

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.¹⁰¹ Yet for too many people, it is out of reach. For instance, only 26.2 percent (3,713) of treatment facilities provided treatment with methadone and/or

⁹⁵ Lake County Health Department Reporting. Email 2/19/15.

⁹⁶ NH, 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.

⁹⁷ NH, 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.

⁹⁸ NH, 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.

⁹⁹ 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.

¹⁰⁰ 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)

¹⁰¹ 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.

buprenorphine.¹⁰² 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 important advancements that have only been available since Congress passed the Drug Addiction Treatment Act of 2000 (DATA 2000). They expand the reach of treatment beyond the limited number of heavily regulated Opioid Treatment Programs that generally dispense methadone. 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 from opioids for 7-10 days. Special training required by DATA 2000 for prescribing buprenorphine is not required for injectable naltrexone.

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 are augmented by an additional 1,377 narcotic treatment programs, far too few providers elect to use any form of medication-assisted treatment for their patients.¹⁰³ 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 percent of U.S. treatment programs offer this medicine for opioid use disorder.¹⁰⁴ Education on the etiology of opioid abuse and clinician interventions is critical to increasing access to treatments that will stem the tide of opioid misuse and overdose.

And there are some signs that these national efforts are working with respect to the prescription opioid problem. 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 2013.¹⁰⁵ 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 2002.¹⁰⁶

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

¹⁰² SAMHSA. *National Survey of Substance Abuse Treatment Services (N-SSATS): 2012 -- Data on Substance Abuse Treatment Facilities* (December 2013).

¹⁰³ Personal communication (email) from Robert Hill (DEA).

¹⁰⁴ Aletraris LI, 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.

¹⁰⁵ 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>

¹⁰⁶ 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>

prescription opioids, and concerns about a reemergence of heroin use, particularly among young adults, underscore the need for leadership at all levels of government.

New Hampshire Policy Status and what People from New Hampshire Can Do

In June 2015, the New Hampshire legislature passed HB 271,¹⁰⁷ a bill that allows health care professionals authorized to prescribe an opioid antagonist to prescribe, dispense, or distribute naloxone directly or by standing order to an individual or family member, friend or any person in a position to assist in the event of an opioid related overdose. The new law permits emergency medical technicians and law enforcement first responders to use naloxone. It also contains a Good Samaritan provision, which prevents criminal or civil liability against a person who administers naloxone acting in good faith if they thought a person was experiencing an overdose. In July HB 270,¹⁰⁸ another Good Samaritan statute, was signed into law, granting immunity from arrest, prosecution, or conviction to a person who requests medical assistance to save the life of an overdose victim.

New Hampshire has a challenge meeting the need of its residents for medication-assisted treatment, given that its population is distributed across a mostly rural region. There are no opioid treatment programs north of Plymouth that provide methadone, and there are only three programs in the northern part of the state that list buprenorphine providers.¹⁰⁹ Recently, HHS announced that community health centers are eligible to apply for grants which will pay for inclusion of at least one MAT provider. This program stands to benefit people in New Hampshire, because a number of community health centers are located in the northern part of the State. We are hopeful that the State takes advantage of these funds and applies by September 28 for these grants,¹¹⁰ so that New Hampshire residents can benefit from MAT.

In addition, many New Hampshire police departments are partnering with DEA to host Drug Take-Back Day events on September 26.¹¹¹ The new DEA take-back regulations permit a variety of other means to dispose of excess drugs. Local communities should develop and fund programs that take advantage of all means of prescription drug disposal allowed under the DEA regulations, including take-back through pharmacies and mail-back programs and use of drug deactivation systems.

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

¹⁰⁷ Chapter 65 New Hampshire HB 271 available at https://legiscan.com/NH/text/HB271/id/1245750/New_Hampshire-2015-HB271-Chaptered.html Linked to on 9-1-2015.

¹⁰⁸ Chapter 65 New Hampshire HB 271 available at <https://legiscan.com/NH/text/HB270/id/1255158>.

¹⁰⁹ New Hampshire Alcohol and Drug Treatment Locator. <http://nhtreatment.org/>

¹¹⁰ See <http://www.grants.gov/view-opportunity.html?opId=278195>.

¹¹¹ https://www.deadiversion.usdoj.gov/NTBI/ntbi-pub.pub?flowExecutionKey=cFD9EE984-E349-C95D-0EC1-E46EEB9B1B86_k8090544E-FF20-C2EE-0FF7-5C51996F7D22

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.