



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

**“Warning: The Growing Danger of
Prescription Drug Diversion”**

House Committee on Energy and Commerce
Subcommittee on Commerce, Manufacturing, and
Trade

Thursday, April 14, 2011
8:00 a.m.
2123 Rayburn House Office Building

Written Statement
of
R. Gil Kerlikowske
Director of National Drug Control Policy

**HOUSE COMMITTEE ON ENERGY AND COMMERCE:
SUBCOMMITTEE ON COMMERCE, MANUFACTURING, AND TRADE
OPENING STATEMENT OF R. GIL KERLIKOWSKA
DIRECTOR, OFFICE OF NATIONAL DRUG CONTROL POLICY
EXECUTIVE OFFICE OF THE PRESIDENT**

April 14, 2011

Chairman Bono Mack, Ranking Member Butterfield, and distinguished members of the Committee, thank you for this opportunity to address prescription drug abuse in our country. The Office of National Drug Control Policy was established 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 program. We also 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 anti-drug activities.

As Director of the White House National Drug Control Policy office and chief advisor to the President on anti-drug matters, I am charged with producing the *National Drug Control Strategy*, which directs the Nation's anti-drug efforts and programs, a budget, and guidelines for cooperation among Federal, state, and local entities. My position allows me to raise public awareness and to take action on drug issues affecting our Nation. The Obama Administration recognizes that addiction is a disease, and that prevention, treatment, and law enforcement must all be part of a comprehensive strategy to reduce drug use, get help to those who need it, and ensure public health and safety.

The *2010 National Drug Control Strategy (Strategy)*, released by President Obama in May 2010, seeks to reduce drug use and its consequences through an evidence based, public health approach to drug policy. This Administration's inaugural *Strategy* reflected a nine-month consultative effort with Congress, Federal agencies, state and local partners, and hundreds of concerned citizens and stakeholders. It serves as a bold call to action for all Americans who share the desire and responsibility to keep our citizens - especially our youth - safe, healthy, and protected from the enormous physical, psychological, sociological and economic costs of substance abuse.

The *Strategy* establishes specific goals by which to measure our success. We have worked and are continuing to work with dozens of agencies, departments, Members of Congress, state and local organizations, and the American people to reduce drug use and its consequences. Our efforts are balanced and incorporate new research and evidence-based approaches to better align policy with the realities of drug use in communities throughout this country. Research shows that addiction is a complex, biological, and psychological disease. It is chronic and progressive, and negatively affects individuals, families, communities, and our society as a whole. In 2009, over 23 million Americans ages 12 or older needed treatment for an

illicit drug or alcohol use problem. However, only 11% received the necessary treatment for their substance use disorder.¹

The 2010 *Strategy* included Action Items comprehensively addressing all areas of drug control. Since its introduction, ONDCP and our Federal partners have made significant progress on these items. In addition, we have highlighted three signature initiatives: prescription drug abuse, prevention, and drugged driving. We are currently finalizing the 2011 *Strategy*, which builds upon the 2010 *Strategy*. The 2011 *Strategy* addresses issues of concern to specific populations, including service members and their families, veterans, college students, women and children, and those in the criminal justice system. The 2011 *Strategy* continues our efforts to coordinate an unprecedented government-wide public health approach to reducing drug use and its negative consequences in the United States, while maintaining strong support for law enforcement. As with the 2010 *Strategy*, the 2011 *Strategy* continues to emphasize drug prevention, early intervention programs in health settings, aligning criminal justice policies and public health systems to divert non-violent drug offenders into treatment instead of jail, funding more scientific research on drug use, and expanding access to substance abuse treatment.

Today, I am here to testify specifically about prescription drug abuse. Prescription drug abuse is the fastest-growing drug problem in the United States and is categorized as a public health epidemic by the Centers for Disease Control and Prevention. In recent years, the number of individuals who, for the first time, consumed prescription drugs for a non-medical purpose was similar to the number of first-time marijuana users.² The 2010 Monitoring the Future study – a national survey on youth drug use – found that six of the top ten substances used by 12th graders in the past year were pharmaceuticals.³ In addition, there has been a four-fold increase in addiction treatment admissions for individuals primarily abusing prescription pain killers from 1998 to 2008.⁴

The increase in the percentage of treatment admissions for abuse of pain relievers spans every age, gender, race, ethnicity, education, employment level, and region. We have also seen the estimated number of emergency department visits linked to non-medical use of prescription drugs double between 2004 and 2008, and this dramatic rise occurred among men and women of all age groups.⁵ Even more alarming is the fact nearly 28,000 Americans died from unintentional drug overdoses in 2007, and prescription drugs—particularly opioid painkillers—are considered major contributors to the total number of drug deaths; in 2007, they represented 42 percent of unintentional drug overdoses.⁶ In 17 states and the District of Columbia, drug-induced deaths are now the leading cause of injury death.⁷

Substance use has also affected our military, veterans, and their families. According to a 2008 Department of Defense survey, one in eight (12%) active duty military personnel reported

¹ Substance Abuse and Mental Health Services Administration 2010. *Results from the 2009 National Survey on Drug Use and Health: National Findings*.

² Substance Abuse and Mental Health Services Administration 2010. *Results from the 2009 National Survey on Drug Use and Health: National Findings*.

³ University of Michigan 2009 Monitoring the Future: A Synopsis of the 2009 Results of Trends in Teen Use of Illicit Drugs and Alcohol.

⁴ Substance Abuse and Mental Health Services Administration 2010. The Treatment Episode Data Set (TEDS) Report.

⁵ Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report. Emergency Department Visits Involving Nonmedical Use of Selected Prescription Drugs — United States, 2004–2008. June 18, 2010.

⁶ Centers for Disease Control and Prevention. Unintentional Drug Poisoning in the United States. July 2010.

⁷ Centers for Disease Control and Prevention. National Center for Health Statistics, “National Vital Statistics Report”, 2009.

past month illicit drug use, largely driven by the abuse of prescription drugs (reported by 11%).⁸ According to the most recent survey from the Department of Justice, nearly 60% of the 140,000 veterans in Federal and state prisons are struggling with a substance use disorder, and 25% reported being under the influence of drugs at the time of their offense.⁹ Equally concerning is the fact that substance abuse affects many of the estimated 75,600 homeless veterans.¹⁰

There are two unique barriers to combating prescription drug abuse compared to illegal drugs, like heroin and cocaine: easy accessibility to the drugs, and low perception of risk. For instance, of persons aged 12 or older who used pain relievers non-medically between 2008 and 2009, nearly 70% obtained the drug they abused from a friend or relative.¹¹ Research also shows that because prescription drugs are manufactured by reputable pharmaceutical companies, prescribed by licensed clinicians, and dispensed by pharmacists, they are perceived as safer to abuse than illegal drugs. Recent studies found teens perceived prescription drug abuse as safer, less addictive, and less risky than using illegal drugs, and believed that drugs obtained from a medicine cabinet or pharmacy as not as dangerous as drugs obtained from a drug dealer.¹²

Although potentially beneficial when used as prescribed by a healthcare professional for legitimate medical purposes in the usual course of professional conduct, prescription drugs can be just as dangerous and deadly as illicit drugs when misused or abused. We must ensure that prescription drugs are only used as prescribed and by the person for whom they were prescribed. A comprehensive, multifaceted approach is required to address this epidemic. Because the prescription drug abuse problem poses unique challenges, it is important to balance prevention, education, and enforcement with the need for legitimate access to controlled substances.

Any policy response must be approached thoughtfully and must strike a balance between our need to prevent diversion and abuse of pharmaceuticals with the need to ensure legitimate access. As science has successfully developed valuable medications to alleviate suffering, such as opioids for cancer pain and benzodiazepines for anxiety disorders, it has also led to the unintended consequence of increased medication abuse. The Administration has created an inclusive Prescription Drug Abuse Prevention Plan which brings together a variety of Federal, state, local, and tribal groups to reduce prescription drug diversion and abuse. Our prescription drug abuse prevention plan has four parts: education, prescription drug monitoring programs, proper medication disposal, and enforcement.

The first part of our response plan is education, to include mandatory prescriber education, as well as patient and parent education. A significant percentage of opioid analgesics are distributed in primary care offices and emergency rooms, and surveys of healthcare professionals and professional schools have shown significant gaps in educational training on

⁸ Bray et al., 2008 Department of Defense Survey of Health Related Behaviors Among Active Duty Military Personnel. (2009). Research Triangle Institute, Research Triangle Park, NC.

⁹ Office of Justice Programs/Bureau of Justice Statistics. *Veterans in State and Federal Prison, 2004*. U.S. Department of Justice. 2007. <http://bjs.ojp.usdoj.gov/content/pub/pdf/vsfp04.pdf>.

¹⁰ U.S. Department of Veterans Affairs Budget Request for Fiscal Year 2012. Statement of Secretary Eric Shinseki. <http://veterans.house.gov/hearings/Testimony.aspx?TID=3785&Newsid=2279&Name=%20Hon.%20Eric%20K.%20Shinseki%20>

¹¹ Substance Abuse and Mental Health Services Administration 2010. *Results from the 2009 National Survey on Drug Use and Health: National Findings*.

¹² http://www.rwjf.org/files/research/Full_Teen_Report%205-16-06.pdf

pain management, substance abuse, and appropriate prescribing.¹³ Mandatory prescriber education is therefore essential. In addition, we should make sure that parents and patients are fully aware of the dangers and prevalence of prescription drug abuse, and educated about the safe use and proper storage and disposal of these medications. The second part of our plan is encouraging each state to have a prescription drug monitoring program. Prescription drug monitoring programs (PDMPs) are state-wide databases that contain information on dispensed controlled substances prescribed by healthcare providers. PDMPs can and should serve a multitude of functions, including serving as tools for patient care, drug epidemic early warning systems (especially when combined with other data), drug diversion investigative tools, and insurance fraud investigative tools. Information contained in the PDMPs can be used by prescribers and pharmacists to detect drug-drug interactions, and to identify patients who may be doctor shopping for prescriptions to sustain an addiction, and, under specific circumstances, regulatory and law enforcement officials can also use the information to pursue cases involving rogue prescribers or pharmacists, or “pill mills” and other forms of diversions. While PDMPs vary from state to state on what data is collected, they can provide clinicians with quick access to information regarding controlled substance prescriptions that were written and dispensed to patients within a specific state.

Despite the benefits of PDMPs, many states still lack the program, and states that do operate a PDMP are currently unable to share prescription data between states. We believe all states should operate PDMPs with mechanisms in place for data sharing between states. There also must be high utilization among healthcare providers, and checking a PDMP should be a regular part of an office visit just like checking for insurance coverage.

The third part of our plan calls for proper medication disposal. Nearly 70% of people report getting their pain killers from a friend or relative. Unused medications sitting in our medicine cabinets are falling into the wrong hands. There is a need for proper medication disposal programs, so unused or expired medications are disposed of in a timely, safe, and environmentally responsible manner. Creating a convenient and consumer-friendly method for disposal of expired or unused prescription drugs will benefit public health, public safety, and the environment. In September 2010, DEA held a National Take-Back Day and collected over 120 tons of drugs at over 4,000 sites across the country in partnership with state and local law enforcement. With this overwhelming success, DEA will hold a second National Take-Back Day on Saturday, April 30th. The passage of the Secure and Responsible Drug Disposal Act in 2010 was an important step forward in our efforts to make prescription drug disposal more accessible to individuals and to reduce the supply of drugs available for diversion and abuse. The DEA is now in the process of rule-making to make disposal of prescription drugs more convenient and accessible.

The fourth and final part of our prescription drug prevention plan is law enforcement. We will assist states in addressing “pill mills”, doctor shopping and other forms of diversion as they contribute significantly to the prescription drug abuse epidemic. More specifically, we plan to ensure that technical assistance on model regulations and laws for pain clinics are available to

¹³ Raofi S, Schappert SM. Medication therapy in ambulatory medical care: United States, 2003–04. National Center for Health Statistics. Vital Health Stat 13(163). 2006. http://www.cdc.gov/nchs/data/series/sr_13/sr13_163.pdf

states. We also will continue to support High-Intensity Drug Trafficking Areas (HIDTAs) as they address diversion and trafficking pharmaceuticals and listed chemicals. Lastly, we must ensure law enforcement has proper prescription drug abuse-related training programs.

In closing, I would like to recognize that none of the things ONDCP and my Executive Branch colleagues want to accomplish for the Nation are possible without the active support of Congress. Thank you for the opportunity to testify here today on this public health epidemic.