PRESCRIPTION DRUG ABUSE EPIDEMIC IN AMERICA

HEARING
BEFORE THE
SUBCOMMITTEE ON CRIME, TERRORISM, AND HOMELAND SECURITY
OF THE
COMMITTEE ON THE JUDICIARY
HOUSE OF REPRESENTATIVES
ONE HUNDRED TWELFTH CONGRESS
SECOND SESSION
MARCH 7, 2012
Serial No. 112–95
Printed for the use of the Committee on the Judiciary

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The Subcommittee met, pursuant to call, at 10:02 a.m., in room 2141, Rayburn Office Building, the Honorable F. James Sensenbrenner, Jr., (Chairman of the Subcommittee) presiding.

Present: Representatives Sensenbrenner, Goodlatte, Marino, Gowdy, Adams, Conyers, Scott, and Jackson Lee.

Staff present: Caroline Lynch, Majority Chief Counsel; Arthur Radford Baker and Tony Angeli, Majority Counsel; Ron LeGrand and Ashley McDonald, Minority Counsel; Lindsay Hamilton, Clerk; and Veronica Eligan.

Mr. SENSENBRENNER. The Subcommittee on Crime will come to order. Without objection, the Chair will be authorized to declare recesses during votes in the House.

The Chair yields himself 5 minutes, in order to make an opening statement.

Today’s hearing examines the subject of prescription drug abuse in America. According to the most recent data from the U.S. Centers for Disease Control and Prevention, legal and illicit drugs killed almost 40,000 people nationwide in 2009. Over 100 people die from drug overdoses in the United States every day.

Nearly 3 out of 4 prescription painkiller overdoses are caused by prescription painkillers, also called opioid pain relievers. Common examples of these painkillers are Vicodin, Percocet, OxyContin, and Demerol.

In 2008, there were nearly 15,000 deaths from prescription painkiller overdoses. For every one of these deaths, there are 10 admissions for drug abuse treatment, and 32 emergency room visits for misuse or abuse of prescription drugs. That amounts to over 475,000 emergency room visits per year, a number which has doubled in just the last 5 years.

Prescription painkillers work by decreasing the perception of pain. These powerful drugs can create feelings of euphoria, cause physical dependence, and frequently lead to addiction. Prescription painkillers also slow down a person’s breathing. A person abusing prescription painkillers might take increasingly larger doses to achieve a euphoric effect. These larger doses can cause breathing
to slow down so much that breathing stops, resulting in a fatal overdose.

Very few prescription drugs involved in overdoses come from pharmacy theft. The vast majority come from physicians’ prescriptions obtained by one person and sold or given to another. More than 3 out of 4 people who misuse prescription painkillers get their drugs from someone else. For the past few years, individuals who doctor shop, or seek care from multiple physicians, but fraudulently pretend to be in pain, have been a primary source of diverted prescription drugs.

The law enforcement officials in Florida, once the epicenter of prescription drug diversion, have left other States to initiate expensive enforcement programs, as the so-called pill mills migrate across the country.

Prescription drug abuse has been an epidemic for much too long. Some of the more notable people who have died from prescription drugs include Marilyn Monroe, Bruce Lee, and Elvis Presley. Even former Indiana Senator Edward A. Hannegan overdosed on morphine in 1859. In December of 2010, a 13-year-old Utah boy died after stealing a bottle of OxyContin from a kitchen counter of a friend’s house. He took all the pills in the bottle, except one, and died in his sleep. Famous or not, no one is immune from the grip of prescription drug overdose.

This hearing will explore the growing issue of prescription drug abuse in our Nation. We have here today four distinguished Members of Congress, who have dedicated their efforts to stop prescription abuse in America. I look forward to hearing about their legislative proposals and other efforts to address a serious national challenge. And I would like to thank our witnesses for participating in today’s hearing.

It is now my pleasure to recognize for his opening statement, the Ranking Member of the Subcommittee, the gentleman from Virginia, Mr. Scott.

Mr. SCOTT. Thank you, Mr. Chairman. Mr. Chairman, prescription drug abuse is a serious problem. The number of overdose fatalities has increased dramatically over the recent years. I must admit, though, Mr. Chairman, I am puzzled as to the purpose and usefulness of today’s hearing. I am used to hearings being an opportunity for witnesses to put forth varying views regarding an issue or issues before us, with the opportunity to question such witnesses to gain a keener insight and understanding of the issues.

We would then have a legislative hearing for further input and analysis, including legal analysis, and ensuring that we have constitutional and effective legislation. While I have no doubt that our colleagues who are witnesses today will provide helpful information, I anticipate that they will discuss the bills that they have sponsored or cosponsored, which makes them advocates for the bills, and limits us to one side of the debate on the issues raised by those bills.

Therefore, I trust and also ask that this hearing not serve as the only basis for any Judiciary Committee or other consideration of legislation that we will hear about, but merely serve as a traditional opportunity we give Members, on occasion, to appear before us to present their legislation.
The bills I anticipate my colleagues will discuss as witnesses include H.R. 1316, 1065, 1925, and 2119. To the extent that they provide additional education, training, and research on safer administration and use of prescription drugs, I am inclined to believe that they may contribute to effectively addressing the problem. However, to the extent that they impose congressionally mandated restrictions on access to legitimate medications and business-as-usual draconian increases in Federal penalties, I am inclined to believe that they will be counterproductive.

Such approach is not likely to be successful, as our efforts to effectively address elicit drugs. They will lead to over criminalization, over federalization, and cause many people the laws purport to protect to end up with unjust and inflexible prison terms, such as the mandatory minimums, which one of the bills calls for.

Mandatory minimums have been proven to be a waste of the taxpayers’ money, and violate common sense, when compared to traditional sentencing. And I would ask unanimous consent, Mr. Chairman, to introduce the Rand study that points this out.

Mr. SENSENBRENNER. Without objection.

[The information referred to follows:]
An Arbitrary Minimum Drug Sentences Cost-Effective?

An Arbitrary Minimum Drug Sentences Cost-Effective?

Objective Analysis, Effective Solutions.

An Arbitrary Minimum Drug Sentences Cost-Effective?

An arbitrary minimum drug sentence has been shown to be an important factor in reducing drug-related crime. The paper argues that such a sentence can be effective in reducing drug-related crime, but that it is necessary to carefully consider the costs and benefits of such a policy. The authors suggest that a minimum sentence of 10 years is necessary to have a significant impact on drug-related crime.

The paper also discusses the potential negative effects of an arbitrary minimum sentence, including the possibility of overcrowding in prisons and the potential for rehabilitation to be neglected. The authors argue that a balanced approach, which includes rehabilitation and education, is necessary to effectively reduce drug-related crime.

The paper concludes by emphasizing the importance of considering the costs and benefits of an arbitrary minimum sentence and suggests that further research is needed to evaluate the effectiveness of such a policy.

Figure 1: Cost-Effectiveness of Alternative Options Compared to the Current Drug Policy

The figure shows the cost-effectiveness of different drug policy options, including the current drug policy. The data suggests that the current drug policy is not the most cost-effective option, and that alternative policies may be more effective in reducing drug-related crime.

Reducing Consequences of Harsher Enforcement against Drug Offenders

The paper also discusses the potential consequences of harsher enforcement against drug offenders. The authors argue that such policies can have negative effects on communities, including increased costs and increased incarceration rates.

The paper concludes by emphasizing the importance of considering the costs and benefits of different drug policies and suggests that further research is needed to evaluate the effectiveness of such policies.

Figure 2: Impact of Drug Policy Changes on Drug-Related Crime

The figure shows the impact of different drug policy changes on drug-related crime. The data suggests that changes in drug policy can have a significant impact on drug-related crime.

Reducing Crime-Related Costs

The paper also discusses the potential cost savings of different drug policies. The authors argue that reducing drug-related crime can lead to significant cost savings, including reduced healthcare costs and reduced costs associated with incarceration.

The paper concludes by emphasizing the importance of considering the costs and benefits of different drug policies and suggests that further research is needed to evaluate the effectiveness of such policies.
Are Mandatory Minimum Drug Sentence Costs Effective? [R]AND

http://www.rand.org/pubs/research_reports/RR5065/index1.html

Many researchers are working at the intersection of drug economics, drug policy, and law, seeking solutions to the complex challenges posed by the illegal drug market. In this paper, researchers at RAND provide a comprehensive analysis of the costs and benefits of mandatory minimum drug sentences, highlighting the need for a more nuanced understanding of the factors driving drug use and abuse. Their findings suggest that mandatory minimums may not be the most effective strategy for reducing drug use and abuse, and that alternative approaches may be more likely to achieve their goals.

Figure 1: Effectiveness of Drug Sentences and Enforcement

This figure illustrates the effectiveness of different drug sentences and enforcement strategies in reducing drug use. As shown, mandatory minimums are significantly less effective than alternative approaches, such as treatment and prevention programs. The researchers argue that these findings highlight the need for a more comprehensive approach to drug policy, one that takes into account the complex interplay between drug use and abuse and the broader social, economic, and political factors that drive these behaviors.

Conclusion

In conclusion, the researchers argue that mandatory minimums are not an effective strategy for reducing drug use and abuse. They call for a more comprehensive approach to drug policy, one that takes into account the complex factors that drive drug use and abuse and the broader social, economic, and political factors that drive these behaviors. The researchers argue that alternative approaches, such as treatment and prevention programs, are more likely to achieve their goals and reduce drug use and abuse.

Figure 2: Comparative Effectiveness of Drug Sentences and Enforcement

This figure compares the effectiveness of different drug sentences and enforcement strategies in reducing drug use. As shown, mandatory minimums are significantly less effective than alternative approaches, such as treatment and prevention programs. The researchers argue that these findings highlight the need for a more comprehensive approach to drug policy, one that takes into account the complex interplay between drug use and abuse and the broader social, economic, and political factors that drive these behaviors.

Conclusion

In conclusion, the researchers argue that mandatory minimums are not an effective strategy for reducing drug use and abuse. They call for a more comprehensive approach to drug policy, one that takes into account the complex factors that drive drug use and abuse and the broader social, economic, and political factors that drive these behaviors. The researchers argue that alternative approaches, such as treatment and prevention programs, are more likely to achieve their goals and reduce drug use and abuse.
Mr. SCOTT. When we think of a pill mill operator dispensing death and destruction on a mass scale, we may conclude that no punishment is too great, but without definition of what limits the application of such person to such circumstances, the, quote, Pill mill operator may be a college student in a dorm room, with a bunch of pills given to his dorm mates.

What has proven to work best to address drug abuse, in general, including prescription drug abuse are evidence-based solutions aimed at preventing drug abuse addiction, injury, and death, rath-
er than inflexibly rushing to increased penalties, and restrict legitimate excess to prescriptive drugs.

We should not continue to take the same approaches, hoping for different results. I am not saying that we should not punish lawmakers, but we are already using the criminal justice system as much as reductively can be used. We now need to focus on prevention and early intervention.

There are innovative evidence-based approaches that are not likely to be discussed today. One is the use of Naloxone. That is a lifesaving medicine used to reverse opiate-based drug overdoses. It has been FDA approved since 1971, and is the first line of treatment for paramedics and emergency room physicians who encounter an opiate overdose victim.

It presents no potential for abuse, because it has no pharmacological effect. It has no effect if it is taken by a person who does not have opiates in their system. It takes as little as 2 minutes to start working, and provides a 30- to 90-minute window to call for medical assistance during a drug overdose.

Drugs that can be reversed are heroin, OxyContin, methadone, Vicontin, and several other drugs. If we are concerned about drug overdose deaths, we should be considering this as one of the suggestions.

The second thing we need to consider, Mr. Chairman, are a 911 Good Samaritan law. The chance of surviving an overdose like that, of surviving a heart attack, depends greatly on how fast one receives medical treatment. Witnesses to heart attacks rarely think twice about calling 911, but witnesses to an overdose often hesitate to call, or simply don't make a call, because they fear police involvement.

People using illegal drugs often fear arrest, even in cases where they need professional and medical advice, or assistance for a friend or family member. The best way to encourage overdose witnesses to speak up and call 911 is to provide some kind of immunity to those that make such calls.

Mr. Chairman, such legislation does not protect people from arrest for other offenses, such as outstanding warrants or other crimes, but this policy protects only the caller and the overdose victim from arrest and prosecution, simply for calling 911. Several State legislatures, including New York, New Mexico, Washington, Illinois, and Connecticut have passed 911 Good Samaritan laws, and Congress should consider doing the same.

For the reasons stated above, Mr. Chairman, I agree with my colleagues that prescription drug abuse is an issue about which we should be concerned. Anyone who has a friend that is a physician or a dentist will recite patients that present with symptoms that call for these drugs, and they go doctor to doctor, shopping, and we need to do something about those who will actually prescribe to those patients. But we should not rush to enact such legislation without thorough assessment of the effective options we have before us, and I certainly do not agree that imposing more severe mandatory minimums on physicians and pharmacists, who provide legitimate medications, would be a good use of our time or efforts.

Mr. Chairman, I would ask, also, unanimous consent to enter into the record a letter to us from the Drug Policy Alliance.
March 7, 2012

The Honorable Jim Sensenbrenner
United States House of Representatives
Chairman, Subcommittee on Crime, Terrorism and Homeland Security
2449 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Robert C. Scott
United States House of Representatives
Ranking Member, Subcommittee on Crime, Terrorism and Homeland Security
1201 Longworth House Office Building
Washington, D.C. 20515

Dear Chairman Sensenbrenner and Ranking Member Scott:

The Drug Policy Alliance is the nation’s foremost organization promoting alternatives to current drug policy that are grounded in science, compassion, health and human rights. We are encouraged that the House of Representatives is taking action against the prescription drug overdose crisis that is plaguing our country – accidental drug overdose is now the number one cause of accidental death in the United States, having surpassed deaths due to motor vehicle collisions. However, we are concerned that legislative proposals under consideration by Congress will severely restrict access to opioid medications and place additional barriers between patients and the analgesic medications they need, without fully utilizing effective interventions to prevent overdose fatalities. The Drug Policy Alliance encourages the House of Representatives to consider alternative means of saving lives and to respond to the prescription drug abuse crisis in a comprehensive manner.

H.R. 1925, the Drug Abuse Prevention and Treatment Act of 2011, contains two areas of concern: banning prescribing of 40 mg methadone diskettes and granting federal law enforcement access to state prescription drug monitoring programs (PDMPs). This legislation would prohibit practitioners (other than hospitals that provide direct patient supervision) from prescribing 40 mg tablets of methadone “unless such prescription...is consistent with the current DEA methadone policy” until an HHS commission issues guidelines on dosing and finds the 40 mg tablet “safe and clinically appropriate.”

This legislation intrudes upon the doctor-patient relationship: Congress should support the ability of a physician or treatment provider to determine the best course of therapy for the patient, not undermine it. There is also concern that this provision interferes with the ability of treatment providers to meet the needs of individuals enrolled in methadone replacement therapy who have a high tolerance for opiates, and whose success in methadone treatment could be dependent upon access to the 40 mg tablet. Methadone providers already contend with extensive federal and state regulations and restrictions when providing treatment services to patients and this legislation would add yet another challenge. Providers and practitioners should have as many treatment options available to them as possible.

In addition, H.R. 1925 would require states receiving controlled substances monitoring program grants to provide information, upon request, to federal drug enforcement officials relating to an individual who is the subject of an active drug-related investigation. Prescription drug monitoring databases should be created and managed with the sole purpose of making prescribing information available to physicians and pharmacists in order to reduce medical errors and over-
prescribing. These databases should not be a law enforcement centered tool, nor should law enforcement have unrestricted access to prescription drug databases, which contain deeply personal information about which medications each American is currently being prescribed.

Allowing federal law enforcement to access state PDMP data at their discretion puts additional and unnecessary scrutiny on physicians whose controlled substance prescribing practices already face scrutiny from the DEA and state licensing boards. In addition to the possibility of targeting physicians who have a large number of elderly patients or patients with chronic pain who rely on opioid analgesic medications, scrutiny by federal prosecutors may have a chilling effect on the prescribing of controlled substances by physicians who fear meddling by federal authorities.

Currently, the House of Representatives is contemplating other pieces of legislation which could further contribute to this chilling effect. H.R. 1318, the Stop Oxy Abuse Act of 2011, would force the FDA to ban the use of oxycodone (Oxy) except for severe pain instead of moderate-to-severe pain, as it is currently indicated. It is the role of the FDA – not Congress – to develop guidelines for the prescribing of opioid medications. Additionally, H.R. 1065, a bill that would amend the Controlled Substances Act to provide for increased penalties for operators of pill mills, is troubling as it fails to define what a “pill mill” is but increases penalties and forfeiture provisions for any pill mill operator. Prescription drug policies should be based on science, not punitive politics, and these bills do not meet that standard.

We encourage the House of Representatives to consider alternative methods of reducing overdose fatalities. One method of doing this is to expand access to naloxone, a life-saving medicine used to reverse opiate- and opioid-based drug overdoses. It has been FDA-approved since 1971 and is the first line of treatment for paramedics and emergency room physicians who encounter an opiate overdose victim. Naloxone presents no potential for abuse as it has no pharmacological effect other than reversing opiate and opioid overdose; it also has no effect if it is taken by a person that does not have opiates in their system. However, it needs to be made more readily available to those who may be in a position to respond to an overdose. Opiate drugs that can be reversed by naloxone include heroin, Oxycontin, methadone, vicodin, percocet, fentanyl, and morphine. Naloxone takes as little as two minutes to start working, and provides additional time to obtain necessary medical assistance during an overdose.

In addition to expanding the availability of naloxone, it is critical that people be trained on how to recognize and respond to an overdose and administer naloxone – greatly increasing the likelihood that a drug overdose will not result in a fatality. Concerted training efforts aimed at those at-risk of an overdose, those who reside with, interact with or care for people at-risk for a drug overdose – such as family members, health care providers, spouses, law enforcement officers and correctional officers – will allow naloxone to be used as widely and effectively as possible – saving as many lives as possible.

Like naloxone, Good Samaritan laws also work to increase the survival rate of prescription drug overdoses. The chance of surviving an overdose, as with surviving a heart attack, depends on how fast one receives medical assistance. Witnesses to heart attacks rarely think twice about calling 911, but witnesses to an overdose often hesitate to call for help or, in some cases, simply don’t make the call. The most common reason people cite for not calling 911 is fear of police involvement. The best way to encourage overdose witnesses to seek medical help is to exempt them from criminal prosecution, an approach often referred to as 911 Good Samaritan laws. Such legislation does not protect people from arrest for other offenses; it only protects the overdose victim and people helping the victim from arrest and prosecution for simple drug
Mr. SENSENBERN. It is now my pleasure to introduce today's witnesses.

Hal Rogers has represented the Fifth District of Kentucky since 1981. He currently serves as Chairman of the House Appropriations Committee, of which he has been a Member for 29 years. He

possession, possession of paraphernalia, and/or being under the influence. Laws encouraging overdose witnesses and victims to seek medical attention may also be accompanied by training for law enforcement, EMS and other emergency personnel. New York, New Mexico, Washington, Illinois, and Connecticut have all enacted a 911 Good Samaritan law and several states are currently considering measures.

In the 111th Congress, Congresswoman Donna F. Edwards (D-MD) introduced the Drug Overdose Reduction Act (H.R. 2855, DORA), providing Congress with a blueprint for a multi-faceted, evidence-based response to the drug overdose crisis. This comprehensive legislation dedicated federal resources to expanding and supporting overdose prevention programs in communities and improved access to naloxone. The legislation also directed federal agencies to strategically boost surveillance, research and reporting efforts aimed at better understanding the overdose crisis and where resources are needed the most. The Drug Policy Alliance encourages the House of Representatives to continue its careful deliberations on how best to reduce overdose fatalities, especially through expanding access to naloxone and implementing 911 Good Samaritan laws, as DORA laid out, but does not endorse any of the bills under consideration in this Congress listed in this letter.

Sincerely,

Bill Piper
Director, Office of National Affairs
received both his bachelor of arts and LLB from the University of Kentucky.

Congressman Nick Rahall has represented the Third District of West Virginia since 1976. He currently serves as the Ranking Member of the House Transportation and Infrastructure Committee, and received his bachelor of arts from Duke University in 1971.

Mary Bono Mack has represented the 45th District of California since 1998. Ms. Bono Mack sits on the House Energy and Commerce Committee, and serves as Chairwoman of the Subcommittee on Commerce, Manufacturing, and Trade. She received her BFA from the University of Southern California in 1984.

Congressman Stephen Lynch has represented the Ninth District of Massachusetts since 2001. He currently sits on the Financial Services Committee, and the Committee on Oversight and Government Reform, where he serves as Ranking Member of the Subcommittee on Federal Workforce, U.S. Postal Service, and Labor Policy. He received his bachelor of arts degree from Wentworth Institute of Technology and his master in public administration in 1998, from Harvard.

Without objection, all of the witnesses' written statements will be entered into the record in their entirety. And I ask that you please summarize your testimony in 5 minutes or less. And we will start out with Congressman Rogers, since I kind of respect seniority.

TESTIMONY OF THE HONORABLE HAROLD ROGERS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF KENTUCKY

Mr. Rogers, I thank you, Mr. Chairman. Chairman Sensenbrenner, Ranking Member Scott, Mr. Gowdy, and other Members of this great Committee, thank you for granting me a few minutes to speak on an epidemic that quietly began in rural parts of Kentucky, West Virginia, and Virginia, one doctor at a time, and now grips every corner of our great Nation in prolific fashion. As you will no doubt hear from the panelists and fellow Members of the Congressional Caucus on Prescription Drug Abuse, the statistics about this problem speak volumes.

In 2010, Mr. Chairman, 254 million prescriptions for opioids were filled in the U.S. That is enough painkillers to medicate every single American adult around the clock for a month. ONDCP has identified prescription drugs as the fastest growing drug problem, easily eclipsing cocaine and heroin abuse.

Our military soldiers are coming back from war hooked on these pain pills. In the last 2 years, over 150 soldiers have died from overdoses. In my home state, we are losing about 82 people a month to prescription drug abuse. More than car crashes. Our medicine cabinets are more dangerous than our cars.

But statistics are just numbers. The four of us on this panel each have been touched in a personal way by this tragedy. In some counties in my district, Mr. Chairman, 50 percent of all children are living in a home without their parents, over half, in large part, because of prescription drug abuse.

I have met with single moms struggling to get through drug court, kids living with foster parents, unsure of where their real
parents are. We have lost mothers, grandfathers, police officers to this scourge. My home county sheriff, Sam Catron, community leader, personal friend, dedicated public servant, was assassinated, because of his pursuit of prescription drug traffickers. A tragic loss. My field representative's nephew, a physician in my district, was shot down, senselessly, by a disgruntled drug abuser unable to get his fix.

The most dangerous job in my district? The driver of a delivery truck, UPS, FedEx, carrying drugs by mail. I suspect my colleagues have similar stories that they would share. This epidemic touches big city movie stars and rugged mountain men, and it has to stop.

We all recognize that this problem will require a coordinated multi-pronged approach that incorporates law enforcement, treatment, education, and research. I have worked closely with Congressman Frank Wolf, to stand up a leading grant program in the Department of Justice, which supports State-run prescription drug monitoring programs. PDMPs monitor the sale and purchases of controlled substances, bridging the gap between legitimate medical need and potential misuse.

Since 2002, we have seen the number of States with authorized PDMPs triple from 15 to 48. That is a huge accomplishment, but our work is nowhere near done. The next challenge will be facilitating the secure interstate exchange of data among these PDMPs, so we can eliminate once and for all the doctor shopping which has fueled the pill pipeline around our country.

In the next few weeks, I plan to introduce legislation to support the DOJ in opening up lines of communications between States. At the appropriate time, I would request that you give this bill, Mr. Chairman, your immediate consideration.

I also helped to establish an organization in my congressional district called Operation UNITE, standing for Unlawful Narcotics, Investigations, Treatment, Education. It is a bright star in our charge to empower our youth and create an anti-drug culture, and knock out abuse for good. So far, on the law enforcement side of that organization, it covers some 42 counties. Those undercover agents, some 30 of them, have sent to the prison around 4,000 pushers, in just my district.

UNITE, with its focus on investigations, treatment, and education, is a fantastic model, ripe for replication around the country. Operation UNITE is the lead sponsor for the national RX drug summit later this spring in Florida.

Collectively, Ms. Bono Mack, Mr. Rahall, Mr. Lynch, and others have introduced a number of bills focused on law enforcement, prescriber education, and research that would help to curb the rising tide of abuse. Many of them have been referred to this Subcommittee.

While I appreciate the opportunity to elevate this issue, which continues to plague my people and communities around the country, I would much rather see your Subcommittee mark up these bills, move the ball forward, and take decisive action to end this debilitating drug problem. And I stand ready, Mr. Chairman, Members of the Committee, willing and able to assist you in any way that you might request.

[The prepared statement of Mr. Rogers follows:]
Congressman Hal Rogers
Statement for the Record

March 7, 2012

House Judiciary Committee
Subcommittee on Crime, Terrorism and Homeland Security

“The Prescription Drug Epidemic in America”

Introduction

Chairman Sensenbrenner, Ranking Member Scott and other distinguished Members of the subcommittee, as Co-Chairman of the Congressional Caucus on Prescription Drug Abuse, I would like to thank you for affording me the opportunity to share some insights about an epidemic that has touched every corner of our great nation and which threatens the very fiber of our American culture.

Over a decade ago, prescription drug diversion began to wreak havoc on communities in my region of Appalachian Kentucky. Local hospitals were experiencing more than an overdose per week, families had been overrun by pain pills, and a feeling of hopelessness had begun to pervade the entire region. These powerful drugs intended to manage pain were suddenly creating pain in the form of overdoses, crime and uncontrollable addiction. While the first wave hit Appalachia, this second wave is hitting America.

Now the diversion of prescription pills is the fastest growing drug problem nationwide with abuse transcending state lines and socio-economic groups. According to the most recent Centers for Disease Control (CDC) data, more people are losing their lives to prescription painkiller overdoses each year than to heroin and cocaine combined. In my state of Kentucky, the picture is even more dire. We are losing 82 people a month to this epidemic, which is a higher rate than car accidents; tragically, our medicine cabinets are more deadly than our cars. The human element aside, the non-medical use of prescription drugs costs health insurers up to $72.5 billion annually in direct health care costs.

We in Congress have a special responsibility to address this problem thoughtfully and proactively, with an eye to solutions that can curb the rising tide of prescription drug abuse to save our people’s lives. For that reason, I joined with my esteemed colleague Mary Bono Mack in establishing the Congressional Caucus on Prescription Drug Abuse. Those of us on the caucus recognize that combating this problem will require a multi-disciplinary approach, incorporating law enforcement, education, treatment and research, and collaboration at all levels of government.

Importance of State-Run Prescription Drug Monitoring Programs

For over a decade, state-run Prescription Drug Monitoring Programs (PDMPs) have been among the most effective and accessible tools to combat prescription drug diversion and abuse, bridging the gap between legitimate medical need and potential misuse. PDMPs acknowledge that a
family doctor, a neighborhood pharmacist and a local law enforcement officer are all critical to keeping these drugs from diversion or abuse. Monitoring programs track vital prescription data so that doctors and pharmacists know when a prescription is being abused and investigators can root out bad doctors who are aiding drug dealers and addicts.

In the Commonwealth, the Kentucky All Schedule Prescription Electronic Reporting System (KASPER) has had unprecedented success in bringing this problem under control. In 2008, KASPER processed nearly 418,000 requests for patient prescription information. Of the 94% which came from the medical community, including physicians, ER doctors and pharmacists, nearly three-quarters of them say KASPER is “important” in helping to ascertain patient intentions and patterns, and to feel comfortable writing prescriptions for patients truly in need of medical attention. In the same year, just over 11,000 KASPER requests came from the law enforcement community, and 96% of these KASPER users agree that the PDMP is an excellent tool for obtaining evidence in criminal investigations.

These reports create informed decision-making for good medicine and good law enforcement. I have heard anecdotally of countless occasions where KASPER has helped a doctor provide better patient care or a law enforcement official interrupt a crime. Since 2002, the U.S. Department of Justice Prescription Drug Monitoring Grant Program has awarded over $62 million to nearly every state to plan, implement and enhance similar state-run programs. Because of these efforts, thirty-five other states are catching on with operational PDMPs, perhaps most notably Florida, where just twelve short months ago almost 90% of the oxycodone was prescribed in the U.S. Only two states have yet to authorize a PDMP, and Missouri is blazing forward thanks to the tireless work of State Senator Kevin Engler. Nationwide, since 2003, there has been a 2,590% increase in the number of prescription reports produced by state-run PDMPs annually— but challenges still persist.

Through interstate doctor shopping, such as that which was occurring between South Florida and Appalachia, unscrupulous drug dealers have found a mechanism to circumvent these vital state-based tracking systems. Critical to shutting down this pipeline will be the next generation of PDMP. In recent years, DOJ has acknowledged the importance of facilitating secure interstate data sharing among PDMPs and has supported the development of national standards to enable such interoperability, as well as an interstate data sharing “hub.” I am proud that the hub was successfully piloted between Kentucky and Ohio, two of the premiere PDMPs in the country. Further, DOJ is poised to support the engagement of additional states with this hub through the formalization of the Prescription Monitoring Information Exchange (PMIX) Architecture, a formal set of technical requirements with which existing and future interstate data sharing hubs must comply to enable state-to-state communication.

I am pleased that important steps have recently been undertaken to facilitate interstate data exchange, but more still needs to be done. Last year, I authored legislation included in our final FY12 Appropriations bill that will allow the Department of Veterans Affairs to interface with state-run PDMPs, which will be integral to supporting our brave military men and women
returning from theater. I am also pleased to announce that in the next few weeks, I'll be introducing another bill, alongside a Senate companion, to support states from a technical perspective as they move towards interoperability. This bill likely will be referred to your subcommittee, and given the urgency and precariousness of the situation, I would appreciate your hasty consideration of this important legislation.

Collaboration of Federal, State, Local and Regional Law Enforcement

While PDMPs are perhaps the most accessible tool at the disposal of the medical community, we must not underestimate the importance of collaboration among our federal, state, local and regional law enforcement partners in shutting down the pill pipeline and putting bad actors behind bars.

This Administration, under the leadership of Office of National Drug Control Policy (ONDCP) Director Gil Kerlikowske, has rightfully made prescription drug abuse a top priority. While approaching the problem with a wide-angle lens, law enforcement has been a key cog in the wheel. For example, after I engaged Attorney General Holder about the dire situation in South Florida last year, the Drug Enforcement Agency (DEA) moved three tactical diversion squads to that region to crack down on the pill mills which were funneling drugs all across the eastern seaboard. Through Operation Pill Nation, over 100 individuals were arrested, over $19 million in cash and assets seized and a number of suspension orders issued to rogue doctors and pharmacies. In just a year, there has been a 97% decrease in oxycodone purchases by doctor in Florida, and the number of Florida doctors in the nationwide list of the top 100 purchasing physicians dropped from 90 to 13.

This is a prime example where collaboration among law enforcement officials can bring about dramatic and positive results. Agencies participating in Operation Pill Nation include the Broward County Sheriff's Office, Palm Beach County Sheriff's Office, Miami-Dade County Police Department, Hollywood Police Department, Sunrise Police Department, Fort Lauderdale Police Department, the Florida Highway Patrol, the Florida Department of Health, and the Florida Department of Law Enforcement. In my region of Kentucky, I have seen DEA work hand-in-hand with state and local law enforcement, as well. This is a model we must continue to replicate across the country, particularly as federal, state and local budgets continue to be squeezed.

As we have successfully cracked down on the problem in South Florida, pill mills are popping up in other hot spots, notably Tennessee, Georgia and my region of Kentucky. For this reason, we must be ever vigilant and allocate our scarce law enforcement resources with precision. I am proud to support legislation sponsored by Congressman Vern Buchanan of Florida that would employ the full gamut of federal resources to crack down even more aggressively on these pill mills, and I am exploring the possibility of introducing legislation that would provide the DEA greater flexibility to track the prescription drug supply chain through the Automation of Reports and Consolidated Orders System (ARCOS).

Community Engagement, Education & Treatment

While monitoring programs and law enforcement have risen to meet the challenges of identifying abuse and diversion, buy-in from local communities might be the single most
important factor in developing an anti-drug culture in towns across the country. I was proud to welcome Director Kerlikowske to my congressional district last year. When I showed him the front page of our local paper, there were some notable omissions – no stories about the town fair or the community pot luck. The front page was chalk full of articles about prescription drug abuse – arrests, thefts, the abandonment of children, and tragically, deaths. To spend a few days in my district, one would think that the situation is truly cyclical and hopeless. However, while I believe the Director has appreciation for the challenges we’re facing with the abuse of these drugs in Kentucky, I don’t think he left with that impression that we can’t pull ourselves out of this mess.

In Southern and Eastern Kentucky, we’ve been employing a multi-pronged approach to combating this abuse for years through Operation UNITE. Since inception, more than 3,100 addicts and non-violent offenders who have fallen prey to this scourge have participated in a UNITE-funded drug court or treatment program, restoring hope and creating opportunity. In addition, 93 schools in 23 southern and eastern Kentucky counties have a UNITE club, encouraging our children to remain drug-free and offering counseling programs. There are countless UNITE Community Coalitions throughout my congressional district, which support educational and faith-based conferences, medical symposiums, technical trainings and health care workshops. Many of these coalitions have received federal support through the Office of National Drug Control Policy (ONDCP) Drug-Free Communities Grant program. Operation UNITE is a bright star in our charge to empower our youth, create an anti-drug culture and knock out abuse for good, and a clear indication that our fight against drug abuse is rooted in small communities across the country. I am pleased that Director Kerlikowske had a desire and an opportunity to witness first-hand the positive impact of this program in our region, and hope that it is a model that can be replicated in communities across the nation.

Research

Finally, we must continue to support research in the pharmaceutical industry and in academic settings which lead to innovation both in the treatment of pain and in the science of recovery. Tremendous strides have been made by researchers on the development of abuse-deterring formulations of pain medication, which will be vital to ensuring that patients with legitimate needs continue to have access to these life-changing drugs, as well as alternatives to the traditional replacement therapy treatment paradigm. To that end, we must push for a regulatory environment which encourages such innovation and gets new, safe drugs to the marketplace while also ensuring that insurance companies have the adequate incentives to cover drugs and treatments aimed at curbing the abuse of these prescription medications.

Conclusion

This will take a collaborative, multi-pronged effort – law enforcement, treatment, education and research are all a part of the puzzle – and I am grateful to have the opportunity to share my perspective with you in the course of this important hearing. I encourage you and all the members of this subcommittee to take to heart all that has been said about the need for legislative action. It is one thing to listen solemnly about the plight of families, soldiers and children around the country; it is quite another to take meaningful and decisive action. The Judiciary
Mr. SENSENBRENNER. Thank you very much, Mr. Rogers. And I understand that you have an appropriations meeting to go to. So, I think it is best we excuse you. But don't forget the appropriation for our Subcommittee for our Subcommittee, please. [Laughter.]

Mr. ROGERS. Rest assured, Mr. Chairman.
Mr. RAHALL. Thank you, Mr. Chairman. I appreciate the opportunity to be before your distinguished Committee today. And while I do outrank Mr. Rogers in seniority, I certainly agree with you yielding to him first, as the Chairman of the Appropriations Committee, and my dear friend and neighbor from across the river, in my district.

Mr. SENSENBRENNER. Praise will get you a long way, my friend.

Mr. RAHALL. I appreciate that, Mr. Chairman. And I certainly associate myself with his testimony, and commend him for his efforts in organizing UNITE, to which he referred in his testimony. I appreciate the efforts of my colleague from California, Ms. Bono Mack, and from Massachusetts, Mr. Lynch.

This is an issue that crosses all partisan lines, philosophical lines, class lines, every line in our society. This issue crosses and affects all of us.

I will be presenting testimony to the Subcommittee on behalf of law enforcement officials from my district, healthcare professionals, and community leaders. And I am sure this Subcommittee will make this testimony public in our continued efforts to educate the public and the American people as to this tremendous epidemic that faces all of us.

It was once described as America’s silent epidemic, but it can now be openly witnessed any hour, any day, or any night on countless street corners across the country. It is the crippling epidemic of prescription drug abuse that we are facing. And every day we face new stories and reports of overdoses, deaths, accidents, families torn apart by the vicious cycle of prescription drug abuse.

Headlines such as this, dealing with addiction in McDonough County, in my district. These appear every day in every newspaper. And believe you, me, they are touching stories about how these communities are trying to deal with this vicious cycle.

Unlike cocaine or heroin, as Mr. Rogers has said, prescription drugs are legal, frequently prescribed by caring physicians, lead by the principle oath of “First, do no harm.” Yet, alarming statistics show that children and adults are blind to the harmful consequences of these drugs. Even as they become addicted, paying upwards of $150 per pill to buy them on the black market.

Distressingly, my home State of West Virginia has our Nation’s highest rate of drug-related deaths. In fact, between 2001 and 2008, more than 9 out of 10 of those deaths involved prescription drugs. And incredibly, as Mr. Rogers has, again, pointed out, drug overdoses now kill more West Virginians than car accidents.

But the alarming use and deaths by prescription drugs is not just in West Virginia. As our other distinguished Members will testify, it is across this country. And I could go into the figures, Mr. Chairman, but you have those figures as well, about what drug overdose death rates are in this great country, how they have tripled since 1990, and have never been higher in our Nation’s history.

I have met numerous times with law enforcement, community organizations, educators, physicians, and many more of my constitu-
ents. We have had drug summits, and we will continue to have networking processes in which we try to involve all aspects of our community, and to involve those that are personally affected, to get them to get to communicate. If they don't want to openly, at least at these networking seminars, with those law enforcement officials with whom, perhaps, they have been afraid to have contact in the past, but now find a forum, and find other people in like circumstances as them, and which their fear is no longer preventing them from coming forward and telling what is happening on the streets, and how they feel the problem can be addressed.

So, these networks are important. This hearing is vitally important. We must strengthen drug diversion, educate our children and adults on prevention, work with the medical community on addiction and pain treatment, and treat and rehabilitate those that are affected by this vicious addiction before they succumb to the death spiral.

There are a number of pieces of legislation I and my colleagues have joined in cosponsoring. This Subcommittee is certainly aware of those. And I leave it in your wisdom to join these bills, perhaps, or to pick, as you see as most appropriate, which bills should make it to the floor of the House of Representatives. But many bills will establish mandatory physician and consumer education, as well as authorizing Federal funding to help States create and maintain prescription drug monitoring programs that all States can access.

This is one of the bills that I have introduced. It would set up a uniform system for tracking painkiller-related deaths, helping States and law enforcement personnel to be able to manage and report data. The West Virginia State Police, our attorneys general, and even physicians all consistently stress the need to access a prescription drug monitoring system that is shared between State lines and updated in real time.

So, Mr. Chairman, I urge you and this Subcommittee to consider and move forward on legislation that encompasses the provisions I have mentioned, and many others. Let us act with dispatch and compassion, with an acute understanding of the enormity of the challenge before us.

I conclude by thanking you once again for conducting this hearing, and allowing me and my colleagues to be with you.

[The prepared statement of Mr. Rahall follows:]
“The Prescription Drug Epidemic in America”  
Committee on the Judiciary, Subcommittee on Crime, Terrorism and Homeland Security  
Wednesday, March 7, 2012  
10am  
2141 Rayburn House Office Building

Thank you Chairman Sensenbrenner and Members of the Subcommittee for this hearing. Thank you to my colleagues – my good neighbor and Chairman of the Appropriations Committee, Hal Rogers, and Congresswomen Mary Bono Mack and Congressman Stephen Lynch – all tremendous leaders on our fight to stop this epidemic.

I appreciate the opportunity to appear before the Subcommittee and to submit statements on behalf of the law enforcement officials, health care professionals, and community leaders I represent. I encourage the Subcommittee make available the full record of this hearing to facilitate a deeper understanding of the drug challenge before us and the need for legislative action by the Congress.

What was once described as America’s “Silent Epidemic,” can now be openly witnessed any hour, day or night, on countless street corners across the country. It is the crippling epidemic of prescription drug abuse that we are facing. Every day, news stories report overdoses, deaths, accidents and families torn apart by the vicious cycle of prescription drug abuse.

And, the cycle is certainly vicious.

Unlike cocaine or heroin, prescription drugs are legal, frequently prescribed by caring physicians, led by the principle of “first, do no harm.” Yet, alarming statistics show that children and adults are blind to the harmful consequences of these drugs – even as they become addicted – paying upwards of $150 per pill to buy them on the black market.

Distressingly, West Virginia has our nation’s highest rate of drug-related deaths. In fact, between 2001 and 2008, more than nine out of ten of those deaths involved prescription drugs. Incredibly, drug overdoses now kill more West Virginians each year than car accidents.

But the alarming use and deaths by prescription drugs is not just in West Virginia. As the other distinguished Members of this panel can tell you, they are seeing and hearing of this epidemic from their communities, as well.

Drug overdose death rates in the United States have more than tripled since 1990 and have never been higher. In 2008, more than 36,000 people died from drug overdoses, and most of these deaths were caused by prescription drugs. From newborn babies addicted to opiates to seniors overdosing, this nationwide problem knows no boundaries and it needs national attention.

I have met numerous times with law enforcement, community organizations, educators, physicians, and many more of my constituents. Clearly, fighting back against prescription drug
abuse will take the efforts of an entire village with determination and persistence and the coordination of federal, state, and local resources and networks.

We must strengthen drug diversion, educate children and adults on prevention, work with the medical community on addiction and pain treatment, and treat and rehabilitate those affected by vicious addiction before they succumb to the death spiral.

I, and my distinguished colleagues, have put forth and supported legislation that aims to combat prescription drug abuse. We know that something more needs to be done from a federal level, and that’s why I introduced H.R. 1925, the Prescription Drug Abuse Prevention and Treatment Act. This bill would implement multiple measures essential to combating prescription drug abuse – education and training, monitoring, evaluation and enforcement – and it provides a good guideline to coordinate federal, state, and local efforts to fight this epidemic.

The bill establishes mandatory physician and consumer education, as well as authorizes federal funding to help states create and maintain prescription drug monitoring programs that all states can access. The bill would also set up a uniform system for tracking pain killer-related deaths, helping states and law enforcement manage and report data. The West Virginia State Police, our state’s Attorney General, and even physicians all consistently stress the need for access to a prescription drug monitoring system that shared between state lines and updated in real time.

I know my colleagues have authored and support similar bills, like H.R. 2119, the Ryan Creedon Act, which also seeks to implement targeted physician education on prescription drug abuse and addiction.

These bills address the critical issues that ought to be part of this Subcommittee’s efforts to craft legislation to assist our states and communities in combating prescription drug abuse.

From the evidence submitted to this Subcommittee, one unmistakable conclusion emerges. The toll of destruction and devastation heaped upon America’s families and our economy by this epidemic demands the United States Congress must act, and act swiftly.

I urge you, Mr. Chairman, to strongly consider and move forward on legislation that encompasses the provisions I’ve mentioned. Let us act with dispatch and compassion and with an acute understanding of the enormity of the challenge before us.

I thank you for your time today, and with the aid of legions of willing and able community professionals and leaders throughout the country, I look forward to working with you and my colleagues in the coming weeks and months to fashion a national response.

Mr. SENSENBRERNN. Thank you very much, Mr. Rahall.
Ms. Bono Mack.
Ms. BONO MACK. Thank you, Mr. Chairman. I am honored to be here with my colleagues, as you hold this critically important hearing on the growing and deadly dangers prescription drug abuse poses to our Nation.

One incident last year, in particular, graphically captures the seriousness of this issue. On June 19th, in Medford, New York, a man walked into a pharmacy and murdered four people for 11,000 tablets of Hydrocodone. One of those gunned down was a 33-year-old customer, who was just engaged to be married. Instead, she was buried in her wedding dress. A 17-year-old pharmacy employee was also killed, and later buried in her prom dress, along with her high school diploma.

This senseless tragedy is just one example of a growing wave of drugstore robberies by prescription drug addicts. But it is also part of a larger rapidly escalating struggle nationwide against prescription drug abuse and addiction, which is expected to claim the lives of nearly 30,000 Americans this year. Just last weekend, I met in California with dozens of parents who have lost children to this horrible epidemic.

Two classes of medicines, painkillers, and insomnia and anxiety drugs, are responsible for about 70 deaths and nearly 3,000 emergency room visits every day. That is right, a day. And these are truly stunning numbers.

But what is very insidious is the way these powerfully addictive narcotic prescription drugs quickly turn people, without any real emotional or physical problems into desperate people suddenly facing life-or-death struggles. Few things are more destructive.

According to the CDC, drug overdose is now the leading cause of injury death in the United States, not just in West Virginia, but in the United States, in large part due to prescription drug abuse. It is not hard to understand why. Today, some 12.5 million Americans regularly abuse prescription drugs, and the problem, as I have said, is growing rapidly. There are approximately 7,000 new abusers every day, many of them teenagers and young adults.

This alarming trend, now a health epidemic, according to CDC, is taking a huge toll on society. Today, the abuse of prescription drugs, especially painkillers, stimulants, and depressants, is the fastest growing drug problem in America.

As Chairman of the House Subcommittee on Commerce, Manufacturing, and Trade, which has jurisdiction over consumer protection, I have made combating prescription drug abuse a top priority. I believe there needs to be a national awakening about the threat this alarming epidemic poses to our families and to our communities. Simply put, we are in the midst of an American tragedy.

What can we do? For starters, we must do a better job of monitoring and limiting access to prescription drugs containing controlled-release oxycodone hydrochloride, including the popular painkiller and killer, OxyContin.

Originally, OxyContin was intended to be prescribed only for severe pain, as a way to help patients dealing with last-stage cancer and other severe illnesses. Today, however, more and more people
across America are prescribed OxyContin, as well as other generic oxycodone drugs for less severe reasons, clinically known as moderate pain, greatly expanding the availability and potential for abuse of these powerful addictive narcotics. Someone with a toothache or a sore knee should not be prescribed a potentially addictive painkiller.

Clearly, expanded public education plays a role in addressing the problem, but we are not going to make any real progress until we limit access to these powerful narcotic drugs, and ensure that only patients in severe pain can obtain them.

We must also improve prescriber education by getting doctors, dentists, nurse practitioners, and other prescribers up to speed on the dangers of addiction. Today, I have legislation pending in Congress, the Ryan Creedon Act, H.R. 2119, to accomplish this goal.

The pervasiveness of prescription drug abuse made national headlines when Federal, State, and local law enforcement agencies, led by the DEA, cracked down on so-called pill mills in Florida, where painkillers were routinely dispensed just like M&Ms from a gumball machine.

Congress needs to make it much more difficult for these rogue pain clinics to operate, and we should treat offenders like any other street drug dealer. By better coordinating the efforts of local, State, and national agencies, and by reducing the supply of highly addictive opioid painkillers, I am convinced that we can eventually save thousands of lives, and spare millions of American families from the heartache of addiction. Mr. Chairman, no child should ever be buried in a prom dress again, because we ignored this problem.

And I just want to say, in closing, that this past weekend, when I met with these parents, a number of them spoke about a Dr. Lisa Tseng, in Rowland Heights, California, who is being charged for three counts of murder for supplying prescription drugs to young men, who all overdosed. These parents went and confronted the doctor, and she showed absolutely no remorse, whatsoever. And I think we should do all we can to ensure she is put away for a very, very long time, if she is found guilty.

So, thank you very much for allowing me to testify today.

[The prepared statement of Ms. Bono Mack follows:]
The Prescription Drug Epidemic in America
House Judiciary Committee
Subcommittee on Crime, Terrorism, and Homeland Security

Wednesday, March 7, 2012
10:00 AM
2141 Rayburn House Office Building

Written Statement of
U.S. Representative Mary Bono Mack
Statement of U.S. Representative Mary Bono Mack

before the
Subcommittee on Crime, Terrorism, and Homeland Security
Judiciary Committee
U.S. House of Representatives

March 7, 2012

Thank you, Mr. Chairman, for holding this critically important hearing on the growing and deadly dangers prescription drug abuse poses to our nation. One incident last year, in particular, graphically captures the seriousness of this issue.

On June 19th in Medford, New York, a man walked into a pharmacy and murdered four people for 11,000 tablets of hydrocodone – an opioid used to manufacture a long list of narcotic pain killers, including Vicodin. One of those gunned down was a 33-year-old customer engaged to be married. Instead, she was buried in her wedding dress. A 17-year-old pharmacy employee was also killed and later buried in her prom dress along with her high school diploma.

This senseless tragedy is just one example of a growing wave of drug store robberies by prescription drug addicts. But it’s also part of a larger, rapidly escalating struggle nationwide against prescription drug abuse and addiction, which is expected to claim the lives of nearly 30,000 Americans this year.

Just last weekend, I met in California with dozens of parents who have lost children to this horrible epidemic.

Two classes of medicines – painkillers, and insomnia and anxiety drugs – are responsible for about 70 deaths and nearly 3,000 emergency room visits a day. That’s right – a day. Those are truly stunning numbers.

Why is it happening? Scientists tell us that childhood trauma, genetics, mental disorders, depression, stress, anxiety, thrill seeking, peer pressure, severe pain from injuries and illnesses and even the horrors of combat all contribute to prescription drug addictions, which often lead to tragic and avoidable deaths.

But what’s even more insidious is the way these powerful addictive narcotic prescription drugs quickly turn people without any real emotional or physical problems into desperate people suddenly facing life-or-death struggles. Few things are more destructive.

According to the Centers for Disease Control and Prevention, drug overdose is the now leading cause of injury death in the United States – in large part due to prescription drug abuse.
It’s not hard to understand why. Today, some 12 and a half million Americans regularly abuse prescription drugs, and the problem is growing rapidly. There are approximately 7,000 new abusers every day—many of them teenagers and young adults. This alarming trend—now a health epidemic, according to CDC—is taking a huge toll on society.

Today, the abuse of prescription drugs—especially painkillers, stimulants, and depressants—is the fastest-growing drug problem in America. As Chairman of the House Subcommittee on Commerce, Manufacturing and Trade—with jurisdiction over consumer protection—I have made combating prescription drug abuse a top priority. I believe there needs to be a national awakening about the threat this alarming epidemic poses to our families and our communities. Simply put, we are in the midst of an American tragedy.

What can we do? For starters, we must do a better job of monitoring and limiting access to prescription drugs containing controlled-release oxycodone hydrochloride, including the popular pain killer OxyContin.

Originally, OxyContin was intended to be prescribed only for severe pain as a way to help patients dealing with late-stage cancer and other severe illnesses.

Today, however, more and more people across America are being prescribed OxyContin, as well as other generic oxycodone drugs, for less severe pain—clinically known as moderate pain—greatly expanding the availability and potential for abuse of these powerfully addictive narcotics. Someone with a toothache or a sore knee should not be prescribed a potentially addictive painkiller.

Clearly, expanded public education plays a role in addressing this problem, but we’re not going to make any real progress until we limit access to these powerful narcotic drugs and ensure that only patients in severe pain can obtain them.

We must also improve prescriber education by getting doctors, dentists, nurse practitioners and other prescribers up to speed on the dangers of addiction. Today, I have legislation pending in Congress, the Ryan Credent Act, HR 2119, to accomplish this goal.

The pervasiveness of prescription drug abuse made national headlines when federal, state and local law enforcement agencies, led by the Drug Enforcement Administration, cracked down on so-called “pill mills” in Florida, where painkillers were routinely dispensed like M&Ms from a gumball machine. Congress needs to make it much more difficult for these rogue pain clinics to operate, and we should treat offenders like any other street drug dealer. By better coordinating the efforts of local, state and national agencies—and by reducing the supply of highly addictive opiod
Mr. SENSENBRENNER. Thank you very much.
Mr. Lynch.

TESTIMONY OF THE HONORABLE STEPHEN F. LYNCH, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MASSACHUSETTS

Mr. LYNCH. Thank you, Mr. Chairman, and Ranking Member Scott, for your kindness in allowing us to testify on this important issue.

My colleagues have told the story of drug abuse in America today, but I do want to amplify the issue that Ms. Bono was speak-
ing about, and that is OxyContin. I will associate myself with the remarks of the 3 previous speakers, and rather than take my whole 5 minutes, I just want to offer a couple thoughts.

Number one, this OxyContin is so powerful, it is so powerful that in a very limited period of time a person who is prescribed this becomes addicted. And we have seen stats now that 99 percent of addicts who are involved with heroin, that are in facilities today in the United States, started on OxyContin. And the pattern is that they stay on OxyContin until they are financially unable to do so, and then they switch over to heroin, which is much, much cheaper.

But when you allow a company to create a product that is so powerfully addictive that in a very short time they create customers for life, that is a very troubling situation. It got so bad in my district that I had to create, well, a residential rehab facility, first, for boys, and then later for girls, because these kids are getting addicted so young, there is nowhere else to send them. We didn't have any adolescent rehab facilities in my State. So, we had to create two.

We have a situation now where Perdue Pharma lost their exclusivity, and now OxyContin is going to go generic. This is tremendously powerful. And think about this, the profits here are enormous. We are creating a national healthcare system that will allow all of these people to continue to financially get the support from these pill mills, the drug from these pill mills, having the American taxpayer contribute to that. So, this is a very, very dangerous situation.

And I noticed that on March 1, OxyContin was actually pulled from the shelves in Canada. That is according to the Toronto Star and the CBC news. I sponsored legislation here in Congress several years ago to remove OxyContin from the market. But, let's face it, there are so many drug company lobbyists up here that that bill didn't have a prayer, because the pharmaceutical company lobbyists outnumber Members of Congress probably 7 to 1.

We have a serious problem here. And I commend you for giving us the time here to try to address it. And I commend my colleagues for the fights that they are making in their own districts, and now, hopefully, we will be able to collectively use our experience to push this issue nationally.

So, I thank you for your time. I appreciate it. And I yield back the balance of my time.

[The prepared statement of Mr. Lynch follows:]
TESTIMONY BEFORE THE
HOUSE COMMITTEE ON THE JUDICIARY SUBCOMMITTEE ON CRIME,
TERRORISM AND HOMELAND SECURITY
THE PRESCRIPTION DRUG EPIDEMIC IN AMERICA
WEDNESDAY, MARCH 7, 2012, 10:00 A.M.

REPRESENTATIVE STEPHEN F. LYNCH

Good morning, Mr. Chairman, ranking member Scott and Members of the Committee. First let me thank you for providing my colleagues and me with the opportunity to testify on the very important issue of prescription drug abuse.

I appreciate that this is a broad hearing on the issue, which is appropriate, because it is multi-layered and has wide-ranging impact.

Prescription drug abuse in the United States is an epidemic, plain and simple.

In fact, according to the centers for disease control (CDC), prescription drugs cause most of the more than 26,000 fatal overdoses each year.

If that many people died from avian flu or some other virus it would make headlines around the world. And that is part of the problem we face. There is a misperception about substance abuse that prevents many people from identifying it as the problem it is. That in turn makes it more difficult to find a real solution.
My colleagues and I are here today to refute that misconception, to testify that this is not an inner
city problem or a problem that affects only those who have made the wrong choices in life.

The focus of us, Mr. Rogers, Mr. Rahall, Ms. Bono Mack, and myself, represent districts that
individually and together reflect the diversity of America.

Many of our constituents struggle with prescription drug addiction and its consequences.

Abuse of prescription medicine, especially pain relievers, is a major problem nationally, and
particularly in Massachusetts, where deaths, emergency room episodes and admissions for
treatment related to non-opioid opioids has skyrocketed in recent years. Of the five thousand
adults admitted to recovery homes in Massachusetts in 2011, nearly 30% listed “other opiate”.

I have been exposed to this problem since before I entered elective office and continue to be
frustrated by its proliferation.

The Boston Public Health Commission reports in its “Health of Boston 2010”, that the substance
abuse treatment rate for my neighborhood of South Boston is 48 admissions per 1000 residents.
That’s nearly 5% of the population. And those are only the people who are getting help. Sadly,
the report also revealed that South Boston had the highest average annual opioid mortality rate in
the City of Boston.

A regional newspaper, The Quincy Patriot Ledger, reported recently that an overdose claims 1
life every 8 days in Massachusetts South Shore communities. And there is no distinot pattern to
the victims. With a median age of 41 years, they are homemakers, professionals, students, and
labourers. Addiction does not discriminate.

We spend precious public and private dollars on substance abuse programs to help individuals
and families who have chosen to face the problem and get help. There are many dedicated
people in the treatment community who are doing wonderful work. But they are treating
increasing numbers of new and relapsed admits, very often with shrinking budgets.
Mr. SENSENBRENNER. Thank you, Mr. Lynch.

I would like to thank all of the Members of Congress who took time out of their schedules to come and testify here, as well as the Members on the Subcommittee who have come and listened to all of these graphic stories. And I am sure that this is just the tip of the iceberg. This is a very serious issue. It is one that needs to be addressed, and it needs to be addressed in the proper manner.

Does the gentleman from Virginia have anything else he wants to say or to insert into the record?
Mr. Scott. Yes, Mr. Chairman. Another Rand study showing that demand investments work better than supply control.

Mr. Sensebrenner. Without objection, the material is inserted.

[The information referred to follows:]

Controlling Cocaine

Supply Versus Demand Programs

C. Peter Rydell
Susan S. Everingham

Prepared for the Office of
National Drug Control Policy
United States Army

DRUG POLICY RESEARCH CENTER

Approved for public release; distribution unlimited
The research described in this report was sponsored by the Office of National Drug Control Policy, by the United States Army, and by RAND’s Drug Policy Research Center with funding from The Ford Foundation.

ISBN: 0-8330-1582-4

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Published 1994 by RAND
1700 Main Street, P.O. Box 2138, Santa Monica, CA 90407-2138
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SUMMARY

The current cocaine epidemic in the United States started in the late 1980s, picked up momentum during the 1990s, and is still going strong in the 2000s. The number of cocaine users peaked in the early 1980s at about 5 million, and has gradually decreased to a little more than 7 million today. However, the downward trend in the total number of users is misleading, because a decline in the number of light users has masked an increase in the number of heavy users.\(^1\)

Heavy users consume cocaine at a rate approximately eight times that of light users, so the upward trend in consumption by heavy users roughly cancels the downward trend in consumption by light users. The result is that total consumption of cocaine in the United States has remained at its mid-1980s peak for almost a decade (see Figure S.1).

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\(^1\)This analysis defines "heavy use" as once a week or more and "light use" as at least once a year, but less than weekly. At the end of 1982, these were an estimated 5.6 million light users and 1.7 million heavy users, by these definitions.
The persistence of high levels of cocaine consumption indicates the magnitude of the cocaine problem and the need for government to think carefully about its response. Part of thinking carefully includes estimating the relative cost-effectiveness of various available interventions. Four such interventions analyzed in this report are:

- **Source-country control:** coca leaf eradication; seizures of coca base, cocaine paste, and the final cocaine product in the source countries (primarily Peru, Bolivia, and Colombia).

- **Interdiction:** cocaine seizures and asset seizures by the U.S. Customs Service, the U.S. Coast Guard, the U.S. Army, and the Immigration and Naturalization Service (INS).

- **Domestic enforcement:** cocaine seizures, asset seizures, and arrests of drug dealers and their agents by federal, state, and local law enforcement agencies; imprisonment of convicted drug dealers and their agents.

- **Treatment of heavy users:** outpatient and residential treatment programs.

This study analyzes the relative and, to a lesser extent, absolute cost-effectiveness of these programs. The first three programs focus on "supply-control." They raise the cost to dealers of supplying cocaine by seizing drugs and assets, and by arresting and incarcerating dealers and their agents. The increased production costs raise retail cocaine prices and thus reduce consumption, partly by discouraging current consumption and partly by modifying the flows of people into and out of cocaine use, so that the number of cocaine users gradually declines.

The fourth program is a "demand-control" program: it reduces consumption directly, without going through the price mechanism. Treatment reduces consumption in the short term, because most clients stop their cocaine use while in the program, and in the longer term, because some clients stay off heavy drug use even after treatment ends.

User sanctions (arresting and incarcerating people for using drugs) and drug-abuse prevention programs (both school-based and community-based) are also viable interventions, but analyzing them is beyond the scope of the present study.

To assess the cost-effectiveness of these programs, one needs to know (1) how much is being spent on them and (2) what benefits accrue from that spending. Determining current spending levels, although time-consuming in practice, is conceptually straightforward.

Currently, an estimated $13 billion is being spent in the United States each year on the four cocaine-control programs listed above. The bulk of these resources goes to domestic enforcement—drug busts, jails, and prisons are expensive. Treatment accounts for only a 7 percent share of this expenditure, even when privately funded treatment is included (see Figure S.2).

Measuring the benefits of the four programs is more difficult, in part because they produce disparate effects. Supply-control programs generate cocaine seizures, asset seizures, and arrest and imprisonment of drug dealers. Treatment programs induce
people to stop using cocaine. These outcome measures cannot be directly compared; they must first be translated into a common measure of effectiveness. For much of this analysis, the common measure used is the cost of a given reduction in U.S. consumption of cocaine.

The analytical goal is to make the discounted sum of cocaine reductions over 15 years equal to 1 percent of current annual consumption. The most cost-effective program is the one that achieves this goal for the least additional control-program expenditure in the first projection year. The additional spending required to achieve the specified consumption reduction is $763 million for source-country control, $306 million for interdiction, $245 million for domestic enforcement, or $34 million for treatment (see Figure 5.3). The least costly supply-controlled program (domestic enforcement) costs 7.3 times as much as treatment to achieve the same consumption reduction.

The short story behind the supply-control cost estimates is that money spent on supply-control programs increases the cost to producers of supplying the cocaine. Supply costs increase as producers replace seized product and assets, compensate drug traffickers for the risk of arrest and imprisonment, and devote resources to avoiding the seizures and arrests. These added costs get passed along to the consumer as price increases, which in turn decreases consumption.

For example, a $246 million additional annual expenditure on domestic enforcement causes annual cocaine supply costs to increase by an estimated $750 million, or 2 percent of the estimated $37.6 billion spent annually by consumers on cocaine. As-
assuming that the percentage decrease in consumption caused by a price increase is half the percentage price increase, the additional control expenditure achieves the goal of reducing consumption by 1 percent.

The specific cost estimates for the supply-control programs are, of course, driven by the assumption that a 1 percent increase in price causes a 0.5 percent decrease in cocaine consumption. (Some of this consumption decrease occurs immediately as this year’s price increase reduces current consumption; the rest occurs gradually over time as the price increase alters flows of people into and out of cocaine use.) If the consumption decrease caused by a price increase is large, the costs of achieving the specified consumption reduction with supply-control programs will be proportionately small. However, the finding that treatment programs are more cost-effective than enforcement programs is not in question, because the effect of price on consumption would have to be 7 times the assumed level to alter that conclusion.

The estimate that an additional $34 million dollars spent on cocaine treatment would reduce cocaine consumption by 1 percent is based on two factors: (1) most users stay off drugs while in treatment, and (2) some users stay off drugs after treatment.

The average cocaine treatment is a mixture of relatively inexpensive outpatient and relatively expensive residential treatments, including partial as well as complete treatments. Costs $1,740 per person treated, so $34 million pays for 19,500 treatments. These additional treatments are assumed to be given to heavy cocaine users (of whom there are about 1.7 million today) with average use of about 120 grams of cocaine a year. The average treatment lasts 0.3 years, and 80 percent of people in treatment are off drugs, so the in-treatment effect of 19,500 treatments is about 5,000
person-years less heavy cocaine use, which amounts to 0.6 metric tons less cocaine consumption.

An estimated 13 percent of heavy users treated do not return to heavy use after treatment. Although not all these departures are permanent, during the 15 years following treatment, the 12,500 treatments would generate an estimated present value of 20,000 person-years less heavy cocaine use, which amounts to 2.4 metric tons less cocaine consumption. If we add the 0.6 metric ton in-treatment reduction to the 2.4 metric ton after-treatment reduction, we find that 13,500 additional treatments would reduce cocaine consumption by an amount equal to 1 percent of the 5.0 billion metric tons currently consumed annually.

The specific cost advantage of treatment over enforcement ($34 million as opposed to $246 million for domestic enforcement to achieve the same benefit) depends crucially on the estimated after-treatment effect. However, the cost advantage is so large that even if the after-treatment effect is ignored, treatment still is more cost-effective than enforcement. The in-treatment effect is one-fifth of the total, and five times $34 million is still less than $246 million.

Reducing the quantity of cocaine consumed is not the only possible measure of program effectiveness. However, our findings about the relative cost-effectiveness of the different control programs do not depend upon the choice of evaluation criteria. The cost-effectiveness ranking of the control programs studied here is the same whether one evaluates the programs in terms of their effects on consumption, the number of users, or societal costs of crime and lost productivity due to cocaine use. That is, in all cases, the supply control programs are more costly than treatment programs per unit accomplishment (see Figure S.4).

![Graph](image-url)
The extent to which supply-control measures are more expensive, however, does vary depending on the evaluation measure chosen. Domestic enforcement costs 4 times as much as treatment for a given amount of user reduction, 7 times as much for consumption reduction, and 15 times as much for societal cost reduction.

These results suggest that if an additional dollar is going to be spent on drug control, it should be spent on treatment, not on a supply-control program. They do not, however, indicate whether or not that dollar should be spent in the first place. It might be that all four programs generate greater benefits than they cost, and treatment is just the least of four good programs. Or, at the other extreme, treatment might be merely the least ineffective of four ineffective programs.

With the first two criteria, quantity of cocaine consumed and number of users, this is as specific as one can get without placing a figure on the dollar value of reducing U.S. cocaine consumption by 1 metric ton or the number of users by 1,000. The benefits under the third criterion, reductions in the societal cost of crime and lost productivity, are, however, already measured in dollars. Hence, using this criterion, we can make some estimates of the four programs' absolute cost-effectiveness. The reader is cautioned, however, that societal costs are difficult to define, let alone measure; thus our estimates are very rough. Nevertheless, the results are intriguing.

This study found that the savings of supply-control programs are smaller than the control costs (an estimated 15 cents on the dollar for source-country control, 32 cents on the dollar for interdiction, and 53 cents on the dollar for domestic enforcement). In contrast, the savings of treatment programs are larger than the control costs; we estimate that the costs of crime and lost productivity are reduced by $7.45 for every dollar spent on treatment (see Figure S.5).

Our findings thus suggest a way to make cocaine control policy more cost-effective: Cut back on supply control and expand treatment of heavy users. In light of this conclusion, four (prominent) alternatives to current policy are explored this study:

- **Alternative A**: decrease each of the three supply-control program budgets by 25 percent.
- **Alternative B**: decrease the supply-control budgets by 25 percent and double the current treatment budget.
- **Alternative C**: decrease the supply-control budgets by 25 percent and treat 100 percent of heavy users each year.
- **Alternative D**: treat 100 percent of heavy users each year without changing the supply-control budget.

Our best estimates of the consequences of pursuing these alternatives to current policy are summarized in Figure S.6 and Table S.1. If supply-control budgets are cut by 25 percent (Alternative A), the cocaine problem (as measured by consumption) gets worse, but the supply-control cuts make the overall control budget decrease. However, spending about half of the supply-control savings on doubling treatment (Alternative B) reduces cocaine consumption below what would occur under current
Figure S.3—Savings in Societal Costs of Crime and Lost Productivity Due to Cocaine Use per Dollar Spent on a Control Program.

Figure S.6—Cocaine-Control Budget vs. Cocaine Consumption.
Table S.1
Comparison of Alternative Composite Cocaine-Control Programs

<table>
<thead>
<tr>
<th>Intervention Strategy</th>
<th>Total Control Cost ($ billions/yr)</th>
<th>Users (millions)</th>
<th>Consumption (metric tons/yr)</th>
<th>Societal Costs (S billions/yr)</th>
<th>Societal Cost plus Control Costs (S billions/yr)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current policy</td>
<td>13.0</td>
<td>7.06</td>
<td>314</td>
<td>29.0</td>
<td>42.0</td>
</tr>
<tr>
<td>Alternative A: Supply control – 25%</td>
<td>10.0</td>
<td>7.28</td>
<td>341</td>
<td>26.0</td>
<td>52.0</td>
</tr>
<tr>
<td>Alternative B: Double treatment</td>
<td>10.0</td>
<td>7.20</td>
<td>204</td>
<td>23.5</td>
<td>36.5</td>
</tr>
<tr>
<td>Alternative C: 100% treatment</td>
<td>12.7</td>
<td>6.07</td>
<td>211</td>
<td>19.9</td>
<td>39.7</td>
</tr>
<tr>
<td>Alternative D: Baseline Supply cut</td>
<td>15.6</td>
<td>6.42</td>
<td>188</td>
<td>19.3</td>
<td>35.9</td>
</tr>
</tbody>
</table>

NOTE: Alternative A cuts all three supply-control program budgets by 25 percent; Alternative B spends one-third of the supply-control savings on doubling the current treatment budget; Alternative C spends nearly all the supply-control savings to treat 100 percent of the heavy users each year and Alternative D treats 100 percent of the heavy users each year with no cut in the supply-control budget. Estimates are annualized values over 15 projected years using a 4 percent real Discount rate.

aEstimated cost of crime and lost productivity due to cocaine use.

policy. Expanding treatment to all heavy users (Alternative C) further reduces consumption and uses up essentially all the savings from the supply-control cut. Finally, if all heavy users are treated and the supply-control budget is not cut (Alternative D), consumption decreases even more, but the control budget is one-fifth higher than it is under current policy.

Decreasing supply control by 25 percent and doubling treatment (Alternative B) would leave the number of users essentially unchanged but would decrease average annual consumption by 20 metric tons (a 6 percent reduction). This composite program would save $2.1 billion in annual costs of cocaine control and $3.3 billion in annual societal costs, for a total annual saving of $5.3 billion.

Further expanding treatment to cover all heavy users (Alternative C) would decrease the number of users by 0.39 million and decrease average annual consumption by 103 metric tons, relative to current policy. The total annual cost of cocaine control would be only $0.3 billion less than under current policy, but societal costs would decrease by $10.0 billion, for total annual saving of $10.3 billion.

Finally, treating all heavy users without changing the current budget for supply control would decrease user counts, annual consumption, and societal costs even more. However, restoring the supply-control budget would increase control costs more than it would decrease societal costs, so the total annual saving relative to current policy, $8.1 billion, would be less than that under Alternative C.

Hence, this report concludes that treatment of heavy users is more cost-effective than supply-control programs. One might wonder how this squares with the (famous) conventional wisdom (that) with treatment, "nothing works." These are two explanations. First, evaluations of treatment typically measure the proportion of people who no longer use drugs at some point after completing treatment; they tend to underestimate the benefits of keeping people off drugs while they are in treatment—roughly one-fifth of the consumption reduction generated by treatment ac-
Mr. CONYERS. Mr. Chairman, can I congratulate you on starting our inquiry in this matter with Members of Congress who have some great and different experiences about this problem? And I thank you for starting it.
Mr. SENSENBRENNER. Well, I thank the Chairman emeritus. I am always happy to accept congratulations. They mean more from that side of the aisle than my own. [Laughter.]
So, again, thank you very much. And without objection, the Committee stands adjourned.
[Whereupon, at 10:36 a.m., the Subcommittee was adjourned.]
Appendix

Material Submitted for the Hearing Record

Opioid Deaths in Rural Virginia: A Description of the High Prevalence of Accidental Fatalities Involving Prescribed Medications

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Abstract

In rural Virginia, drug overdose deaths increased 58.5% from 1997 to 2003. Opiate deaths predominated (57.9%) in this review of 897 medical examiner cases. Prescription opioids (78.0%), amitriptyline (39.4%), and benzodiazepines (39.1%) were more prevalent than illicit drugs. Two-thirds of decedents were 55-84 years old, and 73% were female. When compared to western Virginia nonmetropolitan cases, opiate drug abuse was more common. Specific medication combinations were found, the death rate per population was higher, and fewer illicit drugs were detected. These real prescription overdose deaths differ from illicit drug deaths, suggesting the need for different strategies in prevention, treatment, and intervention by clinicians and policymakers.

Introduction

The National Institutes on Drug Abuse has identified the nonmedical use of prescription medications as a serious and growing public health problem, and the National Survey on Drug Use and Health (NSDUH) and the Drug Abuse Warning Network (DAWN) and Treatment Episode Data Set (TEDS) all report an increase in such use over the last decade. The 2006 NSDUH estimated that 7 million (12.8%) persons aged 12 or older engaged in the nonmedical use of prescription pain and tranquilizer drugs in the past month, and the nonmedical use of prescription pain relievers increased from 4.7 million in 2005 to 5.2 million in 2006. The nonmedical use of prescription pain relievers in 2006 surpassed the use of marijuana among new initiates to illicit drug use.4

The last decade has also seen an alarming increase in the number of deaths from overdose where prescription medications are identified by toxicology. The Centers for Disease Control identified 11 states in which unintentional and intentional poisoning deaths combined increased by an average of 14.5% between 1999 and 2001. While the number of fatal heroin poisonings increased by 12.4% from 1999 to 2002, the number of fatal opioid analgesic

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poisonings in the United States increased to 91.2% in 2003. DAWN (Medical Examiner) reported increased opioid-related drug deaths in Maine, New Hampshire, Vermont, Maryland, Utah, and New Mexico, involving predominantly prescription medications, oxycodone, hydrocodone, and methadone.3

Little is known about the newly emerging group of decedents other than their age at the time of death and the prescription medications identified by toxicology. More detailed description is needed to better understand the unique features of this problem. For example, it is common that responders reporting the nonmedical use of opioids to the NSDUH tend to be younger than those using licit prescription opioids. Prescription deaths are occurring.1,3–5 Specifically, individuals aged 15–25 years old report the highest rates of nonmedical use of prescription drugs, while in-faces of the six states, the highest death rates were among adults aged 35–54 years old.

In order to examine the problem of prescription overdose fatalities in more detail, we studied drug overdose case records of the Office of the Chief Medical Examiner (OCME) in western Virginia, where the number of deaths involving prescription opioids increased rapidly between 1997 and 2003.6 In this paper, we report the demographic characteristics of the decedents, the manner and circumstances of death, and the medications and illicit drugs are commonly present as identified by toxicology—opioids, prescription opioids, benzodiazepines, and antidepressants. We then discuss the implications of these findings with respect to the rural populations, a group that displays an elevated risk for deaths from prescription opioid use and combination of opioids with other medications.

Materials and Methods

This retrospective, population-based review of medical examiner cases in the Office of the Medical Examiner (OCME), Western District of Virginia, began by identifying all cases classified as poisoning deaths occurring between the years 1997 and 2003. This time period coincided with a significant increase in drug overdose deaths, beginning with 667 drug deaths investigated by the OCME in 1997 and concluding with 221 drug deaths in 2003. The work is not intended to be an epidemiological study focused on population comparisons, rather, it is a comprehensive investigation into a set of clearly defined cases in which prescription medications were identified by toxicology. From an epidemiological perspective, our criterion for inclusion, any poisoning deaths in which a drug or drugs were a direct or contributing cause of death, may exclude some deaths involving indirect drug-related causes and thus underestimate the problem.

A medical examiner case is defined as including suspicion of violent death, unnatural deaths, or deaths ruled as the public interest, such as unattended persons or patients in nursing institutions. We collected OCME Western District of Virginia case categories as poisoning deaths. We extracted the complete subset of drug deaths, which also included cases with prescription medications, classified as a direct or contributing cause of death. In the OCME, Western District of Virginia, where there is no suspicion of drug of abuse or poisoning in death, a full autopsy is conducted, and specimens are obtained for toxicological analyses. After autopsy, the pathologist and toxicologist review cases to determine if and how additional toxicological examinations are required. If history and circumstances do not indicate that drugs are a cause of death, a limited toxicology in performed. Likewise, if there is a well-established cause of death, such as smoke inhalation, direct toxicological analysis for alcohol and other relevant substances (e.g., carbon monoxide determinations) are conducted. All of the cases we reviewed included toxicological analyses, and all except one included an autopsy.
The region served by the OCME, Western District, includes 34 counties and 16 municipalities, largely west of the Blue Ridge Mountains, with a population of 1.6 million people. This geographic area includes seven metropolitan statistical areas (Richmond, Lynchburg, Blacksburg, Christiansburg, Radford, Harrisonburg, and Staunton) and two micropolitan statistical areas (Shenandoah Valley and Marion). No microprton statistical areas exist. Virginia has 3,000,000 in population, thus, even the metropolitan areas in this region are relatively small. The remainder of the region (classified nonmetropolitan) consists of 19 counties where no municipalities exceed 10,000 in population and six independent municipalities with populations less than 10,000.

U.S. Government Office of Management and Budget definitions and identifications of metropolitan and micropolitan areas were used to classify locations in which deaths occurred. Metropolitan statistical areas have at least one urban cluster of 50,000 or more population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties. Micropolitan statistical areas have at least one urban cluster of at least 10,000 but less than 50,000 population, plus adjacent territory that has a high degree of social and economic integration with the core as measured by commuting ties. Metropolitan and micropolitan statistical areas are defined in terms of whole counties, or equivalent entities.

Cases Reviewed

We reviewed 983 cases, excluding four cases in which decedents were children under the age of four years, resulting in a final case total of 979 deaths. We exclude the four cases because the manner and circumstances of poisoning in young children differs significantly from adults. The youngest case we included was 14 years of age. The information reviewed from the medical examiner files include autopsy reports, hospital records, physician wives, and records obtained by the OCME in death investigations, death scene reports, police reports of investigations, including witness statements, and death certificates. Information was extracted from the decedent files by researchers associated with the VA. The first 100 files were entered simultaneously by both the RA and the PI (MPW). Due to the objective nature of the data, interrater reliability was nearly 100%. Only five discrepancies were noted in the 100 cases. The research team, including forensic toxicologists (FT), forensic pathologists (FP), and statistician (KSN), received the data entries to resolve discrepancies in data coding. In this manner, we ensured accuracy and completeness in extraction and coding of the data. Throughout the remainder of the project, 10 percent of the remaining files were checked for review using a random number table. Data were coded by both RA and PI, and reviewed by the research team for accuracy and completeness. The data were reviewed quarterly for completeness and accuracy by a multidisciplinary team, including a forensic toxicologist (FT), forensic pathologist (FP), and statistician (KSN).

Decedent socio-demographic information, including date of birth, sex, race, and employment status, were extracted from death certificates. Toxicology data were available for all cases in narrative and did not vary in level of reporting. We had a comprehensive toxicology database, which included quantitative analysis of drugs and drug metabolites in postmortem blood, body fluids, and tissues. Laboratory analyses were performed using a variety of validated analytical methods, including gas chromatography/mass spectrometry (GCMS) and gas chromatography/mass spectrometry (GCMS), high-performance liquid chromatography (HPLC) with diode array or fluorescence detection, and gas chromatography/mass spectrometry (GCMS).

The presence of drugs was evaluated using the following criteria: (1) positive identification of drug metabolite detected in body fluids (blood, urine, gastric fluid, bile, or liver); (2) for decedents not dead at present or near the time of death, positive identification of drug metabolite detected in body fluids; and (3) for decedents not dead at present or near the time of death, positive identification of drug metabolite detected in body fluids.
Results

Data for this study were obtained from the United Network for Organ Sharing (UNOS) database, which contains information on organ donors and recipients. The study included adult patients aged 18 years or older who underwent liver transplantation between January 1, 2001, and December 31, 2006, in the United States. The primary outcome measure was post-transplant mortality at one year.

The study population was divided into two groups: Group A, which received a living donor liver (LDL) transplant, and Group B, which received a deceased donor liver (DDL) transplant. The overall one-year mortality rate was 12.6% for Group A and 17.8% for Group B.

The logistic regression model showed that age, recipient weight, and donor type were significant predictors of mortality. The model was validated using receiver operating characteristic (ROC) curves and bootstrapping techniques.

Overall, the results indicated that LDL transplantation is associated with lower mortality rates compared to DDL transplantation. However, further research is needed to determine the long-term outcomes of LDL transplantation and to identify potential risk factors for post-transplant mortality.

References

### Location of Deaths by Population Density

<table>
<thead>
<tr>
<th>Density</th>
<th>Cause of Death</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Urban</td>
<td>Heart Disease</td>
<td>30%</td>
</tr>
<tr>
<td>Rural</td>
<td>Stroke</td>
<td>25%</td>
</tr>
<tr>
<td>Suburban</td>
<td>Cancer</td>
<td>20%</td>
</tr>
</tbody>
</table>

### Demographics

- Population size: 10,000 people
- Average age: 38 years
- Majority of households have children

### Location of Residence

- 70% in urban areas
- 20% in rural areas
- 10% in suburban areas
Single Drug Toxicity—In the 22.7% of cases of single drug opioid toxicity, methadone was most commonly identified by toxicology and assigned as cause of death. In the 7% of cases of single drug class benzodiazepine toxicity, diazepam was most commonly identified and assigned as cause of death. Although valproate was the most commonly found anticonvulsant overall, in the 10.6% of cases of single drug anticonvulsant toxicity, the cases were distributed across valproate (2 cases), lamotrigine (5 cases), and gabapentin (7 cases).

Figure 2 is a schematic illustrating the distribution of COD across medication classes. Because the majority of deaths were due to multiple medications, we examined differing combinations of drugs present in these cases.

Opioids and Other Drug Classes—Drugs from other pharmaceutical classes were also detected in combination with opioids. In particular, benzodiazepines and anti-depressants were frequently co-occurring. Figure 2 depicts the concurrent presence of opioids, benzodiazepines, and anti-depressants in these decedent cases.

Most notably, all three classes of pharmaceuticals were present in 151 decedent cases (19.8% of the deaths), and an opioid and one of the other classes were present in an additional 327 cases. Overall, 47% of the 659 cause positive for opioids excluding heroin had an anti-depressant, benzodiazepine, or both present.

Multiple Opioids—Table 1 illustrates the distribution of the number of opioids detected in a given case. One of the most commonly occurring opioids was also present. Of the 659 decedent cases in which opioids were identified by toxicology, one opioid was detected in 62.2% of cases, two opioids were detected in 20.9% of the cases, and three or more opioids were detected in 10.9% of cases. Methadone, when found by toxicology, was significantly more likely than other opioids to be the sole opioid identified (p < .05). Hydrocodone was most frequently found with one other opioid. Oxycodeone was equally likely to be found alone or with any other opioid.

In contrast, in the 21 cases where heroin was identified, decedents were more likely to combine it with prescription opioids. Specifically, in more than 60% of the cases where heroin was found, more than one prescription opioid was also noted, with a p-value of less than .001 for other opioids (p < .001).

Combinations of Prescription Medications with a Prescription Opioid—Other medications identified by toxicology, given the identification of methadone, hydrocodone, or oxycodone, are listed in Table 5. As noted in the table, in many cases, decedents ingested other prescription medications and alcohol and/or acetaminophen. Of note, 21-29.7% of the time alcohol was present, while acetaminophen was found in 10.9% of the time. Additionally, antidepressants and valproate were present about 2.3-3.0% of the time regardless of the opioid found. A benzodiazepine was present in at least 11% of the cases, alprazolam was present in at least 19% of the cases, and diazepam present in nearly 1% of cases.

Discussion

Between 1997 and 2006, there was a 208% increase in drug deaths in Western Virginia—an increase strongly associated with the presence of prescription medications by toxicology, with prescription opioids the most commonly identified drug class (54.0%). The findings of this review of decedent cases are consistent with national findings reporting an increase in poisoning deaths over the last decade. They are also consistent with reports of opioid induced deaths outnumber deaths when heroin is involved (7,10). Thus, these decedent cases reflect what is currently known about prescription overdose deaths, and this review expands
our understanding of such drug overdose deaths by providing a level of detail not previously reported. Specifically, this rural report:

- Older individuals, aged 25-44 years, represent the majority of the overdose cases, and women are overrepresented. This same group of decedents more often identify an illicit drug rather than an opiod analgesic.
- Death rates are highest in rural areas, and prescription medications are much more likely to be found than illicit drugs of abuse.
- Polydrug deaths predominat and we have identified the specific opioids, benzodiazepines, and antidepressants and combinations found on toxicology.

Older Individuals and Women

We might expect fatalities to be greatest among individuals using non-medically prescribed opioids, but this is not what we, or others, have reported. This group of decedents includes a disproportionate number of older individuals and women, a finding consistent with demographics reported nationally in prescription medication facilities. Furthermore, epidemiological studies have shown that older adults and young adults (12-24 years old) are more likely to report drug abuse, and studies who use 18-25 year-olds report the highest rates of nonmedical prescription pain reliever use. Perhaps these epidemiological studies do not capture rates of nonmedical use of prescription medications among older people. Alternatively, it may be that the duration of opioid use increases the risk of overdose and death in not what has been identified as nonmedical use. Although some use may have been for euphoria with diverted medications, some of the decedents may have had prescriptions for these medications, and inappropriate use, rather than belief in focused efforts to prevent euphoria (i.e., abuse or addiction), led to overdose death. Therefore, we are less likely to the increase in overdose deaths related to abuse and addiction.

Rural Overdose Deaths

Although there are reports of increased numbers of prescription opioid deaths elsewhere in the nation, our analysis allows us to specifically focus upon rural prescription overdose deaths and highlight how they are different from urban deaths from the same cultural and political region of Virginia. Overall, this group of cases differ substantially from reports of illicit opioid drug overdose deaths. Although in western Virginia, metropolitan and non-metropolitan decedents were more likely to die from abuse of benzodiazepines and cocaine. We have no explanation for the significantly higher rates among rural areas, the prevalence of prescription opioids and benzodiazepines, and the finding that benzodiazepines were more often identified among rural decedents. The similar prevalence of methadone among rural and urban decedents may be secondary to the availability of this drug at a long-acting pharmaceutical level. In rural areas, these decedents appear to have had access to prescription medications rather than heroin and cocaine, more available even to the smaller urban areas of western Virginia. Setting aside the issue of whether or not a decedent had a prescription for the medications listed as cause of death or whether the use in illicit or licit interventions to prevent overdose deaths is more prevalent, these deaths are divergent from patterns for which they were prescribed, and therefore the fatal agent may have been prescribed to this decedent. In any case, the potential toxicity of these agents must be balanced with appropriate access for use as effective medications along with a clear message about safe use of medications with potential for overdose.

[footnotes]

1. Dose calculations; available in TDS 2009 (October 5)
Our findings align with descriptions of the treatment needs of rural residents abusing and addicted to prescription medications. Perhaps inadequate access to prescription medication addiction treatment, often a problem in rural areas, might have provided some of these deaths. For example, among patients in rural New Hampshire, patients are less likely to abuse illicit substances, prescription opioids, and cocaine as drugs of abuse, and patients may not have been prescribed the drug they are abusing in addition to other prescription medications with abuse potential such as benzodiazepines. The medications abused by these patients are similar to those that were fatal among rural decedents. Among 3,663 prescription opioid-dependent individuals admitted to methadone maintenance programs, Ransdell reported that patients from low-density, populated counties were more likely to abuse prescription opioids and were predominantly younger, employed women. Similarly, among our decedents, women were more likely to be employed than men and have more education, as evidenced by a bachelor’s degree, trade, or graduate degree.

Resemblance proximate that the lack of availability of heroin in rural populations insignificantly the predominance of prescription opioids abuse and addiction. There is also a dearth of heroin in rural Virginia; however, this would not explain the presence of multiple prescribers of prescription medications in the same decedent as well as deaths where benzodiazepine medications and benzodiazepines were identified. This would seem to have little to do with a lack of availability of heroin but might again indicate inconsistent protocols for intervention to prevent diversion.

Prevalence of Polydrug Deaths

Rarely was the cause of death one drug, and in 151 cases, all three focal drug classes (opioids, benzodiazepines, and antipsychotics) were detected. These patients are consistent with those of other descriptions of polydrug overdose deaths20,22 and indicate that this is a rather complex area involving the use of multiple medications implicated in these deaths.

In our review, when polydrug use or coadministration was present, more than one opioid was found, indicating that, from whatever source, decedents have access to multiple opioids. When methadone was present, it was the sole opioid present in nearly 70% of the cases. Additionally, methadone was found more commonly among younger people 25–35 years old. Because of the pharmacology of methadone and the potential for lethal overdose, we were not surprised that methadone was found alone, and abuse, in these drug deaths. Nonetheless, we suggest that the frequent presence of methadone as the sole opioid in young decedents should inform the interventions for patients to prevent opioid overdose deaths. Particularly among older decedents, methadone was often used with benzodiazepines and antipsychotics. Again, these medications may not have been prescribed or they were obtained by diversion, but these results emphasize the importance of treating patients to take medications only as directed, and not to obtain medications or combine medications.

Given the known potential for overdose secondary to respiratory depression, we were not surprised to find significant numbers of cases where benzodiazepines and opioids were identified and that at least 20% of the cases alcohol was present with opioids. However, identification of substantial numbers of antidepressants on toxicology, and their association with opioids in 20% of overdoses, was of particular interest from a clinical and toxicological perspective. As has already been discussed, we do not know if antidepressants found were prescribed for the decedent; however, given the co-occurrence of depression and substance abuse, some of these decedents may have had prescriptions for antidepressants. Recent DAWN findings emphasize the co-occurrence of depression and substance abuse as well as potential for overdose using prescribed medications. According to 2006 DAWN data, 4% of overdoses involved benzodiazepines, and over a third of the time, patients were diagnosed with an overdose. Therefore, the identification of...
intervention in these decedents suggests an area for intervention in prescribing patterns and patient education. There may be an overdose risk to the patient prescribed antidepressants, like the opioids and benzodiazepines, if they are not taken as prescribed, combined with other medications, or "shared" with others.

Investigation of the metabolic and toxicological implications of antidepressants, with particular emphasis on the drug-drug interactions and combinations present most often in overdose deaths, is a significant area of interest to forensic toxicologists and forensic pathologists. For example, several antidepressants in the SSR1 and SNRI class (e.g., venlafaxine, fluoxetine, paroxetine, and sertraline) are capable of inhibiting, to varying degrees, CYP2D6 (primarily), CYP1A2, and CYP2E1 enzymes. The result is perturbation in the biotransformation of opioids resulting in increased blood concentrations of the drug and increased pharmacological effect and toxic side effects.38

These cases illustrate that it is not only younger people who are using prescription medications other than as prescribed. One of the factors increasing deaths where prescription medications are found, particularly opioids, may be seen by individuals who seek the younger age group typically identified as abusing drugs and alcohol. For clinicians, the education of patients over age 35 years about appropriate use of prescribed medications can prevent overdose deaths in this population. When prescribing any psychoactive drug for any patient, clinicians must remind all patients that medications should be taken only as directed, should not be combined with other medications unless prescribed, and should be taken only by the patient for whom they are prescribed. In the case of opioid prescriptions, nonmedical use may be prevented by the use of OxyContin and its Nuclear Preparations.39 For patients with chronic non-cancer pain and a diagnosis of addiction, careful prescribing of opioids to prevent diversion is well outlined in guidelines prepared by Weaver and Selnick.32

Limitations

There are inherent limitations in the study and characterization of a population where the cause of death is drug overdose. First, it is difficult to define the exact cause of death in cases with multiple or mixed drug intoxication. Postmortem toxicology is confounded by challenges such as anatomical sampling sites (e.g., central or peripheral blood), pathognomonic and de minimis effects, postmortem redistribution of drugs, and the effects of drug tolerance and abstinence.32 There are inherent difficulties in post-mortem examination.32 Nonetheless, important findings emerged from our analysis. Second, classification for cause of death is determined by more than just presence or absence of a drug or toxicological analysis. Assignments of significance of each drug or drug metabolite may differ among toxicologists and forensic pathologists. We did not include concentrations of drugs or metabolites in this report because contribution to establishing causation without benefit of complete autopsy reports and the totality of each case's investigative information is limiting.

Comprehensive toxicological studies are directed by the nature and circumstances of the death. We are aware that some deaths in this region were not included in this analysis, as described in the methods section, and some decedent's cases were not included because of limited toxicology. Additionally, some of the medical examiner's cases in the Western District of Virginia are initially investigated by local (field) medical examiners and sent for postmortem blood specimens collected shortly limited toxicological examinations, usually only for drug alcohol. Decedents in this group would not be included in the IRB cohort of cases we reviewed. We propose that exclusion of this data probably results in an underestimate of the problem, but it is likely we have little information about the characteristics of these cases not included in our analysis.
Finally, the decedents we studied were from a specific geographic region, and so results may not generalize to other rural areas. However, our results are similar to those found in other primary rural states across the nation and therefore should be of some utility in defining and addressing this emerging problem.3

Summary

Our in-depth study of overdose fatalities presents findings aligned with national epidemiological studies that describe increasing numbers nationwide of prescription medication overdose deaths, particularly among older individuals. In 2001-2003, the National Survey on Drug Use and Health (NSDUH) showed that accidental deaths from nonmedical use of prescription medications, treatment of a medical condition, or euphoria are unknown, hence, these death rates occurred disproportionately among an older population (age 65-69 years old), and the population described as engaged in nonmedical use in national surveys. Particularly among these rural decedents, illicit drugs were not often found in these deaths, suggesting that these decedents were not abusing or addicted to heroin or cocaine at the time of overdose.

Interactions to prevent these deaths will involve, of course, identifying the rural individuals who are abusing or addicted to prescription medications and providing treatment (e.g., opioid agonist medications instead of opioid pain medications) to these individuals. The awareness about potential diversion and the nonmedical use of medications by young adults should also be ensured that no other population of patients (e.g., patients 18-45 years old) may be at risk. Given the identification of older decedents in our study, it is essential to recognize that this population may not be taking these medications in direct contact or may be abusing or addicted to prescription medications instead of illicit drugs. As policy makers and researchers continue to respond to the increase in nonmedical use of prescription medications, all populations should be targeted for education as well as outreach. We should educate all patients, and their families, about taking medications as prescribed, only by the individual for whom it is intended, and the dangers of combining medications without prescriber knowledge.

Acknowledgments

Work on this project was supported by research grant 1S07 DA008874-01 from the National Institute of Drug Abuse, Bethesda, MD (D. Romanelli).

References

3 Substance Abuse and Mental Health Services Administration. Overview of Findings from the 2011 National Survey on Drug Use and Health Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
4 Substance Abuse and Mental Health Services Administration. Results from the 2011 National Survey on Drug Use and Health Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.
5 Substance Abuse and Mental Health Services Administration. Results from the 2010 National Survey on Drug Use and Health Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.
FIGURE 1.
Medical examiner drug-related deaths in Western Virginia. Figure 1 illustrates that the increase in overall drug-related deaths in western Virginia from 1997 to 2003 was primarily due to cases where an opiate was present on toxicology.
FIGURE 2:
Pharmaceutical classes found by toxicology. (N = 795 cases: 96 cases with none of these three drug classes)


### TABLE 1

Percentage of prescription medications and O AM (oxytocin) identified by sex.

<table>
<thead>
<tr>
<th>Medication</th>
<th>Overall</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Methadone</td>
<td>22.6</td>
<td>20.6</td>
<td>24.7</td>
</tr>
<tr>
<td>Hydromorphone</td>
<td>28.8</td>
<td>21.3</td>
<td>33.8</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>15.4</td>
<td>13.5</td>
<td>18.5</td>
</tr>
<tr>
<td>Methaonine</td>
<td>11.6</td>
<td>13.2</td>
<td>11.9</td>
</tr>
<tr>
<td>Naloxone</td>
<td>7.0</td>
<td>6.1</td>
<td>8.3</td>
</tr>
<tr>
<td>Percocet</td>
<td>7.1</td>
<td>3.2</td>
<td>9.7</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>7.3</td>
<td>8.6</td>
<td>6.1</td>
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<tr>
<td>Combustin</td>
<td>3.3</td>
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<td>2.6</td>
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<tr>
<td>Transdol</td>
<td>3.3</td>
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<td>3.3</td>
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<td>Hydromorphone</td>
<td>2.0</td>
<td>2.3</td>
<td>1.5</td>
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<tr>
<td>Nortriptyline</td>
<td>3.6</td>
<td>3.2</td>
<td>4.0</td>
</tr>
<tr>
<td>Mirtaipene</td>
<td>1.6</td>
<td>0.5</td>
<td>0.3</td>
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<tr>
<td>Denalabine</td>
<td>1.2</td>
<td>0.0</td>
<td>4.0</td>
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<tr>
<td>Haloperidol</td>
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<td>0.2</td>
<td>0.2</td>
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<tr>
<td>Hydromorphone</td>
<td>0.1</td>
<td>0.2</td>
<td>0.0</td>
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<tr>
<td>Benzodiazepine</td>
<td>34.5</td>
<td>24.5</td>
<td>41.4</td>
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<td>Aripiprazole</td>
<td>15.6</td>
<td>15.5</td>
<td>15.4</td>
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<tr>
<td>Quetiapine</td>
<td>17.3</td>
<td>16.6</td>
<td>18.3</td>
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<td>Lorazepam</td>
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<td>Temazepam</td>
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<td>Trazodone</td>
<td>3.1</td>
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<tr>
<td>Antidepressive</td>
<td>22.7</td>
<td>23.0</td>
<td>22.4</td>
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Note: Author manuscript, available in TABC 2009 October 5.
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<th>Medication</th>
<th>Overall</th>
<th>Male</th>
<th>Female</th>
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<tr>
<td>Aspirin</td>
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<tr>
<td>Captopril</td>
<td>6.7</td>
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<td>Chlorpromazine</td>
<td>4.4</td>
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<td>Metoprolol</td>
<td>3.1</td>
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<td>1.6</td>
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<td>1.5</td>
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<tr>
<td>Other</td>
<td>26.8</td>
<td>25.2</td>
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</tr>
<tr>
<td>Total</td>
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This table describes the percentage of cases in which prescription medications were initiated or terminated in these medical encounter cases.

* Denotes significant difference in prevalence of initiation.

** Denotes significant difference in prevalence of discontinuation.
<table>
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<td>Female</td>
</tr>
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<td>Male</td>
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<td>Female</td>
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<tr>
<td>Male</td>
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<td>Female</td>
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Note: The above data is a sample and may not reflect the actual demographics of adolescents.
<table>
<thead>
<tr>
<th>Population density</th>
<th>Decedent cases</th>
<th>Population (2004 census)</th>
<th>Annual death rate per 100,000 residents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Metropolitan cities</td>
<td>621 (60.1%)</td>
<td>88,536</td>
<td>10 (2.7%)</td>
</tr>
<tr>
<td>Metropolitan</td>
<td>90 (10.9%)</td>
<td>362,339</td>
<td>7.6 (2.0%)</td>
</tr>
<tr>
<td>Rural</td>
<td>157 (12.7%)</td>
<td>457,729</td>
<td>10.7 (3.1%)</td>
</tr>
<tr>
<td>Opioid present by technology</td>
<td>No other opioids identified by technology</td>
<td>Only one other opioid identified by technology</td>
<td>Two or more other opioids identified by technology</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-----------------------------------------</td>
<td>--------------------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td>Methadone</td>
<td>80%</td>
<td>22.5%</td>
<td>7.5%</td>
</tr>
<tr>
<td>Oxycodone</td>
<td>85%</td>
<td>15.9%</td>
<td>26.5%</td>
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<td>Hydrocodone</td>
<td>27.5%</td>
<td>44.6%</td>
<td>75.5%</td>
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<tr>
<td>Butorphanol Metabolite</td>
<td>50%</td>
<td>70.9%</td>
<td>81.9%</td>
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Note: Additional notes are available in Figure 3.3.2 of the manuscript.
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</table>
Statement for the Record Submitted on Behalf of Ameritox, Inc.
United States House of Representatives Committee on the Judiciary
Subcommittee on Crime, Terrorism, and Homeland Security
Hearing on "The Prescription Drug Epidemic in America"
March 7, 2012

Ameritox, Inc. (Ameritox) appreciates the opportunity to submit this written statement for the record of the Subcommittee’s hearing, entitled “The Prescription Drug Epidemic in America.” Ameritox applauds the Subcommittee’s Leadership and Members for their efforts to focus public attention on this serious and growing problem and to identify potential solutions.

Millions of Americans suffer from debilitating chronic pain, and appropriate use of pain medications provides patients with the relief they need to lead productive lives. However, the legitimate use of long-term pain medication is undermined by the possibility of addiction, substance abuse, diversion of medications, and overdose leading to coma and/or death. According to the Office of National Drug Control Policy (ONDCP), prescription pain medication abuse is now the second most common illegal drug problem in the nation. In 2010, more Americans died from misuse of prescription opioids than from heroin and cocaine combined.1 Additionally, from 1999 to 2006, hospitalizations for poisoning by prescription opioids, sedatives, and tranquilizers increased by 65 percent.2

A major component of ensuring quality of care for chronic pain is appropriate management of opioids and other controlled drugs. Unfortunately, drug misuse, abuse, and diversion are major health and economic problems that have not been effectively addressed. According to a report by the Substance Abuse and Mental Health Services Administration (SAMHSA), there has been alarming growth in the non-medical use of prescription pain medications in recent years. The non-medical use of prescription pain-relievers is now the second most prevalent form of illicit drug use in our nation.3

Physicians need sophisticated tools to help confront this problem and to ensure that their patients are taking their medications appropriately. Medication monitoring, using periodic urine testing provides physicians with critical insights into the use of pain medication, as well as identifying other legal and illegal drugs possibly being used by their patients. As the nation’s leader in performing

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medication monitoring tests, AmeriTox has considerable expertise utilizing advanced clinical laboratory technologies, which hold significant potential to address the problem of diversion.

Medication monitoring testing is an established standard of care for chronic pain patients on opioid therapy and is endorsed by multiple professional societies (e.g., the American Pain Society and the American Academy of Pain Medicine), the Department of Defense, and the Veterans Health System. In addition, State laws in Utah, Louisiana, and Washington support periodic urine drug monitoring as a standard of care for patients receiving chronic opioid therapy.

Expert guidelines and state regulations are based on research that shows that physicians cannot reliably assess the potential for their pain patients to be misusing, abusing, or diverting controlled drugs. A study from Brigham and Women’s Hospital, published in the *Clinical Journal of Pain* in 2002, demonstrated that physicians miss at least 30 percent of cases of patients taking illicit or non-prescribed controlled drugs (verified by urine drug testing) when they used clinical judgment alone.¹

Physicians routinely use urine-based laboratory medication monitoring tests as part of the management of chronic patients to ensure that patients are receiving the prescribed regimen of medications, taking their medication as directed, gaining positive outcomes, and not diverting their medication for other uses. These tests are performed in sophisticated laboratories and provide crucial information to physicians who order these tests.

There is also evidence that medication monitoring is a cost-effective solution that reduces treatment costs while improving quality of care. A recent study published in the *American Journal of Managed Care* analyzed the prevalence and cost of chronic opioid therapy, as well as the economic impact of compliance with pain medication.

The study demonstrated that the average total annual medical spending for patients on chronic opioid therapy was over $23,000 per year (2008 dollars). Patients who were adherent to their opioid regimen had costs that were approximately $3,400 (12%) per year lower than non-adherent patients. In addition, patients with normalized urine drug levels either above or below the expected range had significantly higher annual healthcare costs.²

Further, medication monitoring helps physicians identify potential interactions with other legal prescription medications and over-the-counter remedies. Thus, it saves the health care system millions of dollars every year in unnecessary hospital admissions due to drug poisonings from the use of multiple medications.

In conclusion, AmeriTox strongly supports the Subcommittee’s efforts to highlight the growing problem of prescription drug abuse and to identify potential solutions. AmeriTox believes that medication monitoring tests are an important tool to prevent such abuse and would welcome the opportunity to serve as a resource to federal policymakers.


Statement for the Record by Ameritas, Inc.
March 7, 2012
Page 3 of 3

Thank you for your consideration of our views, and please feel free to contact us for any additional information that may be helpful to the Subcommittee.

Sincerely,

[Signature]

Harry Leider MD, MBA, FACPR,
Chief Medical Officer and Senior Vice President
Ameritas, Inc.
Prepared Statement of Anne McGee, Director, Cabell County Substance Abuse Prevention Partnership

My name is Anne McGee and I have been the director of the Cabell County Substance Abuse Prevention Partnership, a coalition of concerned individuals, agencies and organizations for the past six years. We are located in my hometown of Huntington, WV which is located on the Ohio River and borders Kentucky and Ohio. The single biggest change in my hometown, in my lifetime, has been the devastation wrought by the “drug problem.” When the Cabell County Substance Abuse Prevention Partnership was founded in 2006, we thought that crack cocaine being brought in from Detroit was the main problem. As we gathered data and studied the problem, we learned that crack may be the drug that garnered the headlines and the attention of law enforcement, but far more disturbing and pervasive was the non-medical use of prescription drugs. Our teenagers were reporting increasing use of prescription drugs; the lines at the for profit methadone clinic every morning were out the door; drug overdose fatalities were reaching record highs; obstetricians were reporting more addicted patients; and reports of drug seekers in the emergency rooms were a daily occurrence.

In 2007, we held a roundtable discussion for healthcare providers to discuss the data we had gathered regarding prescription drug abuse. The consensus from those in that earliest discussion was that the overprescribing of prescription pain relievers and benzodiazepines by the local medical community was a major part of the problem. We followed up with a community wide drug summit where we included all sectors of the community. We learned that not only was overprescribing a problem, but it was far more complicated: prescription drugs and the selling of those drugs by the patient on the black-market was supplementing the incomes of many living on fixed incomes; that patients have unrealistic pain expectations and demand and expect pain free recuperation from injury or surgery; that the Appalachian culture promotes and supports the sharing of prescription drugs among friends and family. And that our children were diverting medications prescribed to the adults in their lives for both medical and non-medical purposes. Our schools reported that many of the expulsion hearings were for students caught bringing prescription drugs to school. Local property crime rates were increasing throughout the county and copper and other metal thefts were rampant. Then the Journal of American Medical Association published the findings of a CDC study showing WV had the highest death rates in the nation for prescription drug overdose. Fatality rates began to skyrocket across the nation with WV leading the charge with greatest number of fatalities and Cabell County having some of the highest mortality rates in the state.

As we focused on our youth, we realized there were no evidenced based strategies or programs that focused on preventing prescription drug abuse, we also knew from community readiness assessments that the community as a whole had little or no awareness of the growing prescription drug abuse problem, unless and until it struck too close to home. We took the lessons learned in preventing youth use of other legal drugs like alcohol and tobacco and we started with general awareness strategies combined with attempts to limit youth access to prescription drugs. We recruited a few physicians to our cause and they drafted a letter on the coalition’s behalf to every healthcare provider with prescribing privileges in Cabell County, sharing our data and urging and encouraging the use of the WV Board of Pharmacy Controlled Substances Monitoring Database. We conducted awareness presentations throughout the community. We offered trainings to nurses, teachers, coaches, parents and grandparents. We conducted social marketing campaigns and held dozens of public forums and summits; and we recruited volunteers and coalition members along the way. We have involved the media in every one of our efforts and we have seen community readiness increase and a slight decrease in the percentage of students reporting the non-medical use of prescription drugs.
Knowing that limiting access is a key strategy in reducing youth substance use, we have sponsored and promoted prescription take back events collecting over 500 pounds of unwanted medications in the past year. We have partnered with the local hospital to provide information to local senior citizens regarding medication safeguarding and disposal. We have sponsored programs for the local medical society and we have talked to every elected official who will listen.

Prescription drug abuse is destroying southern West Virginia. The statistics and data support the severity of the problem. Unlike illegal drugs, prescription drugs are subject to regulation and control. Community efforts like the Cabell County Substance Abuse Prevention Partnership can only do so much in reducing the abuse and misuse of these substances. We need stronger and better controls over controlled substances. We are losing our children, our work force, and our quality of life to an epidemic that is 100% preventable.
PRESCRIPTION DRUG PROBLEMS
PLAGUE SOUTHERN WEST VIRGINIA

“How communities are living (and fixing) these problems!”

Presented by...

Greg Puckett
Executive Director
Community Connections, Inc.
215 South Walker Street, Princeton, WV 24740
Phone: (304) 913-4956 – Fax: (304) 913-4964
Email: drugfree@strongcommunities.org
Website: www.strongcommunities.org
Nestled in the heart of the Appalachia, West Virginia is known for its breathtaking scenery, natural wonders, and historical significance. It is also known for its people—hard working, caring and giving. Our communities, both large and small, and those families within them, are a collection of contrasting styles and tradition. From our Ohio River towns on the northeastern side of the state, to the isolated mountain ridges to the east, our state is a plethora of geographical and cultural diversity found nowhere else in the United States.

This is particularly evident in the southern seventeen counties that lie in the third Congressional District (Rahall—WV 3”). From greater metropolitan Huntington area to the southern coalfields to the south, this area is deeply rooted in family and cultural norms that date back generations. Traversing the country roads from west to east, the state transforms from the harsh topography and economic hardships of the coal towns, into a series of rolling hills and farming communities, eventually giving way to the western ridges of the Shenandoah Mountains.

Our people, our land, our resources... All are amazing qualities that define who we are and how we live. We are a proud, giving culture that would give much of ourselves to help the greater well-being of others. Perhaps this is but one of the many reasons why we have seen a problem like we have never seen before become so bad, so fast...

Prescription Drug Abuse.

The problem

With high teen pregnancy, drop-out rates, juvenile delinquency, family violence, and drug and alcohol abuse, many of West Virginia’s youth are left with little opportunity for a healthy and secure future. As automation has replaced manpower, the population is continually struggling to overcome the economic collapse. Hardships are increasingly becoming the norm and increasing poverty levels have taken a high toll on our entire state. These hardships have also increased the number of families in the coverage area to depend on government assistance to meet their family’s needs. These dire circumstances have lead many youth into experimenting with substances (including alcohol, tobacco, and prescription drugs), early sexual behavior, driving under the influence of alcohol, and other harmful behaviors. Youth also tend to have a stronger mindset towards various ‘rites of passages’ – including those with negative results.
In the last ten years, our nation has been plagued with a tragic increase in deaths and overdoses from prescription drugs—largely fueled by a rise in consumption of prescription painkillers, or “opioids.” From 1997 to 2007, the use of prescription opioids in the United States has increased 402 percent. Death rates involving opioids have more than tripled in the United States in the past decade, exceeding deaths from heroin and cocaine overdoses combined.

In 2005-2006, West Virginia exceeded the national rate on self-reported use of “nonmedical use of pain relievers in the past year” in all age groups, particularly 18 to 25 year olds. Nearly 90% of nonmedical users of prescription-type psychotherapeutic drugs reported getting the most recently used drug from a friend or relative or just one doctor (2007). Between 1999 and 2004, West Virginia had a 550% increase in unintentional poisoning deaths. *This is more than double any other state.* Of these unintentional poisoning deaths, approximately 97% involved drugs or alcohol rather than other substances. In 2006, there were 295 fatal overdoses in the state; prescription pain medication contributed to 93% of these deaths.

The major risk factors that contribute to risky behaviors among our youth in the targeted communities include: poverty, abuse and neglect, weak social ties (rural isolation), poor school performance, favorable attitudes toward problem behaviors (alcohol, tobacco and other drug use, violence, school dropout, and teen pregnancy) and availability of alcohol, tobacco, and other drugs. The main protective factors for our youth that have been identified are ‘religiosity’ and attachment to family and community.

In fact, within West Virginia...

- It is estimated that 157,000 West Virginians over the age of 18 have a substance abuse problem.  
- The percentage of women smoking in West Virginia during pregnancy in 2009 was 27.3 percent compared to 23.6 percent of the general population of women who smoke in West Virginia. There were almost 9,000 illicit drug arrests in West Virginia in 2009.  
- Opiates are the number one cause of death associated with drug overdoses in West Virginia. Overdose deaths from 1999-2004 increased by 550 percent.  
- Drug overdose is the leading cause of death for West Virginians under the age of 45.  
- The state ranks highest in the nation for retail prescription drugs filled at pharmacies (over 20 prescriptions per capita).  
- More than 70 percent of people who abused prescription pain relievers received them from friends or relatives; five percent obtained them from a drug dealer or from the internet.  
- A 2009 umbilical cord study in eight West Virginia hospitals concluded that almost 20 percent of babies tested had been exposed to drugs. A new 2010 study revealed that this number had increased in one hospital to 33 percent, compared to a national average of four percent.

The 2009 CASA publication examined the cost of substance abuse on budgets. The report found the following significant costs: in state public programs, 18% of budgets are linked to substance abuse and addiction; states spend 133 times as much to clean up the devastation substance abuse and addiction cause children as they do to prevent and treat it; and of every dollar states spent, $0.06 went to showing up the wreckage of substance abuse and only $0.04 was used to prevent and treat it. The report also found that the most significant opportunity to reduce the burden of substance abuse on public programs and ultimately, on taxpayers is through targeted and effective prevention programs.
**Fixing the Problem**

Since the mid 1990's, there have been multiple community based organizations throughout the state working to change communities for the better. "Family Resource Networks" have continually identified andminster which they served and worked to secure funds to change the norm. These organizations and partners within these communities have been working diligently to unify their message and work cooperatively to leverage existing resources. This community based approach works well within West Virginia.

Just in the past five years, these networks have modified their outreach to become a more comprehensive community anti-drug coalition effort. This movement within the state has changed the ways communities view substance abuse and ways to combat the problems associated with it. Throughout West Virginia, people are focused around getting more engagement from those paying for substance abuse and training them to deliver the appropriate response: increasing the capacity of community prevention coalitions by providing them with leadership and using data-driven prevention strategies to address the local/community needs and focuses, along with addressing state and national level priorities.

Many counties have worked to develop coalitions in the past. Currently there are eight SAMHSA (Substance Abuse and Mental Health Services Administration) Drug Free Community Support Program grants that exist in West Virginia. These are Jackson, Marshall, Morgan, Brooke, Mingo, Cabell, Mercer, and Oho counties. Although there are only eight DFC coalitions in the state, there are forty two more that have membership with the West Virginia CADCA (Community Anti-Drug Coalitions of America) Association. And now, thanks to the strategic prevention framework process within the past years, many coalitions throughout the state are working to leverage their funding and resources to create new initiatives, resulting in a more cohesive environment for cultural change in preventing substance abuse.

In addition, just in the past two years, the West Virginia Bureau for Behavioral Health and Health Facilities has restructured its dissemination of the Federal Substance Abuse Prevention and Treatment Block Grant funds to channel monies to communities across the state to unify these prevention and treatment efforts. And just recently in 2011, Governor Earl Ray Tomblin signed an Executive Order creating a Substance Abuse Advisory Council to:

- Provide guidance regarding the implementation of the approved Statewide Substance Abuse Strategic Action Plan;
- Identify planning opportunities with other interrelated systems to increase both public and private support concerning substance abuse initiatives;
- Recommend a list of priorities for the improvement of the substance abuse continuum of care;
- Receive input from local communities throughout West Virginia; and
- Provide recommendations to the Governor.

In coordination with the Governor's office and with key stakeholders and with the support from our federal, state and local partners, the Bureau for Behavioral Health and Health Facilities, along with the other bureaus of the West Virginia Department of Health and Human Resources, will continue to proceed with the implementation of the Comprehensive Substance Abuse Strategic Action plan to provide a clear direction to this epidemic. Regional task teams will continue to meet monthly to develop
strategies to address problems unique to their particular area. In doing this, we will continue to provide the opportunity for West Virginians to regain a sense of hope that seems to have been lost by so many during these challenging times.

Link to Governor’s comprehensive Substance Abuse Plan
http://governorssubstanceabuseinwv.com/images/Resources/2358_SubStrategicActionPlan_SP_6_0rev100721.doc

It is proven that Governments can reduce their costs linked to abuse of alcohol, drugs and tobacco by adopting strategies to prevent and eliminate, and not just manage the consequences of substance abuse. Using these strategies to deliver prevention activities that would prevent and/or eliminate substance abuse among youth within the coverage area has the potential to save millions of dollars. Cohen (1998) found that if one young person can graduate, stay away from alcohol, tobacco and other drugs, and live crime free then there is potentially $1.7-2.3 million saved by society.

Community Coalitions uniquely work with communities to fill a major gap in the services available to our youth and their families, and is a critical component of our drug and crime prevention and workforce development efforts. Research has shown that preventing disease and injury costs less than treating them. It is estimated that there is at least $10 is saved for every $1 spent on evidence based prevention.

While funds are grossly inadequate to deal with the magnitude of the prescription drug abuse problem, they are better equipped to think strategically and develop action plans that support the long term growth and development of our county’s healthcare and human service infrastructure. Simultaneously, by working together with others, the goal is to reduce drug use and crime within the community, and ultimately contribute to significant cost savings for local, state, federal governments and the United States tax payers.

Throughout the past few years, prescription drug abuse has become a massively detrimental problem on the society of all West Virginians. Through research, we have discovered that this the fastest growing segment for illegal drug use, and more people abuse prescription drugs than the number of people who use cocaine, methamphetamine, and heroin combined. In five years (1999-2004), deaths resulting from drug overdose in West Virginia rose 550%. This was the largest increase of any state in the country and more local data suggests that this has risen at an even greater rate since that time. These statistics, combined with an increasing elderly population, declining economy, and easy access to the drugs, leaves the southern part of the state particularly vulnerable to future problems. This, in turn, stresses the dire need for an adequate continuum of care system that encompasses quality prevention, early intervention, treatment and recovery systems that are funded at their highest possible levels. Only then, can we turn the corner on this deadly epidemic.

For generations the workforce within West Virginia has been seen as a committed, strong, viable, productive group of people ‘willing to work until the job is done’. This is now in jeopardy. With the rising problems associated with the disease of addiction, many businesses are wondering how they can provide quality products and services without having a workforce that can’t pass a drug test. This leaves
not only existing businesses with additional liability and potentially sub par performance, but sends the wrong message to potential businesses that could perhaps look to our state for future opportunities.

If we are to fix these issues, we must internally reinvest in how we deal with the problems associated with drug abuse. Communities across the state are working together to address these issues through local community based coalitions, health and treatment centers, increased law enforcement, local civic and social groups and so much more. These organizations are willing to invest their time and resources towards fixing the problems where they exist most...at the community level. They have received specialized training and have gained expertise in knowing how to implement effective environmental change approaches in dealing with these issues, but only few possess the funds necessary for long term success. Many of these agencies spend much of their time focused on where the next source of funding will come from instead of truly dealing with the problem head on. Research has shown that for every dollar spent in prevention at the community level; nearly $21 is saved in long term detrimental effects to society.

Therefore, in closing, sustainable funding for prevention based initiatives, that are effectively followed by a comprehensive continuum of care system, should be supported at the maximum level possible as quickly as possible. The prescription drug abuse problem that West Virginians face did not occur overnight and the solutions will take time. The Bureau for Behavioral Health and Health Facilities (the state management agency for the Substance Abuse Prevention and Treatment (SAPT) Federal Block Grant), has worked throughout the continuum of care and is dedicated to oversight of this problem within the state. Through their support, all prevention, early intervention, treatment and recovery systems are now working together to make a difference but much like a business looking to gain a customer base, a great deal of monies must be spent on the front end to achieve a long term sustainable effort. The appropriate funding, combined with proven effective, evidence based strategies, will swiftly impact the problems head on and empower communities to battle this disease. The fight against drug abuse is not an easy one, but one we must win."
OUR STORIES...

Debbie Williams
Raleigh County Family Resource Network

“When I was trying to find a place to have the Take Back Day activities (in cooperation with the Drug Enforcement Administration’s National Take Back Day program), I checked with Sam’s Club to see about having it on their parking lot. I spoke with the clerk at the service desk and explained to her what I wanted. She began to get excited and said to me that, ‘It’s about time someone tried to do something about the prescription drug problem. She went on to say that her son was 17 and was addicted to prescription drugs, and that she was having a terrible time trying to find help for him; that there was nowhere to send him for help in West Virginia; and that West Virginia needed a facility for teens who were addicted to prescription drugs.

I asked her how did he get addicted, and was there someone sick in her home. She looked at me in disbelief and said to me, ‘Are you kidding? They are on the streets! They can get them anywhere, and they go for as much as $5.00 to $50.00 or more a pill.’ She said that we really needed to clean up the streets from prescription drugs.

As a mother and grandmother, I did not know that this problem was so strong among our teens. We do have work to do.”
....

Aveda Steiler
Fayette County Family Resource Network / Substance Abuse Task Force

“I became aware of prescription drug abuse over three years ago through conversations at the Fayette County Family Resource Network monthly community meetings. The effects were felt in community corrections (Day Report Center), education (truancy), removal of children from home (Child Protective Services), and so many other venues. In response to these pressing community needs, we created a Substance Abuse Task Force. Activities included holding 50 community forums about this issue (with assistance from the WV Center for Civic Life), initiating a substance abuse prevention education program (Reality Tour) for caring adults and youth, and getting the ADAPT program (intensive outpatient therapy program for youth administered by FDMCS) re-instituted in Fayette County; and more initiatives.

Through this work, I've heard many stories from families, friends, and individuals regarding their experiences with substance abuse - particularly prescription drug abuse. The recurring theme in these narratives was a legitimate injury requiring legal pain medications and then a progression of addiction that led to the destruction of many lives - whether it was overdose/death; losing child custody, marriages, homes, jobs; etc. The power of these drugs scared me.

On the morning of January 26, 2012, my personal life was transformed. My dog was run over by a truck in front of my house. I ran to the road to get her out of the road. As I scooped her up, she defended herself. She grabbed onto my left forearm and I tore free. She then latched her teeth onto my right index finger and I again tore free.

The results of this bizarre incident: 15 stitches to my left forearm (in Summersville); surgery to amputate my right finger tip and reduce/repair a dislocation (in Morgantown); and a legitimate need for pain medication following surgery. Surgery was performed on February 6 and on February 21 the bandages, cast, and dressings were removed. I was not at all prepared for what I would see of my right finger and hand - massive bruising and swelling plus the pin sticking out of my finger.

Pain medication reduces the pain and also makes me feel not unpleasant. On the morning of February 22 (back at home) I was feeling very unpleasant with what I'd seen of my finger though my finger wasn't in pain. My first inclination was to take the pain medication to make me feel not unpleasant. Then it hit me - this is how addiction begins. There's a difference between emotional and physical pain.

Fortunately I am aware of the potential devastating effects of addiction and that I was able to recognize the missing link. Pain medication is for physical pain, not emotional pain. I relayed my 'whoa' moment to a friend of mine who is also a medical provider. When a person goes through significant personal trauma, there will be 'highs' with the novelty and when 'reality' sets in, an anti-depressant may be the non-addicting drug to bridge the gap.”
Ginger Day
McDowell County FACES / HOPE / Prevention Coalition

“Life expectancy is declining for both men and women in McDowell County, and while researchers
determine obesity, diabetes and lung disease to be the cause, people who live in these communities add
another factor: drug overdose deaths.

According to 2011 Kids Count survey, McDowell County ranked the lowest in the state in seven
categories, including the highest number of children in poverty at 52 percent, the highest high school
dropout rate at 23.6 percent, and 19.6 percent of McDowell County kids are “victims of abuse or
neglect”.

When you look at the reports and data you can’t help but think the future is very disheartening.
McDowell County Families Agencies Children Enhancing Services (F.A.C.E.S.) and Health Opportunities for
Positive Education (H.O.P.E.) are working hard to change these statistics. FACES and HOPE have united
with the Board of Education to take steps toward strengthening after-school programs and introducing
evidence based programs such as: Keep A Clear Mind. (KACM) is a take-home drug education program
for upper-elementary-school students (8 to 12 years old) and their parents. KACM lessons are based on
a social skills training model and designed to help children develop specific skills to refuse and avoid the
use of “gateway” drugs. This unique, early intervention program has been shown to reduce risk factors
for later substance use. Two hundred and eighty students and parents/caregivers participated in this
program and demonstrated 40 percent increase in communication.

F.A.C.E.S. was a key component in the planning meetings for McDowell County Day at the Legislature
2012. One agenda item discussed: the need for a County owned and operated treatment facility with a
Suboxone Program. A certified substance abuse counselor on staff is instrumental in combating this
issue. Communities in McDowell County cannot continue to struggle with the complex problem of drug
addiction and be expected to make changes with simple solutions.”
Joanne M. Bolette
Children's Home Society of WV
Mercer County

“The Children's Home Society in Princeton provides a variety of services to children and families in Mercer and surrounding counties from adoption and foster care, to play therapy, to supervised visitation and exchange services, to WE CAN mentoring, and parent education for divorcing parents. There are families across all of these services that have struggled with prescription drug issues. In the most severe instances, children have been removed from families that are unable to keep their children safe while they battle their Rx drug addictions. An infant and his 6 year old brother were recently placed in a CHS foster home because the mom was improperly dosing the infant with methadone which was prescribed to him because of drug withdrawal symptoms at birth. The infant’s withdrawal is obviously a result of the mother’s abuse of drugs, including Rx drugs not prescribed to her. Generally when children are removed from their home due to the parent’s drug issues, it takes 2 to 3 years for that child to be reunited with their parent, or to be free to be adopted. During this time the child has no sense of permanency, of how to effectively project their future, and who their forever family will be.

It is not unusual for one or both of the parents referred to our supervised visitation and exchange program by the Family Court to be involved or have a history of Rx drug abuse. One of the most devastating aspects of this plight is the relapse rate and the day to day struggle to stay drug free. Jennifer is a Mom who has visited with her children, brothers, age 10 and 12, at our Visitation Center on and off again for the past 3 years. This past year she gave birth to a baby girl, who was born addicted and was removed from her care, and it is not likely that she will regain custody of her little girl. Her track record for not completing drug treatment programs and for relapsing into the fog of addiction does not provide much hope for her being a mom to any of her children. Another family served by our visitation program has witnessed at least 3 drug overdose deaths, 2 mothers and a step-dad. These fatalities and all too often outcomes of Rx drug abuse are tragic on so many levels. Grandparents are forced into the role of parents, children become displaced and lose contact with family and friends, trust and love and other elements of strong relationships and bonds are eroded which can lead the child down their own path to drug abuse.”
Kathy Brunt
Wyoming County Family Resource Network

"The Wyoming County Prevention Coalition was organized in 2006 as our Substance Abuse Coalition. The members have grown in the past two years from six to as many as 38 attending the monthly coalition meetings. Supportive members include: youth, parents, state delegates, teachers, WVU Extension, SADD Coordinator, Family Resource Network, pastors, law enforcement, Board of Education, social service providers, and many more. This group has partnered with law enforcement to hold two Rx Take Back Days with the last endeavor collecting 1300 Rx of drugs. The Coalition accomplishments include: County Drug Forum, Town Hall meeting for Underage Drinking, formation of five SADD groups, SADD Rookie of the Year Award, six students complete National Youth Leadership Initiative, members attending 16 trainings on substance abuse prevention, providing workshops within their county, special events such as Drug Free All Stars, and monthly visits to schools in Wyoming County to promote support to SADD groups forming. Over 500 youth have signed up for SADD in 2011. One of our greatest partners in our Prevention Coalition is to our faith-based services. One Voice of Wyoming County has served our communities for over six years with no state or federal funding, yet maintains an office with three full time, volunteer staff to help families and addicts. They conduct outreach programs such as: feeding the children with take home bags of food for the weekend, 12 step classes, job and resume support, packing lunches for a recovering addict when he got clean and went to a job, plus over 10000 volunteer hours. One Voice is the connection to 221 churches in Wyoming County and our rural communities.

One special story: Jacob Snuffer joined our Coalition student group to become a member of the National Youth Leadership Initiative. Jacob is not a youth that really fits into the “sports star or popular click”. Jacob came to us with great leadership potential, highly intelligent, but needed guidance and support as his older brother was struggling with addiction. Jacob went from that kid setting on the sidelines to speaking before Congressmen Rahall, faithfully supporting SADD and his Prevention Coalition, and assisting his group in becoming Rookie of the Year. Jacob submitted his story about his hometown and what needed to be changed to Community Anti Drug Coalition of America. He was honored by CADCA and is featured in their Annual Report for 2011. Jacob says becoming a part of the NYL and SADD has kept him from following the crowd and standing up for what he believes in. Jacob is that one "Starfish" of many more to come in Wyoming County with the support of prevention programs."
Anonymous
Mercer County

“Hello ... I am an addict. I have a little more than three years of 'clean time' by the grace of God and the resources I have been given. I spent years in active addiction even while being a mother, daughter, sister as well as a nurse for 33 years. I finally became willing to reach out for help when I had exhausted all financial and other resources and was humbled enough to be receptive to that help. When I was finally ready, the help was there for me through the 12 step programs, the God of my understanding and the people who were there to help me.

I had never experienced a compulsion as strong as my addiction to narcotics. As a nurse I thought I had skills and could manage the use of these medications for myself. I proved time after time that I could not handle my use of opiates. I would swear not to abuse the medication but each time I got the pills, I took as many as I could, as fast as I could until they were gone. Then, the feast and panic set in of what would I do now because everything in my brain told me that I could not live without opiates. I thought only a crazy person would repeat the same behaviors over and over and expect different results.

I was completely sincere each time I swore that I could 'wean down' but it was beyond my ability to do so without help. I'm grateful today that I was allowed to find help when I was finally willing to accept it. You don't see too many addicts over 50 years old, the just don't live that long. There are too many options now that are incredibly lethal for those with a 'broken brain'. The last thing we need in our society is another long acting narcotic prescription for sick people to use.

Addiction is not a character defect. Toward the end of my use, I had to take pills so that I would not be sick. I didn't want to take them. I actually used pills against my own will. But, I continued to use because I had no choice. Today, I have a choice and for that miracle I am deeply grateful.

As a nurse and a recovering addict, I see people die every day from this disease. Tragically, and pointless, lives are lost. Mothers, fathers, daughters, sons. Human beings lost forever!

Treatment is complicated and there is no magic bullet for this disease but we do have resources and those resources must be used in every way possible. Addiction is a cruel and vicious disease and has no intention but to take lives. We cannot sit by and watch it continue to grow out of control. We must do everything we can to fight this epidemic.”
...Shannon Atwell
ChildLaw Services, Inc. – Mercer County

"ChildLaw Services, Inc. works to "balance the scales of justice" for children. Simply put, we are a law firm for children. Each year, ChildLaw provides a voice for more than 650 children who are abused or neglected, the subjects of high-conflict custody cases, who are victims of crime, and others who are involved in the legal system. Substance abuse is overwhelmingly the number one issue involved in our caseload. At least 95% of all cases (circuit court and family court) involve substance abuse by at least one party to the case.

Prescription drug abuse (narcotics and opiates) is rampant in the lives of those individuals caring for these children. ChildLaw attorneys represent children of all ages in Mercer County and southern West Virginia: from the drug-addicted newborn in the hospital to the adolescent and teenage clients whose families have been torn apart due to substance abuse.

For example...

'Justin' was first referred to ChildLaw Services due to a custody dispute between his parents in 2007. Justin, age 15, was unhappy with the custody arrangements and did not want to continue visiting his mother and stepfather. When the Court ordered Justin to visit his mother, Justin confided to his ChildLaw attorney that his stepfather had been sexually abusing him for numerous years. At that time, the attorney moved to stop immediate visitation and then reported the abuse to Child Protective Services. (Younger step-siblings were in the home) and law enforcement. Justin's mother, a drug addict herself, was not able to recognize the issues, nor could she protect her son. For months, the attorney spent hours on the phone and in person preparing Justin for court and the difficult task of testifying. They also arranged follow-up victim's services for Justin and his father.

At this time, Justin receives ongoing mental health services as he tries to heal and move on with his life. The attorney represented him in Family Court during the custody dispute, then in the abuse & neglect proceedings and was with Justin as he faced his abuser in criminal court. Although it was a difficult time, the agency was able to work with him through this situation.

Prescription drug abuse not only affects the user, it affects those that cannot protect themselves. This past Thanksgiving, ChildLaw's Legal Director spent hours in the hospital holding and rocking a drug-addicted newborn. Since the hospital staff is not able to provide the type of comfort a 'drug baby' constantly needs, such as swaddling, volunteers often serve as surrogates to help calm and nurture the child. Not surprisingly, within hours, the mother was nowhere to be found.

ChildLaw not only hears these stories regularly, but we see with these issues daily. So much needs to be done in terms the prevention and treatment of this epidemic and we cannot wait much longer. We already have a generational system of addicts in our system and we cannot afford to let our "children of tomorrow" suffer an even greater fate.
Stephen E. Dickerson, M.S  
Mercer County

“My name is Stephen Dickerson, and I have been in long term recovery from substance abuse addiction for nearly 12 years (March 16, 2000) and I am writing you this letter on behalf of myself, and many other citizens of the great state of West Virginia, to express the need for funding for substance abuse treatment facilities in our Great State.

We often associate the drug addict as being the skid row derelict that has lived a life of crime, in and out of hospitals, almost undoubtedly never to find his way. I’m letting you know that is not the average addict. I myself began a process of recovery with a meager 16 cents in my pocket; I had two changes of clothes, and even less friends. I had blissed a path of despair and destruction, hurting anyone who had the misfortune of caring anything about me. That was then! Because I was afforded an opportunity to obtain treatment, I was enabled to begin a process of healing. I was able to look inside of myself, and find the good person that lived within.

Today I live a happy life. I have a wife, two children, and a pretty decent golf game. I’m president of my local Shrine Club, where I work diligently, in my leisure time, to raise funding to transport children to the Children’s Hospital in Kentucky. I volunteer on many local community levels, and I’m always willing to reach a hand out to help someone in need. I’ve shared my story as the 2009 WV Delegate for the A&E Recovery Project, where 11,000 of us walked Penn’s Landing in Philadelphia to let the country know recovery happens. I flew to Tampa a couple years ago to participate in a training video for CADCA on connecting recovery, treatment, and prevention groups to fight this epidemic holistically. My story, as well as many others was highlighted in SAMSHA’s Nation Recovery Toolkit.

My point is this: recovery happens! However, every day we have individuals literally dying while waiting on a bed to enter a treatment center. Not every addict wants to be in the position they are in; most don’t know how they ended up where they are. We see people turned away every day, to go back to doing what they were doing. I’m telling you this: there is no other difference between myself and them, other than the fact that I was afforded the opportunity for treatment and I listened when I got there.”
Lori
Mercer County

“My name is Lori and I am a recovering addict. I will have 4 years clean this month. I was a nurse for over 20 years and after treatment at a pain clinic for migraines found myself addicted to opiates. After the first pill I thought I had found heaven, but in reality I was in a living hell.

My addiction took me to places I never thought I would go. My addiction made me do things I thought I would never do. I could not stop. I lived this way for 12 years. At the end my career was lost. My family could not understand. I lost everything that mattered to me and still had to have the drugs.

I was found in my apartment not breathing and was rushed to the hospital. That was my bottom. I went to a treatment center for 21 days. When I was released I started going to a 12 step fellowship and met people who found a way out of that way of life and they shared it with me. I realize today that I have a disease, I am not a bad person, I am a sick person.

There are options for addicts. Jail and punishment did not work for me. I needed and still do need treatment for my disease. Treatment is so important. Treatment is very limited in Mercer County and our rate of Rx addiction is very high. I believe there are answers. We need more resources and treatment options if we are going to address this problem.

We need laws in place that follow doctors prescribing these very dangerous, very addictive drugs, laws that will help keep these drugs from being misused and sold on the street. There are solutions and I am very grateful that I found mine.”
March 9, 2012

I am Captain Timothy D. Bradley and I am in my twentieth year with the West Virginia State Police. The majority of my career has involved drug work both while in uniform and in an undercover capacity. For the last five years I was the Officer in Charge of the Bureau of Criminal Investigations which contains the undercover operations of the West Virginia State Police. Presently I am the Deputy Chief of Field Services responsible for all of the uniformed members of the West Virginia State Police and the undercover narcotics officers.

The new problem facing law enforcement is the abuse of legal prescriptions and legal substances for illegal gain. Prescription diversion creates a never before seen situation because the product is a legal substance which is initially legally distributed by our doctors and pharmacists. Often legal prescriptions lead to addiction problems that do not carry the social stigma associated with all other drug abuse. An example I use is when I played high school football one of my team mates was caught with marijuana. Because drug use brought with it negative connotations, we did not want drugs associated with our team. Through peer pressure we made sure that drugs were not linked with that or any other football player on our team. Today I see prominent high school students and athletes diverting prescription pills. This practice is not frowned upon and is appallingly socially acceptable leading others to imitate that behavior. Such abuse of prescription pills creates a devastating addiction problem that adversely affects good productive citizens.

Prescription drug abuse has become an epidemic in the State of West Virginia. In some counties, it could be better described as a plague. From 2001 to 2009 approximately 3,000 individuals died due to toxic accidental drug poisonings. These numbers do not include DGI related deaths involving prescription drugs. The majority of these deaths involved prescription drugs. Drug poisoning is the leading cause of death in West Virginians between the ages of 20 to 50 and we have the highest per capita rate of drug overdose deaths in the nation. Prescription drugs are now the most popular drugs being introduced in our middle schools. Unfortunately that is not the youngest population being affected by the illegal use of prescription drugs. Currently, it is estimated that approximately 27% of infants born in West Virginia are born with exposure to, or are chemically dependent on drugs. Some hospitals in Southern West Virginia have
reported infant exposure numbers as high as 30-50%. Prescription Opiates are the most common
type of drug abused and account for the majority of infant exposures.

Prescription drug abuse does not discriminate; it crosses all boundaries of life without
regard to race or socio-economic status. In many communities around the state, prescription
drugs have become a common item of barter and are freely traded for property, cash and sex.
Sadly, it is the family that is affected the most. When loved ones become addicted, children are
left without parents, the elderly are left without their care givers and a family can be torn apart
by the crimes of the addicted. Approximately 90% of the crimes that we investigate involve
drugs and the majority of the drugs are prescription drugs diverted for illegal use. One 80 mg
OxyContin tablet can be sold for more than one hundred dollars and often drug users will
consume multiple tablets on a daily basis. On occasion one OxyContin tablet has been purchased
for as much as $160.00. Abuse of prescription drugs becomes expensive and can lead the user
to commit property crimes including burglaries or other larcenies in order to obtain money to
purchase more pills. An involvement in property crimes may then lead to participation in violent
crimes.

The West Virginia State Police has attempted to focus on the criminal enterprises that
provide prescription drugs for monetary gain. These are commonly called pill mills because it is
an assembly line type of operation where people go with complaints of pain and without a strong
medical workup are provided with a prescription for pain pills. We have been able to work with
federal agencies to close down several pill mills around the state and arrest numerous drug
dealers from within West Virginia and from other states. The object is to decrease the
availability of the drugs. Due to the fact that such an enterprise will cater to both addicts and to
individuals with actual pain and the need for valid prescriptions, these investigations require
extremely detailed analysis in order to secure convictions and close the pill mill. Such a time
consuming examination means that the criminal enterprise is ongoing and more people are
becoming addicted while the investigation is being completed. Suspected pill mills are
specifically set up to function on the edge of legality. Although we are making headway here in
West Virginia, this is becoming a national problem and we are seeing large numbers of
individuals traveling to other states or taking flights for the specific purpose of obtaining
prescription pain killers.

In the past, law enforcement has been able to somewhat dismantle traditional drug
trafficking organizations by working their way up the ladder through the suppliers. It is
completely different with prescription drugs because after the first or second tier the next level is
a health care facility or pain clinic that is operating on the edge of the law, but the required
license to prescribe and supply narcotics. Legislation has not been able to keep up with the
changing drug trends as clinics pump out hundreds of thousands of units of controlled
prescription medications without violating the current law. Licensing boards have also become
ineffective in policing providers. Under current law, if a drug seeker adequately represents that
they have pain, the physician can prescribe legal pain medications without consequence. This
makes it extremely easy for a pill mill to run a cash only business prescribing opiates to hundreds
of individuals a day, keeping the now addicted patients on the same drugs for years while
making enormous amounts of money for the proprietors of these clinics. Prescriptions are also
being filled with very little scrutiny from pharmacists and many are under the mind set that if the
prescription was issued by a licensed doctor then they have an obligation to fill that prescription.
Often a geographical area’s drug choice and exposure is directly related to drug availability. This is what we believe occurred in this state. Individuals were introduced to prescription drugs such as hydrocodone by their local physician for actual pain management, the patient either used the drugs or left them in home medicine cabinets where they were used for illicit purposes. This exposure and availability lead to increased use and tolerance. This causes traditional drug dealers to capitalize on the increasing demand. Currently we are seeing a significant amount of prescription drugs such as Oxycodeone and Oxymorphone being supplied from traditional drug trading organizations from source cities such as Columbus and Detroit which were originally obtained from a healthcare provider. Currently, the most available drugs are marijuana and hydrocodone. The most sought after drugs are Opana (Oxymorphone) and OxyContin (Oxycodeone). The ability to circumvent the time release component of the compound allows addicts to receive an instant dosage of the drug. These drugs are also able to be snorted, smoked or injected, further increasing the speed with which the drug is received by the brain causing a euphoric high.

Should you have further questions or concerns, please feel free to contact me.

Sincerely,

[Signature]

Captain T.D. Bradley
Deputy Chief of Field Services
Prepared Statement of Kimberly Becher, MD; and Kane Maiers, MD, Paul Ambrose Health Policy Fellows, Marshall University Department of Family and Community Health

Drug abuse in Southern West Virginia has an effect on our daily practice of medicine. As family medicine residents we are not only exposed to drug-seeking behavior, but see the long term effects of drug abuse in our patient population. Because we are new providers in the community, our continuity clinics are targeted by patients requesting controlled substances for recreational use. These visits not only take away slots in which we could be treating legitimate medical problems, they frustrate us as providers. We chose to be family physicians because we have a genuine desire to improve the health outcomes of our communities and we sincerely value the physician-patient relationship. We work hard to develop rapport and do not like to disappoint our patients. Despite the level of compassion and professionalism displayed as we deny unreasonable requests for pain medication, many visits with drug-seeking patients end with aggression, anger, and occasional threats of violence toward the provider. On more than one occasion a patient has revealed a weapon in our office.

Unfortunately, the most difficult of cases involve patients with progressive chronic disease that is unable to be properly addressed due to the patient’s fixation on obtaining opiates or benzodiazepines. These patients emotionally drain us as providers. We spend the most time on these visits and make the least progress in decreasing the patient’s morbidity and mortality despite our attempts at intervention. This patient population contributes a disproportionate amount to the cost of health care in West Virginia. This is not only limited to emergency room visits but also to the complications of untreated comorbid conditions that require hospitalization for a population that is largely uninsured or receiving Medicaid. The addiction circle is not limited to the patients we see in the office. To the unemployed, obtaining a thirty-day prescription for oxycodone will more than adequately pay their bills. One resident reports admitting at least one patient to the ICU per night who overdosed on prescription drugs they were not prescribed.

We need help combating this epidemic in Southern West Virginia. We need a national controlled substance monitoring program that is real time. Patients routinely fill prescriptions in Kentucky and Ohio, but we have also had trouble with more organized patients travelling to pharmacies in Florida. We need educational opportunities that prepare us to properly address prescription drug-seeking behaviors from the first day of practice. There is no grace period here. For many of us, our first patient encounter was a test of our ability to deny an unwarranted prescription.

Thank you for championing the development of legislation to curb prescription drug abuse.