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“Prescription Drug Diversion: Combating the Scourge”

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

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

STATEMENT OF
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DIRECTOR
OFFICE OF NATIONAL DRUG CONTROL POLICY
EXECUTIVE OFFICE OF THE PRESIDENT

before the

SUBCOMMITTEE ON COMMERCE, MANUFACTURING, AND TRADE
COMMITTEE ON ENERGY AND COMMERCE
U.S. HOUSE OF REPRESENTATIVES

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Chairman Bono Mack, Ranking Member Butterfield, and distinguished members of the Subcommittee, thank you for this opportunity to appear before this Subcommittee once again to address the issue of prescription drug diversion and abuse in our country. As you know, the Office of National Drug Control Policy (ONDCP) was established by Congress with the principal purpose of reducing illicit drug use, illicit manufacturing, and trafficking; drug-related crime and violence; and drug-related health consequences. Our office establishes policies, priorities, and objectives for the Federal drug control program agencies. We also evaluate, coordinate, and oversee the international and domestic anti-drug efforts of executive branch agencies and ensure such efforts sustain and complement state and local anti-drug activities.

As you are also aware, I am charged with producing the *National Drug Control Strategy* (*Strategy*), which directs the Nation's anti-drug efforts and establishes programs, a budget, and guidelines for cooperation among Federal, state, and local entities. The Obama Administration recognizes that addiction is a disease, and that prevention, treatment, and law enforcement must all be included as part of a strategy to stop drug use, get help to those who need it, and ensure public safety. Building upon this national *Strategy*, the Administration has developed the comprehensive *Prescription Drug Abuse Prevention Plan*. As I will discuss later in further detail, this document establishes a plan to reduce diversion and abuse of prescription drugs, while continuing to ensure legitimate access to medications for patients who need them.

The Administration's inaugural *Strategy*, released in May 2010, committed to reducing drug use and its consequences through a science-based public health approach to policy. The *Strategy* established specific goals by which to measure our success. The *Strategy* included action items that comprehensively address all areas of drug control. We added a few more action items relating to special populations as part of the 2011 *Strategy*, and the 2012 *Strategy*, which will be released in the coming weeks, will provide a status update on where we are in terms of meeting these goals. We have made significant progress on many of these items. In addition, we have highlighted three signature initiatives in each year's *Strategy* – prevention, drugged driving, and most pertinent for this hearing, prescription drug abuse.

The Epidemic of Prescription Drug Abuse

Over the past decade, the Nation has witnessed alarmingly high rates of prescription drug abuse and misuse, as well as dramatic increases in the consequences that have been devastating for public health and safety. We have seen increases in substance abuse treatment admissions, emergency department visits, and most alarmingly, deaths attributable to prescription drug overdoses. These trends and the scope of the problem have led the Department of Health and Human Services' (HHS) Centers for Disease Control and Prevention (CDC) to characterize prescription drug abuse as a public health epidemic, a label that draws further urgency to both policy and community-based responses.

The latest survey data show that approximately seven million Americans currently abuse psychotherapeutic drugs. In 2010, 2.4 million Americans aged 12 or older used psychotherapeutics non-medically for the first time, which equates to nearly 6,600 new users per day. The largest share of these new users started with pain relievers (approximately 2.0 million or 5,500 new users per day). This figure is second only to new users of marijuana.[1]

These figures translate into very real consequences. In 2009, estimates indicate over 1.2 million emergency department visits involved the non-medical use of pharmaceuticals, double the estimate from 5 years earlier, and outnumbering visits involving all other illicit drugs combined. Much of this increase is attributable to visits involving narcotic pain relievers, a class of drugs that includes oxycodone, hydrocodone, and methadone.[2] Pain relievers are driving many of the negative trends in prescription drug abuse. Data indicate a six-fold increase in addiction treatment admissions for individuals primarily abusing prescription painkillers from 1999 to 2009.[3] These increases span age groups, gender, race, ethnicity, education, employment level, and region. We also know that pain relievers are the most commonly involved drugs in drug-related suicide attempts.[4]

In 2008, more than 36,000 Americans died from drug overdoses, and prescription drugs—particularly opioid painkillers—were involved in a significant proportion of those deaths. The CDC found that opioid pain relievers were involved in 14,800 of these deaths.[5] Opioid pain relievers are now involved in more overdose deaths than heroin and cocaine combined. In the

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[1] Substance Abuse and Mental Health Services Administration. *Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings*. U.S. Department of Health and Human Services. [September 2011]. Available: http://oas.samhsa.gov/NSDUH/2k10NSDUH/2k10Results.htm

[2] Substance Abuse and Mental Health Services Administration. *Drug Abuse Warning Network, 2009: National Estimates of Drug-Related Emergency Department Visits.* U.S. Department of Health and Human Services. [August 2011]. Available: http://www.samhsa.gov/data/2k11/DAWN/2k9DAWNED/HTML/DAWN2k9ED.htm

[3] Substance Abuse and Mental Health Services Administration. *Treatment Episode Data Set (TEDS) Report*. U.S. Department of Health and Human Services. [2011]. Available: http://wwwdasis.samhsa.gov/teds09/teds2k9nweb.pdf

[4] Substance Abuse and Mental Health Services Administration. *Drug Abuse Warning Network, 2009: National Estimates of Drug-Related Emergency Department Visits.* U.S. Department of Health and Human Services. [August 2011]. Available: http://www.samhsa.gov/data/2k11/DAWN/2k9DAWNED/HTML/DAWN2k9ED.htm

[5] Centers for Disease Control and Prevention. *Morbidity and Mortality Weekly Report: Vital Signs: Overdoses of Prescription Opioid Pain Relievers—United States, 1999-2008.* U.S. Department of Health and Human Services. [November 2011]. Available: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6043a4.htm?s_cid=mm6043a4_w

United States in 2009, drug-induced deaths outnumbered motor vehicle crash deaths for the first time.[6]

Substance use has also affected our military, Veterans, and their families. According to the latest Department of Defense survey, one in eight (12 percent) active duty military personnel reported past month illicit drug use, largely driven by the abuse or misuse of prescription drugs (reported by 11 percent).[7] We also know that substance abuse affects many of the country's estimated 67,000 homeless Veterans.[8]

The human costs of prescription drug abuse are tragic and cannot be overstated for the families and friends that have experienced the loss of a loved one. Yet there is also a cost to society at large. A recent study estimated that the health care, workplace, and criminal justice costs of prescription opioid abuse amounted to over $56 billion in 2007.[9] Financial consequences are just part of the damage caused by prescription drug abuse.

The vast majority of abused pharmaceutical drugs originally enter into circulation through a prescription. And we know that most prescription painkillers are prescribed by primary care physicians, internists, dentists, and orthopedic surgeons, not pain management specialists.[10] The quantity of prescription painkillers sold to pharmacies, hospitals, and doctors' offices approximately quadrupled between 1999 and 2010. In fact, CDC estimates that by 2010, enough opioid pain relievers were sold to medicate every American adult with a typical dose of 5 milligrams of hydrocodone every 4 hours for 1 month.[11]

Unfortunately, once they are prescribed and dispensed, these drugs are frequently diverted to people using them without prescriptions. The latest survey shows that in 2009 and 2010 approximately 55 percent of the nonmedical users of prescription pain relievers got them "from a friend or relative for free." Another 11 percent bought them from a friend or relative, and 5 percent took them from a friend or relative without asking. This means that over 70 percent of people abusing or misusing prescription pain relievers obtained them from friends or family.[12]

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[6] National Center for Health Statistics. (2012). National vital statistics reports: Deaths: Final Data for 2009. Centers for Disease Control and Prevention: Washington, DC. Highlights/Detailed Tables available: http://www.cdc.gov/nchs/data/dvs/deaths_2009_release.pdf

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

[8] Office of Community Planning and Development. *The 2011 Point-in-Time Estimates of Homelessness: Supplement to the Annual Homeless Assessment Report.* U.S. Department of Housing and Urban Development. [December 2011]. Available: http://www.hudhre.info/documents/PIT-HIC_SupplementalAHARReport.pdf

[9] Birnbaum H.G., White, A.G., Schiller M., Waldman T., et al. (2011). Societal costs of prescription opioid abuse, dependence, and misuse in the United States. *Pain Medicine*. 12:657-667. Available: http://www.ncbi.nlm.nih.gov/pubmed/21392250

[10] Volkow ND, McLellan TA, Cotto JH, Karithanom M, Weiss SRB. "Characteristics of opioid prescriptions in 2009." JAMA 2011;305(13):1299–1301. Available: http://jama.ama-assn.org/content/305/13/1299.full

[11] Centers for Disease Control and Prevention. *Morbidity and Mortality Weekly Report: Vital Signs: Overdoses of Prescription Opioid Pain Relievers—United States, 1999-2008.* U.S. Department of Health and Human Services. [November 2011]. Available: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6043a4.htm?s_cid=mm6043a4_w

[12] Substance Abuse and Mental Health Services Administration. *Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings*. U.S. Department of Health and Human Services. [September 2011]. Available: http://oas.samhsa.gov/NSDUH/2k10NSDUH/2k10Results.htm

This same survey shows that 17 percent of Americans using prescription pain relievers non-medically obtained them from one doctor, while just over 4 percent got them from a drug dealer or other stranger, and 0.4 percent bought them online.[13]

Researchers have begun to identify risk factors for overdosing on opioids. The first of these is "doctor shopping" – obtaining multiple prescriptions from different providers.[14,15] Other predictors include taking one or more sedative/hypnotic (Benzodiazepine-like) medications, high daily dosages of prescription painkillers, and multiple overlapping prescriptions as well as prescriptions for certain drugs and visiting multiple pharmacies.[16,17,18,19,20,21] Individuals with histories of mental illness or other substance abuse are also at increased risk.[22]

Regionally, the drug overdose epidemic is most severe in the Southwest and in Appalachia, and rates vary substantially between states. The highest drug overdose death rates in 2008 were found in New Mexico and West Virginia (27.0 and 25.8 deaths per 100,000 population, respectively), which had rates nearly five times that of the state with the lowest rate, Nebraska (5.5 deaths per 100,000). The national average for drug overdose death is 11.9 deaths per 100,000, and California, at 10.4 deaths per 100,000, sits just below the national average.[23]

[13] Substance Abuse and Mental Health Services Administration. *Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings*. U.S. Department of Health and Human Services. [September 2011]. Available: http://oas.samhsa.gov/NSDUH/2k10NSDUH/2k10Results.htm

[14] White AG, Birnbaum HG, Schiller M, Tang J, Katz NP. "Analytic models to identify patients at risk for prescription opioid abuse." Am J of Managed Care 2009;15(12):897-906. Available: http://www.ncbi.nlm.nih.gov/pubmed/20001171

[15] Hall AJ, Logan JE, Toblin RL, Kaplan JA, Kraner JC, Bixler D, et al. "Patterns of abuse among unintentional pharmaceutical overdose fatalities." JAMA 2008;300(22):2613-20. Available: http://jama.ama-assn.org/content/300/22/2613.full

[16] Paulozzi LJ, Kilbourne EM, Shah NG, Nolte KB, Desai HA, Landen MG, Harvey W, Loring LD. A history of being prescribed controlled substances and risk of drug overdose death.Pain Med. 2012 Jan;13(1):87-95. Available: http://www.ncbi.nlm.nih.gov.ezproxy.nihlibrary.nih.gov/pubmed/22026451

[17] Hall AJ, Logan JE, Toblin RL, Kaplan JA, Kraner JC, Bixler D, et al. "Patterns of abuse among unintentional pharmaceutical overdose fatalities." JAMA 2008;300(22):2613-20. Available: http://jama.ama-assn.org/content/300/22/2613.full

[18] Green TC, Graub LE, Carver HW, Kinzly M, Heimer R. "Epidemiologic trends and geographic patterns of fatal opioid intoxications in Connecticut, USA: 1997–2007." Drug and Alcohol Dependence 2011;115:221-8. Available: http://www.ncbi.nlm.nih.gov/pubmed/21131140

[19] Paulozzi LJ, Logan JE, Hall AJ, McKinstry E, Kaplan JA, Crosby AE. "A comparison of drug overdose deaths involving methadone and other opioid analgesics in West Virginia." Addiction 2009;104(9):1541-8. Available: http://www.ncbi.nlm.nih.gov/pubmed/19686524

[20] Bohnert AS, Valenstein M, Bair MJ, Ganoczy D, McCarthy JF, Ilgen MA, et al. "Association between opioid prescribing patterns and opioid overdose-related deaths." JAMA 2011;305(13):1315-1321. Available: http://jama.ama-assn.org/content/305/13/1315.full

[21] Dunn KM, Saunders KW, Rutter CM, Banta-Green CJ, Merrill JO, Sullivan MD, et al. "Opioid prescriptions for chronic pain and overdose: a cohort study." Ann Intern Med. 2010;152(2):85-92. Available: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3000551/

[22] Bohnert AS, Valenstein M, Bair MJ, Ganoczy D, McCarthy JF, Ilgen MA, et al. "Association between opioid prescribing patterns and opioid overdose-related deaths." JAMA 2011;305(13):1315-1321. Available: http://jama.ama-assn.org/content/305/13/1315.full

[23] Centers for Disease Control and Prevention. *Morbidity and Mortality Weekly Report: Vital Signs: Overdoses of Prescription Opioid Pain Relievers—United States, 1999-2008.* U.S. Department of Health and Human Services. [November 2011]. Available: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6043a4.htm?s_cid=mm6043a4_w

There are also some socioeconomic trends in these overdose deaths. According to researchers at the CDC, those living in rural areas are at higher risk for overdose,[24,25,26] as are those in areas with higher proportions of impoverished residents.[27,28] Among individuals on Medicaid, studies have found disproportionate patterns of painkiller use as well as significantly higher risk of overdose on prescription pain relievers.[29,30] In addition, analysis of 31 states' poison control center calls shows that the percentages of residents living in poverty and unemployed correlate with prescription drug abuse reports, while the percentage with bachelor's degrees, and to a lesser extent high school diplomas, are related to less prescription abuse.[31]

These figures highlight the continuing health and safety dangers that prescription drug abuse, misuse, and diversion pose for the country. The ease of access to prescription drugs, combined with a low perception of risk, make reducing prescription drug abuse especially difficult, particularly among youth. When properly and safely prescribed by healthcare professionals, prescription medications can provide enormous health and quality of life benefits to patients. Medical science has successfully developed medications that can alleviate suffering, such as opioids for cancer pain and benzodiazepines for anxiety disorders, and allowed more individuals to have access to the medicines they need. However, we all now recognize that these drugs can be just as dangerous and deadly as illicit substances when misused or abused.

An Improved Response

The ongoing public health and safety consequences of prescription drug abuse underscore the need for action. When I testified before this Subcommittee last April, the Administration had just released its comprehensive *Prescription Drug Abuse Prevention Plan*, entitled "Epidemic:

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[24] CDC grand rounds: prescription drug overdoses - a U.S. epidemic. Centers for Disease Control and Prevention (CDC). MMWR Morb Mortal Wkly Rep. 2012 Jan 13;61(1):10-3. Available: http://www.cdc.gov.ezproxy.nihlibrary.nih.gov/mmwr/pdf/wk/mm6101.pdf

[25] Hall AJ, Logan JE, Toblin RL, Kaplan JA, Kraner JC, Bixler D, Crosby AE, Paulozzi LJ.Patterns of abuse among unintentional pharmaceutical overdose fatalities.JAMA. 2008 Dec 10;300(22):2613-20. Available: http://www.ncbi.nlm.nih.gov.ezproxy.nihlibrary.nih.gov/pubmed/19066381

[26] Wunsch MJ, Nakamoto K, Behonick G, Massello W. Opioid deaths in rural Virginia: a description of the high prevalence of accidental fatalities involving prescribed medications. Am J Addict. 2009 Jan-Feb;18(1):5-14. Available: http://www.ncbi.nlm.nih.gov.ezproxy.nihlibrary.nih.gov/pubmed/19219660

[27] Centers for Disease Control and Prevention. Morbidity and Mortality Weekly Report: Vital Signs: Overdoses of Prescription Opioid Pain Relievers—United States, 1999-2008. U.S. Department of Health and Human Services. [November 2011]. Available: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6043a4.htm?s_cid=mm6043a4_w

[28] Hall AJ, Logan JE, Toblin RL, Kaplan JA, Kraner JC, Bixler D, Crosby AE, Paulozzi LJ.Patterns of abuse among unintentional pharmaceutical overdose fatalities.JAMA. 2008 Dec 10;300(22):2613-20. Available: http://www.ncbi.nlm.nih.gov.ezproxy.nihlibrary.nih.gov/pubmed/19066381

[29] Centers for Disease Control and Prevention. "Overdose deaths involving prescription opioids among Medicaid enrollees-Washington, 2004-2007." MMWR. 2010;59;705-9. Available: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5842a1.htm

[30] Braden JB, Fan MY, Edlund MJ, Martin BC, DeVries A, Sullivan MD. "Trends in use of opioids by noncancer pain type 2000-2005 among Arkansas Medicaid and HealthCore enrollees: results from the TROUP study." J Pain 2008;9(11):1026-1035. Available: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2661263/

[31] Spiller H, Lorenz DJ, Bailey EJ, Dart RC. Epidemiological trends in abuse and misuse of prescription opioids. J Addict Dis. 2009;28(2):130-6. Available: http://www.ncbi.nlm.nih.gov/pubmed/19340675

Responding to America's Prescription Drug Abuse Crisis." This plan builds upon the Obama Administration's *National Drug Control Strategy*, and brings together Federal, state, local, and tribal leaders to reduce diversion and abuse of prescription drugs. It strikes a balance between our need to prevent diversion and abuse of pharmaceuticals with the need to ensure legitimate access, focusing on four major pillars, each designed to intervene at a critical juncture in the process of diversion and abuse. These pillars include education for prescribers and the public; prescription monitoring; safe drug disposal; and effective enforcement. I am pleased to report that we are making significant progress in each of the four major pillars outlined in the plan.

The first pillar of our response plan is education. As stated earlier, most prescription painkillers are prescribed by primary care physicians, internists, dentists, and orthopedic surgeons, not pain specialists. Despite this reality, surveys of health care professionals and schools reveal significant gaps in education and training on pain management, substance abuse, and safe prescribing practices. For these reasons, the Administration continues to support mandatory prescriber education. The urgency of this epidemic and the fundamental need for safe prescribing practices in modern medical care demand effective curricula for prescribers. The HHS Substance Abuse and Mental Health Services Administration (SAMHSA) is providing critical training on prescription drug abuse for physicians both online, and since 2007, in 40 sites in 29 states with particularly high rates of opioid dispensing.

These training programs are providing important knowledge and tools for medical professionals responsible for safely prescribing these medications. In addition, the HHS Food and Drug Administration have developed a Risk Evaluation and Mitigation Strategy (REMS) for long-acting and extended-release opioids. This REMS requires all manufacturers of long-acting and extended-release opioids to develop educational materials and training for prescribers of these medications. The manufacturers must also develop information that prescribers can use when counseling patients about the risks and benefits of opioid use.

Another aspect of this education effort involves the general public, especially people using prescription medications, as well as parents and caregivers. We are working to educate Americans about the risks and prevalence of prescription drug abuse and about the safe use and proper storage and disposal of these medications. Through our National Youth Anti-Drug Media Campaign, ONDCP has developed materials for use by community anti-drug coalitions to educate youth about the dangers of prescription drug abuse. However, we also know that the average age of first non-medical use of pain relievers is 21 years old.[32] Americans start abusing prescription drugs later in life than with other illicit drugs, so we need to ensure that prevention messaging targets adults as well. With these issues in mind, the Administration is producing educational materials, holding public events, and working with other government and private sector stakeholders to provide the right information to Americans who most need it.

The second pillar of the Administration's plan focuses on expanding and improving state Prescription Drug Monitoring Programs (PDMPs). As you know, these state-wide databases

[32] Substance Abuse and Mental Health Services Administration. *Results from the 2010 National Survey on Drug Use and Health: Summary of National Findings*. U.S. Department of Health and Human Services. [September 2011]. Available: http://oas.samhsa.gov/NSDUH/2k10NSDUH/2k10Results.htm

monitor the prescribing and dispensing of controlled substances, and serve a multitude of functions. PDMPs can and should serve as a tool for patient care, a drug epidemic early warning system (especially when combined with other data), and a drug diversion and insurance fraud investigative tool. Information contained in the PDMP can be used by prescribers and pharmacists to detect drug-drug interactions and identify patients who may be doctor shopping or in need of substance abuse treatment. Under specific circumstances, regulatory and law enforcement officials can also use the information to pursue cases involving rogue prescribers or pharmacists, or "pill mills," and other forms of diversions.

In 2006, only 20 states had PDMPs. Today, 48 states have laws authorizing PDMPs, and 40 states have operational programs. Despite this progress and the demonstrated benefits of PDMPs, some states lack operational programs, and many states that do operate PDMPs lack interoperability with other states. All states should have operational PDMPs with mechanisms in place for sharing between states. Additionally, health care providers must use these databases regularly and consistently, incorporating PDMP checks as a standard part of patient care. We are working with other Federal and state health care and law enforcement officials to expand and improve the operations of these PDMPs, as well as resolve issues concerning implementation and interoperability among State databases, as permitted by law. I am also pleased to report that the Administration worked with Congress to secure language in the Consolidated Appropriations Act, 2012, to allow the Department of Veterans Affairs (VA) to share prescription drug data with state PDMPs. VA will soon begin the necessary rulemaking process that ultimately will provide state monitoring programs with critical data from VA prescribers.

ONDCP continues to work with the Office of the National Coordinator for Health Information Technology at HHS to explore connecting PDMPs with health information technology systems and state Health Information Exchanges. We are also exploring ways to incorporate real-time PDMP data at the point of care and dispensing. These advances will maximize the public health and public safety benefits of PDMPs.

The third pillar of our plan focuses on safe disposal of unused and expired medications. As I mentioned earlier, over 70 percent of people misusing prescription pain relievers report getting their painkillers from a friend or relative. Unused medications sitting in our medicine cabinets are falling into the wrong hands. Safe medication disposal programs provide a clear mechanism through which to ensure unused or expired medications are disposed of in a timely, safe, and environmentally responsible manner. The Drug Enforcement Administration (DEA), in partnership with hundreds of state and local entities, is providing more opportunities for safe disposal of unused or expired medications. Through coordinated, nationwide *National Prescription Drug Take Back Days*, DEA has collected more than 498 tons of unused medications to date. The next "Take Back Day" is scheduled for April 28, and we are looking forward to safely collecting, disposing, and preventing diversion of unwanted medications.

The passage of the Secure and Responsible Drug Disposal Act in October 2010 was a critical step forward in expanding prescription drug disposal nationwide. We anticipate the DEA rulemaking process to be completed later this year, making safe disposal of prescription drugs more convenient and accessible for all Americans. If we want to ensure a reduction in the

amount of prescription drugs available for diversion and abuse, a drug disposal program needs to be easily accessible to the public, environmentally friendly, and cost-effective, and the cost burden must not be placed on consumers. ONDCP is working with Federal, state, local, and tribal stakeholders to identify ways to establish take back programs in their communities upon completion of the rulemaking process.

The Administration also recognizes the significant role that "pill mills" and rogue prescribers play in this issue. For this reason, the fourth and final pillar of the Administration's plan focuses on improving law enforcement capabilities to address diversion as the source of prescription drugs. ONDCP has worked with congressional partners and law enforcement and prosecutor groups to raise awareness of the scope of the prescription drug epidemic. The National Methamphetamine and Pharmaceutical Initiative (NMPI), which is funded through ONDCP's High Intensity Drug Trafficking Area (HIDTA) program, is providing critical training on pharmaceutical crime investigations to law enforcement agencies across the country.

This enforcement and prosecution training is an important start to what requires a coordinated, long-term focus. One example of the ongoing challenges comes from Florida, which in 2010 was the epicenter of the nation's pill mill epidemic.[33] At the time, DEA reported that 90 of the top 100 oxycodone purchasing physicians in the nation were located in the state. However, new state laws have stripped doctors of their ability to dispense controlled substances, including opioid based pain relievers, at rogue pain clinics. These state actions, combined with DEA's significant enforcement actions, have resulted in a decreased number of rogue pain clinics. As a result, oxycodone purchases by doctors in Florida have dropped dramatically. In fact, there was a 97 percent decrease in 2011 compared to 2010, and the number of Florida doctors appearing on the list of the top 100 oxycodone purchasing physicians dropped from 90 in 2010 to only 13 in 2011.[34]

The combination of law enforcement, regulatory, and legislative actions are forcing doctor shoppers and others seeking sources for prescription drugs for abuse to turn from Florida to other states in the region. There have been notable increases in doctors purchasing oxycodone in Georgia, Tennessee, and Kentucky. Among oxycodone purchasing doctors, 21 doctors located in Georgia and 11 in Tennessee are now among the top 100.[35] In order to prevent pill mill operators and rogue prescribers from simply popping up in other areas of the country, the Administration is working with state and local leaders to learn from Florida's experience and explore enforcement, regulatory, and legislative options to prevent diversion and its consequences for public health and safety.

There remain other challenges, including data limitations that inhibit our ability to construct a more detailed picture of the prescription drug diversion and abuse problem. In order to address

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[33] Rigg KK, March SJ, Inciardi JA. Prescription Drug Abuse & Diversion: Role of the Pain Clinic. J Drug Issues. 2010;40(3):681-702. [January 2011] Available: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3030470/?tool=pmcentrez

[34] *See* DEA Press Release, "Florida Law Enforcement Prescription Drug Efforts Produce Positive Results," January 30, 2012 Available: http://www.justice.gov/dea/pubs/states/newsrel/2012/mia013012.html

[35] *Ibid.*

these gaps, ONDCP is undertaking an analysis project that uses other data sources to fill in major information gaps. This project will examine methods by which prescription drugs are purchased, patterns in those purchasing behaviors, and whether those patterns are indicative of suspicious behavior. Examples of suspicious acquisition patterns that the project will examine include disproportionate numbers of cash-based purchases or the filling of multiple prescriptions for the same drug in an unusually short period of time. Identification and analysis of behaviors such as these will then be used to develop a complete profile of prescription drug diversion. Having first identified the ways in which the most commonly diverted prescription drugs are acquired, this project will then estimate the proportion of prescription drugs that are likely diverted from the legitimate market either for illicit resale or abuse. This is a crucial effort in developing a fuller understanding of the size and scope of prescription drug diversion in the U.S., and will provide valuable information to policymakers seeking to reduce diversion and its consequences.

Conclusion

As discussed above, we have seen extensive strides in efforts to address the prescription drug abuse problem. The public at large is better aware of the epidemic, and monitoring and disposal efforts have produced results. Unfortunately, however, these efforts have not yet translated into a reduction in prescription drug abuse. This means that we must redouble our efforts to achieve the as-yet unmet goals of the plan, such as mandatory prescriber education and improving PMDP utilization, and make needed enhancements to existing activities. The Administration is committed to maintaining its focus on prescription drug abuse as a signature initiative as part of the *National Drug Control Strategy*.

In closing, I recognize that none of the things ONDCP and my Executive Branch colleagues want to accomplish for the Nation are possible without the active support of Congress. Thank you for your continued support of ONDCP's efforts. I appreciate the opportunity to testify here today on this public health epidemic, and I look forward to continuing to work with you to reduce prescription drug abuse.