

Dr. H. Westley Clark, SAMHSA, Center for Substance Abuse Treatment

Responses to Questions for the Record

Committee on Energy and Commerce, Subcommittee on Oversight and Investigations

April 29, 2014

“Examining the Growing Problems of Prescription Drug and Heroin Abuse”

The Honorable Tim Murphy:

Q1. Two weeks ago SAMHSA posted to its website a report titled "SAMHSA's Einstein Expert Panel Medication-Assisted Treatment and the Criminal Justice System: Proceedings from the October 6- 7, 2011 Expert Meeting." Based on the date (October 2011), it is evident that it took over 2 ½ years for this report to be made available to the public. We are also aware of important practice guidelines on the use of the non-addictive, non-narcotic opioid blocker, extended-release naltrexone that has been held up nearly as long. What can be done to accelerate the pace with which important guidance and related documents are released to the professional community? Is there anything that we can do to assist you?

A1. SAMHSA subject matter experts on Medication-Assisted Treatment have many channels through which they can communicate critical information to key stakeholders including the professional community, such as “Dear Colleague” letters, virtual meetings, newsletters, technical assistance webinars and conference calls, blog posts, website updates, and curriculum development and outreach through continuing education channels such as WebMD, and dissemination of information via our grantees and partner organizations. All of these efforts have been utilized to ensure that the professional community has information related to the best ways to prevent and treat prescription opioid and heroin abuse. Depending on the nature of the content in question, high levels of clearance and oversight may be required when producing a product for the community. SAMHSA maintains a schedule of products undergoing review and is taking several steps to streamline the review of our products so that critical information reaches key stakeholders as quickly as possible.

Q2. SAMHSA has regulatory authority for the 1,300 "opioid treatment programs" or "OTPs" in the United States today. We know from NIDA-funded studies that when these patients stop taking their opioid replacement medications (methadone or buprenorphine) the vast majority will relapse back to illicit opioid use. We also know that the majority of patients in OTPs will in fact drop out of treatment within a matter of months (in the case of buprenorphine) or years (in the case of methadone). In other words, despite the good intentions of treatment providers and policy-makers, opioid dependent individuals are relapsing to illicit opioid use. Given that most individuals on opioid replacement therapy return to illicit opioid use when they stop taking their replacement opioids, and given that the vast majority of patients in OTPs will drop out of treatment, what can SAMHSA [do] to encourage OTPs to employ relapse prevention medications, such as opioid antagonists, and other approaches, designed to establish long-term abstinence? In other words, what is the "exit strategy"?

A2. The reasons for withdrawal from opioid agonist therapy are varied. For example, it has been demonstrated that patients on 60mg or more of methadone are more likely to be in treatment at the end of one year.¹ Also,

¹ Yan-ping Bao. A Meta-Analysis of Retention in Methadone Maintenance by Dose and Dosing Strategy. Am J Drug Alcohol Abuse. 2009;35(1):28-33.

inability to pay prompts a number of patients to leave treatment since many programs currently operate on a cash only basis and do not accept third party reimbursement. However, with implementation of the Affordable Care Act and the Mental Health Parity and Addiction Equity Act, this barrier will be significantly decreased, as more individuals gain access to substance abuse treatment, including medication assisted treatment, through their health insurance.

It should be noted that relapse is not unique to treating substance use disorders; it occurs in the course of treating other chronic public health conditions such as diabetes and high blood pressure. Relapse prevention in treating opioid misuse is a core component of currently provided behavioral interventions. OTPs are also beginning to provide naloxone to reduce the chance of fatal overdose should relapse occur in OTPs. SAMHSA also solicits input from OTP providers regarding barriers to more comprehensive treatment including a wider variety of pharmacotherapies, pre-treatment and aftercare services. Through the Agency's long-standing relationships with the American Association for the Treatment of Opioid Dependence and other groups, SAMHSA maintains an effective communication channel regarding OTP issues and challenges.

Bringing medicines to patients has been used effectively in many low-resource settings where compliance is essential (*e.g.*, drug resistant TB regimens use directly observed therapy administered when necessary so patients never miss a dose).

Transition from opioid-agonist therapy to extended-release injectable naltrexone requires anywhere from three to 10 days of complete opioid abstinence. Many patients cannot accomplish this in the community even after a period of successful opioid agonist therapy and with ongoing support from their program. In some cases, state licensing requirements limit OTPs to opioid-agonist therapy with the result that patients must be discharged upon completing titration from methadone or buprenorphine making transitioning them to antagonist therapy impossible.

Because it is not a controlled substance, any prescriber could offer extended-release naltrexone. Patients leaving detoxification and residential treatment programs or being released from detention are ideal candidates for therapy with extended-release injectable naltrexone. This suggests an important role for the criminal justice system in increasing access to extended-release injectable naltrexone.

Q3. We understand that there are three medications approved by the FDA for the treatment of opioid dependence: methadone, buprenorphine and extended-release naltrexone. SAMHSA's website promotes referrals to methadone treatment providers and buprenorphine treatment providers through provider locators - but there is no SAMHSA provider locator for the one medication that is not a controlled substance (extended release naltrexone). Please help us understand why SAMHSA only promotes referrals through its two Provider Locators to methadone providers and buprenorphine providers, and not the other medication - especially when it is the only one that isn't a drug of abuse?

A3. Questions on naltrexone services were included in the 2013 National Survey of Substance Abuse Treatment Services (N-SSATS), which supplies information used in SAMHSA's Behavioral Health Treatment Services Locator.² On May 16, 2014, a new version of the Locator was released that includes substance abuse treatment facilities that offer oral naltrexone and Vivitrol, as well as methadone and buprenorphine.

² <http://findtreatment.samhsa.gov>

The Honorable Jan Schakowsky

Q1. What are pharmaceutical companies doing to combat the prescription drug abuse problem, including the problem of pop-up clinics? It seems that pharmaceutical companies financially benefit from the prescription drug abuse problem and pop-up clinics, so I am interested in seeing what they are doing to help us combat the crisis.

Q2. What is the trend in the number of new opioid drugs being developed and/or approved? How will this affect prescription drug abuse? What is being done to combat the effects of an increased number of new opioid drugs entering the market? Are most of the prescription opioid drugs that are abused Schedule II drugs? Which drugs are Schedule III? Are there more drugs that can/should be moved to Schedule II?

A1/A2. The Food and Drug Administration (FDA), not SAMHSA, regulates drugs manufactured by pharmaceutical companies. SAMHSA has worked with FDA on implementation of the Food and Drug Administration Amendments Act of 2007 that provided FDA the authority to require a Risk Evaluation and Mitigation Strategy (REMS) of manufacturers to help ensure that the benefits of a drug or biological product outweigh its risks. FDA may also require a manufacturer to conduct post-marketing studies designed to assess the risks of a drug. REMS may also require education for prescribers to help ensure the benefit outweighs the risk of a medication. For example, prescriber training is required as part of the REMS for extended-release and long-acting opioids.

SAMHSA continues to participate in various workgroups, such as the HHS Behavioral Health Coordinating Committee's Prescription Drug Abuse Subcommittee, with FDA and other agencies regarding these and other issues surrounding prescription drug abuse.

According to SAMHSA's 2011 Drug Abuse Warning Network (DAWN) data, 1,244,872 Emergency Department (ED) visits involved nonmedical use of prescription medicines, over-the-counter drugs, or other types of pharmaceuticals (Table 18 in the paper). This represents about a quarter (24.6 percent) of all drug-related ED visits and about half (50.5 percent) of ED visits for drug abuse or misuse. Over half (53.0 percent) of medical emergencies seen in the ED resulting from nonmedical use of pharmaceuticals involved multiple drugs. Such visits will appear multiple times in the table (*e.g.*, a visit involving both methadone and tramadol will appear twice in this table). About one in five (17.6 percent) of ED visits involving nonmedical use of pharmaceuticals also involved alcohol. There were 366,181 ED visits which included narcotic pain relievers, with the majority involving CIIs, particularly oxycodone products, however, hydrocodone products were the second most abuse opioid in the DAWN report accounting for about half of the oxycodone products incidence.³ SAMHSA will continue to track misuse of prescription opioid drugs and report on specific categories of these drugs where possible. The drugs in the DAWN report that are Schedule III include buprenorphine products, codeine products, and hydrocodone products (which is being rescheduled to CII). As for what drugs can/should be moved to Schedule II, we defer to FDA and DEA in regard to making scheduling recommendations.

Q3. According to your testimony, 69% of those who used pain relievers non-medically in the past year obtained them from a friend or relative. What are we doing to combat the 69% of people who get opioids that they misuse from family and friends?

A3. The large number of pain relievers used non-medically that are obtained from a friend or relative presents both a public health and a cultural problem. There is a perception that because pain relievers are legally prescribed that they are safe. Therefore, part of the effort to combat this trend needs to be focused on education. Toward that goal, SAMHSA has developed several programs focused on educating the public –

³ <http://www.samhsa.gov/data/2k13/DAWN2k11ED/DAWN2k11ED.htm#5.1> accessed 9/5/14.

including the “Not Worth the Risk, Even If It’s Legal” campaign, and the “Prevention of Prescription Abuse in the Workplace” effort, both of which were mentioned in SAMHSA’s testimony. Also, for the past several years, SAMHSA participated in the Drug Enforcement Administration’s (DEA) Federal Agency Pharmaceutical Take-Back Days. These events, held in conjunction with the DEA’s national take-back days, provide federal agencies with the opportunity to collect unwanted, unused, and/or expired prescription drugs. Furthermore, SAMHSA’s participation in this effort helps to educate its staff members about the dangers of prescription drug misuse and abuse and broader promotion of the DEA’s national effort to improve public health.

SAMHSA’s Strategic Prevention Framework Partnerships for Success grant program (SPF-PFS), encourages grantees to target prescription drug misuse and abuse among persons aged 12 to 25. Funded states implement a combination of programs designed to reduce availability and access to prescription drugs for non-medical use. Funded strategies include education programs for families about the dangers of prescription drug interactions, educating consumers and prescribers about the dangers of high-risk prescribing, and implementing prescription drug take-back programs throughout targeted communities.

It is also important to take an “upstream” approach in identifying persons misusing opioids. To this end, SAMHSA continues to support the development and implementation of Screening, Brief Intervention and Referral to Treatment (SBIRT). SBIRT is a public health approach to the delivery of early intervention and treatment services for people with substance use disorders and those at risk of developing these disorders.

Finally, it is also important to educate physicians who prescribe these medications to better recognize the potential for misuse and abuse. Through SAMHSA’s SBIRT Medical Residency program and the Physician’s Clinical Support Systems, physicians and clinicians are receiving the information and training needed to help them educate their patients and monitor potential abuse.

The Honorable Ben Ray Lujan

Q1. As you may know, New Mexico has some of the highest rates of substance abuse and overdose in the country. In particular a challenge facing New Mexico is lack of resources for prevention, treatment, rehabilitation, and the unique challenges which face our rural communities. Tell me about what your office is doing to address the challenges of rural districts like New Mexico.

A1. In FY 2013, SAMHSA provided New Mexico with Substance Abuse Prevention and Treatment Block Grant (SABG) funds in the amount of \$8,437,153, and discretionary grants which total \$39,485,588. In FY 2014, the New Mexico Human Services Department, Behavioral Health Services Division will receive an increase in the SABG. SABG funds can be used to provide substance abuse prevention and treatment services in rural communities. In fact, 63 percent of SABG grantees, including the state of New Mexico, indicate that they plan to use SABG primary prevention set-aside funds to target rural communities in FY 2014. SAMHSA informed states and jurisdictions that Substance Abuse Prevention and Treatment Block Grant primary set-aside funds may be utilized to support overdose prevention education and training consistent with legislation. In addition, SAMHSA has notified jurisdictions that block grants – other than primary prevention set-aside funds – may be used to purchase naloxone and the necessary materials to assemble overdose kits and to cover the costs associated with the dissemination of such kits.

SAMHSA has a number of discretionary grant programs which address the unique challenges of rural districts, many of which are active within New Mexico. A number of SAMHSA's Drug Free Communities grantees serve rural New Mexico communities, including the Rio Arriba County Coalition services in Espanola, NM, a rural area with a population of 12,000; and the Taos CARES Health Council services in Taos County, NM, a rural area with a population of 35,000.

New Mexico has also received a SAMHSA Access to Recovery (ATR) grant for 10 years. From the current grant, New Mexico has received \$13 million and has served over 9,000 individuals with treatment and recovery support services. Through the New Mexico ATR program there are currently 165 New Mexico faith based and secular substance abuse treatment and recovery support providers serving individuals across the state. Current efforts are focused on the state's three largest population centers of Bernalillo County, Santa Fe County and Dona Ana County, the rural counties of Otero and Curry, and in the tribal communities of Five Sandoval Indian Pueblos, Inc. Follow-up data collected on program participants indicate 80 percent abstinence from alcohol and drugs at six months.

In FY 2013, New Mexico was awarded a second SBIRT state grant. This 5-year grant is designed to introduce screening, brief intervention and referral to treatment into rural and underserved areas of New Mexico. It is designed to identify early stages of substance misuse and intervene or refer individuals to the appropriate treatment regimen. It is also designed to enhance the utility of health information technology (HIT) into the system to help sustain these services into the era in which electronic health records will be essential for billing. In the future HIT and electronic health records/billing and coding may mean the difference between prosperity or cessation of services in individual clinic or organization settings.

In particular, SAMHSA's Center for the Application of Prevention Technologies (CAPT) is a national substance abuse prevention training and technical assistance center. The CAPT Southwest Resource Team (RT) provides training and technical assistance to SAMHSA-funded grantees in the state of New Mexico on successfully implementing SAMHSA's Strategic Prevention Framework, a five-step planning process that guides the selection, implementation, and evaluation of evidence-based, culturally appropriate substance abuse prevention activities. Within the scope of this contract, the CAPT Southwest RT has provided technical assistance to New Mexico communities in Grant County, Dona Ana County, Luna County, Lea County, and McKinley County. Specifically, the CAPT has reviewed and provided feedback on community needs assessments, readiness and capacity assessments, and strategic plans to help ensure that rural communities select prevention interventions that are most appropriate to the community and most

effective in addressing prescription drug abuse. In the upcoming months, the CAPT will provide training and technical assistance to the state on building the capacity of rural communities to identify and implement effective prevention strategies, such as implementing media campaigns in rural areas to address prescription drug abuse.

Under SAMHSA's Strategic Prevention Framework - Partnerships for Success II cooperative agreement, the state of New Mexico has funded high need, low capacity rural communities which are seeking to address the priorities of non-medical use of prescription drugs and underage drinking.

Q2. Substance abuse is a multifaceted challenge, and there is no silver bullet. What, in your experience and expertise, do you see as the largest impediments to decreasing prescription drug abuse and overdoses? Can you comment on the following challenges, and their relative magnitude in the persistent challenge of prescription drug abuse: The need to raise public consciousness to discard unneeded prescriptions? A lack of access to drug disposal and drop off for an informed public? Lack of insurance coverage and access to rehabilitation and treatment programs? Health care access shortages for those seeking treatment programs? The need to expand access to Naloxone to the public as prescription drug abuse continues to rise? A lack of funding for implementation of proven strategies? The need for legislation?

A2. As stated, the challenge of achieving the goal of reducing prescription drug abuse and overdoses is a complex one that is best approached with activities and programs that focus on prevention, education, and treatment (including early intervention). SAMHSA seeks to weave these approaches, when appropriate, into discretionary grant programs such as the previously described SPF PFS, which implements a combination of strategies designed to reduce availability and access to prescription drugs for non-medical use. Funded strategies include education programs for families about the dangers of prescription drug and opioid interactions, educating consumers and prescribers about the dangers of high-risk prescribing, ensuring proper training of first responders, and implementing prescription drug take-back programs throughout targeted high need communities.

Additionally, recognizing the increase in overdose deaths and lack of funding for expanding access to Naloxone, SAMHSA sent guidance to all Substance Abuse Prevention and Treatment Block Grant (SABG) grantees on April 2, 2014. This guidance stated that SABG primary prevention set-aside funds could be used to support overdose prevention education and training, and SABG funds other than primary prevention set-aside funds could be used to purchase Naloxone and the necessary materials to assemble overdose kits and to cover the costs associated with the dissemination of such kits.

The Affordable Care Act and Mental Health Parity and Addiction Equity Act will expand coverage for substance use disorder treatment, capacity -- particularly for medication-assisted treatment. The most significant barrier is the pervasive misapprehension among health care providers that substance use disorders and related problems are not within their responsibility to address, not within their skills to address, or not treatable.⁴ This stems in large part from the lack of training on substance use disorders as an integral part of the prevention, identification and management of the health of the individual or the public. For this reason, SAMHSA funds the SBIRT Medical Residency program, which integrates substance abuse treatment into residency programs, as well as a series of medical education courses designed to help physicians provide appropriate pain management while minimizing the risk of pain medication abuse.

⁴ Cape, G., Hannah, A. and Sellman, D. (2006), A longitudinal evaluation of medical student knowledge, skills and attitudes to alcohol and drugs. *Addiction*, 101: 841–849. doi: 10.1111/j.1360-0443.2006.01476.x. Saitz, R., Friedmann, P. D., Sullivan, L. M., Winter, M. R., Lloyd-Travaglini, C., Moskowitz, M. A. and Samet, J. H. (2002), Professional Satisfaction Experienced When Caring for Substance-abusing Patients. *Journal of General Internal Medicine*, 17: 373–376. doi: 10.1046/j.1525-1497.2002.10520.x

Q3. Over the last several decades, even as enforcement and imprisonment rates have increased, the street-price for heroin -- and other illicit drugs -- has decreased, leading to proliferation of this drug in virtually every state. In 2011 the ONDCP released its "Prescription Drug Abuse Prevention Plan" with the goal to reduce non-medical use of prescription drugs by 15% in 5 years. What is the progress of this initiative? Is there evidence that this plan is having an impact? Can you comment further on the correlation between prescription drug abuse and heroin use, and if you expect to see a reduction in heroin use as prescription drug abuse decreases?

A3. SAMHSA fully supports the Office of National Drug Control Policy's (ONDCP) four-part strategy and is actively engaged, with other federal agencies, in reaching the goals of that policy. SAMHSA recognizes the significance of the impact on society and its citizens of heroin use and prescription drug abuse. Research supports the perspective that opioid addiction is a medical disorder that can be treated effectively with medications. Medication-assisted treatment (MAT) for opioid addiction has been effective in facilitating recovery from opioid addiction for many patients. Recognizing that MAT may be an important part of a comprehensive treatment plan, SAMHSA allows Criminal Justice grantees to use up to 20 percent of their funding for appropriate medication (*e.g.*, methadone, injectable naltrexone, non-injectable naltrexone, disulfiram, acamprosate calcium, and buprenorphine).

There is continued discussion regarding the relationship between the misuse of pain medication and heroin. SAMHSA pooled the data from the National Survey on Drug Use and Health (NSDUH) for the years 2002 through 2011 regarding this issue. The study finds that past year heroin use is 19 times higher among those who reported prior nonmedical use of pain relievers than among those who did not (0.39 percent vs. 0.02 percent). The study also found that the incidence rate for nonmedical use of pain relievers was almost two times higher among those who reported prior heroin use than among those who did not (2.8 percent vs. 1.6 percent).⁵ Given this data, the Administration's efforts to address and prevention prescription opioid misuse and abuse may also prevent individuals from using heroin as well.

Scarcity of prescription analgesics will drive up the price, making heroin the more affordable option. According to SAMHSA's Treatment Episode Data Set (TEDS) 2012 treatment admissions for heroin increased 16% between 2010 and 2012. According to the National Association for State Alcohol and Drug Abuse Directors (NASADAD) a majority of states report that heroin use and heroin overdose have been rising over the past two years.⁶

Q4. You can't talk about our prison system without discussing the prevalence of substance abuse and dependency that many inmates develop. I know we didn't have someone from the Bureau of Prisons at our hearing, but have you considered the potential impact or expanding rehabilitation programs for inmates, or programs to help the prison population stay off of drugs as they prepare to reenter civilian society? I know there is a call in my district for this approach. Further there is a need for more Adult and Juvenile Treatment facilities, and residential treatment facilities generally. Are there plans to expand access to these types programs in New Mexico?

A4. SAMHSA recognizes the need for substance abuse treatment for an offender population with high incidence of substance abuse dependence and co-occurring mental health disorders. SAMHSA's substance abuse treatment criminal justice portfolio currently includes 215 grants, serving approximately 20,000 individuals in the criminal and juvenile justice system as of this date. Programs include drug courts, re-entry programs and jail diversion programs, totaling \$75 million in FY 2014 funds. SAMHSA expects to fund approximately 75

⁵ Murhuri, PK; Gfroerer, J; Davies, MC (August 2012), Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States, *CBHSQ Data Review*, <http://samhsa.gov/data/2k13/DataReview/DR006/nonmedical-pain-reliever-use-2013.htm>

⁶ <http://www.samhsa.gov/data/2k13/TEDS2011/TEDS2011NTOC.htm>

<http://nasadad.org/wp-content/uploads/2014/05/NASADAD-Prescription-Drug-and-Heroin-Abuse-Inquiry-Full-Report-Final.pdf>

additional Drug Court grants this fiscal year. Funding for approximately 30 of these grants is possible due to the FY 2014 \$10 million increase in Drug Court funding by the Congress.

SAMHSA also published a Request for Application for the Grants to Expand Substance Abuse Treatment Capacity in Adult Tribal Healing to Wellness Courts and Juvenile Courts. The program will fund up to 14 grants. SAMHSA received applications for this program from two New Mexico applicants and the applications are being reviewed for possible funding for up to 3 years, beginning in September 2014.

Currently, the Bernalillo County Metropolitan Court in Albuquerque has a jointly funded BJA/SAMHSA Adult Treatment Drug Court grant. This grant was funded on September 30, 2013 for up to three years. The Court is using the funds to enhance their adult DWI/Drug Court and Mental Health Court and assist nonviolent offenders with successful rehabilitation from the use of drugs and/or alcohol and/or mental health issues. The program has set a goal of serving 220 clients each year for a total of 660 clients over the lifetime of the program. Currently the program has exceeded its intake client target numbers and is well over 100% and is doing well with their six month follow-up rate also. The programs interventions are: implementation of the RANT risk screening tool; implementing gender-specific trauma and other recovery support services; expanding community linkages and providing culturally-competent services to Native American participants; and expanding community supervision by adding community supervision officers.

SAMHSA and the Office of Juvenile Justice and Delinquency Prevention in the U.S. Department of Justice have worked together over the past 6 years to fund newer models of juvenile justice programs such as the “Reclaiming Futures” model. This model is designed to help change the current approach to juvenile justice – treatment linkages. A key component of the model is coordinated individualized response for each juvenile (initial screening and assessment for substance abuse problems using reputable tools), services coordination, and community directed engagement.

SAMHSA also funds the GAINS Center for Behavioral Health and Justice Transformation, a resource and technical assistance center for state planning and coordination among the mental health, substance abuse, and criminal justice systems. The Center focuses on the application of science to services and the documentation and promotion of evidence-based and promising practices in program development.

Q5.I know advocacy groups in my district are always interested in greater access to grants. Who are the people in your office that I can direct citizen groups in New Mexico to-so that there is greater partnership between the federal government and people on the ground who see the challenges New Mexicans face every day?

A2. SAMHSA annually publishes Requests for Applications (RFA) for its discretionary grant funds on the SAMHSA website.⁷ Each RFA contains all the information needed to apply for a grant, *e.g.*, eligibility, estimated award amount, estimated number of awards as well as contact information for program issue and grants management/budget issues.

Constituents can also sign up for e-mail updates from SAMHSA⁸ that provide information on available grants and contracts and new information on topics that are relevant to the full spectrum of the behavioral health field.

Finally, SAMHSA has regional administrators in each of the ten public health regions. Mr. Michael Duffy serves as the Regional Administrator for Region VI which includes New Mexico. Mr. Duffy serves as a tremendous resource for citizens in your district to reach out to for information partnership with SAMHSA.

⁷ www.samhsa.gov/grants

⁸ <http://bit.ly/subscribeSAMHSA>

Q6. What role do you see poverty playing in the current substance abuse trends? Have you seen greater economic development in communities where efforts to deter substance abuse has been effective? Do you have strategies that pair economic development with initiatives to reduce and treat substance abuse?

A6. It is evident that social determinants, such as poverty, education, employment, age, social class, etc., have a dramatic impact on peoples' physical and behavioral health. According to the 2012 NSDUH, adults aged 18 and older who graduated from college or university had a lower rate of substance dependence or abuse than those who did not graduate from high school (7.2 percent vs. 10.3 percent). A higher percentage of unemployed adults were classified with dependence or abuse than were full-time employed adults (16.9 percent vs. 9.1 percent). An analysis of 2006-2008 NSDUH data of individuals aged 12 or older living in poverty reported that 12.3 percent (3.7 million persons) were classified as being in need of substance use treatment in the past year.

Existing research and data suggest that common or *shared* risk and protective factors throughout life impact both substance abuse and mental health outcomes. Examples of shared risk factors include poor grades/achievement and family history of substance use disorders. Examples of shared protective factors include parental support and bonding as well as participation in social activities. Understanding these factors is critical to designing substance abuse prevention interventions to help individuals develop the intentions and skills to act in a healthy manner as well as focusing on the creation of environments that support healthy behavior. The most effective prevention interventions are those that incorporate both these approaches. Practitioners can use these interventions to target their prevention efforts to meet the needs of sub-populations that may be at increased risk of developing substance abuse and related behavioral health problems.

SAMHSA's substance abuse treatment grant programs report outcome measures based on the social determinants, including social connectedness, employment, housing, and criminal justice involvement. Overall, these data demonstrate the connectivity of increasing quality of life with decreased substance abuse. SAMHSA's Office of Behavioral Health Equity (OBHE) was established in accordance with section 10334 of the Affordable Care Act. Launched in 2012, OBHE coordinates SAMHSA efforts to reduce behavioral health (mental health and substance abuse) disparities for diverse racial and ethnic and lesbian, gay, bisexual and transgender (LGBT) populations. OBHE's efforts are geared to promote health equity for all racial and ethnic and LGBT populations, and support populations vulnerable to behavioral health disparities.

OBHE is organized around five key strategies: data, communication, policy, quality practice and workforce development and customer service/technical assistance. OBHE seeks to impact SAMHSA policy and initiatives by:

- Creating a more strategic focus on racial, ethnic and LGBT populations in SAMHSA investments;
- Using a data-informed quality improvement approach to address racial and ethnic disparities in SAMHSA programs;
- Promoting behavioral health equity at a national level;
- Increasing awareness and access to information regarding behavioral disparities and strategies to promote health equity;
- Ensuring that SAMHSA policy, funding initiatives and collaborations include emphasis on decreasing disparities;
- Implementing innovative, cost-effective training strategies to a diverse workforce;
- Serving as a trusted broker of behavioral health disparity and equity information.

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“Examining the Growing Problems of Prescription Drug and Heroin Abuse”

The Honorable Michael C. Burgess

Q1. The federal government has put a lot of money and effort on behalf of taxpayers into drug prevention, treatment, and law enforcement. What is it about the current system that is not working?

A1. One of the biggest challenges is the lack of health coverage that includes payment for substance abuse treatment. According to 2012 NSDUH data, 38 percent of individuals seeking treatment for substance use/abuse did not receive it because they lacked health coverage and could not afford it. Another 10 percent had health coverage that did not cover substance use treatment. With the implementation of the Affordable Care Act and the Mental Health Parity and Addiction Equity Act, this barrier will be significantly decreased, as more individuals gain access to substance abuse treatment through their health care insurance.

In addition, more research is needed to develop best practices around prescription drug misuse and abuse. As an evolving issue, efforts to prevent prescription drug and opioid misuse and abuse require our continued attention. Through the efforts of SAMHSA’s Partnership for Success grantees and Substance Abuse Prevention and Treatment Block Grant recipients, SAMHSA continues to collect relevant data to ensure programs targeting prescription drugs are evidence-based. In addition to efforts being conducted at SAMHSA, the National Institute on Drug Abuse continues to work collaboratively with SAMHSA and other agencies to bring new information to the field.

Q2. What is the cost of a single dose of Naloxone? Is the cost of Naloxone a barrier to making the antidote more readily available?

A2. The cost of naloxone has been estimated to be approximately \$6 per dose or \$25 to \$40 if packaged with the necessary supplies for use. Scarcity and lack of competition in the manufacture of naloxone has also led to price increases in recent years and, consequently, the cost may be a barrier to some individuals without insurance coverage. In the aggregate, the cost born by some states with a great need for wide availability may become prohibitive.⁹ The price for the new autoinjector product has not been released by Kaleo but it is expected to be more costly. However it lasts 2 years, is certified to be able to withstand difficult environments such as temperature extremes and requires little training other than learning to recognize the signs of an overdose. Where insurance covers this product cost should not be a barrier.

⁹ Coffin PO, Sullivan SD. Cost effectiveness of distributing naloxone to heroin users for lay overdose reversal. *Ann Intl Med.* 2013;158:1–9. Substance Abuse and Mental Health Services Administration. SAMHSA Opioid Overdose Prevention Toolkit. HHS Publication No. (SMA) 13-4742. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.