REDUCING THE U.S. DEMAND FOR ILLEGAL DRUGS

A REPORT

BY THE

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ON
INTERNATIONAL NARCOTICS CONTROL

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LETTER OF TRANSMITTAL

SENATE CAUCUS ON INTERNATIONAL NARCOTICS CONTROL

June 2012

Dear Colleague:

Drug consumption in the United States continues to increase. According to the National Survey on Drug Use and Health, in 2010, about 22.6 million Americans aged 12 and older were current illegal drug users, representing 8.9 percent of the population. This is the largest proportion in the past decade of people aged 12 and older identified as current illegal drug users. As members of the Senate Caucus on International Narcotics Control, we find this unacceptable. Illegal drug use in the United States has created a major public health problem here at home while also fueling violence in drug producing and transit countries in Latin America and the Caribbean.

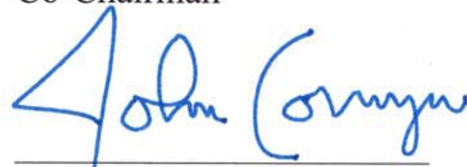
This report outlines a series of concrete steps that the President and Congress can take to reduce the massive U.S. demand for illegal drugs. It draws on information gathered by Caucus staff through travel to key prevention, treatment and recovery programs in California, Arizona and Illinois, briefings, interviews and a review of documents from both government and non-government subject matter experts. We look forward to working with you to implement the policy recommendations proposed in this report.

Sincerely,

Senator Dianne Feinstein
Chairman

Senator Charles Grassley
Co-Chairman

Senator Tom Udall



Senator John Cornyn

FINDINGS AND RECOMMENDATIONS

1. ***Finding:*** Drug abuse and addiction costs the United States $193 billion a year in preventable health care, law enforcement and addiction expenses.[1] President Obama and the Office of National Drug Control Policy (ONDCP) have reconfigured U.S. drug policy to increasingly focus on curbing the U.S. demand for illegal drugs. Still, greater presidential leadership is needed.

   ***Recommendation*:** The White House should begin a high-level national dialogue on illegal drug prevention. Such a campaign could be led by First Lady Michelle Obama or Vice President Joe Biden. This national dialogue should focus on the impact of illegal drug use and abuse on the individual and society.

2. ***Finding:*** ONDCP views prescription drug abuse as "the Nation's fastest-growing drug problem."[2] **Overdose deaths from prescription painkillers now outnumber deaths involving heroin and cocaine combined, accounting for 20,044 of 36,450 overdose deaths in the U.S. in 2008.**[3] Painkillers and prescription drugs are often purchased on the Internet, without a valid prescription.

   ***Recommendation*:** The easy accessibility of prescription drugs through illegitimate online drug sellers contributes to the growing prescription drug abuse problem. Congress should pass the Online Pharmacy Safety Act of 2011 which was introduced in the Senate by Senators Feinstein and Sessions (S. 2002) and in the House of Representatives by Representatives Bill Cassidy and Mike Ross (HR 4095).[4] This legislation would help stop criminals from exploiting the Internet to illegally sell prescription drugs.

3. ***Finding:*** Methadone is the most commonly used drug to treat heroin addiction. Since the 1960s, it has been crucial in reducing overdose deaths and lowering the threat of diseases spread by injections, such as HIV/AIDS and hepatitis B and C. The Substance Abuse and Mental Health Services Administration describes methadone as a "well-studied, safe and powerful medication when prescribed and consumed properly."

   ***Recommendation*:** The Caucus supports the use of methadone by opioid treatment programs as a means to curb drug abuse, stop overdose deaths and prevent the spread of disease. While the Caucus also supports methadone for pain management, we have concerns about the increasing abuse of

methadone for this purpose. From 1998 to 2006, methadone prescriptions for pain management grew from about 531,000 to 4.1 million. From 1999 to 2005, methadone-related deaths jumped from 786 to 4,462. The Caucus believes that physicians who prescribe methadone for pain management purposes must receive greater training on the impact of the drug, so that its abuse does not continue. Similarly, the Caucus recommends greater training for doctors prescribing other legal pain management drugs which are illegally abused.

4. ***Finding:*** Before being reconfigured, ONDCP's National Youth Anti-Drug Media Campaign was criticized for not being relevant to children and adolescents. However, ONDCP Director Gil Kerlikowske revamped the program in 2010. The Senate and House of Representatives both eliminated this program in their respective Fiscal Year 2012 budgets. President Obama requested $20 million for the program in his Fiscal Year 2013 budget.

   ***Recommendation*:** While funding for the Youth Anti-Drug Media Campaign was eliminated by Congress in Fiscal Year 2012, the program still has an unobligated balance of $6.15 million. This money should be used to keep the program alive while Congress considers funding for Fiscal Year 2013. In the meantime, ONDCP should work to leverage greater private resources for this program. Given the current fiscal environment, an eventual public-private partnership for the media campaign would be very beneficial.

   A potential model for such a partnership is the privately funded Meth Project which was created by a businessman in Montana and provides hard-hitting methamphetamine prevention media campaigns. **Since its launch in Montana in 2005, the Meth Project has helped to cut teen methamphetamine use in the state by 63 percent and methamphetamine-related crime by 62 percent.** Finally, the media campaign should make maximum use of public service spots.

5. ***Finding:*** Dangerous, new synthetic drugs are being chemically produced to mimic the active ingredients in drugs such as methamphetamine and marijuana. These include synthetic cannabinoids, such as K2 and Spice, and synthetic stimulants, including so-called bath salts. **The American Association of Poison Control Centers has noted that centers nationally received 6,348 calls about synthetic marijuana in 2011. There were 2,882 calls in 2010 which is up from a reported 14 calls in 2009.**

Additionally, there were 5,853 calls into poison centers concerning "bath salts" use in 2011 which is a significant increase from 303 calls in 2010.[5]

Recommendation**:** As dangerous synthetic drugs become more popular among teenagers, laws should be enacted to ban certain synthetic substances and to provide federal agencies greater flexibility to prevent related substances from entering the market in the future. The House of Representatives passed the Synthetic Drug Control Act of 2011 (H.R. 1254) in December 2011 by a vote of 317-98. This bill bans synthetic marijuana products, such as K2 and Spice, substances marketed as bath salts and a synthetic hallucinogen known as 2C-E among others. It also includes a provision to increase the time the Drug Enforcement Administration and the Department of Health and Human Services have to ban substances on an emergency basis from 18 months to 36 months. The Senate acted in May 2012 by including provisions dealing with the increasing use of synthetic substances that mimic scheduled drugs in S.3187, the Food and Drug Administration Safety and Innovation Act. The Caucus believes these bills should expeditiously become law.

According to the Drug Enforcement Administration (DEA), teenagers and young adults are the most frequent users of synthetic substances which are often marketed to them as being the "legal" alternative to methamphetamine, marijuana and cocaine. In addition to pending congressional action, the Caucus believes business owners have to act more responsibly in not selling these products. Many merchants likely know that adolescents are using these products to get high, sometimes with deadly consequences. Emergency room physicians in Rochester, New York noted that that teens and adults in their early 20s are coming into emergency rooms in violent, paranoid, hallucinogenic states and they are seeing strokes, heart attacks and deaths from synthetic drug use. Synthetic drugs are often sold at gas stations and smoke shops. The Caucus urges store owners to remove all such products from their shelves, even those that are not yet banned.

6. ***Finding:*** The Hawaii Opportunity Probation with Enforcement (HOPE) program is a probation system that emphasizes quick punishment when a probationer violates his or her conditions of probation and has proven to be highly successful at reducing recidivism. The program provides quick and clear responses when probationers use drugs.

Specifically, under HOPE, probationers are assigned a color code. Every morning, probationers call a hotline to hear if their color was selected for random drug testing. If it is selected, they must appear at the probation office before 2:00 p.m. for a drug test. If a HOPE probationer fails to appear for his or her drug test, a bench warrant is issued and served immediately. A probationer who fails the random drug test is immediately arrested and within 72 hours is brought before a judge. If the probationer is found to have violated the terms of probation, he or she is immediately sentenced to a short jail stay. Typically, the term is several days, servable on the weekend if the probationer is employed. Sentences increase for successive violations.

For one year, HOPE probationers were compared to a control group and among other results, **only 13 percent of HOPE probationers used drugs compared to 46 percent of control group probationers.** At a similar program for juvenile offenders in Maricopa County, Arizona, **offenses of juveniles on probation were down 42 percent in 2011 compared to 2010 when the program was not in place.** The HOPE Program has shown that when individuals know that there are set consequences that will be quickly applied, these consequences act as a deterrent to future criminal activity.

Recommendation: The Caucus believes that programs like HOPE that apply testing and quick sanctions to probationers while also reducing spending should be encouraged. While the HOPE program is showing great promise, its results should continue to be studied. The National Institute of Justice is in the process of completing a study to determine if and how the program can be more broadly applied. Future studies should specifically ask (1) What type of offenders respond best to the HOPE program? (2) How can HOPE be replicated on a national scale? and (3) How specifically can HOPE save taxpayer dollars? Once further positive information is developed from these studies, consideration should be given to developing this program for national application.

7. ***Finding:*** Drug courts have proven to be effective. **According to a 2006 study, approximately three-quarters of drug courts – or 78 percent – were found to have significantly reduced crime**. The personal attention provided in drug courts can have life-changing effects for participants. However, the Caucus has found that there is no single framework of agreed upon best practices for these courts. The majority of existing drug courts disqualify individuals with histories of violence or extensive criminal records. Some experts, however, have criticized "cherry picking" by some

drug courts of the least habitual offenders so that their programs are viewed as successes.

***Recommendation*:** Baseline standards should be developed for drug courts which receive federal funding. The National Association of Drug Court Professionals is working with the Bureau of Justice Assistance to develop standards by the summer of 2013. The Caucus believes that these standards should be used to designate federal funding for drug courts. Federal funds should not be provided to drug courts that do not agree to follow best practice guidelines. At the same time, flexibility should be given to consider local factors. For example, some rural drug court models would not work well in big cities and vice-versa. Further, federal funds used to support local drug courts should prioritize drug court programs that will be able to support themselves via self-sustained state funding sources within two to three years.

8. ***Finding:*** Most Americans are unaware of the impact that illegal drug consumption has in fomenting violence in drug producing and transit countries in Latin America and the Caribbean. Today, Mexico is a prime example. Mexican **drug trafficking organizations have become major criminal organizations and have contributed to the over 50,000 estimated murders in the country in the past five years.** Americans must understand that their drug use contributes to this violence.

   ***Recommendation*:** Efforts should be made to demonstrate the correlation between violence in drug producing and transit countries and consumption in the United States as part of all anti-drug messaging at the federal, state, and local level. In so doing, we should look to Colombia as an example. In 2005, the Colombian government launched a public information campaign that raises awareness about the environmental devastation caused by cocaine production.

9. ***Finding:*** In its Fiscal Year 2012 budget request, the Substance Abuse and Mental Health Services Administration (SAMHSA) proposed merging prevention funding for both substance abuse and mental and behavioral health into one joint account. This is an inappropriate use of funds as it is important for drug prevention funding not to stray too far from its intended purpose. The Senate Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies responded with Appropriations report language stating that this structure "would be detrimental to the specific programmatic and policy expertise of each center,

especially as it relates to substance abuse prevention and substance abuse treatment." Ultimately, Congress wisely decided not to merge prevention funding for substance abuse and mental and behavioral health.

Recommendation**:** The Caucus urges SAMHSA to follow the limitations set forth in appropriations law and to not merge substance abuse and mental health prevention programs in future budget proposals. Doing so would only reduce the impact of each program.

10. ***Finding:*** There is insufficient data on drug use and abuse in the United States. While it is not easy to compile reliable statistics on illegal activities, data collected on drug use and abuse needs to be brought up to the same standards as data collected on other major health and medical problems.

    Recommendation**:** There are many different sources of data for drug use and abuse collected by the federal government. The Arrestee Drug Abuse Monitoring Program is an ONDCP-maintained database that collects data on drug use among arrested and booked persons in ten United States cities. Additionally, the System to Retrieve Information from Drug Evidence (STRIDE) is a Drug Enforcement Administration-maintained database that records information on the price and purity of illegal drugs. STRIDE analyses are only published on an ad hoc basis by ONDCP. More frequent analyses and greater dissemination of these analyses would be extremely useful for all policymakers, especially local, state and federal law enforcement.

    Next, Title IV of the Elementary and Secondary Education Act (ESEA) authorizes funding for state grants for the Safe and Drug Free Schools and Communities program. As part of this program, data is collected on illicit drug use and trends among youths. Congress should act to ensure that the reauthorization of the ESEA requires grantees to allocate a portion of their funds for data collection.

    Finally, the most important data used by policymakers on drug use is the annual National Survey on Drug Use and Health which provides data on drug usage. Data collection for this survey should be expanded to better survey subpopulations with high rates of substance abuse. This should include "hidden populations," such as street-injection heroin users.

The Federal Government, and Congress, should consider leveraging these various data sources into a comprehensive data source that tracks drug use and abuse so that resources may be better leveraged to combat drug abuse.

11. ***Finding:*** Traditionally, U.S. Presidents – through ONDCP – have divided drug demand reduction into two main categories: prevention and treatment. However, the Obama Administration has added a third area: recovery. For the first time ever, in its 2010 National Drug Control Strategy, ONDCP focused on the need to invest in recovery. Treatment for drug abusers usually takes place during a fixed period of time. However, recovery is a lifelong process.

    ***Recommendation*:** The private sector should foster the development of businesses that positively affect the lives of people in recovery by increasing employment opportunities for them.

12. ***Finding:*** Residential treatment is a commonly used form of treatment. However, many states are facing a shortage of residential treatment beds. The shortage of beds is especially true for women with children seeking treatment. Last year, there were only 80 family-based treatment programs in the United States. Many of these programs have limits on the age of children women can bring with them as they receive treatment, further limiting access to care for women with children.[6] The federal government does not have a precise measure for determining the shortage of residential drug treatment spaces.

    SAMHSA administers a survey – the National Survey on Substance Abuse Treatment Services – of specialty treatment facilities, including residential facilities. This survey includes questions to determine the proportion of facilities that offer residential services and the number of beds available in such facilities. However, the survey is not able to provide an estimate of the demand for these beds. Most facilities do not track and record such information.

    Recommendation: Across the country, there needs to be real time reporting on the demand for beds in residential treatment. There also needs to be a more rapid response in areas with bed shortages to ensure treatment is available when individuals request it.

13. ***Finding:*** Residential treatment programs are costly which often leads to individuals not receiving long enough treatment to stop their substance abuse dependency. Some residential treatment programs, such as the Delancey Street Foundation, are self-funded. The Delancey Street Foundation sustains itself by the work of residents who live on the premises and complete work in areas such as catering, holiday decor and moving services.

    Recommendation: In the current difficult fiscal climate, residential treatment programs should look to the Delancey Street Foundation as a possible funding model that is self-sustaining without relying on federal, state and local funds.

Introduction

Overview

Over the past two years, the Senate Caucus on International Narcotics Control has issued three bipartisan reports outlining ways to improve our counternarcotics policies in Mexico, Central America, and Afghanistan. The Caucus has also held several hearings focused on our policies in these countries, West Africa, the Andes and the Caribbean.

While we believe that we must continue to improve and strengthen our supply-side counternarcotics policies, we also believe that the United States must do significantly more to reduce our country's demand for illegal drugs. Ultimately, it is drug consumption in the United States that fuels violence throughout Latin America and the Caribbean. Our country's drug consumption habits also create a challenge to public health in the United States. **Only if we prevent drug use in the United States can we prevent drug trafficking and the violence and loss of life it brings.**

On June 21, 2011, Senators Feinstein and Grassley asked the Government Accountability Office (GAO) to conduct a study to evaluate the successes and shortcomings of congressionally funded drug prevention and treatment programs in the United States. A copy of this request letter is included in the report's appendix.

While we await the results of this study, we have prepared this report which includes several specific policy recommendations. This report will focus on five areas that we believe are essential in curbing the demand for illegal drugs:

(1) Drug Prevention
(2) Drug Treatment
(3) Recovery
(4) Best Practices in the Justice System
(5) Collecting Better Statistical Information

The report will begin with **an overview of the challenges posed by specific narcotics, including marijuana, methamphetamine, prescription drugs and dangerous, new synthetic substances**.

Recent Drug Abuse Trends

Overview

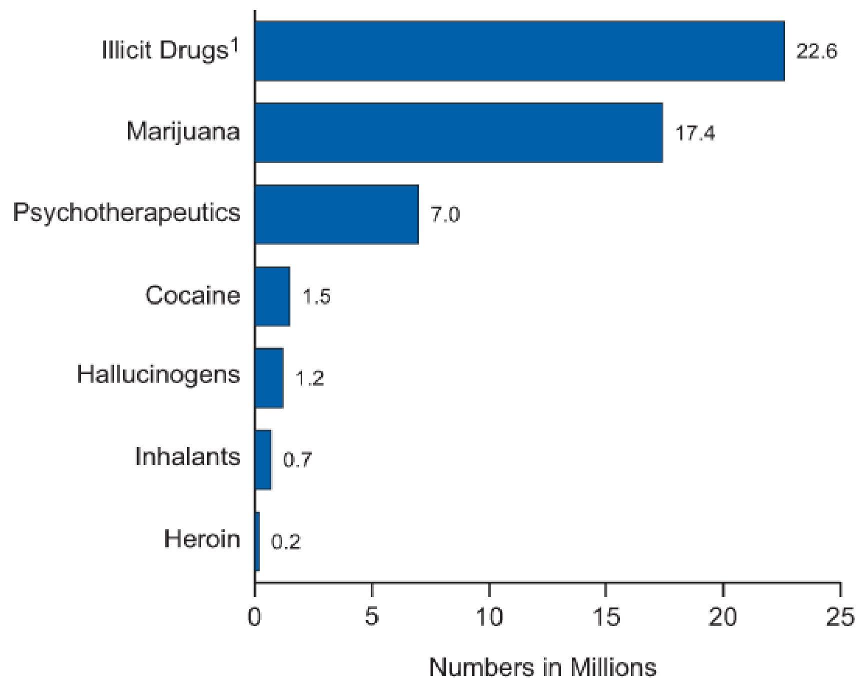
The Obama Administration has focused on drug treatment, prevention, and intervention to diminish the market for illicit drugs.

For example, the federal substance abuse prevention component of President Obama's Fiscal Year 2013 National Drug Control budget totals $1.4 billion. Still, the Caucus believes much more remains to be done.

In spite of efforts to increase funding for drug prevention and treatment programs, the United States continues to be the world's largest consumer of illegal drugs. According to the National Survey on Drug Use and Health, in 2010, about 22.6 million Americans aged 12 and older were current (in the past month) illegal drug users, representing 8.9 percent of the population. This represents the largest proportion in the past decade of people aged 12 and older identified as current illegal drug users.[7]

As the graph on the next page indicates, marijuana was the most commonly used drug, accounting for over 75 percent of all illegal drug use. And while marijuana use grew by only .3 percent of the population (700,000 people) from 2009-2010, it represents the highest rate of use in the past decade.[8]

2010 Illicit Drug Use in the Past Month Among Persons Aged 12 or Older



Source: *2010 National Survey on Drug Use and Health*, SAMHSA, accessed October 25, 2011.

Marijuana Use

Marijuana was the illicit drug that had the highest levels of past year dependence or abuse (4.5 million) followed by pain relievers (1.9 million) and cocaine (1 million).[9] It is estimated that 9 percent of people who use marijuana become addicted. However, this number increases to roughly 17 percent among those who first try marijuana at a younger age and up to 25 to 30 percent among those who are daily marijuana users.[10]

State Laws

Colorado and California are among the 16 states, along with the District of Columbia, that have laws permitting marijuana use for medicinal purposes. Studies have shown an increase in marijuana use among states with medical marijuana programs versus non-medical marijuana states. A study published in *Drug and Alcohol Dependence* by researchers at Columbia University looked at two separate datasets and found that residents of states with medical marijuana

programs had marijuana dependence rates almost twice as high as states without such laws.[11] Furthermore, a third of the states with the highest percentage of marijuana usage (as measured by past month use), among youth ages 12 to 17, were states with medical marijuana programs, according to the 2006 to 2007 State Estimates of Substance Use.[12] Including Washington D.C., 13 of the 17 states that have legalized medical marijuana rank among the states with the lowest perceived risk of smoking marijuana. [13]

State laws have also impacted the societal norms surrounding growing marijuana. For example, at a December 2011 hearing, the Caucus heard concerns from federal, state, and local officials about the increased illicit growing of marijuana on public lands, farm lands and residential properties. This included testimony from Sheriff Mims from Fresno County, California. Sheriff Mims described how large, publicly visible grows of marijuana are popping up in residential and farming communities in Central California and that the product is being sold as far away as Massachusetts, despite the state law providing limited parameters for growing marijuana for medical use.[14] The increasing trend in marijuana production in states with permissive medical marijuana laws cannot be ignored given the considerable danger domestic cultivation poses to changing attitudes among American youth.

Attitudes Toward Marijuana

Attitudes are proven to impact youth marijuana use rates. Research shows that there is a direct correlation between the perceived harm of a drug, societal approval of the drug, and increases in drug use. According to the National Institute on Drug Abuse's 2009 Monitoring the Future Survey, more 10th graders are smoking marijuana than cigarettes, because they view cigarettes as more harmful than marijuana.[15] Yet, marijuana smoke contains 50 to 70 percent more carcinogenic compounds, including tar, than cigarettes.

A July 2010 RAND Corporation study found that legalizing marijuana in California would increase consumption, possibly up to 50 to 100 percent. Researchers from the University of Illinois at Chicago ImpacTeen Project and the University of Michigan Youth Education and Society Project reported in 2000 that marijuana use among youth decreased as marijuana prices and perceived harmfulness rose. Their study also assessed the extent to which trends in marijuana prices and perceptions of risks predict cycles in youth marijuana use. The study shows that perceived risk of harm from marijuana use had a substantial impact on the reduction in marijuana use between 1981 and 1992 (as perceived risk

rose) and in the subsequent increase in use after 1992 (as perceived risk declined).[16]

At the same time, the National Monitoring the Future Survey shows that illegality is a top reason teenagers cite for not using marijuana.[17] In the 2008 Survey, 51.5 percent of 12th graders cited a fear of being arrested as one of their main reasons for not using marijuana.[18]

Potency

Marijuana is much more potent today than in the past. In recent decades, marijuana growers have been genetically altering their plants to increase the percentage of delta-9- tetrahydrocannabinol (THC), the main active ingredient in marijuana. THC impacts parts of the brain, triggering a series of reactions that ultimately lead to the "high" users experience when they smoke the drug.

The average potency of tested marijuana from federal seizures more than doubled from 1998 to 2008. The University of Mississippi found that the average THC content rose from 2.8 percent (in 1985) to 10.1 percent (in March 2009).[19] Today in California, the average THC content of marijuana is 12 percent.

Coinciding with higher levels of THC, today's marijuana contains reduced levels of Cannabidiol (CBD) which offsets the impact of THC in marijuana. CBD is believed to reduce a number of the negative effects of THC, including its psychoactive effects.[20] Between 1996 and 2008, the median levels of THC dramatically increased while CBD decreased to near negligible levels.[21]

Alternatives to Marijuana

Many are researching the active ingredients of marijuana and considering alternatives to scheduled marijuana that may have equal or superior medicinal qualities. We believe focusing resources on alternative medicine development through an approved Federal Drug Administration (FDA) process, rather than the legalization of marijuana, is the best route to explore. This could allow individuals to receive prescribed FDA-approved, marijuana-based medications if they have a serious illness.

One promising product – a tongue spray that includes THC – is in the final phase of the FDA's trials for approved use in the United States. The drug is already approved in Canada, the United Kingdom and other parts of Europe for the

treatment of multiple sclerosis spasticity and cancer pain. The Caucus urges the FDA to complete a careful review of this product in a timely manner.

Prescription Drug Abuse

The second most common form of drug abuse in the United States is the misuse of prescription drugs.[22] The Office of National Drug Control Policy views prescription drug abuse as "the Nation's fastest-growing drug problem."[23] **An even more striking demonstration of this trend is the fact that overdose deaths from prescription painkillers now outnumber deaths involving heroin and cocaine combined, accounting for 20,044 of 36,450 overdose deaths in the U.S. in 2008.**[24] In contrast, only 4,000 people died of overdoses related to these types of drugs in 1999.[25]

A 2011 ONDCP strategy on curbing prescription drug abuse focuses on prescription opioid abuse. The strategy cites data showing that from 1997 to 2007, the milligram per person use of prescription opioids in the U.S. increased from 74 milligrams to 369 milligrams – a 402 percent increase.[26] It further states that in 2000, retail pharmacies dispensed 174 million prescriptions for opioids. In 2009, that number rose to 257 million prescriptions – a 48 percent increase.

The easy accessibility of prescription drugs through illegitimate online drug sellers contributes to the growing prescription drug abuse problem. The National Association of Boards of Pharmacy has consistently found that 96 percent of all Internet pharmacies do not require a prescription, are not appropriately licensed and sell unregulated drugs.[27]

On December 15, 2011, Senators Feinstein and Sessions introduced the Online Pharmacy Safety Act of 2011(S. 2002) to help stop criminals from exploiting the Internet to illegally sell prescription drugs. The bill has two main components:

- **First,** it requires at least one in-person medical evaluation for a patient receiving prescription drugs. This will prevent illegitimate online pharmacies from selling drugs over the Internet with sham prescriptions.

- **Second,** it establishes a registry of legitimate online pharmacy websites. This will protect consumers who will know that they are dealing with lawful online pharmacies and help law enforcement to crack down on illegitimate websites.

The Caucus urges quick passage of the Online Pharmacy Safety Act of 2011.

It is important to note that Florida is a national hotbed for the illegal prescription of large amounts of painkillers, like oxycodone. In 2010, seven people died in Florida each day from prescription drug overdoses.[28] In 2011, the U.S. Attorney for the Southern District of Florida said that according to estimates, Florida prescribes ten times more oxycodone pills than all other states combined. In addition to prescriptions filled in Florida, "pain doctors" in Florida issue a large number of prescriptions that are then filled out of state. According to a Florida Department of Health report, "In 2009, 223,700 controlled substance prescriptions were dispensed by out-of-state pharmacists in Alabama, Louisiana, North Carolina, Arizona and Vermont for prescriptions written by Florida prescribers."[29]

So-called "pill mills" traditionally have been able to operate in Florida due to lax laws and the absence of a state prescription monitoring program. In July 2011, Florida barred physicians from dispensing narcotics in their offices and clinics and in October, Florida began a prescription monitoring system which is now operational.

The Drug Enforcement Administration (DEA) has also intensified their activities against pill mills over the past year with large scale operations and by initiating a new tactical diversion squad in Central Florida responsible for investigating prescription drug diversion.

Senator Grassley Oversight Investigation

In 2010, Senator Grassley sent a letter to all 50 state Medicaid Directors asking them for their top ten prescribers of the top eight most over prescribed prescription drugs on the market (Abilify, Geodon, Seroquel, Zyprexa, Risperdal, OxyContin, Roxicodone, and Xanax). Many states provided the data Senator Grassley requested, and the statistics were alarming. There were instances where single prescribers wrote thousands of prescriptions per year. For example, in Maine, the top prescriber of OxyContin wrote 1,867 prescriptions in 2009, nearly double the number of prescriptions than the second top prescriber. This same provider also wrote 1,723 prescriptions for Roxicodone, nearly three times the number two top prescriber.

In January, Senator Grassley followed up on this information and wrote again to all 50 states, requesting updated data and asking the states what, if any,

action they took with the top prescribers, and what systems they had in place to prevent excessive prescribing from taking place. While the responses from the states are still being gathered and analyzed, many states have reported a selection of top ten providers that are prescribing at rates double or triple that of their peers. While some of these outliers are legitimate providers working in high-volume practices, such as mental hospitals, many cannot be explained away. For example, the top prescriber of antipsychotics in Nevada wrote 7668 prescriptions for the drugs over 2010 and 2011, more than ten times some of the other top prescribers identified. For context, no individual prescriber in Colorado wrote more than 2,000 prescriptions for the same drugs over the same period. This single doctor in Nevada accounted for more than $3.4 million in payments from the Medicaid system.[30]

As a result of Senator Grassley's request, South Carolina has investigated 34 of the 83 providers who appeared on those lists for possible Medicaid abuses. This investigation resulted in repayments of nearly $1.9 million that more than 30 of the health care providers inappropriately billed to the state Medicaid agency. Texas has opened investigations into dozens of the prescribers identified in the list, making several referrals for criminal prosecutions and the state licensing board. California, Wisconsin, Tennessee, South Carolina, Nevada, New Hampshire, Minnesota, Kansas, Iowa, and Hawaii have taken similar actions against prescribing outliers in their Medicaid program. These steps taken by the states highlight the aggressive role that each and every state should be taking in monitoring and investigating prescription drug practices in the Medicaid program.

Pharmacy Violence

Another dangerous trend by those seeking prescription drugs is the increase in pharmacy violence. For example, an April 5, 2012 press report highlighted a number of high profile robberies of pharmacies across the country. According to the report, since 2006 there has been an 82% increase in the rise in pharmacy robberies, from 385 in 2006 to 701 in 2011.[31] This increase in robberies is attributed to addicts and thieves targeting pain medicine which can reach nearly $80 per pill in street value. The Caucus is concerned with this trend and believes Federal, state, and local law enforcement should work together with the pharmacy community to ensure that adequate safeguards are taken to protect the lives of pharmacists and customers – in addition to securing pain medicine.

Methamphetamine

First-time methamphetamine use showed a decrease in 2010 with 105,000 people 12 or older reporting usage in the past year compared to 154,000 in 2009.[32] There is no clear consensus on why first time methamphetamine use declined, but the Director of the Center for Behavioral Health Statistics and Quality at the Substance Abuse and Mental Health Services Administration (SAMHSA) attributes it at least partially to a combination of better "law enforcement and policy changes," noting "You can't get all the Sudafed you want anymore."[33] However, this does not take into account Mexican methamphetamine production which recent seizures suggest has increased significantly. It should also be noted that shifts in methamphetamine use are not uncommon with 157,000 new users in 2007 dropping to 95,000 in 2008 before increasing to 154,000 in 2009.[34]

Potential reasons for a drop include increased seizure rates both domestically and abroad, new laws on precursor chemicals, and an increased negative perception of methamphetamine use. In addition, although first-time methamphetamine use rates are among the lowest in a decade, this does not account for longer term users. SAMHSA estimates that as of 2010, roughly 5.1 percent of the U.S. population 12 or older had used methamphetamines in their lifetime.[35]

The Caucus believes that methamphetamine prevention and treatment programs should be included in the nation's drug demand reduction efforts not only because of the large number of users, but also because of the enormous costs associated with the drug. Methamphetamine abuse not only ravages the individual user, but also has serious consequences for entire communities. Those injured in the production or use of the drug have overwhelmed hospitals, with average stays that cost 60 percent more than the average patient, forcing taxpayers to pay "well into the tens if not hundreds of millions of dollars."[36] This problem has significantly increased with the so-called "shake and bake" methamphetamine production method. This occurs in small batches and often in two liter plastic bottles on a widespread basis. Methamphetamine also has a disastrous impact on the environment with five to six pounds of hazardous waste associated with each pound of methamphetamine produced. This results in staggering clean-up costs.[37]

Synthetic Drugs

Unfortunately, the abuse of synthetic cannabinoids and stimulants as "legal" alternatives to scheduled drugs also has become increasingly common. Although there is little data on current usage levels, anecdotal evidence such as significant increases in calls to poison control centers and hospital admissions due to synthetic drug use suggests a growing pattern of abuse.

The American Association of Poison Control Centers has noted that centers nationally received 6,348 calls about synthetic marijuana in 2011. There were 2,882 calls in 2010 which is up from a reported 14 calls in 2009. Additionally, there were 5,853 calls into Poison centers concerning "bath salts" use in 2011 which is a significant increase from 303 calls in 2010. In order to counter this trend, the Drug Enforcement Administration used its emergency scheduling authority to ban five synthetic cannabinoids in March 2011 and proposed this ban to become permanent in March 2012.[38] Synthetic stimulants – many used in so-called "bath salts" – were also emergency scheduled in October 2011. However, drug makers continue to manipulate chemical compounds to work around this ban and threaten the health of young people.

The House of Representatives passed the Synthetic Drug Control Act of 2011 (H.R. 1254) in December 2011 by a vote of 317-98. This bill bans synthetic marijuana products, such as K2 and Spice, substances marketed as bath salts and a synthetic hallucinogen known as 2C-E among others. It also includes a provision to increase the time the Drug Enforcement Administration and the Department of Health and Human Services have to ban substances on an emergency basis from 18 months to 36 months. The Senate acted in May 2012 by including provisions dealing with the increasing use of synthetic substances that mimic scheduled drugs in S.3187, the Food and Drug Administration Safety and Innovation Act. The Caucus believes these bills should expeditiously become law

Cocaine Use Declining and Hallucinogen Use Steady

On a more positive note, cocaine use was at the lowest point in a decade with only .6 percent of Americans 12 or older reporting use in 2010. The National Drug Intelligence Center reports that this is the result of reduced cocaine availability in the United States. *The National Drug Threat Assessment for 2011* states that:

> "Intercartel fighting and counterdrug activity disrupted traffickers' ability to move cocaine from South America toward the United States. Decreased cocaine production in Colombia…coupled with an increase in cocaine smuggling to non-U.S. markets, particularly Europe, has resulted in lower cocaine availability in U.S. markets."[39]

Use of hallucinogens remained relatively flat over the year and decade at around .5 percent of the population.[40]

Heroin Usage and Methadone

According to SAMHSA 2010 survey data, 0.2 percent of Americans aged 12 and older used heroin within the past month. Methadone is the most common drug used to treat heroin addiction. SAMHSA describes methadone as a "well-studied, safe and powerful medication when prescribed and consumed properly."[41] According to the Centers for Disease Control and Prevention (CDC), methadone occupies brain receptor sites affected by heroin and other opiates and:

- Blocks the euphoric and sedating effects of opiates;
- Relieves craving for opiates which is a major factor in relapse;
- Relieves symptoms associated with withdrawal from opiates;
- With stable dosing, does not cause euphoria itself and therefore allows a person to work and participate in society; and
- Is excreted slowly, so it can be taken once a day.[42]

Methadone maintenance treatment – a program where heroin addicts receive a daily dose of methadone – was developed in the 1960s.[43] It has been crucial in reducing overdose deaths and lowering the threat of diseases spread by injections, such as HIV/AIDS and hepatitis B and C.[44] According to the CDC, 5,000 to 10,000 injection drug users die of drug overdoses each year.[45]

Methadone is used for two classes of individuals: those in treatment for drug addiction and those using it for pain management. When methadone is used for addiction treatment, it must be prescribed by an opioid treatment program. By

contrast, any licensed physician can prescribe methadone for pain management purposes.

The Caucus supports the use of methadone by opioid treatment programs as a means to curb drug abuse, stop overdose deaths and prevent the spread of diseases, such as HIV/AIDS. While the Caucus also supports the use of methadone for pain management, we have concerns about the increasing abuse of methadone for this purpose. From 1998 to 2006, methadone prescriptions for pain management grew from about 531,000 to 4.1 million. From 1999 to 2005, methadone-related deaths jumped from 786 to 4,462. The Caucus believes that physicians who prescribe methadone for pain management purposes must receive greater training on the impact of the drug, so that its abuse does not continue.

Best Practices in the Justice System

Through staff site visits, the Caucus was able to evaluate several innovative programs in the justice system which have helped to significantly reduce drug-related and overall criminal recidivism. Below is an overview of two of the model programs – the Hawaii Opportunity Probation with Enforcement (HOPE) program and drug courts.

HOPE Program

The HOPE program is a probation system that the Caucus believes has great promise. HOPE emphasizes quick punishment when a probationer violates his or her conditions of probation and has proven to be highly successful at reducing recidivism. The program provides quick and clear responses when probationers use drugs.

Specifically, under HOPE, probationers are given a color code. Every morning, probationers call a hotline to hear if their color was selected for random drug testing. If it is in fact selected, they must appear at the probation office before 2:00 p.m. for a drug test. [46] If a HOPE probationer fails to appear for his or her drug test, a bench warrant is issued and served immediately. A probationer who fails the random drug test is immediately arrested and within 72 hours is brought before a judge. If the probationer is found to have violated the terms of probation, he or she is immediately sentenced to a short jail stay. Typically, the term is several days, servable on the weekend if the probationer is employed. Sentences increase for successive violations.

HOPE differs from other probation programs by:

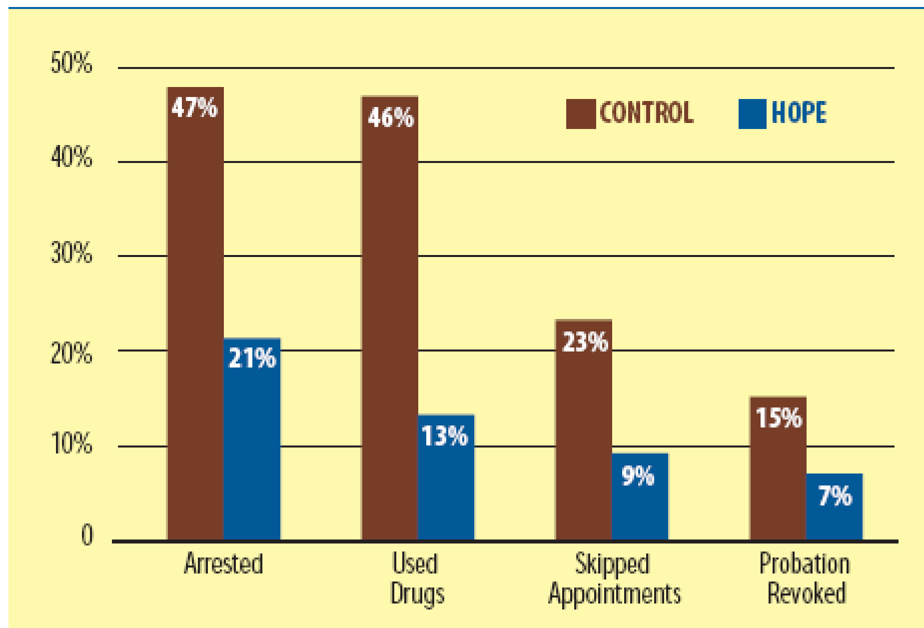
- Focusing on reducing drug use and missed appointments rather than solely on drug treatment and imposing drug treatment on every participant;

- Mandating drug treatment for probationers only if they continue to test positive for drug use, or if they request a treatment referral. A HOPE probationer who has a third or fourth missed or "dirty" drug test may be mandated into residential treatment as an alternative to probation revocation;

- Requiring probationers to appear before a judge only when a violation is detected — in this respect, HOPE requires less treatment and court resources than drug courts.

The chart below shows outcomes of the HOPE program for probationers compared with standard probation programs. **For one year, HOPE probationers were compared to a control group and among other impressive results, only 13 percent of HOPE probationers used drugs compared to 46 percent of control group probationers.** The HOPE Program and similar programs have shown that when individuals know that there are set consequences that will be quickly applied, these consequences serve as a deterrent.

HOPE Program Outcomes: 12 Month Comparison



Source: National Institute of Justice, April 23, 2010.

The HOPE program is being replicated in a few U.S. cities. Caucus staff visited Project Swift Accountable Fair Enforcement (SAFE) in Maricopa County, Arizona. Maricopa County has chosen to focus on juvenile probationers. These probationers – who otherwise would be in jail or on standard probation – are assigned a random color just like the HOPE program and subject to random drug testing. In the court, Judge Sally Duncan issues quick sanctions – including short 3 to 5 day jail sentences – for drug use.

To be clear, like the HOPE program, youth in Project SAFE are not necessarily in the program for drug offenses. However, it has been proven that keeping them clean and putting in place sanctions when they fail drug tests helps reduce recidivism. **As a result of this program, offenses of juveniles on**

probation in Maricopa County, Arizona were down 42 percent in 2011 compared to 2010 when the program was not in place.[47]

The Caucus believes that programs that apply testing and quick sanctions to drug users incarcerated and on probation need to be expanded. In the long term, further integration of these programs into the criminal justice system will both reduce recidivism rates and serve as a cost saving tool.

While the HOPE Program is showing great promise, more information is needed on the effectiveness of the program. In particular, future studies must evaluate (1) What types of offenders respond best to the HOPE program; (2) how HOPE can be replicated across the country; and (3) the extent to which the program can save money.

Drug Courts

There are more than 2,000 drug courts in the United States. The first drug court opened in Miami in 1989, offering treatment as an alternative to incarceration.[48] Drug courts are judicially supervised court dockets that handle the cases of non-violent substance abusing offenders under the adult, juvenile, family and tribal justice systems.

Drug courts operate under a specialized model in which the judiciary, prosecution, defense, probation, law enforcement, mental health, social service, and treatment communities work together to help non-violent offenders find restoration in recovery and become productive citizens.[49]

Caucus staff witnessed just this during visits to drug courts in Phoenix, Arizona and Chicago, Illinois. Both courts pay a great deal of personal attention to their individual participants and require them to receive drug treatment services. Caucus staff witnessed a pre-trial "staffing" in Chicago in which Judge Charles Burns met with the prosecutor, the public defender, the probation officer and a treatment counselor before court began to review the specific cases and how drug court participants had been successful or not. This is a standard practice in drug courts.

Generally, in drug courts, quick sanctions are applied to those who test positive for drugs or do not attend their drug treatment programs. This could include a few days in jail or community service. Short and long term treatment options are also made available. In Caucus staff's visit to a drug court in Phoenix,

Arizona, Judge Karen Barnes gave out small gift certificates (to restaurants, for example) to drug court participants who were making good progress in their treatment programs.[50]

The Caucus believes that drug courts have proven to be highly effective. According to a 2006 study, approximately three-quarters of drug courts – or 78 percent – were found to have significantly reduced crime.[51]

According to a recent report by GAO, drug court program participation was generally associated with lower recidivism. The GAO explains:

> "Across studies showing re-arrest differences, the percentages of drug court program participants re-arrested were lower than for comparison group members by 6 to 26 percentage points. **Drug court participants who completed their program had re-arrest rates 12 to 58 percentage points below those of the comparison group.**"[52]

All criminal courts carry the burden of weighing public safety in their decisions. This burden is omnipresent with drug court programs since they are specifically designed to allow the drug offender back into the general public. Therefore, an experienced court is essential to the success of the program. Caucus staff interviewed one such experienced Judge and sat in on an active hearing where drug court participants' progress was evaluated. Judge Brouhgton M. Earnest – a County Administrative Judge for the Second Judicial Circuit of Maryland who has been involved in the criminal justice system for over 40 years – calls drug courts a "common sense approach to dealing with the drug problem" and "cost effective" as opposed to incarceration.

Judge Earnest advised that his primary concern is to keep drug-addicted persons in his program from becoming recidivists. To Judge Earnest, that includes some violent offenders, saying that a blanket policy of not allowing violent offenders into drug court is a "misguided exclusion." His reasoning is simple: if the goal is to stop recidivism, then that goal should include violent recidivists. Judge Earnest does acknowledge that some egregious acts of violence should preclude inclusion into the program but that the reality is that violent offenders eventually get out of prison. Judge Earnest advised that public safety is not compromised since his program has built in "check and balances" and the District Attorney has the power to veto any candidate for the program.

The Caucus supports drug courts. Programs that can show positive outcomes at a lower cost to the taxpayer deserve a closer look. However, there is no single framework of agreed upon best practices for these courts. While the majority of existing drug courts disqualify individuals with a history of violence or extensive criminal records, some experts have criticized "cherry picking" by some drug courts of the least habitual offenders so that their programs are viewed as successes.

The Caucus understands that a "one size fits all" model may not be the best option for all drug courts throughout the United States. We, nevertheless, believe that baseline standards should be developed and agreed upon by all drug courts that apply for and receive federal funding. The National Association of Drug Court Professionals is working with the Bureau of Justice Assistance to develop standards by the summer of 2013. The Caucus believes that these standards should be used to designate federal funding for drug courts.

Drug Prevention

Overview

Compared to the high costs associated with the rehabilitation of drug addicts in the health care and criminal justice systems, drug prevention is relatively inexpensive. According to the National Drug Intelligence Center, drug abuse and addiction costs the United States $193 billion in preventable health care, law enforcement, crime and other expenses each year.[53] The National Institute on Drug Abuse has concluded that every dollar invested in research-based drug use and abuse prevention programs has the potential to save up to $7 in areas such as drug abuse treatment, health care and criminal justice system costs.[54] The Caucus believes that key investments in illegal drug prevention programs are worthwhile in the long run.

On the other hand, some scholars have argued that the results from drug prevention programs are few and far between. In a recent book on drug policy, Mark Kleiman, Jonathan Caulkins and Angela Hawkens write:

> "Drug prevention is not actually very effective compared with (for example) childhood vaccination against infectious disease. If one gives the very best prevention program to a group of youths who would have used drugs, most will go ahead and use drugs anyhow. Even cutting-edge school-based programs only reduce marijuana use by 5 to 15 percent, and the effects of most programs decay by the end of high school."[55]

Yet, the same authors point out that drug prevention programs are cheap. Even in their skepticism, they note that "Since preventing drug use is so valuable and prevention so inexpensive, prevention can be cost-effective even though it is not very effective."[56]

The Caucus believes that drug prevention is in fact quite valuable. Research over the last two decades has proven that drug addiction is both preventable and treatable. According to Dr. Nora Volkow, the Director of the National Institute on Drug Abuse, "It is vital that prevention is heavily emphasized, because addiction is a developmental disorder that begins in adolescence, sometimes as early as childhood."[57]

The reach of drug prevention programs is, of course, directly correlated with the amount of money invested in them. Thomas Babor points out that "societies

tend to make a small investment in prevention and, on average, they reap a small return."[58] Given the current fiscal environment in the United States, the Caucus recognizes that major new, high-cost programs are not realistic right now. At the same time, we realize that greater investment in prevention is fundamental as it will save lives and money in the long term.

High-Level Government Spokesperson

In the early 1980s, former First Lady Nancy Reagan coined the now-famous slogan "Just Say No" as part of her national anti-drug campaign. While her strategy has been criticized by some for oversimplifying illegal drug use and abuse, she was able to use the White House as a national platform to address these issues.

The Caucus believes that the White House should again be used as a platform for a high-level national dialogue on illegal drug prevention. A campaign led by First Lady Michelle Obama or Vice President Joe Biden – a former Chairman of the Senate Caucus on International Narcotics Control – would be extremely useful. While there are several effective drug prevention programs throughout the U.S. government, political leadership on illegal drug prevention must come from the top. A conversation on drug prevention that focuses on the public health impact of drug use and abuse should immediately begin.

Youth Media Campaign

When carried out properly, anti-drug media campaigns have the potential to have a significant impact. The Office of National Drug Control Policy's (ONDCP) National Youth Anti-Drug Media Campaign has been criticized in the past for not being relevant to children and adolescents. However, ONDCP Director Gil Kerlikowske revamped the program in 2010. Since then, the campaign has shown promising results.

Two independent studies published in peer-reviewed journals have concluded that exposure to the Above the Influence campaign lessens the likelihood of teen drug use. One study, funded by the National Institutes of Health concluded that "exposure to the ONDCP campaign predicted reduced marijuana use" compared to those not exposed to the campaign. Another study, published in the March 2011 issue of the American Journal of Public Health, provided specific evidence that greater exposure to anti-drug advertisements was associated with lower rates of past-month marijuana use among eighth grade girls. The

associations were not as significant for adolescent boys or students in grades 10 and 12.[59]

The re-tooled campaign – called Above the Influence – uses paid advertising, interactive media, and the dissemination of public information to reach youth. Funding provides for television, radio, newspaper, Internet and non-traditional advertising. In addition, the Media Campaign now focuses on the substances – both licit and illicit – most often abused by young people, including prescription drugs, marijuana and alcohol.

ONDCP's media campaign has shown results from a small investment. It costs ONDCP approximately $1.40 to reach each teen in America an average of 27 times per year through the Above the Influence campaign. The campaign targets teenagers between the ages of 12 and 17 through television, social media and school programs and attempts to inspire them to make good choices and demonstrate that drugs and other negative influences stand in the way of reaching their full potential.[60] **Currently, 85 percent of teens report that they are aware of advertising from the Above the Influence campaign.** This is more than the 79 percent of teens who say they are aware of advertising for Burger King and Coca-Cola. **Since its page launched in June 2010, 350,000 teens have become fans of the campaign on Facebook and 1 million kids have viewed the Above the Influence ads on YouTube.**[61]

In Fiscal Year 2012, President Obama requested $45 million for the National Youth Anti-Drug Media Campaign. Congress eliminated funding for this program in its final budget that was signed into law. However, the program still has an unobligated balance of $6.15 million. In addition, President Obama has requested $45 million for the program in his Fiscal Year 2013 budget. The Caucus recommends that the current unobligated balance be used to keep the program alive while Congress considers FY 2013 funding. In the meantime, the Caucus believes that ONDCP should work to raise greater private resources for the program. An eventual public-private partnership for the media campaign would be very beneficial.

A potential model for such a partnership is the privately funded Meth Project which was created by businessman Thomas Siebel in Montana and provides hard-hitting methamphetamine prevention media campaigns and community outreach events. Funded through a grant from the Thomas and Stacey Siebel Foundation, the Meth Project utilized an advertising firm to conduct in-depth research on teens'

perceptions of methamphetamine. They then approached methamphetamine as a consumer product and set out to "unsell" methamphetamine by:

- Increasing the perceived risk and decreasing the perceived benefit of trying methamphetamine so that perceptions reflected accurate information about the drug;
- Promoting dialogue about the drug between parents and teens; and
- Stigmatizing use and making methamphetamine use socially unacceptable, just as cigarette smoking has become in recent decades.[62]

Since its launch in Montana in 2005, the Meth Project has helped to cut teen methamphetamine use in the state by 63 percent and methamphetamine-related crime by 62 percent.[63]

Media Campaigns and Synthetic Drugs

The Senate Caucus on International Narcotics Control has focused a great deal on dangerous, new synthetic drugs – many of which are marketed as innocent products like incense and plant food. These include synthetic cannabinoids, such as K2 and Spice, and synthetic stimulants, such as so-called bath salts which are thought to mimic methamphetamine.

As these products become more popular among teenagers, the Caucus urges greater public awareness to be raised among younger people through public service announcements and possibly the ONDCP media campaign. It is crucial for public education and awareness to keep up with the latest drug trends and make their impact and effect clearly known to all.

Making the Connection Between U.S. Drug Use and International Drug Violence

The Caucus also believes that much more must be done to make all Americans – not just youth – aware of the impact that illegal drug consumption in the United States has in fomenting violence in drug producing and transit countries. Most Americans are unaware that consumption of illegal drugs in the United States fuels violence in Mexico and Central America. As Eric Farnsworth from the Council of the Americas wrote in a recent article, more must be done to show the direct link between the two:

"…there has been virtually no public emphasis on prevention or efforts to reduce demand in recent years. Where, for example, are the media campaigns including new media, celebrity spokespeople, pronouncements from senior officials, the public condemnation of drug use in the same manner as smoking or helmetless motorcycle riding? Where is the effort to show the link between drug use and killings in Central America and Mexico, along the same lines as the campaign to stop the "blood diamond" trade? 'Just say no' is not an effective approach, perhaps, but at this point, nobody seems to be saying much of anything."[64]

In having U.S. media campaigns demonstrate the correlation between violence in drug producing and transit countries and consumption in the United States, we should look to Colombia as an example.

The Colombian government – in cooperation with the United Nations Office on Drugs and Crime and the Andean Development Corporation – began a public relations campaign in 2005 that creates awareness about the environmental impact of cocaine production. The campaign – called *Shared Responsibility* – attempts to "create global awareness about the environmental devastation caused by coca cultivation in Colombia."[65] The campaign takes place on a global scale and brings delegations of international journalists to Colombia to see the social and environmental impact of cocaine production. **The Caucus urges ONDCP to use the Colombian *Shared Responsibility* campaign as a model for future media campaigns that emphasize the links between international drug violence and environmental degradation and U.S. drug consumption.**

Community-Based Drug Prevention Programs

The Caucus believes that the best approach to drug prevention is through community-based programs. In particular, the Drug Free Communities (DFC) program – run by ONDCP – is a grant-based program that provides drug prevention funding based on specific community needs.

The Drug Free Communities program responds to local drug use problems through a multi-sector approach. Local grantees know the needs in their communities and therefore are able to respond to "emerging drug trends identified in their communities, such as meth, synthetic drugs, and prescription and over-the-counter drugs."[66]

Finally, the Drug Free Communities program is cost-effective as it requires grantees to provide a dollar for dollar match in non-federal funds. Given the current fiscal climate, the Drug Free Communities approach of raising both public and private funds is crucial.

Caucus staff visited an impressive former Drug Free Communities grant recipient: the North Coastal Prevention Coalition in Oceanside, California. The coalition has been particularly innovative in dealing with synthetic drugs. For example, youth in the coalition have directly confronted stores selling synthetic drugs, like K2, Spice and bath salts. They have even done so in conjunction with local media. Adults in the coalition have worked to pass local ordinances classifying head shops as adult businesses and limiting the areas where they can operate. The coalition also holds drug and alcohol free functions on New Year's Eve and other holidays.[67]

An independent evaluation of the Drug Free Communities program found that **marijuana use within the past 30 days was lower for high school students in Drug Free Communities-funded areas than among a nationally representative sample of high school students taking the Youth Risk Behavior Survey.** The Office of National Drug Control Policy notes that "even though drug use is increasing in the U.S., drug use is decreasing in communities with Drug Free Communities and other proven prevention mechanisms."[68]The Caucus recommends the continuation of the Drug Free Communities Support Program.

Keeping the Focus on Drug Prevention

As is the case with the Drug Free Communities program, the Caucus believes it is important for drug prevention programs to take into account specific community needs. This means expanding beyond illegal drug prevention and looking at other risk factors that are specific to communities.

However, we also believe that drug prevention programs cannot stray too far from their purpose. Unfortunately, the Substance Abuse and Mental Health Services Administration (SAMHSA) has been attempting to do just that. In their Fiscal Year 2012 budget request, SAMHSA proposed merging prevention funding for both substance abuse and mental and behavioral health into one joint account. The Senate Appropriations Subcommittee on Labor, Health and Human Services, Education and Related Agencies responded with report language stating that this structure "would be detrimental to the specific programmatic and policy expertise of each center, especially as it relates to substance abuse prevention and substance

abuse treatment."[69] Ultimately, Congress wisely decided not to merge prevention funding for substance abuse and mental and behavioral health in the 2012 budget that President Obama signed into law.

The Caucus urges that SAMHSA not merge substance abuse and mental health prevention programs in future budget proposals. Doing so would only reduce the impact of each program.

Drug Treatment and Recovery

Overview

According to the National Treatment Improvement Evaluation Study, drug treatment can cut drug abuse in half, reduce criminal activity up to 80 percent, and reduce arrests up to 64 percent. [70] Treatment for drug addiction rests on the science of addiction which since the 1970s has asserted that "drug addiction is a complex but treatable disease that affects brain function and behavior."[71] According to the National Institute on Drug Abuse, there are three fundamental components that need to be considered in U.S. drug treatment policy:

- Treatment must be long enough to have lasting results – this means that access and costs must allow for long-term care;
- Services need to fit the needs of individuals in criminal justice populations; and
- A balance of rewards and sanctions must exist to encourage treatment participation. [72]

Substance abuse treatment funding in the United States was estimated by the federal government to cost $23.5 billion in 2006. This includes $5.1 billion in private insurance and personal funds, $1.1 billion in Medicare, $4.2 billion in Medicaid (State and Federal), $9.8 billion in other state and local public funding, and $3.3 billion from a variety of federal programs. These resources provide treatment for an estimated 2.6 million people annually. [73]

The treatment component of President Obama's National Drug Control Strategy is based on two main principles:

(1) Addiction treatment must be an integrated, accessible part of mainstream health care; and

(2) Addicted patients and their families must receive high-quality care.[74]

President Obama's Fiscal Year 2013 budget proposal includes "$9.2 billion in Federal funds for early intervention and treatment services for substance abusers."[75] This represents a 4.6 percent increase ($403 million) over the Fiscal Year 2012 enacted level.[76]

The National Institute on Drug Abuse (NIDA) estimates that substance abuse costs the United States over $500 billion dollars annually.[77] In addition to federal costs, there are significant expenditures at the state level. As part of the state of California's Corrections and Rehabilitation budget, over $160 million is estimated to have been spent on substance abuse programs in Fiscal Year 2011-2012 while the Governor's 2012-2013 budget calls for over $172 million.[78] At one facility, California's Substance Abuse Treatment Facility and State Prison at Corcoran, 6,647 inmates were housed and treated at a cost of $148 million or approximately $22,265 per inmate.[79] While treatment programs represent a significant expenditure, treatment is a cost-effective option for dealing with drug abuse.

Treatment costs are far lower than those of incarceration. For example, in the case of heroin addiction, methadone treatment costs $4,700 annually whereas imprisonment would cost approximately $24,000.[80] According to NIDA, every $1 invested in addiction treatment programs yields a return of between $4 and $7 by reducing drug-related crime, criminal justice costs, and theft.[81] Effective, well-funded treatment programs are an essential part of the National Drug Control Strategy and deliver good value per dollar spent, particularly in lowering criminal recidivism rates.

The goal of treatment is "to assist individuals in achieving stable, long-term recovery, enabling them to become productive, contributing members of society and eliminating the substantial public health, public safety, and economic consequences associated with active addiction." Treatment comes in varying forms and often starts with a detoxification process. From there, cognitive, behavioral, family and residential therapy options are utilized. Medication is also often useful in treating withdrawal symptoms and aiding in long-term recovery.

Successful treatment often combines both medical and behavioral methods to assist patients in overcoming their addiction. To be most effective, treatment must encompass a comprehensive approach including medical and mental health services, and appropriate follow-up.[82]

The Delancey Street Foundation, which operates in five cities in the United States, is self-funded through the creation of businesses run by its own residents. It therefore does not rely on any public funding. Delancey Street is an intensive, two year residential treatment program that stresses education, vocational training and "social training" to stop the cycle of drug use and criminal activity. Delancey Street sustains itself by the work of residents who live on the premises and

complete work in areas such as catering, holiday decor and moving services. Caucus staff visited the Delancey Street Foundation's Los Angeles facility which receives most of its funding through catering and other holiday services.[83]

Access to Treatment

According to the Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey on Drug Use and Health, 23.1 million people or 9.1 percent of the U.S. population aged 12 or older needed treatment for an illicit drug or alcohol use problem in 2010. Of these individuals, 2.6 million, or 11.2 percent of those who needed treatment, received treatment at a specialty facility such as a hospital, drug or alcohol rehabilitation or mental health center. **Therefore, 20.5 million people, 8.1 percent of the population aged 12 or older, needed treatment for an illicit drug or alcohol use problem but did not receive it.** This does not necessarily mean that care was not available, as the majority of people dealing with addiction issues do not attempt to access treatment. Only an estimated 1.7 percent (approximately 348,500 people) felt they needed treatment and made an effort to get care, but were unsuccessful in receiving it.

Residential Treatment

The Caucus believes that the United States must have an infrastructure that allows for those who seek specialized care to receive it. This can be done not just through government funding but also by supporting private non-governmental efforts. There is currently a shortage of residential treatment across the country. Although it is difficult to assess the severity of this shortage, it is most extreme for mothers who need to have their children with them while they complete treatment. This is important both for the unity of the family and the mother's willingness to complete the program.[84]

Nationwide, wait times for residential treatment programs are far too high, as reported by members of the States Associations of Addiction Services. **In Massachusetts, residential treatment providers indicate they have 25 to 30 calls a day for which they do not have a bed available. In Oregon, residential treatment wait time can be up to three months and the waiting list typically has 300 people.** [85]

Specialized Treatment Programs

There are a number of specialty treatment programs tailored to accommodate the specific needs of particular individuals — namely, women, families and prison inmates.

Women

According to the Obama Administration's *2011 National Drug Control Strategy*, drug treatment poses several challenges for women (and particularly women with families) because "many treatment programs are designed for and used mostly by men" while many women must consider family concerns that prevent them from seeking treatment as programs for women rarely accommodate their children. **Traditional drug abuse treatment programs do not allow for the inclusion of children, posing a dilemma for women between the need for treatment and the need to provide care for their children.** Further complications for women seeking treatment arise from the fact that "admitting to a substance abuse problem may lead to involvement with the criminal justice system and the loss of custody of children."

This dilemma was shared with Caucus staff on a visit to SHIELDS for Families, a family-centered non-profit residential treatment program in Compton, California. SHIELDS for Families allows women to have their children (and sometimes spouses) live on the premises while they receive services five days a week such as counseling, drug treatment, child development, vocational training, education and medical care. SHIELDS is the only program in the United States that allows entire families to live in the treatment environment in individual family apartments. Caucus staff heard stories of women who had previously reached out for help to break their addiction on several occasions, but because of the age of their children, were hesitant to enter treatment programs and abandon their children.

While the exact number of available beds is not known, in 2005, only 8 percent of California's treatment facilities had beds for children.[86] This shortage impacts both treatment admission and longer term sobriety. Studies show that mothers in family-based substance abuse treatment programs were more likely to stay drug-free as compared to those who lost or voluntarily gave up custody of their children. Both the emotional rewards and tangible success at SHIELDS were apparent. **Evaluations show that over 80 percent of SHIELDS residents complete the program, compared to a national average of only 25 percent; 95**

percent are reunified with their families; residents receive an average of 646 days in treatment – well above the national average of 90 days; and all clients obtain a high school diploma.[87]

The *2011 National Drug Control Strategy* calls for the creation of more treatment centers that specifically address the challenges faced by women seeking drug abuse treatment. The Caucus believes this would be beneficial in reducing drug use.

Treatment of Inmates

Drug treatment programs can cut down on recidivism rates and thereby improve public safety and reduce crime-related expenditures. Inmates who either committed a crime to get drugs or were under the influence of drugs at the time of their crime are among the most likely to re-offend. Of the 2.3 million inmates imprisoned in the United States, 65 percent meet the medical criteria to be considered addicted to either drugs or alcohol.[88] The National Center of Addiction and Substance Abuse at Columbia University found that between 1996 and 2006, while the number of adults incarcerated in the U.S. increased 33 percent to 2.3 million, the number of inmates with substance abuse issues increased by 43 percent to 1.9 million. Due to the potentially large societal benefits, it is important to make available the most effective treatment programs for addicted prisoners.

Unfortunately, inmates who are substance abuse-involved continue to be re-incarcerated at greater rates than those who are not abusing drugs. **One reason for this is that there is a serious "treatment gap," where of the 1.5 million inmates who were substance abusers in 2001, only 11.2 percent received treatment since admission to prison, according to the National Center on Addiction and Substance Abuse at Columbia University.**[89] This is due at least in part to fact that treatment in specialized settings, which is recognized to be more effective, is only available in 16.6 percent of facilities.

Drug users are more likely than non-drug users to reoffend. These repeat offenders make up a significant share of the prison population.[90] Furthermore, the treatment provided is often generic. Prison treatment programs often consist only of peer counseling or drug education. These types of treatment alone are often ineffective in helping inmates to become sober or significantly reducing recidivism rates.

However, the Federal Bureau of Prisons also utilizes highly successful programs such as the Residential Drug Abuse Programs where participants engage in a combination of behavioral treatment, counseling, and re-entry preparation programs following their release. Prisoners in this program will typically live in a special section of the prison and split the day between drug abuse program activities and prison work or educational programs.

The Caucus believes that the Bureau of Prisons should focus its funding on programs that have proven effective in increasing rates of sobriety and reducing the likelihood that program participants will re-offend following completion. The Residential Drug Abuse Program is one such program.

Recovery

Traditionally, U.S. Presidents – through ONDCP – have divided drug demand reduction into two main categories: prevention and treatment. However, the Obama Administration has added a third area: recovery. For the first time ever, in its 2010 National Drug Control Strategy, ONDCP focused on the need to invest in recovery. That strategy explains:

> "A key to solving America's drug problem is greater support for and partnership with the huge number of our citizens who have recovered from addiction and who deserve the opportunity to fully rejoin society. The millions of Americans who are in recovery are the most compelling evidence that there is hope for every addicted American in the ongoing process of recovery, individuals not only stop using substances, they reestablish friendships and family ties, become productive and responsible citizens, and very often help other addicted people begin to walk the same path."[91]

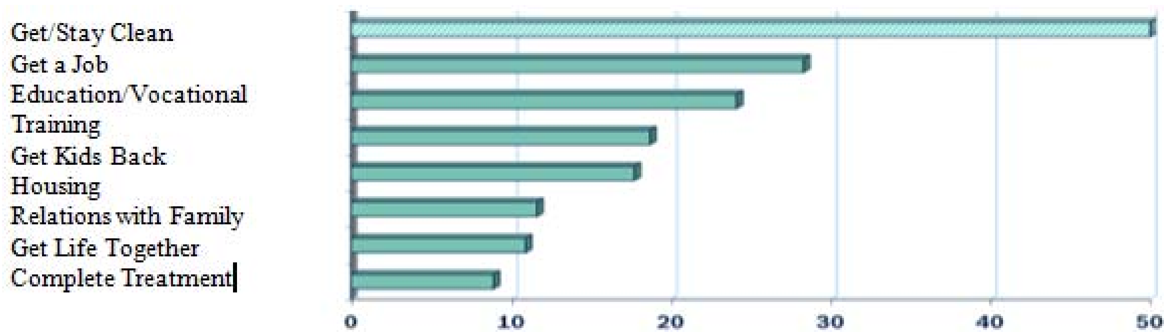
Treatment for drug abusers usually takes place during a fixed period of time, whereas recovery is a lifelong process.

Recent research suggests that while drug abstinence remains an essential prerequisite to a successful recovery program, treating a patient's substance abuse alone will not ensure his or her recovery.[92] For many individuals, drug addiction is a chronic problem that impacts one's occupation, familial relations, physical and mental health, friendships, residential status and access to social services.[93] Drug abstinence, while an essential first step in the recovery process, is unlikely to immediately reverse these longer term problems by itself. Even after a patient abstains from drug use, he or she may face several practical challenges left

unresolved by an acute treatment strategy, such as difficulty securing housing or employment.

Those in recovery recognize the need to address multiple aspects of their lives that have been negatively impacted by drug addiction. One study shows that although "staying clean" ranked first among the concerns of individuals in recovery, these individuals were also concerned about other long-term, "lifestyle" issues – employment, education, vocational training, housing and personal relationships. The chart below illustrates priorities among those in recovery:

Priorities of Individuals in Recovery



Source: Laudet, Alexandre. "The Road to Recovery: Lessons from the Recovery Experience."

The implementation of effective, long-term recovery programs is a central element in President Obama's 2010 and 2011 National Drug Control Strategies. Specifically, the Obama Administration has:

(1) **Expanded the Access to Recovery program** which provides funding to promising drug abuse recovery programs at the federal, local and state levels. These programs provide services such as child care, transitional housing, peer counseling, transportation to work and/or recovery meetings, and employment assistance. [94]

(2) **Expanded community-based recovery support programs**, including peer-led programs, recovery schools, recovery support centers and mutual help groups.

(3) **Addressed legal and policy barriers to addiction recovery** by identifying and eliminating regulations which impede the ability of recovering individuals to fully integrate back into the workforce and society. Many

current laws and regulations do not distinguish between active drug users and those in recovery who need employment, education, housing, child care, and a number of other social services in order to achieve a full recovery and become productive citizens.

The Caucus recommends specific actions to support those in recovery and supports businesses that positively affect the lives of people in recovery by increasing employment opportunities for those in recovery.

Collecting Better Statistics

The lack of good statistical information on drug use and abuse in the United States is a clear sign that there is an inadequate focus on drug demand reduction. Peter Hakim, the president emeritus of the Inter-American Dialogue who wrote a recent article on U.S. drug policy, argues that data on drug use and addiction needs to be brought up to the same standards as data collected on other major health and medical problems. He writes:

> "It is never easy to compile reliable statistics on illegal activities. But much can be done to remedy the incomplete, incomparable, and often contradictory data on drugs. Data on drug use and addiction, in short, needs to be brought up to the standards for other major health and medical problems."[95]

As Hakim notes, collecting data on illegal behaviors is always going to be difficult. Still, we must make every effort to collect the best data possible, so that appropriate drug prevention, treatment and recovery solutions can be sought.

The Arrestee Drug Abuse Monitoring (ADAM) Program is an Office of National Drug Control Policy (ONDCP)-maintained database that collects data on drug use among arrested and booked persons in 10 United States cities. Under the National Institute of Justice, it was expanded to 35 sites before funding was eliminated in 2003. Fortunately, ONDCP resumed the program on a smaller scale in 2007. The ADAM system generates information on the behavior of drug markets and criminally-involved drug users. According to a 2010 National Research Council report, the ADAM system is a crucial platform for studying the behavior of the population that accounts for most of the cocaine, heroin and methamphetamine use in the United States. The Council reports that "At present, it appears impossible to develop estimates of the quantities used and the expenditures on illegal drugs without data from these populations." [96] Restoring the ADAM program on a greater scale would help policymakers to better estimate the size of illicit drug markets.

Next, the System to Retrieve Information from Drug Evidence (STRIDE) is a Drug Enforcement Administration-maintained database that records information on the price and purity of illegal drugs. STRIDE analyses are only published on an ad hoc basis by ONDCP. More frequent analyses and greater dissemination of these analyses would be extremely useful for all policymakers, especially local, state and federal law enforcement.

In addition, Title IV of the Elementary and Secondary Education Act (ESEA) requires the collection of data on youth illicit drug use including: rates of use, age of first use, and perceptions of drug use. This data provides essential insights into drug abuse prevalence, patterns and emerging trends among the nation's youth. In addition, it provides a valuable metric to evaluate the effectiveness of agencies that receive federal funds through the Safe and Drug Free Schools and Communities program. Congress's reauthorization of the ESEA should maintain the data collection requirement and add a provision that agencies receiving funds under Title IV should set aside a portion of those funds for data collection. This will provide policymakers, law enforcement and health officials with the clear information needed for effective drug prevention and treatment programs.

Finally, perhaps the most important data used by policymakers on drug use is the annual National Survey on Drug Use and Health which provides data on annual drug usage. The National Research Council has recommended that data collection for this survey be expanded to "more effectively survey subpopulations with high prevalence of substance abuse."[97] They note that this should include so-called "hidden populations" such as street-injection drug users.

Conclusion

With almost nine percent of the U.S. population using illegal drugs in 2010, it is difficult to argue that enough is being done to reduce our demand for illegal drugs. **Drug abuse in the United States poses a major public health challenge while also costing our country $193 billion a year in preventable health care, law enforcement and addiction expenses.** On top of that, our nation's consumption habit fuels drug-related violence in both the drug producing and transit countries throughout Latin America and the Caribbean.

In an ideal world, significant resources would be available to better fund drug prevention, treatment and recovery programs in the United States. However, given the difficult fiscal situation our country faces, that is simply not possible.

Therefore, the Caucus has recommended a number of concrete actions that we hope will help to reduce the U.S. demand for illegal drugs. These include:

- Passage of legislation which would help stop criminals from exploiting the Internet to illegally sell prescription drugs;
- Funding for programs that are cost-effective and have significantly reduced recidivism, such as the Hawaii Opportunity Probation with Enforcement (HOPE), which emphasize quick punishment when individuals violate conditions of their probation;
- Use of the White House as a platform for a high-level national dialogue on illegal drug prevention that could be led by either the First Lady or Vice President;
- Reorientation of U.S. anti-drug media campaigns to demonstrate the correlation between violence in drug producing and transit countries and consumption in the United States;
- Blocking of any efforts to merge substance abuse and mental health prevention programs by the Substance Abuse and Mental Health Services Administration; and
- Improved collection of data on U.S. drug use.

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APPENDIX

I. Letter from Senators Dianne Feinstein and Charles Grassley to Government Accountability Office (GAO) Comptroller General Gene Dodaro requesting GAO conduct a study evaluating congressionally funded drug prevention and treatment programs

II. List of drug prevention, treatment and recovery site visits made by Senator Feinstein's Caucus staff

DIANNE FEINSTEIN, CALIFORNIA, CHAIRMAN
CHARLES E. GRASSLEY, IOWA, CO-CHAIRMAN
CHARLES SCHUMER, NEW YORK
SHELDON WHITEHOUSE, RHODE ISLAND
TOM UDALL, NEW MEXICO
JOHN CORNYN, TEXAS
JAMES E. RISCH, IDAHO

TELEPHONE: 202.228.3081
FACSIMILE: 202.228.3064

United States Senate

SENATE CAUCUS ON
INTERNATIONAL NARCOTICS CONTROL
HART SENATE OFFICE BUILDING, ROOM 818–C
WASHINGTON, DC 20510

June 21, 2011

Mr. Gene L. Dodaro
Comptroller General
U.S. Government Accountability Office
441 G Street, NW
Washington, DC 20548

Dear Mr. Dodaro:

The massive demand for illegal drugs in the United States creates both a challenge for public health in our own country and a challenge to security in countries throughout the world that are battling drug trafficking organizations. In spite of efforts to increase funding for drug prevention and treatment programs, the United States continues to be the world's largest consumer of illegal drugs.

According to the National Survey on Drug Use and Health, in 2009, about 21.8 million Americans aged 12 and older were current (in the past month) illegal drug users, representing 8.7 percent of the population. This represents the largest proportion in the past decade of people aged 12 and older identified as current illegal drug users. This is in spite of years of U.S. investment in drug prevention and treatment programs.

We request that the Government Accountability Office (GAO) conduct a study to evaluate the successes and shortcomings of congressionally funded drug prevention and treatment programs in the United States. We also request this study include a survey of drug prevention and treatment professionals impacted by congressionally funded drug prevention and treatment programs.

Given the current tight fiscal climate, this study would help Congress to determine how best to invest in future programs aimed at reducing the demand for illegal drugs.

Specifically, we request that GAO answer the following questions:

- Which drug treatment programs have been most effective in preventing recidivism? Which programs have been least effective?

- Which drug prevention programs have been most effective in ensuring that children and adolescents do not consume illegal drugs? Which programs have been least effective?

- How many different sources of federal funding, including various federal grant programs, are authorized and appropriated to reduce demand for illegal drugs, and to provide substance abuse prevention and treatment? Do these programs have any duplication and/or overlap? Would programs benefit from consolidation or streamlining in order to reduce administrative costs and duplicative efforts?

- Are federal grant programs that provide funding for illegal drug demand reduction, substance abuse treatment, and substance abuse prevention evaluated to determine whether they are successful in achieving the stated purposes or goals? Are these programs evaluated for empirical evidence that stated goals are actually achieved by the grant programs?

- How successful are drug courts in preventing recidivism? Are there any specific drug courts that have been particularly effective or ineffective? If so, why?

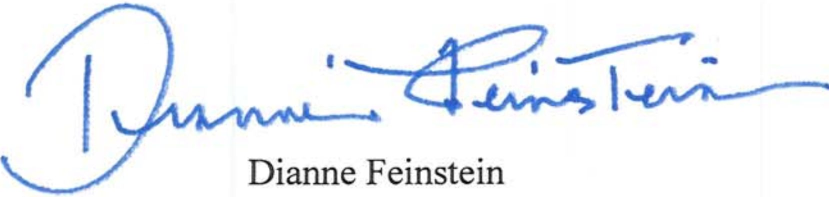
- To what extent has the 2010 National Drug Control Strategy, which is heavily focused on reducing the U.S. demand for illegal drugs, been implemented? How successful has the strategy been in preventing and reducing illegal drug use?

- Does the Office of National Drug Control Policy (ONDCP) have adequate metrics to evaluate the successes and shortcomings of drug prevention and treatment programs? If not, please recommend an alternative way to measure the successes and shortcomings of these programs.

- How have other societal factors such as state laws allowing the use of marijuana for medical purposes, the drug legalization movement, and pro-drug movies and messages contributed to youth drug use rates?

We appreciate your attention to this request.

Sincerely,



Dianne Feinstein
Chairman

Charles Grassley
Co-Chairman

Site Visits Made by Senator Feinstein's Caucus Staff

From January 8 through January 13, 2012, members of Senator Feinstein's Senate Caucus on International Narcotics Control staff traveled to model drug prevention, treatment and recovery programs in California, Arizona and Illinois to conduct report research. A list of the sites visited is provided below:

- **North Coastal Prevention Coalition (Oceanside, California):** The North Coastal Prevention Coalition brings together the public and private sectors to carry out drug and alcohol prevention in the cities of Carlsbad, Oceanside and Vista. The program was originally funded with federal Drug Free Communities dollars and trains high school students to work with their peers and within their communities to carry out drug prevention campaigns.

- **The Phoenix House (Santa Ana, California):** The Phoenix House provides residential housing and treatment programs using a therapeutic community model for adults and juveniles. Individuals can be referred by either the criminal justice system (drug courts or probation) or attend voluntarily.

- **Delancey Street Foundation (Los Angeles, California):** Delancey Street is an intensive, two year residential treatment program that stresses education, vocational training and "social training" to stop the cycle of drug use and criminal activity.

- **SHIELDS for Families (Compton, California):** SHIELDS is a family-centered non-profit residential program that allows women to live with their children (and sometimes spouses) on the premises while they receive services five days a week such as counseling, drug treatment, child development, vocational services and medical care.

- **Project SAFE (Phoenix, Arizona)**: Project SAFE drug tests juvenile probationers and if the results of their tests are positive or if they admit to drug or alcohol use, they are subject to swift, minor sanctions. This program is modeled on the Hawaii's Opportunity Probation with Enforcement (HOPE) program.

- **Maricopa County Drug Court Program (Phoenix, Arizona)**: This drug court is based on the national drug court model and works to help

participants overcome substance abuse issues that lead to their placement on probation. Karen Barnes presided over this court.

- **Treatment Alternatives for Safe Communities (Chicago, Illinois):** TASC is a non-profit organization that links offenders on probation and parole to drug abuse treatment and other services in the community, effectively fostering cooperation between the justice and treatment sectors.

- **Safer Foundation (Chicago, Illinois):** The Safer Foundation runs two residential transition facilities which allow incarcerated individuals to serve out the last 30 days to 24 months of their sentences in a community-based work-release setting. One of these centers has in-house drug treatment and recovery services. The Safer Foundation also operates employment services.

- **Women's Rehabilitation Alternative Probation Program (Chicago, Illinois):** This drug court provides gender-specific treatment services. Approximately 165 participants are under supervision per day. Judge Charles Burns presided over the court.