# DYING WAITING FOR TREATMENT

## The Opioid Use Disorder Treatment Gap and the Need for Funding

**A report by the Democratic Staff of the**

**Senate Committee on Finance**

**October 10, 2016**

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# OPIOID ADDICTION AND TREATMENT SHORTFALLS IN THE UNITED STATES

## INTRODUCTION

Every day in the United States, 78 people die from an opioid overdose – more than one person every 20 minutes. Since 1999, the number of overdose deaths involving opioids in America has quadrupled.[1] This country is the midst of an epidemic, yet there is a devastating lack of capacity to treat those seeking help. Several recent studies have revealed that upwards of 80 percent of people in need of treatment are unable to access services – with many put on waiting lists for weeks or even months before there is capacity to care for them.[2,3] More than 30 million people live in counties that do not have a single provider of medication assisted treatment.[4] The vast majority of these are rural counties, where mental and behavioral health professionals are also scarce, leaving people in many regions of the U.S. without options for treatment.[5]

On July 13, Congress passed the Comprehensive Addiction and Recovery Act of 2016 (CARA).[6] The bill was "comprehensive" in name only; without funding, its policies are little more than empty promises. Recognizing the funding shortfall, Senators Wyden, Murray, and Leahy offered an amendment during negotiations on the bill to include $920 million for treatment. The amendment was rejected on a party line vote.[7] Democrats also voted for Senator Shaheen's amendment which would have offered emergency funding of $600 million, but this too was blocked.[8] As President Obama said upon reluctantly signing the bill into law, "I am deeply disappointed that Republicans failed to provide any real resources for those seeking addiction treatment to get the care that they need."[9]

The Republican response to the opioid crisis so far has been like using a piece of chewing gum to patch a cracked dam. The continuing resolution passed on September 29 funded the government for just 10 weeks – until December 9, 2016 – and provided roughly $7.1 million of funding for CARA.[10] That money is split between the departments of Justice and Health and Human Services. The bottom line is that Republicans have guaranteed just $3.27 million for treatment grants – 0.35 percent of the White House's $920 million budget request, and the equivalent of roughly $1,000 for every county in the country.

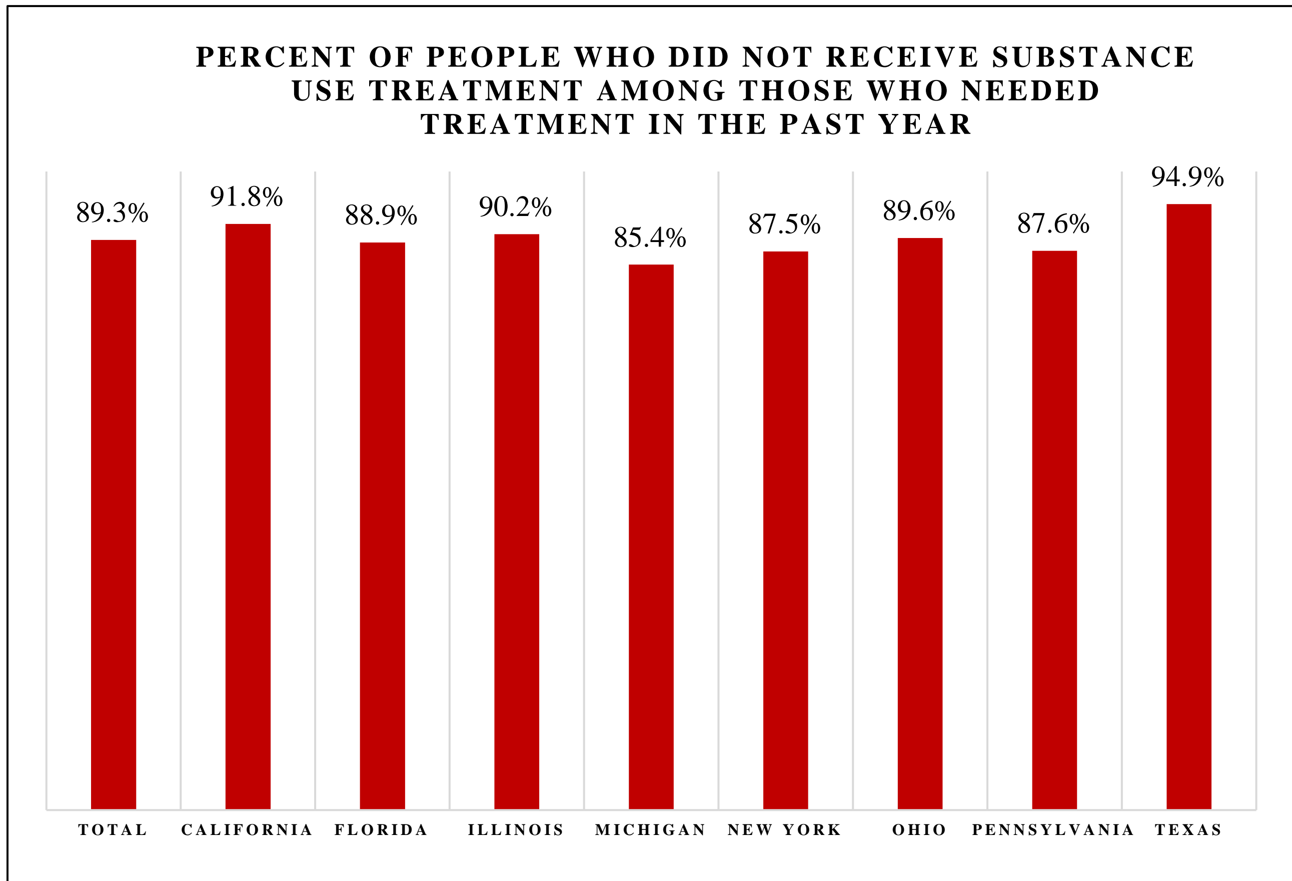
With state budgets stretched to the brink, building capacity to meet the surge in demand has proven challenging. Republicans had the chance to bridge the treatment gap, but failed to do so. Earlier this year, the White House asked Congress for $920 million over two years to expand access to treatment in the states, as part of a $1.1 billion request to address the opioid epidemic.[11] That $920 million would mean all 50 states would receive significant funding to make treatment available and affordable to those in need – a national response to a national epidemic.

## ACCESS TO TREATMENT IS VITAL

Opioid addiction is a complex condition that affects each person, each family, and each community differently. It's critical that those searching for help are able to access the entire range of treatment options and to choose the one that works best for them. The last thing a person needs when they make that difficult choice to reach out and fight their addiction is to be told, "Sorry, you have to wait." For

someone struggling with addiction, those hours, days, or even months of waiting can be the difference between life and death.

Management of opioid addiction is similar to other chronic conditions, often requiring both medical and psychosocial intervention. Treatment options can range from individual and group therapy, to 12-step programs, to outpatient treatment, to fulltime residential or inpatient treatment.[12] There is particularly strong evidence that outpatient medication assisted treatment with either buprenorphine or methadone is safe and cost-effective. Medication assisted treatment is associated with reduced overdose risk, reduced risk of HIV infection, and improved maternal and fetal outcomes in pregnancy.[13]




Source: SAMSHA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health (NSDUHs), 2008 to 2010

Access to treatment is too often limited or nonexistent, even though it helps reduce the chance of serious illness, injury and death associated with opioid use disorder. A team at John's Hopkins University recently outlined a comprehensive approach to addressing the opioid crisis. The researchers describe the gap in access to care, stating: "Unfortunately, the need for opioid addiction treatment is largely unmet. In regions of the country where the epidemic is most severe, there are waiting lists for treatment."[14] If Congress funded the White House's $920 million request, the money would go toward helping states eliminate these wait times and ensure access for those in need.

## A NATIONWIDE DEFICIT IN CAPACITY AND ACCESS

The Center for Behavioral Health Statistics and Quality at the Substance Abuse and Mental Health Services Administration (SAMHSA) reported that each year approximately 90 percent of the people who need substance use disorder treatment do not receive it.[15] A study published in the Journal of the American Medical Association earlier this year echoed those results, finding that close to 80 percent of those with opioid use disorder are not getting the care they need. The percentage of those receiving treatment has risen slightly, from 16.6 percent in 2004-2008 to 21.5 percent in 2009-2013. While this shows a slow growth in access, it also reveals a persistent gap in care.[16]

There are two major issues that need to be addressed so that those with substance use disorder can access care. First, there is not enough treatment, and second, people cannot access the treatment that does exist. Both of these issues require funding.

First looking at lack of capacity, a study in the American Journal of Public Health (AJPH) found that in 2012, all but two states had opioid use disorder or dependence rates higher than potential treatment capacity. The researchers found while 2.3 million Americans aged 12 years or older suffered from opioid use disorder or dependence, there was only enough treatment capacity to serve 1.4 million people. That leaves a gap in capacity of nearly 1 million people.[17]

**1 in 112**

**Americans suffer from opioid use disorder.**

**There are enough providers to treat 1 in 238.**

**Only 1 in 834 are actually accessing the treatment they need.**

**Source:** Jones, et al, "National and State Treatment Need and Capacity for Opioid Agonist Medication-Assisted Treatment."

The need for more treatment is particularly acute in rural areas. Just three percent of primary care physicians, the largest group of physicians in rural America, are approved to provide medication assisted treatment. In fact, 1,678 counties —more than half – do not have a single physician who is approved to prescribe this type of therapy.[18] Rural counties also have the lowest numbers of behavioral and mental health professionals per capita, leading to a major gap across both medical and psychosocial treatment options in these communities.[19]

Wait times for treatment are also frequently cited as a sign that more capacity is needed. One study found that when looking to just to get assessed for treatment, less than a third of participants got an appointment within 24 hours, 40 percent waited between three and seven days, and 12 percent waited more than a week. Waiting times for treatment itself were even worse, averaging 43 days. Three months later, more than one-third of participants had not been linked with a treatment provider.[20] Many found these wait times to be too much, and simply gave up before they got care.

Even where treatment capacity exists, access to that treatment remains an issue. The AJPH study found that while need outweighed availability, the number of people who actually got treatment was even fewer - just 1 in 834. While most outpatient treatment centers were close to capacity, the existence of any extra beds shows that funding is also needed to remove other barriers to care. These barriers include

lack of awareness of treatment options and understanding about addiction, stigma among patients and providers, and lack of affordability.

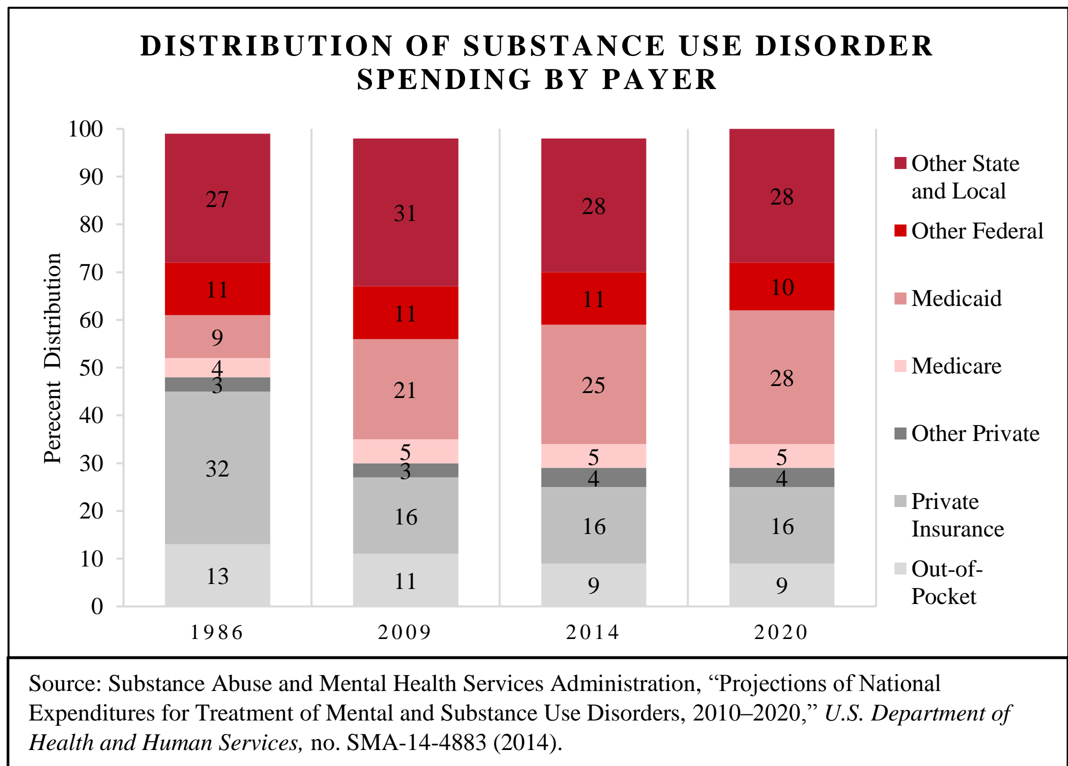
For example, just 2 percent of all providers are trained to provide medication assisted therapy. That's nowhere close to enough to treat everyone in need. In addition, those 2 percent are often only treating a small number of patients.[21] One study found that providers approved to administer this type of treatment were only serving an average of 26 patients, and a quarter of physicians had not treated a single patient since receiving the approval.[22] Clearly more funding is needed to break down stigma and institutional barriers to getting trained and using that training to provide this important type of treatment.

## DISPROPORTIONATE IMPACT ON THE MOST VULNERABLE

While this crisis has affected people of all ages and across every region of the country, the poor and the elderly have felt a disproportionate impact. Both groups tend to be sicker and have a higher number of prescriptions than other groups. More than one-third of Part D beneficiaries were prescribed an opioid in 2011, and opioid overuse-related stays for this group have been increasing by more than 10 percent per year for the past decade.[23] Likewise, Medicaid beneficiaries are prescribed painkillers at twice the rate of non-Medicaid patients and are three-to-six times more likely to overdose.[24]

Because of this, Medicare and Medicaid spent $4.35 billion on substance use disorder treatment services in 2014, more than any other federal agency spent on their prevention, treatment, law enforcement, and other drug related programs combined.[25] By 2020, the two programs will account for one-third of all substance use disorder spending.[26]

At the same time, current Medicaid policy presents another barrier to access. The Medicaid Institutions for Mental Diseases (IMD) exclusion has been interpreted to prohibit the use of federal Medicaid matching funds for payments made to some mental health and substance use disorder residential treatment facilities. As part of the Medicaid program since its enactment in 1965, the IMD exclusion was intended to ensure states maintained primary responsibility for funding inpatient psychiatric services. In practice it has meant that many Medicaid beneficiaries lack access to a significant source of residential care for substance use disorders.




Source: Substance Abuse and Mental Health Services Administration, "Projections of National Expenditures for Treatment of Mental and Substance Use Disorders, 2010–2020," *U.S. Department of Health and Human Services,* no. SMA-14-4883 (2014).

## THE NEED FOR FUNDING TO EXPAND ACCESS TO TREATMENT

The White House asked Congress for $920 million so that states can tackle the significant barriers to treatment and recovery faced by the people in their communities. Among other state-identified activities, this funding could be used to:

- Expand the number of providers trained and willing to provide treatment;
- Increase the number of facilities that offer treatment;
- Ensure that patients are aware of the range of treatment options and engage them in their care;
- Educate providers, patients, and the community to reduce the stigmas associated with substance use disorder and treatment;
- Ensure these services are accessible and affordable for those who need them.

The Obama administration has taken a number of actions to improve treatment access,[27] such as raising the cap on the number of patients that approved physicians can treat with buprenorphine from 100 to 275.[28] The administration also sent letters to all 50 state governors encouraging more physicians to take advantage of the free federal training and approval to provide this type of care.

Federal and state agencies have taken "every available action they can to address the opioid epidemic," according to Michael Botticelli, Director of the White House Office of National Drug Control Policy. "To fully address the crisis, however, Congress must act to provide additional funding to make lifesaving treatment available to everyone who seeks it."[29]

SAMHSA currently gives out a small number of targeted grants to expand access to medication assisted treatment. This year the Administration announced plans to double that program, giving a total of $25 million to 22 states by the end of 2016.[30]

**The White House's request for $920 million would mean that all 50 states could receive grants to expand access to treatment and make care affordable for those that need it most.**

**Source: "**Fact Sheet: President Obama Proposes $1.1 Billion in New Funding to Address the Prescription Opioid Abuse and Heroin Use Epidemic," *White House Press Office*, February 2, 2016.

However, if Congress were to fund the $920 million request it would mean that more than 18 times that amount of funding would go to all 50 states.[31] That funding would also be more flexible, allowing states to identify and address multiple barriers to treatment, including affordability, capacity, and awareness (see *Appendix B* for the details of the proposal).[32] The White House has specified the amount of funding each state would receive based on the severity of the epidemic in their state and on the strength of their strategy to respond to it (see *Appendix A* for a the list by state).[33]

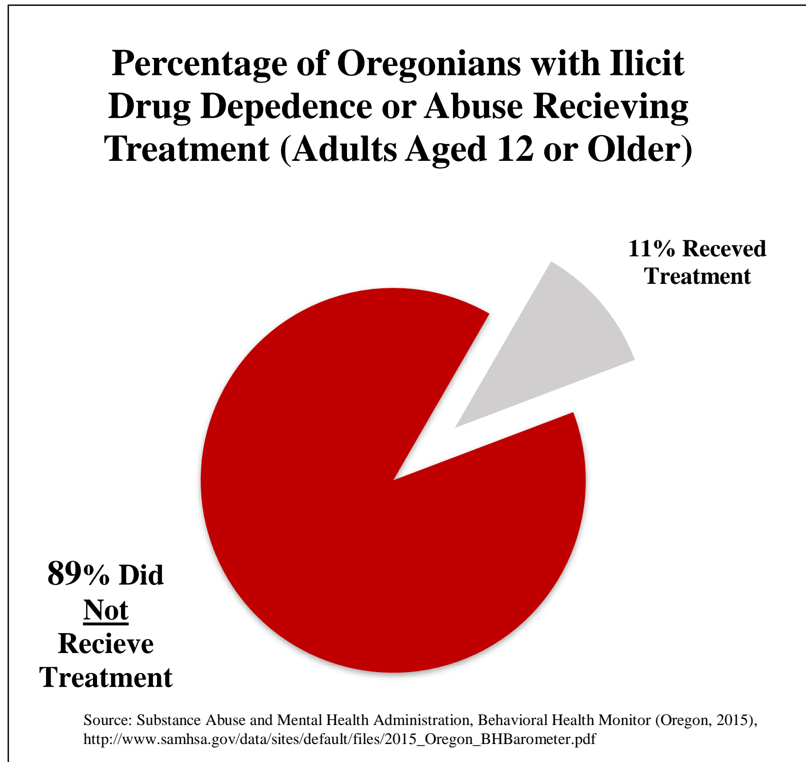
# SNAPSHOTS OF OPIOID ADDICTION IN FIVE STATES

States and communities are at the front line of the opioid epidemic, which is why the White House proposed providing $920 million in addiction treatment funding. The remainder of this report highlights the unique issues affecting five of the states that have been hit hardest by this epidemic: Oregon, California, Ohio, Pennsylvania, and New Hampshire. If Congress were to fund the White House request, each of these states would be eligible to receive vital funding to combat the epidemic and break down the barriers to care most relevant to the people in their communities.

**OREGON**

Earlier this year, Senator Wyden wrote an op-ed about a young man named Jordan Strickland who lost his life to opioid addiction. Jordan was prescribed opioid pain relievers for a basketball injury, got addicted, and then turned to heroin. Unable to access treatment, Jordan died before his 25th birthday.[34]

The sad truth is that Jordan is not alone. There were 522 opioid related deaths in the state in 2014, a jump of 13 percent from the prior year.[35] In an average year, just over 1 in 10 Oregonians are receiving the treatment they need.[36] Jordan is the face of the other 90 percent who are suffering from addiction, and yet unable to access care.



Source: Substance Abuse and Mental Health Administration, Behavioral Health Monitor (Oregon, 2015), http://www.samhsa.gov/data/sites/default/files/2015_Oregon_BHBarometer.pdf

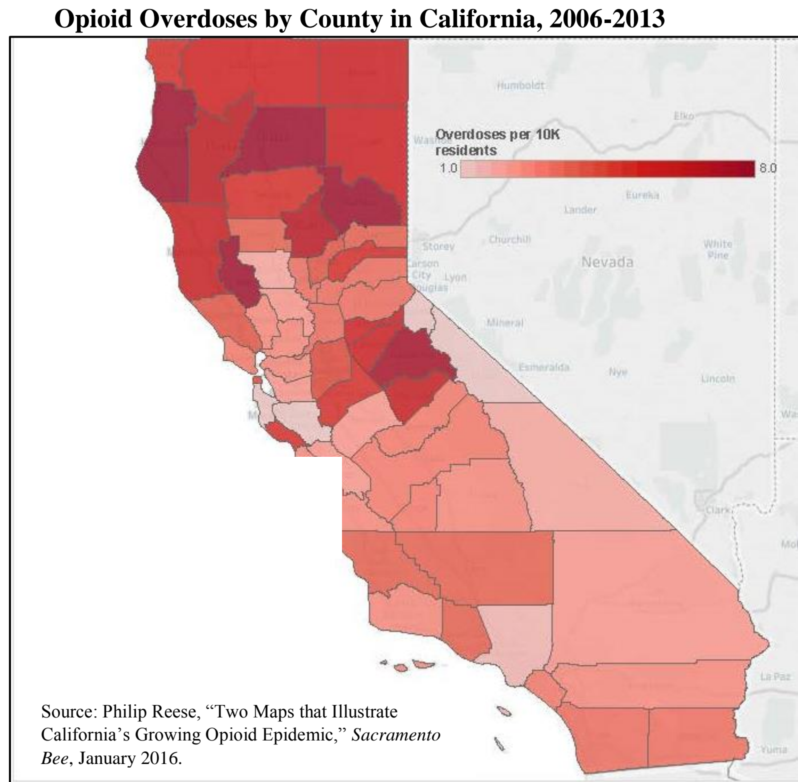
The need for more treatment is particularly dire in Oregon, which has the highest non-medical use of prescription painkillers of any state in the country.[37] An average of 120,000 people were suffering from opioid use disorder in the state from 2010 to 2014.[38] To put that in perspective, that is nearly the entire population of Salem, the Oregon's capital and third largest city.

Despite the high level of need, treatment capacity in the state is woefully inadequate. The most recent federal data show that in 2013 there were only 12 facilities offering medication assisted treatment in the state, serving just 4,347 people. Like most other states, there is also little spare capacity. In 2013, 85 percent of all residential substance use treatment beds and 75 percent of inpatient hospital treatment beds in Oregon were filled.[39] The American Journal of Public Health study found similar results, reporting that 75 percent of Oregon's outpatient treatment facilities were more than 80 percent full.[40] Even if every provider of medication assisted treatment in the state was treating as many people as legally allowable, there would still be more than 35,000 people in need of, but unable to receive, treatment.

If Congress were to fund the White House's full request, the state of Oregon would be eligible to receive $11 million – enough to provide a year of medication assisted treatment to 2,340 people, or help hundreds through inpatient rehabilitation programs.[41] That funding could expand the state's treatment capacity and ensure that people like Jordan can get the help they need before it's too late.[42]

## CALIFORNIA

**Opioid Overdoses by County in California, 2006-2013**




Source: Philip Reese, "Two Maps that Illustrate California's Growing Opioid Epidemic," *Sacramento Bee*, January 2016.

California has the highest opioid-related mortality rate in the country, with 4,521 opioid related deaths in 2014 alone.[43] In 2013, California hospitals treated 11,500 people for overdoses – roughly one overdose every 45 minutes.[44] California also demonstrates how this epidemic has had a disproportionate impact on rural communities. The map to the right shows how counties in the less dense, northern part of California have been hit hard. The *Sacramento Bee* reported that Shasta County, with a population of just under 180,000, reported 1,100 overdoses between 2006 and 2013 – triple the statewide average.[45]

Despite the high level of need, California's treatment capacity is not keeping pace. During the years 2010-2014, more than 87 percent of those dependent on or abusing illicit drugs were not accessing the care they needed.[46]

SAMHSA data shows that California treatment facilities have some of the most severe capacity shortfalls in the nation.[47] Close to 95 percent of all substance use disorder residential treatment beds and 102 percent of inpatient hospital beds in California were filled.[48] That 102 percent number shows that hospitals are using beds not even intended for substance use disorder treatment just to keep up with demand. The American Journal of Public Health study found similar results, reporting that in 2012, 71 percent of California's outpatient treatment facilities were at greater than 80 percent capacity.[49]

**California Treatment Facilities – Capacity and Utilization Rates**

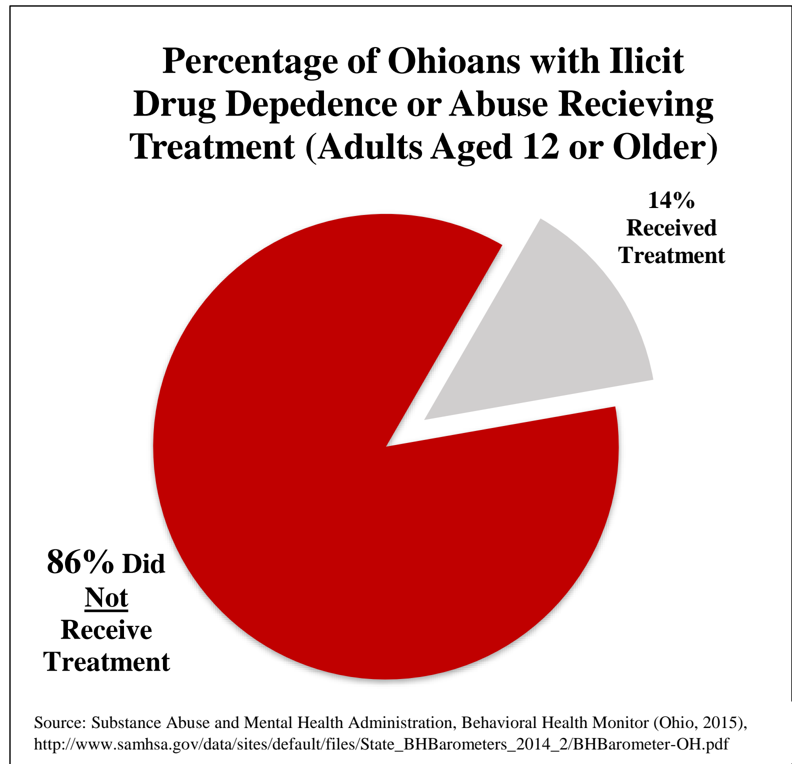
| | Residential | Hospital Inpatient |
|---|---|---|
| Number of Clients | 12,898 | 765 |
| Number of Beds | 13,688 | 750 |
| Utilization Rate | 94.2% | 102.0% |

**Source:** Substance Abuse and Mental Health Services Administration Center for Behavioral Health Statistics and Quality. "2013 State Profile — California National Survey of Substance Abuse Treatment Services (N-SSATS)".

If Congress were to fund the White House's full request, California could receive up to $78 million. That money could be used to help those northern counties that have been hardest hit expand their treatment capacity and make care more affordable for those in need.[50]

**OHIO**

For many people, Ohio is the face of the nation's opioid epidemic. It is the seventh largest state by population, but in 2014 it had the second highest number of opioid deaths.[51]




The state has responded by creating an "Opioid Action Team,"[52] and reallocating some state funding to bolster treatment and rehabilitation services in the state.[53] But with the mortality rate increasing by close to 20 percent from 2013, totaling 2,774 opioid-related deaths in 2014 alone,[54] it is unlikely these steps will be enough.

According to the American Journal of Public Health study, the current rate of opioid dependence in the state of Ohio is 1 out of every 100 people. However, the state only has enough treatment providers for 1 in 250.[55] "Waiting lists and delays discourage many users from seeking help," *The Toledo Blade* wrote in a 2014 editorial. "Local agencies and boards must do more to monitor how long it takes to get people into treatment and then add resources to effective programs that need them."[56] For the state to be able to do more, Congress must also give communities the resources to bring such programs to people who desperately need them.

Between lack of treatment capacity and numerous other barriers, nearly 86 percent of those with drug dependence or misuse in Ohio are not accessing the care they need.[57] In 2012, every single one of Ohio's outpatient treatment facilities for substance use disorder was more than 80 percent full.[58] "The gaps in treatment in Ohio are enormous and unacceptable," State Rep. Robert Sprague (R., Findlay) told *The Blade*.[59]

The state has already pulled $36 million from other programs to fight this epidemic, and yet the gap in care remains.[60] If Congress were to fund the White House's full request, the state of Ohio would be eligible to receive an additional $45 million to expand its treatment capacity.[61] Looking at the numbers, additional funding is desperately needed.

**PENNSYLVANIA**

The Centers for Disease Control and Prevention (CDC) estimated that Pennsylvania had 2,732 opioid related deaths in 2014 alone.[62] From 2009 to 2013, less than 17 percent of those with drug dependence or misuse in Pennsylvania were receiving treatment.[63]

The epidemic is so severe that Pennsylvania that Governor Tom Wolf called a special legislative planning session this year to address the opioid crisis in his state. "We have too few treatment centers," he said at the time, "and we can treat too few people who have this disease."[64]

According to the American Journal of Public Health (AJPH) study, nearly 1 out of every 250 Pennsylvania residents needs opioid treatment, but cannot access it because there are simply not enough beds and providers to care for them.[65]

**Pennsylvania Treatment Facilities – Capacity and Utilization Rates**

| | Residential | Hospital Inpatient |
|---|---|---|
| Number of Clients | 5,236 | 437 |
| Number of Beds | 5,756 | 529 |
| Utilization Rate | 91.0% | 82.6% |

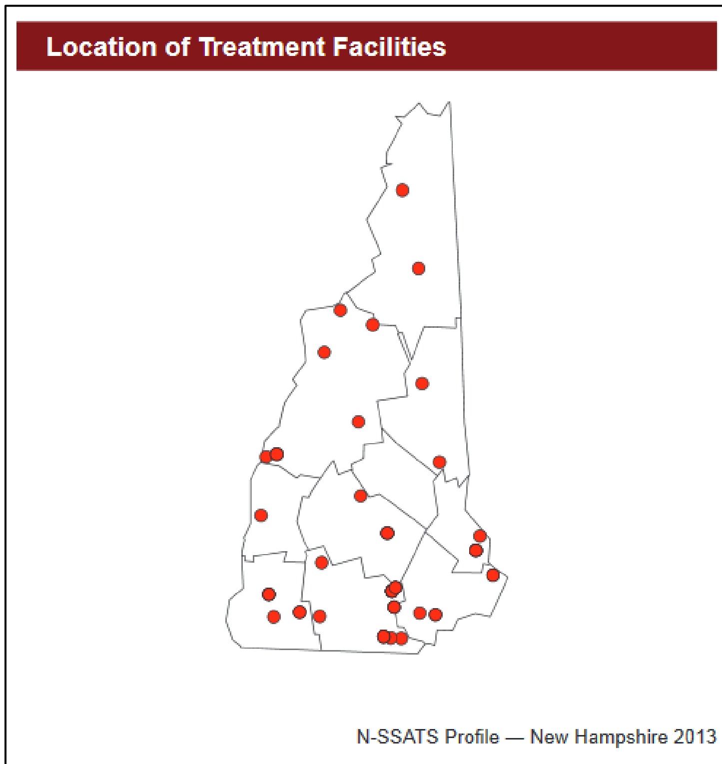
**Source:** Substance Abuse and Mental Health Services Administration Center for Behavioral Health Statistics and Quality. "2013 State Profile — Pennsylvania National Survey of Substance Abuse Treatment Services (N-SSATS)".

Federal data shows that, in 2013, 91 percent of the state's substance use disorder residential treatment beds and 83 percent of inpatient hospital beds were filled.[66] The AJPH researchers found similar results, reporting that in 2012, 87.3 percent of Pennsylvania's Outpatient Treatment facilities were at greater than 80 percent capacity. These numbers again highlight that there is a need beyond capacity, and that in cases where there is unused capacity, education and outreach, in addition to increased financial support, are necessary to make sure states are using all of the care they do have. In both circumstances one thing is true – changing the status quo takes funding.

If Congress were to fund the White House's full request, the state of Pennsylvania could receive up to $46 million of that funding.[67] These resources are vital to help ensure there are enough beds, enough providers, and enough understanding of the disease to treat the 83 percent of people in the state who right now cannot get the care they need.

**NEW HAMPSHIRE**

Sean Warren was struggling with heroin addiction for years. When he finally had had enough and reached out for help, he was told it would be nine weeks before he received treatment. "If I stayed out for nine weeks, I guarantee I wouldn't have survived," Warren told WBUR.[68] Fortunately, Sean was able to access treatment from another provider, but others have been less lucky. According to its director, Friendship House treatment center in New Hampshire has wait times of four-to-six weeks, which is better than the six-month long lists reported at some facilities in the southern part of the state.[69]




New Hampshire is one of the states that have suffered most severely from the opioid epidemic, with the third highest rate of opioid overdose deaths per capita. The CDC estimates that the state had a total of 334 opioid related deaths in 2014 alone, an astounding increase of nearly 75 percent from 2013.[70]

At the same time, New Hampshire has the second lowest level of access to substance use disorder treatment in the U.S.[71] From 2009 to 2013, an average of 37,000 people were dependent on or abusing illicit drugs, but an average of only 6,000 of those people were receiving treatment. That means that more than 83 percent of those dependent on or abusing illicit drugs were not accessing the care they needed.[72]

Additionally, in 2013 there were only 8 providers of outpatient medication assisted treatment in the state, and nearly 90 percent of all substance use disorder residential treatment beds were filled.[73] The American Journal of Public Health study found similar results, reporting that in 2012, 75 percent of New Hampshire's outpatient treatment facilities were at greater than 80 percent capacity.[74]

If Congress were to fund the White House's full request, the state of New Hampshire would be eligible to receive up to $5 million of that funding.[75] Those resources could be used to reduce wait times, build more treatment centers, and help people like Sean get access to life-saving care they need.

# IT'S TIME FOR CONGRESS TO ACT

In the U.S., nearly half a million people died from drug overdoses between 2000 and 2014. Too many of these people died afraid or unable to access care.

In every state, across the country, treatment capacity simply does not match the need. States are doing all they can to fight the epidemic, but as it stands now they do not have the money to build that capacity. In northern California the emergency rooms continue to be filled with opioid overdoses, and in New Hampshire people like Sean continue to be told they will have to wait months to access care.

In 2016, federal spending is expected to be nearly $4 trillion.[76] Comparatively, the White House request for $920 million over two years is a drop in the bucket. Yet, this would be an exponential increase in the amount of funding for states to expand access to treatment, and a long-awaited lifeline for those in need.

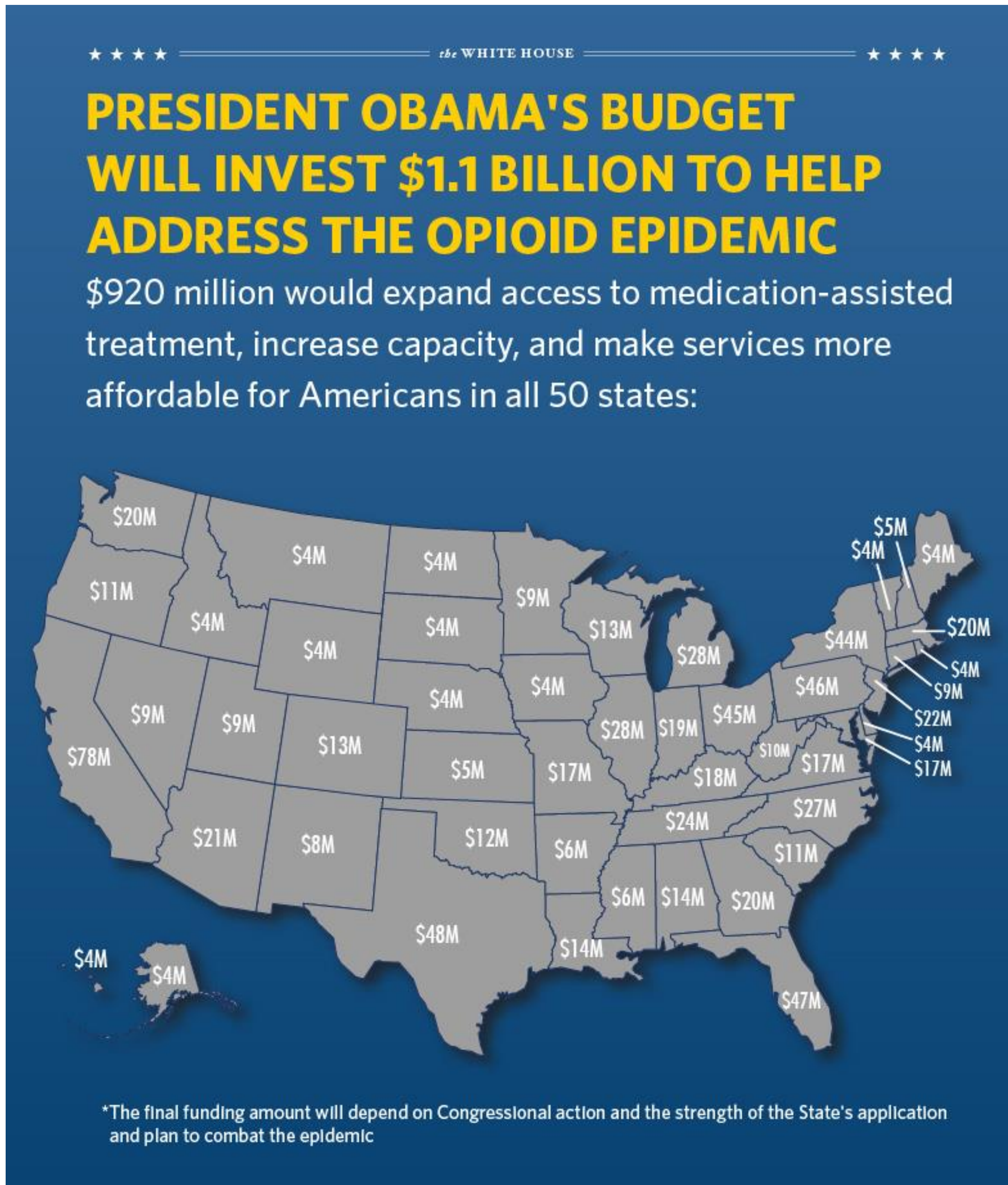
> ***"Every day that passes without Congressional action on funding to support the treatment needs of those suffering from opioid use disorders is a missed opportunity to save lives."***
>
> ***Michael Botticelli, Director of the White House Office of National Drug Control Policy***

Congress failed to follow through on the promises to states, communities, families, friends and individuals affected by the tidal wave of opioid addiction sweeping the country. Instead of providing desperately needed funding for treatment, Republicans put politics over people by appropriating treatment grants equivalent to just $1,000 for each county in the United States. This miniscule funding will not put a dent in this epidemic.

It is time for Congress to act. Every day Congress does not do so, another 78 people die waiting for someone to answer their call for help.

# APPENDIX A

The White House's proposal to distribute $920 million for opioid addiction treatment included a detailed breakdown of how much each state would receive, which is shown in the below map and table:




**Source:** www.whitehouse.gov/blog/2016/06/17/its-time-congress-provide-funding-we-need-opioid-epidemic

| State | Funding Level* *(in millions)*** | Age-Adjusted Drug Poisoning Rate***[77] | National Rank in Drug Poisoning Death Rate**** |
|---|---|---|---|
| Alabama | $14 | 15.2 | 22 |
| Alaska | $4 | 16.8 | 20 |
| Arizona | $21 | 18.2 | 15 |
| Arkansas | $6 | 12.6 | 34 |
| California | $78 | 11.1 | 40 |
| Colorado | $13 | 16.3 | 21 |
| Connecticut | $9 | 17.6 | 17 |
| Delaware | $4 | 20.9 | 9 |
| District of Columbia | $4 | 14.2 | 25 |
| Florida | $47 | 13.2 | 31 |
| Georgia | $20 | 11.9 | 36 |
| Hawaii | $4 | 10.9 | 41 |
| Idaho | $4 | 13.7 | 29 |
| Illinois | $28 | 13.1 | 32 |
| Indiana | $19 | 18.2 | 15 |
| Iowa | $4 | 8.8 | 44 |
| Kansas | $5 | 11.7 | 37 |
| Kentucky | $18 | 24.7 | 4 |
| Louisiana | $14 | 16.9 | 19 |
| Maine | $4 | 16.8 | 20 |
| Maryland | $17 | 17.4 | 18 |
| Massachusetts | $20 | 19 | 13 |
| Michigan | $28 | 18 | 16 |
| Minnesota | $9 | 9.6 | 43 |
| Mississippi | $6 | 11.6 | 38 |
| Missouri | $17 | 18.2 | 15 |
| Montana | $4 | 12.4 | 35 |
| Nebraska | $4 | 7.2 | 46 |
| Nevada | $9 | 18.4 | 14 |
| New Hampshire | $5 | 26.2 | 3 |
| New Jersey | $22 | 14 | 26 |
| New Mexico | $8 | 27.3 | 2 |
| New York | $44 | 11.3 | 39 |
| North Carolina | $27 | 13.8 | 28 |
| North Dakota | $4 | 6.3 | 47 |
| Ohio | $45 | 24.6 | 5 |
| Oklahoma | $12 | 20.3 | 10 |
| Oregon | $11 | 12.8 | 33 |
| Pennsylvania | $46 | 21.9 | 8 |

| | | | |
|---|---|---|---|
| Rhode Island | $4 | 23.4 | 6 |
| South Carolina | $11 | 14.4 | 24 |
| South Dakota | $4 | 7.8 | 45 |
| Tennessee | $24 | 19.5 | 11 |
| Texas | $48 | 9.7 | 42 |
| Utah | $9 | 22.4 | 7 |
| Vermont | $4 | 13.9 | 27 |
| Virginia | $17 | 11.7 | 37 |
| Washington | $20 | 13.3 | 30 |
| West Virginia | $10 | 35.5 | 1 |
| Wisconsin | $13 | 15.1 | 23 |
| Wyoming | $4 | 19.4 | 12 |
| **Total** | **$920** | **14.7******* | |

*Final funding amounts will depend on Congressional action and the strength of the state's plan to combat the opioid epidemic.

**Funding amounts are over two years.
*** Note that death rates are age-adjusted using a standard 2000 population. Number of opioid deaths per state is included in Appendix C.
****Some states are tied in National Rankings.
*****National Average

Additional information for individual states can be found at: https://www.whitehouse.gov/factsheets-prescription-opioid-abuse-and-heroin-use

# APPENDIX B

The President's budget request for the Substance Abuse and Mental Health Services Administration (SAMSHA) included adetailed discussion of how the $920 million of treatment funding would be used.

This appendix excerpts portions of the budget justification. The full document can be found here: http://www.samhsa.gov/sites/default/files/samhsa-fy-2017-congressional-justification.pdf.

## State Targeted Response Cooperative Agreements

| Program Activity | FY 2016 | FY 2017 | FY 2018 |
|---|---|---|---|
| State Targeted Response Cooperative Agreements (Mandatory Funding) | --- | $460,000,000.00 | $460,000,000.00 |

Authorizing Legislation ........................................................................................New Legislation
FY 2017 Authorization ..........................................................................................New Legislation
Allocation Method ..................................................................................................Formula Grants
Eligible Entities...................................States, Territories, Freely Associated States, District of Columbia, and the Red Lake Band of Chippewa Indians of Minnesota

**Program Description and Accomplishments**

Death from overdose of opioids, a class of drugs that includes prescription pain relievers and heroin, has taken a heartbreaking toll on too many Americans. In 2014, 28,647 deaths were related to overdose of opioids. Americans are abusing opioids and too few are getting treatment. Individuals who want to but do not undergo treatment often report cost and lack of access as reasons why they do not get treatment. The State Targeted Response Cooperative Agreements program is a new two-year program to address commonly cited barriers to receiving treatment. This funding is part of the Administration's $1.0 billion Expanding Access to Treatment Initiative to address opioid misuse epidemic by helping all Americans who want treatment to access it and get the help they need. These cooperative agreements will be awarded to states based on need and the strength of their strategies proposed to close the opioid use disorder treatment gap. Proposed strategies must be evidence-based and focused on the main factors preventing individuals from seeking and successfully completing treatment, and achieving recovery. States would be required to track and regularly report progress toward closing the opioid use disorder treatment gap and reducing opioid-related overdose deaths based upon measures developed in collaboration with HHS. Eligible activities would include but not be limited to:

- Addressing commonly cited barriers to receiving treatment by reducing the cost of treatment, expanding access to treatment, engaging patients in treatment, and addressing stigmas associated with accessing treatment;
- Training and approving opioid use disorder treatment providers like physicians, nurses, counselors, social workers, care coordinators and case managers;
- Supporting innovative delivery of Medication Assisted Treatment;
- Eliminating or reducing treatment costs for under- and uninsured patients;
- Providing treatment transition and coverage for patients reentering communities from criminal justice settings or other rehabilitative settings;

- Enhancing prevention using evidence-based methods proven to reduce the number of persons with opioid use disorders;
- Supporting innovative telehealth in rural and underserved areas to increase the capacity of communities to support behavioral health; and
- Integrating health IT programs, including enhancing clinical decision tools, to support identification of patients with opioid use disorder and engage them in treatment.

A portion of the funds would be used to support an evaluation.

**Budget Request**

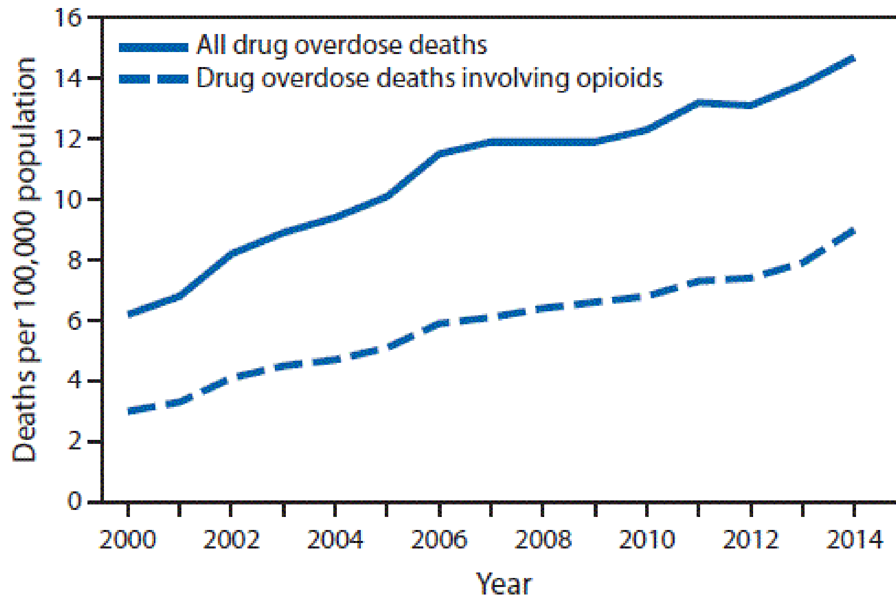
The FY 2017 Budget Request is $920.0 million ($460.0 million in FY 2017 and $460.0 million in FY 2018). This new effort will address commonly cited barriers to receiving treatment. This funding is part of the Administration's $1.0 billion initiative to increase access to treatment for prescription drug misuse and heroin use. This funding will help all those who seek treatment, access it and get the help they need.

# APPENDIX C

The Centers for Disease Control and Prevention released "Increases in Drug and Opioid Overdose Deaths — United States, 2000–2014" as a Morbidity and Mortality Weekly Report on January 1, 2016. This appendix excerpts portions of the report, which found "the rate of deaths from drug overdoses has increased 137%, including a 200% increase in the rate of overdose deaths involving opioids (opioid pain relievers and heroin)."

The full report can be found here: http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm

**FIGURE 1. Age-adjusted rate* of drug overdose deaths† and drug overdose deaths involving opioids§,¶ — United States, 2000–2014**




**Source:** National Vital Statistics System, Mortality file.
* Age-adjusted death rates were calculated by applying age-specific death rates to the 2000 U.S. standard population age distribution.
† Drug overdose deaths are identified using *International Classification of Diseases, Tenth Revision* underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14.
§ Drug overdose deaths involving opioids are drug overdose deaths with a multiple cause-of-death code of T40.0, T40.1, T40.2, T40.3, T40.4, or T40.6. Approximately one fifth of drug overdose deaths lack information on the specific drugs involved. Some of these deaths might involve opioids.
¶ Opioids include drugs such as morphine, oxycodone, hydrocodone, heroin, methadone, fentanyl, and tramadol.

| **TABLE. Number and age-adjusted rates of drug overdose deaths,* by sex, age, race and Hispanic origin,† Census region, and state —United States, 2013 and 2014** | | | | | |
|---|---|---|---|---|---|
| **Decedent characteristic** | **2013** | | **2014** | | **% change from 2013 to 2014** |
| | **No.** | **Age-adjusted rate** | **No.** | **Age-adjusted rate** | |
| All | 43,982 | 13.8 | 47,055 | 14.7 | 6.5§ |
| **Sex** | | | | | |
| Male | 26,799 | 17.0 | 28,812 | 18.3 | 7.6§ |
| Female | 17,183 | 10.6 | 18,243 | 11.1 | 4.7§ |
| **Age group (yrs)** | | | | | |
| 0–14 | 105 | 0.2 | 109 | 0.2 | 0.0 |
| 15–24 | 3,664 | 8.3 | 3,798 | 8.6 | 3.6 |
| 25–34 | 8,947 | 20.9 | 10,055 | 23.1 | 10.5§ |
| 35–44 | 9,320 | 23.0 | 10,134 | 25.0 | 8.7§ |
| 45–54 | 12,045 | 27.5 | 12,263 | 28.2 | 2.5 |
| 55–64 | 7,551 | 19.2 | 8,122 | 20.3 | 5.7§ |
| ≥65 | 2,344 | 5.2 | 2,568 | 5.6 | 7.7§ |
| **Race and Hispanic origin†** | | | | | |
| White, non-Hispanic | 35,581 | 17.6 | 37,945 | 19.0 | 8.0§ |
| Black, non-Hispanic | 3,928 | 9.7 | 4,323 | 10.5 | 8.2§ |
| Hispanic | 3,345 | 6.7 | 3,504 | 6.7 | 0.0 |
| **Census region of residence** | | | | | |
| Northeast | 8,403 | 14.8 | 9,077 | 16.1 | 8.8§ |
| Midwest | 9,745 | 14.6 | 10,647 | 16.0 | 9.6§ |
| South | 15,519 | 13.1 | 16,777 | 14.0 | 6.9§ |
| West | 10,315 | 13.6 | 10,554 | 13.7 | 0.7 |
| **State of residence** | | | | | |
| Alabama | 598 | 12.7 | 723 | 15.2 | 19.7§ |
| Alaska | 105 | 14.4 | 124 | 16.8 | 16.7 |
| Arizona | 1,222 | 18.7 | 1,211 | 18.2 | -2.7 |
| Arkansas | 319 | 11.1 | 356 | 12.6 | 13.5 |
| California | 4,452 | 11.1 | 4,521 | 11.1 | 0.0 |
| Colorado | 846 | 15.5 | 899 | 16.3 | 5.2 |
| Connecticut | 582 | 16.0 | 623 | 17.6 | 10.0 |
| Delaware | 166 | 18.7 | 189 | 20.9 | 11.8 |
| District of Columbia | 102 | 15.0 | 96 | 14.2 | -5.3 |
| Florida | 2,474 | 12.6 | 2,634 | 13.2 | 4.8 |

| Decedent characteristic | 2013 | | 2014 | | % change from 2013 to 2014 |
|---|---|---|---|---|---|
| | No. | Age-adjusted rate | No. | Age-adjusted rate | |
| Georgia | 1,098 | 10.8 | 1,206 | 11.9 | 10.2§ |
| Hawaii | 158 | 11.0 | 157 | 10.9 | -0.9 |
| Idaho | 207 | 13.4 | 212 | 13.7 | 2.2 |
| Illinois | 1,579 | 12.1 | 1,705 | 13.1 | 8.3§ |
| Indiana | 1,064 | 16.6 | 1,172 | 18.2 | 9.6§ |
| Iowa | 275 | 9.3 | 264 | 8.8 | -5.4 |
| Kansas | 331 | 12.0 | 332 | 11.7 | -2.5 |
| Kentucky | 1,019 | 23.7 | 1,077 | 24.7 | 4.2 |
| Louisiana | 809 | 17.8 | 777 | 16.9 | -5.1 |
| Maine | 174 | 13.2 | 216 | 16.8 | 27.3§ |
| Maryland | 892 | 14.6 | 1,070 | 17.4 | 19.2§ |
| Massachusetts | 1,081 | 16.0 | 1,289 | 19.0 | 18.8§ |
| Michigan | 1,553 | 15.9 | 1,762 | 18.0 | 13.2§ |
| Minnesota | 523 | 9.6 | 517 | 9.6 | 0.0 |
| Mississippi | 316 | 10.8 | 336 | 11.6 | 7.4 |
| Missouri | 1,025 | 17.5 | 1,067 | 18.2 | 4.0 |
| Montana | 137 | 14.5 | 125 | 12.4 | -14.5 |
| Nebraska | 117 | 6.5 | 125 | 7.2 | 10.8 |
| Nevada | 614 | 21.1 | 545 | 18.4 | -12.8 |
| New Hampshire | 203 | 15.1 | 334 | 26.2 | 73.5§ |
| New Jersey | 1,294 | 14.5 | 1,253 | 14.0 | -3.4 |
| New Mexico | 458 | 22.6 | 547 | 27.3 | 20.8§ |
| New York | 2,309 | 11.3 | 2,300 | 11.3 | 0.0 |
| North Carolina | 1,259 | 12.9 | 1,358 | 13.8 | 7.0 |
| North Dakota | 20 | 2.8 | 43 | 6.3 | 125.0§ |
| Ohio | 2,347 | 20.8 | 2,744 | 24.6 | 18.3§ |
| Oklahoma | 790 | 20.6 | 777 | 20.3 | -1.5 |
| Oregon | 455 | 11.3 | 522 | 12.8 | 13.3 |
| Pennsylvania | 2,426 | 19.4 | 2,732 | 21.9 | 12.9§ |
| Rhode Island | 241 | 22.4 | 247 | 23.4 | 4.5 |
| South Carolina | 620 | 13.0 | 701 | 14.4 | 10.8 |
| South Dakota | 55 | 6.9 | 63 | 7.8 | 13.0 |
| Tennessee | 1,187 | 18.1 | 1,269 | 19.5 | 7.7 |

| Decedent characteristic | 2013 | | 2014 | | % change from 2013 to 2014 |
|---|---|---|---|---|---|
| | No. | Age-adjusted rate | No. | Age-adjusted rate | |
| Texas | 2,446 | 9.3 | 2,601 | 9.7 | 4.3 |
| Utah | 594 | 22.1 | 603 | 22.4 | 1.4 |
| Vermont | 93 | 15.1 | 83 | 13.9 | -7.9 |
| Virginia | 854 | 10.2 | 980 | 11.7 | 14.7§ |
| Washington | 969 | 13.4 | 979 | 13.3 | -0.7 |
| West Virginia | 570 | 32.2 | 627 | 35.5 | 10.2 |
| Wisconsin | 856 | 15.0 | 853 | 15.1 | 0.7 |
| Wyoming | 98 | 17.2 | 109 | 19.4 | 12.8 |

**Source:** National Vital Statistics System, Mortality file.
* Deaths are classified using the *International Classification of Diseases, Tenth Revision* (ICD–10). Drug overdose deaths are identified using underlying cause-of-death codes X40–X44, X60–X64, X85, and Y10–Y14. Age-adjusted death rates were calculated by applying age-specific death rates to the 2000 U.S standard population age distribution.
† Data for Hispanic origin should be interpreted with caution; studies comparing Hispanic origin on death certificates and on census surveys have shown inconsistent reporting on Hispanic ethnicity.
§ Statistically significant change from 2013 to 2014.

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