

EXAMINING THE GROWING PROBLEMS OF
PRESCRIPTION DRUG AND HEROIN ABUSE:
STATE AND LOCAL PERSPECTIVES

HEARING
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND
INVESTIGATIONS
OF THE
COMMITTEE ON ENERGY AND
COMMERCE
HOUSE OF REPRESENTATIVES
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¹ Available at: <http://docs.house.gov/meetings/IF/IF02/20150326/103254/hhrg-114-IF02-20150326-sd008.pdf>.

² Available at: <http://docs.house.gov/meetings/IF/IF02/20150326/103254/HHRG-114-IF02-20150326-SD007.pdf>

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THURSDAY, MARCH 26, 2015

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:15 a.m., in room 2123 of the Rayburn House Office Building, Hon. Tim Murphy (chairman of the subcommittee) presiding.

Present: Representatives Murphy, McKinley, Griffith, Bucshon, Brooks, Mullin, Hudson, Collins, Upton (ex officio), DeGette, Schakowsky, Tonko, and Kennedy.

Staff present: Sean Bonyun, Communications Director; Leighton Brown, Press Assistant; Noelle Clemente, Press Secretary; Brittany Havens, Legislative Clerk; Charles Ingebretson, Chief Counsel, Oversight and Investigations; Chris Santini, Policy Coordinator, Oversight and Investigations; Alan Slobodin, Deputy Chief Counsel, Oversight; Sam Spector, Counsel, Oversight; Jeff Carroll, Democratic Staff Director; Chris Knauer, Democratic Oversight Staff Director; Una Lee, Democratic Chief Oversight Counsel; Elizabeth Letter, Democratic Professional Staff Member; and Tim Robinson, Democratic Chief Counsel.

OPENING STATEMENT OF HON. TIM MURPHY, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. MURPHY. Good morning.

As I call to order this Oversight and Investigations Subcommittee hearing to examine the growing problem of prescription drug and heroin abuse, allow me to share a few quotes from an article in the New York Times, citing the views of Dr. Hamilton Wright of Ohio. In the article, Dr. Wright is quoted as saying: "Of all the nations of the world, America consumes the most opium, in one form or another. The habit has this Nation in its grip to an astonishing extent. Our prisons and our hospitals are full of victims of it, it has robbed ten thousand business men and women of sense. The drug habit has spread throughout America until it threatens us with very serious disaster."

What is striking about these statements is not the dismal picture they paint, but rather, that these remarks were published over 100 years ago in 1911. Back then, of course, we did not have the sci-

entific or government involvement that we have today. Back then, there was no National Office of Drug Control Policy—the ONDCP—and there was no Department of Health and Human Services, no Substance Abuse and Mental Health Services Administration, and there was no National Institute on Drug Abuse. Yet despite all of our science and public health agencies, and despite the billions of federal dollars devoted to fighting the opioid problem, the situation is no better than it was 100 year ago. Indeed, many would say the situation is far worse.

According to the Centers for Disease Control, in just the past 3 years alone, the number of heroin overdose deaths in the United States has tripled. Tripled. And in some parts of the country, such as the Midwest, heroin overdose death rates have increased over 900 percent. Every day 120 people die from a drug overdose. The vast majority of these overdose deaths are due to prescription opioid medications. That is more than 43,000 deaths last year, or the tragic equivalent of one jetliner going down every single day.

In 2009, an estimated 13,000 babies were born in the United States addicted to heroin or prescription opioids. That is about one opioid-addicted baby every hour of the day, every day of the week. Please note that this statistic is from 2009, several years before the CDC announced our country was in the midst of an overdose epidemic and before the current explosion of heroin overdose deaths. The number of babies born addicted to opioids is much worse today. I used to work in a newborn intensive care unit, and I have watched too many tiny infants go through withdrawal symptoms. But seeing only one is enough to break your heart.

Something is desperately wrong with our Nation’s response to the opioid epidemic, and it is quite literally a matter of life and death that we get honest answers and not remain misguided in our approach to how we solve this crisis.

Every Member of Congress is seeing the consequence of the federal government’s failure because it touches every community and every family across America. My own district in Pennsylvania has seen the terrible consequences of addiction and death from opiate overdoses, and the problem has only gotten worse over the past year. In Westmoreland County, Pennsylvania, the drug overdose death total for 2014 surpassed that of 2013—a record to that point—by an additional death, and during that time, the number of accidental deaths caused by heroin in the county increased by over 30 percent. In 2014, Allegheny County, where Pittsburgh is, had 281 fatal overdoses reported, compared to 278 the previous year, and it is climbing for this year.

No federal agency has a more central role in this ongoing epidemic than the Department of Health and Human Services. HHS and its Substance Abuse and Mental Health Services Administration, otherwise known as SAMHSA, are tasked with leading our Nation’s public health response to opioid and heroin abuse and addiction. SAMHSA regulates our country’s 1,300 opioid maintenance—formerly known as methadone clinics—and is responsible for certifying the 26,000 physicians who prescribe the semi-synthetic opioid buprenorphine. According to testimony provided by SAMHSA before this subcommittee in April of last year, nearly 1.5 million people were “treated”—and I put “treated” in quotes—with

these opioids in 2012. That is a five-fold increase in the last 10 years. Now, I might add, I will not call this treatment. It is addiction maintenance.

Buprenorphine can more safely maintain a person's dependence by reducing the need for illegal opioid abuse, such as heroin, and thereby the risk for overdose. But make no mistake, buprenorphine is a highly potent opioid, which according to SAMHSA, is 20 to 50 times more potent than morphine. So it is worth considering that our national strategy to combat substance abuse is to maintain addiction by either prescribing or administering a heroin-replacement opioid. When you consider research from the National Institute on Drug Abuse documenting that almost everyone who stops taking buprenorphine relapses to illicit opioid use within a matter of weeks, it is deeply concerning that we don't have the best solutions for addiction recovery. According to the Drug Enforcement Administration, when police conduct a prescription drug bust, the third most frequently seized drug by law enforcement is buprenorphine—more than methadone, more than morphine, more than codeine. And unlike clinics that administer methadone, there are no requirements for buprenorphine clinics to offer or even discuss non-addictive treatment alternatives with patients, no requirements to develop treatment plans, no requirements to protect the public against it being diverted for illicit use. Meanwhile, the CDC reports that buprenorphine is the most frequently cited prescription drug in poisonings of children, accounting for nearly 30 percent of all opioid-related emergency department visits and 60 percent of emergent hospitalizations among children.

Worse yet, of opioid-addicted babies who start their fragile lives being medically detoxified off of opioids, nearly half of their mothers are on buprenorphine or methadone maintenance in HHS/SAMHSA-regulated or -certified practices.

This is government-supported addiction. It is not moving people to sobriety. We should not just focus on the extraordinary costs of detoxifying babies off of buprenorphine, but also the profound consequences for these babies whose entire experience in the womb and after they are born is dominated by buprenorphine dependence. Further, there are significant concerns about short- and long-term neurodevelopmental impacts of opioid exposure in utero. Why is the government subsidizing this harm?

Despite these problems, HHS and SAMHSA continue to actively and aggressively promote the use of buprenorphine, yet noticeably silent on promoting research and innovative measures with the goal of ending opioid addiction, not simply continuing addiction through drug maintenance programs of methadone. It concerns me that HHS and SAMHSA have no practical guidance on how to get people off of this prescribed opioid when those on buprenorphine maintenance for substance abuse disorders use illicit opioids an average of four times a week.

Now, I recognize this morning that HHS announced new plans and funding to work on this issue, and this committee eagerly awaits to see the details on how that will play out.

Compounding this crisis is the lack of evidence-based treatment to end opioid addiction, not merely replace an illicit drug with a government-sanctioned one. Evidence-based treatment includes de-

cisions based on scientific studies with quantitative data, and is distinguished from those relying on anecdotes and subjective observations.

Only about 10 percent of persons with a substance abuse disorder will get any form of medical care. Of those who are lucky enough to get care, only 10 percent of them will get evidence-based treatment for the disease of addiction. Yet most medical professionals are not sufficiently trained to diagnose or treat the disease of addiction, and most providing addiction care are not medical professionals and are not equipped to provide the full range of effective treatments.

Now, I believe in recovery. I believe in lives being restored and every individual living up to their full God-given potential and doing so drug-free. I desperately want our federal efforts to work in every community and for every family that seeks care for addiction disorders. And I know that working together, at the federal, State, and local level, we will achieve success. But we have to set our eyes on the goal of full recovery, not just addiction maintenance. We can do this, I have no doubt.

We continue our oversight series today by listening to law enforcement and public health officials who are working at the on the front lines to protect our communities and our families in this national epidemic. We are grateful for your service and for taking the time to be with us today.

[The prepared statement of Mr. Murphy follows:]

PREPARED STATEMENT OF HON. TIM MURPHY

Good morning. As I call to order this Oversight & Investigations Subcommittee hearing to examine the growing problem of prescription drug and heroin abuse, allow me to share a few quotes from an article in the New York Times, citing the views of a Dr. Hamilton Wright, of Ohio. In the article, Dr. Wright is quoted as saying: "Of all the nations of the world, America consumes the most opium, in one form or another."

"The habit has this Nation in its grip to an astonishing extent. Our prisons and our hospitals are full of victims of it, it has robbed ten thousand business men [and women] of sense"

"The drug habit has spread throughout America until it threatens us with very serious disaster." What is striking about these statements is not the dismal picture they paint, but rather, that these remarks were published over 100 years ago in 1911.

Back then, of course, we did not have the scientific or government involvement that we have today. Back then, there was no National Office of Drug Control Policy (ONDCP); there was no Department of Health and Human Services (HHS), no Substance Abuse and Mental Health Services Administration (SAMHSA); and there was no National Institute on Drug Abuse (NIDA). Yet despite all of our science and public health agencies, and despite the billions of federal dollars devoted to fighting the opioid problem, the situation is no better than it was 100 year ago. Indeed, the situation is much worse.

According to the Centers for Disease Control (CDC) in just the past three years alone, the number of heroin overdose deaths in the United States has tripled. And in some parts of the country, such as the Midwest, heroin overdose death rates have increased over 900 percent.

Everyday 120 people die from a drug overdose. The vast majority of these overdose deaths are due to prescription opioid medications. That's more than 43,000 deaths last year, or the equivalent of one jetliner going down every single day.

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According to the Drug Enforcement Administration, when police conduct a prescription drug bust, the 3rd most frequently seized drug by law enforcement is buprenorphine. More than methadone. More than morphine. More than codeine. And unlike clinics that administer methadone, there are no requirements for buprenorphine clinics to offer or even discuss non-addictive treatment alternatives with patients. No requirement to develop treatment plans. No requirements to protect the public against buprenorphine being diverted for illicit use.

Meanwhile, the CDC reports that buprenorphine is the most frequently cited prescription drug in poisonings of children, accounting for nearly 30% of all opioid-related emergency department visits and 60% of emergent hospitalizations among children.

Worse yet, of opioid-addicted babies who start their fragile lives being medically detoxified off of opioids, nearly half of their mothers are on buprenorphine or methadone maintenance in HHS/SAMHSA regulated or certified practices. This is government-supported addiction. It is not moving people to sobriety. We should not just focus on the extraordinary costs of detoxifying babies off of buprenorphine, but also, the profound consequences for these babies whose entire experience in the womb and after they are born is dominated by buprenorphine dependence. Further, there are significant concerns about short and long term neurodevelopmental impacts of opioid exposure in utero. Why is the government subsidizing this harm?

Despite these problems, HHS and SAMHSA continue to actively and aggressively promote the use of buprenorphine, yet noticeably silent on promoting research and innovative measures with the goal of ending opioid addiction, not simply continuing addiction through drug maintenance programs of methadone or buprenorphine. It concerns me that HHS and SAMHSA have no practical guidance on how to get people off of this prescribed opioid when those on buprenorphine maintenance for substance abuse disorders use illicit opioids an average of four times a week.

Compounding this crisis is the lack of evidence-based treatment to end opioid addiction, not merely replace an illicit drug with a government sanctioned one. Evidence-based treatment includes decisions based on scientific studies with quantitative data, and is distinguished from those relying on anecdotes and subjective observations. Only about 10 percent of persons with a substance abuse disorder will get any form of medical care; of those who are lucky enough to get care, only 10

percent of them will get evidence-based treatment for the disease of addiction. Yet, most medical professionals are not sufficiently trained to diagnose or treat the disease of addiction, and most providing addiction care are not medical professionals and are not equipped to provide the full range of effective treatments.

I believe in recovery. I believe in lives being restored and every individual living up to their full God-given potential and doing so drug free. I desperately want our federal efforts to work in every community and for every family that seeks care for addiction disorders. And I know working that together, at the federal, state and local level, we will achieve success. But we have to set our eyes on the goal of full recovery, not just addiction maintenance. We can do this, I have no doubt.

We continue our oversight series today by listening to law enforcement and public health officials who are working at the on the front lines to protect our communities and our families in this national epidemic. We are grateful for your service and for taking the time to be with us today.

Mr. MURPHY. And with that, I now recognize Ms. DeGette of Colorado.

OPENING STATEMENT OF HON. DIANA DEGETTE, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF COLORADO

Ms. DEGETTE. Thank you very much, Mr. Chairman, for convening this hearing today.

As you noted, the opioid epidemic is nothing short of a public health crisis. In 2013, prescription painkillers were involved in over 16,000 overdose deaths, and heroin was involved in an additional 8,257 deaths. Over 2.1 million Americans live with a prescription opioid addiction while 467,000 Americans are addicted to heroin. These are devastating numbers, and they have been trending upwards for far too long.

These numbers only paint a partial picture of the heavy toll of the epidemic in our society. Throughout this country, countless families and communities have been shattered by opioid abuse, misuse and addiction. It is time that we really truly pursue best practices supported by scientific research that will reverse this problem.

Recent advances in science have shown us that addiction is a disease of the brain. This demands that we approach the problem not only as a public safety issue but also as a public health issue. Yes, we must stop drug smugglers and crack down on pill mills, but we also must work with prescribers to educate them and prevent the over-prescription of opioids for pain management. And most importantly, we must improve our ability to identify and treat people with substance abuse disorders.

In 2013, for example, only 1 in 10 Americans with a substance abuse disorder received any form of treatment. That is just unacceptable, and we should be asking why so few Americans are accessing the treatment they need.

Research indicates that medication-assisted treatment, or MAT, combined with counseling is the most effective way to treat opioid addiction. Studies further demonstrate that MAT reduces the risk of drug overdoses, infectious disease transmission, and engagement in criminal activities.

Despite this track record, in 2013, MATs were available in only 9 percent of substance abuse treatment facilities nationwide. Even more troubling are reports that some treatment facilities that adopt an abstinence-based approach to drug treatment do not allow

patients to take MATs while enrolled in their programs. According to experts, a high percentage of opioid addicts in abstinence-based treatment return to opioid abuse within 1 year, and as you said, Mr. Chairman, even within a few weeks. Given the limited success of these programs in promoting long-term recovery in opioid addicts, we must ask some hard questions regarding how we should be spending our limited resources for treatment.

Finally, we know that patients with substance abuse disorders continue to face significant barriers to treatment. For example, right now there is a nationwide shortage of qualified substance abuse providers, particularly people who can prescribe MATs. Recent press reports also suggest that patients face long waiting lists for admission into treatment facilities, and according to the American Society of Addiction Medicine, both State Medicaid programs and private insurers have policies in place that are limiting patients' access to MATs. We need to better understand these barriers and what we can do at the federal level to address them.

There are some reasons for optimism, however. First, the Affordable Care Act has expanded access to substance abuse treatment for millions of Americans. Insurance companies are now required to provide coverage of treatment for substance abuse disorders just as they would for any chronic disease. These policies represent the largest extension of treatment access in a generation, and hopefully they will guide millions into successful recovery.

Second, we do have some sense of what works. Some of our witnesses today who have firsthand knowledge on what strategies are effective to treat and prevent substance abuse will talk about that. They know what has worked in their communities, and we need to have them help us inform the national discussion.

I do want to thank our witnesses today, Mr. Chairman. We have asked all of you to attend this hearing because of the important work that you are doing to raise drug awareness, break down the stigmas long associated with substance abuse disorders, and put people on the path to recovery.

Finally, Mr. Chairman, your continued oversight on this issue gives me reason to be optimistic that this committee can play a role in turning the tide. You have indicated your intention to conduct a series of hearings on this topic, and I am certainly glad to be your partner in this inquiry.

To that end, I suggest that our next hearing focus on state responses to the epidemic. There is significant variation from state to state on treatment quality, access and coverage. Some states are making progress but some are not, and we should hear the best practices. We also need to hear from federal agencies on these same topics.

This committee has an opportunity to make a meaningful difference in addressing the problem, and I am welcoming all of our joint efforts.

And with that, Mr. Chairman, I just want to let the witnesses know, this committee has a bill on the floor right now, so I have to run down and make a statement on the floor. I am leaving us in the capable hands of Mr. Kennedy, and I will be back after my statement. Thank you.

Mr. MURPHY. I thank the gentlelady, and thank you for your comments—very pointed.

I now recognize the chairman of the full committee, Mr. Upton, for 5 minutes.

OPENING STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

Mr. UPTON. Well, thank you, Mr. Chairman.

Today we continue our important review of the growing epidemic of prescription drug and heroin abuse. The state and local perspective of this growing threat is essential as we evaluate what steps we can take at the federal level to help address the crisis.

Sadly, communities all across the country have been affected by prescription drug and heroin abuse, including my district in southwest Michigan. Devastatingly, heroin overdoses sadly are on the rise due to a combination of high demand and purity that can make the drug even more lethal. There were 13 suspected overdoses in Kalamazoo in the first quarter of 2013, compared to nine in the quarter before that in the earlier year. This unwelcome trend is unfortunately all too familiar as opiate-related overdoses have recently become the number one cause of death in Michigan and nationwide, surpassing motor vehicle crashes, suicide, firearms, and homicide.

I know personally a number of families that have been shattered by that overdose. The reality of heroin overdoses has hit hard in Kalamazoo County the last few years. In 2008, we lost a beautiful little girl named Amy Bousfield, 18 years old. In 2012, Marissa King died at 21. She began using heroin in 2009, despite having lost two friends to the drug. Marissa had an underlying mental illness. She was diagnosed with bipolar disorder, had struggled with depression, and had abused prescription drugs before turning to heroin after graduating from a local high school. These are just a few of the heartbreaking stories that we see all across the country. We are losing about 20,000 people a year from abuse of prescription pain killers or heroin.

As we continue to mourn the loss of all these lives, testimony from you all today will provide us an effective approach making a real difference in fighting this awful abuse. This is a great opportunity for this committee, on a bipartisan basis, to help improve the federal government's response to this epidemic. I am especially pleased to welcome one of today's witnesses, my good friend Vic Fitz, the Cass County Prosecutor and the President of the Prosecuting Attorneys Association of Michigan. He has 31 years of experience in prosecuting drug cases, and will certainly share his insights today as he has done with me over the past number of years and with other fellow prosecutors in Michigan on this issue. I would note that the heroin dealer who sold the heroin that killed Amy Bousfield was caught, convicted, and sentenced to 10 ½ to 40 years in prison. We appreciate the work of Vic and his fellow prosecutors who have held dealers accountable to the law, and helped addicts straighten out their lives. I thank him and all of you for your service, and for participating at today's hearing, and I yield the balance of my time to Mr. McKinley.

[The prepared statement of Mr. Upton follows:]

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Today we continue our important review of the growing epidemic of prescription drug and heroin abuse. The state and local perspective of this growing threat is essential as we evaluate what steps we can take at the federal level to help address this crisis.

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This unwelcome trend is unfortunately all too familiar as opiate-related overdoses have recently become the No.1 cause of death in Michigan and nationwide, surpassing motor vehicle crashes, suicide, firearms, and homicide.

The reality of heroin overdoses has hit hard in Kalamazoo County the last few years. In 2008, we lost Amy Bousfield, 18 years old and a graduate of Portage Central High School. In 2012, Marissa King died at 21 years old. She began using heroin in 2009, despite having lost two friends to the drug, including Amy Bousfield. Like 40 percent of those who abuse drugs, Marissa had an underlying mental illness. She was diagnosed with bipolar disorder, had struggled with depression, and had abused prescription drugs before turning to heroin after graduating from Comstock High School.

There are many heart-breaking stories like this across the country. We are losing about 20,000 people a year from abuse of prescription pain killers or heroin. As we continue to mourn the loss of all these lives, testimony from today's witnesses provides us hope that there are effective approaches making a real difference in fighting opioid abuse. This is a great opportunity for this committee, working on a bipartisan basis, to help improve the federal government's response to this epidemic.

I am especially pleased to welcome one of today's witnesses, my friend Vic Fitz, the Cass County Prosecutor and the President of the Prosecuting Attorneys Association of Michigan. Vic has 31 years of experience in prosecuting drug cases, and will share his insights as well as those of his fellow prosecutors in Michigan on this issue. I would note that the heroin dealer who sold the heroin that killed Amy Bousfield was caught, convicted, and sentenced to 10 and a half to 40 years in prison. We appreciate the work of Vic and his fellow prosecutors who have held dealers accountable to the law, and helped addicts straighten out their lives. I thank him for his service, and for participating at today's hearing.

Mr. MCKINLEY. Thank you, Mr. Chairman, and thank you, Mr. Murphy, for holding this hearing today focusing on this growing epidemic. Thank you to the witnesses for coming here to testify.

Prescription drug and heroin abuse has steadily increased. You have heard it throughout the comments that have been made here and throughout our country, and I have seen it firsthand in my home State of West Virginia. Currently, West Virginia is suffering from the highest rate of drug overdose mortality rates in the entire country.

Since coming to Congress in 2010, our office has been working on solutions. We have had roundtable meetings throughout the district with law enforcement, healthcare professionals, educators, and community leaders about how to address this problem. What we have heard is at least three solutions. One is, we need to be focused better on education; secondly, on proactive prevention; and thirdly, resources for our law enforcement to take these drug traffickers off our streets. Therefore, by expanding the High Incident Drug Traffic Area—HIDTA—in West Virginia, it has provided an incredibly effective tool for catching drug offenders and taking them off the streets. This is just one option. I hope to learn more from the rest of this panel today.

Thank you, and I yield back my time.

Mr. MURPHY. Thank you. The gentleman yield back. I now recognize Mr. Kennedy of Massachusetts for 5 minutes.

OPENING STATEMENT OF HON. JOSEPH P. KENNEDY, III, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF MASSACHUSETTS

Mr. KENNEDY. Thank you, Mr. Chairman. Thank you very much to all the witnesses that are here today who have dedicated so much of their time, efforts, energy, and lives to confronting this crisis, either through treatment, community health or through law enforcement. We are grateful for your commitment and all you do to try to address this problem head-on, and I want to thank the chairman of the committee and of the subcommittee as well for calling an important hearing.

There are few people in this country that have been spared the heartbreaking impact of watching a loved one, a neighbor, a friend, a colleague fall victim to opiate addiction. It is an epidemic striking red states and blue states, small towns and big cities, neighborhoods rich and poor. The breadth and depth of this epidemic is truly staggering, and there is no silver bullet. But perhaps there is a silver lining, which you have heard already this morning. It translates into strong bipartisan consensus here in Washington that we have to do something about it.

Back home in the 4th District of Massachusetts, there is not an event that I go to where this topic does not come up. Communities like Fall River in Taunton have been particularly hard-hit. Local leaders are working tirelessly to respond.

Across the Commonwealth, we confront a growing epidemic. In 2013, there were 978 opioid-related deaths in Massachusetts, according to the Department of Public Health, which has yet to release 2014 figures. In fiscal year 2014, there were more than 104,000 admissions to State-contracted substance abuse treatment programs in Massachusetts, more than 53 percent of which were for heroin addiction.

Despite these numbers, I repeatedly hear from providers in my district that there is a profound lack of resources for the prevention and treatment of substance abuse, especially when it comes to opioid addiction. Insufficient wraparound services, low reimbursement rates, and bureaucratic barriers to treatment harm patients and undermine our efforts to reverse addiction trends.

According to CPAC, the New England Comparative Effectiveness Public Advisory Council, 133,000 people in New England abuse or are addicted to opiates. Of those, 70 percent meet the criteria for treatment but cannot access it. We know that this is a problem with no silver bullet solution. We are working to chip away at it, and I am proud to have joined Representative Whitfield this morning in reintroducing legislation to reauthorize the NASPER program, the National All Schedules Prescription Electronic Reporting program. The program is designed to provide grants to states for the establishment, implementation, and improvement of prescription drug monitoring programs. We know that timely access to patient records and high standards of interoperability are successful with PDMPs, and this legislation will give providers the tools that they need to identify and treat at-risk behavior.

To those of you who are here today to testify, you are on the frontlines of this epidemic. You are fighting every single day for our communities, our neighborhoods and our backyards. This gives you unparalleled insight into what works and to what doesn't. We are here today to learn from you, to take the lessons that you have learned from your cities and towns, and try to transport them across the entire country.

Let me just say I first became aware of the scope of this addiction and the scope of this problem as a prosecutor in local communities in Massachusetts, finding young men and women that were breaking into 15 cars in a night, five, six homes over the course of the weekend, undercover agents that were putting themselves at great risk to try to keep our communities safe. So for those of you in law enforcement that are here, I look forward to hearing your ideas. From those folks back home that I have talked to, they have profound recognition that we will not arrest our way out of this problem, but very much look forward to hearing your solutions as to what we can do going forward, and I yield back my time.

Mr. MURPHY. I thank the gentleman for yielding your time. You are all done on your side? All right. Thank you.

What we are going to do is, I am going to swear in the witnesses and then I am going to ask members who invited witnesses to introduce each one of you briefly, and hopefully we will get your testimony done before votes because we do want to hear from you and ask questions.

So you are all aware that the committee is holding an investigative hearing, and when doing so has the practice of taking testimony under oath. Do any of you have any objections to giving testimony under oath? Seeing no objections, the chair then advises you that under the rules of the House and the rules of the committee, you are entitled to be advised by counsel. Do any of you desire to be advised by counsel during your testimony today? No one indicates they want counsel, so in that case, if you would all please rise and raise your right hand, I will swear you in.

[Witnesses sworn.]

Mr. MURPHY. You may sit down. All the witnesses have indicated in the affirmative. You are under oath and subject to the penalties set forth in Title XVIII, Section 1001 of the United States Code.

We will call upon you each to give a 5-minute summary of your written testimony. We will start off with Mr. Fred Wells Brason, and Mr. Hudson of North Carolina will introduce the witness.

Mr. HUDSON. Thank you, Mr. Chairman.

I am pleased today to introduce Fred Wells Brason, a former hospice chaplain, now President and CEO of Project Lazarus from my home State of North Carolina. Mr. Brason has had tremendous success in saving lives from opioid overdoses, and I look forward to hearing his testimony and learning from his great work.

Mr. MURPHY. Mr. Brason, you are recognized—is it Brason or Branson?

Mr. BRASON. Brason.

Mr. MURPHY. Mr. Brason, you are recognized for 5 minutes. Turn the mike on, pull it close to you, watch the red light. That will tell you when you are done. Thank you.

STATEMENT OF FRED WELLS BRASON, II, EXECUTIVE DIRECTOR, PROJECT LAZARUS, MORAVIAN FALLS, NORTH CAROLINA; DR. SARAH T. MELTON, PHARMD, BCPP, BCACP, CGP, FASCP, ASSOCIATE DIRECTOR OF PHARMACY PRACTICE, GATTON COLLEGE OF PHARMACY AT EAST TENNESSEE STATE UNIVERSITY, JOHNSON CITY, TENNESSEE, AND CHAIR OF THE BOARD OF DIRECTORS OF ONECARE OF SOUTHWEST VIRGINIA, BRISTOL, VIRGINIA; STEFAN R. MAXWELL, M.D., ASSOCIATE PROFESSOR, PEDIATRICS, WVU SCHOOL OF MEDICINE, MEDNAX MEDICAL GROUP, MEDICAL DIRECTOR, NICU, WOMEN AND CHILDREN'S HOSPITAL, CHARLESTON, WEST VIRGINIA; RACHELLE GARDNER, CHIEF OPERATING OFFICER, HOPE ACADEMY, INDIANAPOLIS, INDIANA; VICTOR FITZ, CASS COUNTY, MICHIGAN, PROSECUTOR, AND PRESIDENT OF THE PROSECUTING ATTORNEYS ASSOCIATION OF MICHIGAN (PAAM), CASSOPOLIS, MICHIGAN; CORPORAL MICHAEL GRIFFIN, NARCOTICS UNIT SUPERVISOR—K9 HANDLER, SPECIAL INVESTIGATIONS DIVISION, TULSA POLICE DEPARTMENT, TULSA, OKLAHOMA; AND DR. CALEB BANTA-GREEN, SENIOR RESEARCH SCIENTIST, ALCOHOL AND DRUG ABUSE INSTITUTE, UNIVERSITY OF WASHINGTON, SEATTLE, WASHINGTON

STATEMENT OF FRED WELLS BRASON, II

Mr. BRASON. Thank you very much. Chairman Murphy, thank you for convening this and giving us the opportunity to share what is happening on the streets of our communities and our response to the issues that we encounter, and I am talking back to 2004 as a hospice chaplain realizing the medication issues that were happening in our community homes where families were stealing, sharing, and selling the medication of and with the patients.

Having addressed it that way and not having any solutions, we in Wilkes County, North Carolina addressed it from a public health perspective: this is our house, our community, and we need to fix it. And by doing that, we convened all the community sectors that we could, and working with each single one to derive a solution-based process from our schools to our law enforcement to our medical community to our prescribers, and in doing that, we created a public health model to sort of bring awareness to the issue but then also making sure that there is a balanced approach so that we are talking about prevention, intervention, and treatment across the spectrum. We do want to prevent the overdoses from occurring but we also want to ensure that patients can have access to care, receive the medication and the treatment that they are entitled to but receive it safely and appropriately, but then those individuals who do have and have developed a substance use disorder, disease of addiction and so forth, that they have a safety net so that they are not just pushed into the heroin or they are not pushed someplace else.

A community has to address all of those facets, and we began by addressing first community awareness and community education so that individuals receiving a prescription can take it correctly, store it securely, dispose of it properly, and never share. Unfortunately, those are common practices that go on in our community with the

right prescription for the right person but when it is in the home, the family is feeling like, well, it is OK because the doctor wrote it. Those are some of the public health reversals that we need to do. Then we work with our prescribing community to, you know, look at how to best manage chronic pain, how to manage acute pain, how to appropriately prescribe but then also how to assess patients, how to determine they are at risk, you know, possibilities, but then also looking within the community, and if there is a risk of something already has developed, who can I have the warm handoff to for the treatment that is necessary to them, whether it is an abstinence program, whether it is a medication-assisted treatment, whether it is a methadone or a buprenorphine or naltrexone. There isn't one treatment that works for everybody but there is treatment that works for everybody, so we have to make sure our communities have accessibility for all of that, and that is what we look for in our community and we are able to do that by education.

When I first mentioned methadone, I thought I was leaving North Carolina permanently. It was not a pleasant time. But after education and understanding of what treatment is and how the brain is affected when somebody has been using for a while, there has to be a stabilization. There has to be a bridge, and we have to be able to provide that to those who are in trouble.

But then as we address the prescribing community, then we also had to talk to our law enforcement, work with them on diversion techniques, the take-back programs, the permanent drop-offs for old meds in the home because in 2012, we did dispense 259 million prescriptions, which means we have accidental ingestion going on, especially among toddlers. So we have patients misusing, unfortunately overdosing. We have toddlers' accidental ingestion, unfortunately overdosing. We have families and friends sharing with unfortunate overdosing. We have recreational users going out for a good time and somebody having a pill for them dying from an overdose, and then we have those with substance use disorder dying from an overdose. Looking at all of those categories within our population groups, we have to address all population groups, all ages from a public health perspective to reverse the behaviors, the misconceptions, and the problems that arise from that but ensuring that those that need it can receive it, those that need treatment can receive it and have it.

So as we did that, then we looked at, you know, what treatments could we bring into the community, and then we introduced naloxone. The North Carolina Medical Board was the first medical board in the country to come forth with a position statement that best practice is supporting and having an available naloxone, especially co-prescribing that with a medication to those individuals who are at risk. A person at risk could just be released from jail or person. A person at risk could be receiving methadone for treatment or for pain. A person at risk could be receiving opioid medication for their pain or they have a previous history for substance use. So, there is a broad base for the naloxone. It just needs to be made available, and thankfully, out of the State of Virginia, they are putting forth a law that sort of mandates co-prescribing of naloxone to a person receiving extended release or long-acting opioid medication. It is a safety factor. It is not a treatment but it

is a rescue medication, and many of our communities now, especially Massachusetts, North Carolina and others, law enforcement are saving lives, and that is what is important to them. So it is a safety factor to do that.

But without a comprehensive approach, there is not any one single bullet, there is not any one single thing. It has to be everything and it has to be all of us in order to drive the change from a public health perspective and have best practice from the individual to the prescribers, to the emergency departments, and everybody in between to accomplish that.

Thank you for your time.

[The prepared statement of Mr. Brason follows:]

U.S. HOUSE OF REPRESENTATIVES COMMITTEE ON ENERGY AND COMMERCE**Hearing on “Examining the Growing Problems of Prescription Drug and Heroin Abuse: State and Local Perspectives.”****Testimony: Fred Wells Brason II, President/CEO Project Lazarus**

SUMMARY: Project Lazarus is a public health, nonprofit organization established as a response to extremely high mortality rates due to prescription medications in Wilkes County, NC, which had the third highest overdose death rate in the nation in 2007; 46.6 per 100,000 pop., according to the Centers for Disease Control and Prevention. In order to effectively target overdose deaths in Wilkes, the Project Lazarus Model, a public health model based on the twin premises that prescription medication overdose deaths are preventable and that all communities are responsible for their own health, was devised and implemented for prevention, intervention, and treatment.

- *Prevent opioid related sedation and drug overdoses*
- *Present responsible pain management*
- *Promote substance use treatment and support services*

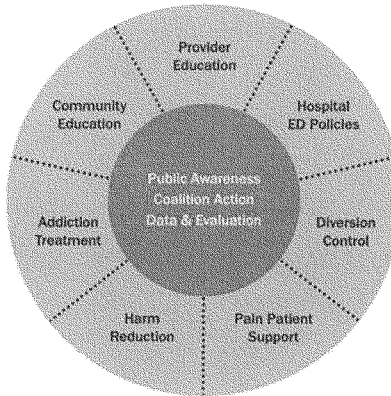
The overdose mortality rate decreased to 29.0 per 100,000 pop. in 2010 and to 14.4 per 100,000 pop. by 2011 after implementation of the Project Lazarus Model. This indicates a 69% drop within two years. Wilkes scripts related to overdose in 2008 were at 82% and decreased to 0% in 2011, substance use ED visits were down 15.3 %, opioid treatment program admissions were at 0 in 2010, but in 2014 were at 400+, and the community widely began accepting medication assisted treatment to the extent that local Wilkes churches are supporting individuals in treatment.

After the success in Wilkes, Project Lazarus began expanding statewide into all 100 NC counties. With the expansion through collaborative partners and funders (Kate B. Reynolds Trust, NC Office of Rural Health, Community Care of NC, Mountain Area Health Education

Center, and Project Lazarus) counties statewide are implementing the Project Lazarus Model to address the issues surrounding prescription medications. Once a coalition is established and completed the necessary Project Lazarus training, communities will be able to operate and sustain their coalition based on the Project Lazarus Model.

To date, Project Lazarus has been involved in the implementation of legislation, programs, and county coalitions across NC, various US community and state projects (FL, IN, KY, MD, MI, NJ, NM, OK, PA, TN, UT, VA, WV, and others), Tribal Groups, and the US Military (Operation OpioidSafe, which reduced overdose deaths among soldiers within the Warrior Transition Unit from 15 out of 400 to 1 out of 400 in first year of implementation).

Project Lazarus enables overdose prevention by providing training and technical assistance to create and maintain community coalitions, as well as capacity building for existing coalitions in the foundation of locally tailored drug overdose prevention programs and connecting coalitions to state and national resources. Project Lazarus also assists in the provision of access to naloxone, the overdose rescue medication, to those at risk of an overdose or to family and friends who have a loved one at risk. Lazarus Recovery Services has been launched to provide community based peer support for those currently using or seeking recovery and/or treatment.



The Project Lazarus Model provides a bottom-up approach coupled with top-down policy, practice, and initiative changes, including promotion and support from State / Federal levels.

- I. **Public Awareness** is important because there are widespread misconceptions about the risks of prescription medication misuse and abuse. It is crucial to build public identification of prescription medication-related respiratory depression causing overdose as a community issue and that overdose is common, as well as preventable.

- Identify issue at local level
- Broad-based outreach- all population groups

Federal and State programs for awareness by ONDCP, SAMHSA, HRSA, Offices of Rural Health, Department of Health and Human Services.

- II. **Coalition Action-** A functioning coalition should exist with strong ties and support from each of the key sectors in the community, along with a preliminary base of community

awareness on the issue. Coalition leaders should have a strong understanding of what the nature of the issue is in the community and what the priorities are on how to address it.

➤ Community Sectors- answering the questions, providing best practice solutions

- Why am I needed?
- What do I need to know?
- What needs to be done?

Federal and State initiatives by ONDCP and SAMHSA with Drug Free Community Support Program grants, SAMHSA with Strategic Prevention Framework-Partnerships for Success (SPF-PFS) grants, and Block Grant Funding.

- III. **Community Education** efforts are those offered to the general public and are aimed at changing the perception and behaviors around sharing prescription medications and improving safety behaviors around their usage, storage, and disposal.

Prescription Medication: “Take Correctly, Store Securely, Dispose Properly, and Never Share. TM”

- IV. **Data and Evaluation** to ground a community’s unique approach in their locally identified needs and improve interventions. It is very important to provide local data information in as real time reporting as possible.

Federal CDC and State Public Health working jointly for aligned data analysis and effective reporting. Assistance needs to be provided to states for data collaboration among various state agencies to share the data information in order for local communities to access and evaluate outcomes.

V. **Prescriber Education**-Toolkit is taught through local office lunch-and-learns, CME events, grand rounds, and medical management meetings.

➤ Key components:

- Opioids in the management of chronic pain
- Patient assessment and management
- Opioid overdose prevention- co-prescribing of rescue medication, naloxone
- Prescriber & patient education materials, resources, and referral mechanisms
- Screening forms and brief intervention
- Use of prescription drug monitoring programs
- 49 States have prescription drug monitoring programs in various stages of operation or establishing.

SAMHSA has provided the Overdose Prevention Toolkit for best practice for the prescribing community and other sector groups, such as law enforcement and first responders. National organizations are publishing responsible pain practice and prescribing material: AMA, Federation of State Medical Boards, State Medical Boards, Professional Academies, etc.

<http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit-Updated-2014/SMA14-4742>

FDA has approved medications with labeling indicating abuse deterrent properties that collectively are expected to reduce abuse via intranasal, intravenous, and oral routes. These should be readily available and indicated as preferred in order to further reduce medication manipulation for abuse.

<http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=bfdfe235-d717-4855-a3e8-a13d26da4ede>

http://www.accessdata.fda.gov/drugsatfda_docs/label/2014/205777lbl.pdf

<http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=a7658a2d-b7a9-4fb5-8d65-a20ca1b9ad1f>

<http://dailymed.nlm.nih.gov/dailymed/drugInfo.cfm?setid=b7d23ac2-e776-9f62-3290-e64e2d6eb353>

VI. **Hospital Emergency Department (ED) Policies-** it is recommended that hospital ED's develop a system-wide standardization with respect to prescribing narcotic analgesics as described in the Project Lazarus Toolkit for managing patients with pain.

- Embedded ED case manager
- "Frequent fliers" for chronic pain: non-narcotic medication and referral
- No refills of controlled substances
- Use of prescription drug monitoring programs
- Limited dosing (10 tablets)

Emergency Administration Policy changes worked with system wide acceptance and implementation occurring within hospital networks.

VII. **Diversion Control** is supporting and educating individuals on prescription medication: "Take Correctly, Store Securely, Dispose Properly, and Never Share. TM"

- Providing law enforcement, pharmacist, and facility training on forgery, methods of diversion, and drug seeking behavior.
- Supporting and providing medication take back events, and placement of permanent disposal containers within law enforcement, pharmacies, hospitals, and clinics.

DEA provided new policy October 2014 to allow for retail pharmacies, hospital and clinic based pharmacies, long term care facilities, and narcotic treatment programs to begin to take back controlled substances providing further pathways for proper disposal and less medications within communities.

http://www.deadiversion.usdoj.gov/fed_regs/rules/2014/2014-20926.pdf

VIII. **Pain Patient Support-** In the same way that prescribers benefit from additional education on managing chronic pain, the complexity of living with chronic pain makes supporting community members with pain important.

- Proper medication use and alternatives. “Take Correctly, Store Securely, Dispose Properly, and Never Share. TM”
- Alternatives: health and wellness, music, breathing, physical therapies, acupuncture, yoga, exercise, etc.

IX. **Naloxone/Harm Reduction** overdose prevention and intervention-it is a rescue medication for reversing overdose.

- Increasing access to naloxone for community, patients, military and tribal groups, individuals, family members, law enforcement, and first responders is one component of a broader approach to help reduce opioid-related morbidity and mortality.
- Distributing a script that gives patients specific language they can use with their family/caregiver to talk about overdose and develop an action plan, similar to a fire evacuation plan.
- Determined at-risk factors of opioid respiratory depression and overdose if there is a combination of prescription opioids with any of the following:

- Smoking, COPD, emphysema, asthma, sleep apnea, or other chronic respiratory disease
- Renal dysfunction or hepatic disease that may interfere with opioid metabolism or elimination from the body.
- Known or suspected concurrent substance use, including alcohol use
- Concurrent benzodiazepine prescription
- Concurrent anti-depressant prescription
- Recent emergency medical situation for opioid poisoning and/or intoxication
- Suspected history of illicit or non-medical opioid use
- Prescription for a high dosages of opioids
- Methadone prescription (specifically, opioid naïve patients)
- Use of an extended release or long-acting opioid preparation
- Recent release from incarceration
- Recent release from an opioid detox or mandatory abstinence program
- Enrolled in a methadone or buprenorphine detox and/or maintenance program for addiction or pain
- Voluntary request from patient or family member
- Difficulty accessing EMS due to distance, remoteness, etc

Federal ONDCP and SAMHSA have been leading the way for promotion and availability of naloxone to those who are at risk for overdose. It is essential that naloxone be available across all community sectors reaching all those potentially at risk.

In 2014, the FDA fast tracked approval of a new naloxone auto injector device providing a more streamlined availability that is specifically FDA approved for use outside medical settings by

family members or caregivers versus the off-label combination of a prefilled syringe and the application of a nasal atomizer. The traditional draw and inject intramuscular administration remains available as the least expensive and is widely provided heroin using populations, but requires training on preparation and administration. Hindrances remain due to lack of broader acceptance among Medicaid, CMS, and private insurers, though within Department of Defense and Veterans Administration, it is covered. There is a possible increase in funding for naloxone within the 2015/2016 Federal budget that needs to be appropriated.

National medical and law enforcement organizations have published best practice and position statements indicating the need to have and provide naloxone to those at risk of potential opioid related sedation and drug overdose.

Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis.

OPEN ACCESS Alexander Y. Walley assistant professor of medicine, medical director of Massachusetts opioid overdose prevention pilot 1 3, Ziming Xuan research assistant professor 2, H Holly Hackman epidemiologist 3, Emily Quinn statistical manager 4, Maya Doe-Simkins public health researcher 1, Amy Sorensen-Alawad program manager 1, Sarah Ruiz assistant director of planning and development 3, Al Ozonoff director, design and analysis core 5 6

BMJ 2013;346:f174 doi: 10.1136/bmj.f174 (Published 31 January 2013) Zedler, B., Xie, L., Wang, L., Joyce, A., Vick, C., Kariburyo, F., Rajan, P., Baser, O. and Murrelle, L. (2014), Risk Factors for Serious Prescription Opioid-Related Toxicity or Overdose among Veterans Health Administration Patients. *Pain Medicine*, 15: 1911–1929. doi: 10.1111/pme.12480

Substance Use Disorder/Addiction treatment, especially opioid agonist therapy like methadone, partial agonist buprenorphine treatment and naltrexone, has been shown to dramatically reduce overdose risk and provide for successful recovery. There is not one treatment that works for all, but there are sufficient treatments that work for all and they should be widely available, effectively covered with providers accepting reimbursement.

Unfortunately, access to treatment is limited by a few main factors:

- Acceptability, Availability and Accessibility of treatment options.
- Negative attitudes or stigma associated with addiction in general and drug treatment.
- Limited providers and limits on providers.

Hubbard, Jule. "Local Methadone Clinic Helps Reduce Rx Deaths." The Journal Patriot 12 Mar. 2014. Web. 24 Mar. 2015. <http://www.journalpatriot.com/news/article_dbd0f6e8-aa0c-11e3-8435-001a4bcf6878.html>.

Federal agency SAMHSA providing Grant to various States to increase Medication Assisted Treatment availability. <http://www.samhsa.gov/grants/grant-announcements/ti-15-007>

Mr. MURPHY. Thank you very much.

Now we are going to recognize Dr. Sarah Melton, and Mr. Griffith of Virginia is going to introduce you.

Mr. GRIFFITH. Thank you very much, Mr. Chairman.

I am glad to introduce Dr. Sarah Melton. Dr. Melton chairs OneCare of Southwest Virginia, a consortium of substance abuse coalitions attempting to turn the tide against substance abuse. She is an Associate Professor of Pharmacy at ETSU and most recently was appointed by Governor Terry McAuliffe to the Virginia Task Force on Prescription Drug and Heroin Abuse, an idea first proposed to the Governor by myself and others in the Virginia Congressional Delegation.

Dr. Melton has a long history of working to address the substance abuse problems in southwest Virginia. She was instrumental in bringing Project Lazarus to Virginia, and she is also working on the naloxone issues in southwest Virginia and in Virginia. I want to thank you, Dr. Melton, for being here today and sharing your experience with our committee.

Mr. MURPHY. Dr. Melton, you are recognized for 5 minutes.

STATEMENT OF SARAH T. MELTON

Ms. MELTON. Thank you, Mr. Chairman, and thank you, Congressman Griffith and the other members of the subcommittee.

During my testimony, I am going to address key areas related to state and local initiatives that are making an impact, and I will also address key areas where I feel the federal government can assist in these areas.

The first key area I will address is education of prescribers. As you are all aware, students and residents in healthcare professions have limited exposure to curricula in identifying and treating substance use disorders and appropriate prescribing and dispensing of controlled substances for chronic pain, but in Virginia, we are working together to bring leaders from all healthcare schools together to assure that our prescribers and dispensers of controlled substances have received an adequate education on addiction and the treatment of chronic pain.

Overall, more funding is needed from the federal level to provide expanded graduate medical education opportunities for training in the identification, referral, and treatment of substance use disorders. As changes in federal funding allocated for graduate medical education are currently being discussed, it is an opportune time to assess how funding can best address training in addiction medicine.

Tennessee has a mandated annual continuing education requirement for prescribers. Virginia, however, does not have that. OneCare of Southwest Virginia has joined with the Medical Society of Virginia and the Virginia Department of Health to provide no-cost continuing medical education to all healthcare prescribers as well as dispensers. We have been able to educate over 2,000 prescribers and dispensers in the past 3 years. We are currently evaluating how that continuing education has changed prescribing habits, attitudes, and registration to the prescription drug monitoring program as well as other outcomes.

I wanted you to know that in January, a letter was sent directly from Secretary of Health and Human Services, Dr. Bill Hazel, to all prescribers in Virginia. The letter specifically addressed new legislation that requires prescribers to be monitored, to be registered in the prescription drug monitoring program, but it also talked about how to use the PMP programs in clinical practice. I am happy to report as a result of that letter, the prescription drug monitoring program registrations dramatically increased, and we are seeing a steady increase in inquiries to the PMP in the clinical setting. We are going to be sending a letter to all pharmacists in the Commonwealth in the next month.

With regard to access to naloxone, both Virginia and Tennessee have recently passed legislation that will provide wide access to this lifesaving medication, and OneCare has worked extensively with the Virginia Department of Behavioral Health and Developmental Services to train people across the Commonwealth through Project Revive. Last summer, Senator Tim Kaine attended one of those trainings in Lebanon, Virginia, and as a result of his training, he has introduced legislation through the Opioid Overdose Reduction Act to offer Good Samaritan protection for first responders. It is my hope that Congress will pass this legislation so that we have a consistent Good Samaritan protection across the Nation.

One barrier we are finding with naloxone, though, is the cost. It is not mandated by insurance companies to cover this medication, and it really should be.

With regard to treatment, medication-assisted treatments with methadone, buprenorphine, and naltrexone have become an essential component of a comprehensive treatment plan for opioid use disorders. The issue that we have now is that we need a modernization of federal law to further expand access to these lifesaving medications but we need specific best practice requirements and recommendations for prescribers and insurers such as Medicaid and Medicare to make sure that certain patients are receiving comprehensive care by competently trained healthcare providers. Also critical is reimbursement for parts of these programs such as urine drug screens and the necessary psychotherapy that accompanies the medication treatment.

With regard to monitoring with the prescription drug monitoring program, both Virginia and Tennessee are members of the National Association of Boards of Pharmacy Interconnect program, and I am very happy to find that the bill that will find NASPER is being proposed because the funding for that allocation will help all States be able to participate in a national prescription drug monitoring program. There is one concern I have, though. You may or may not know, a concern that we encounter daily in clinical practice is that methadone clinics are not required to report methadone dispensing to the prescription drug monitoring programs. This is a very serious situation because if these patients do not disclose this to their primary care providers and they don't know it when they access the prescription drug monitoring program, we often see other opioids being prescribed, benzodiazepines that can lead to death. So that is an issue of concern. And in contrast, buprenorphine, of course, is reported to the State prescription drug monitoring pro-

grams that allow us more monitoring for safety and appropriate use.

Thank you for the opportunity to testify and for your ongoing commitment to this epidemic across the United States.

[The prepared statement of Ms. Melton follows:]

**Testimony before the House Energy and Commerce
Oversight and Investigation Subcommittee
U.S. House of Representatives**

Hearing on

**“Examining the Growing Problems of Prescription Drug and Heroin Abuse:
State and Local Perspectives.”**

Statement of

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East Tennessee State University Gatton College of Pharmacy

March 26, 2015

INTRODUCTION

Chairman Murphy and members of the Subcommittee, thank you for this opportunity to examine the growing problems of prescription drug and heroin abuse from the state and local perspectives.

My name is Sarah Melton, and I chair One Care of Southwest Virginia.¹ One Care serves as a consortium of 16 substance abuse coalitions working throughout the 21 counties and cities in the southwestern region of the Commonwealth of Virginia. The 28-member Board of Directors includes representatives from community service boards, faith based organizations, social services, health care, higher education, law enforcement, business, and recovery communities. The One Care of SWVA Board operates collaboratively and has committed to undertaking a broad based strategic planning initiative - a blueprint for the control and mitigation of substance abuse and misuse in southwest Virginia facilitated by the Healthy Appalachia Institute and with the encouragement of the Southwest Virginia Health Authority, regional partners and elected officials.²

I serve as associate professor of pharmacy practice at the East Tennessee State University Gatton College of Pharmacy and am an active member of the Prescription Drug Abuse and Misuse Working Group.³ This working group is interdisciplinary and is doing extensive research and outreach in the areas of prescriber education, neonatal abstinence, and appropriate storage and disposal of controlled substances.

¹ One Care of Southwest Virginia; <http://www.onecareva.org/home> . Accessed March 21, 2015.

² One Care of Southwest Virginia. Blueprint for Substance Abuse and Misuse Prevention, Treatment and Control. August 2011. Available at <http://www.appalachianaware.org/uploads/content/201107281627076950.pdf> Accessed March 21, 2015.

³ East Tennessee State University Prescription Drug Abuse and Misuse Working Group; <http://www.etsu.edu/cph/pdam/> . Accessed March 21, 2015.

I serve on the Virginia Task Force on Prescription Drug and Heroin Abuse established by Governor Terry McAuliffe in September 2014. I serve as co-chair of the Education Subcommittee and work closely with the other subcommittees of Treatment, Enforcement, Data and Monitoring, and Disposal. I am a board certified psychiatric pharmacist and work clinically with patients with the disease of addiction to heroin and prescription medications on a daily basis.

During my testimony, I will address key areas relating to state and local initiatives that are making an impact in the area of heroin and prescription drug abuse. I will also address key areas where the federal government can assist in these areas.

EDUCATION OF PRESCRIBERS

Students and residents in healthcare professions often have limited exposure to curricula on identifying and treating substance use disorders. In addition, experiential clinical training on appropriate prescribing and dispensing of controlled substances is lacking. Inappropriate prescribing and an inability to identify patients at risk of substance abuse have played a tremendous role in the abuse of prescription medications and the development of substance use disorders. In Virginia, we are working together to bring leaders from schools of medicine, pharmacy, nursing, and physician assistants together to assure our prescribers and dispensers of controlled substances have received adequate education on addiction and treatment of chronic pain.

A recent comprehensive report by the National Center on Addiction and Substance Abuse (CASA) at Columbia University found that most doctors fail to identify or diagnose substance

abuse “or know what to do with patients who present with treatable symptoms.”⁴ Addiction is linked to more than 70 diseases or conditions and accounts for a third of inpatient hospital costs, according to CASA, but addiction medicine is rarely taught in medical school or residency training. This 5-year study found that, despite the prevalence of addiction, the enormity of its consequences, the availability of effective solutions and the evidence that addiction is a disease, both screening and early intervention for risky substance use are rare, and only about 1 in 10 people with addiction involving alcohol or drugs other than nicotine receive any form of treatment. Of those who do receive treatment, few receive anything that approximates evidence-based care. Overall, more funding is needed from the federal level to provide expanded graduate medical education opportunities for training in the identification, referral, and treatment of substance use disorders. As changes in federal funding allocated for graduate medical education is currently being discussed, this is an opportune time to assess how funding can best address training in addiction medicine. In addition, interdisciplinary training among health care providers is a necessity so that providers are not working in silos of care.

Tennessee has a mandated annual continuing education requirement on appropriate prescribing. Virginia does not have this requirement, and multiple attempts to have this requirement legislated have failed. However, One Care of Southwest Virginia joined with the Medical Society of Virginia and the Virginia Department of Health to provide no-cost continuing medical education to over 2,000 prescribers and dispensers over the past 3 years. Topics for education include universal precautions when prescribing controlled substances, the prescription drug monitoring program, neonatal abstinence syndrome, and opioid risk, evaluation and

⁴ CASAColumbia. Addiction Medicine: Closing the Gap between Science and Practice. Published June 2012. Available at <http://www.casacolumbia.org/addiction-research/reports/addiction-medicine>. Accessed March 21, 2015.

mitigation strategies. We are evaluating data on changing of prescribing habits and attitudes, registration to the prescription monitoring program, and other outcomes at this time.

In Virginia, a letter was sent directly from Secretary of Health and Human Services, Dr. William Hazel, to all prescribers in January of 2015. The letter specifically addressed new legislation requiring prescribers to be registered with the prescription monitoring program (PMP) in 2016. However, the letter also provided education about the prescription monitoring program and how it should be integrated into clinical care. As a result of that letter, prescription drug monitoring program registrations dramatically increased, and we are seeing a steady increase in inquiries for PMP reports being used in the clinical setting. A similar letter to all pharmacists will be sent in the next month.

Access to Naloxone

Naloxone is a medication called an “opioid antagonist” that is used to counter the effects of opioid overdose. Naloxone is used in opioid overdoses to counteract life-threatening depression of the central nervous system and respiratory system, allowing an overdose victim to breathe normally. Naloxone works only if a person has opioids in their system; the medication has no effect if opioids are not present. Naloxone can be administered by minimally trained laypeople, making it ideal for treating overdose in people who have overdosed on prescription opioids or heroin in the community. Naloxone has no potential for abuse.

Both Virginia⁵ and Tennessee⁶ have recently passed legislation that provides for widespread access to naloxone for lay rescuers. The legislation provides Good Samaritan

⁵ Commonwealth of Virginia, HB 1458. Naloxone or other opioid antagonist; pharmacist may dispense in cases of opiate overdose. Available at <http://lis.virginia.gov/cgi-bin/legp604.exe?151+sum+11B1458> Accessed March 21, 2015

protection in the form of immunity from civil liability for licensed healthcare practitioners who prescribe or dispense naloxone or any person who administers naloxone in good faith belief that the other person is experiencing an opioid related drug overdose, and the person exercises reasonable care in administering the naloxone.

One Care has worked extensively with the Virginia Department of Behavioral Health and Developmental Services to provide training on the appropriate administration of naloxone to lay rescuers through Project REVIVE!⁷ Last summer, Senator Tim Kaine attended one of these trainings in Lebanon, Virginia. As a result of his training, Senator Kaine introduced legislation through the *Opioid Overdose Reduction Act* of 2015 to offer the same kind of “Good Samaritan” protection to protect first responders, health professionals, and family members who are educated in administering overdose prevention drugs from being sued.⁸ It is my hope that Congress will pass this legislation in order to provide consistent “Good Samaritan” protection across the nation. This legislation will allow naloxone to be used to save as many lives as possible from opioid overdose while limiting fears of civil liability.

A barrier we have encountered in providing naloxone to lay rescuers is the cost associated with obtaining the medication. While some insurance companies will cover the cost of naloxone, the majority do not. Mandatory coverage of this life-saving medication through all prescription insurance plans would allow this medication to reach key populations at risk.

⁶ State of Tennessee, Public Chapter No. 623, Senate Bill No. 1631. Available at <http://state.tn.us/sos/acts/108/pub/pc0623.pdf> Accessed March 21, 2015

⁷ Project Revive! Available at <http://www.dbhds.virginia.gov/individuals-and-families/substance-abuse/revive> Accessed March 21, 2015

⁸ S.707 - Opioid Overdose Reduction Act of 2015, 114th Congress (2015-2016). Available at <https://www.congress.gov/bills/114th-congress/senate-bill/707/text> Accessed March 21, 2015

TREATMENT

The Substance Abuse Prevention and Treatment Block Grant funds treatment services for indigent people. However, the funding is not sufficient to address the prescription drug epidemic in Tennessee and Virginia. It is recommended that additional funding be allocated to fund treatment services for the uninsured, undersinsured, and indigent populations.

Medication-assisted treatments with methadone, buprenorphine, or naltrexone have become an essential component of a comprehensive treatment plan for opioid use disorders, allowing patients to regain control over their health and lives. The Substance Abuse and Mental Health Services Administration (SAMSHA) has published evidenced-based guidelines on the use of these medications to treat opioid addiction.⁹ The development of buprenorphine and its authorized prescribing from physicians' offices has expanded access to treatment dramatically, especially in remote and rural areas of the country. However, modernization of federal law is needed to further expand access to these life-saving treatments prescribed by trained prescribers, to decrease stigma associated with medication-assisted treatment, and to promote research on best-practices when these medications are prescribed. More specific best-practice requirements and recommendations are needed for prescribers and insurers, including Medicaid and Medicare, to make certain patients are receiving comprehensive care by competently trained healthcare providers. Also critical is provision of reimbursement for the provision of essential components of the comprehensive treatment plan including psychotherapy and urine drug screening.

Women with children need specialized treatment services tailored to meeting their needs as well as the needs of their children. These services include a full continuum of treatment

⁹ Center for Substance Abuse Treatment. *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*. Treatment Improvement Protocol (TIP) Series 43. DHHS Publication No. (SMA) 12-4214. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2005.

services as well as other wraparound services to assist mothers in caring for their children. These services include safe drug-free housing and aftercare services to ensure recovery is maintained and support is offered when required. While some services are being offered to meet the needs of this specialized population, there is still considerable unmet need.

MONITORING

The prescription drug monitoring programs (PDMPs) collect data from pharmacies on dispensed controlled substance prescriptions and make it available to authorized users through a secure, electronically accessible database. Research strongly suggests that PDMPs serve essential functions in combating the prescription drug abuse epidemic through identifying major sources of prescription drug diversion such as prescription fraud, forgeries, doctor shopping, and improper prescribing and dispensing. PDMPs have become essential tools in patient care by providing providers with information is crucial for providing good medical care and ensuring patient safety. Both Virginia and Tennessee participate with the National Association of Boards of Pharmacy InterConnect Program.¹⁰ This program facilitates the transfer of PDMP data across state lines to authorized users. It allows participating state PMPs across the United States to be linked, providing a more effective means of combating drug diversion and drug abuse nationwide. Allocation of federal funding to help achieve participation from all states with PDMP programs to achieve a national PDMP program should be considered.

A concern encountered daily in clinical practice is that methadone treatment facilities are not required to report dispensing of methadone to prescription drug monitoring programs. Therefore, patients receiving methadone for an opioid use disorder who do not disclose this to

¹⁰ National Association of Boards of Pharmacy InterConnect Program. Available at <http://www.nabp.net/programs/pmp-interconnect/nabp-pmp-interconnect> Accessed March 21, 2015

their other health care providers are at risk of receiving other medications that may interact with methadone and cause significant toxicity or death. Federal regulations at 42 CFR Part 2 concern the confidentiality of alcohol and drug abuse treatment records.¹¹ Section 2.1 states "records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any drug abuse prevention function conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall, except as provided in subsection (e) of this section, be confidential and be disclosed only for the purposes and under the circumstances expressly authorized under subsection (b) of this section." In contrast, buprenorphine dispensed for opioid dependence is reported to the state PDMP programs, which allows better monitoring for safety and appropriate use.

DISPOSAL AND STORAGE

In recent years, the topic of pharmaceutical waste has become a public health issue of increasing urgency. The Drug Enforcement Administration (DEA), Environmental Protection Agency (EPA), Centers for Medicare and Medicaid Services (CMS), and Food and Drug Administration (FDA) have all taken steps to address pharmaceutical waste in both the community and institutional settings. However, these efforts have not been coordinated and have in some cases conflicted with one another.

Tennessee and Virginia have made great strides in bringing stationary disposal units to many locations across the states. Increased federal funding made available to states in order to place a stationary disposal unit in each county would be optimal. However, we are encountering significant barriers associated with the disposal of the medications placed in these stationary

¹¹ Electronic Code of Federal Regulations, 42 CFR Part 2. Available at <http://www.ecfr.gov/cgi-bin/text-idx?c=ecfr&sid=3b047bc10bbce7b3854b2e4067207222&rgn=div8&view=text&node=42.1.0.1.1.2.1.1.1&idno=42>. Accessed March 21, 2015

units. There are very high costs associated with incineration of the medication wastes often associated with air-quality control measures mandated by the EPA. In October, the U.S. Drug Enforcement Administration (DEA) finalized rules for the Secure and Responsible Drug Disposal Act of 2010¹² that allow hospitals and pharmacies to be collectors; however, there is no funding for this. During the same time period, the DEA ended sponsorship of its highly successful medication take-back events.

CONCLUSION

Those of us who work in addiction medicine and mental health will continue to work with our local, State, and Federal partners to continue to prevent and reduce the devastating consequences of prescription drug and heroin abuse. There is tremendous work being done on the local and state levels that is clearly making a difference, but we have a tremendous amount of hard work in front of us to end this epidemic. Thank you for the opportunity to testify and for the subcommittee's ongoing commitment to address this public health crisis.

Additional Resources of Information: Prescription for Success: Statewide Strategies to Prevent and Treat the Prescription Drug Abuse Epidemic in Tennessee¹³ and National Governors Association Policy Academy: Virginia Prescription Drug Abuse Reduction Plan¹⁴

¹² Department of Justice, Drug Enforcement Administration, 21 CFR Parts 1300, 1301, 1304, 1305, 1307, and 1317 [Docket No. DEA-316] RIN 1117-AB18. Disposal of Controlled Substances. Available at http://www.deadiversion.usdoj.gov/fed_regs/rules/2014/2014-20926.pdf. Accessed March 21, 2015

¹³ Prescription for Success: Statewide Strategies to Prevent and Treat the Prescription Drug Abuse Epidemic in Tennessee. Available at <http://tn.gov/mental/prescriptionforsuccess/>. Accessed March 21, 2015

¹⁴ National Governors Association Policy Academy: Virginia Prescription Drug Abuse Reduction Plan. Available at https://www.dhp.virginia.gov/dhp_programs/pmp/docs/PrescriptionDrugAbuseReductionPlan.pdf. Accessed March 21, 2015

Mr. MURPHY. Thank you.

Now I am going to recognize the vice chair of the subcommittee, Mr. McKinley, to introduce Dr. Maxwell.

Mr. MCKINLEY. Thank you, Mr. Chairman.

Dr. Stefan Maxwell is a neonatalist in Charleston, West Virginia, caring for the sickest of the newborns for the past 30 years. He is Chairman of the West Virginia Perinatal Partnership, which focuses on reducing the number of babies born who are exposed to drugs. A study in this topic in 2009 revealed that 20 percent, one in five, babies born in West Virginia were exposed to a substance during the pregnancy.

Dr. Maxwell's work in the Perinatal Partnership in West Virginia has led to great strides in finding ways to identify women in need of drug treatment counseling and reduce the number of babies born exposed to drugs. His leadership as Chairman of the Perinatal Partnership and the Committee on Substance Abuse in Pregnancy, a member of the West Virginia Governor's Advisory Council on Substance Abuse, and caring for sick babies at Charleston Area Medical Center has made him a leading expert on this topic.

Thank you, Dr. Maxwell, for attending here today and providing us your experiences.

Mr. MURPHY. Doctor, you are recognized for 5 minutes.

STATEMENT OF STEFAN R. MAXWELL

Dr. MAXWELL. Thank you Congressman McKinley and thank you, Mr. Chairman for the opportunity. It is pretty humbling to be asked to speak with such an august group, but hopefully this testimony will help us in your quest to quell this rising tide that is a scourge in our Nation.

I have had the opportunity to take care of these babies that are suffering from neonatal abstinence syndrome, and so at the time back in 2006 when the West Virginia Perinatal Partnership was established, their mission was to look at areas that we could improve the health of mothers and babies in West Virginia, and at the time when all of the providers got together in a room, we decided that substance abuse in pregnancy or substance usage in pregnancy was an issue that we had to address, mainly because at the time, these babies that had neonatal abstinence syndrome were taking up most of the beds in the ICU, and level III institutions could not accept sick, small, premature babies from outlying institutions. Some of them had to be transported out of the State.

So at the time, we really were not understanding the whole impact of what was happening in the State. So I missed a meeting and became chairman of the substance abuse committee, I have to say, and I was given that responsibility, and over the ensuing 3 years or so, we tried to figure out what was the prevalence of this problem in our State, and so we embarked upon the umbilical cord tissue study, which looked at eight hospitals through the State, scattered throughout the State. We collected as many umbilical cord tissue samples as we could as sort of a pilot over a month-long period. We ended up collecting almost 800 samples, and then we realized that one in five of those samples was positive for a substance, many of them being polydrug abusers, which included opiates, marijuana, and so forth.

So this was obviously a daunting problem, and so at the Perinatal Partnership we decided to try to be proactive rather than reactive, and by that, I mean we wanted to see if we could reduce the numbers of babies with neonatal abstinence or at least reduce the severity of the neonatal abstinence syndrome at the end of the pregnancy. So we embarked upon a project that we called the Drug-Free Mothers and Babies Project whereby we sent out requests for proposals, got four or five in, and now have established four or five programs that are in the process. The aspects of this project are, one, we screen all women at the first antenatal visit, whether we do it using biological specimens like urine or we do it with screening tools such as what we call SBIRT screening, brief intervention, referral, and treatment. And then once we have identified a woman, a pregnant woman, who is using an opiate specifically, we then refer them to an addiction counselor and behavioral medicine, and try to follow them throughout that pregnancy with a goal to reducing or first of all converting the substance they are using to another drug that we can probably wean throughout the pregnancy with a goal to reducing the amount of drug that the baby is exposed to during the pregnancy and ultimately get them either off the drug or on a very small dose so that the severity of neonatal abstinence would be that much reduced.

Well, one of those programs has been operating now for about 2 years, and we have had great success with one of those programs, reducing their incidence of 19 percent of positive umbilical cord tissue samples at birth to 8 percent, which means that the cost associated with neonatal abstinence has been significantly reduced. We have also been following these ladies who have been in the program for up to a year. We don't have 2 years' worth of follow-up yet, but the goal is to follow them at home for the first 2 years after delivery and reinforce that behavioral modification that went on throughout the pregnancy.

The ultimate goal if this is a successful program is to develop what we call a pay-for-success program, whereby we can now try to save the government money in the long run by having an investor fund these programs, have an independent entity such as the Partnership administer the program with an independent audit, and at the end hopefully show that we have reduced the cost and ultimately improved the lives of these people that are ravaged by this terrible disease.

Thank you for the opportunity, Mr. Chairman.

[The prepared statement of Dr. Maxwell follows:]



**Testimony to the Subcommittee on Oversight and Investigations
of the
Energy and Commerce Committee
March 26th 2015
Hearing on " Examining the Growing Problems of Prescription Drug and Heroin Abuse:
State and Local Perspectives"**

Stefan R. Maxwell, MD
Chair, West Virginia Perinatal Partnership
MEDNAX Medical Group,
Director NICU, Charleston Area Medical Center
Charleston, West Virginia.

Mr. Chairman,
Honorable Members of the Committee,
Ladies and Gentlemen;

Thank you for the opportunity to provide testimony to this subcommittee. It is an honor and a privilege to be asked to testify here today, and I hope my testimony will be of some assistance in your quest to quell the rising incidence of substance abuse, specifically opioid abuse, that is ravaging our country, especially in the perinatal population. West Virginia continues to experience some of the highest rates of substance use and abuse in the country. In 2010, West Virginia had the highest rate of overdose deaths in the country (CDC data 2010). Additionally, from 2001 to 2010 there was a 214 percent increase in the number of prescription drug overdoses in West Virginia. According to the most recent report by the West Virginia Maternal and Infant Mortality Review Team, 27 percent of maternal mortality in this state from 2007 to 2012 was a result of drug abuse.

A project of the West Virginia Higher Education Policy Commission, Division of Health Sciences

1018 Kanawha Boulevard, Unit, Suite 1100, Charleston, West Virginia 25301, Tel: 304.528.0530 x. 5 Fax: 304.558.0572

In 2006, the West Virginia Perinatal Partnership was established to work toward the improvement of perinatal health in West Virginia. The Partnership coordinates programs and develops policies to address the State's health outcomes among mothers and their babies and consists of health care professionals (neonatologists, pediatricians, maternal-fetal specialists, obstetricians, nurses, social workers, behavioral health care providers) and state and local health policymakers. We were charged with identifying key problem areas that needed to be addressed in order to improve the health of mothers and babies in West Virginia. Substance use in pregnancy and its effects on the fetus and newborn was one of eight areas of concern highlighted by the Partnership. I was elected Chairman of the Committee on Substance Use in Pregnancy, and subsequently Chairman of the Perinatal Partnership, hence my presence here today.

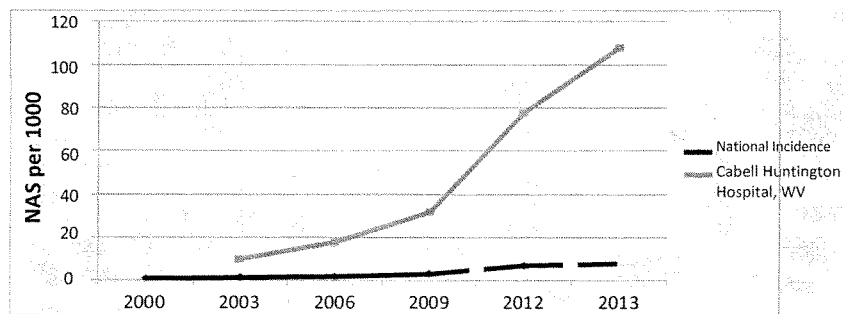
Over the past 9 years our Partnership has taken the following steps to address this issue of substance use in pregnancy:

Firstly, we conducted a pilot study in August 2009 using de-identified cord tissue specimens from 759 babies from 8 hospitals throughout the state. These specimens were analyzed by the US Drug Testing Laboratory and determined that 19% were positive for a significant substance, such as marijuana, opioids or alcohol. Most were positive for more than one substance (*West Virginia Medical Journal*, Stitley, et al <http://www.wvsma.com/Portals/0/SubstanceAbuse10.pdf> pp. 48-52). We have subsequent evidence that the incidence has continued to escalate ever since, and that the rates of Neonatal Abstinence Syndrome (NAS) have risen exponentially over the past 5 years or so (see chart below). NAS is withdrawal that occurs in infants with *in utero* exposure to certain addictive substances such as opiates. The affected babies may be born prematurely, low birth weight, have

feeding difficulties, irritability, seizures and experience significantly longer hospital stays.

Withdrawal symptoms develop shortly after birth. Symptoms exhibited are loud, high-pitched crying, sweating, tremors, yawning and gastrointestinal and respiratory difficulties.

We also know that the opioids being used have changed over the years, from prescription painkillers (oxycodone, hydrocodone, Norco, Percocet) to the increased usage of heroin. This change may have resulted from policies that the Governor's Advisory Council on Substance Abuse (est. by Gov. Earl Ray Tomblin in 2012) have implemented in regards to pharmaceutical tracking of prescriptions and identification of prescribers and dispensers which resulted in making prescription drugs less easily available.



Secondly, we believe that pregnancy offers a unique opportunity for treating substance abuse as a woman's healthcare issue, before it becomes a newborn's substance exposure issue.

Regard for the welfare of her baby is a powerful driving force to help a pregnant woman make positive decisions for her own health and the future of her infant. Pregnant women are typically

highly motivated to modify their behavior in order to help them deliver a healthy baby. Also the obstetrical provider is in a key position to oversee the screening, early diagnosis, counseling and initiation of treatment of pregnant women who use these substances. The pregnant woman and her family will benefit from factual, non-judgmental information about the maternal and fetal risks of substance use, and counseling about options that will ultimately assist in the weaning and cessation of substance use. We also know that these women may not seek prenatal care because of fear, guilt, shame, as well as concerns about any legal consequences. The removal of these barriers is a key part of our efforts.

In response to the results of the umbilical cord study revealing the high rate of substance use in pregnancy, the WV Perinatal Partnership initiated the "Drug Free Mothers and Babies" project in 2012. This project is a comprehensive and integrated medical and behavioral health program for pregnant and postpartum women. The project supports healthy baby outcomes by providing prevention, early intervention, addiction treatment, and recovery support services. This three-year project is supported through funding from the West Virginia Department of Health and Human Resources, Bureau for Behavioral Health and Health Facilities, the WV Office of Maternal, Child and Family Health, and the Claude Worthington Benedum Foundation.

Key aspects of the Drug Free Moms and Babies Project include:

- Screening, Brief Intervention, Referral and Treatment (SBIRT) services integrated in maternity care clinics;
- Collaboration with community partners for the provision of comprehensive medical, behavioral health, and social services;

- Long term follow up for two years after the birth of the baby provided by a recovery coach. In addition, home visits and other services to help women maintain sobriety and access needed resources are provided;
- Program evaluation of effective strategies for identifying women in need, preventing addiction and abuse, treating women with substance abuse problems, and recovery coaching services;
- Provider outreach education to other maternity care clinics in West Virginia to facilitate the duplication of successful model programs.

The Project is implemented in the following four pilot sites:

- Shenandoah Valley Medical Systems, Inc. – A federally qualified community health center located in Martinsburg, WV that serves a three county area in the Eastern Panhandle of the state. Its rural patient population comes from surrounding counties in West Virginia, Maryland and Virginia.
- Thomas Memorial Hospital – A private, non-profit community hospital located in South Charleston, WV that serves a twelve county area in the southwestern part of the state.
- Greenbrier Valley Medical Center – A small, rural hospital located in Ronceverte, WV that serves six West Virginia counties and one county in Virginia.
- West Virginia University Ob-Gyn Department – A large, tertiary care center located in Morgantown, WV that serves women from all over the state, as well as women from southwestern Pennsylvania, western Maryland, and eastern Ohio.

Though we are just a few years into the project, we have had some initial success using this model, and at least in one of these sites, we have reduced the percentage of positive cord tissue samples at birth from 19% to 8% (<http://www.wvperinatal.org/gvnc-drug-free-mother-baby-program-showing-results/>).

In addition to these four pilot sites the project is currently supporting a special research project on alcohol use in pregnancy. The program is located at Charleston Area Medical Center, Women and Children's Hospital in Charleston, WV. The high risk prenatal clinic of the hospital is evaluating the effectiveness of new testing methods to identify women using alcohol during pregnancy.

The WV Perinatal Partnership seeks to utilize the Drug Free Mom's and Babies model (an integrative and comprehensive approach to serving substance using pregnant and parenting women) for a Pay for Success (PFS) initiative. Under a PFS model, an investor finances the implementation of a "proven" or evidence-based social intervention program that is expected to improve social welfare and save government money in excess of the program implementation costs. The government repays the investment only after the program can measurably reduce state expenditures as a result of its successful implementation. Before embarking on this approach we are standardizing our definitions of NAS diagnosis among the providers in West Virginia in regard to coding, so that we can collect more accurate baseline data before implementing that initiative.

This subcommittee needs to be aware, however, that one of the significant barriers we have encountered includes the treatment of pregnant women on Methadone. Physicians are not

able to prescribe this medication for the treatment of drug addiction outside of a licensed Opioid Treatment Center, and we must therefore rely on the "methadone clinics" to provide the medication to their patients. This is done without consultation or facilitation with the patient's obstetric provider resulting in fragmented care of the pregnant woman for her pregnancy. Typically the methadone clinics will escalate the dosage of medication during pregnancy which increases the physical dependence of the pregnant woman on the drug and increases the withdrawal effects on the newborn. Some providers in West Virginia have sought certification for prescribing Buprenorphine as an alternative medication to be used during pregnancy in order to control their patients' dosing. They attempt to stabilize the patients on the lowest possible maintenance dose, thus reducing the severity of NAS in the infant at birth.

In West Virginia there are other unique barriers to addressing this population such as lack of transportation, child care, access to treatment services, judgmental attitudes and willingness of obstetric providers to care for these patients. Other states have similar barriers to successful management of the substance-using mother that also make the treatment of the mother and her fetus problematic.

There are many other projects and initiatives to address the rising problem of NAS and the care of these infants in our state. These include the establishment of Lily's Place in Huntington, WV (<http://www.lilysplace.org/>), which is modeled after the Pediatric Interim Care Center in Seattle, WA. This facility provides specialized temporary residential care for infants experiencing NAS, offering a homelike atmosphere and using proven therapeutic handling methods and the latest weaning techniques outside of the hospital environment. Traditionally babies experiencing NAS are cared for in the NICU or hospital nursery. These environments are

not ideal for the withdrawing infant who needs a quiet environment with reduced stimuli. Additionally, there are research projects at the West Virginia University Department of Pediatrics in Morgantown, WV and at Cabell Huntington Hospital (Marshall University), in Huntington WV as well as Charleston Area Medical Center, Women & Children's Hospital in Charleston, WV. It is our hope that these programs will ultimately serve as national models for the successful management of the substance-abusing mother.

Lest the committee think that this problem is an isolated one, we are aware of national data that indicates a dramatic national increase in the number of infants being admitted to neonatal intensive care units (NICUs) nationally for NAS. Unless we can formulate successful programs to address and manage this issue, the costs of care from maternal drug addiction and NAS will continue to rise.

Thank you for inviting me to address you on this current epidemic affecting our country, especially as it relates to our pregnant mothers and their babies. I am happy to try to answer any questions you may have at this juncture.

Stefan Maxwell, MD, FAAP

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of the Energy and Commerce Committee March 26th 2015 Hearing on
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State and Local Perspectives**

Stefan R. Maxwell, MD
Chair, West Virginia Perinatal Partnership
MEDNAX Medical Group,
Director NICU, Charleston Area Medical Center
Charleston, West Virginia.

West Virginia has some of the highest rates of substance use and abuse in the country. In 2010, West Virginia had the highest rate of overdose deaths. Between 2001-2010 WV experienced a 214% increase in the number of prescription drug overdoses. This epidemic has been especially hard and has not spared our pregnant women and their babies. Between 2007-2012, 27% of maternal deaths in WV was a result of drug abuse.

A 2009 umbilical cord tissue study found that 19% of babies born in WV were exposed to one or more substances in utero. Rates of neonatal abstinence syndrome have risen significantly.

Substance use in pregnancy and its effects on the fetus and newborn is an area of major concern for the West Virginia Perinatal Partnership. Established in 2006, the Partnership coordinates programs and develops policies to improve health outcomes among mothers and their babies.

Pregnancy offers a unique opportunity for treating substance abuse because women are typically highly motivated to modify their behavior in order to deliver a healthy baby. In 2012, the Partnership initiated the Drug Free Moms and Babies project to provide comprehensive and integrated prenatal and behavioral health services. Although early, results have been promising - in one of the pilot sites, the percentage of positive cord tissue samples dropped from 19% to 8% in the first two years.

The Partnership seeks to utilize the Drug Free Moms and Babies model for a Pay for Success (PFS) initiative. Under a PFS model, an investor finances the implementation of a "proven" or evidence-based social intervention program that is expected to improve social welfare and save government money in excess of the program implementation costs.

Other initiatives to address the rising problem of NAS and the care of these infants include the establishment of Lily's Place in Huntington, WV (<http://www.lilysplace.org/>). The Partnership along with others in WV continue to work on addressing barriers to care, including transportation, child care, judgmental attitudes, and lack of providers.

Mr. MURPHY. Thank you.

Now we are going to go to Ms. Brooks to introduce her guest here today.

Mrs. BROOKS. Thank you, Mr. Chairman.

Rachelle Gardner is here today representing the Hope Academy in Indianapolis, Indiana, in my district. Rachelle is the Chief Operating Officer and one of the founders of Hope Academy, a tuition-free Indiana public charter high school for students in recovery from drug and alcohol addiction.

As 80 percent of students relapse from recovery upon returning to their own high school, Hope Academy is essential in combating the staggering statistic. Hope Academy is the only recovery high school in Indiana and one of only 35 within the United States. Rachelle also serves as the Director of Adolescent Services at Fairbanks Drug and Alcohol Treatment Center, and she is the Board Chair for the Association of Recovery Hospitals. And so I want to welcome Ms. Gardner and the other panelists today.

Mr. MURPHY. Thank you.

You are recognized for 5 minutes. Thank you.

STATEMENT OF RACHELLE GARDNER

Ms. GARDNER. Thank you, Mr. Chairman and Congresswoman Brooks and members of the committee for allowing me to speak to you today. My name is Rachelle Gardner, and I have the privilege of serving as the Director of Adolescent Services for Fairbanks, an addiction treatment provider, and the Chief Operating Officer of Hope Academy, a recovery high school, both located in Indianapolis, Indiana.

Hope Academy is the only recovery high school in Indiana and one of 35 recovery schools in the United States. For the last 4 years, I have served as the Chair of Board of Directors for the Association of Recovery Schools, also known as ARS, and the purpose of ARS is to support and inspire recovery schools around the country. My entire career has been dedicated to working with youth who are struggling with substance abuse.

The abuse of opiates continues to rise in central Indiana. According to the Indiana University Center for Health Policy, the number of adolescents receiving treatment for opiate dependence has risen 9 percent over the last 5 years. One of the most staggering statistics is that since 1999, the number of opiate-related deaths has quadrupled in Indiana. Over the last 18 months, Fairbanks has admitted 360 young people ages 15 to 23 who indicated opiates as their primary drug of choice.

Heroin holds a firm grip on its victims and the withdrawal experience from this drug is extremely painful and challenging to overcome. Another danger of heroin is the significant potential for a fatal overdose. According to the Indiana State Department of Health, in 2011 there were 63 heroin-related deaths in Indiana and in 2013 that number increased to 152.

All of the programs and services at Fairbanks for adults and adolescents are driven by our mission to focus on recovery. Recovery from alcohol and drug addiction is challenging for anyone, but especially for our young people who have yet to develop the coping skills necessary to work a successful recovery program.

In the United States, 80 percent of students relapse from recovery upon returning to their high school following primary treatment for substance abuse. Fairbanks was seeing this same trend and in response, opened Hope Academy in 2006. Hope Academy is a public charter school sponsored by the Mayor of Indianapolis. We serve students in grades 9 through 12 who are seeking a safe, sober, and supportive environment. We are committed to small class sizes with highly qualified teachers who are well trained to educate and support students in recovery from drug and alcohol addiction. Most of our students struggle with co-occurring behavioral and mental health issues as well, yet because of the expertise of our staff, we are able to address these issues.

The key to a successful recovery program is changing the people, places, and things in your life. Sending a child back to their former school puts them in the environment that may have led to their drug and alcohol use. Hope Academy provides these students with an environment that contributes to academic success, personal growth, and life-long recovery. Our students' success is measured in growth. We define growth in many ways: the number of days they remain abstinent from drugs and alcohol, their ability to obtain credits and graduate, repairing relationships with families and friends, and developing much-needed life skills.

Over the last 9 years we have served more than 500 students at Hope Academy. Some of these students felt strong enough in their recovery to successfully transition back to their home schools and graduate. Yet over 100 students chose to stay and are now alumni of Hope Academy. Many have pursued postsecondary education or advanced vocational training with the goal of joining the workforce and contributing positively to their communities.

Academic achievement and recovery success are our primary goals at Hope Academy. We have partnered with Indiana Wesleyan University's Addictions Counseling Program to produce a Web site for the purpose of sharing research outcomes with other recovery schools around the country. One recent study produced data that strongly suggests students attending Hope Academy were overall persistent in their education, which in turn reduced their behavioral and mental health issues while increasing the strength of their recoveries.

Through my work with the Association of Recovery Schools, I have become quite familiar with the national advocacy efforts surrounding the Comprehensive Addiction and Recovery Act of 2015, or CARA. Last year, Senator Whitehouse of Rhode Island and Senator Portman of Ohio submitted this critical piece of federal legislation. If passed, this would authorize increased funding for treatment, recovery, and criminal justice systems while aiming to reduce opioid misuse and overdose deaths. In section 303 of CARA, the National Youth Recovery Initiative is of special importance to the various organizations I represent because of the attention it pays to adolescent treatment and recovery resources. Each of you can help us get the resources needed to make a lasting impact on the opiate crisis at a national level by first empowering our local communities. This passage of legislation is critical to helping our youth, our families and our communities who are fighting this epidemic on a daily basis.

The disease of addiction has permeated our society for hundreds of years. In my 25 years of experience, I have never, ever seen a class of drugs take hold of young people like I have with opiates. They are highly addictive and too often lead to premature death, which unfortunately I have seen way too many times. Opiates are claiming the lives of our country's future leaders.

My hope in testifying today is that together we can not only provide young people the access to treatment and recovery supports they need but also to restore their hope for a positive future.

Thank you for the opportunity to be here today and I look forward to answering any of your questions.

[The prepared statement of Ms. Gardner follows:]

Thank you Mr. Chairman and members of the committee for allowing me to speak to you today.

My name is Rachelle Gardner and I have the privilege of serving as the Director of Adolescent Services for Fairbanks, an addiction treatment center, and as the Chief Operating Officer of Hope Academy, a recovery high school, both located in Indianapolis, Indiana. Hope Academy is the only recovery high school in Indiana and one of 35 recovery schools in the United States. For the last four years, I have served as the chair of the board of directors for the Association of Recovery Schools, also known as ARS. The mission of ARS is to support and inspire recovery schools for optimum performance, empowering hope and access to every student in recovery. My entire career has been dedicated to working with youth who are struggling with substance abuse.

The abuse of opiates continues to rise in Central Indiana. According to the Indiana University Center for Health Policy, the number of adolescents receiving treatment for opiate dependence has risen 9% over the last five years. In the same time period, the number of young adults ages 18 to 24 receiving treatment for opiate dependence has risen 5%. One of the most staggering statistics is that the number of deaths related to overdose from opiates has quadrupled since 1999. Over the last 18 months, Fairbanks has admitted 360 young people ages 15 to 23 who indicated opiates as their primary drug of choice.

Heroin holds a firm grip on its victims and the withdrawal experience from this drug are extremely painful and challenging to overcome. Another danger of heroin is the significant potential for a fatal overdose. According to the Indiana State Department of Health, in 2011 there were 63 heroin-related deaths in Indiana and in 2013 that number increased to 152.

All of the programs and services at Fairbanks for adults and adolescents are driven by our mission to 'focus on recovery'. Recovery from alcohol and drug addiction is challenging for anyone, but especially for our young people who have yet to develop the coping skills and realistic life perspectives necessary to work a successful recovery program. In the United States, 80% of students relapse from recovery upon returning to their high school following primary treatment for substance abuse. Fairbanks was seeing this same trend and in response, opened Hope Academy in 2006.

Hope Academy is a public charter school sponsored by the Indianapolis Mayor's Office. We serve students in grades 9 through 12 who are seeking a safe, sober and supportive environment. As an alternative education school we are committed to small class sizes with highly qualified teachers who are well trained to educate and support students in recovery from drug and alcohol addiction. Even more, most of our students struggle with co-occurring behavioral and mental health issues; yet because of the expertise of our staff, we are able to concurrently address these issues. Because of these essential aspects to educating substance impacted youth, running a recovery high school can be costly. The average cost in the United States to educate a student in a recovery high school is \$20,000 per year. At Hope Academy we receive about \$14,000 per student from the state each year.

The key to a successful recovery program is changing the people, places and things in your life. Sending a child back to their former school puts them in the environment that may have led to their drug use. Hope Academy provides these students with an environment that contributes to academic success, personal growth and life-long recovery. Our students' success is measured in growth. We define growth in many ways; the number of days they remain abstinent from drugs and alcohol, their ability to obtain credits to

graduate, repairing relationships with families and friends and developing much needed life skills such as communication, organization and good decision making.

Over the last nine years we have served more than 500 students. Some of these students felt strong enough in their recovery to successfully transition back to their home school and graduate. Yet, over 100 students chose to stay and are now alumni of Hope Academy. Many have pursued a postsecondary education or advanced vocational training with the goal of joining the work force and contributing positively to their communities.

Academic achievement and recovery success are our primary goals. As such, we are actively involved in conducting research to help us understand what works at Hope Academy, as a means to continuously enhance outcomes. We have partnered with Indiana Wesleyan University's Addictions Counseling Program to produce a website that publishes our joint studies conducted at Hope Academy for the purpose of sharing outcomes with other recovery schools. One recent study produced data that strongly suggests students attending Hope Academy were overall persistent in their education, which in turn reduced their behavioral and mental health issues while increasing the strength of their recoveries.

Through my work with the Association of Recovery Schools, I have become quite familiar with the national advocacy efforts surrounding *The Comprehensive Addiction and Recovery Act of 2015* or CARA, for short. Last year, Senator Whitehouse of Rhode Island and Senator Portman of Ohio submitted this critical piece of federal legislation. If passed, this would authorize increased funding for treatment, recovery and criminal justice systems while aiming to reduce opioid misuse and overdose deaths. In section 303 of CARA, the National Youth Recovery Initiative is of special importance to the various organizations I represent because of the attention it pays to adolescent treatment and recovery resources. We have learned from our research that having the necessary wrap around services available for adolescents and their families is critical. We know now that long-term recovery does not occur in a vacuum especially for youth and young adults. This bill would provide the funding necessary for these services at a macro-level. This passage of the legislation is critical to helping our youth, our families and our communities who are fighting this epidemic on a daily basis.

How can you help? Each of you can help us get the resources needed to make a lasting impact on the opiate crisis at a national level by first empowering our local communities.

The disease of addiction has permeated our society for hundreds of years and drug trends change with the times. In my 25 years of experience, I have never seen a class of drugs take hold on young people like opiates. They are highly addictive and too often lead to premature death. Opiates are claiming the lives of our country's future leaders. My hope in testifying today is that together we can not only provide young people the access to treatment and recovery supports they need but also to restore their hope for a positive future.

Thank you for the opportunity to be here today and I look forward to answering any of your questions.

Mr. MURPHY. Thank you, Ms. Gardner.

Now, Mr. Fitz, I will recognize you. You are the prosecutor of Cass County, Michigan, also the President of the Prosecuting Attorneys Association of Michigan. Welcome here. You are recognized for 5 minutes.

STATEMENT OF VICTOR FITZ

Mr. FITZ. Chairman Murphy and esteemed members of the Oversight and Investigations Subcommittee, as indicated, my name is Victor Fitz and I am the prosecutor in Cass County, Michigan. Cass County is a medium-sized county in lower Michigan abutting South Bend on the Indiana border. We are equidistant from Chicago and Detroit, 2 hours to the west of Chicago, 2 hours to the east is Detroit. I want to thank you for the opportunity to be here today both on behalf of the Cass County Prosecutor's Office as well as the Prosecuting Attorneys Association of Michigan, particularly to address this very serious and horrifying epidemic that we are facing in Michigan as well as the Nation as a whole.

Michigan, like the rest of our States, is extremely diverse from county to county, but we are all similar in one way, Michigan from our Upper Peninsula to the shores of Lake Superior right down to our urban areas of Detroit, Saginaw, Muskegon, Flint and the like, and that is that we are dealing with the devastating problem of prescription drug abuse and heroin abuse. It is devastating all of our communities. It is not just an inner city problem. It is not just a rural problem. It is there and everywhere in between.

All people are vulnerable to abusing these drugs because they are so very addictive. This abuse can start innocently, for instance, a teenager who becomes addicted to OxyContin after a serious athletic injury or someone perhaps recreationally who starts using less addictive drugs and graduates their drug use to heroin. It takes only one time to become addicted to heroin, and that one time is ruining futures, it is ruining families, and it is ruining lives.

The opiates found in prescription pills are the addictive ingredient in heroin, and that is why users of prescription drugs eventually seem to turn to heroin. It is also simple economics. As we have found in Michigan as well as other parts of the Nation, it is actually cheaper to use heroin than prescription drugs on many occasions. We found in Michigan that heroin is actually cheaper in many areas than even marijuana. It can be smoked, it can be snorted, and it can be injected. It is quick and it is easy.

Statistics in the State of Michigan indicate that in the year 2001, there were 271 heroin overdose deaths in our State—I am sorry. That would have been the year 2001 and 2002, a 2-year period. Fast-forward to 2011. That number quadrupled. For one year, the year 2011 had 728 heroin deaths.

I know the congressional representative from Colorado spoke earlier about the 8,000 heroin deaths in the United States, and allow me just for a moment to personalize that from a prosecutor's perspective, from a law enforcement perspective. We had about 2 years ago in Cass County and Bering County in southwest Michigan, our two counties, we had a heroin death that occurred, or suspected heroin death. In Michigan we now have a law that indicates that if you deliver heroin or any drug and that causes the death of that

person, it is the equivalent of a second-degree murder charge. Unfortunately, because of the newness of this statute, law enforcement not having protocols, did not seize upon the opportunity to investigate in that fashion initially. So as the investigation did take forward once my office became aware of it by the exhumation of the body, which I can tell you was something that was quite traumatic to the victims of the teen who had been killed from suspected drug activity. While that investigation was going on, in an effort to show that the death came from the use of heroin and other drugs that were supplied, this individual was still out on bond and he again delivered to another person, who also died from a heroin overdose. I can tell you that the pain and the agony is palpable for the victims and for those families.

On Monday of this week, I was talking to another family of a homicide situation, didn't happen to be drugs, but I can tell you when it is a violent death, when it is a death from a drug overdose, the pain never leaves the family. Again, these are real. The number 8,000, as mentioned earlier, every one of those is a tragedy for the family and for the community and for the friends.

We are also seeing pre-teenagers abusing prescription drugs and heroin. It is a terrifying tragedy. Anything that we can do to battle this epidemic needs to be done. The Michigan Department of Community Mental Health in my State has developed a work group to design a strategic plan to combat this type of drug abuse. The plan, which is in place through the year 2015 through September 30, 2015, generally recommends the following: increasing multisystem collaboration across agencies, broadening statewide media messages, increasing training for physicians regarding drug abuse for education in schools, and increased access to databases regarding controlled substances for health professionals and law enforcement. In my written testimony, I provide some other potential options in that regard. Anything we can do to combine strategies and improve operations to get our citizens help and to put an end to what is deteriorating lives should be done.

If I could have just one moment, I want to mention very briefly our prosecutor from Wayne County in the Detroit area. Kim Worthy asked me this morning to just pass on a couple things very quickly that again this is not just a rural issue, it is also an urban issue, and they have excessive pill mills, violent crime, robbing of pharmaceutical vehicles going through their neighborhoods, murders occurring from these situations, and she again emphasizes we need to attack it on both the supply and the demand end.

Thank you very much.

[The prepared statement of Mr. Fitz follows:]

3-26-15 Testimony of Victor Fitz

My name is Victor Fitz. As a 31 year prosecution veteran, the current elected Prosecutor for Cass County Michigan and the President of the Prosecuting Attorneys Association of Michigan (PAAM) it is an honor to appear before the Energy and Commerce Commission Chaired by Congressman Fred Upton, and more particularly, its Subcommittee on Oversight and Investigations chaired by Congressman Tim Murphy--as well as the other distinguished members of this Subcommittee. I know that your presence in Congress as well as on this committee is a strong reflection on your commitment to our jurisdiction and our nation we humbly and proudly call the United States of America.

It is my understanding that I have been called to provide information and insight regarding the scourge of illicit prescription drug abuse and heroin abuse at the state and local level in Michigan. I am honored to have this opportunity.

Some brief background.

During my 30 plus years dedicated to public safety and prosecution I have had a significant focus as a drug prosecutor in both small and medium sized jurisdictions of St. Clair, Tuscola, Muskegon and Cass Counties.

In particular I spent 8 years as a full time narcotics prosecutor in Muskegon Michigan, an ethnically diverse community with major drug challenges in the way of prescription drug abuse, powder and crack cocaine, heroin and marijuana. Many of our investigations "took us" to places such as Orange County California for large scale multi-kilo cocaine operation, Wall Street New York for a multi-state heroin distribution racket, Kansas City, Missouri regarding a multi-kilo drug network, Romania for the extradition of a drug conspirator, Florida, the Caribbean and elsewhere. Our investigations also routinely touched other parts of the Michigan and the mid-west including Flint, Detroit, Saginaw, Chicago, Minneapolis and Des Moines.

For the past decade I have been an elected prosecutor in a small, primarily rural community on the Indiana border north of South Bend and Elkhart Indiana---Cass County Mi. The county has particular pride in having been a pivotal stop on the Underground Railroad during the pre-civil war era. The community has provided Michigan with notables including "America's No. 1 Spaceman"---Ivan Kincheloe, former Mayor of Detroit Dennis Archer and Bronze Medal Olympic Wrestler Chris Taylor.

Our major drug problem in Cass County is methamphetamine and marijuana, but we have also seen evidence of other drug activity including heroin and prescription drug abuse. This has included multiple overdose deaths involving heroin in the past 2-3 years.

In Cass County we have engaged in aggressive prosecution and have motivated Judges who have brought specialty courts including Family Treatment Court, Adult Treatment Court, Sobriety Court, Mental Health Court, Veterans Court and "Swift and Sure" Intensive Probation.

As a long-time prosecutor and the current President of PAAM, I have had many discussions with my colleagues regarding our drug challenges in Michigan. In preparation for the Subcommittee testimony I have also reached out in recent days to my fellow elected prosecutors regarding Prescription Drug Abuse and the Heroin challenge in Michigan and beyond. A summary of their response is provided in the attachments to this testimony.

I draw upon the above insight, materials and information for my comments below.

As prosecutors, we remaining zealous in commitment to the statutory and constitutional responsibilities of seeking justice and protecting the public. In that light, we also recognize that like crime in general, we will never be able to eliminate illegal drug activity. Like so many other crimes, our job is, through education, prevention, prosecution, programming, collaboration, probation, punishment, incarceration and other available tools, to constantly work to minimize the scourge that illicit drug activity brings to our communities, our state and our nation.

As an extreme example let me analogize to the crime of murder. Law enforcement and prosecution consider the investigation and prosecution of these cases to be of highest priority. We solve many such cases, but we are not always successful. In Michigan alone, for example, FBI statistics indicate that there are over 11,000 unsolved Michigan murders since 1980. Statistics in other states are quite similar. We would like to solve all of these crimes. We don't. But our lack of perfection in this area of law enforcement does not deter our efforts to continue to try and solve as many murder cases as possible. Such actions support justice for victims and defendants, deter others from committing murder and provide appropriate punishment for wrongdoing. We will never win a war on murder. The inability to eliminate murder as a crime in our Country does not cause us to give up on solving as many as possible. But it is the desire of Prosecutors and Law Enforcement to provide justice in as many murder cases as possible.

Similarly, Prosecutors recognize that we will never "win the war" on drugs. But we also realize that illegal drug activity has a terrible impact on our society and it IS our job to use all tools available to minimize the terrible societal impact that illegal drug activity has on our communities.

So what is the impact of illegal drug activity?

Drug activity, including dealing, possession and use have an immense and long term negative impact on the quality of life in our community. More so than practically any other crime, drug activity compromises the long-term safety of entire neighborhoods. When drug dealing becomes commonplace in a community, it can take years to reverse the negative impact on safety, property values and the like. Children cannot go out and play in their yards. Elderly citizens are prisoners in their own homes. Importantly, significant drug activity creates a generation of addicts who in turn sell drugs, steal property, rob and----as a result of drug altered states, assault and kill ----other citizens as part of a vicious cycle.

Tragically, when our youth become immersed in drug activity and use, we endanger large swaths of an entire generation. Lives can be wasted and we even compromise national security when we fall behind other nations educationally and economically in our global world due to drug use. Local industries cannot keep qualified workers due to failures on drug tests.

Upper, middle and street level drug dealing is indeed a challenge and a danger. Sadly, drug users all too often fall into this category as well. They create dangers such as

- Child abuse
- General Assaults
- Domestic Assaults
- Felony Assaults
- Murders
- Vehicular Homicide
- Sexual assaults
- Property Crimes
- Financial/economic Crimes

As Prosecutor Bob Cooney from Traverse City Michigan states:

What so many people miss about this problem is that heroin and prescription drug abuse is NOT a victimless crime. The victims are the people whose homes, cars and businesses are broken into in the search for drugs, or property to pawn in the pursuit of drugs, the children who are abused physically and sometimes sexually by the abusers, the domestic violence victims who suffer at the hands of the addict, the persons who are killed or seriously injured by persons like Vince Eaton who was loaded up with cocaine, methadone, etc. and seriously injured – lifelong injuries – 2 people last fall in our county. Or the drug dealer who was stabbed and left to die last year on our community college campus by three individuals wielding knives in an attempt to steal drugs. I would estimate that 80% of the crime in Grand Traverse County can be linked to illegal drugs.

The problem of drug abuse will always be with us. Heroin and prescription drugs are the latest concern, following the epidemics of marijuana, powder cocaine, crack cocaine, methamphetamine and others. The key is to minimize use and its impact.

Illegal drug activity is a problem that will not disappear

Illegal drug activity is a problem that will not go away

Illegal drug activity is a problem that will never be eradicated

Illegal drug activity is a problem we need to be vigilant on

Illegal drug activity is a problem that we will always have to work on.

Illegal drug activity is a problem that we can have an impact on.

But we cannot put our heads in the sand.

As stated above drug abusers cause enormous problems for our communities in the way of damaged lives, crime and economic loss.

There is no one cure.

There is no one solution.

Different things work for different drugs and different persons. Prosecutors see a multi-faceted approach as critical to our efforts to MINIMIZE drug activity, including the prescription drug and heroin problem.

This multi-faceted approach includes many options including:

- Education
- Prevention
- Preparation
- Strengthening families
- Involvement of mothers and fathers in the lives of their kids

- Enforcement
- Prosecution
- Treatment
- Diversion
- Public Protection
- Incarceration

So what is the specific problem in Michigan regarding prescription drugs and heroin?

We clearly have challenges.

Michigan has significant problems with both issues.

Prescription Drug Abuse

Our nation is quite indulgent when it comes to drug use. We consume large percentages of the drugs available around the world. Some examples:

- Global Consumption of hydrocodone was 43 ton in 2011, with the U.S. accounting for more than 99 percent of the world total. *(2012 International Narcotics Control Board Reported Statistics On Narcotic Drugs)*
- Global Consumption of oxycodone was 81.6 tons in 2011, with the U.S. accounting for 81 percent of the world total. *(2012 International Narcotics Control Board Reported Statistics On Narcotic Drugs)*

Michigan---like most if not all states in the Union---has a significant prescription drug abuse appetite and problem.

- Michigan generated more painkiller prescriptions than it had citizens in 2012. Specifically, there were 107 prescriptions for every 100 persons. *(12 SOURCE: CDC Vital Signs: Opioid Painkiller Prescribing; July 2014).*
- 4th highest retail prescription rate in the United States for hydrocodone in 2013 *(Source: Drug Enforcement Administration, Office of Diversion Control, Pharmaceutical Investigations Section, Targeting and Analysis Unit)*
- 3rd highest retail prescription rate in the United States for hydrocodone in 2014 *(Source: Drug Enforcement Administration, Office of Diversion Control, Pharmaceutical Investigations Section, Targeting and Analysis Unit)*
- 10th highest practitioner prescription rate in the United States for hydrocodone in 2013 *(Source: Drug Enforcement Administration, Office of Diversion Control, Pharmaceutical Investigations Section, Targeting and Analysis Unit)*

- 10th highest practitioner prescription rate in the United States for hydrocodone in 2014 (Source: Drug Enforcement Administration, Office of Diversion Control, Pharmaceutical Investigations Section, Targeting and Analysis Unit)
- 17th highest Practitioner and 20th highest Retail prescription rates in the United States for oxycodone in 2014 (Source: Drug Enforcement Administration, Office of Diversion Control, Pharmaceutical Investigations Section, Targeting and Analysis Unit)

Specific examples include:

- A Detroit area doctor (Dearborn Heights) who would see over 100 patients a day in Hamtramck. 1.5 million Transferred to bank in Amman Jordan. Convicted of 34 counts in 2014. (Detroit Free Press April 17th, 2014)
- Monroe County Doctor (Oscar Linares) near Toledo, Ohio, operated a large-scale prescription mill prescribing OxyContin and other painkillers to up to 250 patients a day, and fraudulently billed Medicare for more than \$57 million. Read more at <http://www.toledoblade.com/Police-Fire/2011/03/25/Alleged-pill-mill-raided-in-Monroe-County.html#qY3zOx5qdZjsqcLO.99>

Reference to the attached Drug Enforcement Administration Power Point provides significant additional information regarding the influx of prescription drug abuse and heroin activity in Michigan.

Monroe County has a population of 150,376. It's Prosecutor, Bill Nichols advises that Dr. Linares was at one time the #1 dispenser of oxycodone in North America. Further, that his parking lot was like an airport landing strip, with employees directing vehicle to open parking spots. License plates from multiple states, including West Virginia, Florida and other states were not unusual.

Prosecutor Dale Hilson indicates:

"In Muskegon County, [population 171,008] our prescription drug problem is out of control. In reviewing police activity over the last couple of years, our county-wide drug team finds illegally possessed prescription pills on just about every search warrant. In 2014, based on two search warrants at separate times, our team took from the same defendant over 20,000 pills, a majority of which were scheduled drugs and over \$100,000 in money. This particular defendant was an illegal pharmacy. It tells us in law enforcement that our illegal possession and use of pills is voluminous and almost impossible to accurately account for."

In Michigan's rural counties the problem is similar. Gladwin County has a population of ____ and is located in the middle of the Lower Peninsula. It's Prosecutor, Aaron Miller indicates:

"The number of prescription drug arrests (possession, use, or delivery) has quadrupled since 1994. This is in spite of the fact that our State Police Post was eliminated and we have almost insignificant coverage from MSP. And that we've lost 15% of our Sheriff Deputies to lay-offs."

Michigan Automated Prescription System data for Gladwin County indicates that in 2010 there were 2,789,361 Schedule 2 & 3 pills prescribed. By 2013 this number increased by 20% to 3,459,498. For a population of 25,000 people these numbers are obscene and indefensible."

Iron County Prosecutor Melissa Powell, from the western Upper Peninsula bordering Wisconsin estimates that 25% of their criminal drug activity is prescription drug and 70% is heroin.

In Cheboygan County, immediately south of Michigan's historic and famed Mackinaw Island, it is even higher. Prosecutor Darryl Vizina indicates

*"Approximately 80% of our felony caseload is directly or indirectly alcohol/drug related. My yearly statistics indicate that **60.2% of our felony drug charges involved prescription drugs**. It is a huge problem. I am continually stunned when I look at MAPS reports that doctors continue writing opiate scripts for individuals who have so many other opiates prescribed."*

Soberly, with this prescription abuse comes loss of life. This includes, overdoses, drug related robberies and drug-induced killings. Michigan _____ in prescription drug deaths.

At the county level Gladwin County Prosecutor Aaron Miller again weighs in:

"Between 6-9 deaths per year directly attributed to prescription drug abuse with no other contributing factors. For a county of approximately 25,000 this is significant. This does not account for related (i.e. suicide) that are prescription drug related. Prescription drug overdose calls to 911 are a regular occurrence at our Central Dispatch."

And from Cheboygan Prosecutor Vizina:

"Two summers ago we had 3 overdose death in a 4 day window. That gives a sample of the problem. That is concerning for a county of only 26,000 people. We successfully tried an Overdose Causing Death case in 2012."

Clearly, Michigan has a significant prescription drug abuse problem throughout the state.

Heroin

Michigan also has a growing and dangerous heroin problem. As prosecutors from around the state indicate, when prescription drugs become unavailable or too expensive, heroin has become the default option. It is particularly challenging and troublesome amongst our youth.

Muskegon County Prosecutor Hilson reports:

"We have seen a large increase over the last five years of heroin cases in our county. In 2009 there were four cases. Within five years that increased to 48 cases in 2014. Sadly, 12 of those cases were heroin overdoses. This trend is continuing in 2015. We are starting to see our pill abuses switching to heroin as it is cheaper and easier to get."

Berrien County Prosecutor Mike Sepic indicates:

Leelanau County Prosecutor Joe Hubbell, in a county of 21,747 on the western shores of the Lower Peninsula, advises that:

"As a result of the crack down prescription drugs, and the increased availability of cheap heroin, the usage in this county has increased. In addition the prescription drug and heroin

abuse problems have increased cases involving theft from family and employers as well as breaking into cars and homes."

His neighbor, Prosecutor Cooney from Grand Traverse County advises:

"We experienced a significant increase in the number of heroin cases beginning about 2012. We almost never had heroin cases prior to 2012. Heroin has been linked to at least one stabbing/assault with intent to murder case involving three suspects. I see at least one or more cases involving heroin per week."

With the increased heroin use, deaths related to the drug are becoming far too common. Situated near less than 2 hours from Chicago and with a population of 155,252, Berrien County Prosecutor Mike Sepic indicates:

"Peaking, during 2013 and 2014 we had approximately 1 heroin overdose death every 1 - 2 months. Several we were able to work as Delivery Causing Death. We are aware of a number of overdose situations in which Narcan is used to reverse heroin effects, subject lives. Parents now have access to Narcan and while that saves a life it doesn't always cure the problem."

In neighboring Cass County, we have had several heroin overdoses causing death in the past 2-3 years... In a particular instance an offender delivered heroin to two different persons in Southwest Michigan, both of them dying from a drug overdose shortly thereafter. In a separate investigation involving a different suspect, we are awaiting an April 10th, 2015 jury trial for delivery of heroin causing death. The penalty for this crime is life or any term of years. At least two other criminal investigations for heroin deaths remain active.

Across Lake Michigan from Milwaukee, Oceana County (population 26,245), known as a Michigan vacation venue, has this report from Prosecutor Joe Bizon:

"In the last 6 years, I have prosecuted 2 cases of delivery of heroin causing death. We have had 6 deaths at the semi-famous Electric Forrest Festival, 5 of which were attributed to controlled substances. 2 of those were heroin. They were not able to be prosecuted due to lacking evidence as to who provided the drugs."

Treatment

In dealing with prescription drug abuse and heroin, the common refrain amongst prosecutors is "Not enough options".

Prosecutors, as indicated above recognize the need to hold persons accountable for the wide variety of crimes they commit while using these drugs. An addiction is not an excuse for criminal behavior. Incarceration is often appropriate. Dealing with a criminal case involves far more than the individual defendant. It also includes public safety, sending a message of deterrence to other offenders and the benefit that punishment also provides to a wrongdoer, including but not limited to drug addicts. However, prosecutors also recognize that if treatment can also be incorporated, the chance of recidivism may well be reduced.

Surprising to some, rehabilitative and treatment providers often also see the merit to the use of criminal prosecution to teach accountability and the threat of incarceration as a real life, practical tool to get addicts to embrace treatment, rehabilitation, etc.

Prosecutors, Defense attorneys and again, treatment providers also see the benefit of periods of incarceration to bring sobriety and a "drying out" period and a clear mind to drug offenders, including prescription and heroin offenders. In Cass County, defense attorneys have repeatedly commented that drug users staying in jail often helps achieves these important things.

*"We have had mixed success. **Putting them in jail for a period of time to clean them up (between 30-120 days) before putting them in treatment has helped increase our success rate.** Employment is a huge factor in their success. They are more likely to be successful in specialty court, no matter what their drug of choice is, if they are employed."*
 - Iron County Prosecutor Melissa Powell

But the follow-up treatment is often not available:

"We work closely with our treatment providers, but we need more money for treatment as the working poor cannot afford treatment and often their insurance doesn't cover enough of the treatment leaving them to have to come up with thousands of dollars out of their own pocket which they do not have."
 - Iron County Prosecutor Melissa Powell

"Few programs. Inpatient programs are in other counties."
 - Houghton County Prosecutor Mike Makanien
 (Population 36,225)

"We have one local treatment provider who handles rather small scale outpatient treatment for drug abuse...Community Mental Health (CMH) ... continually under-diagnoses patients to keep them with CMH when they [actually] need inpatient treatment, or just refuses to treat harder cases such as co-occurring disorders."
 - Oceana County Prosecutor Joe Bizon

"We have very limited options in regards to treatment programs. This is certainly true as it relates to programs that service the under privileged. This population is the one abusing both prescription pills and heroin the most."

Specialty/Treatment Courts

Interwoven with treatment and rehabilitation are Specialty/Treatment Courts. Prosecutors consider these programs to have some promise, but also are cautious about the high cost and the straining of already sorely pressed resources. As a specific example, in Cass County, the existence of specialty courts has increased the entire attorney workload for the office by approximately 10%. This is a significant challenge when dealing with attorneys who are already working long hours to deal with traditional caseloads.

Many prosecutors also believe that an independent analysis of the cost and the success of specialty courts is merited.

Other general elected Prosecutor comments include:

"Treatment is a great idea, but this has to be balanced. Abusers who engage in violent crimes or property theft crimes cannot be excused from crime because they are addicts. A balanced punishment component needs to remain in place."

- Oceana County Prosecutor Joe Bizon

"A common occurrence is for a heroin user going through rehab through drug court programming, getting clean for some months, relapsing to the previous level of usage and overdosing because the body cannot take that dose anymore."

- Berrien County Prosecutor Mike Sepic

We have treatment programs, but not the sort of long term treatment that truly works for addicts.

- Grand Traverse County Prosecutor Bob Cooney

"We are working closely with treatment providers to identify gaps in treatment. We need better treatment programs for younger people for all substance abuse, but in particular, for heroin since they appear to be the primary users. Funding for treatment remains a continuing problem."

- Leelanau Prosecutor Joe Hubbell

Suboxone

Prosecutors do not see suboxone as a "miracle drug to cure all woes of heroin use. Like methadone and other medications, it has its areas of success and abuse. It is sold on the streets like other drugs. Rather, from their experiences in the trenches, some, but not all prosecutors see it as another tool that may be useful under proper circumstances.

"Too new to know its value for treatment. It is becoming a street drug presumably to ward off withdrawal and presumably is available on the street when patients find their preferred drug and sell the suboxone."

- Houghton County Prosecutor Mike Makinen

"Suboxone can be a disaster. We prosecute a large number of suboxone deliveries. I've been to multiple conferences where I hear suboxone is a miracle drug that helps opiate addicts and cannot be abused. I always ask why drug seekers are buying it on the street. We do NOT prohibit suboxone in our drug court. I think it is a problem."

- Cheboygan County Prosecutor Darryl Vizina

"Suboxone is not allowed as a treatment directive in our drug court. It has been repeatedly abused and sold by drug court members and by our average population so we do not utilize it. We do not permit the use of any scheduled controlled substances, nuerontin, ultram, or the like while participating in drug court. Drug Court members view suboxone as the new methadone (methadone is still sold and abused on the street). The preference in our treatment court at this time is to address the underlying reasons for the addiction through therapy. One of our treatment providers has also had a pilot project using nutritional supplements for opiate addicts and it has been somewhat successful. The use of suboxone seems to be a gateway for our participants to continue or relapse into criminal behavior. If it's viewed as a "miracle" pill to block the cravings, then they tend to not address the underlying issues that led them to use drugs. Alcoholics and other drug addicts must deal with "cravings" without the use of a "blocker"."

- Iron County Prosecutor

"We had an involuntary manslaughter case in 2013 which a man who was taking suboxone to overcome heroin addiction shot and killed his girlfriend. He is serving 11-19 years."

-Grand Traverse County Prosecutor Bob Cooney

We have seen the negative side to suboxone. Our drug team has been seeing this drug being sold on the street and they have recently been able to purchase on the street in undercover capacity.

-Muskegon Prosecutor Dale Hilson

"It [suboxone] is abused every bit as much as any other prescription drug. Though I am sure they may exist, I have yet to see anyone make legitimate use of it."

- Gladwin County Prosecutor Aaron Miller

As discussed below, Monroe County, near south of Detroit and near Toledo, has taken a number of substantive steps to address their prescription drug and heroin issues. Their Prosecutor, Bill Nichols is an active participant and integral player in the Monroe County Substance Abuse Coalition. Ms. April Demers, representing the Monroe County Substance Abuse Coalition offers the following regarding suboxone:

"Medication-assisted recovery using Suboxone has been both successful and challenging in treating opiate/opioid addiction in our State. As an opiate/opioid antagonist, Suboxone blocks the effects of heroin and prescription pain pills to the brain and also helps to eliminate cravings. When combined with cognitive behavioral therapy and other recovery supports, Suboxone treatment has proven to be effective.

Suboxone has the potential for abuse and diversion when used outside of these treatment guidelines because it can be used to mask withdrawal symptoms between fixes for someone currently abusing.

Both Suboxone (opiate/opioid antagonist) and Methadone (opioid medication that is gradually titrated) are useful in medication assisted treatment of opiate/opioid addiction. While sometimes viewed as controversial, if used within the treatment guidelines, it has proven to be a successful treatment modality and it also provides a significant reduction in harm for a patient that suffers from withdrawal and relapse tendencies.

Suboxone is especially helpful in treating opiate/opioid addiction in the prenatal population, which is on the rise in Michigan."

As indicated above, Michigan Prosecutors, drawing from their "in the trenches" experience" have varying opinions regarding suboxone, with some willing to consider it as a tool in the heroin recovery effort, and many expressing concern over its abuse and it being portrayed as a miracle drug.

Response/Solutions/Substantive Steps

Michigan has taken a number of substantive steps to address the prescription drug and heroin concerns in the state. This has included the following. See also attachments related to these steps:

--Statewide Prescription Drug and Heroin Summit 2013

--Comprehensive State of Michigan Website dealing with Prescription and Over-The-Counter Drug Abuse http://www.michigan.gov/mdch/0,4612,7-132-2941_4871_29888_48562-149065--,00.html

--Treatment/Specialty Courts

--Michigan Automated Prescription System (MAPS)

Monroe County Michigan has been impacted particularly hard by prescription abuse and heroin issues. Accordingly, they began in 2012 to address this challenge. Their Prosecutor Bill Nichols took a central role in the effort. In particular, meetings with the following stakeholders have occurred repeatedly and formal organization has occurred.

- o Medical
- o Treatment and Recovery
- o Prevention and Awareness
- o Impacted Families
- o Law Enforcement/Government

A number of impressive documents related to their efforts are attached. The subcommittee is encouraged to consider closely their efforts as well as direct contact with their Prosecutor Bill Nichols.

Other Needs/Considerations

Recognize there is more than one solution. Can vary from person to person. Not a one-solution fits all problem

More resources for Law enforcement, Treatment, Specialty Courts

Increased Narcan availability

Establish Michigan Law Enforcement protocols on prescription drug and heroin death cases

More upfront incarceration for detox (30-120 days)

Reach out to Faith Based Community

- Hope's Door
- Teen Challenge
- Community

Employment

INDEPENDENT ANALYSIS of success of treatment programs

Mr. MURPHY. Thank you very much.

Now Corporal Mike Griffin will be introduced by Mr. Mullin of Oklahoma.

Mr. MULLIN. Thank you, Mr. Chairman.

It is a very great privilege I have to introduce not just Corporal Mike Griffin but a friend of mine. Mike and I used to meet just about every Friday morning to have breakfast, and in his words, he says just to help me stay grounded.

Mike has worked with the Tulsa Police Department for 17 years and spent 12 of those years in an undercover capacity conducting drug investigations. For the past 10 years, he's been a supervisor within the department's narcotics unit. Previously, Corporal Griffin was with a special agent with the Bureau of Alcohol, Tobacco, and Firearms. He has also served as a member of the Oklahoma Army National Guard. Mike, thank you for being here today.

Mr. MURPHY. You are recognized for 5 minutes.

STATEMENT OF MICHAEL GRIFFIN

Mr. GRIFFIN. Chairman Murphy, Ranking Member DeGette, and members of the committee, on behalf of Chief Chuck Jordan and the Tulsa Police Department, thank you for the opportunity to discuss prescription opioid abuse, heroin abuse, and heroin trafficking.

Although heroin abuse and trafficking in Tulsa lags far behind the abuse and tracking of methamphetamine, heroin is trafficked into Tulsa in the same manner as methamphetamine and cocaine, and its abuse leads to similar related criminal activity ranging from petty larceny to armed robbery and even murder.

Narcotics investigators within the Tulsa Police Department know that a large majority of individuals currently addicted to heroin began their drug abuse by abusing prescription drugs. The Tulsa Police Department currently has 751 sworn police officers. TPD believes the focus of drug investigations should be on those individuals who are responsible for trafficking drugs into and through our community rather than on those individuals who are merely addicted to drugs. This is because of our belief that resources are best utilized at the source of the problem rather than on the symptoms of a problem. With that goal in mind, of the 751 sworn officers working for TPD, one investigator is assigned to investigate prescription drug cases within the city. Our lone prescription drug investigator spent the last 20 years investigating prescription drug cases. He believes that Oklahoma has one of the best prescription monitoring programs in the United States. Oklahoma's PMP is real time and allows doctors and pharmacists to quickly access an individual's prescription drug history to evaluate if they are possibly doctor-shopping to gain access to prescription drugs.

If a person gets addicted to opioids, it is not long before they realize that obtaining prescription drugs are harder to access due to Oklahoma's PMP and more expensive than heroin. Because these individuals already are addicted to opioids, the transition to heroin is easier and cheaper.

Heroin trafficking in Tulsa is operated by Mexican drug trafficking organizations. Similar to other drug investigations conducted at the local or state level, the individuals most often arrested and prosecuted are the local dealers and operation leaders.

However, the individual profiting most from the illegal distribution of heroin resides in Mexico and is usually beyond prosecution at the state level.

Additionally, and still consistent with other drug investigations, when the individuals at the local or state level are arrested, Mexican DTO simply replaces those individuals with other low-level people within the organization. Therefore, the drug-trafficking organization is able to continue distributing drugs within a community almost uninterrupted.

Data confirms that drug abuse not only provides a demand for drugs to be trafficked into and throughout the United States but also that drug abuse and distribution leads to other crimes occurring in a community. An approach targeting drug trafficking without taking into account a need to prevent drugs from even entering the United States is shortsighted. Prior efforts by law enforcement agencies and state legislators to prevent drug crimes and crimes that occur because of drug dependence and distribution have shown to be successful. For example, reducing the availability of pseudoephedrine has shown to reduce the number of meth labs operating in Oklahoma and other States with similar legislation. This legislation has not only reduced the number of meth labs operating within a state but is also shown to significantly lower associated criminal activity. According to the FBI, no other country in the world has a greater impact on the drug situation in the United States than does Mexico. The FBI states that each of the four major drugs of abuse are either produced in or transported through Mexico before reaching the United States.

Mexican drug-trafficking organizations use numerous methods to smuggle drugs into our country to include aircraft, horses and mules, tunnels, vehicles, and even people walking across the border. Data provided by the DEA shows that the supply of heroin coming from Mexico has increased over the past 5 years and that part of the increase in heroin seizures may be due to the decrease in U.S. demand for Mexican marijuana, which has led Mexican drug farmers to increasingly plant opium poppies in lieu of marijuana.

It is clear that prescription opioid abuse and the related heroin abuse are issues that affect communities across the United States. Without a comprehensive approach to these issues, many people across the county will continue to be affected by these drugs.

The Tulsa Police Department recommends a continuation of the comprehensive approach to drug trafficking currently in place, which relies on coordination among law enforcement agencies, community-oriented policing, intelligence and information sharing, and improved technology. The Tulsa Police Department also encourages additional federal efforts be made to prevent drugs of all kinds from crossing our international borders and finding their way into communities across the United States.

[The prepared statement of Mr. Griffin follows:]



Tulsa Police Department

STATEMENT OF

**CORPORAL MICHAEL GRIFFIN
SPECIAL INVESTIGATIONS DIVISION
TULSA POLICE DEPARTMENT
TULSA, OKLAHOMA**

BEFORE THE

**SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON ENERGY AND COMMERCE
U.S. HOUSE OF REPRESENTATIVES**

FOR A HEARING ENTITLED

**“EXAMINING THE GROWING PROBLEMS OF PRESCRIPTION DRUG
AND HEROIN ABUSE: STATE AND LOCAL PERSPECTIVES”**

PRESENTED ON

MARCH 26, 2015

Testimony of Corporal Michael Griffin
Special Investigations Division, Tulsa Police Department
Before the Energy and Commerce Subcommittee on Oversight and Investigations
U.S. House of Representatives
March 26, 2015

Introduction

Chairman Murphy, Ranking Member DeGette, and Members of the Committee, on behalf of Chief Chuck Jordan and the Tulsa Police Department (TPD), thank you for the opportunity to discuss prescription opioid abuse, heroin abuse, and heroin trafficking.

I have been a Tulsa Police officer for approximately 17 years, and have spent the majority of my career investigating drugs and/or drug related crimes. Of my 17 years as a Tulsa Police officer, I have spent approximately 12 of them in an undercover capacity, with nearly 10 of those years spent as a supervisor of a narcotics unit within the Special Investigations Division. My training and experience includes being the Honor Graduate of the Bureau of Alcohol, Tobacco, and Firearms New Professional Training Academy, completion of the Oklahoma State Bureau of Investigations Clandestine Laboratory Basic Safety and Site Safety courses, the DEA Basic Narcotics Investigators School, and Advanced Undercover Techniques and Survival, among other courses. I have been involved in over 1000 drug trafficking investigations, and have been the affiant on over 300 search warrants, primarily dealing with the distribution and/or manufacture of dangerous drugs.

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Background

According to data from the Drug Enforcement Administration (DEA), the number of heroin users nationwide almost doubled between 2007 and 2013 to an estimated 681,000. Data from the Centers for Disease Control (CDC) show that heroin overdose rates in 28 U.S. states increased more than twofold between 2008 and 2012, accounting for almost 19 percent of drug-related overdose deaths nationwide in 2013.¹

Although heroin abuse and trafficking in Tulsa lags far behind the abuse and trafficking of methamphetamine, heroin is trafficked into Tulsa in the same manner as methamphetamine and cocaine, and its abuse leads to similar related criminal activity, ranging from petit larceny to armed robbery and even murder.

Heroin Use among Prescription Drug Abusers

According to the DEA, heroin use is 19 times higher among former abusers of prescription drugs, with 80% of new heroin abusers first being abusers of prescription

¹ DEA Intelligence Bulletin dated February 13 – 17, 2015

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drugs. The reasons given for this increase in heroin abuse are availability, price, and OxyContin reformulation.²

Narcotics investigators assigned to the Special Investigations Division within the Tulsa Police Department know from their training and experience that a large majority of individuals currently addicted to heroin began their drug abuse by abusing prescription opioids.

Prescription Drug Investigations in Tulsa

The Tulsa Police Department currently has 751 sworn police officers. The Tulsa Police Department believes the focus of drug investigations should be on those individuals who are responsible for trafficking drugs into and throughout our community, rather than on those individuals who are merely addicted to drugs. This is because of our belief that resources are best utilized at the source of the problem, rather than on the symptoms of a problem. With that goal in mind, of the 751 sworn police officers working for TPD, one investigator is assigned to investigate prescription drug cases within the City.

² DEA Domestic Strategic Intelligence Unit: Trends in Heroin Abuse and Trafficking

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Tulsa Police officer Joe Gho, a 29 year veteran of the Tulsa Police Department, has spent the last 20 years investigating prescription drug cases. He believes that Oklahoma has one of the best Prescription Monitoring Programs (PMP) in the United States. Oklahoma's PMP is real-time and allows doctors and pharmacists to quickly access an individual's prescription drug history to evaluate if they are possibly doctor shopping to gain access to prescription drugs.

Officer Gho stated the two prescription drugs most abused in Tulsa are Hydrocodone and Oxycodone, both of which are opioids. Through his training and experience, he knows that individuals get addicted to these drugs for numerous reasons, to include beginning with a real medical need for the drugs as well as to doctors over-prescribing them at times. Once a person is addicted to opioids, it is not long before they realize that obtaining prescription opioids are harder to access (due to Oklahoma's PMP) and more expensive (up to \$30/Oxycodone pill) than heroin. Because these individuals are already addicted to opioids, the transition to heroin is easier and cheaper.

Heroin Investigations in Tulsa

Heroin trafficking in Tulsa is operated by Mexican Drug Trafficking Organizations. A typical heroin trafficking operation in Tulsa has a dispatcher who takes calls from

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an individual wishing to purchase heroin. That dispatcher takes the order from the individual wishing to purchase heroin, then tells the individual they will return their call shortly. Shortly thereafter, the dispatcher returns the call to the individual wishing to purchase heroin and tells the customer where to meet the dealer and the type of vehicle the heroin dealer will be driving. Those individuals meet near a major intersection in Tulsa, and the customer follows the heroin dealer into a nearby neighborhood. Once in the neighborhood and comfortable that they are not being followed by law enforcement, the heroin dealer will pull to the side of the road and allow the customer to enter his/her vehicle. The two of them will then drive through the neighborhood, conducting the drug transaction in the vehicle, all the while watching for law enforcement. If they do not observe law enforcement, the heroin dealer returns the customer to his/her vehicle, and they part ways. Heroin in Tulsa sells for approximately \$250-\$300 per gram. In Tulsa, a dosage unit of heroin, which is typically 1/10th of one gram sells for \$40.

The individuals selling the heroin to the customers in Tulsa usually receive a small place to stay, possibly a vehicle, and a daily allowance for their efforts. Their job consists of the distribution of the heroin, collection of the money, and securing the money until it can be sent back to Mexico.

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According to the DEA, the same Mexican Drug Trafficking Organization that is operating this type of heroin trafficking operation in Tulsa also operates in the same manner in multiple cities throughout the United States.

Similar to other drug investigations conducted at the local or state level, the individuals most often arrested and prosecuted are the local dealer and/or operation leader, however the individual profiting the most from the illegal distribution of heroin resides in Mexico and is usually beyond prosecution at the state level. Additionally, and still consistent with other drug investigations, when the individuals at the local or state level are arrested, the Mexican Drug Trafficking Organization simply replaces those individuals with other low-level people within the organization, therefor the DTO is able to continue distributing drugs within a community almost uninterrupted.

Correlation between Drugs and Crime

According to the Department of Justice, as many as 83 percent of incarcerated people are past or current drug abusers, with more than 51 percent of those individuals reporting substance abuse while committing the offense which led to their

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incarceration.³ The state of Oregon reported in 2009 that 78% of property crimes that occurred in that state were committed by drug addicts stealing to pay for their addiction.⁴

Data confirms that drug abuse not only provides a demand for drugs to be trafficked into and throughout the United States, but also that drug abuse and distribution leads to other crimes occurring in a community. An approach targeting drug trafficking without taking into account a need to prevent drugs from entering the United States is short-sighted.

Prior efforts by law enforcement agencies and state legislatures to prevent drug crimes and crimes that occur because of drug dependence and/or distribution have shown to be successful. For example, reducing the availability of pseudoephedrine has proven to reduce the number of methamphetamine labs operating in Oklahoma and other states with similar legislation. This legislation has not only reduced the number of methamphetamine labs operating within a state, sometimes up to 96%, but has also shown to significantly lower associated criminal activity.⁵

³ 1999 National Drug Control Strategy – Office of National Drug Control Policy

⁴ http://www.doj.state.or.us/about/pdf/annual_report_2009.pdf

⁵ <http://www.oncgonddcc.org/pse.htm>

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United States Border with Mexico

The United States border with Mexico is the primary entry point for the vast majority of marijuana, cocaine, heroin, and methamphetamine smuggled into the country. At the U.S. – Mexico border, Mexican DTOs use numerous methods to smuggle drugs into this country, to include aircraft, horses and mules, tunnels, vehicles, and even people walking across the border.

According to the Federal Bureau of Investigation (FBI), no other country in the world has a greater impact on the drug situation in the United States than Mexico. The FBI states that each of the four major drugs of abuse – marijuana, cocaine, heroin, and methamphetamine – are either produced in or transported through Mexico before reaching the United States. The FBI has further identified Mexico as the number one foreign supplier of marijuana and methamphetamine, and the major transportation corridor for cocaine and heroin.⁶

⁶ <http://www.fbi.gov/news/testimony/drug-trafficking-violence-in-mexico-implications-for-the-united-states>

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Data provided by the DEA shows that the supply of heroin coming from Mexico has increased over the past five years. According to the DEA, heroin seizures at the Southwest Border are on the rise:

- Heroin Seizures on the Southwest Border (2009-2014)
 - 2009 – 802
 - 2010 – 1,068
 - 2011 – 2,660
 - 2012 – 2,294
 - 2013 – 2,070
 - 2014 – 2,181

Part of the increase in heroin seizures on the southwest border may be due to the decrease in U.S. demand for Mexican marijuana, which has led Mexican drug farmers to increasingly plant opium poppies in lieu of marijuana.⁷

⁷DEA Intelligence Bulletin dated February 13 – 17, 2015

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Conclusion

It is clear that prescription opioid abuse and the related heroin abuse are issues that affect communities across the United States. Without a comprehensive approach to these issues, many people across the country will continue to be effected by these drugs. The Tulsa Police Department recommends a continuation of the comprehensive approach to drug trafficking currently in place, which relies on coordination among law-enforcement agencies, community-oriented policing, intelligence and information sharing, improved technology, as well as additional federal efforts made to prevent drugs of all kinds from finding their way into communities across the United States.

Mr. MURPHY. Thank you, Corporal. I appreciate your testimony. Last but not least is Dr. Banta-Green, Senior Research Scientist at the Alcohol and Drug Abuse Institute at the University of Washington in Seattle.

Doctor, you may now give a 5-minute summary of your written statement.

STATEMENT OF CALEB BANTA-GREEN

Mr. BANTA-GREEN. Good morning, Chairman Murphy and members of the committee. I am honored to speak to you today about how we can improve the health of our communities as they struggle with how to manage stress, pain, and addiction in a society and a healthcare system that has historically valued and incentivized quick fixes over real health and wellness. We face big challenges but we do know what needs to be done.

I am a Senior Research scientist at the Alcohol and Drug Abuse Institute at the University of Washington, where I am also Affiliate Faculty in the School of Public Health and the Harborview Injury Prevention and Research Center. My current work includes leading a study of an intervention to prevent opioid overdoses among heroin and pharmaceutical opioid users that is funded by the National Institutes of Health. I have a project analyzing prescription monitoring program data and developing interventions with those data to improve health for those taking controlled substances. This is funded by the Bureau of Justice Assistance with an award to our State Department of Health; and I am currently running the Center for Opioid Safety Education which supports communities across Washington State so that they can respond to the overwhelming impacts of opioid abuse and overdose in their communities. That funding is from the SAMHSA block grant to our state substance abuse agency.

As a public health researcher, I think in terms of primary prevention—preventing a problem from starting; secondary prevention—intervening in a problem to prevent it from getting worse; and tertiary prevention—to prevent death and serious harm.

Given that our communities are in crisis, let us start with preventing death and serious harm. Overdoses can be prevented and most can be reversed before they become fatal if people know how to recognize an overdose and how to respond. Overdoses are a crisis of breathing. 911 needs to be called. An antidote, naloxone, needs to be administered, rescue breathing needs to be initiated and the overdose victim needs to be monitored. Naloxone is a proven, safe medication yet far too few people who need it even know about it, can get it easily or can afford it. Overdose education on naloxone can be provided in a doctor's office, by a pharmacist, at jails or via community-based health education programs such as syringe exchanges. Those at highest risk for overdose are heroin users. Syringe exchanges have the staffing expertise and trusting relationships with our loved ones who use heroin that are necessary to provide lifesaving services.

At the same time, far more people are using pharmaceutical opioids. About 3 percent of adults use opioids chronically for pain. They also need overdose education and take-home naloxone.

Fatal overdose prevention is a necessary first step, but it is a short-term emergency response. Given that opioid addiction leads to changes in the brain and that addiction is a chronic and relapsing condition, it needs to be treated as a chronic medical condition. We are fortunate to have medications to support opioid addiction recovery. Methadone and buprenorphine have been consistently shown in research to save lives and be cost efficient. However, access is still limited by regulatory, geographic, and financial barriers.

Switching to those using opioids for chronic pain, realistic expectations about pain relief need to be discussed, including the fact that long-term opioid use may not lead to good pain control and in fact may reduce functioning. Washington State has led the nation by implementing chronic pain management guidelines in 2007 which have subsequently been codified in State law. Key points of these guidelines include: a dosing threshold trigger for consultation with a pain specialist; patient evaluation elements; periodic review of a patient's course of treatment; encouraging prescriber education on the safe and effective uses of opioids; and the use of medication-assisted treatment if a person is not successfully tapered off of opioids and has an opioid use disorder.

So, how do we prevent opioid addiction in the first place? Given that the majority of young adult heroin users now report they were first hooked on pharmaceutical opioids, it is clear that addressing inappropriate initiation is essential. The decision to begin prescribing opioids for minor injuries and pain needs to be carefully considered as does the total quantity dispensed if they are prescribed. Opioids in the home need to be carefully monitored and immediately disposed of when no longer needed. Parents need to know how to talk with their kids about medication safety as well as how to manage stress and pain without medications, drugs, or alcohol.

To conclude, we can keep people alive, we can treat harms related to opioid use and we can prevent misuse, but, given the potential harms of improper care for those with opioid use problems, we need to take a strategic approach based upon the fact that pharmaceutical opioids can be used interchangeably with heroin and we need to work on prevention and intervention simultaneously.

Thank you very much.

[The prepared statement of Mr. Banta-Green follows:]

Testimony of Caleb Banta-Green, PhD MPH MSW

University of Washington, Alcohol & Drug Abuse Institute

Subcommittee on Oversight and Investigations "Examining the Growing Problems of Prescription Drug and Heroin Abuse: State and Local Perspectives."

March 26, 2015

Good morning Chairman Murphy and members of the committee,

I am honored to speak to you today about how we can improve the health of our communities as they struggle with how to manage stress, pain and addiction in a society and a health care system that has historically valued and incentivized quick fixes over real health and wellness. We face big challenges, but we know what needs to be done.

I am a Senior Research Scientist at the Alcohol and Drug Abuse Institute at the University of Washington in Seattle where I am also affiliate faculty in the School of Public Health and the Harborview Injury Prevention and Research Center. My current work includes:

- leading a study of an intervention to prevent overdoses among heroin and pharmaceutical opioid users that is funded by the National Institutes of Health;
- a project analyzing prescription monitoring program data and developing interventions to improve health for those taking controlled substances funded by the Bureau of Justice Assistance awarded to our State Department of Health; and
- running the Center for Opioid Safety Education which supports communities across Washington so that they can respond to the overwhelming impacts of opioid abuse and overdose in their communities, funding is from the SAMHSA block grant via our state substance abuse agency.

As a public health researcher I think in terms of:

Primary prevention-Prevent a problem from starting

Secondary prevention - Intervene in a problem before it gets worse

Tertiary prevention -Prevent death and serious harm

Given that many communities are in crisis, let's start with preventing death and serious harm:

Overdoses can be prevented and most can be reversed before they become fatal IF people know how to recognize an overdose and how to respond. Opioid overdoses are a crisis of breathing. 911 needs to be called. An antidote- naloxone- should be administered, rescue breathing initiated and the overdose victim monitored. Naloxone is a proven, safe medication- yet far too few people who need it know about it, can get it easily or can afford it. Overdose education and naloxone can be provided in a doctor's office, by a pharmacist, at jails or via community based health education programs such as syringe exchanges. Those at highest risk for overdose are heroin users. Syringe exchanges have the staffing expertise and trusting relationships with our loved ones who use heroin that are necessary to provide life saving services. At the same time, far more people use pharmaceutical opioids, about 3% of adults chronically, and they also need overdose education and take-home-naloxone.

Fatal overdose prevention is a necessary first step, but it is a short term emergency response. Given that opioid addiction leads to changes in the brain and that addiction is a chronic and relapsing condition, it needs to be *treated* as a chronic medical condition. We are fortunate to have medications to support opioid addiction recovery- methadone and buprenorphine have been consistently shown in research to save lives and be cost efficient; however, access is still limited by regulatory, geographic, and financial barriers.

Switching to those using opioids for chronic pain, realistic expectations about pain relief need to be discussed, including the fact that long term opioid use may not lead to good pain control and in fact may reduce functioning. Washington State has led the nation by implementing chronic pain management guidelines which have subsequently been codified in state law. Key points of these guidelines include:

- A dosing threshold trigger for consultation with a pain specialist
- Patient evaluation elements
- Periodic review of a patient's course of treatment
- Encouraging prescriber education on the safe and effective uses of opioids AND
- The use of medication assisted treatment if a person is not successfully tapered off of opioids and has an opioid use disorder

So, how do we prevent opioid addiction in the first place? Given that the *majority* of young adult heroin users now report they were first hooked on pharmaceutical opioids it is clear that addressing *inappropriate* initiation is essential. The decision to begin prescribing opioids for minor injuries and pain needs to be carefully considered as does the total quantity dispensed if they are prescribed. Opioids in the home need to be carefully monitored and immediately disposed of when no longer needed. Parents need to know how to talk with their kids about

medication safety as well as how to manage stress and pain without medications, drugs or alcohol.

To conclude- we can keep people alive, we can treat harms related to opioid use and we can prevent misuse, but, given the potential harms of improper care for those with opioid use problems, we need to take a strategic approach based upon the fact that pharmaceutical opioids can be used interchangeably with heroin and we need to work on prevention and intervention simultaneously.

Thank you.

Mr. MURPHY. I thank the entire panel. We will try and get through as many questions of members as possible, and we will have votes, but we will continue on because one vote will be brief.

So Dr. Melton, let me start off with you. What is the goal of medication to deal with opioid addiction? Is it to keep the addict maintained for life or is the goal to have it part of a program of getting the person clean and sober from the drugs?

Ms. MELTON. That is a great question and a point of controversy in the clinical setting. Of course, to me the goal of medication-assisted treatment is to provide a treatment for the patient where they are able to do the hard work and become productive members of society. And so the way I think of it as a patient who has addiction has constant craving and constant thoughts of where am I going to get my next opioid. When they are prescribed methadone or buprenorphine, the craving is relieved and they are able to focus their efforts on doing the really hard work that is necessary, and that is the psychotherapy, group, 12-step programs, et cetera. So the overall goal is for the patients to receive the treatment for a limited period of time. We usually tend to think of it as 2 years, 1 year for them to become stable and do the hard work and perhaps a year to taper off of it. However, there are some patients that are wanting to have this maintenance for life. We know we have seen that in some patients, but the goal is eventually for them to be productive members of society and not to be maintained long-term.

Mr. MURPHY. I am looking at a study here that was in the New England Journal of Medicine by Johnson, et al, and it reports that patients on buprenorphine used illicit opioids an average of four times per week. So I don't know how much that is working. Can you comment on that?

Ms. MELTON. Well, what I would say with that and I address in my testimony is that we are in dire need of more regulations and recommendations on evidence-based care of how these programs should be run. We know in Tennessee and southwest Virginia some buprenorphine programs have become pill mills where the physicians charge them high prices, they come in and get their medication, and they leave.

Mr. MURPHY. So there is an incentive, are there incentives because there are cash transactions in many cases and what you describe, they become pill mills? Is that what it has become?

Ms. MELTON. Yes. We are seeing that, and it is devastating in many circumstances. There is a dearth of access to good treatment, and by "good treatment," I mean patients being seen frequently, getting urine drug screens at nearly every visit, if not every visit, requiring 12-step programs, group counseling, and not co-prescribing with other drugs of addiction such as benzodiazepines.

Mr. MURPHY. Because otherwise with the government funding these things, we are just in that great term that we use, the clinical terms, we are codependents, we are enablers if we create these incentives.

I move on to another—Dr. Brason, your experience with Project Lazarus, what has been the most effective approaches in getting addicts completely off drugs?

Mr. BRASON. Getting patients off—

Mr. MURPHY. Yes, off drugs.

Mr. BRASON. A comprehensive approach and determining and assessing that individual of what the best treatment modality may be. Some can walk right into a 12-step abstinence program. Others who have been using for even longer then do need that maintenance therapy in order to give them that stability so that you can work on their entire life. Now, somebody who is getting the methadone or the buprenorphine can receive that, and that takes maybe—if they are getting daily dosed—an hour and a half a day. What happens to the other 22, 23 hours of that person's life when they had gone from 24/7 of looking to use, getting to use and figuring out where they are going to obtain that? It takes community support. You have got to have the life systems around that individual so that if they are getting the right maintenance therapy or the right 12 steps, they have got the counseling, they have all of those in place, but what happens when they go home? You talk about a rural community. They leave their house or they go to detox and they leave detox during the same home, same environment, same friends. If there is no other support around that to help them stay strong in that environment, then they fall back into the same situation.

Mr. MURPHY. So somewhere out there in America, we hope someone is watching this hearing that themselves is dealing with drug addiction. If you had a chance to look them in the eye and say something to that addict, what do you say?

Mr. BRASON. My word to them would be: We are here, I am here to help you, and let us walk through this together to see what best works for you so that we can then work on all the circumstances, situations, and issues that brought you to that place. We can talk about the drug problem, but what caused all of that?

Mr. MURPHY. And in simple words too, Ms. Gardner, is there hope? Can you give someone hope that they can get off drugs?

Ms. GARDNER. Well, we have talked a lot about the disease and the negative effects and the horrible things that happen with this disease, but there is hope. There are lots of people across this country staying clean and sober, have multiple years. I get the pleasure of working with young people, watching them graduate, watching them go on to postsecondary education, watching them become productive members of the communities.

I work with lots of young people around the country who have gone through similar situations through high school and collegiate recovery that are doing great things. There is a lot of hope. I agree with the panelists. We are all saying the same thing. It is a comprehensive approach to this between medications, between law enforcement, between schools, between educating doctors. There is hope.

Mr. MURPHY. Thank you.

Ms. GARDNER. And we need to focus on the hope.

Mr. MURPHY. Thank you.

I am out of time, and I will recognize Ms. DeGette for 5 minutes.

Ms. DEGETTE. Thank you very much, Mr. Chairman.

Dr. Banta-Green, I was very interested in your testimony that when somebody becomes addicted to opiates, there are actually changes in their brain. Is that right? And I am assuming, Dr.

Melton, you would agree with that as well from your testimony. You need to answer.

Ms. MELTON. I agree, yes.

Ms. DEGETTE. Thank you. And so Dr. Banta-Green, I think this is why you are saying that somebody who is addicted to opiates, the best treatment is not just to have counseling or a 12-step program for most patients; they also need to have something to sort of rejigger their brain. Is that right? That is not a scientific term, by the way.

Mr. BANTA-GREEN. Rejigger? I am not familiar with that one, but I know what you mean. So I think that is right. I think what we need, as Mr. Brason said, is we need a range of options.

Ms. DEGETTE. Right.

Mr. BANTA-GREEN. We need a menu of things. Different things work for different people.

Ms. DEGETTE. And would you agree with that, Dr. Melton?

Ms. MELTON. I also agree, yes.

Ms. DEGETTE. And so what we have learned is, and we have been referring to this, there was a recent article that said that abstinence-based treatment only works in about 10 percent of opiate addicts. Would you agree with that, Dr. Banta-Green?

Mr. BANTA-GREEN. I am not sure it is exactly 10 percent. What I—

Ms. DEGETTE. But it is a low percentage, right?

Mr. BANTA-GREEN. It is a minority. I think it is important—Dr. Roger Weiss at Harvard had a paper come out last month that followed up after 42 months people who had started on buprenorphine. Some did well at the front end. Some did not. After 42 months, only 8 percent were still addicted to opioids but about a third of those people had managed to not be on medication-assisted treatment but many had still been on medication-assisted treatment.

Ms. DEGETTE. OK.

Mr. BANTA-GREEN. There are different paths for different people.

Ms. DEGETTE. Yes, but the best protocol would be for these folks to have the option to have the medication-assisted treatment, the MAT, plus the counseling that Dr. Melton talked about?

Mr. BANTA-GREEN. Absolutely. There is no question about that.

Ms. DEGETTE. And were you aware that the MAT treatment was only available in about 9 percent of all substance abuse treatment facilities nationwide?

Mr. BANTA-GREEN. I know that it is a very low proportion.

Ms. DEGETTE. And Dr. Melton, were you aware of that too?

Ms. MELTON. Yes.

Ms. DEGETTE. OK. And Mr. Brason?

Mr. BRASON. Yes.

Ms. DEGETTE. Now, Dr. Melton, you probably see this in your practice. One of the biggest problems that we have with the lack of the MAT treatment is in rural areas. Is that true in the areas where you practice?

Ms. MELTON. That is correct.

Ms. DEGETTE. And Mr. Brason, you are nodding your head. Are you seeing that too?

Mr. BRASON. That is correct also, yes.

Ms. DEGETTE. Now, I am hearing from folks—and you know, for those of us who are concerned about over-prescription of opiates, who are concerned about young people getting addicted to heroin and other opiates, the idea of substituting one for another like with methadone or other drugs, that sort of goes against our instincts, but in fact, I guess I will ask this question: Is the use of those medications simply replacing one addiction with another, Dr. Banta-Green?

Mr. BANTA-GREEN. No. A person who is being managed on medication-assisted treatment, per the Diagnostic and Statistical Manual, the American Psychiatric Association, it is not addicted anymore. They are physiologically dependent on opioids. We need to separate out addiction from dependence. Addiction is what we see, all the social and psychological pieces plus the physical. You address the physical and then you can deal with the rest.

Ms. DEGETTE. And Dr. Melton talked about how if you can get folks into adequate treatment with the MATs, then with the counseling, she said the goal would be sort of a 2-year process. One is to get them to be stabilized and thinking, and the other one is to get them off. Would you agree with that type of thought?

Mr. BANTA-GREEN. No.

Ms. DEGETTE. OK.

Mr. BANTA-GREEN. I would say that the goal is for the person to do well, and for some of them, that is going to be to go off the medications immediately. They are not going to do well on those medications. For other people, they are going to have a short period. For people who have been involved in addiction and a lot of their life has been wrapped around it for 10, 15, 20 years, that is going to take a long time to work through and it is going to take a longtime for them to recreate that life. So some people may need to be on them long term, some not at all, some short term.

Ms. DEGETTE. So Dr. Melton, what would you say about my question about is the use of these medications simply replacing one addiction for another?

Ms. MELTON. Absolutely not. I agree with him. It is not addiction. We are getting them into a state of where those behaviors that meet the criteria for addiction are gone. They are now in a state of physiologic dependence on the opioid, but because of that dependence, they are able to do the hard work that we have discussed, and I totally agree when I said the 2-year, when you look at insurance companies, they limit buprenorphine a lot of times to 2 years.

Ms. DEGETTE. OK.

Ms. MELTON. But for some people, it will be a lifetime, as I said.

Ms. DEGETTE. And for some people, they don't even need the MATs, right?

Ms. MELTON. Some people are able to do abstinence.

Ms. DEGETTE. And you agree with that too, Mr. Brason?

Mr. BRASON. Yes, I do.

Ms. DEGETTE. Thank you very much, Mr. Chairman.

Mr. MURPHY. Thank you, Ms. DeGette. I now recognize Mr. McKinley for 5 minutes.

Mr. MCKINLEY. Thank you again, Mr. Chairman.

Two things, and if I could direct those to Dr. Maxwell. You said something that I found very intriguing in your remarks and also in your testimony, and that was about pay for success, and I spent a little time, I was looking—I did a little research, the beauty of Google, to be able to read that, and I understand that program may be working across the country. Can you give us a little bit more information about, one, the program of pay for success, and two, this proactive role that you talked about for drug-free moms and babies? I am curious about it because what I am hearing from you is that you have actually got programs to solve this, and so I am curious to see, or at least address it. Could you answer both of those two questions?

Dr. MAXWELL. I will try, sir. The pay-for-success model I was introduced to last year when I attended as one of the representatives for our State at ReadyNation.org meeting in Charlotte, which was their first meeting, and they have brought this pay for success or social impact bond concept to the United States based on Great Britain's experience a few years ago looking at recidivism rates for juveniles going back into jail, and they had some success in Great Britain. The program was brought here by Robert Dugger and some other members of the ReadyNation organization, and I can't tell you exactly how many States but Virginia, North and South Carolina, I think New Jersey have implemented some of these programs. Some are actually social impact programs, some are pay-for-success programs looking at early childhood education and so forth.

I was intrigued when I heard of the model, and the model, I will have to read it for you because it makes a little bit more sense if I read it. Under this model, an investor finances the implementation of a proven or evidence-based social intervention program that is expected to improve social welfare and save government money in excess of the program implementation cost. So the government at the end repays the investment only after the program can measurably reduce state expenditures as a result of its successful implementation. So I thought that looking at our drug-free moms and babies model, that if it in fact is successful, that we could have this end up in a pay-for-success program because you identify women early in pregnancy using a screening tool, and as I said, urine is not a very good screening tool because if the woman has not done a substance in 2 or 3 days, then the urine will be negative, especially for alcohol, but for narcotics, I think that if they use it within a 24-hour period of time prior to the test that the urine will be positive. But the urine is not universally positive. And so we depend upon another tool. In West Virginia, we are using a tool that we call SBIRT. There are other areas. People in Chicago, Dr. Ira Chasnoff and his people are using the Five Piece Plus model, which is trademarked and so forth, so it is expensive.

So we use the SBIRT model, and there are people who train others to use this screening tool because the questions have to be asked in a specific way in order to get the answers. And so once you have screened them and you realize that they are positive, then we hope that we can get them into addiction counseling, and I have found looking at the programs that we have had in place now for the last 2 years or so, that addiction counseling and rehabilitation using behavioral medicine specialists seems to be the way

to go because pregnancy is a unique opportunity, I think, to address addiction, and we find, I believe, that there is a very positive motivating force that occurs when you are pregnant because a woman really wants to deliver a healthy baby, believe it or not.

And so I have found that if we can intervene early in pregnancy, that throughout that pregnancy we might be able to have some behavior modification, and if not necessarily take them off the drug completely because sometimes that might be dangerous for the life of the fetus, but at least reduce their dependence upon the substance, hopefully using buprenorphine. Methadone has been a barrier because the problem is that we have now two people taking care of the patient. You have the methadone clinics, which are prescribing the medication to the mom, and sometimes they actually increase the amount of methadone that they are using throughout pregnancy rather than decreasing it.

So we like the conversion method where whatever opioid they are using gets converted to buprenorphine or Subutex. We can then control that mom a little bit more closely. We can wean her off the Subutex during pregnancy and reduce the amount of drug the baby is exposed to and hopefully reduce their length of stay. They are still probably going to withdraw at the end but the withdrawal period will be much shorter than the average of 16 or 20 days, whatever it is, and reduce the cost of stay and also improve the health and the welfare of both mom and baby as they go home.

Mr. MCKINLEY. Thank you very much. I yield back my time.

Mr. MURPHY. Thank you. Mr. Tonko, you are recognized for 5 minutes.

Mr. TONKO. Thank you, Mr. Chair, and welcome to the panelists. Thank you for bringing your intellect and your passion to the table. It is most helpful.

In October of last year, the Atlantic magazine published an article titled "The New Heroin Epidemic," which looked at a number of challenges facing addicts in West Virginia. I would like to enter this article into the record, Mr. Chair.

Mr. MURPHY. Without objection.

[The article has been retained in committee files and can be found at: <http://docs.house.gov/meetings/if/if02/20150326/103254/hrg-114-if02-20150326-sd008.pdf>.]

Mr. TONKO. Thank you.

The article discusses the challenges faced by opiate addicts seeking treatment including lack of doctors, poor reimbursement rates by Medicaid, and long waiting lists for some that are seeking treatment. I would like to discuss these barriers with the panel and ask whether sufficient resources currently exist to get treatment to those who need it.

Dr. Maxwell, you have tremendous experience caring for patients in the State of West Virginia. Do those wishing to get help for opioid addiction have sufficient access to effective treatment programs, particularly those in rural areas where addiction specialists might be hard to find?

Dr. MAXWELL. Well, to be honest, sir, I don't have as much experience as you might think with addiction—people who are addicted to opiates. I really am a newborn intensivist, and I take care of the babies that are a product of those addicted moms.

But having said that, I am on the Governor's Advisory Council for Substance Abuse in West Virginia. Governor Tomlin established this probably 3, 4, years ago now, and we have an advisory council that oversees the work of task forces within the State. We have split the State into six different areas, and each area, each of those six areas has a task force, and the task force has meetings every month or bimonthly at the community level where they get information from the people. And then they bring that to the advisory council and we meet once or twice a year to collate all that information in terms of access to care, who is getting what and so forth, and where treatment centers are needed, et cetera, and we have had some success. The first year we had \$7 million to spend, and we advised the Governor how to spend that money by identifying areas within the State that needed a treatment center, or because I am biased and it was for women and pregnant women treatment center, so we are working on that problem. I don't have all that information with me but I can get it to you.

Mr. TONKO. Thank you. That would be most helpful.

And Dr. Banta-Green, a similar question. What are the resource challenges facing those who wish to find effective treatment for addictions, and are there research challenges in your State of Washington or the surrounding States like Idaho and Oregon? What are you seeing out there as a person so deeply invested in this arena?

Mr. BANTA-GREEN. Thank you for the question. So just to be clear, methadone maintenance is done in large treatment facilities, generally in larger cities, and there actually is demand for that. We actually at one of our large facilities had afternoon dosing last year because there was such demand. But in terms of buprenorphine, which is really important, because as opiate addiction has spread across the states into more rural areas, methadone clinics aren't going to be able to serve all those places. You can't go and dose 6 days a week. You need something like buprenorphine. It is much easier to access from a geographic perspective.

But Dr. Roger Rosenblatt at the University of Washington recently published literature on this and found that many, many of the rural communities do not even have a single Suboxone provider, and what I think it is important to understand is that there is the geographic barrier in terms of many communities don't even have a Suboxone provider. My understanding, and he has done research with those physicians, particularly those who have already been trained and waived by DEA to provide buprenorphine for addiction treatment, most still don't ever prescribe, and the reason they do not prescribe is that they are not getting adequate reimbursement is one piece of it, but there are inadequate addiction counseling services in their communities and also they do not want to be the only doctor prescribing, and in fact, they should not be the only doctor prescribing. It is not appropriate to have a single provider in a community doing addiction treatment. So those are some of the barriers that are faced in terms of having enough physicians step up to prescribe at the same time is really important. There are reimbursement issues and then there are also those geographic issues as well.

Mr. TONKO. So is it basically a function of the trained, talented, skilled set of people or is it a function of resources made available beyond reimbursement rate levels?

Mr. BANTA-GREEN. I think in the very short term—and I think what is really important is, we need to understand that buprenorphine as a medication is overdose prevention. It is long-term overdose prevention. Naloxone is 90-minute overdose prevention. Buprenorphine is potentially many, many years' worth of overdose prevention. So there are clearly reimbursement issues but there are also many providers with very poor training in addiction. They know very little about addiction. They are very uncomfortable with it just as they are very uncomfortable with prescribing opioids, which they also have very poor training in, which are pretty important issues, given what we are talking about, that there is not adequate training.

Mr. TONKO. Especially with it being a gateway to the addiction, heroin addiction.

I thank you very much. I see my time is exhausted, and I yield back, Mr. Chair.

Mr. MURPHY. They called votes. We are going to try and get through another one. Mr. Griffith, you are recognized for 5 minutes.

Mr. GRIFFITH. Thank you, Mr. Chairman. I appreciate that very much.

Dr. Melton, we have been talking some about naloxone, and I know there are going to be folks watching this at home today and who will be watching it at home over the next week or so as the C-SPAN replays it. Can you explain to the public what naloxone does in the case of a heroin or opioid overdose?

Ms. MELTON. Sure. In simple terms, naloxone is an opioid antagonistic or a blocker, and so when naloxone is administered either intranasally, IV, or intramuscularly, it goes to the receptors in the brain to block opioid receptors. And so it will kick off heroin, other opioids immediately, and by doing that, it reverses respiratory depression and other central nervous system depression that leads to death. So what happens is the patient goes into nearly immediate withdrawal, but unfortunately, naloxone only lasts for a short period of time and so often additional dosing is needed, especially with methadone overdoses, which has a very long activity in the body.

Mr. GRIFFITH. So it is not to help somebody who has got a problem continue their problem but it is to help them if they have had an overdose so that they don't die. Isn't that correct?

Ms. MELTON. Absolutely right. It should never be considered that people will use naloxone so that they can have a higher dose of heroin. You ask any addict if they want to go into immediate withdrawal, and they will tell you it is their worst nightmare.

Mr. GRIFFITH. I recently wrote a bipartisan letter with 22 of my colleagues here in the House calling on the Administration to develop practices for naloxone use and reprogram existing funds to provide naloxone to medical providers. I think that is a good idea. You have mentioned here in your earlier testimony Senator Kaine's bill that provides Good Samaritans with some immunity from liability unless they are acting grossly negligently or maliciously.

What else do you think that we can do to promote this from a congressional standpoint and make sure that the public is aware of it?

Ms. MELTON. Well, I think one issue is, I think we are getting the awareness going across the country now but access to it, patients being able to afford it is a difficulty. It really needs to be mandated coverage by insurance companies so we are able to access it easily at the pharmacy. Virginia's new legislation will allow pharmacists to, through a collaborative practice agreement, write prescriptions for patients that come in and ask for it and train them on the spot, which I think is a huge step forward, so that will increase access, but again, the payment issues are a barrier.

Mr. GRIFFITH. And nobody is accusing the Virginia legislature of being soft on drugs or being liberal in this area, wouldn't you agree?

Ms. MELTON. I agree.

Mr. GRIFFITH. Yes, ma'am.

Now, in my district, our region of southwest Virginia shares borders with four other States: West Virginia, Kentucky, Tennessee and North Carolina, two of which are represented here today as well. This makes it easy for people to cross State lines to doctor-shop and gather multiple prescriptions and from multiple pharmacies to get large amounts of prescription painkillers. What effect has this doctor-shopping had on our problem and how might we address it? And I will start with you, Dr. Melton, but the folks from Tennessee and West Virginia are welcome to chime in.

Ms. MELTON. OK. So as I stated in my testimony, Virginia, Tennessee, West Virginia and the other border States will soon be participating in the Interconnect, which allows prescription drug monitoring programs to connect across States lines, so when I have a patient that comes in, I automatically run a query, let us say from Virginia I can access 15 different States immediately and see if they have had any prescriptions filled in other States. It has been amazing to see how we are able to identify doctor shoppers and identify them as a potential for addiction and get them into treatment.

Mr. GRIFFITH. And I would have to say for those that don't the area well, you would have to work at it but you could actually hit all five states in a single day if you really organized.

Do either of the folks want to add something?

Mr. BRASON. From North Carolina, obviously we are along Virginia and Tennessee and so forth, and we have the same program to where prescribers can access each individual State so that they can check the patient's history to make sure that they are not crossing those lines.

Mr. GRIFFITH. Very good.

Dr. Maxwell?

Dr. MAXWELL. From West Virginia, yes, we have recently passed legislation for pharmaceutical tracking, et cetera.

Just one point is that an unintended consequence from cracking down on the pill mills or whatever may be responsible for the increase in heroin use that we are seeing now because the patients that are coming in are not on oxycodone or hydrocodone or Percocet or any of these drugs any longer but they are on heroin, which is

more easily available, and that might have been an unintended consequence.

Mr. GRIFFITH. Yes, sir. I appreciate it very much.

I see my time is up, Mr. Chairman. I thank you and yield back, and thank all the witnesses for being here today.

Mr. MURPHY. Thank you, Mr. Griffith.

We are going to take a brief break to have votes. We should be back here, let us aim for around 12:15, and we will continue on with our questions, and I thank the panel for waiting.

[Recess.]

Mr. MURPHY. All right. We reconvene this hearing of Oversight and Investigations on substance abuse and addiction.

I am now going to recognize Mr. Mullin of Oklahoma for 5 minutes.

Mr. MULLIN. Thank you, Mr. Chairman, and Mike, thank you again for taking the time to come up here and give your professional opinion.

Earlier this year, the Oklahoma Department of Health released a report that showed that heroin deaths in Oklahoma had increased tenfold in the past 5 years, and between 2007 and 2014, treatment centers in Tulsa County saw a 99 percent increase of those being admitted for heroin and prescription drug use. That is astounding, and one thing that we constantly hear about is where are the drugs coming from, and Mike, being that you have worked—or Corporal Griffin, sorry—being that you have worked undercover for literally 12 years, you continue to arrest people in Tulsa and some places even farther than that, but where does the barrier happen? What are your limitations?

Mr. GRIFFIN. So the barrier, or the goal, of course, in all our drug investigations is, like I said earlier, we are not targeting individuals addicted to drugs. We are going after the people that are hurting other people by supplying drugs and ruining those people's lives. So when you think of methamphetamine, cocaine, heroin, things like that, you are always working up the ladder, so to speak, to get to the biggest drug dealer we can find and almost always that leads us back to the U.S. border with Mexico. Different from that is prescription drugs where in those situations—I hate to use the word “dealer” but the dealer in that situation is a doctor or a pharmacist. Ninety-nine-plus percent of those people are law-abiding people doing the right thing for all the right reasons. A very small percentage of them may be taking advantage of the situation.

Even in those situations where it is maybe a rogue doctor or pharmacist, the laws that are set up in Oklahoma make it almost impossible for us to pursue them through the law enforcement for the way that we do cases, so that is part of why we have so few people dedicated to that and so many dedicated to the other major drugs of addiction.

Mr. MULLIN. And Corporal Griffin, your job is to catch the bad guy, and once you catch the first person, sometimes that is the user, maybe it is the seller, but you try tracking it back as far as you can go?

Mr. GRIFFIN. Yes, sir.

Mr. MULLIN. Are you being successful at that?

Mr. GRIFFIN. We are very successful at it. We have a great relationship with other law enforcement agencies in the area to include DEA and FBI. We are constantly working on cases that cross State boundaries. We are working a very big case right now. Hopefully we will really start moving further down the road within the next week or two, and we already know that that case is an international case that has been operating for a long, long time, not only in the United States but in Oklahoma, and that is a case we will work all the way into Mexico with the help of federal law enforcement agencies.

But even if we were to say we were successful in that operation and get the people that are in Oklahoma and Texas and other places that are making millions of dollars from their illegal distribution of methamphetamine, cocaine, even at that level and we take them off, the drug-trafficking organization is going to replace them and before long they will be right back up and running because it is so easy to smuggle those drugs into our country that if we don't address that issue, I am a hamster on a wheel and just keep spinning.

Mr. MULLIN. Mr. Fitz, Corporal Griffin, his team, they make the arrest. The paperwork ends up on your desk. What happens at that point?

Mr. FITZ. Well, again, it depends on the type of case. In my office, we do not negotiate—we don't dismiss the charges. We plead to all the charges, and we basically have the philosophy, get clean or get prison, and we have a big meth problem in addition to obviously things such as heroin and cocaine and so forth but our biggest problem actually is methamphetamine, and what we—

Mr. MULLIN. Corporal Griffin, you have a tremendous amount of knowledge about meth too.

Mr. GRIFFIN. Methamphetamine is just the biggest drug facing Oklahoma right now.

Mr. FITZ. So what we have, I think something that actually our treatment providers are very much—they subscribe to it and they buy into it. What we do is, we indicate to the defendant that our guidelines on meth, for instance, are fairly high, and we indicate to them that they plead as charged to everything and they agree that they will go into a treatment program. Usually is a yearlong treatment court, family treatment court, adult treatment court, and if they get clean, they never go to prison, but if they don't, then they go to prison for a substantial period of time, 4, 5, 6 years.

Mr. MULLIN. Corporal Griffin made a statement right at the end of it, and Mr. Chairman, if you would indulge me just an extra minute? Corporal Griffin made a statement that he feels like he is a hamster on the wheel. Although he believes in the process, it revolves over and over again. Do you see that same thing happening in the court system? I mean, do you see the same people coming back over and over again?

Mr. FITZ. There is a large percentage, but again, that is just the tragic reality of drug activity is not only the users but also the dealers because oftentimes the penalties are quite lenient. And let me just comment on that too. We see cartel activity in Michigan also on these drugs. It is a very real problem. And I agree with him that I think it is very important to try to address this problem on

the border but maybe let me also mention something I think that is important to keep in mind when dealing with these type of issues is that I look at drug activity, and I know many of my colleagues do as well, it is like cutting the grass. You need to remember that grass will never stop growing, drugs will not ever stop coming in, but if you stop cutting the grass, your lawn is going to get out of control. If we stop vigorous enforcement, we are going to see things far worse than what we even see right now. And maybe just one other analogy I would give to you also. Sometimes you do hear that we can't arrest our way out of the problem, and I do agree with that, that arresting is not the only solution. It has to be a multifaceted approach to it. But that doesn't mean we stop arresting people that do bad things such as drug dealing, murder. We are never going to stop murder, we are never going to stop home invasions, but we continue to address the problem, and again, because it does have the churn effect, it does have justice, it does involve public safety as well.

Mr. MULLIN. Corporal Griffin, Mr. Fitz, thank you so much. Thank you, Mr. Chairman.

Mr. MURPHY. Thank you. The gentleman yields back. I now recognize Ms. Brooks for 5 minutes.

Mrs. BROOKS. Thank you, Mr. Chairman, for holding this hearing. I have to say, I wish that we could actually spend hours upon hours discussing this critical problem.

I have actually been a defense attorney. I have been a United States attorney. I was at our State's community college and have dealt with individuals with addiction but nothing really touched me as much as when I went and visited the Hope Academy and saw a recovery high school and realized that that is the type of program—because I have been involved in the take-downs of the big cartels and organizations in our community in the southern district of Indiana, but we have to stop it. There is always going to be a supply but I want to focus a bit on the demand and what we are doing on the demand side, and I really appreciate you being here, Ms. Gardner, and want to ask about those recovery supports that are so important and what are some of the things—I would like you to talk a bit more about how the high school works and about what—because there are only 35 in the country but yet you have had really very wonderful results. You have alumni who are involved. Fairbanks Hospital has brought the community together, but I have to tell you, when I sat in the circle with kids who had the support group, and when a young girl said to the group she was turning 17 the next day and it was her first birthday in 4 years that she would be sober, it broke my heart.

And can you please talk with us about your kids and about what are the recovery supports and how should we at the federal level be supporting recovery efforts?

Ms. GARDNER. So a little bit about the school. We are a high school so we are 9th through 12th grade, public education, so it is a tuition-free school. It looks a little different at our school. They start a little later. What we have in the school is called recovery coaches. So, it is a dual recovery. It is about gaining better grades so that they can go on to higher education but it is also about helping them to stay in long-term recovery. Sometimes that is a daily

battle. Some kids have been there that have been there, that have 6 months to a year sober. Some have 30 days. They come to us from treatment centers. They come to us from private therapists. They come to us from jails, from probation. So we are dealing with a wide variety of young people. But the whole goal is to help them be in a safe, sober environment and to be able to go on to graduate and be successful.

We have done lots of research with our students in the sense of what works for different students who have different drugs of choice, but what we know is, is that if we can help them sustain daily recovery and we look at long-term recovery as staying abstinence free, doing 12 steps or doing other types of recovery supports, that we know there is a chance to move on and to have their brains as their brains are developing become more salient and more ability to learn and make better choices and develop some positive coping skills, the better the success is going to be.

Mrs. BROOKS. Can you share with us what you think we at the federal level can do to help provide support for programs like yours?

Ms. GARDNER. So we have talked a lot about law enforcement, we have talked a lot about medication. Access to treatment is a problem across the country. The Affordable Care Act has allowed the ability for more people to get it. My opinion in Indiana currently, our young people don't get to stay long enough in treatment. We look at young people like we look at adults. Their brains haven't developed the ability to make informed decisions and so you are looking at a young person who is addicted but also having to be an adolescent and help them grow with their development. They need longer times away from those people, places and things, and their ability to access recovery supports, be it schools, be it things within a traditional school, be it long-term aftercare kinds of programs, which aren't funded.

Mrs. BROOKS. Thank you for that.

Focusing and moving a bit to adults, I do want to ask Mr. Fitz because Ms. Gardner talked about treatment and the length of treatment. Can you give me your thoughts on the benefits of substance abuse treatment courts in our criminal justice system and what you know about them in my brief time remaining? I have been a proponent but I would like to hear what you in your role believe.

Mr. FITZ. In my jurisdiction, we happen to have multiple specialty courts. I think it is five or six of them, and we do have a fair number of them in the State of Michigan. So my response, I guess, would be not just from my perspective but from other prosecutors. Prosecutors generally feel that there is a need for more treatment because obviously if we can get someone clean, they are less likely to come back into the system, and that makes our job easier and makes the public safer.

But again, it is a balance because we recognize that if they don't get clean, that we need to continue to protect the public because even drug addicts sometimes do very unfortunate things—child abuse, sexual abuse, thefts, things of that sort, crimes of violence. So it invasive species balance but prosecutors do see a need for more treatment.

Mrs. BROOKS. Thank you. I yield back.

Mr. MURPHY. Thank you, Ms. Brooks.

Ms. DeGette, you have a follow-up question?

Ms. DEGETTE. I will follow up on what Ms. Brooks was just asking Mr. Fitz.

We have some drug courts in Denver too and actually the Denver district attorney is a good friend of mine, Mitch Morrissey. I don't know if you know him. But one thing—

Mr. FITZ. I don't.

Ms. DEGETTE. But one thing that drug courts do is, they will order people to go—I mean, one reason we have drug courts is exactly the problem that you talked about I think in response to Mr. Mullin's question. You see so much recidivism with drug abusers, right?

Mr. FITZ. Yes.

Ms. DEGETTE. I mean, it is a terrible problem. So one reason they have started drug courts is so that we can find a way to do the different kinds of treatment that all of the experts here talked—every single expert said it is not just a one-shot deal with people who get addicted to these opiates. Since it changes your brain, different people need types of treatment. But something that is unique about drug courts is that they are trying to send these offenders to programs. They are not just saying to folks, OK, now go get clean. I mean, they send them into programs, right?

Mr. FITZ. Really, what especially courts are doing, they are doing what prosecutors have lawyers felt that traditional probation should be, which is very intensive including—

Ms. DEGETTE. Right.

Mr. FITZ [continuing]. Daily drug testing, the things they need to get on the straight and narrow, so to speak.

Ms. DEGETTE. Right, and that includes programs, which they may be given these medications, right?

Mr. FITZ. Again, there is a split of opinion on that in my state. In our jurisdiction, they don't focus on those, and again, I am not educated enough on that to give you the expertise as to whether that is good or bad, but I will say that, for instance, Monroe County, one of our counties that I suggested to one of your staffers would be a good county in Michigan to talk to, Bill Nichols, the prosecutor, they do use those Suboxone—

Ms. DEGETTE. Dr. Banta-Green, you are nodding your head here. Did you want to talk about that?

Mr. BANTA-GREEN. Sure. So most drug courts do not allow people on medication-assisted treatment or in fact taper them off. I think it would be actually great to do the opposite, which is to allow all drug courts in fact to require that they allow some type of medication-assisted treatment with methadone or buprenorphine, and as I talked about that doctor shortage in rural areas, part of the thing they need are supports. So if they had the support of a court that they knew had criminal sanctions over this person, right, so they are concerned about having all these addicted patients they don't feel like have much control over, partnering with the court—

Ms. DEGETTE. Right.

Mr. BANTA-GREEN [continuing]. Would be a nice partnership and maybe a win-win both for the community in terms of having a lot less crime—

Ms. DEGETTE. And you might see less recidivism too.

Mr. BANTA-GREEN. Absolutely.

Ms. DEGETTE. Just one more thing, Mr. Chairman. The Department of Justice has actually said in its discretionary grant program for drug courts that drug courts need to use these medication-assisted programs as part of it because it really is medicine, not drug addiction, and I guess I would like to put that into the record, Mr. Chairman.

Mr. MURPHY. Sure. Without objection.

[The information has been retained in committee files and can be found at: <http://docs.house.gov/meetings/IF/IF02/20150326/103254/HHRG-114-IF02-20150326-SD007.pdf>.]

Ms. DEGETTE. And let me just say, I really appreciate this panel coming. Congresswoman Brooks and I were saying during the vote how extremely helpful we thought all of your testimony was, so thank you, and I yield back.

Mr. MURPHY. Thank you. The gentlelady yields back.

I know that today HHS announced they are going to put \$113 million toward addressing the opioid epidemic focusing on providing training, education, resources including updated prescriber guidelines, assist health professionals regarding the over-prescribing, increasing use of naloxone as well as continuing to support the development and the distribution of the lifesaving drug, and expanding the use of medication-assisted treatment, the MAT program. I think this is good news. We will want to work with them.

We had a recent hearing where the Government Accountability Office had told us that federal agencies were not working well together, 112 programs that deal with mental illness. But I think Secretary Burwell is really trying to make some changes in this, and we applaud that, so we will be looking forward to seeing how that does.

But I want to ask one follow-up question. On that first issue of dealing with healthcare professionals who over-prescribe, some doctors have told me that now as they are rated by patients, one of the things they are rated on is, you know, the comfort level and managing pain, and of course, a physician who is looking to boost their ratings doesn't want that patient to leave their office in pain. So there is an incentive there, again, one of these bizarre incentives we have to over-prescribe. Any of you have any comments on that and how we deal with that aspect of things? Mr. Brason.

Mr. BRASON. Yes. We addressed that with the prescribing populations that we have taught and trained on managing pain and appropriate prescribing is instituting best practice methods for doing that frontend assessment to determine what kind of risk do we have here: do you have a biological risk, do you have a cultural risk, do you have an environmental risk. and if those are answered, then you know how to appropriately prescribe or put in the safeguards with the urine screens and pill counts and so forth.

And then coupled with that, the FDA has been approving abuse-deterrent formulations to make them available to individuals so

that they can't crush and they can't snort and they can't inject. So when you are combining that federal level work with the local prescriber, you can still prescribe but then it is a much safer product.

The problem we have is the coverage in order to pay for that, you know, that obviously that probably boosts the price of the drug a little more so while the copay for this is \$5, the copay for this is \$50, the patient is going to want the \$5. It is a generic that is abusable, and then we have the issues, and I was recently with a doctor in southwest Virginia, a great pain management facility, and I said are you prescribing the abuse-deterrent formulations, and she says I can't get coverage, you know, so those are some of the areas that, you know, we have got one end doing what they want to do and on the other end the prescribers doing what they want to do, but the people in the middle that cover this and pay for this, you know, are problematic.

But the prescribers for the most part are willing to do best practice as long as they continue to treat and then have the mechanism to help somebody who needs the help.

Mr. MURPHY. Anybody else have a follow-up statement you want to make on that point?

Dr. Banta-Green.

Mr. BANTA-GREEN. I would just mention so at the University of Washington in terms of trying to limit opioid use and treat pain well, and again, as you mentioned, the JCAHO is actually focused on pain as the fifth vital sign, and we think that is part of what has led a lot of visits. It is easy to quickly treat pain with an opiate, and what we are seeing is that, as I mentioned earlier, it may lead to a lot of dysfunction, but if pain is your measure, if symptom relief is your pure measure, you are in trouble, because what we really care about is functioning, and that is really the idea that we are moving towards. There is a nice computer-based support for physicians called the Pain Tracker that among other things really helps that patient focus every visit on what is their functioning, not just their pain level, but really, what is their functioning.

Mr. MURPHY. Good point. I know I was once on a congressional visit to Iraq, and unfortunately, I was in a rollover accident and hurt my spine and a little bit paralyzed for a while, but I know—and part of this is military medicine, patch them up, ship them out, but I know coming back from there, I was on OxyContin, Percocet, Tylenol, which is the mildest one, and fentanyl patches, and you are that kind of a cocktail and you don't know which way is up, and for myself, I said I am not doing this anymore. I ripped off the fentanyl patch and did everything. It was not a pleasant experience. I can't imagine what it is like for someone who has been taking those kind of things for months or years.

So as a person who has dealt with folks with substance abuse, as a person who has lived with someone with substance abuse, as someone who has treated and worked with infants in newborn intensive care units, I want to thank you all for your work. Some of you like Corporal Griffin putting your life on the line, thank you for your service. Mr. Fitz, thank you for doing those things at a prosecutor level. Ms. Gardner, great stories of what is happening in the school. Keep up the great work. I understand one of your graduates is in medical school?

Ms. GARDNER. Yes, sir.

Mr. MURPHY. That is awesome.

Ms. GARDNER. Thank you.

Mr. MURPHY. We wish him the best. And all of you, thank you for your front line work.

We will be having other things on this. You heard Ms. DeGette talk about we will want to be looking at state policies and federal policies. Please don't let be your last contact. You were brought here by some distinguished Members of Congress who believe in a lot of what you do. Keep that conversation going, and encourage your colleagues from around the country too. We want to know what to do here because this deadly epidemic is something that we have to address, and we look forward to hearing your expert opinions on this.

Thank you all so much. Have a wonderful Easter. And it is now adjourned.

[Whereupon, at 12:40 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

PREPARED STATEMENT OF HON. FRANK PALLONE, JR.

Mr. Chairman, thank you for convening this hearing today on this important issue.

Prescription drug abuse is an epidemic in the United States. We see its effects throughout the country in all of our districts. In New Jersey, we have seen the rate of drug overdose deaths nearly double in the last ten years.

I want to use today's hearing to understand what we can do to combat this epidemic. We must work together - at the local, state, and federal levels - to expand effective prevention and treatment efforts for opioid abuse.

We need to focus on what works. Research tell us that medication-assisted treatment combined with counseling is the most effective method of treating opioid addictions. Yet throughout the country, many treatment facilities continue to be based in an abstinence-only model that prohibits the use of medication. We need to understand why that is the case and how we can increase access to medication-assisted treatment.

I want to highlight some of the work being done in New Jersey to address the opioid addiction epidemic. In 2013, the New Jersey legislature passed a law to expand access to naloxone, a life-saving medication that reverses the effects of a drug overdose. Nearly 30 states now have such laws.

In my district, Rutgers University was one of the first colleges to offer a residential program for the growing number of students with substance use disorders. In 1988, the University first established the Collegiate Recovery Community to provide a safe place for students in recovery. There are now over twenty such programs across the nation.

Just outside my district, the Raymond J. Lesniak Recovery High School, New Jersey's first and only public recovery high school, opened earlier this year. It serves students who wish to recover from their substance use disorders in a safe environment.

Here in Congress, we took significant steps to expand access to health care for all Americans, including those with substance use disorders, with the passage of the Affordable Care Act. For many addicts, the lack of insurance or the cost of treatment presents an insurmountable barrier to receive the help they need. The Affordable Care Act addresses these problems by expanding insurance coverage and requiring that insurance cover the cost of substance abuse services. This will mean that millions of people will have access to the tools they need to break their addictions.

I also want to speak for a moment in support of the reauthorization of the National All Schedules Prescription Electronic Reporting Act - or NASPER. This legislation helps states set up prescription drug monitoring programs in order to combat prescription drug abuse and supports interoperability of state programs. It is critical that we continue support for this program through federal funding.

I want to thank all the witnesses for appearing before us today. I'm eager to hear about the work you're doing to combat this epidemic. I yield the remainder of my time to Rep. Kennedy.



U.S. HOUSE OF REPRESENTATIVES
COMMITTEE ON ENERGY AND COMMERCE

March 24, 2015

TO: Members, Subcommittee on Oversight and Investigations

FROM: Committee Majority Staff

RE: Hearing on "Examining the Growing Problems of Prescription Drug and Heroin Abuse: State and Local Perspectives."

On Thursday, March 26, 2015, at 10:00 a.m. in 2123 Rayburn House Office Building, the Subcommittee on Oversight and Investigations will hold a hearing entitled "Examining the Growing Problems of Prescription Drug and Heroin Abuse: State and Local Perspectives." The hearing will review the recent prescription drug and heroin epidemic in the United States, featuring witnesses at the state and local level. These witnesses will provide a "boots on the ground" perspective to discuss trends they are observing and specific local impacts, why the problem is getting worse, how they are handling it at a state and local level, what works and what does not, and how we can improve federal public health response efforts to prevent and treat prescription drug and heroin abuse. The purposes of the hearing are to identify "success stories" at the local level that could have national application and to get feedback on the effectiveness of federal programs aimed at reducing prescription drug and heroin overdoses.

WITNESSES

- Fred Wells Brason II, Executive Director, Project Lazarus, Moravian Falls, North Carolina;
- Dr. Sarah T. Melton, PharmD, BCPP, BCACP, CGP, FASCP, Associate Professor of Pharmacy Practice, Gatton College of Pharmacy at East Tennessee State University, Johnson City, Tennessee, and Chair of the Board of Directors of OneCare of Southwest Virginia, Bristol, Virginia;
- Dr. Stefan R Maxwell, MD, Associate Professor, Pediatrics, WVU School of Medicine, MEDNAX Medical Group, Medical Director, NICU, Women & Children's Hospital, ; Charleston, West Virginia;
- Rachelle Gardner, Chief Operating Officer, Hope Academy, Indianapolis, Indiana;

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- Corporal Michael Griffin, Narcotics Unit Supervisor - K9 Handler, Special Investigations Division, Tulsa Police Department, Tulsa, Oklahoma;
- Dr. Caleb Banta-Green, Senior Research Scientist, Alcohol and Drug Abuse Institute, University of Washington, Seattle, Washington; and
- Victor Fitz, Cass County, Michigan, Prosecutor, and President of the Prosecuting Attorneys Association of Michigan (PAAM), Cassopolis, Michigan.

BACKGROUND

The focus of this hearing is on opioids, a class of drug that includes both heroin and many prescription painkillers. These substances resemble morphine in their physiological or pharmacological effects, especially in their pain-relieving properties.

This hearing follows up on the April 29, 2014 Subcommittee hearing on “Examining the Growing Problems of Prescription Drug and Heroin Abuse.” At last year’s hearing, the Subcommittee heard from a federal panel that included witnesses from the Office of National Drug Control Policy (ONDCP), the National Center for Injury Prevention and Control (CDC), the Office of Diversion Control (DEA), the National Institute on Drug Abuse (NIH), and the Center for Substance Abuse Treatment at the Substance Abuse and Mental Health Services Administration (SAMHSA).

Scope of the problem

A year later, the problem has continued to grow with drug poisoning (overdose) being the leading cause of death from injury, surpassing motor vehicle accidents, suicide, firearms, and homicide. A recent CDC report found a four-fold increase in heroin-related drug-poisoning deaths between 2000 and 2013. Prescription opioid deaths claimed more than 145,000 lives over the last decade, with more than 20,000 Americans dying each year from overdoses of these products. The number of seniors in the Medicare program using prescription painkillers has increased sharply. In 2012, the average number of seniors misusing or dependent on prescription pain relievers over the past year grew to an estimated 336,000, up from 132,000 a decade earlier, according to survey data from SAMHSA. Misuse is defined as using the drugs without a prescription or not as prescribed.¹

Another CDC report found that the use of stronger opioid painkillers may be on the rise. The report shows that from 1999-2002 to 2011-2012, the percentage of opioid users who used an opioid stronger than morphine increased from 17 percent to 37 percent.

The numbers of people starting to use heroin have been steadily rising since 2007. According to the National Institute of Drug Abuse (NIDA), this may be due in part to a shift from abuse of prescription pain relievers to heroin as a readily available, cheaper alternative and

¹ <http://www.usatoday.com/story/news/nation/2014/05/20/seniors-addiction-prescription-drugs-painkillers/9277489/>

the misperception that highly pure heroin is safer than less pure forms because it does not need to be injected.

According to NIDA, research now suggests that abuse of opioid medications may lead to heroin use. Nearly half of young people who inject heroin surveyed in three recent studies reported abusing prescription opioids before starting to use heroin.² In addition to the direct health risk factors, heroin use can also create a higher risk for contracting HIV/AIDS and hepatitis B and C. Heroin use during pregnancy can result in neonatal abstinence syndrome (NAS). NAS occurs when heroin passes through the placenta to the fetus during pregnancy, causing the baby to become dependent along with the mother.

In response to the opioid abuse epidemic, in the Fiscal Year 2016 budget, CDC requested an increase of \$54 million to fund prescription drug overdose and heroin prevention efforts. Overall, the federal government spends over \$25 billion annually, of which about \$10 billion goes toward drug prevention and treatment program across 19 federal agencies having a hand in over 70 drug control programs.³

The costs attributed to prescription opioid abuse, such as healthcare, lost productivity, criminal justice, were close to \$56 billion in 2007. Another estimate shows employers, state and federal programs incur an estimated \$72.5 billion each year due to opioid abuse. For every dollar spent on prescriptions for abusers, it is estimated that another \$41 in related medical claims is generated.⁴

The overprescribing trigger

Overprescribing of painkillers has triggered an opioid and heroin crisis. Since 1997, the number of Americans seeking treatment for addiction to painkillers has increased by 900 percent. The prevalence of opioid addiction started rising as long-term prescribing of opioids for chronic pain, a practice encouraged by opioid manufacturers, became more common.⁵

In 2012, health care providers wrote 259 million prescriptions for painkillers, enough for every American adult to have a bottle of pills.⁶ Twice as many painkiller prescriptions per person are written in the U.S. as in Canada. Data suggest that where health care providers

² NIDA Report Series, "Heroin," NIH publication number 15-0165, 3 (November 2014, rev.). Some data have higher estimates. Data from SAMHSA shows that 81 percent of people who started using heroin from 2008 to 2010 had previously abused prescription drugs. Amy Pavuk, *Rx for Danger: Oxycodone crackdown drives addicts to other drugs*, Orlando Sentinel, July 28, 2012, http://articles.orlandosentinel.com/2012-07-28/health/os-oxycodone-drug-shift-dilaudid-20120728_1_oxycodone-prescription-drugs-dilaudid-pills.

³ Eileen Larence and Linda Kohn, *Office of National Drug Control Policy: Office Could Better Identify Opportunities to Increase Program Coordination*, United States Government Accountability Office, March 2013, <http://www.gao.gov/assets/660/653354.pdf>.

⁴ <http://insurancefraud.org/downloads/drugDiversion.pdf>

⁵ Science Daily, "Opioid and heroin crisis triggered by doctors overprescribing painkillers," Brandeis University, February 4, 2015.

⁶ CDC Vital Signs, "Opioid Painkiller Prescribing," July 2014, <http://www.cdc.gov/vitalsigns/opioid-prescribing/>

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practice influences how they prescribe, as healthcare providers in different parts of the U.S. do not agree on when to use prescription painkillers and how much to prescribe.

Law enforcement efforts to address the prescription drug abuse problem have targeted operations such as “pill mills” and “doctor shopping.” States such as Kentucky, Florida, and West Virginia started to make extensive use of their prescription drug monitoring programs (PDMP) as a tool to monitor prescription sales of controlled substances.⁷ Efforts that began at the end of the Clinton administration and continued under the George W. Bush administration dispatched anti-drug agents and encouraged prescription drug monitoring programs to help detect suspicious prescriptions. As a result, federal arrests for illegal use of prescription drugs skyrocketed more than 900 percent between 2001 and 2007, according to the National Drug Intelligence Center.⁸

In addition to the overprescribing of prescription painkillers, public health risks have worsened by the increased prescribing of methadone for pain (as opposed to use in addiction treatment). The use of methadone as a treatment for pain has expanded in recent years. Although methadone can effectively treat pain, it carries outsized risks due to its unique pharmacologic properties, such as a long half-life, short analgesic window relative to respiratory-depressant effect, and potential for drug-drug interactions.⁹ Methadone accounts for two percent of opioid prescriptions for pain control, but is responsible for one-third of overdose deaths, according to a 2012 CDC Vital Signs report.¹⁰ Most state Medicaid programs encourage the prescribing of methadone as a first line treatment for pain, often due to its low cost, even though safer therapies are available.¹¹

Higher prescribing of painkillers is associated with more overdose deaths, according to CDC Vital Signs, July 2014. Further, the CDC has been investigating the rise in opioid-addicted newborns and lack of timely treatment. Investigators found nearly all of the babies with confirmed cases of NAS identified in three hospitals in Florida had documented in utero opioid exposure.¹² Yet only 10 percent of their mothers received or were referred for drug addiction rehabilitation or counseling at the time of their infants’ birth.

Untreated addiction

⁷ Ileana Arias, et al., Prescription Drug Overdose: State Health Agencies Respond, Association of State and Territorial Health Officials, 2008, <http://www.astho.org/Programs/Prevention/Injury-and-Violence-Prevention/Materials/Prescription-Drug-Overdose/>.

⁸ Jerry Markon, Experts: Officials missed signs of prescription drug crackdown’s effect on heroin use, The Washington Post, March 6, 2014, http://www.washingtonpost.com/politics/experts-officials-missed-signs-of-prescription-drug-crackdowns-effect-on-heroin-use/2014/03/06/2216414a-9fc1-11e3-b8d8-94577ff66b28_story.html.

⁹ The Pew Charitable Trust, “Prescription Drug Abuse Epidemic: Spotlight on Methadone,” August 2014, <http://www.cdc.gov/vitalsigns/MethadoneOverdoses/>.

¹⁰ The Pew Charitable Trusts’ Prescription Drug Abuse Project, Undated handout (provided to committee staff, March 20, 2015).

¹² Diana Phillips, CDC Investigates Rise in Opioid-Addicted Newborns, Medscape, March 9, 2015, http://www.medscape.com/viewarticle/841081_print

More broadly, a five-year study by the Center for Addiction and Substance Abuse at Columbia University (CASA Columbia) found that only about 1 in 10 people with addiction involving alcohol or drugs other than nicotine receive any form of treatment. Of those who do receive treatment, only 10 percent receive evidence-based treatment.¹³ This compares with 70 percent to 80 percent of people with such diseases as high blood pressure and diabetes who do receive treatment.

Not only do few addiction treatment programs offer evidence-based treatments, but many have no qualified staff. Seriously ill patients may never see an M.D. The 2012 CASA Columbia report found that most medical professionals who should be providing addiction treatment are not sufficiently trained to diagnose or treat the disease, and most of those providing addiction care are not medical professionals and are not equipped with the knowledge, skills or credentials necessary to provide the full range of effective treatments. Based on 2012 data, a University of Washington study found that 30 million Americans lived in counties without a single doctor certified to prescribe Suboxone. The majority of these counties were in rural areas. According to the DEA, out of 625,000 eligible physicians nationwide, only 25,000 are certified to prescribe buprenorphine. A mere 2.5 percent of all primary care doctors have gone through the certification process.

The CASA Columbia report concluded that “[m]isunderstandings about the nature of addiction and the best ways to address it, as well as the disconnection of addiction medicine from mainstream medical practice, have undermined effective addiction treatment.” The report raises questions about the direction and effectiveness of federal government programs aimed at improving and increasing addiction treatment.

To further understand the medications used to treat opioid addiction, here are summary descriptions:

- *Methadone* - Opioid. Habit-forming. Controlled substance. Taken at specialty clinics. Daily pill. Cost: about \$150 per month. Eliminates withdrawal symptoms and relieves drug cravings by acting on the same brain targets as other opioids like heroin, morphine, and opioid pain medications. Has been used successfully for more than 40 years to treat heroin addiction, but must be dispensed through opioid treatment programs.
- *Buprenorphine* - Opioid. Habit-forming. Controlled substance. Must be prescribed by doctor who receives a DEA waiver. Pill often taken every other day. Cost: About \$300 per month (generic).
- *Naloxone* - Rescue drug used to revive an overdose victim.
- *Buprenorphine/naloxone (Suboxone)* - Daily film placed under tongue. Habit-forming. Controlled substance. Must be prescribed. Requires DEA waiver. Cost:

¹³ “Put another way, 90 percent do not receive evidence-based treatment, according to Thomas McLellan, a professor of psychiatry at the University of Pennsylvania and Executive Director of the Treatment Research Institute. Evidence-based treatment refers to decisions made based on scientific studies, and that these studies are selected and interpreted by the norms of that specific practice, typically considering quantitative studies as what counts as evidence.

About \$450 per month. Partial agonist medications which have a ceiling on how much effect they can deliver, so extra doses will not make the addict feel any different.

- *Naltrexone* - Antagonist medication that prevents opioids from activating their receptors. Used to treat overdose and addiction, although its use for addiction has been limited due to poor adherence and tolerability by patients.
- *Naltrexone shot (Vivitrol)* - Opioid blocker. Not habit-forming. Non-controlled. Must be prescribed. Does not require waiver or registration with DEA. Monthly injection. Cost: About \$1000 per month. About 40 jails out of 3,000-plus, run Vivitrol programs. Washington County, Maryland has given shots to 83 people in 3 and a half years with only two patients having used illegal drugs or alcohol while receiving the medication.

There is evidence that medication-assisted treatment (MAT) is effective in reducing overdose deaths. Between 1995 and 1999, France reduced overdose deaths by 79 percent as buprenorphine use in treatment became widely accepted.¹⁴ By 2004, almost all of Australia's heroin addicts in treatment were on methadone or buprenorphine, and the country had reduced its overdose deaths.¹⁵ A study showed that the publicly funded Baltimore Buprenorphine Initiative, aimed at increasing access to medical treatments, helped lead to a roughly 50 percent reduction in the city's overdose deaths between 1995 and 2009.¹⁶

Scientists have identified best practices to treat addiction — a menu of behavioral, pharmacological and psychological treatments.¹⁷ However, most treatment programs have not accepted medically assisted treatments such as Suboxone because of "myths and misinformation," according to SAMHSA's director of the pharmacological therapy division.¹⁸ In fiscal year 2014, SAMHSA, which helps to fund drug treatment throughout the country, had a budget of about \$3.4 billion dedicated to a broad range of behavioral health treatment services, programs and grants. However, a SAMHSA official said he did not believe any of that money went to programs specifically aimed at treating opioid-use disorders with Suboxone and methadone. It is up to the states to use block grants as they see fit.¹⁹

Summary of Expected Testimony

The witnesses will include:

- Fred Brason – Executive Director of Project Lazarus, a North Carolina-based group that partners with several individuals and organizations on addressing

¹⁴ Jason Cherkis, "Dying To Be Free: There's A Treatment for Heroin Addiction That Actually Works. Why Aren't We Using It?", The Huffington Post, January 28, 2015.

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ David Sheff, "One Thing Obamacare Can't Fix: Bad Addiction Treatment," Time, November 13, 2013.

¹⁸ Cherkis, note 11.

¹⁹ *Id.*

substance abuse. Gil Kerlikowske, former director of the White House Office of National Drug Control Policy, has called Project Lazarus a model for other communities. According to the Project Lazarus Web site, overdose deaths fell 69 percent in Wilkes County between 2009 and 2011 and the County had logged 28 straight months of steady declines in overdose deaths in those years. Yet, in 2011, not a single Wilkes County resident died of a prescription opioid from a prescriber within the county. In 2010, 10 percent of fatal overdoses were the result of a prescription for an opioid analgesic from a Wilkes prescriber, down from 82 percent of those with a prescription in 2008. Hospital emergency department visits for overdose and substance abuse fell 15 percent between 2009 and 2010 in Wilkes County, compared with a 6.9 percent increase in the rest of the state.

- Dr. Sarah Melton – Associate Professor of Pharmacy Practice at the Gatton College of Pharmacy at East Tennessee State University, a clinical pharmacist, and Chair of the Board of Directors of OneCare of Southwest Virginia. She is expected to testify about the efforts of her OneCare coalition of health professionals, law enforcement officers, and community leaders in fighting drug abuse in Southwest Virginia.
- Dr. Stefan Maxwell – Chief of Pediatrics and director of Neonatal Intensive Care Services at the Charleston Area Medical Center Women and Children’s Hospital in Charleston, West Virginia. He is expected to testify about the problem of drug-addicted babies, a study of umbilical cord samples showing that 19 percent tested positive for substance abuse, and an early-intervention approach aimed at preventing or reducing the severity of the problem of drug-addicted babies.
- Rachelle Gardner – Chief Operating Officer for Hope Academy in Indianapolis, Indiana. She is expected to testify about the heroin/opioid epidemic facing her community, and about Hope Academy, a charter high school for substance impacted students to work on their recovery from drug and alcohol addiction and obtain a Core 40 high school diploma allowing them to pursue secondary education instead of crime.
- Mike Griffin – an undercover narcotics detective from Tulsa, Oklahoma who is expected to testify about the nature of the drug abuse problem in the area, the business of illicit drugs, and the sourcing of the illicit drugs from cartels south of the U.S. border.
- Dr. Caleb Banta-Green – a research scientist at the University of Washington, who has advised and worked at ONDCP. Much of his work tracks trends in opioid abuse, and is working on prescribing guidelines.
- Victor Fitz – The Cass County, Michigan Prosecutor and President of the Prosecuting Attorneys Association of Michigan (PAAM), Cassopolis, Michigan.

Majority Memorandum for March 26, 2015, Subcommittee Oversight and Investigations Hearing
Page 8

He has over 30 years of experience prosecuting drug cases, and will also share perspectives from other prosecutors in the state of Michigan.

ISSUES

The following issues may be examined at the hearing:

- What actions have been effective in reducing drug overdose deaths?
- What actions have been effective in sustaining recovery and preventing relapses?
- Is medication-assisted treatment essential to getting opiate addicts off drugs?
- How can effective treatments for opioid addiction be more widely used?
- What approaches work in reducing the risks of prescription drug abuse?

STAFF CONTACTS

If you have any questions regarding this hearing, please contact Alan Slobodin, Sam Spector, or Brittany Havens of the Committee staff at (202) 225-2927.

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115
Majority (202) 225-2977
Minority (202) 225-3641
April 16, 2015

Dr. Sarah T. Melton
Associate Professor of Pharmacy Practice
Gatton College of Pharmacy
East Tennessee State University
P.O. Box 70657
Johnson City, TN 37614

Dear Dr. Melton:

Thank you for appearing before the Subcommittee on Oversight and Investigations on Thursday, March 26, 2015, to testify at the hearing entitled "Examining the Growing Problems of Prescription Drug and Heroin Abuse: State and Local Perspectives."

Pursuant to the Rules of the Committee on Energy and Commerce, the hearing record remains open for ten business days to permit Members to submit additional questions for the record, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions with a transmittal letter by the close of business on Thursday, April 30, 2015. Your responses should be mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to brittany.havens@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,



Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: The Honorable Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachment

Sarah T. Melton, PharmD, BCPP, BCACP, CGP, FASCP

Chair, One Care of Southwest Virginia

Associate Professor of Pharmacy Practice, East Tennessee State University Gatton College of Pharmacy

May 1, 2015

The Honorable Tim Murphy
Chairman, Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515-6115

Dear Chairman Murphy,

Thank you for the opportunity to appear before the Subcommittee on Oversight and Investigations on Thursday, March 26, 2015 to testify at the hearing entitled "Examining the Growing Problems of Prescription Drug and Heroin Abuse: State and Local Perspectives." This letter is in response to additional questions related to my testimony by the **Honorable Larry Bueshon**.

What changes in Medicare and Medicaid policies are needed to expand access to medication-assisted treatment (MAT)?

Under the current Medicare system and most Medicaid programs, there are significant barriers to the provision of MAT. The most significant barrier involves payment to providers of MAT. An issue that is sweeping the country involves providers who refuse to accept Medicare or Medicaid as payment for treatment because the reimbursement is inadequate to cover the comprehensive treatment required for recovery. An effective and comprehensive treatment program must cover the office visit with the prescriber, urine drug screening, and psychotherapy with a licensed addiction counselor. As I noted in my testimony, the medication is an important part of the treatment program, but it **MUST** be accompanied by the other key components of therapy for a patient to reach long-term recovery. Medicare does not cover services provided by licensed professional counselors. Providing this reimbursement for services would greatly expand access to care with qualified therapists needed in the comprehensive treatment for addiction.

Access to comprehensive outpatient MAT programs is challenging for patients with addiction across the country. Changes should be considered to the Drug Addiction Treatment Act of 2000 to expand prescription authority to mid-level providers under the supervision of addiction specialists. For example, The College of Psychiatric and Neurologic Pharmacists and the American College of Clinical Pharmacy have urged Congress to enact legislation to provide

Medicare patients with coverage for comprehensive medication management (CMM) within the Part B medical benefit. This direct patient care service, provided by qualified clinical pharmacists working as members of the patient's health care team, has been demonstrated to significantly improve clinical outcomes and enhance the safety of medication use by patients. Board Certified Psychiatric Pharmacists are uniquely qualified to provide provision of CMM to patients with the disease of addiction in collaboration with prescribers. Changes should be considered to the DATA 2000 to allow board certified psychiatric pharmacists operating under a collaborative drug therapy management agreement or with prescriptive authority under state law the ability to prescribe, adjust, and monitor buprenorphine therapy as part of the comprehensive outpatient management of opioid addiction.

With regard to changes in Medicaid program, California's Medicaid program is providing care "outside the box" through an 1115 Demonstration Waiver. The final version of the demonstration waiver is currently under review by CMS. With a state population of close to 40 million (12 million in Medicaid) this project will set the new standard for addiction treatment through the Medicaid system across the country. The last draft of the waiver that the state has made publically available can be located online at <http://www.dhcs.ca.gov/provgovpart/Documents/2nd-Draft-STCs-for-stakeholders.pdf>.

Counties that opt in to the demonstration waiver will be required to provide critical MAT services such as methadone maintenance which is lacking in many rural areas. This may be through traditional methadone clinics or office-based opioid treatment-methadone sites which are geographically distinct. Buprenorphine, naltrexone and naloxone will also be prescribed at the sites. Through the waiver, pharmacists are identified as eligible providers similar to the way they are in mental health.

Many Medicaid state policies have very tight restrictions on drugs like buprenorphine that provide coverage for only short-term basis. Short-term treatment has not been shown to result in long-term recovery for the vast majority of patients. CMS, as the federal partner paying large dollar amounts into the Medicaid system, should demand progress in access to critical MAT drugs and substance abuse services. The same applies for Medicare Part D formularies and Medicare's reimbursement for substance abuse services.

An example of challenges in the Medicaid system in providing MAT can be seen in Virginia. There are six Virginia Medicaid managed care companies and each have differing policies regarding payment of buprenorphine. It would be optimal if these companies developed a single unified policy that pays for comprehensive services that get patients into recovery and decreases long-term expenses that result from continued illicit drug use. For example, one company will not pay for urine drug screens or office visits. Another company allows payment for urine drug screens only every 3 months. Many companies require prior authorization for medication with every prescription or for every counseling session. It is clear why medical offices refuse to

accept Medicaid or Medicare for MAT when the plans are so difficult to work with and reimbursement for services is so little.

Should access to medical therapy including methadone, naltrexone, and buprenorphine all be available at federally funded substance abuse clinics?

Yes. Methadone, buprenorphine, and naltrexone are all FDA-approved for the treatment of opioid dependence and should be available as a treatment option at federally funded substance abuse clinics. Selection of the best medication option depends on patient-specific factors and having all three treatment options available will not only expand access to appropriate treatment, but make sure the individual patient is receiving the best medication for their treatment needs. In addition to the provision of these medications, the federally funded substance abuse clinics should closely follow the Federal Guidelines for Opioid Treatment Programs by the Substance Abuse and Mental Health Services Administration, located at <http://store.samhsa.gov/product/Federal-Guidelines-for-Opioid-Treatment-Programs/All-New-Products/PEP15-FEDGUIDEOTP>.

Please feel free to contact me for any clarifications or further questions.

Sincerely,

A black rectangular box used to redact the signature of Sarah T. Melton.

Sarah T. Melton, PharmD, BCPP, BCACP, CGP, FASCP

FRED UPTON, MICHIGAN
CHAIRMAN

FRANK PALLONE, JR., NEW JERSEY
RANKING MEMBER

ONE HUNDRED FOURTEENTH CONGRESS
Congress of the United States
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2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515-6115
Majority (201) 225-2927
Minority (202) 225-3641

April 16, 2015

Dr. Stefan R. Maxwell
Medical Director, NICU
Women & Children's Hospital
830 Pennsylvania Avenue
Suite 406
Charleston, WV 25302

Dear Dr. Maxwell:

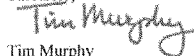
Thank you for appearing before the Subcommittee on Oversight and Investigations on Thursday, March 26, 2015, to testify at the hearing entitled "Examining the Growing Problems of Prescription Drug and Heroin Abuse: State and Local Perspectives."

During the hearing, Members asked you to provide additional information for the record, and you indicated that you would provide that information. Descriptions of the requested information are attached. The format of your responses to these requests should be as follows: (1) the name of the Member whose request you are addressing, (2) the complete text of the request you are addressing in bold, and (3) your answer to that request in plain text.

To facilitate the printing of the hearing record, please respond to these requests with a transmittal letter by the close of business on Thursday, April 30, 2015. Your responses should be mailed to Brittany Havens, Legislative Clerk, Committee on Energy and Commerce, 2125 Rayburn House Office Building, Washington, D.C. 20515 and e-mailed in Word format to brittany.havens@mail.house.gov.

Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,



Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: The Honorable Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachment



Working together for healthier mothers and babies

1031 Kanawha Blvd., L., Suite 1100
Charleston, WV 25301
P: 304.558.0530
F: 304.558.0532

wvperinatal.org

May 4, 2015

Brittany Havens
Legislative Clerk
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

Dear Ms. Havens,

Please find below my response to the request for additional information that was sent to me by Tim Murphy on April 16, 2015. It was a privilege to testify before the Subcommittee on Oversight and Investigations at the March 26, 2015 hearing entitled "Examining the Growing Problems of Prescription Drug and Heroin Abuse: State and Local Perspectives." I appreciate the Subcommittee's interest in this area and hope this additional information is useful in your work.

Request from The Honorable Paul Tonko:

During the hearing I asked you about barriers and resources, specifically for those wishing to get help for opioid addiction and whether or not they have sufficient access to effective treatment programs. We also discussed those in rural areas where addiction specialists might be hard to find. Please provide additional information to the subcommittee on this topic.

West Virginia continues to face large obstacles in providing treatment to our many residents who have substance use disorders, especially those addicted to opiates. In December 2011, the West Virginia Governor's Council on Substance Abuse reported that 152,000 of our citizens were in need of treatment. While much work has been done to address this need, barriers still exist. The state does not have enough residential treatment beds, and many who can be treated on an outpatient basis have trouble accessing services. Many of the physicians who are licensed to provide medication assisted treatment are at full capacity. In addition, finding counselors with training and expertise in addiction can be challenging. As a result, many treatment providers in West Virginia report that they have long waiting lists for services.

In rural areas, accessing treatment services can be especially difficult. Even when services are available, transportation is a significant barrier to care. Another barrier for patients is navigating through the process. Even in areas where treatment is available, community members do not know where and how to access the services. The lack of community support groups available to those who are on medication assisted treatment presents other problems. For example, most comprehensive treatment programs require that their patients attend NA or AA meetings. Yet, these types of groups rely on an abstinence-based model and are not always welcoming to those who are on buprenorphine as part of their treatment. This can become a barrier to care when participants have trouble meeting all the requirements of their treatment program.

As noted, West Virginia has implemented a number of initiatives to address these and other barriers to care. Notably, on September 6, 2011, Governor Earl Ray Tomblin established the Governor's Advisory Council on Substance Abuse (GACSA) and six (6) Regional Task Forces. These groups meet regularly and have developed priorities, including building the capacity and competency of our substance abuse workforce and increasing access to prevention, early identification treatment and recovery management.

Specific strategies to address access to treatment in West Virginia include:

- Medicaid reimbursement for Suboxone and Vivitrol is available. In August 2011, a new Subutex /Suboxone /Vivitrol policy was issued by the state that mandates adequate therapy services, strict documentation requirements, drug screening requirements, and treatment guidelines.
- Legislation passed in 2012 that required physician prescriber education, supported improvements to the Prescription Drug Monitoring Program system and reporting guidelines, increased coordination and oversight and further regulation of Opioid Treatment Programs and pain clinics, and provided \$7.5 million in additional state revenue for additional treatment based on regionally identified need.
- The Governor's decision to expand Medicaid services in West Virginia, made on May 2, 2013, provided insurance coverage for a large number of individuals who have substance abuse and behavioral health needs, allowing the State to draw down federal funds to treat these problems that were currently addressed with State and Federal Block Grant funds.
- Telemedicine, based on model policies developed by the American Psychiatric Association, is being expanded in rural areas due to transportation and workforce barriers. The Bureau for Medical Services (Medicaid agency) has worked to ensure that payment codes are in place for providers to be able to bill for services that are commonly provided face to face.
- A treatment by county locator has been established on the Bureau for Behavioral Health and Health Facilities website to link communities and providers with services and resources, <http://www.dhhr.wv.gov/bhhf>. The GACSA has recommended funding

for a Behavioral Health Referral & Outreach Call Center, a statewide, centralized point of entry, 24-hour call center, providing resources and referral support for those seeking behavioral health services. The Call Center will maintain a "real time, live" data base which will be updated daily and be connected to regional and local service providers. Anyone that contacts the call center will be offered education on behavioral health and information on service options in their region, as well as a facilitated referral to an appropriate level of care based on the individuals need in coordination with providers.

I hope this answers your questions. This is a complex problem and I appreciate the opportunity to work with policymakers at both the federal and state levels on seeking strategies to address these issues. If you have any other questions or need additional information, please feel free to contact me.

Sincerely,

A handwritten signature in cursive script that reads "Stefan Maxwell MD".

Stefan R. Maxwell, M.D.
Chair, West Virginia Perinatal Partnership
CAMC Women and Children's Hospital, Medical Director, NICU
MEDNAX Medical Group

FRED UPTON, MICHIGAN
CHAIRMAN

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Majesty (202) 225-2022
Minority (202) 225-3643

April 16, 2015

Dr. Caleb Banta-Green
Senior Research Scientist
Alcohol and Drug Abuse Institute
University of Washington
1107 N.E. 45th Street, Suite 120
Seattle, WA 98105

Dear Dr. Banta-Green:

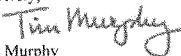
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Thank you again for your time and effort preparing and delivering testimony before the Subcommittee.

Sincerely,


Tim Murphy
Chairman
Subcommittee on Oversight and Investigations

cc: The Honorable Diana DeGette, Ranking Member, Subcommittee on Oversight and Investigations

Attachment

UNIVERSITY of WASHINGTON

ADAI

Alcohol &
Drug Abuse
Institute

April 28, 2015

Representative Tim Murphy
Chairman
Subcommittee on Oversight and Investigations
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington DC 20515-6115

Chairman Murphy-

Thank you for an opportunity to present to the sub-committee on March 26, 2015. I received your letter requesting a response to additional questions for the record. Below are my responses.

The Honorable Tim Murphy asked:

Question:

1. During your testimony you cited a long-term, 42-month follow-up study conducted in NIDA's Clinical Trial Network led by Dr. Roger Weiss.
 - a. This study relied on telephone interviews to find out if patients were still using illicit opioids, or in fact, were opioid-free. There were no drug tests administered. In the "Limitations" section of the study, the authors stated that relying only on telephone interviews "may have inflated rates of good outcomes" (p.7). Do you agree with the authors?

Response:

Yes, this is a limitation of the study; however urinalysis data also can have substantial limitations. Self-report has generally been shown in the research literature to have reasonable reliability and validity, there still could be bias towards inflating good outcomes. However, drug usage is not the only meaningful outcome of interest. Treatment engagement is a very important outcome measure also documented in the study and an outcome that is strongly associated with improved functioning and cost savings across multiple studies.

Question:

- b. Out of the original 653 participants in the study, 375 were enrolled to participate in this telephone interview follow-up study. Of those 375 that enrolled, 306 completed the 42-week telephone interview (less than half of the original sample). In the "Limitations" section of the study, the authors state that the results of the study "may not be generalizable." (p. 7) Do you agree with the authors?

Response:

There are actually two different issues: 1) representativeness of the follow up group relative to the whole group and 2) representativeness relative to a much larger, general population.

UNIVERSITY of WASHINGTON



In terms of the first question:

Somewhat.

It is a limitation to not have everyone in the follow up study, but this was strongly related to the time since involvement in the original study. The group that did not participate in the follow up study was very similar to the participating group, so there is no indication the resulting data are biased with regards to representativeness of the subset to the larger study.

Regarding the second questions:

Yes.

The question of generalizability is a limitation of virtually every research study conducted unless it is a massive study, e.g. tens of thousands, across an enormous population. Every diligent researcher discusses the limitations of their study, in fact it is a requirement of research journals to discuss limitations.

The Honorable Larry Buschon asked:

Question:

1. What changes in Medicare and Medicaid policies are needed to expand access to medication-assisted treatment?

Response:

- Medicare should pay for medication assisted treatment including methadone provided by Opioid Treatment Programs.
- Medicaid should pay for buprenorphine and naltrexone dispensed in Opioid Treatment Programs. Dispensing fees, should be reimbursed so that those who require more frequent dosing/dispensing can receive their medication as needed whether it is once a month or three times per week.
- Medicaid coverage should continue while people are incarcerated so that they can be maintained or initiated on medication assisted treatment.
- Regulations should require inpatient programs (detoxes, residential, medical and psychiatric hospitals) to affiliate with programs offering methadone, buprenorphine and naltrexone to allow for direct admission upon transition from inpatient to outpatient settings. Inpatient to outpatient transitions of care are where patients often relapse and overdose.

Question:

2. Should access to medical therapy including methadone, vivitrol, and buprenorphine all be available at federally funded substance abuse clinics?

Response:

Sort of.

Medication assisted treatment with buprenorphine should be available at all federally funded substance abuse clinics serving opioid addicted person. However, given the pharmacology of methadone it should only be provided by federally and state approved opioid treatment programs. Given the limited evidence base for extended-release-naltrexone/Vivitrol it could be offered at substance abuse clinics, but should not be the only type of medication assisted treatment offered.

UNIVERSITY of WASHINGTON



Methadone and buprenorphine have an excellent evidence base in terms of improving functionality, saving lives and being cost effective, see for example, *Medication-assisted treatment of opioid use disorder: review of the evidence and future directions*. By Hillary Connery in the *Harvard Review of Psychiatry* 2015 Mar-Apr;23(2):63-75. However, to date, extended-release-naltrexone/Vivitrol does not have a strong evidence base for opioid addiction; there are several ongoing clinical trials funded by the NIH/NIDA.

Residential treatment programs should be required to admit and maintain patients on medication assisted treatment, working with appropriate opioid treatment providers as necessary.

Per my discussions with many physicians and opioid treatment providers expert in medication assisted treatment, it is my opinion that Vivitrol should not be the only form of medication assisted treatment offered to opioid addicted persons whether it is a federally funded substance abuse clinic or a federally funded drug court or corrections facility. This is because: 1) the evidence base for the real world effectiveness Vivitrol for opioid use disorder is weak, 2) there is increased potential for overdoses during the transition onto and off of Vivitrol, and 3) we have two other effective medications. Offering patients multiple treatment options when they are available is good medicine. Just like we offer multiple possible anti-depressant medications to those with depression, it is appropriate to offer multiple effective medications for opioid use disorders, different people do well on different medications.

Lastly, given that opioid addiction is a chronic relapsing condition, patients should be allowed to be on medications as long as it is resulting in improved functioning.

Please contact me if I can provide any additional information.

Sincerely,

A handwritten signature in blue ink, which appears to read "Caleb J. Banta-Green".

Caleb J. Banta-Green PhD MPH MSW
 Senior Research Scientist- Alcohol & Drug Abuse Institute
 Affiliate Associate Professor- School of Public Health
 Affiliate Faculty- Harborview Injury Prevention & Research Center