S. Hrg. 114–681

OPIOID CRISIS

FIELD HEARING

BEFORE THE

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

SECOND SESSION

BORDER SECURITY AND AMERICA'S HEROIN EPIDEMIC: THE IMPACT OF THE TRAFFICKING AND ABUSE OF HEROIN AND PRESCRIPTION OPIOIDS IN WISCONSIN, APRIL 15, 2016

EXAMINING THE IMPACT OF THE OPIOID EPIDEMIC IN OHIO, APRIL 22, 2016

Available via the World Wide Web: http://www.fdsys.gov/

Printed for the use of the
Committee on Homeland Security and Governmental Affairs

OPIOID CRISIS—2016

S. Hrg. 114–681

OPIOID CRISIS

FIELD HEARING

BEFORE THE

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS UNITED STATES SENATE

ONE HUNDRED FOURTEENTH CONGRESS

SECOND SESSION

BORDER SECURITY AND AMERICA'S HEROIN EPIDEMIC: THE IMPACT OF THE TRAFFICKING AND ABUSE OF HEROIN AND PRESCRIPTION OPIOIDS IN WISCONSIN, APRIL 15, 2016

EXAMINING THE IMPACT OF THE OPIOID EPIDEMIC IN OHIO, APRIL 22, 2016

Available via the World Wide Web: http://www.fdsys.gov/

Printed for the use of the
Committee on Homeland Security and Governmental Affairs

U.S. GOVERNMENT PUBLISHING OFFICE

22–773 PDF WASHINGTON : 2017

For sale by the Superintendent of Documents, U.S. Government Publishing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS

RON JOHNSON, Wisconsin *Chairman*

JOHN MCCAIN, Arizona
ROB PORTMAN, Ohio
RAND PAUL, Kentucky
JAMES LANKFORD, Oklahoma
MICHAEL B. ENZI, Wyoming
KELLY AYOTTE, New Hampshire
JONI ERNST, Iowa
BEN SASSE, Nebraska

THOMAS R. CARPER, Delaware
CLAIRE MCCASKILL, Missouri
JON TESTER, Montana
TAMMY BALDWIN, Wisconsin
HEIDI HEITKAMP, North Dakota
CORY A. BOOKER, New Jersey
GARY C. PETERS, Michigan

CHRISTOPHER R. HIXON, *Staff Director*
BROOKE N. ERICSON, *Deputy Chief Counsel for Homeland Security*
MEGAN HARRINGTON, *Legislative Assistant, Office of Senator Portman*
GABRIELLE A. BATKIN, *Minority Staff Director*
JOHN P. KILVINGTON, *Minority Deputy Staff Director*
HOLLY A. IDELSON, *Minority Senior Counsel*
MARIANNA L. BOYD, *Minority Staff Director, Subcommittee on Federal Spending Oversight and Emergency Management*
LAURA W. KILBRIDE, *Chief Clerk*
BENJAMIN C. GRAZDA, *Hearing Clerk*

CONTENTS

BORDER SECURITY AND AMERICA'S HEROIN EPIDEMIC: THE IMPACT OF THE TRAFFICKING AND ABUSE OF HEROIN AND PRESCRIPTION OPIOIDS IN WISCONSIN

FRIDAY, APRIL 15, 2016

U.S. SENATE,
COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
Pewaukee, Wisconsin

The Committee met, pursuant to notice, at 2:30 p.m., in the RTA Conference Room, Waukesha County Technical College, Hon. Ron Johnson, Chairman of the Committee, presiding.

Present: Senators Ron Johnson and Tammy Baldwin.

OPENING STATEMENT OF CHAIRMAN JOHNSON

Chairman JOHNSON. This hearing of the Senate Homeland Security and Governmental Affairs Committee will come to order.

I want to first thank Senator Baldwin for making this a very nice bipartisan effort and getting us a little bit closer here.

[Applause.]

Totally off topic. The Senate is actually a very collegial place. We actually get along quite well together. We serve on a couple of Senate Committees together. So, I think that is actually an area of hope for our country. We really do get along, so I really do appreciate you understanding what an important issue this is and participating in this today.

I want to thank our witnesses. I will be thanking them in greater detail a little bit later as I start introducing them, but, particularly, those that have suffered. This takes real courage, and we certainly appreciate you coming here and sharing your story because if we are going to solve this problem, we need to understand it, we need to understand that the use and abuse of drugs, there is nothing glamorous about it. It ends in squalor and death and broken lives and broken families. So, we truly appreciate you coming here.

Now, I have a written opening statement, which I never read, I just enter them into the record.[1] So, with consent, I would ask that that occur.

I also do want to add a—I have been requested by Senator Ayotte to enter her statement in the record as well.[2] And, in that, by the way, she thanks Commissioner Kerlikowske, with the U.S.

[1] The prepared statement of Senator Johnson appears in the Appendix on page 47.
[2] The prepared statement of Senator Ayotte appears in the Appendix on page 51.

Customs and Border Protection (CBP). The commissioner has been extremely helpful, and he has attended not only this hearing. We held a field hearing down in Arizona. We held a field hearing in New Hampshire on this issue. He is going to be going to a field hearing in Ohio.

And, it really is these hearings, rather than in Washington, D.C., when we come into our communities, that can really impact and highlight these problems so that we can hopefully develop a consensus on how to start solving some very difficult issues.

As part of this committee, as a matter of fact, our first field hearing was in Tomah, Wisconsin. In many ways, a very related hearing, the tragedies that occurred because of opioid overprescription at the Tomah Veterans Affairs (VA) health care facility.

We also held a field hearing in Milwaukee on school choice, one up in Stevens Point on "Waters of the United States," and now this one here today in Pewaukee.

So, again, I want to thank the witnesses. I want to thank all of the members of the community for coming out here. I hope you will find this as informative as Senator Baldwin and I will.

Let me just kind of speak from the heart in terms of how this journey to Pewaukee and this hearing really began. When I took over the Chairmanship of the Committee, we first established a mission statement. It is pretty simple: To enhance the economic and national security of America.

And then, we established four priorities on the homeland security side: border security, cyber security, protecting our critical infrastructure, and combating Islamic terrorists.

The first one we addressed—border security, we have held 15 hearings on border security. We have issued an approximately 100-page report, and it is right here—I would recommend you going online or getting a copy of it—laying out the findings of our hearings.

You might ask, well, how does border security relate to a hearing here in Wisconsin on the effect of heroin and the use and abuse and the overdoses here in Wisconsin. Well, certainly, my conclusion, as well as I think a number of our committee Members is, among many causes of our unsecure border, I place at the top of the list America's insatiable demand for drugs.

Now, that maybe is not readily apparent, but let me explain why I believe that. The fact that we have this demand for drugs, the flow is always going to meet the demand, the supply will meet the demand. General Kelly, formerly the Commissioner of U.S. Southern Command (SOUTHCOM) provided that information on a hearing we had in Washington, D.C., on Tuesday.

Because of our demand, we have created these drug cartels, some of the most evil people on the planet. The drug cartels control whatever part of the Mexican side of the border they wish to control. They are destroying public institutions in Mexico and Central America.

As a result, we have porous borders. If you want a metric on that, by the way, we only interdict between 5 and 10 percent of illegal drugs coming through the southwest border.

Evidence that we are not reducing the supply is in 1981, in inflation-adjusted dollars, the cost of heroin, a little more than 30 years ago, was $3,260 per gram. Today, you can buy a gram of heroin for

about $100 a gram. There is ten doses in a gram. So basically, one dose, one hit of heroin, costs $10, which is roughly the equivalent of a nice craft beer in a fancy restaurant. Unfortunately, this is a very affordable addiction, and it is an affordable addiction that is destroying people's lives.

In early January, I also did a national security swing through Wisconsin. And, every public safety official I spoke to, local, State, and Federal, when I asked them what is the number one problem you are dealing with, they responded that is drug abuse, because the crime it is creating, it is the broken families, the broken lives, the overdoses.

So, you combine the fact that every public safety official is saying drugs is the biggest problem, with what we found out with our border security hearings, that drug demand is the root cause of our unsecured border, which, by the way, threatens our national security, public health and safety, and really prevents us from fixing the illegal immigration problem, you start realizing our insatiable demand for drugs, the abuse of drugs, is fueling all these enormous problems that we face today in America.

So, that is something we need to take to heart, and it is a problem we have to lay out the reality of, and that is, quite honestly, the purpose behind every one of these hearings of this committee: to lay out the reality so that the people attending the hearing, both senators at the dais here, or people in the audience, walk away from that hearing having taken the first step in solving any problem, which is admitting you have one and understanding the depth of it.

So, again, I just want to thank everybody for coming here. I am looking forward to the testimony. Again, I thank the witnesses for having the courage to share your stories and also for, the dedication as public safety officials trying to solve a problem.

With that, I will turn it over to Senator Baldwin.

OPENING STATEMENT OF SENATOR BALDWIN

Senator BALDWIN. Thank you, Chairman Johnson, for convening us here in our home State. I will also go through the formality of asking that my written opening statement be made a part of the record[1] and follow your lead in speaking from the heart.

We had a chance to talk between our formal meetings, just about how this impacts everybody, sometimes very immediately in one's own family—sometimes coworkers, neighbors, and fellow congregants—just as it affects everyone across our State and affects everyone across our Nation and, regrettably, has not gotten the policy attention that it really has needed until recent years.

I think part of that has to do with something we have struggled with as a nation over the years of stigmatizing issues and making it more difficult for individuals and family members to come forward and tell their stories, be vocal, be visible, but if we only realized we can solve problems when we do that.

And so, I want to add my words to Senator Johnson's in thanking the witnesses who sit before us right now, and we will have a second panel, and I want to greatly thank the second panel of wit-

[1] The prepared statement of Senator Baldwin appears in the Appendix on page 49.

nesses in advance for being leaders and helping us sort of charge right through that stigma.

I do not want anybody here to feel sorry for us in terms of the jurisdiction of our Committees. So, I am going to actually speak a little bit beyond the jurisdiction of the Homeland Security and Governmental Affairs Committee (HSGAC), because both Senator Johnson and I have the ability to serve on a couple of different Committees, and epidemics, crises, and tragedies do not fit neatly into necessarily one Committee's jurisdiction.

And so, I want to just add that in terms of addiction, the supplier is not always a drug cartel many miles away. Sometimes it is a medicine cabinet that has been left with unused pills. And, sometimes it is a prescriber who has been trained and takes an oath to care for our health and well-being, but yet well-meaning, has overprescribed or is overrelying on prescription drugs.

And, the pathway to the tragedy and epidemic that we are seeing right now, I guess I will say there is several pathways, and we, as policymakers at the Federal level, and we will be joined by some amazing leaders at the State level in our next panel, can not be limited just by this this committee's jurisdiction and not the other. We have to work together and put together comprehensive problems, because when, in 2014, 28,000 Americans lost their lives to either prescription opiates or illegal opiates, such as heroin and fentanyl, it demands that we work together and form those solutions.

Recently, the Senate took a really significant step forward with the passage of an act called the Comprehensive Addiction and Receovery Act (CARA), and I think it is going to be a policy step forward. Resources need to come too. Because all of the treatment programs in the world unfunded will not provide the care and support that people need to lick an addiction and to stay sober and to partake in lifelong recovery.

And so, the Federal Government is a partner, one partner of many, that need to come together to solve this issue, to strengthen our communities, but that is what needs to be done.

And again, thank you, Chairman Johnson, for convening us here, and I so look forward to hearing from our witnesses, putting a face on those unspeakable statistics, in terms of overdose deaths and people in need.

Chairman JOHNSON. Thank you, Senator Baldwin. It is the tradition of this Committee to swear in witnesses, so if you will all rise and raise your right hand.

Do you swear the testimony you will give before this Committee will be the truth, the whole truth, and nothing but the truth, so help you, God.

Please be seated.

Our first witness is James Bohn. Mr. Bohn is the Director of the Wisconsin High Intensity Drug Trafficking Area (HIDTA), within the Office of National Drug Control Policy (ONDCP), a position he has held since February 2015. Prior to this, Mr. Bohn worked for the U.S. Drug Enforcement Administration (DEA), for almost 30 years, 15 on which was spent serving as a special agent in charge of the DEA Milwaukee District Office. Mr. Bohn.

TESTIMONY OF JAMES F. BOHN,[1] DIRECTOR, WISCONSIN HIDTA, OFFICE OF NATIONAL DRUG CONTROL POLICY

Mr. BOHN. Chairman Johnson, Senator Baldwin, and distinguished Members of the Committee, it is my privilege to address you on behalf of the Executive Board of the Wisconsin High Intensity Drug Trafficking Areas program concerning the statewide drug threat assessment of Wisconsin, and in particular, the HIDTA-designated region.

My name is James F. Bohn, and I have been the Director of the Wisconsin HIDTA since February 2015. The HIDTA-designated counties in Wisconsin incorporate approximately 46 percent of the State's population. The HIDTA program is designed to support and encourage Federal, State, local, and tribal law enforcement agencies to work together in task force situations to target identified drug threats in the local HIDTA-designated areas.

Each year the Wisconsin HIDTA Investigative Support Center conducts a comprehensive assessment of the drug threats in our area to identify and prioritize any new and continuing trends or threats affecting Wisconsin.

Wisconsin can best be described as a destination State for illegal drugs and drug activity. By "destination" state, I am referring to the fact that in most instances, once illegal drugs enter Wisconsin's borders, they are almost always going to be used and/or resold within the State.

Wisconsin's proximity to the major source cities of Chicago and Minneapolis has a direct and significant impact on the presence of illegal drugs and drug activity in Wisconsin. Within Wisconsin, Milwaukee is considered a source area for illegal drugs for other parts of the State.

Now, while Wisconsin is geographically located on the Northern border, our investigations and intelligence reports of any significant seizures being sourced by drug trafficking organizations on the Northern border from the Northern border, which are relatively few, confirm that their initial entry into this country occurred via some other Northern border location, such as Detroit or one of the more western States, or by shipped parcel, prior to making its way into Wisconsin.

The Wisconsin HIDTA Drug Threat Assessment has consistently found that the vast majority of drugs entering Wisconsin are via passenger vehicle on one of the major highways intersecting the State.

Preliminary indications of the 2016–17 Drug Threat Assessment are confirming some notable differences from last year's threat assessment. However, what is the same is that opioid abuse, including both heroin and prescription drug abuse, remain the number one drug threat in Wisconsin. And, while Wisconsin has historically experienced relatively low levels of methamphetamine (meth)-related activity, methamphetamine is now beginning to show a much greater presence all around the State as well.

For years, most of the methamphetamine activity in Wisconsin was concentrated along the western portions of the State due to its proximity to Minneapolis. However, within the past year, much

[1] The prepared statement of Mr. Bohn appears in the Appendix on page 53.

larger quantities of methamphetamine are showing up all around the State. Most of the seizures have been directly linked to groups out of Minneapolis and, at times, Chicago. Minneapolis continues to be a distribution center for large amounts of Mexican-produced methamphetamine coming directly from the southwest border by Mexican drug trafficking organizations bringing it into the Minneapolis area.

Much of the heroin abuse in Wisconsin stems from users transitioning from prescription opioid drugs to heroin. Last year, 100 percent of the Wisconsin survey respondents listed heroin as their number one drug threat. For 2015, Milwaukee County alone reported 109 heroin-related overdose deaths, with the vast majority of the heroin in Wisconsin being sourced from Chicago-based traffickers with connections to the southwest border and Mexican cartels.

Over the course of the past 2 to 3 years, the majority of heroin present in Wisconsin is one of the several types of high purity Mexican heroin, as opposed to the high purity South American heroin that was routinely seen for the decade or more prior to that.

In addition, the growing heroin problem has led to increased violence and challenges for law enforcement, especially in the Milwaukee area, not only by the ever-increasing number of overdoses and deaths, but also due to changes in the retail distribution market.

In Milwaukee, for example, mobile drug houses have become commonplace and have presented law enforcement with new and more dangerous challenges. These opportunistic traffickers travel around the city in stolen vehicles, usually with multiple violators and weapons inside the vehicle, posing an increased level of danger not only for law enforcement, but also to the public.

Of growing concern during 2015 and continuing into 2016 is the increased presence of fentanyl. This most recent increase in fentanyl abuse appears to stem from the importation of fentanyl that is most likely clandestinely produced in Mexico and mixed in with quantities of heroin being smuggled into Wisconsin.

In response to Wisconsin's identified drug threats, the Wisconsin HIDTA program uses a multi-faceted approach to address the identified threats and is committed to facilitating cooperation among Federal, State, local, and tribal law enforcement and prevention efforts through the sharing of intelligence, and by providing support to coordinated law enforcement efforts toward identified drug threats.

Thank you for the opportunity, and I would be happy to answer any questions that you may have.

Chairman JOHNSON. Thank you, Mr. Bohn.

Our next witness is Dr. Timothy Westlake. Dr. Westlake is the Vice Chairman of the State of Wisconsin Medical Examining Board and Chairman of the Controlled Substance Committee. Dr. Westlake also serves on numerous boards designed to combat against the heroin and opiate epidemic, including as the Wisconsin State Coalition for Prescription Drug Abuse Reduction Chairman. For his day job, Dr. Westlake works as an emergency physician at the Oconomowoc Memorial Hospital. Dr. Westlake.

TESTIMONY OF TIM WESTLAKE,[1] M.D. VICE CHAIRMAN, STATE OF WISCONSIN MEDICAL EXAMINING BOARD AND CHAIRMAN, CONTROLLED SUBSTANCE COMMITTEE

Dr. WESTLAKE. Thank you. I would like to take this time to thank Chairman Johnson and Senator Baldwin for holding this hearing. I am grateful for the opportunity to testify and share my experiences.

My name is Tim Westlake. I am a full-time emergency physician at Oconomowoc Memorial Hospital, and I have been practicing there for 15 years.

In my role as an emergency physician, I have witnessed firsthand the evolution of this crisis. This past week alone, I treated two heroin overdoses. One of them survived, and one did not. I later found out that the patient we could not save was the fourth person from his high school class to die of an overdose.

The coroner that slipped him into the body bag said he has recently been seeing on average two opioid overdose deaths per day taken down to the Milwaukee County Medical Examiner.

What can be said to comfort those who have lost a loved one in this way? Sometimes I feel like all I can do is sit there with the family and bear witness to the unimaginable pain and suffering that they experience.

I wish I was making this next part up, but, while I was writing out the testimony, my wife received a text about the tragic news of another overdose death of a child in our area. He was at my daughter's high school last year. He took a single pill. How dangerous could one single pill be? It was very dangerous. It was a highly potent, long-acting opioid and suppressed his respiration so much, his heart stopped and he's brain-dead. And, I believe right now his organs are being harvested.

And, tragedies like this play out every day once every 24 minutes in America, and it is truly the public health crisis of our time. But, there is hope. Awareness is increasing, and I applaud the efforts being made to address this issue.

It is critical to remember that the lion's share of healthcare regulation occurs at the State and local level, and as such, most of the responsibility for addressing the prescription drug epidemic will come from the State's hospital systems and physicians themselves. The Federal Government has a limited, but useful, role, and there are small areas really only where that best solution involves Federal legislative change.

The opioid crisis did not exist in epidemic proportions until the last 15 years. That was mainly due to a shift in the opioid prescriptive practices in the late 1990s. It was directly related to the premise that pain was being undertreated and that patients had a right to have their pain treated. And, people know this as the pain scale that we see every time you go into the doctor's office, several times usually.

This originated with the Federal Government as a probably well-intentioned program through the Centers for Medicare and Medicaid Services (CMS) and the Department of Veterans Affairs, and then it quickly was reinforced by the Joint Commission on Accredi-

[1] The prepared statement of Dr. Westlake appears in the Appendix on page 61.

tation of Health Care Organizations (JCAHO) and embedded into the culture of the practice of medicine. It is now embedded, literally, in every single doctor-patient relationship, and it has been and continues to be a driving, causative factor in overprescription that is occurring.

Earlier this week, I was working a night shift and woke up and got an e-mail and text saying that I could not believe how excited I was that Senator Johnson's released a bill that will eliminate the pain scale, effectively. It is called the Pressure to Reduce Overprescribed Painkillers (PROP Act). It will make the Federal Government unable to tie medical reimbursement to pain outcome measures and will help take the government out of the doctor-patient relationship.

It is already gained broad bipartisan support and backing from the medical community and recovery community.

Senator Johnson, thank you. You really do not have an idea how much impact this will have in eliminating the pain scale. Perhaps as far as what you could do for regulation of prescribers, it is the single-most important piece of Federal legislative reform that you could do. It is very important.

Another area of Federal legislative reform that was useful is the area of reform for prescriptive practices within the VA system, and legislation in this area was recently authored and released by Senator Baldwin, and I applaud her for the two bills.

The Jason Simcakoski Memorial Opioid Safety Act models the reforms in the VA system after the best practices that the States are doing, and it applies them at the Federal level.

Now, she also has another bill that passed some Senate hearings as well, the Heroin and Prescription Drug Abuse Prevention Act, and then there are good pieces that cover expanding access to Suboxone, increase the availability of Narcan, and access expansion for treatment, which is important.

There are over 9 billion—with a B—Vicodin pills prescribed in the United States every year. It is estimated that between one-to two-thirds of these are not taken and are available lying around as leftovers. That is an excess supply every year of three to six billion pills. Fifty to 70 percent of the adolescents and young adults that abuse prescription drugs start by taking these leftovers.

As the person becomes opioid dependent, tolerance develops, they need more pills, the cost of taking the increasing amounts of pills becomes too great, and the next step is, almost invariably, a switch to heroin use. As the chairman said, it is $10 a day or $10 a dose, so much cheaper than buying pills. In fact, 80 percent of heroin use starts with prescription opioids first.

With the relatively cheap cost of heroin trafficked over the porous Southern border, along with drugs such as fentanyl and other synthetic opioids coming in over the border and through mail order, Wisconsin is awash in opioids. And, any bill that would encourage a change in this prescriptive practice, thus decreasing the amount of the excess opioid pills, would go a long way in addressing the current epidemic.

We are actually currently working on a bill, fleshing an idea for a bill with Senator Johnson that would do exactly that, decrease that excess leftover supply.

It is a small-volume, time-limited refill of a short-acting pain medication used for acute pain. Right now you cannot do refills on any medications. I want to go into a lot more detail to explain it, but I do not have the time. I had to cut some stuff.

Chairman JOHNSON. We will give you some time.

Dr. WESTLAKE. Excellent. So, at the State level here in Wisconsin, we have been blessed with the available leadership of Representative Nygren and Attorney General (AG) Schimel, who have thoroughly explored the best paths looking forward and what works and what does not in other States and truly listening to and involving all stakeholders in the process.

In fact, we just came from a coalition meeting that had all the major health systems from the State in Madison, just like literally an hour ago, and that the purpose is to try to prepare the health systems unifying the best practices across the systems.

They are really leading the country in establishing the ways that State government can best position the State and the community resources to address the epidemic.

Thank you again, Chairman Johnson and Senator Baldwin, for the opportunity to testify, and thank you especially for your leadership on this issue in the battle against the scourge of prescription drug abuse. The bills you have both introduced will really help best position the State and our country to move forward, and it makes me proud to be from Wisconsin to see you guys both up there. Thank you.

Chairman JOHNSON. Thank you, Dr. Westlake. And, we will give you some time in that question-and-answer period to expand on some of those points you made.

Our next two witnesses are a brother and sister, but they are also joined by their parents, Rick and Sandi Scott. And, again, I just want to thank you as a family for your courage coming forward. This is not an easy thing to talk about. It is not, you are laying your life out there, you're subjecting yourself to real scrutiny here, but you are doing it to save other lives. So, we really do appreciate that. So, we have Tyler Lybert and his sister, Ashleigh Nowakowski.

Tyler is a recovering heroin addict and will share his personal experience with addiction and recovery. He is accompanied today by his sister, Ashleigh, who will provide her perspective as the sister of an addict for 11 years. Both Tyler and Ashleigh serve as public speakers for Your Choice to Live, Inc., a drug and alcohol awareness program created by their family to provide Wisconsin youth with the knowledge and skills to remain substance free.

Again, Tyler and Ashleigh, thank you for sharing your story, and we are looking forward to hearing it. Tyler.

TESTIMONY OF TYLER LYBERT[1], ACCOMPANIED BY ASHLEIGH NOWAKOWSKI, YOUR CHOICE–LIVE, HARTLAND, WISCONSIN

Mr. LYBERT. Thank you for having us. This is a real honor. We are honored that you guys asked us to come. I mean, we do this all of the time, and, honestly, I am nervous now.

[1] The joint prepared statement of the Lybert family appears in the Appendix on page 70.

But, like you said, I am a recovering heroin addict. I started really young. I started experimenting in sixth grade. It was introduced to me by older people. And, when I was younger, I was chubby and hyper, so it was a bad combination and I did not have many friends. Parents did not want me coming over because I was too hyper and stuff like that.

So, alcohol was introduced to me by older people and I saw that as my golden ticket to popularity. I thought, "Yes, I can finally have friends now. All these old people want me to drink with them." And so, I started drinking in sixth grade and I started smoking pot in seventh grade. I was doing pills by 15 and I was doing heroin by 16 or 17 years old.

And, I never planned on this. I did not wake up and say, "My goodness, when I grow up, I cannot wait to be a heroin addict." It started with that first small steppingstone. It started with drinking, it started with smoking pot, and it increased.

And so, I chose drugs over everything else in my life. In going through high school, I got expelled from high schools, I got arrested all of the time, and I was in and out of jail. And, after high school, it just gave me more time to do whatever I wanted to. So, after high school, I worked every day, and I looked for drugs every night—and that was my entire life for 10 years.

And, before drugs and alcohol, I was this hyper, fun-loving kid that was always in a good mood, always laughing, always smiling, always joking around. But, the farther I got into drugs and the more I got in trouble and the more that drugs mattered to me, the less I became who I was, and instead of being this hyper, fun-loving, little chubby kid, I was an angry, violent monster. I was never in a good mood. I did not laugh anymore. I did not know what smiling was. I did not know what life was anymore. And, the only thing that mattered to me was drugs. That was it. Just as long as I was getting high, that was the only thing that mattered.

And, in the midst of it, I did not see what I was doing to everybody around me. While I was in it, the only thing that was important were, like I said, drugs. So, I did not care what was happening to my family, I did not care what was happening around me, and I did not really see what kind of damage I was doing until I got into treatment and I got sober.

And, in my family, I have my sister and my mom and my dad. From each of them, I looked for something else. My mom—I am a mama's boy, I can admit that. I looked for her support and her love. She was always there for me and she was always in my corner. From my dad, I just wanted his approval. And, from my sister—yes, she was my sister, so——

Chairman JOHNSON. Your older sister.

Mr. LYBERT. Yes, my older sister.

But, because of what I was doing, because I was getting arrested and going to jail and getting expelled, because I was making really bad choices all the time, I never got any of that from them.

My sister wanted nothing to do with me, my mom cried every day because of what I was doing, and my dad and I fought like it was World War II every single day. And, I would wake up every morning terrified of what I did the night before, because I could usually never remember. And, I would wake up every morning ter-

rified to go downstairs because I did not want to have to face my family. And, I hated it. I hated my life. I hated everything about it.

And, we had tried multiple different treatments. We had tried inpatient and outpatient, Suboxone, methadone, everything under the sun, but nothing was working. So, I started to come to the conclusion that I was never going to be sober.

And, coming to the conclusion that I was never going to be sober and hating the way my life was going, I drew one ultimate conclusion from that, that I did not think I should be here anymore. And, I figured that maybe if I die, maybe my family can finally get some peace and maybe if I die, maybe my family can finally lead the lives they were supposed to lead without me having to drag them down anymore.

And, in the mornings, instead of wondering what I did the night before, I would start wondering, "Why am I still here?" And, instead of being terrified to go downstairs, I would pray that I would not wake up the next day. There was nothing good in my life, there was nothing positive, and I could not stop what I was doing.

And so, it eventually came to the point where my family came to the—well, they did not come to the same conclusion, but they came to the conclusion where they had tried everything they possibly could, but nothing was working. And so, they kicked me out, and I went down and I lived in Milwaukee, and I had given up on life completely.

I was on the verge of taking my own life when I got a phone call from my mom. And, my mom goes, "You have two options, and these are the last two options we will ever give you. You can keep doing what you are doing, but we never want to see you again. You are not welcome to our house, you are not welcome to call us, you are not welcome to talk to us. If you choose this, you are no longer our son and we never want to see you again. Or you can get help, and we will support you 100 percent."

And so, I went into treatment again and learned more in treatment than I ever had in the past because this time I wanted to be sober.

And so, I got out of treatment. I have been sober for a little over 7 years now and, hands down, it has been the best——

[Applause.]

Thank you. It means a lot. But, obviously, my family is still here supporting me.

And so, that is my story. I will let Ashleigh talk.

Chairman JOHNSON. Thank you, Tyler.

Before Ashleigh begins, normally Rick, Sandi, and Ashleigh all chime in and tell us stories. For time, we are going to let Ashleigh speak for herself and for her parents. But, again, thank you for sharing this and we look forward to your testimony.

TESTIMONY OF ASHLEIGH NOWAKOWSKI

Ms. NOWAKOWSKI. OK. So, my name is Ashleigh. I am Tyler's older sister. I am 3 years older than him. And, on behalf of my parents and myself, Tyler's drug use deeply impacted all of us. We hurt 10 times more than he did because we were watching someone we love destroy his life. My mom cried all the time and blamed her-

self for his problems, my dad was always angry, and I hated him for what he was doing to our family.

When we should have been making childhood memories by going on vacations and spending time together, we were fighting, crying, and living in fear that we would get the phone call that Tyler was never coming home again.

I could not even have him stand up in my wedding because I did not think he would be alive for it, and I did not want to have to explain to my wedding guests why there was a missing groomsman.

My mom even had his funeral planned. There were times when I thought, "God, if you are going to take him," just take him. He was suffering, we were suffering, and we did not know that there was a way out.

When Tyler went into treatment, I did not think it was going to work. But, after many therapy sessions—and as a family we had family sessions—we were able to repair some of the broken pieces in our relationship.

Today, I cannot put into words what the past 7 years of having Tyler clean and sober has brought to our family. Tyler is not only my little brother, but my best friend and someone I can look up to.

We know that he can go back at any day and start using again, and that is a fear we will have to live with for the rest of our lives. And, we also have survivor's guilt because we know so many families that are not as fortunate as us and do not get to experience what it is like to get their loved ones back.

So, thank you.

[Applause.]

Chairman JOHNSON. Thank you for sharing that. I know that was not easy.

Our final witness on this panel is Lauri Badura. Lauri lost her son Archie Andrew Badura to an overdose at age 19 in 2014. As a result, the foundation Saving Others for Archie (SOFA) was founded.

Ms. Badura is a resource to Wisconsinites across the State of Wisconsin in sharing her story and offering hope to many. Today she is here to share this incredibly personal experience. Lauri.

TESTIMONY OF LAURI BADURA,[1] MOTHER OF ARCHIE BADURA, OCONOMOWOC, WISCONSIN

Ms. BADURA. Good afternoon. My name is Lauri Badura, and I am a wife, a mother, and a dedicated businesswoman. I want to thank my family, my husband behind me, my two sisters, and my two very best friends, Bill and Kelly, who are on my board, and all of the countless other people—there are several people that have lost children that came here today—or have children in detox today. So, I just wanted to share that before I start.

I want to thank you, first off, for listening.

Second, I wish to thank you both for your past and future commitment to stemming the raging tide of this epidemic.

In 2014, the year that my son Archie died, in our country, we lost over 47,000 people. My statistic was quoted from the Centers

[1] The prepared statement of Ms. Badura appears in the Appendix on page 74.

for Disease Control (CDC). That is right, you heard it correctly. The figure was not a mistake. 47,000 people perished in this Nation due to drug addiction in one year alone!

Those of us who have lost loved ones to an opiate epidemic, those of us who advocate for more attention to this issue, please understand what we certainly understand, why the latest news reports center upon the gravity of worldwide incidents across the globe, where a dozen of people might be killed by terrorists, or where 25 or 68 people perish in a single suicide bomber attack, but we all defiantly cannot understand the importance of these news stories, with 47,000 compared to that.

But, for moms and dads like us, we have lost our children to this opiate addiction and this epidemic. The lack of attention on this ridiculously large numbers of deaths, 47,000 in a single year, we do not always understand this lack of attention and outrage.

That is why today is monumental. Because of your listening today and the scheduling of this hearing, you have changed the contours of this entire conversation. On behalf of the survivors here today, I applaud your leadership and express my deepest gratitude to each of you for the gift of your time and your talent.

I was invited to speak to you because my son Archie died from a heroin overdose on May 15, 2014. And, I hope you have read my biography. I brought it along. You will read about the harrowing details of our family's personal hell. You will learn about Archie's cousin, who, while remaining alive, now lives with a debilitating traumatic brain injury at age 44. He will continue to require 24-hour, around-the-clock medical care for the rest of his life.

Over the course of the past 2 years, I have told our story, a story of survival, to countless audiences of all ages, shapes, and sizes. But, today I want to talk to you about another aspect of my life. You see, every week I get calls from across southeastern Wisconsin, mostly from people who, like me, are coping with the pain of the death of a child.

These people, many of them survivors of this opiate epidemic, are referred to me. Who refers them? You name it. I receive referrals from psychiatrists, psychologists, nurses, priests, and business professionals—even my boss.

And, this is not an exaggeration—I receive referrals from funeral homes. I have the Kleenex to prove it. That is right, funeral homes. The directors give my name out now.

My commitment to all of these people is unwavering. I talk to each and every person who calls me seeking help. Each person is suffering with and struggling with the horrors of substance abuse addiction, and I am one who can empathize, identify, and relate to their experience.

What does my inner drive to serve others come from? I am not entirely sure. No doubt my faith of God sustains me. There is also no doubt that my son Archie motivates me. I refuse to allow his life to be taken in vain.

I make sure that his memory will live on, even if, through the efforts of his mom to help others cope with their pain and suffering, it is my mission to ensure that Archie's life story will continue to serve as an agent of change and transformation to saving others for Archie.

So, what you might ask, is my life like today? Well, I just want to share that, 10 days ago, when I received your invitation to the hearing—I want to recount a few details of what these days are like, similar to Dr. Westlake. I think we get the same texts, possibly. I hope you will gain a little bit of vision of what it is like in my life today.

On April 5, a mother called me. Her teenage son had died, and she wanted to know if her hell would ever be put away or will ever go away.

Two days later, on April 7, another mother called. She got my name from a funeral director who buried her child, and she told me she does not know how she will ever get out of bed and get a break from her personal grief. She is just devastated.

On April 8, I learned of a young man who knew both of our sons from childhood who died of a heroin overdose this weekend. I cooked dinner, brought it to their family, and we all sobbed in each other's arms as we looked at their Catholic school grade pictures. There were no words of comfort to offer. I sat in silence. This boy had carried my son's casket. It made no sense. That young man's funeral happened this past Saturday. I attended. The wounds reopened. I cried some more.

Out of the blue a week ago, a psychologist called me. He asked permission to give my personal cell number to a patient, a woman that he feels he cannot reach. The psychologist has worked with this mother for a full year after she lost her 28-year-old daughter.

This past weekend, a mother reached out to me with her 38-year-old son, who was turned away at the emergency room (ER) for a detoxer treatment. She had found him with a needle in his arm and did not know what to do. So, I made sure that she was armed with Narcan. She tried to call a hospital to get in, it would not be until next week, and she went to bed that night with the Narcan sleeping next to him. For two nights, that is how it was. The third morning, he was not there. He is still not home. The system let this mother and son down.

I am not done, though. My son Augie called me from the University of Wisconsin (UW)-Eau Claire Sunday evening. Another freshman student in his dorm overdosed on opiates. Augie, who serves as a public speaker and knows more than anyone should at his age about drug addiction—it was Augie who was the first responder to this UW-Eau Claire student and called 911. The fellow student did survive and was grateful for Augie's quick thinking.

So, you see, it is all over. There are several more messages on my phone looking for help, several that I have not even returned as of yet today. But, why me? Why do they call me? Why do psychologists, business professionals, and funeral directors call me? Sometimes I feel like I am not quite sure, because I have terrible days. You know what I am talking about, these days when you can barely get out of bed. The heaviness of the grief is insurmountable.

In other venues, it may look like I have it all together. I enjoy a good deal of success as a business marketing executive. I feel quite natural serving clients across the Nation from the East Coast to California. In this realm, I am comfortable and I am confident.

But, here in this realm, there is no business school for parents whose children are addicted to opiates, like heroin. In this realm,

there is no textbook or guidebook to follow when you learn that your child has an addiction, no.

But, people continue to reach out to me. I believe it is because I am raw, living-proof knowledge of this addiction storm. I lived it day after day with my son, Archie, and then I buried my own son.

I am not embarrassed, nor do I apologize. I do not wallow in shame, nor do I blame others. Instead, I seek to find resources—resources which will build knowledge, create understanding, and help counsel others through this nightmare.

Besides being a seeker, I am also waiting. I am waiting for leaders like you. It may be too late for my Archie and our family, but can we work together to save others? This hope is why I came today.

I wanted to briefly share some urgent needs that I think are important from all the telephone calls and what I have heard from across the State, for not only our State, but our Nation.

First, the medical treatment model needs reworking. Think diabetes: Lifelong care; lifelong approach. Addiction: Lifelong care; lifelong approach. We need to change the way we use healthcare in our Nation when it comes to opiate addiction. We need a treatment model because true opiate addiction needs medication. And, also, treatment needs to be uninterrupted by insurance companies. Addicts need to be able to focus on the recovery and not whether or not their insurance company is going to deny or end their coverage.

Second, the window to get treatment is so narrow, and these families are being turned away each day they come to an ER to get help. HFS–75 opiate detox, in general, is urgently needed to stabilize a person and is part of a treatment-oriented system of care. Traditional opiate detox is not generally covered by health insurance. The need for some type of detox facility remains in communities, and alternatives to traditional opiate detox are being explored by the private sector, such as ambulatory detox, rapid, home-based programs, and even visiting nurses.

Third, step up the medically assisted treatment to aid the opiate epidemic. Use medical-assisted treatment for opiate users in a recovery program and in drug courts as part of the law. We must provide Vivitrol for those incarcerated and for those newly released.

Fourth, restricting access to drugs not just from Mexico, but from all our borders and boundaries and professional responsibility. Tighten up education to drug companies and better educate physicians, oral surgeons about the how-to's of writing an opiate script.

Lastly, look into the data on those that have survived opiate overdose and the suffered brain trauma that are now wards of our State, like my nephew, that will need 24-hour care for the rest of his life and is unable to give back to society.

Harnessing all of our stories together and looking at the hard facts for policymakers, this is the other side of the epidemic that nobody wants to speak about.

So, I close with these five important unmet needs, and I hope my perspective provides you with insight so they may be reality for future policy changes. I thank you for your time, and hopefully together we can save lives. Thank you.

[Applause.]

Chairman JOHNSON. Thank you, Lauri. Obviously, our sincere condolences to you and your family. Our sincere thanks for your commitment to help others turn your tragedy and the loss of Archie to something positive, trying to help others, and just for your courage for testifying here today.

Tyler, I want to go to you, because you said you tried different types of treatments—different types of medications to get you off of heroin, and then finally one worked.

Can you describe what did not work and why it did not work and what finally worked with you?

Mr. LYBERT. I think the biggest part of why treatment did not work for me is because, at the first six treatments, I did not really want to be sober yet. I think that is the most crucial part to anyone getting sober is wanting to be sober.

And, for everybody it is different. Methadone may not have worked for me, but it has worked for plenty of other people. Vivitrol may work for somebody else—it may not work—it is different for everybody. But, I think the key thing is, is that person has to be at a State where they are willing to change.

Chairman JOHNSON. So, in your testimony, you described yourself pretty low stages for quite some time.

Mr. LYBERT. Yes.

Chairman JOHNSON. But, I mean, we always hear hitting rock bottom. I mean, it really was when your parents kicked you out of the house, you were living in some situation, and then it was when your mom called? I mean, what—describe rock—I hate to say this, but describe rock bottom, and what was different about it than what you were describing, which sounded pretty rock bottom while you were in the house as well every morning waking up. What is the difference?

Then, Lauri, I am going to come to you, because I want to hear how that relates in terms of your situation.

Mr. LYBERT. Well, I think the biggest thing is, is the last time that, every time that I hit rock bottom before that, I was like, well, this is just a fluke. This will not happen again. I will not get this low again. I will make sure of it. I will be better this time. I will be a better addict this time.

The last time that I went in was the final realization that this just is not working anymore and that rock bottom was—I had a knife. I was ready to end everything. I was done. I could not take the burden anymore.

Chairman JOHNSON. Ashleigh, real quick, did you and your parents, did you recognize rock bottom? Did you see something different about it this time?

Ms. NOWAKOWSKI. Not at first we did not. When my parents kicked him out of the house, I had moved out of the house, but they had called me and said, we have kicked him out, and this is the ultimatum. If he calls you, do not answer his phone calls.

And so, they were the ones that went to go pick him up and take him to treatment. But, it took a little bit for us to realize that he wanted to get help. So, at first, I did not know if we noticed a change in him or anything like that, but he felt it.

Chairman JOHNSON. Other than that attitude of now I really hit rock bottom, was there a difference in the treatment or was it strictly just the attitude?

Ms. NOWAKOWSKI. I think a big thing that helped him was we changed as a family. So, we had to go to family sessions and—because throughout all the other treatments, my parents would take him, drop him off, pick him up, he was fixed. Like, you fix him, and he will come back into our house. And, that was not working.

So, when we went to the final treatment, we actually had to go to family sessions and work on changing dynamics within the entire family.

Chairman JOHNSON. So, you were with Tyler. So, now you went through treatment, to a certain extent, together.

Ms. NOWAKOWSKI. Right, exactly.

Chairman JOHNSON. And, that was the first time that happened. And, Tyler, was that—I mean, in addition to hitting rock bottom, was that family treatment, was that also key?

Mr. LYBERT. Yes, I think that was a huge part, because family was—no matter how much I did that was wrong to them and how much I said I hated them, they were still the most important thing to me. So, knowing—like seeing their support and, seeing my dad tell the counselor that, well, I work every day, and I am not going to be there because you cannot set a meeting early enough, and the counselor saying, hey, tough luck, you are coming. And, for all of us to be in the same room and to be able to share, what we were feeling to each other, that was the first time that has ever happened. So, yes, I think that was a major part.

Chairman JOHNSON. Lauri, I hate to even ask, because I hate to have you go through this process again, but were there attempts to put Archie in treatment? Did those work, did they not work, or—and/or can you talk about because you are helping so many other people, can you relate to this? Can you kind of——

Ms. BADURA. Yes, I can. And, I do not feel guilty, Tyler. We love you, and we are so glad you made it. But, Tyler is an anomaly. There is not a lot of them that make it out, there really is not. I wish there was a lot of Tylers. I wish I knew them; I do not. So, I am so glad. I mean, our families are close. We know each other well. They knew Archie.

I guess, I have my sisters and husband, and it was 4 years of hell. It was marijuana. So, everybody says, oh, heroin. That was not even introduced before 2 months before he died.

So, I guess rock bottom? There were so many rock bottoms. We kept thinking, this is it, this is it. But, if you look on the last page, when you walk into an ER and see that your kid ingested an opiate patch, and the physician said most kids ingest a spoonful, he ate the entire patch and was foaming at the mouth. This is his first overdose. He should have died that day, January 3; he did not. If anybody wants to see it back there.

There were several times. And, just like any addict, they do not want to die. They are off trying to get to a high of feeling better, but this drug owns them. They are in a jail of something that none of us can understand.

I cannot tell you how many people said to me, how in the world could that boy carry your casket and then he overdose this week-

end? I said, because you do not get it, you really do not get it. People who say that, "Oh, they can just stop"—they cannot. You cannot. And, it does, it starts with the pills. It starts with the pills, and then it goes, as you said, $10.

Chairman JOHNSON. Tyler, when we were in the back and I asked Neal what he knows about the percentage of successful treatment. About 1 in 10 is what he said. That actually surprised me as being high.

By the way, Rick and Sandi, if you would not mind, at the end of the panel, I will have you come forward if you wanted to just say a couple words or if there is something that you want to express here. That may be powerful.

I do want to go to Mr. Bohn and Dr. Westlake. Anything you can kind of chime in on the treatment aspect of this? Things that you know, that we understand. Obviously, Dr. Westlake, you treat the emergency side of this equation.

But Mr. Bohn?

Mr. BOHN. One of the things we have learned from law enforcement over the years is the fact that it is going to take treatment to get people, otherwise we are going to see them again and again in the criminal justice system. We have now got an entire generation of addicted people out there.

We focus on the people that bring it in. We focus on the people that deal in this stuff. But, I can tell you, the high level violators that bring this stuff in are smart enough to know not to use it, because they know how dangerous it is.

So, it will take a lot of prevention, it will take a lot of rehabilitation, but law enforcement has a duty as well to keep it out as much as possible.

Chairman JOHNSON. Could you just kind of speak to what we know about the success rate of treatment? Then I will turn it over to Senator Baldwin to ask questions.

Dr. WESTLAKE. So, yes, I mean, my area of expertise really is more in emergency medicine, some of the policy areas, but it is abyssmal results. I mean, once someone gets addicted, it is, one out of 20, one out of ten tops. So, there is a lot of different drugs that are addictive.

Alcohol, you are an alcohol addict, and you have maybe 50 years of drinking before you die. You get too drunk, you pass out, you throw up, maybe a car accident if it is that horrible.

You take too much heroin one time, you take one pill, like this kid last week, and you are dead. And so, there is just no room for error.

And, the biggest thing, we just had this coalition meeting, we asked the health systems, how can we partner together? We brought States together, the Department of Homeland Security (DHS) and all kinds of players at that level, and the shortfall is in the treatment. So, there is not enough treatment fighters.

If we could get all the addicts, 168,000 opioid addicts, if we could get them into treatment now, we do not have, so that is an important piece.

I believe in limited government, that the funds really need to be justified to be spent, but I think the return on investment for getting people clean is huge, and it is well worth the cost.

Chairman JOHNSON. What was shocking, before I turn it over to Senator Baldwin, in the testimony, I think you said the average beginning age was 11. Eleven years old. You were in sixth grade—11 or 12?

Mr. LYBERT. Eleven, yes.

Chairman JOHNSON. Nothing glamorous about that, is there?

Mr. LYBERT. No.

Chairman JOHNSON. Senator Baldwin.

Senator BALDWIN. Thank you all again for your amazing and powerful testimony. I want to just pursue a number of the issues that each of you raised a little more deeply.

Lauri Badura, if I can start with you. You just described your last few weeks. You are like the key resource for people who have your cell number and people who give out your cell number. We have an epidemic, and it strikes me that people have no idea where to turn, what to do. It does not sound like an emergency response to an epidemic at all.

Tell me, what is out there for parents? When you talk to them, of course, you are doing some personal counseling. You are sharing your experience, hugging them. What sort of formal resources are out there, especially if you are hearing from parents who have not lost their children yet?

Ms. BADURA. Absolutely. I am so glad you are asking. I am on the Alcohol and Other Drug Abuse (AODA) advisory committee for Waukesha County, and there are several wonderful things that are out there, but there are many—it is hard getting the word out there. They are doing great things, but no one really—I call it connecting the dots. That is if you look up my name—most people Google "heroin mom," and my name comes up.

So, I call it connecting the dots in the State because each county is doing fabulous. I mean, I have worked with Milwaukee. No one is talking to each other. Why redo each other's work? But, what I would tell somebody that would call is there is something called 211, which is—you know what that is, right?

Senator BALDWIN. Of course.

Ms. BADURA. OK, the 211. And then, a lot of people do not know it. So, they are just comforted with that fact.

If they cannot, most of the problem is a lot of these people, the resources are tapped, there is no more insurance, they have done treatments, most of them, I would say, have done three, under their family's insurance, and they are tapped out.

So, then they go to a county, and the county it takes 4 or 5 days on a good day. That is what my friend was waiting for this past weekend when the boy—they were trying to wait to get him in, and that is just because they are so backed up.

But, I know so besides that, it is arming—if you are living with somebody with an addiction and they are using opiates, you have to have the Narcan, and the public does not know about that.

There is great resources here that are training, they are handing out needles, they are doing things here, but they just need help getting the word out.

There is also the Addiction Resource Council (ARC), they are doing fabulous things, but we do not even have counselors. The counselors are going to age out soon, and there is not enough coun-

selors to counsel people. Because, really, Archie was 77 days clean. He wanted to be clean. That is the most dangerous time. You can get them through treatment, but they still need—that is why I am saying, "We need the care like diabetes, where for life, you are getting looked at, you are getting to see a doctor and saying, 'OK, how is it going? Well, maybe you need to go do this again.'"

So, those are the steps. And, there is also—I give several different numbers of private homes, that care that will take the people, and then public places, but there is not many beds.

Senator BALDWIN. About those beds. Just in terms of your own knowledge and your own experience, is it because of lack of professionals to staff them or lack of local resources, State resources, national resources to fund them, lack of insurance coverage, all of the above?

Ms. BADURA. It is really all the above.

Senator BALDWIN. I think I know the answer to the question, but I want to hear you——

Ms. BADURA. No, but it is a great question. Like Lutheran Social Services (LSS) is one I can tell you in Waukesha County who has been pushed around because they cannot get a building. Nobody wants them. And, they have the funds, they are ready to have a building, and I know they are working on that, so—but people do not want a hospital full of addicts maybe in their neighborhood, I do not know. I know that is one problem.

I think that they are definitely limited on doctors. I think we do not have the physicians as many as possible. I know we do not have the counselors. I absolutely know that.

But, I think our resources for what the epidemic has done. Because I joined this advisory group when Archie was alive, I came to this meeting saying, please help, my son is so sick, please help, I do not know what to do. And, I wanted to educate myself.

I can tell you, in those 2 years, these people that are working in their daily job—it is not my daily job—they are tapped. There is nothing. They are not getting any more help. I mean, we really need more people, more resources, more help. And, I am thinking almost like hospice care, where it is, it is in your home, and people come. I am not sure, because I know it is expensive. But, we have to save lives.

Senator BALDWIN. That is right.

Tyler and Ashleigh, before I ask the question, I also want to give you permission to plug the prevention work that you have done through Your Choice to Live. We will get a series of public service announcements as I go across and ask questions, so if you want to say anything about that as a precursor.

But, Tyler, I want to ask you about the impact of your interactions with the criminal justice system. You talked about several arrests, I think several incarcerations at the local level. And, I understand that everybody's path is different. Were those experiences helpful or motivational for you to actually make the decision to ultimately seek treatment? How did that play out in the path that your addiction took?

Mr. LYBERT. Well, I think one of the things, and we talk about this quite a bit, but, back 10 years ago, when I was using or—yes, it is—wow, it was 10 years ago, when I was 18, when I was 19,

when I was 20, things like that, there was not the problem there is now. So, the—the—oh, my gosh.

Ms. NOWAKOWSKI. Criminal system?

Mr. LYBERT. That is it. The criminal system did not have the resources they did either. So, when I was arrested for driving under the influence (DUI)—or whatever I was arrested for—I was never offered classes, I was never offered anything like that. So, for me to say it helped me, not necessarily, because I would blame the system every time.

Now, a lot of different things are put into place for people that do get arrested and things like that, like the 180 Diversion Program. I went through the alcohol treatment court in Waukesha County after my third DUI. And so, in that respect, it did help, because that gave me a year after I was already sober to be held accountable.

So, I think that the criminal system is getting better and doing better at trying to help addicts rather than lock them up. Especially in our community in Waukesha County, Oconomowoc specifically, when kids get in trouble for underage drinking or paraphernalia or possession or anything like that, their first offenses, Judge Kay in Oconomowoc, he refers them to our program, to our detour class, so they can take a 12-hour class on—all about risk taking and choices and making better decisions and stuff like that. So, I think that the justice system and criminal system together is starting to see a need for help rather than sentencing.

Senator BALDWIN. Dr. Westlake, I have a question for you, but before, you just heard Ms. Badura say that too few people even know about Narcan or naloxone. So, for people in this room who might not know, for people who might be hearing about this hearing by watching the nightly news, can you give us one minute on what the heck those two drugs—or what that one drug with two different names is, what it does, and why people need to know about it?

Dr. Westlake. Sure, yes. Narcan, or naloxone is the drug name for it, is an opioid reversal agent. So, what happens when you take opiates is they sedate your respirations, they fill these chemical receptors in your brain, and eventually it suppresses your respirations so much, you stop breathing, it lowers your oxygen level, and your heart stops after that.

What the Narcan does, if you can get it in before that whole cycle is completed, is it kicks off all the opioid chemical analogs, and so it clears it, just immediately, literally takes them off. I have given it to patients where they come in and they are breathing at two breaths a minute and they are blue, I give it to them, and if you give a little too much, sometimes they are wide awake and they are angry as heck right away. I mean, it is just like turning a switch, if you can get it in the patient in time.

Chairman JOHNSON. Just real quick, is there any danger to having that in the general population? Is there any abuse of that drug?

Dr. WESTLAKE. No. The theoretical risk would be, well, are you motivating people to feel safer using? And, initially, I kind of thought that maybe 10 years ago, until I had some insight into it. And absolutely, those people are going to be using. When you are an addict, that is what you do, is you use.

And then, I think Attorney General Schimel is going to talk about it, he is pushing to possibly go the Food and Drug Administration (FDA) with no prescription necessary.

And, I think—I mean, the only issue I would have would be that we have to make sure the supply is enough that we can get it in the ambulance services. I would not want it to just disappear, and all of a sudden there is shortages, because there are drug shortages on a lot of different things. So, but apart from that, there is no—other than, you feel a lot of pain if you give it to someone.

Chairman JOHNSON. Is it injected, or how is it——

Dr. WESTLAKE. You can shoot it in someone's nose. So, there is a nasal atomizer that you can use. You can inject it.

Chairman JOHNSON. Sorry to take your time.

Senator BALDWIN. No, I absolutely wanted this to be a public service announcement on this topic. I have a question too, but——

Dr. WESTLAKE. Yes, it is a great message.

Senator BALDWIN [continuing.] No, I think it is a really important question. And, not unlike the distribution of clean needles to prevent other deaths related to people who shoot drugs, this does have that side debate, but it reverses an overdose.

So, my question for you actually relates to the recently released Centers for Disease Control safe prescribing guidelines. I think they went through a fairly long process trying to look at the latest evidence on appropriate and safe use of opioid pain medications.

I would like to ask you, in terms of educating your peers in the medical community about safe and appropriate prescribing, sort of what is the most important piece of information that this guidance should include to support prescribers in preventing adverse outcomes of addiction and recognizing addiction in their practices?

Dr. WESTLAKE. Yes, the guideline piece is—we actually just pushed and Representative Nygren had a bill that went through that we just signed that gave the Medical Exam Board the ability to promulgate guidelines. We actually—Mike McNett is a doc that I work with who would come—modified the CDC guidelines and put them into our language.

The thing that is important is to get the changes to come from underneath within. So, you have to get the providers, which I think there is an awareness now, to understand that there is inappropriate prescription. So, it cannot just be another Federal mandate like, you got to do this and it needs to come from underneath within the health systems and from within the doctors. And so, what we are trying to do at the State level, through the controlled substances committee, which is what promulgates the guidelines, is to have input from the stakeholders.

So, then when we come out with these guidelines, the systems can then say, OK, these are reasonable guidelines, they are good guidelines. And, when you get buy-in from the providers in the systems, then it can be incorporated into the culture of the practice, and education is important with that as well.

It has to be limited, though. Because, again, we have a crisis now, so there is a huge opioid epidemic. The problem I have with legislation, State and especially Federal, is once it is in place, it is never going to get repealed. There is never going to be enough will to repeal it.

So, if you put something in place—there is a great piece of legislation that had, continuing medical education (CME)—4 years of opioid CME per year for the DEA. The problem with that is in 20 years, hopefully, the culture will have changed that it will not be a problem, but I will still be stuck doing 4 hours of opiate CME.

And so, that is the thing is, that Representative Nygren used sunsetting. So, after three years, the restrictions on checking the prescription database will go away. And then, hopefully by then, the culture of prescriptive practice will have changed. So, that is the wisdom of the legislation.

Senator BALDWIN. Yes. But, and you raise a great point. I remember reading an article about how sometimes change in the medical community is slow, and it was Dr. Gawande talking about how a recipe change in New York City was adopted universally in all the certain type of restaurant in 7 days, but it took 7 years to change a protocol at the medical profession. So, we obviously need to put a huge exclamation point behind these new guidelines.

Dr. WESTLAKE. And, have the systems within own their part of the guidelines.

Senator BALDWIN. Yes, exactly.

One last question of this panel from me for you, Mr. Bohn. So, you have the rather unique role of overseeing the coordination among so many different levels of the Federal, State, and local law enforcement efforts to combat drug trafficking.

And, I guess I just want to—from that unique perspective, I want to know how you believe it Is working and what more we can be doing at the Federal level in Congress to support coordination to more effectively combat the flow of heroin and other illegal opioids into this community.

Mr. BOHN. It is just that the support is both funding for training, for enforcement, and for prevention methods. In HIDTA, we have a heroin-specific task force that we have just beefed up by about 50 percent with more manpower, but at the same time, we are always doing costly training out there.

We are training law enforcement, because in a lot of the communities, this is something relatively new to, on how to handle overdose investigations and—because it is in every community.

At the same time, we do a lot of public awareness training to go out and just let people know that this is out there. And, we have participated in countless heroin summits around the—and opioid summits around the State to raise awareness both within law enforcement and within the public in general.

We are working hard to get the intelligence sharing that needs to be done at the law enforcement level so that all the agencies that are participating in these share intelligence so that we can make connections and close those intelligence gaps as well.

So, there is several levels to the problem, several levels to the solution, and it is not going to be one thing; it is going to be a multifaceted solution.

Senator BALDWIN. Thank you.

Chairman JOHNSON. Thank you, Senator Baldwin. I do not want to put too much pressure on Rick or Sandi. Would you like to make any comments before we seat the next panel? Do you think Ashleigh did a pretty good job for you?

Ms. SCOTT. I do.

Chairman JOHNSON. OK. I think she did as well.

Mr. LYBERT. Are you sure, mom? [Laughter.]

Ms. SCOTT. Yes.

Chairman JOHNSON. Thank you all for your powerful testimony. This is not the last hearing on this, trust me. So, thank you, and we will seat the next panel with that.

[A recess was taken from 3:42 p.m. to 3:46 p.m.]

Chairman JOHNSON. As I mentioned to the earlier panel, it is our tradition to swear in witnesses, so if you all rise and raise your right hand.

Do you swear the testimony you will give before this Committee will be the truth, the whole truth, and nothing but the truth, so help you, God.

Please be seated.

Our first witness is Commissioner Gil Kerlikowske, and we know you have a hard stop at 4:30, so when we get done with the testimony, we will come to you and ask you the questions, and then, feel free to, I guess, probably catch your plane, right?

Commissioner KERLIKOWSKE. Thank you, Senator. I appreciate it.

Chairman JOHNSON. So, Commissioner Gil Kerlikowske is our first witness. He is the Commissioner of the U.S. Customs and Border Protection at the U.S. Department of Homeland Security. Commissioner Kerlikowske is also the former director of the Office of National Drug Control Policy. Mr. Kerlikowske has four decades of law enforcement and drug policy experience.

And, again, I just want to express our—this committee's thanks for all the traveling you have done to participate in these similar types of hearings in the States which are being affected by this tragedy. Commissioner.

TESTIMONY OF THE HONORABLE R. GIL KERLIKOWSKE,[1] COMMISSIONER, U.S. CUSTOMS AND BORDER PROTECTION, DEPARTMENT OF HOMELAND SECURITY

Commissioner KERLIKOWSKE. Thank you.

Chairman Johnson and Senator Baldwin, thank you so much for the opportunity to appear today and to be here to discuss this significant abuse and addiction issue of heroin. It is an important discussion about a complex, difficult challenge that our Nation faces.

Customs and Border Protection has a critical role in the effort to keep heroin and other dangerous drugs out of communities. We seize nearly 4 tons of illegal drugs every single day, and it is a variety of drugs. Our seizures of heroin increased 22 percent in the last fiscal year (FY).

While the vast majority of the seizures still occur along the southwest border, we interdict heroin in all modes, air, land and sea, in both the travel and the cargo environments. Add in between the ports of entry (POE), our frontline officers and agents use a variety of technology and assets, everything from canine to large x-radiation (x-ray) equipment, etc., along with intelligence and information sharing with our State, local, and Federal partners.

[1] The prepared statement of Mr. Kerlikowske appears in the Appendix on page 76.

Continued efforts to intercept drugs at the border are a key aspect of addressing the crisis, but I think we all know and recognize that interdiction and arrests alone will not solve this problem.

President Obama conveyed just a couple weeks ago at the National Prescription Drug Abuse and Heroin Summit in Atlanta that we need to focus efforts on prevention and treatment in conjunction with the deterrence of drug trafficking via criminal organizations. And, we need to better integrate our efforts and share information.

I am pleased to support the Department of Justice (DOJ) and the Office of National Drug Control Policy on the National Heroin Task Force, which fosters a collaborative relationship between public health and law enforcement across all levels of government.

Law enforcement at all levels is committed to security, but also in protecting the health and safety of the public. And, for Customs and Border Protection, this is especially important because nationwide we encounter nearly 1 million people every day that come into our country through our ports of entry. And, we were the first Federal law enforcement agency to initiate naloxone training for our officers who may encounter someone experiencing an overdose.

I want to acknowledge the significant strides that we have made with Mexico and that they have taken in recent years to address transnational organized crime, and narcotic smuggling specifically. The relationship with our Mexican counterparts is stronger today than it ever has been, and while more can be done, we know that we receive information from Mexican authorities on a daily basis. They sit with us in some of our targeting centers, we work closely with them, and I think the recognition that we are all very much in this together is clear.

So, thank you for holding this important hearing, and I am happy to answer your questions at the appropriate time. Thank you.

Chairman JOHNSON. Thank you, Commissioner.

Our next witness is Attorney General Brad Schimel. Attorney General Schimel was elected as the Wisconsin Attorney General on November 4, 2014. A front-line prosecutor, first elected Waukesha County District Attorney in 2006, Schimel has pledged as attorney general to put public safety over politics and continue to fight against heroin and human traffickers. General Schimel.

TESTIMONY OF THE HONORABLE BRAD SCHIMEL, ATTORNEY GENERAL, DEPARTMENT OF JUSTICE, STATE OF WISCONSIN

Mr. SCHIMEL. Good afternoon. And, thank you, Chairman Johnson and Senator Baldwin, for the opportunity to testify, and thank you for both of your commitment too.

Thank you for your commitment to finding bipartisan ways to address this opiate epidemic that we are facing. Some of the legislation that you have both proposed will make a difference in this battle for us.

And, Senator Baldwin, you asked whether—in the question-and-answer (Q&A) period earlier, whether this was an—this sounded like an emergency response to a crisis, and it does not. And, many of the people in this room have been on kind of the speaking circuit together for a long time, and we have been asking for a long time,

after we talk about the nature of the problem, we are asking people what are we prepared to do about this?

We have seen in the course of a little over a decade, opiate overdose deaths more than quadruple. And, if we saw that kind of a change in traffic crash deaths, we would put a roundabout every 200 feet. We would lower speed limits to 15. We would not let people get their driver's license till they are 30. We would do things that sound crazy. And yet, as to this, we are still kind of struggling for awareness. So, I appreciate your committee's willingness to help raise this awareness.

I do not want to repeat things that others said, but I will reiterate what Mr. Bohn said. This is also driving virtually every other kind of crime in our nation.

Dr. Westlake, he has had enough in the emergency department. Me, I have had enough. There have been years in Waukesha County where we have had close to 50 overdose deaths, right in this one county while I was the district attorney (DA). I have met now all along the way, hundreds of parents who have buried their children. I have had enough. I am tired of this.

The law enforcement officers and emergency medical services (EMS) that are in this room today, they have had enough, of often going back over and over to the same house, to the same person, who was saved recently and just went right back to using, because we do not have enough help for them. And, they are often, as Tyler Lybert said, they are often not ready to get help.

And, the Lyberts and Mrs. Badura, we have spoken together dozens of times, and still, every time any of them talk, I still get choked up and get teary-eyed, because their story does not get any better no matter how many times you hear it.

So, ask any law enforcement officer here in this room or anywhere, what is the worst problem we have seen in the last quarter century, this is it, this is the one.

And, now, you have heard a lot about how this devastates people in many ways. There is one way that has not been mentioned yet, and that is employers. It is affecting our economy. Four out of five employers in a survey conducted in Indiana, which is not so different from Wisconsin, four out of five employers in that survey had to address opiate abuse and addiction in their workplace. Conservative estimates suggest that opiate abuse is costing employers nationwide over $26 billion annually. This is affecting our economy.

And, I do not want to repeat all the things that have been said about the issue on the border, but any discussion about this problem has to include a discussion about our Nation's international borders. In years past, heroin came to America from southeast and southwest Asia. Because it was so hard to get it here, it had to be cut drastically in order to be profitable.

In the 1980s, the average heroin purity on the street was about 5 percent. We do not see 5 percent anymore, because it is so easy to get it into our country, they do not have to cut it to make it profitable. Instead, they are competing with each other for who has the most potent heroin. And so, now we find heroin between 20 percent and all the way up to close to 80 percent pure. And, when you look at it in your hand, you do not know what you have. That is part of why we are seeing so many overdoses, because a young person,

or even a middle-aged person, using that has no idea. So, it is going to be necessary in this to address the border security as part of this problem.

And, I want to mention methamphetamine. Mr. Bohn mentioned it briefly. Wisconsin and many other States took drastic steps to make it harder to produce methamphetamine here in America. So, we made it harder to buy the necessary ingredients to make it, and we have cut down domestic production.

Unfortunately, the production shifted to Mexico. Our problem with methamphetamine is worse than it was before, and it is growing, and it is spread to parts of our State that did not use to have the problem. So, we do have to address the border in this issue.

And, in terms of how we are going to solve this problem, it has been said as well today that this is an all-hands-on-deck answer that we need to have. Law enforcement will not do this alone, treatment will not do it alone, and prevention will not do it alone, but they all three have to be as a part of this.

One of the challenges is that unlike investigating an armed robbery that happens at one place and one point in time, the drug trafficking does not respect any municipal or State boundaries. It is moving everywhere. And, it is necessary for law enforcement to be able to work across jurisdictions together.

One of the ways they have been able to do that over the years is through the assistance of the Byrne Justice Assistance Grants. Those grants have been shrinking over the years, and it is making it harder for the local, municipal police departments and the metropolitan drug enforcement groups to do their work.

And, it has been years ago already now in Waukesha County, and I am a little bit reluctant to even say this out loud, but years ago we stopped focusing on marijuana at all with our metropolitan drug enforcement group because the opiate problem is consuming so much of our efforts.

Narcan has also been mentioned today, and I just want to echo the comments. There is no reason to take it unless you need to reverse an opiate overdose. You do not get high off of it, it does not do anything to you, it has no harmful effects. Still, it requires a prescription. I am hoping we can see that change.

Also, medication assisted treatment has been mentioned. And, you heard from Mrs. Badura about the concerns that oftentimes, a person who has been confined, be it a jail, a prison, or inpatient treatment, oftentimes the most dangerous time for them is right after their release. Relapse is a very common phenomenon, and their tolerance is now lower, and frequently they try to use at the same level they did before they were confined, and we are seeing so many of the overdose deaths happen at that time frame.

Medication-assisted treatment (MAT) can help with this. We should fund having this available to people who are about to get out of jail or prison, people who are going to get out of a treatment setting, so that they can have assistance in resisting those urges that result in relapse.

And, then one of the wisest things we have done in the criminal justice system—and that was also mentioned by Tyler Lybert—have been treatment courts. And, we have now treatments courts in about half of the counties in Wisconsin.

Most of the counties that did that, like Waukesha County, when we started up our drug treatment court, we did so with Federal grant assistance, a startup grant. That is invaluable. You cannot get your county board to pony up the money to start it until you can demonstrate that it is doing something, that those startup grants are critical. You can start them up and you can show your county board the graduates and how your county is becoming healthier as a result, and then they will continue to fund it. So, please continue to support those grants to startup treatment courts. It is the wisest thing we have done, because we have started as a criminal justice system to treat addiction not as a felony, but as the disease it is, and it is a real opportunity for us.

And, I also encourage making available more competitive grants. There are innovative ideas out there, in law enforcement, in social services, in nongovernmental groups. The only problem is, they are expensive, and, again, they have to demonstrate success before they can get that outside funding. Start-up grants, a competitive process, administered by the Office of Justice Assistance or the National Association of Attorneys General (NAAG), you name it, they can make a difference in finding new ways to approach this problem.

So, I appreciate very much the committee's interest in tackling this Nation's opiate epidemic, and thank you, Chairman Johnson and Senator Baldwin, for the opportunity to testify today and for your work.

Chairman JOHNSON. Thank you, General Schimel.

Our next witness is Senator Jon Erpenbach. Senator Erpenbach was elected to represent the 27th Senate District in November 1998. His Senate colleagues elected him Senate Democrat leader in December 2002 through 2004. Currently, Senator Erpenbach is a member of the Joint Committee on Finance of the Wisconsin Legislator's Budget Writing Committee. Senator Erpenbach.

TESTIMONY OF THE HONORABLE JON ERPENBACH,[1] STATE SENATOR, DISTRICT 27, STATE OF WISCONSIN

Senator Erpenbach. Thank you, Mr. Chairman.

First, I would like to commend Brad and John for their work on this issue. They say Democrats and Republicans in Madison cannot get along. We have on this issue. And, especially John with his work on this has been great, and you too as well, Mr. Chairman and Senator Baldwin. I really truly appreciate what you have done.

The problem we are talking about today is well documented. I do not need to spend a whole lot of time on statistics other than to say, we would not be here if it was not the urgent problem that it is.

The State of Wisconsin and the Federal Government need to partner together if we are going to be successful in the fight against this epidemic. In my testimony today, I will talk about a couple of different ways that we can partner together, the local, State, and Federal Governments, to combat the epidemic that brings us all here today.

---

[1] The prepared statement of Senator Erpenbach appears in the Appendix on page 86.

I am proud to represent Sauk County in my Senate District. Sauk County is home to the Community Activated Recovery Enhancement (CARE) program. This is a program that could, potentially, be a statewide or even a nationwide model. There are several things we can do to help it be even better.

In Sauk County in 2010, law enforcement and the medical community started noticing a growing problem. There were 20 heroin and opiate deaths in a 2-year period. Ambulance companies and first responders reported over 80 uses of Narcan, an opiate that—we have talked about that already.

Law enforcement and the medical and legal community and local businesses—this is important, local businesses—joined together to address what they saw as a community crisis. They had the foresight to recognize that this problem could not be solved by law enforcement alone, and they knew they needed a more comprehensive approach, so they developed the CARE program.

CARE is an integrated system, putting the individual at the center of their treatment, which empowers the individual to make better life choices. CARE recognizes that addiction can be treated and overcome using an integrated, multidisciplinary approach that requires medical treatment, mental health services, social services, and healthy support systems. It is a program that recognizes addiction is a disease, as the attorney general said. A lot of us used to see it the other way around, as somebody just choosing to do this. It is a disease, and as a speaker said earlier, it needs to be treated throughout the lifetime.

It is an important piece of the CARE program is Vivitrol, a drug that we have heard about already, injected monthly and blocks the receptors in the brain responsible for an opiate high. Vivitrol is expensive. The average cost of a monthly shot is about 1,200 bucks.

St. Vincent de Paul was the first to step in in Sauk Prairie to cover the cost for the drug for inmates who agreed to the program, but they could not afford it much longer.

While enrolling inmates in the CARE program, Sauk County realized that Medicaid-eligible inmates leaving jail were experiencing a gap in coverage, jeopardizing their ability to continue to receive the shots. Wisconsin is a State that chooses to terminate rather than suspend Medicaid coverage for those who are incarcerated, and that needs to change.

With us here, by the way, in the audience tonight from the UW-Extension is a member of the CARE team in Sauk County, Dr. Morgan McArthur, and he is a great resource for anybody on your committee who has any questions about the CARE program and how it is worked to this point.

According to the National Conference of State Legislatures, at least 18 States currently suspend rather than terminate Medicaid coverage for people who are incarcerated. The suspension approach yields administrative savings related to reapplication eligibility determination process, which can take as long as 45 to 90 days.

I would be remiss if I did not take this opportunity, Mr. Chairman, to advocate for Wisconsin to take the Federal Medicaid Expansion dollars that have available to it through the Affordable Care Act (ACA). Our Legislative Fiscal Bureau estimates that Wisconsin is losing about $320 million over the biennium. 13.4 percent

of the people in Wisconsin that would qualify for this Medicaid expansion have substance abuse disorders, 13.4 percent. So, needless to say, they could be helped by this.

Mr. Chairman, in order to confront this horrible epidemic head-on, in order to begin to win this fight, we must break down the barriers, we must change the way we look at addiction, and, again, treat it as a disease.

And, on a personal note, we heard from Tyler and Ashleigh. Growing up in my family, my sisters, Mary and Kim, and I were Ashleigh. My brother, Will, was Tyler. We lost Will in January. He was 53 years old—lifelong battle with addiction. He used up until the day he died. He did not die of a single overdose. He just died of a lifetime of abuse. He was a brother, he was a son, and most importantly, he was a father. And, even being a father could not help him overcome this.

And, I remember, Ashleigh talked about counseling. I remember the Erpenbachs going to family counseling in middle school and high school, and back then I had no idea why I was there. I was angry. I was really upset with my brother. I just wanted him to knock it off. And, there were days, in fact even months, when he would not use. But, when we would not see him for 2 or 3 days, or 2 or 3 weeks, or 2 or 3 months, we knew what was going on.

I saw what it has done to my mom and dad. And, the one picture I will remember on the day he died, which was this past January, were two people approaching 80 years old, being married together probably close to 60 years now, hugging in a hallway of the hospital, turning and walking out. I am a dad. I cannot imagine that. I cannot imagine that whatsoever.

We have a real serious problem, and it is threefold. It is the border issue, which is way above my pay grade, but it is also an issue how society sees drugs and addiction. And, it is not just drugs. It is addiction, period. It is gambling. Addiction takes on many forms, but the results are the same. It tears the individual apart, tears the family apart, tears the community apart, tears society apart.

If you want to look at it as a dollars and cents figure—and this is the last thing I will say, and then I will be happy to answer questions—the amount of money taxpayers could save if we do this right would be tremendous, not only in Wisconsin, but certainly nationally.

Thank you.

Chairman JOHNSON. Thank you, Senator Erpenbach.

Sorry for your loss and thank you for sharing that. Our final witness is Representative John Nygren. Representative Nygren was elected as a Wisconsin State Representative from the 89th Assembly District in November 2006. Representative Nygren has made addressing the heroin-opiate epidemic in Wisconsin a major priority, leading the way in the passage of 17 bills by the Wisconsin legislature, 16 of which have been signed into law. And, again, a person of real courage to kind of lay bare your story for public scrutiny. So, we certainly appreciate your willingness to do so. Representative Nygren.

TESTIMONY OF THE HONORABLE JOHN NYGREN,[1] STATE REPRESENTATIVE, DISTRICT 89, STATE OF WISCONSIN

Representative NYGREN. Thank you, Senator Johnson and Senator Baldwin, for having a hearing today on the impact of trafficking and abuse of heroin and prescription opiates in Wisconsin.

It is already been said, our country is currently facing a prescription opiate and heroin epidemic. This problem knows no boundaries. All demographics of people are affected in one way or another, no matter their income, no matter their race, no matter whether they are from an urban community or a rural community. And, Senators, no matter if you are Republican, no matter if you are a Democrat.

Many of us know too well that Wisconsin is not exempt from this epidemic. As mentioned, I have a daughter, Cassie, who is now 27 years old, who, unfortunately, to this day, is still struggling with addiction. Hers began with an illegally obtained prescription. We had a doctor selling prescriptions of OxyContin that, unfortunately, she got access to. When that supply dried up, she moved onto heroin, like many others.

So, my family is no different—my community is no different. The county of Marinette led the State in overdose deaths per capita a couple years in a row. Initially, as an elected official—initially as a parent—we dealt with this problem, privately, like most would. But, when I began to read the obituaries of my friends' and neighbors' children, it was a call to action, and it was for that reason that I am very proud of the steps that the legislature in Wisconsin has taken over the past 3 years to combat this devastating problem in our State.

In 2013, we laid the foundation of what was to become the Heroin Opiate Prevention and Education Agenda (HOPE). This foundation was laid with seven bills that aimed to fight heroin's use and addiction in our State.

We expanded access to drug treatment opportunities; made opiate antagonists, like Narcan, more readily available to first responders; and enacted a Good Samaritan law. However, after the session ended, it was very clear that there was much more work to be done to combat our problem in Wisconsin.

As this session began, we continued our work to build on the HOPE Agenda. Instead of specifically targeting heroin—heroin gets a lot of headlines, it is very dramatic and oftentimes has been talked about in the news, but it starts much more innocently in most cases. The root problem of our situation in Wisconsin has been readily agreed by many experts lies with prescription opiate misuse, abuse, and addiction.

Studies show that in most cases, heroin addicts begin with an addiction to prescription painkillers. Whether these medications are obtained legally or not, we need to do our best to curtail the illegal use of these dangerous medications.

As a continuation of the HOPE agenda, this session we passed 10 additional bills—9 of which have already been signed into law by Governor Walker. These bills continue to expand access to opiate antagonists to reduce incidents of overdose deaths, further ex-

[1] The prepared statement of Representative Nygren appears in the Appendix on page 91.

pands access to treatment and diversion programs so people addicted to opiates can get the help they need in lieu of incarceration. And, we have expanded the use of Wisconsin's Prescription Drug Monitoring Program (PDMP), so instances of overprescribing become less common.

It is our hope that these important pieces of legislation will reduce the number of people who become addicted to legal prescription opiates, and in turn, reduce the number of people who eventually turn to heroin and other dangerous substances.

here are 17 HOPE Agenda bills total, and all of them were approved unanimously by both houses of the Wisconsin State Legislature. Governor Walker has signed 16 of these proposals into law, and we are expecting the 17th to be signed very soon.

Once again, it is important to note, this is not a Republican issue, this is not a Democrat issue. When people contact my office to bare their soul about their personal stories, we never ask what their party affiliation is; but rather, this is a public health and safety issue.

I am proud that there has been such widespread support for these pieces of legislation from people throughout our State, including the medical community, law enforcement, my colleagues in the legislature, the Governor, attorney general, and countless addiction advocates.

Now it is time to start combating this devastating problem. I am proud that Wisconsin is leading the way with efforts like the HOPE Agenda and confident that other States will begin to look to us for guidance as far as what can be done.

The laws that make up the HOPE Agenda are not a silver bullet that will solve this epidemic, but each proposal is an important step in the right direction. With that, I look forward to continuing our work to further build upon the HOPE Agenda in the future. Future efforts look to reduce current barriers to treatment, as well as provide additional access to treatment.

I appreciate the opportunity to testify before your Committee today on the HOPE Agenda and the State of Wisconsin's efforts, and I hope to be able to be a resource for your work as we continue to address this problem nationally.

Thank you.

Chairman JOHNSON. Thank you, Representative Nygren. We do have——

[Applause.]

We do have about 15 minutes with the Commissioner, so let me start asking questions, then I will turn it over to you, Senator Baldwin, for the Commissioner, and then we will move on to the rest of the panel.

Commissioner, on Tuesday, when we held a hearing in D.C., we had the former head of Southern Command, General John Kelly, testify before the Committee, and in previous testimony, the other 15 hearings we have had, and you have participated in a number of those as well, we certainly found that the vast majority of drugs that move into America through the southwest border actually come through our ports of entry. I believe that is true, I will let you comment on that, but General Kelly, I was surprised when he said we have visibility of about 90 percent of the flow of illegal

drugs. We have visibility of it—we just, simply, cannot interdict it. Is that kind of your understanding? I understand you are Customs and Border Protection at the border. General Kelly is Southern Command in Central America, but I know DHS is cooperative down there as well. Can you just kind of lay out what the reality is in terms of our visibility of the flow, our inability to interdict, and just the problem we have.

These drug traffickers are very sophisticated in their use, and I have been to the border, the use of dogs, the use of imaging technology, it is extensive, and yet, according to testimony with former drug Czar General Barry McCaffrey we only interdict between 5 and 10 percent of illegal drugs coming in through the southwest border. So, just can you speak to that, the difficult nature of the task?

Commissioner KERLIKOWSKE. Sure, Mr. Chairman. I would separate out two things that General Kelly said. One is certainly the drugs that come across through the waterways in the Caribbean, et cetera. I think he is very clear that we have a lot more visibility on that than we have ever had, for a variety of reasons.

Customs and Border Protection flies the Airborne Warning and Control System (AWACS). We do that in conjunction with our partners in the Coast Guard. We have an incredible center in the Joint Interagency Taskforce (JIATF) South in Key West, Florida and we have a lot of information, a lot of visibility, et cetera. What we do not have are the assets to go after that.

Now, what we are talking about here mostly is cocaine, either destined for the United States, but frankly, given the appetite that Europe and Africa and others have for cocaine, this is cocaine going all the way across. It would be like when I was a police chief and we had a call of a robbery at a 7-Eleven, and I would say thank you for the information, but I do not have anybody to send. We could actually use more assets to be able to respond because we do have very good information, both technology and also informant information.

On the other hand, the drugs that flow, and we are talking here mostly heroin, the drugs that flow into the United States from Mexico, again, speaking about heroin, is almost always interdicted through our ports of entry. We do not see many backpackers or others coming between the ports of entry, and when we do interdict drugs, it is almost always marijuana being done in those backpacks.

So, it is coming through the ports of entry, whether it is John F. Kennedy International Airport (JFK) or the San Ysidro POE, and it is people that are carrying it on their person, it is people that have swallowed it, and it is hidden inside of vehicles, and of course our best deterrence to that has been able to interdict.

I will tell you that I look at a lot of data, and I have seen that testimony and heard that testimony from General McCaffrey, who is a friend and a colleague and a mentor, but I would be very reluctant to cite to you the percentage of drugs that we either seize or do not seize. That being said, if we seized 50 percent or 70 percent, your earlier statement in the opening about our appetite for drugs and the fact that this is such a high profit area is going to make it extremely difficult if we seized 80 percent.

Chairman JOHNSON. I mean, the percentage is neither here nor there. The supply is meeting the demand and then some. To have the prices go from $3,000 a gram to $100 a gram, there is a real problem.

Oftentimes we hear that the use of drugs is a victimless crime, and I think we have heard in testimony there is no such thing, the broken families, the broken lives. Again, these are the drug cartels, they are businesses. They expand their product line into human trafficking and sex trafficking.

I do want you to speak to the brutality of these drug cartels, but I do want to talk a little bit about what we saw in Guatemala, where we visited a shelter—no address on it because they are trying to protect themselves from the drug cartels—the sex traffickers, but a shelter for sex-trafficked little girls. The youngest was 11, the oldest was probably about 16—average age is about 14—and they have cribs because they, obviously, get pregnant. So, anybody who thinks this is a victimless crime, go down to Guatemala and see just one sliver of that type of victimhood.

But, again, you are on the front lines. You see the brutality. General Kelly was talking about anybody in public safety that would even begin to think of going up against the drug cartels, they get a little compact disc (CD) with their pictures of their family and their little girls. I mean, can you speak to what you know of why there is such impunity on the part of drug cartels, because they are simply untouchable because they are so brutal?

Commissioner KERLIKOWSKE. And, I think we are talking mostly then about Central America, because I have visited Guatamala. We certainly know the statistics in those three Central American countries, Honduras, El Salvador——

Chairman JOHNSON. Well, Mexico is quite bad as well, is it not?

Commissioner KERLIKOWSKE. Well, although, actually, in the last year of President Calderon and continuing through President Pena, we have seen a decrease in their violent crime. It is still significantly higher than that of the United States.

But, in those visits and in looking at that data, the level of violence, Honduras and El Salvador have homicide rates that oftentime top the world in the per capita killings, and I think that is what we have seen in the number of unaccompanied children (UAC) and others that have come across the border.

But, it is driven by gang violence. And, I would go back and say that as much as the work that has been done by the Department of State (DOS), International Narcotics and Law Enforcement to provide rule of law training, to provide technology, to provide training for professional law enforcement, until, as Secretary John Kerry mentioned, in Davos, Switzerland, recently, until the corruption issue is addressed in these countries, you are not going to find people that are going to want to pick up and go to a local law enforcement official and say, I want to report something, I need help. So, I would say corruption drives part of this.

Chairman JOHNSON. But, can you talk about specifically the techniques the drug cartels use to gain the impunity with which they operate?

Commissioner KERLIKOWSKE. Well, I think they are going——

Chairman JOHNSON. This is not just gang violence. I mean, this is a very dedicated effort on their part to be incredibly brutal against the family members of public safety officials, beheadings, those types of things.

Commissioner KERLIKOWSKE. Yes, we have seen time after time after time, and including in Mexico, very high level law enforcement officials, many of whom have reputations that have been brought in to essentially improve things, to do public safety, they have been killed, their families have been killed. The mayor, just outside of the city of Mexico City, within the State of Mexico, was murdered only several days after her election. The intimidation and the threats to prosecutors, to law enforcement officials, et cetera.

Which often then comes back to why in the United States we have not seen anywhere near that level of intimidation or violence. And, that is because, quite frankly, we have law enforcement officials that are not corrupt, we have prosecutors that will not back off from prosecuting, at the greatest and most severe level, people that would do that type of intimidation or threats.

But, you are absolutely correct. The better things that would improve in those countries for safety, security, etc., the better we would be when it comes to our drug issue.

Chairman JOHNSON. So, my final point, and I will turn it over to Senator Baldwin, the breakdown of those public safety institutions, that impunity, that is driven by our insatiable demand for drugs, and it is important for us to recognize that. Senator Baldwin.

Senator BALDWIN. Thank you. Commissioner, I want to hear you elaborate a little bit more about the pilot with regard to training your officers to administer naloxone.

As I understand it, the beginning of Phase II implementation of that pilot is going to begin in the next couple of months. I would like to hear about when the initial pilot project will be complete and your thoughts about whether this pilot needs to be further expanded.

Commissioner KERLIKOWSKE. We should actually——

Senator BALDWIN. Perhaps describe it, because many in the audience might not be familiar with it.

Commissioner KERLIKOWSKE. When I served as the president's drug policy adviser starting in 2009, the issue of prescription drugs was known in the medical community; it was basically unknown anywhere else, unless people had been adversely affected. They knew about it, but frankly, you could count on one hand the number of articles about prescription drug overdoses. It is on the tip of everyone's tongue. It is knowledgeable. It is the subject of these hearings and many others. And so, one of the things that we saw very clearly was that if we can save people's lives, and, frankly, the first responders are often law enforcement, although the medical community does respond very quickly, the use of naloxone can reverse overdose.

I think when the doctor testified about the concern that, well, naloxone is only going to encourage someone because they know they are not taking the chance, I also heard from the young woman at the end of the panel when she talked about, look, people cannot

stop. If they could make a decision and say, you know what, I am going to quit, by heaven, I think they would have made that decision and quit.

So, we wanted to see naloxone in the hands of every local law enforcement, State troopers, deputy sheriffs, and police officers, but we also wanted to see it in the hands of our people because we deal with a million people a day coming into the country.

And, when I was in Boston this morning, they talked about people who were overdosing in the restroom of Boston Logan International Airport, and the State troopers there have naloxone and are able to use it. We need the same thing. I can assure you, Senator, that when the pilot is over, we will make sure that naloxone is at every one of our ports of entry.

Senator BALDWIN. Thank you.

Chairman JOHNSON. Again, Commissioner, thank you for your service to the country and thank you for coming again. Your dedication to these hearings on a local basis is really much appreciated, and thank you.

Commissioner KERLIKOWSKE. Thank you.

[Applause.]

Chairman JOHNSON. So, it is down to three.

General Schimel, you talked a little bit about the problem businesses are having. Coming from a manufacturing background myself, I can tell you that we have been drug testing, and as I have traveled around the State now and talked to manufacturers, who, cannot hire enough people, not one, for a variety of reasons.

One of the reasons is that so many drug tests, 50 percent of people that come in for an application do not show up for the drug test—and these are just basic anecdotal percentages—another 50 percent that actually take it, fail. So, this is an enormously difficult problem.

You talked a little bit about the purity. Does anybody on the panel really understand the issue of fentanyl now? Is that being blended with heroin? I mean, this is kind of a new drug on the scene in the last year and a half, correct?

Mr. SCHIMEL. Well, it is gained a lot more attention. It has been working its way through for some time now, but fentanyl is extraordinarily frightening because it is exponentially more powerful than heroin and exponentially more deadly, and when it is laced in with heroin, the user may not have any idea that it is in there.

Chairman JOHNSON. What is the pricing of fentanyl?

Mr. SCHIMEL. I do not know the answer on that. I am sorry.

Chairman JOHNSON. Why would they lace that into heroin? If you are saying heroin now is so cheap, it can be so pure, why would they blend? Anybody know?

Mr. SCHIMEL. There is a competition for who has the best heroin, who has the drug that gets you the most high, that you can use the smallest amount to get to where you want to be. That is actually not a fair way to put it. I do not think they want to be there, but the place they need to be.

As I have heard, many people who are in recovery from addiction—or are still struggling—talk about this, and once they progress very far into their addiction, they no longer get high. They simply are taking the drug to not get sick. There is not even the

joy of feeling good from using it anymore. There is no joy left in their lives.

So, by making the drug more powerful, they can maybe shoot past getting around being sick and still have some joy. It is incredibly dangerous, and we are seeing really shocking numbers of deaths from fentanyl.

Chairman JOHNSON. Do people take it on their own? And, is this injectable, is this snortable, or how is fentanyl administered?

Mr. SCHIMEL. Like the more potent heroin, you can take it in all the different manners now. That is one of the major differences, is several decades ago, with the 5 percent pure heroin, the only way to really get high was to shoot it up. Now, with the higher purity heroin, you can start by smoking it or snorting it, and that is less frightening a move than strapping a tourniquet around your arm and searching for a vein.

Chairman JOHNSON. You talked about methamphetamine. I think in your testimony you talked about it is really prevalent more on the western side of the State. Is that just simply a supply issue, that it is just more readily available through markets in Minneapolis or Minnesota?

Mr. SCHIMEL. It used to be very much a northwest phenomenon in our State. That has changed, and the southwestern part of our State is—law enforcement there is howling for help. Treatment providers there are very concerned about what they are seeing.

Southeastern Wisconsin avoided it because there had always been a steady supply of cheap crack cocaine from the Chicago area, and that seemed to offset that demand. But, methamphetamine is on the move, and it is moving across our State. It will be everywhere soon.

Chairman JOHNSON. But, again, we used to manufacture here. You shut down those meth labs, and now it is just coming in, again, flowing freely into the United States from Mexico.

Mr. SCHIMEL. The only kind of labs we have in the State anymore are what—we call them "one pots," and it will be an individual who is cooking up enough for themselves and maybe a girlfriend or boyfriend, but that is it. No more commercial manufacturing.

Chairman JOHNSON. OK. Senator Erpenbach, you mentioned the drug Nivitrol. Can you tell me a little bit more what you know about that? You said the price is high. If it was more widely——

So, if we administered more of it, would that price come down? I mean, could you just——

Senator ERPENBACH. That I do not know. Not being a pharmacist, I can tell you that I have read that it blocks certain receptors that lead to the high. It is expensive because the pharmaceutical companies can make it that way, I guess. They can charge whatever it is they choose to charge.

But, the point is, if somebody really, truly wants to make that step and has truly decided that, yes, I am done with drugs, we, as a community, need to be there for them. And, one of the ways we can be there is to try and make Vivitrol as prevalent as we possibly can to those who do need it.

And, again, in the situation in Sauk County when they are identifying inmates who want to be part of this program and we have

that gap coverage where Medicaid shuts off for people that we incarcerate in jails and then there is a wait to get back on, if they can get back on at all, that Vivitrol, that shot of Vivitrol, once they are out and they have made that decision to change their life, has to be available to them.

Because if it is not, shortly after they are out, if they do not get the support they need, the help they need, and the community is not behind them and government is not behind them, they are going to end up right back in jail because they ended up stealing something because they needed the money to go out and buy some heroin or do whatever. I mean, that was the case with my brother.

Senator BALDWIN. Can I just——

Chairman JOHNSON. Sure.

Senator BALDWIN. So, I am one of those people who just learned a little bit more about this issue recently, and so, dangerous with the knowledge, but I had a chance to visit with participants in a Vivitrol program in Dane County, seven or eight people who were quite successfully being treated on the drug.

It is particularly useful in that hand-off between jail and the community, because you have had to—and doctor, you can let me know if I have said anything incorrectly—but you had to have been free of opioid use for about 14 days beforehand. And so, reaching that 14 days is extremely challenging for addicts in the community. But, when you are in jail——

Senator ERPENBACH. It is there. In my brother's situation, whether it was a county jail, Waupun, Green Bay, or Oshkosh—whatever prison he happened to be in, services, things that he needed, they were available. When he was out, they were not.

And, it got to the point where, much like Tyler and Ashleigh's mom and dad basically saying to Tyler, you are out of here. I mean, we went through that process with my brother, Will. But, at the same time, you are still always holding out hope.

So, as a community and as a government, whether we are State government officials or Federal Government officials, if there is funding available to help somebody who, again, has made that decision and they are transitioning out of a county jail, and we are saying, sorry, you do not qualify for this shot, good luck out there on the streets, we are going to see them right back there again.

And, I ended my comments by saying, you want to talk dollars and cents, because a lot of us talk tough on taxes, you want to save money, you start investing in programs that work, and we will be saving a tremendous amount of money here in Wisconsin and nationally.

Chairman JOHNSON. Let us face it, it costs somewhere between $30,000 and $50,000 per year to incarcerate somebody. But, talking to the Lyberts, they thought that the one treatment for Tyler was about $78,000 worth.

Senator ERPENBACH. About how much?

Chairman JOHNSON. About $78,000. And, when you hear the other—I do not know what the exact stats are, but one in 20, one in ten. I mean, that is part of the problem, is this is enormously expensive, unfortunately. So, 10 percent or 5 percent effective. I mean, it is one of those problems we have to be honest with, in

terms of what is actually going to work. That is why something like Vivitrol, if it really blocks those receptors——

Senator ERPENBACH. Yes. And, I know it is expensive, and I saw my parents write checks when I was growing up once insurance ran out, and I have seen other families go through it as well. But, again, there are programs out there that work, and that is what we need to invest in.

Chairman JOHNSON. And, that is what we need to explore, which is why I have the hearing.

Representative Nygren, you did not really mention Cassie—other than just the name—in your testimony. You have talked about her. Would you be willing to share a little bit more of that experience before I turn it over to Senator Baldwin? Because it is these examples—it is that courage.

And, by the way, my nephew overdosed a couple months ago—and the family wants to keep that private—I have a buddy that I played softball with, his daughter has been struggling with heroin for 5 years. He heard about this hearing, texted me, and said, "Boy, use that as an example anonymously."

So, I mean, I understand the problem and the pain, and this is very hard to make public, but, we have to address the demand side, we have to take the glamour out of it, and the way you take the glamour out of it is this kind of testimony—it is so powerful.

So, if you do not want to, just tell me, I will turn it over to Senator Baldwin, but if you are willing to share, it is helpful and it is very powerful.

Representative NYGREN. Well, we have talked about it before. As I said, initially, families typically deal with this privately, especially when you are a little bit more in the spotlight—and besides, it was a private, personal issue, family issue.

But, Cassie's involvement with drugs began with probably—I should not say probably, I know it first began with alcohol, then marijuana, and——

Chairman JOHNSON. Just at what age?

Representative NYGREN. Well, I would say alcohol, probably, but she did not like alcohol. That started probably around 13 and 14. Marijuana started around 15 or 16 and prescription drugs started around 17.

Now, I mean, we have not really talked about the legalization of marijuana. That is one of those movements that is out there, and I know the attorney general has talked about this before, but there is people that will argue that marijuana is not a gateway drug, but I would argue that each of those are gateway drugs for some people.

I grew up in the generation where a lot of people probably smoked marijuana, and those are the people in decisionmaking positions today, and they think, well, it did not affect us, so it would be OK to legalize it. But, as the attorney general, who has more knowledge on this, has talked about, we are talking about marijuana that is probably six or seven times stronger than what it was back in the 1970s.

Chairman JOHNSON. I think it is more than that, isn't it?

Representative NYGREN. So, I mean, this is not your daddy's marijuana we are talking about, but——

So, that was kind of her progression. And, as a family, we went through all the—if you sat somebody—Lauri Badura or, somebody else who has had a loved one with an addiction right next to me, we could probably tell a pretty similar story. Tell you a story about robberies in your home, or break-ins in your home, missing dollars, missing valuables, those type of things, things that began to disappear. All those things were difficult as a family.

Seeing somebody who was once a straight-A student not graduate from high school was difficult. Seeing her eventually, in orange in county jail or eventually prison was difficult.

But, the most difficult thing as a parent was when they are in active addiction, waiting for that phone call to come. That phone call came for me. I got there, was able to try to help her breathe until the paramedics arrived and administered Narcan. If it would have been the basic-level emergency medical technicians (EMTs) in Marinette, they could not administer Narcan at that point in time; we have changed that. But, waiting for that to happen. She has an opportunity today to lead the life that we dreamed for her. Unfortunately, she is still struggling.

But, Tyler mentioned it earlier, there is a certain amount of guilt when you talk about this, because it is difficult for me to talk to—dramatically about the challenges my family has faced when I know of so many others who their children do not have that opportunity for hope.

Chairman JOHNSON. They are gone.

Representative NYGREN. They are gone. So, I try to be that voice for them. There is so many people working very hard on this issue throughout our State. It was talked earlier that we all need to work together, and we do.

We tried to create a website recently to try and bring all those different links, all those different resources together, HOPE Agenda website, but there is so many people trying, and I do believe we are making progress, but there is so much more work that needs to be, and for Cassie there is a lot of work that needs to be done as well.

Chairman JOHNSON. God bless you and her, and we, obviously, are praying for her.

First of all, thank you for sharing that, and thank you for all your efforts.

And, with that, Senator Baldwin.

Senator BALDWIN. Thank you.

Attorney General, I would like to hear your thoughts on the most pressing gaps that still exist. Your testimony you talked about—well, you gave a real strong voice to the need to have, basically, a seamless interaction between law enforcement and public health systems in order to tackle this emergency. Your expertise, of course, is on the law enforcement side, but you have seen both.

You talked about the fact that the Edward Byrne Memorial Justice Assistance Grants (JAG) program keeps shrinking, you talked about the treatment courts and the fact that new counties are unlikely to start them if there is not a Federal contribution, and you talked about the importance of innovation that is happening around this State, that competitive grant programs would also be of great importance.

As well as I do, about the fiscal constraints we face nationally, statewide, but where do you see the most profound gaps that would benefit from greater Federal attention to better grapple with this emergency and acknowledging it is a crisis and an emergency?

Mr. SCHIMEL. The biggest future challenge we face is going to be availability of treatment resources. It is now already. But, as we have great collaboration with our medical community in Wisconsin, and as a result, combining that with some law changes, we are going to see prescribing of opioids decrease, and probably dramatically. That is going to limit the amount of prescription narcotics that are available for diversion and abuse, and those who are already addicted are going to turn to heroin then.

Numbers from 2013 already suggested then 163,000 people in Wisconsin were abusing opiates in some manner. We cannot treat those. We cannot treat that many. We cannot even come close. We are going to have to be prepared for that.

It is something that I am very proud of our medical community in Wisconsin, because they get this, and they are working on it. They are working to change education for doctors, they are working to change the conversation between doctors and patients, and they are working to make sure there are more Suboxone providers.

One of the things we could do is address right now what many assert is an artificial limit for the number of patients that a Suboxone-certified doctor can see.

Senator BALDWIN. Yes.

Mr. SCHIMEL. They can see more, and many recommend that we eliminate those artificial limits, or at least raise them, because Suboxone will be—and as Tyler Lybert described, not every kind of treatment works for everybody, it is all different, but we need to have it available, and that does work for many people as a support while they are also getting treatment.

These are medication-assisted treatment; it is important to remember that. It still will always circle back. But, we can stretch our treatment capabilities if we have the medication assisting someone in getting through treatment as well. I believe treatment providers can serve more people if their patients are stabilized with some kind of medication assistance. And, prevention dollars are so important.

And, I want to expand a little bit on drug treatment courts. In Waukesha County, our drug treatment court costs about $2,700 a year to have an individual in that court. That included all of their treatment, drug testing, case management, constant trips to court. Did I say drug testing? I meant to. Everything. They did not have to come up with any money to be in the program. $2,700, I cannot keep somebody in the county jail for 3 months. $2,700, I cannot keep them in the State prison for one month. $2,700 will not pay for an autopsy and the toxicology reports that are necessary.

All of the people that enter into the drug treatment courts in our State are coming there with two destinations that were awaiting them otherwise. They were either going to overdose and die, or they were heading to prison, and drug treatment courts are interfering with that path, and it is the best thing we're doing.

Senator BALDWIN. One quick additional question. As you have taken a journey from being the head law enforcement official in

this county, to a statewide perspective, I have also gone from representing a part of the State to representing the whole State, are there any geographical gaps that you would want to bring to my attention? I know I get calls from constituents who talk about the distances that they need to travel to seek treatment, to seek support, to seek help.

Mr. SCHIMEL. Treatment resources are taxed severely everywhere, but in the more rural communities, it is most profound. People sometimes have to travel a hundred miles or more to get to a treatment provider, and many of these individuals do not have money left to have a reliable car. They may have——

Senator BALDWIN. They may not have a license.

Mr. SCHIMEL [continuing.] Lost their driver's license a long time ago, and there is certainly no bus.

We are seeing innovations in the treatment community, where treatment providers are utilizing videoconferencing for it, and I am told by treatment providers that it is demonstrated to be as effective or can be as effective as in-person treatment provided, but it needs to be—the person receiving that videoconferencing should be in some kind of a medical facility where they can get help and advice face-to-face as well.

But, these are some of the things that we are attempting to do to expand these resources to meet a demand that, frankly, we hope will become overwhelming. We hope that these tens of thousands of people that need to be in treatment, we are hoping that more and more of them will be ready to accept treatment.

Senator BALDWIN. Thank you.

Senator Erpenbach, I want to continue this discussion about the nexus between law enforcement and public health and care and treatment for those with addiction based on your testimony about the incredible work that is being done in Sauk County.

You talked a little bit about some of the treatment that begins in jail and how there are often interruptions when a person leaves and tries to seek that same treatment in the community. I think the Vivitrol example is a key example. How is the treatment funded when it is offered in a jail setting? How is it not being covered when it becomes an issue of community treatment for the profile of people who are needing it?

Senator ERPENBACH. Well, I do know that in Sauk County, with St. Vincent de Paul, who first stepped up and started paying for it, and, obviously, they cannot afford it, they have had about 30 people who have gone through the CARE program and gone through it successfully. And, obviously, you identify who would be good candidates while people are serving their time in Sauk County Jail.

And, again, if we, as a State, decided to suspend, as opposed to terminate, Medicaid services for folks who are sitting in county jails, that would go a long way. That would be a very first good step.

The next step, again, would be, in my opinion, to taking the Medicaid expansion, because somebody who is making minimum wage is not eligible for BadgerCare in Wisconsin, and there is 13 percent of those who would be eligible from the 100 percent to the 138, 13 percent of those or so who have addiction-related issues that are

costing society and their families and themselves ultimately, in many cases the ultimate in their death, when they die.

So, one thing we should do in Wisconsin, and, I am going to talk with Representative Nygren about this at some point when we head into the next session, is what we can do in working with DHS to just suspend, not terminate, those services for those folks who lose their Medicaid eligibility.

Senator BALDWIN. Thank you.

Representative Nygren, I just want to commend you on your work on the HOPE Agenda, the work that we have talked about, in terms of coordinating at the State and Federal level. I would love it if you could spend a few moments further talking about the agenda pieces that improve access to Narcan, or naloxone, and whether you are already hearing any feedback about how those are working in communities across the State.

Representative NYGREN. Sure. So, you know what, we in Wisconsin, I think we are a true citizen legislature. We all bring different experiences to the table. My background in insurance, finance, the restaurant business, as a small business owner—so I kind of thought that would be my area of expertise, but God had a different plan in addition to that, having a daughter with an addiction. So, a lot of the experiences that I have already went through with Cassie have enabled us to turn some of those experiences into legislation.

So, the day that we got that phone call and we found her purple, struggling to breathe, needle in her arm, and I tried to help her breathe until the paramedics arrived—or EMTs. Marinette we have both basic-level EMTs, who are emergency rescue squad, which is all volunteer; and we have paramedics assigned to Bay Area Medical Center.

The paramedics showed up first. I did not know the difference, necessarily. But, they administered naloxone and brought her back to life. So, that experience began to get me thinking about it. It is like, well, what happens if I am in a rural area, and it is a police officer that shows up first? At that time, basic-level EMTs, the rescue squad folks, or police and fire, unless they have advanced EMT training, did not have the ability to carry and administer naloxone. So, we changed that.

In addition to that, this session we also expanded access to naloxone through what is called a standing order. There are a number of pharmacies, Walgreens, CVS, Aurora in our State that are allowing for naloxone to be purchased with some simple training through what is called a standing order with the local pharmacist.

There is not a lot of data yet on that, but I have been kind of pushing my folks in the administration, my staff, to try and get data on that first piece. And, I can tell you that we recently got a graph, actually an outline of the State of Wisconsin, showing the number of administrations of naloxone during the last year. And, the total was, I believe, nearly 4,000.

So, you know that oftentimes we pass legislation that we do not necessarily know or have a good idea of what the immediate effects are, but it has been argued by some that putting naloxone into more hands enables that behavior. The objective here is getting

more people in recovery so they can be productive, tax-paying citizens living the American dream. Sorry for that, spouting that ideal. Well, they cannot do that, they cannot recover, they cannot get into recovery if they are dead. So, the more access to that, the better.

Senator BALDWIN. Thank you.

Chairman JOHNSON. Would you like to just do a closing statement, because people have been very patient. So, just have a couple closing comments before we close out the hearing?

Senator BALDWIN. I just think it has been an extraordinary opportunity to hear from Wisconsinites who tackle this issue from various perspectives, some having faced tragedy. Frankly, even those who were coming to speak because of the office they held—everybody has a personal experience with this.

But, we have an extraordinary amount of education due to make everyone aware that this is an epidemic, that this is an emergency. And, I think that the better job we can do of understanding the root causes from cartels in Central America to well-intentioned physicians and prescribers in communities across America, who are just trying to alleviate pain, but are not prescribing in manners that are safe, with the guidance they need, once we understand that, we can do a much better job, and I think we are with these State leaders, we are moving in the right direction. But, boy, this epidemic is far ahead of us right now, and we need to catch up, and we need to do it fast.

Thank you again. Thank you to the audience members who sat through—I suspect everyone in here is here because you have a passionate belief in getting this right. So, thank you for that time and attention and any help you can give us to get the job done.

And, Chairman Johnson, thank you for having this hearing.

Chairman JOHNSON. Thank you.

I am an accountant. I got some numbers. Let me just run a couple numbers by before I do my closing statements.

What we are witnessing here, obviously, are tragedies to individuals and to families, and what we are seeing here is, I think, some pretty extraordinary, but I would say probably not uncommon, cooperation at the local and State level, trying to grapple with a very difficult problem.

One of the issues we have, when we talk about funding, is there are always limited resources. Just so you understand, on a Federal Government level, for fiscal year 2016, we will spend about $30 billion on the war on drugs, about half of it on the demand side, half of it on the supply side.

This hearing is just one in a series, and one of the things we will definitely do is try and delve into that $30 billion that we spend and see if there a better way to deploy it. Are we better off, rather than spending $30,000 or $50,000 per prisoner, looking at using that in terms of treatment? But, again, the treatment costs are high, and we just really do have to really figure out a better way of addressing these problems.

It is very complex. There is the supply side, there is the demand side, there is the treatment side. From the Federal Government's standpoint, we do need to concentrate on that supply side, and, the fact that we do not have those secure borders, the fact we have

those drug cartels creating such barbarity and evil in the world. I mean, we definitely have to address that. And so, we will do that.

But, again, I commend you folks for working together in a very bipartisan fashion. I commend you for taking the time to be here today. Hopefully, the public does take a look at this and go, it is possible, we do do it, we do like each other, we do try and work together, and the approach to be used is try and find areas of agreement.

There are plenty of things that divide us. I mean, even in this hearing, there are some differences, no doubt about it, but we are all human beings. There is no one political party that has a monopoly on compassion. We want to solve these problems. If we concentrate on those areas of agreement, it is just a whole lot easier finding common ground.

And, if you will indulge me for 2 seconds. I was not going to do this, but prior to this hearing, my wife did reach out to her brother and got a text. And, I did not want to bring in anything like that, but I just have to read some—there is a text with probably about 20 different lines in it.

Talking about the autopsy report, "he could not read it. Too sad. I am still crying. Just tears to me now, big tears".

That is what is affecting people's lives, these tragedies on an individual basis.

So, again, Senator Baldwin, thank you for your involvement in this issue, things you are trying to work on. Gentlemen, thank you for what you are doing. Again, the audience members, you are probably here because you have been touched, you have been affected by this.

This is not going to end. This is a big problem, it is a complex problem, many components to it. But, if we work together, if we concentrate on areas of agreement, the shared goal of trying to rid this country, quite honestly this world, of this scourge, we just might start finding some commonality.

So, with that, let us close it out. The hearing record will remain open for 15 days, until April 30 at 5 p.m., for the submission of statements and questions for the record.

Thank you all. This hearing is adjourned.

[Applause.]

[Whereupon, proceedings were adjourned at 4:57 p.m.]

APPENDIX

Chairman Johnson Opening Statement
"Border Security and America's Heroin Epidemic: The Impact of the Trafficking and Abuse of Heroin and Prescription Opioids in Wisconsin."

Friday, April 15, 2016

As submitted for the record:

Over the last 15 months, this committee has spent a great deal of time studying and describing the realities related to American border security. Today will mark the 16th hearing focused on border security and our third hearing highlighting the rising heroin epidemic across this country. These topics are closely related, as it is my belief that the primary root cause of our unsecure border is America's insatiable demand for drugs.

The accumulated testimony and information that forms the committee's record indicates that America's borders are not secure. One key indicator of our insecure border is the fact that, according to testimony before this committee, we interdict less than 10 percent of illegal drugs coming across our southwest border and somewhere between 11-18 percent coming in through our maritime borders. The declining price of heroin—from a nationwide average of $3,260 per gram of pure heroin in 1981 to $100 per gram on the streets of Milwaukee today—is a metric that proves the point.

In Wisconsin, this translates to one "hit" of heroin costing anywhere from $10 to $12 in Milwaukee and $18 to $20 in Green Bay. These low prices and the relative ease of access have had devastating effects in the state. While Wisconsin averaged only 27 heroin deaths from 2000 to 2007, by 2014 more than 250 heroin-related deaths occurred in Wisconsin. In Milwaukee County alone, 109 heroin-related deaths occurred in 2015. In fact, last November, it was reported that six people died in Milwaukee in a 24-hour period due to prescription medication or heroin overdoses.

Mexican transnational criminal organizations, which represent the greatest criminal drug threat in the U.S., generate $19-$29 billion per year in U.S. drug sales. A kilogram of heroin costs around $5,000 to produce in Mexico and can be sold to U.S. dealers for as much as $80,000. This is enough to motivate the cartels to find a way, any way, to penetrate our borders. Once these drugs cross the border, they are sent to distribution hubs in such places as Phoenix, Arizona, or Chicago, Illinois. From there, street gangs further disseminate the drugs into local communities throughout America. In Wisconsin, Milwaukee-based traffickers often travel several times a week to bring in 100-150 gram quantities of heroin from Chicago.

In order to address the heroin and opioid epidemic, we must secure our borders. If our borders remain porous, as they are today, supply will continue to increase, prices will continue to fall, and Wisconsinites will continue to use these deadly narcotics that destroy the lives of not only those who use the drug, but also their family members and loved ones.

Today, Attorney General Schimel, Senator Erbenbach, and Representative Nygren will explain what is being done at the state level to address root causes. The Wisconsin legislature has

unanimously passed 17 bills as part of the Heroin Opiate Prevention and Education (HOPE) Agenda, 16 of which have been signed into law. At a federal level, I was happy to support the Comprehensive Addiction and Recovery Act to battle the opioid epidemic in March and earlier this month I introduced legislation to reduce the pressure doctors currently face that may lead to overprescribing painkillers. These bills will go a long way in addressing our public health crisis, but until we increase the security at our borders, the problem will persist.

I thank all of our witnesses for appearing today and for sharing their stories, and I look forward to your testimony.

Opening Statement of Senator Tammy Baldwin
Border Security and America's Heroin Epidemic: The Impact of Trafficking and Abuse of Heroin and Prescription Opioids in Wisconsin
April 15, 2016

Thank you, Chairman Johnson, and thank you to all of the witnesses for being here today. Each of you are on the front lines of Wisconsin's heroin and opioid abuse crisis. For many, this issue has directly touched your family – so I look forward to hearing from you on how we can improve the health and safety of our communities.

Heroin use and the abuse of opioid painkillers in the U.S. has now reached epidemic levels. In 2014, 28,000 people died from opioids, including heroin, which is tragically a new record high. Today we are facing the grim fact that more Americans die every year from drug overdoses than they do in motor vehicle crashes.

Particularly troubling in Wisconsin is a surge in deaths tied to Fentanyl, a potent painkiller 50 times more powerful than heroin. According to a recent report from the Milwaukee County medical examiner's office, Fentanyl killed 30 people in 2015 – an increase of 500% from 2012.

But Milwaukee County is not alone in facing this crisis. Communities across Wisconsin struggle with this epidemic every day. I recently heard from Leonard, from Colfax, Wisconsin, whose grandson, Nathan, was killed in a car accident when he was just 16 years old. The driver of the other car was under the influence of heroin at the time.

I have also heard from a mother from South Milwaukee, whose son suffered from addiction for 20 years. While he is now in recovery, at one point, she found him unconscious from a heroin overdose on their bathroom floor. And, another mother from Mukwonago wrote to tell me how her son's life was saved by paramedics who administered naloxone during his overdose.

We are now in the midst of a public health emergency and we have a responsibility to guarantee that our communities and families have the resources they need to fight this.

I am proud that Wisconsin has already made progress in addressing this crisis. State leaders, led by State Representative Nygren as well as Senator Erpenbach – who we'll hear from today – have already advanced several measures to help prevent opioid abuse and improve access to mental health services. And, our medical provider community is leading the country in improving safe opioid prescribing education.

But, this crisis requires both our state *and our federal leaders* to step up and take action. That is why I have championed several important reforms in Congress to fight opioid and heroin abuse.

I recently introduced the Heroin and Prescription Drug Abuse Prevention and Reduction Act with my colleague Senator Brown of Ohio. This bill outlines a comprehensive approach to tackle the epidemic in four key areas: prevention, crisis, treatment, and recovery. This bill would:

- improve access to lifesaving opioid reversal drugs, like naloxone;
- expand access to medication-assisted treatments; and
- provide for greater treatment and recovery services for our hardest hit communities, like adolescents.

I was pleased that several of these provisions passed the Senate HELP Committee last month.

As we've seen from the tragic events at the Tomah VA facility here in Wisconsin, opioids and addiction have hit our veterans extremely hard. In the Senate, I have authored bipartisan legislation - named in honor of Marine veteran Jason Simcakoski - that would provide safer and more effective pain management services to our nation's veterans.

My bill would require stronger opioid prescribing guidelines for VA providers, give veterans and their families a stronger voice in patient care and hold the VA system accountable for providing appropriate, quality care. This bill recently passed out of the Senate Veterans' Affairs Committee, and I will continue to fight to see that it is enacted into law.

However, our efforts to combat this epidemic will only be effective if we have a federal commitment to invest resources in our state and local communities. I have been proud to support bipartisan legislation that would supply emergency funding for prevention, treatment and recovery efforts. Unfortunately, this legislation has stalled in Washington because not enough Republicans joined Democrats to support this investment. It is my hope that today's discussion can send a strong message that more must be done.

In addition, as a member of the Senate Appropriations Committee, I will continue to champion increased funding for programs to take on this epidemic, including the funding requested by President Obama.

The impact of opioid and heroin abuse knows no political party. Nor is it a problem that either law enforcement or the health care system can tackle alone. The federal government can't solve this problem by itself, just as we can't expect states or local communities to address it alone. It is an issue that unites us all and we need to work as partners.

So, I look forward to learning more about how we can help our Wisconsin communities recover and stay healthy, and how we can work together to tackle a big problem with bold solutions. Thank you.

U.S. Senate Committee on Homeland Security and Governmental Affairs

Border Security and America's Heroin Epidemic: The Impact of the Trafficking and Abuse of Heroin and Prescription Opioids in Wisconsin

April 14, 2016

Senator Kelly Ayotte Statement for the Record

I want to thank Chairman Johnson and Ranking Member Carper for holding today's hearing to discuss the most urgent public health and safety issue facing my home state of New Hampshire—the fentanyl, heroin, and prescription opioid abuse epidemic. I know this is an issue of grave concern to Wisconsin, as well, and I am pleased that the committee has again taken its work on the road to hear from those who are being directly affected by this public health and safety crisis.

Last September, we held a field hearing in Manchester, New Hampshire, and invited top federal officials from Washington to hear first-hand from members of our treatment community, local law enforcement, and families affected by this epidemic. I especially appreciated that Commissioner Kerlikowske traveled to New Hampshire to also take part in that hearing.

In New Hampshire, the number of drug overdose deaths is staggering: In 2015, there were over 430 drug overdose deaths —159 of which could be attributed to fentanyl alone. These tragic statistics are more than just numbers. They are family members, friends and neighbors. I've had too many families tell me that they've lost a daughter, or a son, or mother – this epidemic is touching every community in our state.

Solving this crisis requires a comprehensive approach. Over the past two years, I've spent a lot of time meeting with families, treatment providers, law enforcement, first responders, health professionals and individuals in recovery to better understand what they're seeing and to identify ways that we can help at the federal level.

Whether it's speaking with families, hosting community forums, or riding along with first responders when they respond to overdose calls, these experiences have all served to reinforce my commitment to work with anyone to find effective solutions to this problem. That is why I am proud to be an original cosponsor of the Comprehensive Addiction and Recovery Act—bipartisan legislation that has the support of over 130 groups across the nation, including the National District

Attorneys Association, the Major County Sheriffs' Association, Community Anti-Drug Coalitions of America, and the National Association of Attorneys General.

The Comprehensive Addiction and Recovery Act would expand opioid abuse prevention and education efforts, expand the availability of naloxone to first responders and law enforcement, support additional resources to identify and treat incarcerated individuals struggling with substance use disorders, expand drug take-back efforts to promote safe disposal of unused or unwanted prescriptions, strengthen prescription drug monitoring programs, and launch a prescription opioid and heroin treatment and intervention program.

CARA would be a strong step towards combatting this epidemic, both in my state and across the country. Last month, the Senate passed the legislation by a vote of 94-1, and I am hopeful that the House of Representatives will pass this legislation quickly.

Finally, I want to touch on the role of fentanyl in drug overdose deaths. Fentanyl continues to cause more drug overdose deaths in New Hampshire than heroin. Eric Spofford, CEO of the Granite House and New Freedom Academy in New Hampshire, has said that fentanyl is a "serial killer." It should be treated as the deadly drug we know that it is.

In September of last year, I introduced the Stop Trafficking in Fentanyl Act to reform trafficking penalties for fentanyl, ensuring that the law appropriately reflects the potency of this drug—which is estimated by the DEA to be up to 50 times more powerful than heroin—and takes into account its increasing prevalence in drug overdose deaths.

Law enforcement is working tirelessly to take these drugs off the streets. But we can't simply "arrest our way out of" this problem. I've heard from law enforcement in New Hampshire that key pieces they need to confront this public safety issue are more prevention efforts, more treatment options and more support for individuals in recovery. CARA would address all of these priorities.

I thank Chairman Johnson and Ranking Member Carper for their strong leadership on this issue and for holding this field hearing.

STATEMENT

OF

JAMES F. BOHN

EXECUTIVE DIRECTOR
WISCONSIN HIGH INTENSITY DRUG TRAFFICKING AREA PROGRAM

BEFORE THE
UNITED STATES SENATE
COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS

"WISCONSIN'S DRUG THREAT ASSESSMENT AND THE HIDTA PROGRAM'S RESPONSE"

APRIL 15, 2016

Statement of

James F. Bohn
Executive Director
Wisconsin High Intensity Drug Trafficking Areas Program
(Wisconsin HIDTA)

Before the U.S. Senate Committee on
Homeland Security and Governmental Affairs
"Wisconsin's Drug Threat Assessment and the HIDTA Program's Response"
April 15, 2016

Chairman Johnson, Senator Baldwin, and distinguished Members of the Committee:

It is my privilege to address you today on behalf of the Executive Board of the Wisconsin High Intensity Drug Trafficking Areas (HIDTA) program concerning the statewide drug threat assessment of Wisconsin, and in particular, the HIDTA designated region. My name is James F. Bohn and I have been the Director of the Wisconsin HIDTA since February 2015. Prior to that time I was employed as the U.S. Drug Enforcement Administration's (DEA) Assistant Special Agent in Charge responsible for overseeing DEA's three offices in Wisconsin. The HIDTA program in Wisconsin incorporates seven (7) counties around the state. In particular, the HIDTA designated counties include Milwaukee, Racine, Kenosha, Waukesha, Dane, Rock, and Brown counties, which thereby incorporate approximately 46% of the state's population.

As I am sure you area aware, the HIDTA program is designed to support and encourage federal, state, local, and tribal law enforcement agencies to work together in Task Force situations to target identified drug threats in the local HIDTA-designated areas. Each year the Wisconsin HIDTA Investigative Support Center (ISC) conducts a comprehensive assessment of the drug threats in our area to identify and prioritize any new and continuing trends or threats affecting Wisconsin. It is also designed to provide the HIDTA participating agencies with

strategic intelligence to assist in the development of drug enforcement and prevention strategies. The Wisconsin HIDTA currently has a total of 28 participating federal, state, local, and tribal agencies. In addition, the Wisconsin HIDTA program assists numerous other non-member agencies throughout the state with investigative and intelligence support.

Due to Wisconsin's geography, location, and population, Wisconsin can be described as a "destination" state for illegal drugs and drug activity. By "destination" state, I am referring to the fact that in most instances, once illegal drugs enter Wisconsin's borders, they are almost always going to be used and/or re-sold within the state. Wisconsin's proximity to the major source cities of Chicago and Minneapolis has a direct and significant impact on the presence of illegal drugs and drug activity in Wisconsin. Within Wisconsin, Milwaukee is considered a source area for illegal drugs for other Wisconsin cities in other parts of the state. While Wisconsin is geographically located on the norther border of the United States, our investigations and intelligence reports of any significant seizures being sourced by drug trafficking organizations from the northern border (which are relatively few) confirm that their initial entry into this country occurred in some other northern border location, such as Detroit or one of the more western states, or via the U.S. Postal or some commercial delivery service, before making its way into Wisconsin. While there is often speculation about the possibility of drug smuggling via watercraft transiting the Great Lakes into Wisconsin, there have been no seizures or credible intelligence reports that this type of smuggling activity has occurred, or is presently occurring.

The latest Wisconsin HIDTA Threat Assessment found that, just as in years past, the vast majority of drugs entering Wisconsin are via passenger vehicle on one of the major highways intersecting the state, such as I-94 that goes northwest across the state all the way from Chicago to the south, through Milwaukee, through Madison, and on to the Minneapolis area. In addition, I-90 is also used to transport drugs from Chicago to the Madison area with connections to Wisconsin cities in the northern part of the state. I-43 is a major transit point for Green Bay area drug traffickers to travel to Milwaukee to buy their drugs, or to continue on to Chicago.

The Wisconsin HIDTA is currently in the process of completing its 2016-17 annual Drug Threat Assessment. The preliminary indications are that there are some notable differences from last year's Threat Assessment; however, what is the same is that opioid abuse, including both heroin and prescription drug abuse, remain the number one drug threat in Wisconsin – mirroring the trend of much of the rest of the country. Wisconsin's drug trends often mirror the country's drug trends, albeit sometimes in a delayed status, or on a somewhat smaller scale. For years, Wisconsin experienced relatively low levels of methamphetamine-related activity, while much of the rest of the country struggled with both methamphetamine from Mexico, as well as domestic clandestine laboratories. Unfortunately, methamphetamine is now beginning to show a much larger presence all around Wisconsin.

For years, most of the methamphetamine activity in Wisconsin was concentrated along the western portions of the state due to its proximity to Minneapolis. However, within the past year, larger quantities of methamphetamine are showing up all around the state, but particularly in northeastern Wisconsin (around Green Bay), and also in southern Wisconsin (around the Madison area), as well as the western and northwestern portions of the state, such as in the Eau Claire area. Most of the seizures have been directly linked to groups out of Minneapolis. However, in late 2015, a joint Kenosha County investigation with ties to Chicago resulted in the seizure of 17 kilograms of methamphetamine being seized just over the Wisconsin border. This seizure resulted in the arrest of four Hispanic male defendants who are suspected of adulterating it in such a way as to give it the appearance of cocaine so that it could be criminally marketed as such. In the northeast, around Green Bay, the methamphetamine trafficking has been between Asian (primarily Hmong) groups both in Wisconsin and Minneapolis. In Eau Claire, on the western edge of Wisconsin, methamphetamine trafficking and abuse is significantly more prevalent than heroin. The methamphetamine from Minneapolis is usually sourced from Mexico, and distributed by a number of criminal retail groups, including the Asian groups with ties to the Brown County/Green Bay area. Minneapolis continues to be a distribution center for large amounts of Mexican produced methamphetamine coming directly from the

southwest border by Mexican cartel/drug trafficking organizations (DTOs) into the Minneapolis area.

Much of the heroin abuse in Wisconsin stems from users transitioning from prescription opioid abuse to heroin. In 2015, 100% of the Wisconsin survey respondents listed heroin as their number one drug threat which was up from 41% of respondents as recently as three years ago. For 2015, Milwaukee County alone reported 109 heroin-related overdose deaths. The vast majority of the heroin in Wisconsin is sourced from Chicago-based traffickers with connections to the southwest border and the major Mexican cartels. Wisconsin traffickers, in particular Milwaukee-based traffickers, will often travel 90 miles south to the Chicagoland area several times per week and return with 100-150 gram quantities of heroin, usually of the Mexican or South American variety. The traffickers rely on passenger vehicles, often rental vehicles, to transport their drugs across the border. Some of these vehicles contain hidden compartments to further secret their illegal drugs and/or proceeds.

Over the course of the past two-three years, the majority of heroin present in Wisconsin is one of the several types of high purity Mexican heroin (with the exception of Mexican black tar heroin), as opposed to the high purity South American heroin that was seen routinely for the decade or more prior to that. As I'm sure the Committee is aware, the ultimate sources for the heroin are one or more of the major Mexican cartels with distribution cells based in Chicago. In 2015, Wisconsin HIDTA associated or led Initiatives seized a total of over 10 kilograms of heroin, including the seizure of three kilograms of heroin from a Milwaukee residence, indicating the presence of much larger quantities than previously experienced locally. That Wisconsin investigation traced the source back to Chicago. In that instance, like in most instances of Wisconsin traffickers, the Chicago source was within the same ethnic and/or racial group, or they will have familial ties. Ultimately, the Chicago-based drug trafficking organization (DTO) at some point will have ties to a Mexican source associated with one or more of the major cartels.

In addition, in Milwaukee in particular, the growing heroin problem has led to increased violence and challenges for law enforcement; not only by having to deal with the ever-increasing number of overdoses and deaths, but also due to the change in how the retail market has evolved. In Milwaukee, "mobile drug houses" have become commonplace and have presented law enforcement with a new and more dangerous challenge. Retail distributors will travel around the city and region in passenger vehicles with heavily tinted windows, delivering retail amounts of illegal drugs (usually heroin) to dozens, sometimes hundreds, of customers daily. These transactions literally take just seconds to complete. These perpetrators then brazenly refuse to stop for law enforcement. These traffickers are almost always armed and there will often be more than one violator and more than one weapon inside the vehicle if and when they are stopped; posing an increased level of danger not only to law enforcement, but also to the public with their reckless driving and disregard for their own safety and the safety of the innocent public as they are fleeing.

Of growing concern during 2015 and continuing into 2016 is the increased presence of fentanyl, which has also contributed to the record number of overdose deaths in Milwaukee County. This most recent increase in fentanyl abuse appears not to stem from the diversion of pharmaceutical fentanyl, such as transdermal patches, but rather from fentanyl that is most-likely clandestinely produced and mixed in with quantities of heroin being smuggled into the region.

In addition to all types of illegal drugs sourced from cartel distribution cities and hubs such as Chicago, Wisconsin is also the destination state for a large number of parcel packages that contain all types of illegal substances. In 2015, the Wisconsin HIDTA Interdiction Initiative, based in Milwaukee, interdicted a total of 289 parcels containing a variety of substances, the most common of which was high-grade marijuana. Most of these packages were from western and southwest border states such as California, Colorado, Washington, Arizona, and Texas. The packages range in size from relatively small amounts up to 50 or more pounds. They are usually addressed to vacant lots or buildings. The majority of these packages are sent through the U.S. Postal Service, as well as other commercial delivery companies. Due to the geographical distances between Wisconsin and

the west coast and/or the southwestern border, many drug trafficking organizations find it more economically feasible and less risky to ship numerous parcels to Wisconsin rather than driving larger loads that long distance.

In response to Wisconsin's identified drug threats, the Wisconsin HIDTA program uses a multi-faceted approach to address the identified threats. In particular, the Wisconsin HIDTA has a multi-agency task force made up of federal, state, and local investigators specifically targeting heroin DTOs operating in and around Wisconsin. In the past year, several additional investigators from numerous departments, many of which from smaller suburban departments, have joined the task force due to the prevalence of heroin abuse and trafficking in their areas. However, almost all of the Wisconsin HIDTA enforcement initiatives routinely conduct some level of heroin or opioid focused investigations due to the scope of the problem all around the state.

In addition, our ISC works closely with many departments and agencies around the state to assist with analyzing evidence, in particular, communication devices found at overdose death crime scenes in order to find links between traffickers at all levels. With HIDTA funding and support, our ISC supports numerous intelligence programs and investigative efforts that are specifically designed to encourage collaboration and intelligence sharing so as to identify connections and close intelligence gaps between jurisdictions and agencies.

The Wisconsin HIDTA has been actively and routinely involved in training and education related specifically to the heroin and opioid abuse problem. Wisconsin HIDTA participating agencies regularly conduct heroin-specific training for law enforcement, as well as awareness-type training for the public. During the past several years, the Wisconsin HIDTA has participated in numerous "heroin/opioid summits" all around the state to raise community and public awareness of the problem. The Wisconsin HIDTA funds and supports six full-time collocated local prosecutors, one of which is dedicated solely to prosecuting heroin and pharmaceutical diversion cases.

Our prevention initiative, Safe & Sound, also works closely with residents, youth, and law enforcement in and around Milwaukee's most affected neighborhoods to

assist with the prevention of future detrimental behavior and activity. In 2015, the Wisconsin HIDTA received some discretionary funding from ONDCP that will enable the Safe & Sound program to assist other Wisconsin communities by replicating its unique approach toward improving the quality of life for communities negatively impacted by drugs and the associated violence and crimes.

The Wisconsin HIDTA is committed to facilitating cooperation among federal, state, local, and tribal law enforcement and prevention efforts through the sharing of intelligence, and by providing support to coordinated law enforcement efforts toward identified drug threats.

On behalf of the Wisconsin HIDTA Executive Board, I want to thank you for the opportunity to appear before the Committee today, and for your continued support of the HIDTA program.

TESTIMONY

OF

TIM WESTLAKE, MD, FFSMB, FACEP

VICE CHAIRMAN, STATE OF WISCONSIN MEDICAL EXAMINING BOARD
CONTROLLED SUBSTANCES COMMITTEE CHAIRMAN

BEFORE THE
UNITED STATES SENATE
COMMITTEE ON HOMELAND SECURITY AND GOVERNMENT AFFAIRS
FIELD HEARING

"BORDER SECURITY AND AMERICA'S HEROIN EPIDEMIC:
THE IMPACT OF THE TRAFFICKING AND ABUSE OF
HEROIN AND PRESCRIPTION OPIOIDS IN WISCONSIN"
PEWAUKEE, WISCONSIN
APRIL 15, 2016

Chairman Johnson, Ranking Member Carper, Senator Baldwin and other distinguished Members of the Committee:

It is an honor and privilege to testify, and I thank you for the opportunity to address you today on behalf of the patients and doctors in the State of Wisconsin.

I serve as Vice Chairman of the State Medical Examining Board, where I am also the Controlled Substance Committee Chairman. I work as a full-time Emergency Physician, and have over 15 years of practice in the suburban Milwaukee area. I am also EMS medical director for many of the EMS agencies in the communities surrounding my hospital. In these roles, I have been both in the trenches intimately involved in the treatment of heroin and prescription drug abuse, as well as helping lead the State's response on a regulatory and policy level. I would like to share some of my experiences on this complex issue, what we are doing in Wisconsin in the battle, and finally propose a few small changes to federal code that you as federal legislators could do to help support our communities in battling this scourge.

As is now becoming common knowledge, there is an epidemic occurring from the use of prescription opioids almost invariably followed by heroin in this country. Across the United States you are statistically more likely to die of an accidental prescription drug or heroin overdose than from a motor vehicle crash. In my practice as an emergency physician in a small suburban hospital in it is not uncommon for me to see one or more opioid overdoses per week, and of the 20 or so patients I see per day, usually 3-4 are on chronic opioid medications. The diagnosis of opioid use disorder has a mortality and long term survival prognosis similar to a diagnosis of cancer. Over 80% of the heroin use in general and nearly all of the teenage and young adult use starts with prescription drugs. The direct and indirect costs to our society is astronomical, but is easily dwarfed by the the impact of the pain and suffering experienced by the users and their families. On average across America, someone dies from an opioid overdose every 24 minutes. Quite simply, It is the public health crisis of our times.

To speak frankly, there can be no doubt that the sources of the supply of opioids stem from the ease of availability of prescription opioids due to over-prescription by doctors themselves. We physicians need to own our part in the problem. It is incontrovertible that over 80% of heroin users start first with prescription opioids. Almost inevitably, when the pills are too expensive and the person is opioid-dependent, the next step is to move into heroin use. With the relatively cheap cost of heroin trafficked over the southern border and with synthetic opioids such as fentanyl and other synthetic opioids coming by mail order, Wisconsin is awash in opioids.

As an emergency physician, I unfortunately see the carnage up close and intimately, and on a far too frequent basis. I have been witness to heartbreak beyond comprehension and have had to tell innumerable families that their beloved family member will never come home. I will never forget sitting next to and telling a good friend and nurse colleague from my very emergency department that the patient in room 3 was dead. I could not save her own son from a prescription drug overdose. My friend Carolyn's son Josh had started on prescription opioids, then moved to heroin, and went back and forth based on what he could beg, borrow or steal. Eventually one morning Josh was found dead in his underwear in the front yard of a drug house and brought to the ER at which his mom and I worked. The paramedic that was called to the scene and tried to resuscitate him and was a close family friend and knew Josh from when he was a baby. What can be said to a mom who just lost her child? Sometimes all I can do as an

emergency doctor is to bear witness to the pain and suffering in my community. As far too many reading this are aware, there are almost no families untouched by the scourge of addiction.

It is very important when looking for the cure of a disease, to understand the causative factors that led to the development of the disease in the first place. To be honest, as long as healers have been using opioids to relieve pain, there has been abuse. As physicians, it is a fine balance we walk while attempting to alleviate the suffering of our patients while at the same time being responsible prescribers and not enable the devastation and destruction of addiction. The surge in abuse was and is made possible by the increased availability of prescription drugs directly related to regulatory changes that occurred in the late 1990's. The origins come from the idea that pain was under-treated and physicians should be more generous with opiate prescriptions. You will all recognize one outcome as the pain scale that is incessantly asked of you when you visit your doctor. As with many regulatory mandates in healthcare, it started as a well intentioned idea, but has had devastating unintended consequences.

Traditionally, and up until the early 2000's, opiates had not been used in cases of chronic non-cancer pain. But then the "Pain as the fifth vital sign" initiative was released federally (coincidentally first by JCAHO, CMS and at the VA), which artificially alters literally all patient encounters and keeps patients focused on their pain. It is well established that patients can be comfortable while having moderate pain, and the pain scale itself has never been proven scientifically to be an empirically sound tool for guiding pain treatment and management. At the same time the pain scale was federally mandated, there was also a very effective legislative push by pain advocacy groups, pain specialists, and drug companies to alter state statutes that prohibited the use of opiates for chronic non-cancer pain. Also occurring concurrently new extremely potent and potentially addictive long acting pain medications like Oxycontin and MS-Contin were released to market. All of these lobbying effects were extremely successful, and by 2003 there were only 5 States that had not changed their regulations and/or statutes to allow more permissive use of opiates in cases of chronic non-cancer pain. The effect was to open the flood gates and the amount of prescribed opiates has increased explosively since. The scourge of the prescription drug epidemic is a direct unintended consequence of these changes.

I cannot state strongly enough that the urge to try to do something and address this crisis by federal legislative solutions needs to be resisted. The lions share of healthcare regulation occurs at the State and local level, and as such, most of the responsibility for addressing the prescription drug epidemic will come from the States, hospital systems, and physicians themselves. It is very important to remember that in the first place, most agree that the spark that ignited and continues to fuel the epidemic was born out of federal regulatory effort.

In Wisconsin, we are blessed to have the insightful leadership of State Rep. John Nygren and Attorney General Brad Schimel. They understand that the most useful role of government is to provide and encourage the best environment where the healthcare providers and systems themselves can find the solutions that work in their own communities-for both the prescription opioid as well as other problems. We have been involved in the NGA Best Practice Policy Academy for Reducing Prescription Drug Abuse, and have extensively studied what other states have done and looked at what legislative and regulatory reform has worked and what has not, in order to come up with the best possible regulatory reform for our state. State Rep. Nygren has led the state with phenomenal innovation and insight in crafting and shepherding the passage of wise legislation that really addresses the root of the problem while remaining as least-invasive as possible. Rep. Nygren has real skin in the game with a daughter who's battled opioid

addiction, and he's committed to finding and implementing the best possible solutions. He has sought out stakeholders from all areas of what his legislation touches and asked real questions and listened and adjusted his legislation accordingly. Attorney General Schimel has been visionary in attempting to find real solutions to this crisis, not just lay on the heavy hand of law enforcement. I remember when he was the Waukesha County District Attorney almost 7 years ago and came to my hospital and was educating the doctors and staff about the crisis that was occurring in prescription opioid and subsequent heroin abuse, a proverbial canary in a coal mine. He has always said we can't arrest our way out of the epidemic, a comprehensive approach was needed. He made impacting the opioid crisis a plank of his campaign for election to the Attorney Generals office and it is a cornerstone of his work to this day.

At the State policy level, under the leadership of AG Schimel, Rep. Nygren and me, we have established the Wisconsin State Coalition for Prescription Drug Abuse Reduction. This is a collaborative impact practice model that leverages the strengths of the members of the coalition to position the state's resources in a way to best address the prescription drug abuse issue and any intended and unintended consequences from the regulatory and legislative changes. Members of the coalition represent all the stakeholders in healthcare: Legislature, Attorney Generals office, Medical/Nursing/Dental Exam Boards, Wisconsin Medical/Nursing/Dental/ Pharmacy Societies, Hospital Association, addiction community, treatment community, public health community, Department of Human Services/Medicaid, insurance providers, rural hospital cooperatives, and most importantly representatives from almost all the health systems across the state large and small. We are looking at what can be done to provide support to the doctors in the trenches and the patients to whom they are giving care. We are looking at ways to find and share best practices system to system and implement the reform from within the systems and medical community ourselves with the least collateral damage to those already addicted. We understand that the true solutions will come from within the communities and health systems themselves and have worked to engage stakeholders from every level.

In looking at causes of over-prescription we have seen that we are dealing with 2 main types of prescriptive behavior. The first and by far most common is the 99% of prescribers that are meaning well, but whose arguably "overly generous/loose" prescriptive practices have helped lead to patient addiction directly and also indirectly by "leftovers" that are then abused. On the other hand, there are the prescribers that know what they are doing and intentionally profit from the prescribing--I see them as the "doctor dealers". Both groups are completely different and require different measures to address them effectively. The "doctor dealers" will and should be addressed by law enforcement and state medical examining boards. State legislative and regulatory reforms are being instituted across the country at the state and local level which are significant improvements.

We have come up with 2 areas that could significantly help in fighting the scourge of prescription drug abuse, that would require a change to US statutory code. I will go into detail below.

1)The biggest "bang for the buck" federal legislative solution that would likely have the largest impact in curbing excessive prescriptive behavior would be for some type of legislative change that would restrict federal agencies/entities from being able to fiscally mandate use of the pain scale. It has been my privilege to work with Senator Johnson's staff in helping determine what federal legislative changes would be most effective in this battle. We are extremely excited to hear that Senator Johnson has just released a bill last week that does exactly that! The bill

already has broad bipartisan Senate support and is the PROP act (Act to Reduce Pressure to Overprescribe Painkillers). Sen. Ron Johnson was joined by his colleagues Sens. Joe Manchin (D-W.Va.), John Barrasso (R-Wyo.) and Richard Blumenthal (D-Conn.) in introducing the bill. Johnson's bill is the Senate companion to H.R. 4499, a bipartisan measure introduced by Rep. Alex Mooney (R-W.Va.) that has been endorsed by the American Medical Association, American Hospital Association, American Society of Addiction Medicine, American Academy of Neurology, American Osteopathic Association, Physicians for Responsible Opioid Prescribing, Hazelden Betty Ford Foundation, Friends of NIDA, and American Association of Orthopedic Surgeons.

Let me explain how the use of "the pain scale", "pain as a fifth vital sign", and the use of pain-related quality metrics in medical/hospital system reimbursement has significantly altered the physician patient relationship and led to over prescription. It has literally altered every single doctor patient interaction. As it stands, CMS is responsible for the 2 main parameters that are used to measure "Quality" but also have the unintended consequence of increasing the amount of opiates prescribed overall. The main item is the PQRS (Patient Quality Reporting System) item 0420- Pain Assessment and Followup. It looks at the percentage of patients aged 18 years and older with documentation of a pain assessment through discussion with the patient including the use of a standardized pain tool(s) on each visit and documentation of a follow-up plan when pain is present. The second CMS parameter is from the HCAHPS (Hospital Consumer Assessment of Healthcare Providers and Systems) --item 0166-Question on Pain Control. These have very significant downstream impact on prescriptive practices.

The effect of these financial reimbursement based mandates has been the unintended consequence that pain is brought up again and again in every single patient encounter in the country. Pain is a completely subjective symptom, and is highly variable. When a provider is artificially forced to ask all patients again and again to rate their pain, this causes the patients to focus on their pain unnecessarily increasing the subjective experience of it. When you add in making the provider responsible for formulating a plan to address this elevated non-scientific pain measure, this completely changes the encounter. It is invariably skewed to the almost inevitable outcome that more narcotics will be prescribed. Having to use the pain scale introduces questions in a way they would not normally be asked. It is not useful to me, nor is it my natural practice, to be forced to always ask patients repetitively what their pain level is. It is much more natural to instead ask about pain without making focusing completely on it. I prefer to ask about how comfortable the patient is, and if they need/want anything else done to be more comfortable. Many patients when asked if they want anything more for their pain will respond "No", even with a pain rating of 7. The current federal reimbursement pain measures mandate that we address the patients pain and establish a plan to bring it down if it hasn't numerically changed after treatment, even if the patient is comfortable enough with the treatment and doesn't ask for further pain treatment.

Having to use the pain scale is like having a federal regulator in the room of every single patient encounter asking the patient over and over what their pain level is. I have given the example of 6 research studies that back up the idea that not only does the pain scale not symptomatically improve pain control, it is actually responsible for significant problems with over medication and over-prescription. Again, another example of unintended consequences to a well-intentioned idea. Now that we know how ineffective and potentially damaging it actually is, it is time to do away with the pain scale. Below I point to several evidence-based research with some interesting titles:(1)"Increased Adolescent Opioid Use and Complications Reported to a Poison Control Center Following the 2000 JCAHO Pain Initiative", (2) "Kindness Kills:The Negative

Impact of Pain as the Fifth Vital Sign", (3)"Measuring Pain as the Fifth Vital Sign Does Not Improve Quality of Pain Management", (4)"Government Regulatory Influences on Opioid Prescribing and Their Impact on the Treatment of Pain of Nonmalignant Origin", (5)"Has The Pendulum Swung Too Far in Postoperative Pain Control?" ....These articles are eye opening and give credence to what almost every provider instinctively knows. I can provide links to the articles as needed. Just ask any doctor, nurse or medical assistant--It is well past time to do away with the pain scale! Thank you Senator Johnson for starting the process! We have had more than enough of the harmful consequences of over-regulation.

That being said, it will also be very important to address the role and effects that JCAHO has played and continues to play in this epidemic. JCAHO is an abbreviation for Joint Commission on Accreditation of Healthcare Organizations. Only hospitals that have been accredited by JCAHO can receive payments from government plans like Medicare and Medicaid, making the group's standards highly influential. is a vital accreditation to have, and not having it could mean going out of business.

To me in an eerie coincidence, I will use the emergency department I work at (Oconomowoc Memorial Hospital) as an example of the how this JCAHO issue plays out. Our emergency department has been able to achieve 10 consecutive years of patient satisfaction in the 95th percentile or above (usually the 99th) -every quarter in a row for the past 40 quarters measured by the Press Ganey company. There is literally no other ED in the entire US that has been able to accomplish this. I'm not saying it to brag, just to underscore that our patients are most likely very satisfied with how their pain is being managed. But in November, we had our routine JCAHO survey. They found that we were not documenting having asked our patients follow-up questions after pain medications were given, and we were cited for not being compliant. Coincidentally this measure comes directly from the Affordable Care Act, it is actually the piece about pain quality measures that Sen. Johnson's bill would repeal. Our hospital was given one quarter to get our compliance up to 90%. As you can imagine, providing emergency care is crazy most of time, and we are constantly running around time-managing what we really need to do to address the patients true needs. Well, we did not meet the 90% compliance goal, and we were just told that due to our 75% compliance, we did not meet the pain reassessment documentation requirement. Due to that alone, our JCAHO accreditation is at risk for the entire hospital. If we don't get the accreditation, it would likely cost the hospital huge resources (from tens to hundreds of thousands of dollars) to undergo a new survey and get reaccredited. This is for an emergency department that literally has the highest patient satisfaction in the country. Incidentally, our patient satisfaction continued to remain 99% for that same period. Isn't it common sense that our patients are most likely getting their pain management needs addressed? And the threat is to lose accreditation for the entire hospital. That is just one part of the craziness of the current state of excessive bureaucratic regulation in the day to day work of medicine, fighting the regulatory requirements to provide the care our patients deserve. We are seeing the bureaucratization of medicine as never seen before.

Coordination with JCAHO and healthcare quality and patient satisfaction measuring companies is also vital to help reverse the unintended consequences that the emphasis on pain measures has had, and needs to be concurrently undertaken along with prompt passage of the PROP Act. It is time remove the government from the middle of the doctor-patient relationship. In a related note, more than five dozen nonprofit groups and medical experts sent a letter this Wednesday to the Joint Commission asking it to revisit its standards for pain management. The medical and

addiction community are unifying behind the dismantling of the "pain as a fifth vital sign" movement.

2)The second area of potentially very useful federal legislative change I'd like to address is a way to decrease the supply of "leftover medications". One of the most impactful ways to address the current opioid crisis is to simply decrease the availability/supply of opiate pills prescribed. It is estimated that 80% of heroin users start by using prescription opiates first. It is also estimated that over 50% of prescription opiate abusers obtain their pills by diverting them from a relative. Many times kids end up stealing them from pill bottles kept from old prescriptions (ie raiding mom and dad's or grandma's medicine chest). There are over 9 billion (with a "B") individual Vicodin pills prescribed in America alone every year. It is estimated that only 1/3-2/3 of these pills are taken. That leaves 3-6 billion leftover Vicodin pills lying around, waiting to be mis-used. Any change in prescriptive practice that would decrease the amount of excess opiate pills and hence downstream supply, would go a long way in addressing the current epidemic.

This is where a legislative tweak to the federal Controlled Substances Act could further such a change. As current federal law (and state law that mirrors federal) stands, it is not legal to provide a refill for schedule II narcotics, a physical prescription must be taken to the pharmacy, and cannot be phoned-in or faxed. And now with the recent change to reclassify hydrocodone medications as schedule II, this makes it even all the more difficult to prescribe.

The unintended consequence of not allowing refills is that proceduralists (surgeons, dentists, and doctors that perform procedures with painful after-effects) and providers that treat acute pain are usually going to err on the side of over-prescription. They are more likely to prescribe more than they think the patient will likely need. This is done to make sure the patient doesn't suffer from unnecessary pain, and so the patient will not have to call the doctor (or perhaps the doctor's on call covering partner) back at night or on the weekend or during the busy daytime asking for a little more pain medicine. I think of this as the "hassle factor"--it is real. By prescribing a larger amount in this way, the patient and the doctor aren't likely to be inconvenienced by having to get a physical prescription refill. But, this almost always ensures there will be leftover opiate pills, in many cases in significant numbers. Almost everyone you talk to has stories of something like getting a tooth pulled or breaking their hand and then having 48 vicodin left over, sitting in the medicine cabinet. Therein is the excess supply that enables and is a catalyst for abuse.

For example, the way this plays out for a surgeon who performs a hand surgery is that he expects the patient to be in pain for 4-5 days afterwards, so he estimates at maximum the patient would need 20 vicodin. But some patients are more sensitive to pain, so not being able to write for a refill, he is likely to give a quantity of pills that would be likely more than most patients would need--like 40 pills. If he could instead write a time-limited small-volume refill that would expire after one week, then the patient would be able to control the amount dispensed, and there would be significantly fewer "left-overs". If most patients need less than 20-which is likely, then that many less would be in circulation. Again, it is estimated that there are 3-6 billion leftover Vicodin pills every year!

So what we propose as a solution would be to amend USC Title 21 Section 829 which states no refills of schedule II drugs . The statute is found here https://www.law.cornell.edu/uscode/text/21/829 . We have extensively looked at ways to decrease this over-prescribing behavior. I

would propose a change to allow an exemption for one refill of hydrocodone based prescriptions that would expire in 1 week for quantities of less than 20 intended only for cases of acute pain management. After that time, if the patient had more symptoms he would need a physical prescription for any further quantities-as is the case now.

There would be no change to chronic pain management. It would not touch how those medicines are currently prescribed, or how those patients are currently treated. Medications for chronic pain would continue to be prescribed for as is, and still require new prescriptions every single time with no refills allowed (as is the law now). The argument that this change would negatively affect chronic-pain patients has no validity, because there would be no restrictions to or changes in the way prescriptions are currently handled. There would just be the new availability for prescribers to write for less than 20 pills with a one time refill limited to a week. We think this would go a long way to help meet the goal of decreasing the availability of prescription opiates and keep them out of the hands of our children and adolescents.

There are things that the federal government is doing that are working well and where federal legislation can have a significant impact in the battle. It is in the ability to bring resources to the states themselves to use for grant programs for health and law enforcement efforts. Wisconsin lawmakers are helping lead the way in this critical area. The most recent example other than the PROP Act is the Comprehensive Addiction and Recovery Act (CARA). It is a great example of the bipartisan legislative action in the battle against prescription drug abuse. I applaud both Wisconsin Senators Johnson and Baldwin for their support of this important bill, as well as Wisconsin Congressman Sensenbrenner for releasing it.

Senator Baldwin has also done some very good work in this area of prescription drug abuse reform. She has authored the Jason Simkakoski Memorial Opioid Safety Act, which passed a Senate Committee hearing and has some very good reforms to affect change in prescriptive practice within the VA. It mirrors what we have done in Wisconsin with our reforms, taking what has worked at the state level and applying it in the VA system. It has emphasis on best-practice prescribing guidelines, targeted opioid continuing medical education for prescribers, encouraging use of prescription drug monitoring programs, and oversight by the regulatory body to ensure minimum standards are met, among other things.

Senator Baldwin also has authored a bill the Heroin and Prescription Drug Abuse Prevention and Reduction Act which covers prevention, crisis, treatment and recovery. In it are great pieces that cover expanding access to buphrenorphine to help with medication assisted treatment, and also increasing availability of naloxone to reverse opioid overdoses,as well as expanding access to treatment.

The question of justifying expenditures and funding is a very important one, and I feel the money put into prevention, management and treatment will deliver a significant return on investment as far as total costs/benefits to society and the quality of life in America. I have heard of an economic impact analysis that was done on a buprenorphine program in Peoria Illinois. They spent $600,000 on the program. Sadly, as is common the case with medication assisted treatment and treatment opioid treatment in general, the compliance/success rate was less than 20%. Even with that compliance rate, the estimated savings to society in Peoria was estimated to be $12,000,000 due to money that wasn't spent on incarceration, medical costs, and losses from crime associated with continued abuse related crimes. Truly the case seems to be strong that the the return on investment is likely worth the expenditure.

In closing, I applaud the efforts that Wisconsin federal and state legislators and leaders, and for that matter the government in general is taking in battling the scourge of prescription opioid and heroin abuse. We are seeing some great energy and interest in understanding and looking at how to best address this epidemic. The legislation so far has been thoughtful and not over-reaching. The legislation Sen. Baldwin has been leading would be very useful in helping the Veterans Affairs system, the states and our communities in battling this epidemic. I literally cannot say how excited I am about Sen. Johnson's PROP bill -(the Act to Reduce Pressure to Overprescribe Painkillers). It puts us on a simple, straightforward and commonsense path. It moves us back towards allowing the medical community to do what we do best, take care of our patients without artificial interference.

I think it is wise to remember that legislation and regulation is difficult to repeal and filled with unintended consequences that can be worse than the problem that is being addressed. The case in point is taken from the movement and follows federal policy in the 1990's that was trying to address the perceived problem that pain was being under-treated by health providers, which was the spark for the current prescription drug epidemic. This quote is from a press release taken from Surgeon General Murtha that was released just this last Tuesday, April 8th. "*I came across a training document from the early 1990s that was directed at nurses and doctors. And one of the lines stood out to me clearly," he said. "It said, 'If your patient is concerned that they may develop dependence on opioids, you can safely reassure them that addiction to opioids is very rare in patients who have pain." "That one line haunts me" he said. "I remember being taught that during my training and having to unlearn it. And I know there are many clinicians who were taught the same and still practice based on this teaching — with the best of intentions."*

The last opioid overdose death that I treated was this past week. I could not resuscitate him. He was in his early 20's. He told his friend he was going to shoot up and to give him narcan if he wasn't breathing. His friend came in 30 minutes later and he was flatline. He was the 4th kid to die from opioids in his high school class, from the local high school that sits next to my hospital. The police couldn't locate his family, and he was taken to the morgue with no family having said goodbye. The coroner who took him away said the Milwaukee County Medical Examiner's office was seeing about 2 opioid deaths per day. There have been 30 fentanyl-related deaths in Milwaukee County alone so far this year. There were 5 fentanyl-related deaths in 2012. This is the public health crisis of our times. It is not easy work we are doing in setting policy and regulations, but it will make a difference if we do it right.

Thank you for the opportunity to contribute and testify in this hearing.

Lybert Family Story

Tyler's Perspective

My name is Tyler Lybert and I am a recovering drug addict. I started experimenting with drug and alcohol at the very young age of 11 years old. Alcohol was introduced to me by older people in 6th grade and the only reason I started was because I wanted friends. I saw alcohol as an opportunity to make those friends so I started to drink and party on the weekends. Eventually I was introduced to weed in 7th grade and saw it as not that harmful so I started to smoke. I quickly became an everyday user and started to make really bad choices. I was arrested when I was 12 for underage drinking and ended up getting arrested 16 more times after that for the same reason.

Once I got into high school it opened up my world of partying to a lot more people who were doing the same things as I was. So dugs and alcohol became a way of life to me. Nothing else seemed to matter. Grades, school, football, and family became less and less important as drugs and alcohol where more the focus. Pills, more specifically OxyContin, were introduced to me when I was 15 and I couldn't resist. It was something new and exciting and I didn't have the will power to say no. Once I had said yes to my first hard drug, I rarely ever said no to anything. Acid, mushrooms, cocaine, or anything put in front of me was never refused.

I ended up getting expelled from Arrowhead High School, and Devine Redeemer, and eventually landed back at Arrowhead's alternative program. There I graduated with and HSED.

Once I got out of high school I had a new freedom to party more and do more of what I had grown to love so much. I had tried Heroin in high school but it had always scared me so I stuck to pills. At this time in my life I was already a drug addict and had that constant need to use all the time. The pills were becoming too expensive so I did what most people who can't afford to do pill anymore do, I switched to heroin.

The cost of drugs out weighed what I was making at work so I had to result to different sources of income. The easiest source I saw at the time was to steal. So that what I did, I started to rob people and steal anything I could. The sad part is that the easiest people to steal from was my family. I stole and forged personal checks, business checks, cash, jewelry, and even TV's. Anything I could steal I would. I didn't like doing it but I had to. The voice inside my head was too loud and the only way to quite it down was to get high.

This went on like this for years. Everyday I woke up hating myself, asking myself how can I keep doing this. Every morning I would avoid life because I didn't want to face it anymore. I hated my life, I hated everything about it. I had crushed every opportunity that was ever put in front of me, I had gone nowhere in life, and I was destroying my family. I hated what I was doing but I couldn't stop. I was an addict and drugs where more important.

Eventually it came to a point where I hated my life so much that I couldn't find a reason why I was still living. I started to wake up praying that I wouldn't wake up anymore. I started praying that I would die. Every morning I woke up was a disappointment that it hadn't happened yet. We had tried multiple different treatments, inpatient, IOP, Methadone, Suboxone, and nothing worked. So my conclusion was that being sober wasn't possible, and that my only way out of this would be death. I figured maybe if I died my family could finally get some peace, maybe if I die my family can finally lead the lives they where supposed to lead without me having to drag them down anymore.

My family was at the point where they couldn't take it anymore either. They had been living this hell for 10 years and had tried everything. So they decided there was nothing more they could do for me and they kicked me out. I went down to Milwaukee and lived in a drug house for a bit. I was done, I couldn't take life anymore. I hated everything about my life and couldn't see a way out of it. It was then that I wanted to finally end it all and take my own life. I was in a dark room by myself with knife ready to end it all, when I got a phone call from my mom. She said "you have 2 options; you can keep doing what your doing but we never want to see you again. You're not welcome at our house, you can't call us, if you choose this we never want to see you again. Or you can go inpatient and we will support you %100."

I went into inpatient and spend 5 and a half months in inpatient. There I had to learn how to live again. I had to relearn how to do everything. I had grown up learning to lie and steal, and manipulate. They had to undo all that and teach me how to live again.

My family has been here every step of the way and I am proud to say that I have ben sober for 7 years.

Ashleigh's Perspective

My name is Ashleigh Nowakowski and I am Tyler's older sister. When Tyler and I were little, we were inseparable, we played video games, Ninja Turtle's and house. As we got older and more involved in our own sports and activities, while I was doing really well, Tyler started making bad choices including drinking and using drugs.

At first, I thought he was just being a teenage boy and he would grow up and grow out of it. But he did not and I began to hate him. I hated him for my parents fight all the time. I hated him for my mom crying every day. I hated the fact that every time the phone would ring at our house everyone would jump thinking is this phone call that he is never coming home again. I hated even coming home from school because I didn't know what I was going to come home to, were the cops going to be there, were my parents going to be fighting? I wasn't known for my academic merits or my great horseback riding ability, I was known as the drug addict's sister. The thing I hated the most was how someone I loved so much could turn around and hurt me so badly.

As a sibling, I felt like I had to be perfect. I felt that if I could get the best grades and be the best at my sports, maybe I could keep my family together. I often felt like the middle man in my parent's fights. I did everything I could possibly think of to keep my family somewhat normal.

Our family never took trips to the Dells or camping or family vacations because of the fear of what Tyler would do. Tyler robbed me and himself of having those experiences.

I also felt neglected by my parents. They were so focused on Tyler 100% of the time that they forgot about me. They would come to my horse shows and cheer me on, but they were never 100% there. They were always concerned about where Tyler was and what he was doing.

In the deepest darkest times, I would secretly wish that he would die. I thought that if he did die, he wouldn't have to fight the demons anymore. I also felt that if he did die, then we would have to worry about him 24/7.

Tyler didn't go into treatment until after my wedding. Tyler's drug use was so bad during the planning of my wedding that I couldn't even have him stand up. I didn't believe he would be alive to see me get married. I thought if I had him stand up and he died, then I would have had

to explain to everyone at my wedding why there was a missing groomsman and I didn't want to have to that.

When Tyler decided to go into treatment, I thought it would not work because it hadn't worked before. So it took me a good year and half to trust him and want to be around him again. I had to figure out how to separate Tyler the drug addict from Tyler my brother because they were two completely different people.

Today, Tyler and I are closer than ever before. I am so lucky and grateful that he is sober and alive. But, there will always be that fear that at any day he could go back to using.

Rick's Perspective

My name is Rick Lybert and I am Tyler's father. I am not the same man I was 10 years ago. Back then, I was a very angry man and it was because of what Tyler was doing to my family. I watched Sandi for many years in a deep depression. It got so bad she couldn't even get out of bed. And I was mad at Tyler because he just couldn't stop, no matter what I did. The fighting, the yelling, the so-called house arrest, he just wouldn't stop.

I was brought up to believe that as a father it was my job to protect my family. But Tyler's addiction was out of my control and I could no longer protect them. Even Ashleigh could no longer take it and she moved out of the house, I wish I could have gone with her.

It wasn't until we me Charlie, Charlie was Tyler's drug and alcohol councilor in inpatient. Charlie told us that Tyler couldn't stop, he was an addict. What he told me next was something I'll never forget. He said "In order for Tyler to change, you have to change to." I can remember thinking, "why do I have to change? He's the one with the problem." What he was trying to tell me was that if nothing changes nothing can change. So we did start to change, and we saw a change in Tyler.

I honestly never thought we would be in the place we are today. Tyler was an 80-pound heroin addict. I used to call him the walking dead. Sandi even had his funeral planned. Today, we are so very proud of Tyler and the man he has become. We have met so many families that are not as fortunate as we are.

Sandi's Perspective

My name is Sandi Lybert and Tyler is my son. Tyler was a great kid growing up. He was always happy and outgoing. When Tyler started to hang around different friends and using drugs and alcohol, he changed. He became withdrawn and angry. I watched my son dissolve in front of my eyes into a drug addict, a monster.

I feel guilty because I missed the signs of drugs use. When I finally caught on to what he was doing and did start to see the signs, I ignored them because I didn't know what to or where to go for help. I felt that if I loved him enough and did everything for him he would quit. I began to enable him. I lied to my husband because I didn't want to fight anymore. I lost who I was as a person, a wife and a mother because I was so consumed with fixing Tyler.

Tyler destroyed my life, his dad's life and Ashleigh's life for 11 years. We can never get those 11 years back. Tyler would yell scream, swear at me at the top of his lungs about what a terrible pathetic mother I was and how much he hated me because I was the fault of all of his problems. He would push me against the wall and punch holes around me and verbally abuse me until I gave him what he wanted. And even as I was crying, curled up, scared of my own son

and his anger, he would walk away and not care as long as he got what he wanted. Then there was the soft side of Tyler when he would try to stop using. It was very hard to watch him withdraw; the sweating, shaking, vomiting, the begging to make it all stop. That broke my heart.

When Tyler received his third DUI, I went to the jail to see him. He was in an orange jumpsuit and I couldn't touch him. I looked in his eyes and I saw nothing, he had nothing left. I left the jail that day and said "I am loving my son to death." So I went home, told Rick all the secrets I had been keeping and we made the hardest decision of our life, to kick Tyler out of the house.

When I called Tyler, who was living in the drug house, to give him the ultimatum, I honestly didn't know if he would accept the offer of help. But, he did and we as a family, worked on his recovery together. I am so very proud of the person Tyler has become today.

Wisconsin Barriers

1) There needs to be more treatment options for adolescents and people who cannot afford treatment. We send most adolescents out of state because treatment centers here won't take them unless they have a dual diagnosis. Also, for those who don't have insurance, they have to go to Health and Human Services where the wait time to be seen can be 6 weeks or more.
2) Adolescents can refuse and walk out of treatment at the age of 14. This leaves families hopeless. If their child has a drug/alcohol problem, and they refuse treatment, what are parents supposed to do? They continue to live in a vicious cycle until their child turns 18 and they can kick them out.
3) Funding for prevention. The average age of first use in Wisconsin is 12 years old. Kids need to hear clear and consistent prevention messages from 6th grade until 12th grade. In an age where everything is real life, reality shows, facebook, snapchat, etc, kids want the same prevention messages, from real people who have lived it. Where prevention has the most impact is in schools where everyone hears the same message. Currently, schools don't have funding for prevention. We have teachers who pay out of their pocket to bring us in. Our greatest chance to stopping this problem is to educate them before they make that first choice to use. Thank you for your time.

Testimony of Lauri A. McHugh-Badura

"Border Security and America's Heroin Epidemic: The Impact of the Trafficking and Abuse of Heroin and Prescription Opioids in Wisconsin"

April 15, 2016

Good Afternoon,

I'm consumed with grief as yet another overdose death in our small town community, of Oconomowoc, WI. This was no ordinary boy, this was someone dear to my own heart that I treated as my very own and loved.
This was someone that I chose to carry the casket at my late son, Archie Badura's funeral just under two years ago, of heroin.
For you see, yesterday I received the terrible news that Archie's childhood best friend John Paul G., had overdosed on heroin late Sunday afternoon. When I heard the news I buckled over was stunned with disbelief for a moment and silently prayed.

I immediately left my office and raced to the G. Family home with some food and no words. I simply cried and held John's sobbing mother and reopened the wounds that will never completely heal--for no parent will ever get over the loss of their child--ever! The room was filled with sorrow and disbelief. I finally wiped her tears and promised her I would fight for our boys, that they would not die in vain. To cling to her faith and our Lord-the boys knew Jesus and were now in a joyous place--free at last from the chains of addiction!

I assured her it was no one's fault as these drugs take over an addicts body and demand more--even though he was clean, and in recovery she thought doing so well, but that is when they are most vulnerable. This family was in total shock, was trying to see what they could have done differently ...if only...

When I stood to leave John's mother asked that I help gather pictures of her son so I have spent most of today organizing pictures for the upcoming funeral--I'm devastated, their family is forever shattered and so is our entire community.
When I got home several teens/early twenties, from all over (one even from CO) contacted me last night, as they each had heard the news to jucry and share their utter disbelief of John Paul's passing. Each one saying, "Please make it stop Mrs. Badura, I can't take this anymore!!" For your see, another close friend of theirs is now forever gone.

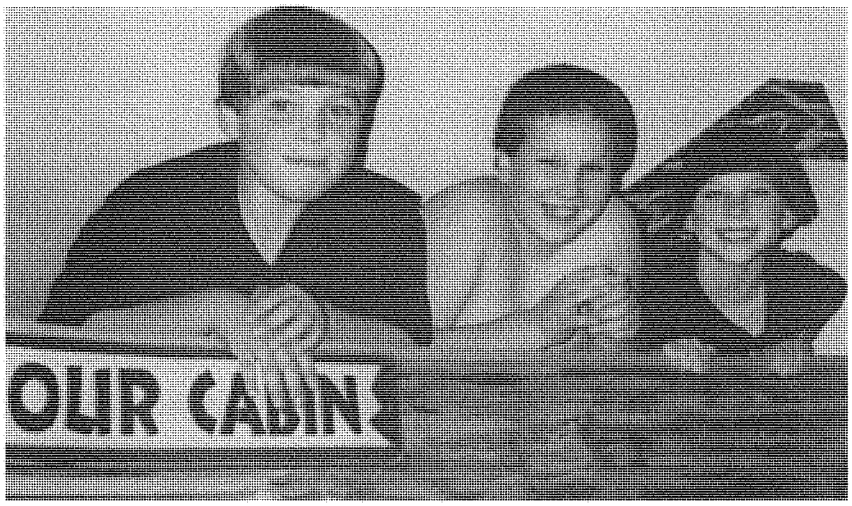
I promised each of them that I would continue to fight this battle and help implement changes in policy and legislation at county, state and at a national level.

Please take a good long look at these two beautiful boys pictured below--now lost to this epidemic. Two kindred souls tangled in the mess of addiction that lost their battle. I know we are not alone, WI and our entire nation is sadly plagued and paralyzed by the epidemic/addiction and the fear of this possibly creeping into to their own individual families.

This truly must stop. I can only hope and pray that after this hearing on April 15th, that we can implement some new measures for border control and tighten drugs from crossing in and help save lives and give hope back to all our nations precious families.

We are losing an entire generation, --that is why I'm so very driven and full of raw emotion to make a difference.

Thank you -- L.A.M.B.



My Archie on the left died May 15, 2014 at age 19, his best friend John Paul, pictured middle, died 4-4-2016 at age 22, Augie my surviving son on the right is 20, is devastated by yet another blow of such a deep loss due to this epidemic.

TESTIMONY OF

R. GIL KERLIKOWSKE
Commissioner
U.S. Customs and Border Protection
Department of Homeland Security

For a Field Hearing

BEFORE

United States Senate
Committee on Homeland Security and Governmental Affairs

ON

"Border Security and America's Heroin Epidemic: The Impact of the Trafficking and Abuse of Heroin and Prescription Opioids in Wisconsin"

April 15, 2016
Milwaukee, Wisconsin

Introduction

Good morning, Chairman Johnson, Ranking Member Carper, and distinguished Members of the Committee. Thank you for the opportunity to appear today in Wisconsin to discuss the role of U.S. Customs and Border Protection (CBP) in combating the flow of dangerous drugs into the United States.

The use and availability of heroin and other illegal opioids, as well as the nonmedical use of prescription opioids in the United States, have been increasing at an alarming rate. The situation is one of the most important, complex, and difficult challenges our Nation faces today. According to a recent report from the Centers for Disease Control and Prevention, between 2002 and 2014, the rate of heroin-related overdose deaths quintupled, and more than 10,500people died in 2014.

There is no single entity, nor a single solution, that can address this problem. Tackling this complex threat involves a united, comprehensive strategy and aggressive approach by multiple entities – from law enforcement, science, medicine, education, social work, and the public health sector – across all levels of government. While continued efforts to interdict heroin and other drugs at the border are a key aspect of addressing this crisis, interdictions, arrests and convictions alone cannot mitigate the far-reaching effects of nonmedical prescription opioid and heroin use. We need to focus on prevention and treatment, and identify the characteristics of developing cases of opioid use disorder before they escalate. We must also concentrate on deterring opioid trafficking by transnational criminal organizations (TCO).

To do this effectively, we must better integrate our efforts, share information, and partner with federal, state, local and tribal communities as well as the private sector. In 2015, the Office of National Drug Control Policy (ONDCP) announced the High Intensity Drug Trafficking Areas (HIDTA) Heroin Response Strategy,[1] which fosters a collaborative partnership between public health and law enforcement entities. The strategy seeks a comprehensive response to this complex epidemic by addressing the broad range of efforts required – on the international, national, and local levels – to reduce the use, distribution, and trafficking of this dangerous substance.

As America's unified border agency, CBP has a critical role in the efforts to keep dangerous drugs like heroin and other opioids out of the hands of the American public. Interdicting drugs at and in between our ports of entry (POE), and combating TCOs, are key components of our multi-layered, risk-based approach to enhance the security of our borders. This layered approach to security reduces our reliance on any single point or program, and extends our zone of security outward, ensuring that our physical border is not the first or last line of defense, but one of many.

Secretary Johnson's Unity of Effort initiative has put in place new and strengthened management processes to enable more effective, integrated DHS component operations to address TCOs, drug-trafficking, and other cross-border threats. In addition, DHS-wide border and maritime security activities are guided by the new Southern Border and Approaches Campaign Plan and complement the Administration's National Drug Control Strategy, and the *National Southwest Border Counternarcotics Strategy*. Aimed at leveraging the range of unique Department roles,

[1] https://www.whitehouse.gov/the-press-office/2015/08/17/white-house-drug-policy-office-funds-new-project-shigh-intensity-drug

responsibilities, and capabilities, the Campaign enhances our ability to work together in a more unified way to address these comprehensive threats. In support of this new Campaign, on November 20, 2014, the Secretary announced the creation of three new joint task forces (JTF) to coordinate the efforts of the combined resources of DHS component agencies. Joint Task Force-East is responsible for the maritime approaches to the United States across the southeast, from the Gulf of Mexico to the Caribbean. Joint Task Force-West (JTF-W) is responsible for the Southwest land border from Texas to California. And, supporting the work of the other two task forces is a standing Joint Task Force for Investigations (JTF-I). These three JTFs reached full operational capability on July 30, 2015.

Interdictions and Trends

In Fiscal Year (FY) 2015, CBP officers and agents seized 3.3 million pounds of drugs across the country, representing a four percent increase from FY 2014 in overall nationwide seizure events, but a six percent decrease in drug seizures by weight. Additionally, heroin total seizure amounts for FY 2015 increased 23 percent to more than 6,000 pounds. CBP seizures of synthetically made opioids like fentanyl, while relatively small compared to heroin, have also significantly increased from 2.4 pounds in FY 2013, to 8.2 pounds seized in FY 2014, to 197.8 pounds seized in FY 2015. These figures demonstrate the continued effectiveness of CBP's detection and interdiction abilities, but also attest to the significant increase in heroin production in Mexico.[2]

Mexican manufacturers and traffickers continue to be major suppliers of heroin to the United States. Heroin is most commonly brought to the United States across the Southwest land border[3] or transported by couriers on commercial airlines.[4] With regards to fentanyl, the most significant source countries are Mexico and China. Fentanyl is smuggled into the United States across the Southwest border, and also shipped to a variety of locations within the United States via mail services.

The reach and influence of Mexican cartels, notably the Sinaloa , Gulf, and Jalisco New Generation Cartels, stretch across and beyond the Southwest border, operating through loose business ties with smaller organizations in communities across the United States. The threat of TCOs is dynamic; rival organizations are constantly vying for control, and as U.S. and Mexican anti-drug efforts disrupt criminal networks, new groups arise and form new alliances.

CBP Resources and Capabilities to Counter Drug Trafficking Organizations

CBP, responsible for America's frontline border security, has a significant role in the Nation's efforts to combat the cross-border criminal activity of cartels and other drug trafficking organizations. In the past decade, DHS has deployed more resources, technology, and tactical infrastructure for securing our borders than at any other time in history. Technology and detection capabilities significantly contribute to identifying and deterring the entry of potentially dangerous people and contraband.

---

[2] "Drug Trafficking Across the Southwest Border and Oversight of US Counterdrug Assistance to Mexico", Caucus on International Narcotics Control, United States Senate, November 17, 2015, Statement of Michael P. Botticelli, Director, ONDCP http://www.drugcaucus.senate.gov/sites/default/files/Michael%20P.%20Botticelli.pdf.

[3] Heroin intercepted at the Southwest land border is most often from Mexico, but sometimes from South America.

[4] Heroin intercepted in the international commercial air travel environment is from South America, Southwest Asia, and Southeast Asia.

At Our Nation's Ports of Entry

At POEs, the Office of Field Operations (OFO) utilizes technology, such as non-intrusive inspection (NII) x-ray and gamma ray imaging systems, and canine teams to detect the illegal transit of drugs hidden on people, in cargo containers and in other conveyances. Since September 11, 2001, NII technology has been a cornerstone of the CBP multi-layered enforcement strategy. As of October 15, 2015, 315 Large-Scale (LS) NII systems are deployed to, and in between, our POEs. In FY 2015, LS-NII systems were used to conduct more than 7.2 million examinations resulting in more than 2,400 seizures and more than 390,000 pounds of seized drugs and more than $4 million in U.S. currency.

Smugglers use varying and innovative tactics to conceal heroin. For example, on January 21, 2016, CBP officers at the Port of Nogales, in Arizona, discovered almost 29 pounds of heroin concealed within a hidden compartment of a privately owned vehicle. And, on July 18, 2015, CBP officers at the Port of Hidalgo, in Texas, seized 151 pounds of heroin concealed within the back wall of a commercial bus. While vehicles may be a popular conveyance for smuggling, DTOs also move heroin in smaller quantities to try to evade detection. Just recently, CBP officers working at the express consignment facility in Cincinnati intercepted a package manifested as "candy." The package, which contained a tub of chocolate icing, showed some irregularities during an x-ray examination. After conducting a physical inspection, CBP officers determined that smugglers had placed a sealed bag of approximately two and a half pounds of heroin in the chocolate. And, on March 12, 2016, CBP officers at the Orlando International Airport discovered six pounds of heroin concealed in the lining of a traveler's backpack.

OFO deploys 478 specialized detection canine teams throughout the nation, trained to detect drugs and concealed humans. The majority of the canine teams are concentrated in four field offices along the Southwest border. Canine operations are an invaluable component of CBP's counternarcotic operations at POEs. For example, on December 17, 2015, at the DeConcini POE, in Nogales, Arizona, a canine team conducting post-primary inspections resulted in the referral of a 31-year-old Phoenix woman for a further search of her Chrysler sedan. Officers then discovered nearly 44 pounds of heroin, valued at nearly $617,000, hidden within the rocker panels. During FY 2015, OFO canine teams were responsible for the seizure of 603,283 pounds of drugs, $34,991,253 in seized property, and $39,323,455 in currency.

Responding to the upsurge in heroin use across the Nation, and increased seizures at POEs, in October 2015, CBP completed Phase 1 of a pilot program to train and equip CBP officers with Naloxone, a potentially life-saving drug for the treatment of opioid overdoses. During Phase I, CBP officers, at seven participating POEs[5] received training in recognizing the signs and symptoms of an overdose, administering Naloxone, and were certified as CPR instructors. Over the next few months, CBP will initiate Phase 2 of the Naloxone Initiative Pilot Program, expanding the pilot to an additional eight POEs.[6] CBP was the first federal law enforcement agency to implement such a program.

---

[5] Phase 1 Naloxone Pilot Program POEs include El Paso; Laredo; Fort Lauderdale International Airport; John K. Kennedy International Airport; San Luis: San Ysidro; and Seattle/Blaine.

[6] Phase 2 Naloxone Pilot Program POEs include Miami Int'l/Miami Seaport; Boston; Buffalo; Detroit; Newark; Chicago; Houston Int'l/Houston Seaport; and Dallas.

Along the Southwest Border

Along the Southwest border, between the POEs, CBP has deployed capable resources to increase our situational awareness, identify changes in the border environment, and rapidly respond, as appropriate, to emerging threats and areas of increasing risk or illegal cross-border activity. The use of tactical infrastructure and advanced surveillance and detection technology in the border environment is an invaluable force multiplier to increase situational awareness.

For example, CBP's Tactical Aerostats and Re-locatable Towers program, originally part of the Department of Defense (DoD) Reuse program, uses a mix of aerostats, towers, and electro-optical/infra-red cameras, to provide U.S. Border Patrol (USBP) with increased situational awareness through an advanced surveillance capability over a wide area. This capability has proven to be a vital asset in increasing CBP's ability to detect, identify, classify, and track activity. As of December 2015, USBP agents seized 122 tons of narcotics with the assistance of existing aerostats and towers.

In addition to the hundreds of canine teams OFO deploys to the POEs, the USBP Canine Program deploys over 808 specialized detection canine teams — trained to detect narcotics and concealed humans — throughout the nation. The majority of the canine teams are concentrated in the nine Sectors along the Southwest border. During FY 2015 USBP canine teams were responsible for the seizure of 432,761 pounds of narcotics, $3,073,313 in currency, and 39,942 human apprehensions. Just last month, canine teams in the San Diego Sector aided in the detection and seizure of narcotics valued at more than $1.2 million, including 14.35 pounds of heroin valued at $172,200, on a single day.

Through the deployment of these complementary and effective resources, CBP gains more coverage and situational awareness of surveillance gaps, and increases its ability to adapt to changing conditions to effectively detect, identify, classify, track, and interdict potential threats along the borders.

From the Air and the Sea

CBP's Air and Marine Operations (AMO) is an essential component of a successful integrated strategy for border security, as well as a significant contributor to the national security and emergency response efforts of various Federal, state, tribal, and local agencies. AMO operates aerial and marine assets – including unmanned aircraft systems and strategic and tactical aerostats – providing critical surveillance coverage and domain awareness for counternarcotic efforts on the ground, in the air, and at sea. Nationally, AMO contributed to the seizure of 225 pounds of heroin in FY 2013; 724 pounds in FY 2014; and 627 pounds in FY 2015.

In the maritime domain, AMO employs high speed Coastal Interceptor Vessels that are specifically designed and engineered with the speed, maneuverability, integrity and endurance to intercept and engage a variety of suspect non-compliant vessels in offshore waters, as well as the Great Lakes on the Northern border.

AMO P-3 Orion Aircraft (P-3s) have also been an integral part of the successful counternarcotic missions operating in coordination with Joint Interagency Task Force South (JIATF-S). The P-3s patrol in a 42 million-square mile area known as the Source and Transit Zone, which includes

more than 41 nations, the Pacific Ocean, Gulf of Mexico, Caribbean Sea, and seaboard approaches to the United States. In Fiscal Year 2015, AMO's P-3 aircrews contributed to 198 seizure, disruption, or interdiction events in the transit zone, resulting in the interdiction of 213,000 pounds of cocaine.

In addition, DHS Science and Technology Directorate (S&T) is working with CBP to develop, test, and pilot new technology for securing and scanning cargo, improving surveillance of the Southwest border, and enhancing detection capabilities for radar-evading aircraft. S&T is also pursuing and fielding new technology to monitor storm drains, detect tunnels, track low-flying aircraft, monitor ports, and enhance current mobile/fixed radar and camera surveillance systems to increase border security. Recently, S&T-developed technology was put into operational use at the US-Mexican Border. These technologies included a new general aviation aircraft scanner in Laredo, TX, and a new Brownsville-Matamoros Rail Non-Intrusive Inspection Microwave Data Transmission System.

Intelligence and Information Sharing

Criminal intelligence sharing is a key component of countering drug-trafficking along the Southwest and Northern borders at and in between the POEs. CBP contributes to several initiatives to improve the combined intelligence capabilities of Federal, state, local, tribal, and international partners.

CBP hosts monthly briefings/teleconferences with Federal, state and local partners regarding the current state of the border – the Northern border and Southwest border – in order to monitor emerging trends and threats and provide a cross-component, multi-agency venue for discussing trends and threats. The monthly briefings focus on drugs, weapons, and currency interdictions and alien apprehensions both at and between the POEs. These briefings/teleconferences currently include participants from: the Government of Canada; the Government of Mexico; JTF-W; U.S. Immigration and Customs Enforcement (ICE); U.S. Coast Guard (USCG); Drug Enforcement Administration (DEA); Federal Bureau of Investigation (FBI); U.S. Northern Command; Joint Interagency Task Force-South; Bureau of Alcohol, Tobacco, Firearms, and Explosives (ATF);; U.S. Attorneys' Offices; Naval Investigative Command; State and Major Urban Area Fusion Centers; and other international, Federal, state, and local law enforcement as appropriate.

Substantive and timely information sharing is critical in targeting and interdicting individuals that move drugs and illicit merchandise from the POEs to their destinations throughout the United States and Mexico. CBP contributes to the whole-of-government effort to combat drug-related threats by sharing critical information on travelers and cargo with investigative and intelligence partner agencies to identify and disrupt sophisticated routes and networks. Recognizing the need for open and sustainable channels to share information with our law enforcement and intelligence partners, CBP co-locates interagency personnel at its National Targeting Center (NTC) to support efforts to combat drug and contraband smuggling by integrating real-time tactical intelligence into CBP targeting efforts and enforcement actions. This whole-of-government counter network approach has resulted in TCOs being identified and dismantled, and their smuggling routes shut down. An example of this successful collaboration can be seen in the aggressive targeting of heroin transiting, or destined for, the United States. In FY 2015, CBP efforts at the NTC, in conjunction with increased cooperation from foreign and domestic law enforcement partners, resulted in 40 seizures of heroin and several arrests.

Physical evidence gathering and forensic analysis is also valuable to the information sharing effort. Improved technology and enhanced capabilities have also expanded the collection, analysis, and dissemination of information between law enforcement partners working to dismantle DTO networks. For example, CBP's Laboratories and Scientific Services Directorate (LSSD) uses advanced techniques to provide qualitative identification and quantitative determination as well as pollen analysis of heroin, cocaine, marijuana, and methamphetamine to assist with identifying potential drug smuggling routes. In November 2014, CBP launched a new program that involves the close collaboration of CBP chemists in the laboratories and CBP officers on the frontlines. The purpose of the program is to rapidly identify questionable materials through presumptive chemical testing, while simultaneously allowing for the quick release of non-offending, detained importations. The key to the success of the program is the rapid turnaround time of presumptive chemical testing of questionable materials. Through the end of 2015, over 7,300 items were examined. During this period, ICE's Homeland Security Investigations (ICE-HSI) executed a significant number of controlled deliveries based on CBP's presumptive findings. The most noteworthy takedown resulted in the seizure of $2.5 million in cash, tens of millions of dollars in assets, and 14 indictments.

CBP exchanges information with our partners within the Government of Mexico. This information sharing, facilitated by the CBP Attaché office in Mexico, has allowed for an unprecedented exchange of real-time information through deployments of personnel between our countries. Today, Mexican Federal Police personnel sit with our personnel in Tucson, Arizona, and Laredo, Texas, where they assist us with targeting criminal activity through the sharing of Mexican criminal history database information. Likewise, CBP personnel are assigned to Mexico City under the Joint Security Program where we exchange alerts on suspicious TCO movements through the monitoring of our Advance Passenger Information System. This information sharing has also led to numerous seizures and cases within Mexico that serve to disrupt the activities of TCOs throughout the Western Hemisphere.

Enhancing counternarcotic operations in the air and maritime environments, AMO's Air and Marine Operations Center (AMOC), a state-of-the-art law enforcement radar surveillance center, integrates data from multiple sensor sources to provide real-time information on suspect targets to responders at the Federal, state, and local levels. AMOC's capabilities are enhanced by the continued integration of DHS and other Federal and Mexican personnel to increase efforts to identify, interdict, and investigate suspected drug trafficking in the air and maritime domains.

Operational Coordination

A whole-of-government approach that leverages interagency and international partnerships as a force multiplier has been and will continue to be the most effective way to keep our border secure.

Providing critical capabilities toward the whole-of-government approach, CBP works extensively with our Federal, state, local, tribal, and international partners to address drug trafficking and other transnational threats at POEs and along the Southwest border, Northern border, and coastal approaches. Our security efforts are enhanced through special joint operations and task forces conducted under the auspices of multi-agency enforcement teams. These teams are composed of representatives from international and U.S. Federal law enforcement agencies who work together

with state, local, and tribal agencies to target drug and transnational criminal activity, including investigations involving national security and organized crime.

Under the Secretary's Unity of Effort initiative and with the three new DHS JTFs, CBP is enhancing our collaboration with other DHS components – specifically ICE and USCG – to leverage the unique resources, authorities, and capabilities of each agency to more effectively and efficiently execute our border security missions against TCOs, drug-trafficking and other threats and challenges. JTF operations also increase information sharing with Federal, state and local law enforcement agencies, improve border-wide criminal intelligence-led interdiction operations, and address transnational threats.

For example, the JTF-W's integrated intelligence, interdiction, and investigation efforts in the South Texas Corridor recently led to coordinated enforcement actions against a TCO, significantly disrupting the organization's ability to smuggle their commodity. Under Operation Fusion One-Five, multiple members of the Brewster Criminal Organization, to include the leader of the organization, were targeted and arrested. This investigation resulted in an additional 22 criminal arrests, the apprehension of 497 undocumented aliens, and the seizure of various types of narcotics. On August 10, 2015, members of the Brewster Organization appeared in federal court and received a cumulative sentence of 12.5 years for their roles in human smuggling. This was an HSI-led investigation with support from CBP assets.

CBP is a critical partner in the ICE-led Border Enforcement Security Task Forces (BESTs), which are composed of Federal, state, local, and international law enforcement and intelligence stakeholders working together to counter TCOs and enhance border security. BESTs currently operate in 38 locations, including 14 along the Southwest border. In FY 2015, BESTs made more than 3,700 criminal arrests and 960 apprehensions for immigration violations; seized more than 276,000 pounds of drugs, 800 weapons, and $29 million in currency and monetary instruments; and federal prosecutors obtained more than 2,300 indictments and 1,800 convictions in BEST-investigated cases.

Other investigative agencies such as ICE-HSI, DEA, and FBI utilize AMO specific skills for air and marine relevant investigations to help identify and dismantle the organized flow of narcotics and TCOs. This leads to significant intelligence and seizures, and the critical information gained is often crucial to identifying TCO suspects, associates, and accomplices. The threat in the air and maritime domains requires specialized skills and tactics tailored to the specifics of each of those environments. In the maritime domain, AMO personnel routinely augment vessel crews from investigative partner agencies when air and marine investigative skills and technical expertise are needed for investigation or operation of these maritime assets.

Because DTOs are also known to use legitimate commercial modes of travel and transport to smuggle drugs and other illicit goods, CBP partners with the private sector to increase awareness and enforcement of international and domestic drug smuggling activities. In the air domain, AMO detects, identifies, investigates, and interdicts potential air threats to the United States, including general aviation (GA) aircraft involved in the aerial transit of contraband. The AMOC monitors complex airway traffic to identify illicit use of aircraft and those attempting to blend in with legitimate traffic. AMO, through its national SKY PRO initiative and in collaboration with ICE-HSI, the Federal Aviation Administration, and state, local, and tribal law enforcement agencies,

works to enhance law enforcement interactions with the GA community to increase awareness and intelligence on international and domestic smuggling activities. CBP also partners with the private sector to provide anti-drug smuggling training to air, sea, and land commercial transport companies (carriers) to assist CBP with stopping the flow of illicit drugs; to deter smugglers from using commercial carriers to smuggle drugs; and to provide carriers with the incentive to improve their security and their drug smuggling awareness. Participating carriers sign agreements stating that the carrier will exercise the highest degree of care and diligence in securing their facilities and conveyances, while CBP agrees to conduct site surveys, make recommendations, and provide training.

Heroin trafficking is a global problem, and CBP continues to work with our international partners to share information and leverage resources to combat this threat. Through the 21st Century Border Management Initiative, the U.S. Government and Government of Mexico (GOM) are working to strengthen our collaborative relationship and efforts to secure and facilitate the cross-border flows of people and cargo. CBP also has Border Patrol International Liaison Units (ILU) who facilitate cooperation between U.S. and Mexican law enforcement authorities as part of a multi-layered effort to target, disrupt, and dismantle criminal organizations. During FY 2015, USBP and GOM conducted multiple joint bi-national operations targeting TCOs. During these operations, and as a direct result of intelligence sharing with GOM, USBP and GOM were able to locate more than 30 illicit tunnels, and seize approximately 80,000 pounds of drugs.

AMOC's coordinating efforts with the GOM and the deployment of shared surveillance technology has enabled the GOM to focus aviation and maritime enforcement efforts to better combat TCO operations in Northern Mexico and the contiguous U.S./Mexico border. For example, in January 2015, officers working at the AMOC detected a suspicious aircraft travelling north towards the United States. AMOC subsequently alerted GOM of the activity, and both the Mexican Federal Police and Air Force responded to investigate. The abandoned aircraft was located by Mexican officials a short time later, where 27 bags containing approximately 858 pounds methamphetamine, 174 pounds of cocaine, 174 pounds of white heroin, and 3.3 pounds of black tar heroin were discovered and seized. Also, AMO actively participates in Operation Martillo, an international counter illicit trafficking initiative whereby U.S. and regional partner nations' military and law enforcement agencies patrol the air and sea environments in the Caribbean Sea, Gulf of Mexico and the Eastern Pacific on a year-round basis.

CBP's Office of International Affairs (INA) Technical Assistance Division (INA/ITAD) conducts International Border Interdiction training, funded by Department of State, for various countries worldwide. These courses provide instruction on multiple aspects of border security, including targeting and risk management, interdiction, smuggling, search methodologies, analysis, canine enforcement, and narcotics detection identification. Within the last six months, INA/ITAD has conducted anti-smuggling training in heroin and opiate source countries such as Panama, Guatemala, Columbia, Ecuador, Peru, Mexico, Indonesia, India, Thailand, Afghanistan, Kenya, Cambodia, and Philippines.

Lastly, it is important to acknowledge the significant strides that Mexico has taken in recent years to address transnational organized crime generally, and drugs smuggling specifically. Overall, CBP's relationship with its Mexican counterparts is stronger today than it has ever been. We receive information from Mexican authorities on a daily basis that helps us better target drugs

smugglers at the border. Last October, I participated in a high level bilateral and interagency security cooperation meeting in Mexico City, where senior Mexican officials committed to working with the U.S. Government even more closely—including expanding efforts to combat heroin cultivation, production, and trafficking, and sharing more information on smuggling routes and networks, and crafting a binational action plan specifically focused on heroin smuggling. CBP will continue to work closely with our Mexican counterparts as we seek to identify, interdict, and take down the cartels.

Conclusion

CBP, through collaboration and coordination with our many Federal, state, local, tribal, international government, and other partners, has made great strides with regard to the integrity and security of our borders.

With continued support from Congress, CBP, in coordination with our partners, will continue to refine and further enhance the effectiveness of our detection and interdiction capabilities to combat transnational threats and the entry of heroin into the United States. We will continue to work with the Intelligence Community and our law enforcement partners to improve the efficiency of information sharing with relevant partners, to guide strategies, identify trafficking patterns and trends, develop tactics, and execute operations to address the challenges and threats posed by TCOs to the safety and security of the American public.

Chairman Johnson, Ranking Member Carper, and distinguished Members of the Committee, thank you for the opportunity to testify today. I look forward to your questions.

JON ERPENBACH

STATE SENATOR

April 15, 2016

Testimony before the United States Senate Committee on Homeland Security and Governmental Affairs

BORDER SECURITY AND AMERICA'S HEROIN EPIDEMIC: THE IMPACT OF THE TRAFFICKING AND ABUSE OF HEROIN AND PRESCRIPTION OPIOIDS IN WISCONSIN

Chairman Johnson, Senator Baldwin, Fellow Speakers and Guests:

Thank you for allowing me the opportunity to speak with you today regarding an epidemic that is devastating our Wisconsin communities and the nation at large.

The problem is well-documented. According to the Wisconsin Department of Health Services Division of Mental Health and Substance Abuse Services, the proportion of drug deaths where heroin is mentioned has drastically increased from 5% in 2006 to 33% in 2014. And according to the Centers for Disease Control, there has been a 200% increase in opioid drug overdoses nationally since the year 2000.

The solution must be comprehensive. If we are to be successful, the State of Wisconsin and the federal government need to be partners in the fight. We have made great strides with the introduction and passage of the HOPE package. Representative Nygren and the people he worked with to develop HOPE, are to be commended for all of their hard work. We can't stop there, there is more to be done.

I am proud to represent Sauk County, Wisconsin. Sauk County has a growing population of about 60,000 residents. It is heavily impacted by the tourism industry, followed closely by trade and manufacturing. Its unemployment rate is about 5%. In 2010, law enforcement and the medical community started noticing a growing problem. There were 20 heroin and opiate deaths in a 2 year period. Ambulance companies and first responders reported over 80 uses of Narcan, an opiate antidote used during suspected ineidents of overdose, in that same period.

Law enforcement, the medical and legal community and local businesses joined together to address what they saw as a community crisis. They had the foresight to recognize that this problem couldn't be solved by law enforcement alone. They knew they needed a more comprehensive approach. They developed the CARE program.

CARE, or Community Activated Recovery Enhancement is an integrated system putting each individual at the center of their treatment, which empowers the individual to make better life choices. CARE recognizes that addiction can be treated and overcome using an integrated multi-

disciplinary approach that requires medical treatment, mental health services, social services, and healthy support systems. It is a program that recognizes addiction is a disease that not only negatively affects the individual struggling with the condition, but also significantly impacts family, friends, and the community.

CARE is a collaboration that is made up of many public and private entities including: St. Vincent DePaul – Sauk Prairie/Robury, Sauk Prairie Police, Sauk Prairie Healthcare, Prairie Clinic, Ho-Chunk House of Wellness, Sauk County Department of Health and Human Services, Sauk Prairie EMS, Sauk Prairie School District, Sauk County UW-Extension, Sauk County District Attorney's Office, Sauk County Public Defender's Office, Sauk County Probation and Parole, and private business owners.

The program began in Sauk Prairie, it worked-and people noticed. The program served 87 people. Soon, the state of Wisconsin and the CARE project received a grant totaling $3 million over three years from the Substance Abuse and Mental Health Services Administration. The grant funding allowed them to expand the program county-wide and it is now serving an additional 20 participants and more interested individuals call each day.

An important piece of the CARE program is Vivitrol, a drug that is injected monthly and blocks the receptors in the brain responsible for an opiate high. It helps to stem the body's biological need to use opiates. In short, it makes it nearly impossible for a user to get high. Thanks to St. Vincent DePaul, Vivitrol was made available to inmates in the Sauk County Jail. Those who agree to the CARE program and the use of Vivitrol, must commit to a year of monthly injections and counseling.

In 2013, Dr. John McAuliffe, a family practice doctor at the Prairie Clinic, was the first and only doctor who participated in the Vivitrol protocol for inmates in the Sauk County Jail. Through his leadership there are now 7 doctors who have joined the cause.

Vivitrol is expensive. The average cost of the monthly shot is $1200. St. Vincent DePaul was the first to step up in Sauk Prairie to cover the cost of the drug for inmates who agreed to the program but could not afford it. The grant money will help offset the cost for others. It is here where we begin to see where the state and federal government can step in, where we can do better, where we can go further in the fight against opiates.

While enrolling inmates in the CARE program, Sauk County realized that Medicaid-eligible inmates leaving jail were experiencing a gap in coverage, jeopardizing their ability to continue to receive the expensive Vivitrol injections. **Wisconsin is a state that chooses to terminate, rather than suspend Medicaid coverage for those that are incareerated. That needs to change.**

According to the National Conference of State Legislatures, at least 18 states currently suspend rather than terminate Medicaid coverage for people who are incarcerated. The suspension approach yields administrative savings related to the reapplication and eligibility determination process, which can take as long as 45 to 90 days. This period of time is absolutely critical to the people in the CARE program receiving Vivitrol injections. Suspension instead of termination

would allow for the continuity of care, and a better chance at a successful community re-entry. There are several organizations, including Community Advocates Public Policy Institute, that are leading the advocacy efforts for this Medicaid policy change in Wisconsin.

The Wisconsin Department of Health Services has, to its credit, developed a health coverage enrollment assistance program for inmates upon their release, and that is very important. However, the eligibility determination process can be complicated, and can take a long time. A simple policy change could give these offenders a better chance to stay sober, and a better chance at a successful life post-incarceration.

In choosing to terminate Medicaid instead of suspend it, Wisconsin also loses out on federal grant money that is available. We need more funding to combat our opiate problem, and should not turn our backs on any pot of money that is available to us.

I would be remiss if I did not also take this opportunity to advocate for Wisconsin to take the federal Medicaid Expansion dollars that are available to it. Our Legislative Fiscal Bureau estimates that Wisconsin is losing out on $320 million over the biennium to help more individuals, many of whom are offenders seeking successful re-entry into our communities, pay for health insurance. 13.4% of people in Wisconsin that qualify for Medicaid under the expansion have substance use disorders.

People who are earning minimum wage make too much money to qualify for Medicaid in Wisconsin. These people are then forced into a Federal Marketplace that was never intended for people of their income level. It is just plain wrong to see our tax dollars going to give people in other states the health insurance that people in Wisconsin deserve and paid for.

There are 30 people in Sauk County who have successfully completed the CARE program and have re-integrated into the community. When those folks went and got jobs and changed over to employer-sponsored health insurance, a notable success by many standards, they encountered yet another problem. Private health insurance has required that a person first have a "FAIL" on the pill form of the "opiate-high blocker" before they will cover the injectable Vivitrol. This too, is absolutely ridiculous. To require that someone "FAIL" in their recovery before covering a drug that has kept them sober is just plain wrong. **Another place that we can make a difference is by discouraging this fail-first practice of the insurance industry.**

A key part of the success of the Sauk County CARE program was the fact that law enforcement professionals like Sauk Prairie Police Chief Jerry Strunz recognized that the heroin epidemic was a community issue. We must engage our criminal justice partners in the fight. Chief Strunz is an advocate for law enforcement education programs that help officers on the street recognize addiction as a disease and help them look at the issue through a different lens. **Wisconsin should adopt statewide training standards for law enforcement officers on how to deal with people they encounter that are struggling with addiction.**

Chief Strunz also gives his officers a card they are able to hand out to anyone on the street that they feel might benefit from the services of the federal grant program. It lists a phone number that people can call and talk to a live person 24 hours a day about getting help.

And, in 2016, Sauk County started a Drug Court. Since January they have had 7 participants. The Drug Court team is reviewing applications on a weekly basis. Their goal in the first year is to provide services to 30 people. Drug courts, and others like them, work to provide services to the individuals involved and get them the help they need while still holding them accountable for any criminal actions they might have engaged in. There are currently over 70 drug courts in Wisconsin. **Expanding treatment courts is a very cost-effective way to address the burden drug addiction is putting on our criminal justice system.**

I am proud to represent Sauk County and I firmly believe that the CARE program could serve as a model of success for Medication Assisted Treatment around the state and the nation.

Wisconsin also faces a critical shortage of treatment professionals. Nationally, nearly one in four substance abuse clinicians chooses to leave the job each year, with burn-out and low pay cited most frequently as the reason they choose a new career. **While the Affordable Care Act went a long way toward increasing access to mental health and substance abuse treatment services, we need to find a way to encourage more people to enter the field so those people get the help they need, not put on a waiting list for services.**

Pew Charitable Trusts reports that "Of the estimated 18 million adults potentially eligible for Medicaid in all 50 states, at least 2.5 million have substance use disorders. Of the 19 million uninsured adults with slightly higher incomes who are eligible for subsidized exchange insurance, an estimated 2.8 million struggle with substance abuse, according to the most recent national survey by the U.S. Substance Abuse and Mental Health Services Administration."

Research conducted by Jeff Zornitsky of the Advocates for Human Potential using 2010 data from the Department of Labor Statistics and Substance Abuse and Mental Health Services Administration indicates that in Wisconsin there are 30 treatment professionals per 1,000 non-elderly adults with a drug or alcohol addiction. That is just below the national average. Nevada is the worst with 11 and Vermont is the best with 70.

We have to find a way to eliminate waiting lists for treatment, encourage mental health and substance abuse professionals to practice in underserved areas, encourage more people to do this important work, and address the reasons that so many people are leaving the field. These shortages have created treatment bottlenecks, especially in rural areas.

At the federal level, support and passage of legislation like the Opioid and Heroin Epidemic Emergency Supplemental Appropriations Act (S. 2423 and H.R. 4447), co-sponsored by Senator Baldwin, will make great strides in assisting the efforts that Wisconsin is currently undertaking to battle its heroin and prescription drug abuse problems. It would help fund the community policing efforts like the ones that Chief Strunz supports, provide support for the Medication Assisted Treatment programs like the CARE program, and help pay for the improvements we've made to our Prescription Drug Monitoring Program through the HOPE legislation.

Mr. Chairman, in order to confront this horrible epidemic head on, in order to begin to win this fight, we must break down barriers. We must change the way we look at addiction and treat it as a disease instead of a choice that people make. We must eliminate the hurdles placed in the way of those who seek treatment. We must more appropriately value our treatment professionals and the important work they do every day. We need to adequately fund the people on the front lines of the crisis. We need to take a community approach to the problem, to work together toward a shared goal- stemming the tide of the opiate epidemic.

Thank you again for the opportunity to be here today.

John Nygren
WISCONSIN STATE REPRESENTATIVE ★ 89TH ASSEMBLY DISTRICT
Co-Chair, Joint Committee on Finance

Wisconsin's Heroin and Opioid Epidemic
State Rep. John Nygren
Friday, April 15, 2016

Thank you Senator Johnson and the members of the Committee on Homeland Security and Governmental Affairs for holding a hearing on the impact of trafficking and abuse of heroin and prescription opioids in Wisconsin.

Our country is currently facing a prescription opioid and heroin epidemic. This problem knows no boundaries; all demographics of people are affected in one way or another, no matter their income level, race, or how urban or rural their communities are. Many of us know too well that Wisconsin is no exception to this epidemic. It is for this reason that I am proud of the legislative steps my colleagues and I have taken over the past three years to combat this devastating problem in our state.

In 2013, we began what has become the foundation of Wisconsin's Heroin, Opioid Prevention and Education (HOPE) Agenda. This foundation was laid with seven bills that aimed to fight heroin use and addiction in our state. We expanded access to drug treatment opportunities, made opioid antagonists like Narcan more readily available to first responders, and enacted a Good Samaritan law. However, after the 2013-14 legislative session ended, it was clear that there was much more work to be done to combat Wisconsin's heroin and opioid epidemic.

As the 2015-16 session began, we continued our work to build upon the HOPE Agenda. Instead of specifically targeting the devastating effects of heroin, we took the opportunity to focus on what many believe is the root of Wisconsin's heroin epidemic: prescription opioid misuse, abuse, and addiction. Studies show that, in many cases, heroin addiction begins with an addiction to prescription painkillers. Whether these medications are obtained legally or not, we need to do our best to curtail the illegal use of these dangerous substances.

As a continuation of the HOPE Agenda this session, we have passed ten additional bills – nine of which have already been signed into law by Governor Walker. These bills continue to expand access to opioid antagonists to reduce instances of overdose deaths, further expand access to Treatment and Diversion (TAD) programs so people addicted to opioids can get the help they need in lieu of incarceration, and expand the use of Wisconsin's Prescription Drug Monitoring Program (PDMP) so instances of overprescribing become less common. It is our hope that these important pieces of legislation will help reduce the number of people who become addicted to legal prescription opioids and, in turn, reduce the number of people who eventually make the switch to heroin and other dangerous illegal substances.

There are 17 HOPE Agenda bills total, and all 17 of them were approved unanimously by both Houses of the Wisconsin State Legislature. Governor Walker has signed 16 of the proposals into law, and we expect him to sign the final HOPE Agenda bill into law in the near future. It's important to note that this is not a Republican or a Democrat issue, but rather a public health and safety issue. I am proud that there has been such widespread support of these pieces of legislation from people around the state

Capitol: P.O. Box 8953 • Madison, Wisconsin 53708-8953 • (608) 266-2343 • Toll-Free: (888) 534-0089 • Fax: (608) 282-3689
Rep.Nygren@legis.wi.gov

John Nygren
WISCONSIN STATE REPRESENTATIVE ★ 89TH ASSEMBLY DISTRICT
Co-Chair, Joint Committee on Finance

including the medical community, law enforcement, my colleagues in the legislature, the governor, the attorney general, and countless addiction advocates.

As I mentioned before, the heroin and opioid epidemic knows no boundaries, and now is the time to start combatting this devastating problem. I am proud that Wisconsin is leading the way with efforts like the HOPE Agenda, and I'm confident that other states will be able to look to us for guidance on what can be done nationwide. The laws that make up the HOPE Agenda are not the silver bullet that will solve this epidemic, but each proposal is an important step in the right direction. With that said, I look forward to continuing our work to further build upon the HOPE Agenda in the future.

I appreciate the opportunity to testify before your committee today on the HOPE Agenda and the state of Wisconsin's heroin and opioid epidemic. Please don't hesitate to contact me with any comments, questions, or concerns.

Capitol: P.O. Box 8953 ★ Madison, Wisconsin 53708-8953 ★ (608) 266-2343 ★ Toll-Free: (888) 534-0089 ★ Fax: (608) 282-3689
Rep.Nygren@legis.wi.gov

EXAMINING THE IMPACT OF THE OPIOID EPIDEMIC IN OHIO

FRIDAY, APRIL 22, 2016

U.S. SENATE,
COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
Cleveland, OH.

The Committee met at 10:13 a.m. in the Ruhlman Conference Center, University Hospitals of Cleveland, 11100 Euclid Avenue, Cleveland, Ohio. Senator Rob Portman presiding.

OPENING STATEMENT OF DR. SIMON, PRESIDENT OF UNIVERSITY HOSPITALS CASE MEDICAL CENTER

Dr. SIMON. Good morning. My name is Dr. Dan Simon. I am the president of University Hospitals (UH) Case Medical Center. Welcome to Ohio and to the flagship hospital of the University Hospitals system.

On behalf of our Chief Executive Officer (CEO) Tom Zenty, our senior leaders, our 26,000 doctors, nurses and employees and the community we serve, we are honored to host this important hearing.

We are grateful to the U.S. Senate Committee on Homeland Security and Governmental Affairs (HSGAC) for confronting the opioid crisis.

I would like to thank Chairman Johnson and Ranking Member Carper for their leadership on the Committee and their staffs for being here this morning.

I would also like to thank our fine Ohio Senators Sherrod Brown and Rob Portman for honorably representing Ohioans in Washington.

We were privileged to host Senator Portman for a round table event last January to discuss his legislation, the Comprehensive Addiction and Recovery Act (CARA). We are pleased that it passed the Senate and hope for speedy consideration in the House.

Thank you for your strong leadership on a very complicated issue.

Now I would like to turn things over to Senator Portman.

OPENING STATEMENT OF SENATOR PORTMAN[1]

Senator PORTMAN. Dan, thank you very much. I appreciate that. And, I am now going to officially call this hearing to order.

[1] The prepared statement of Senator Portman appears in the Appendix on page 139.

I appreciate everybody being here. This is a distinguished group of Cleveland area citizens and a really distinguished panel, two panels, in fact. We look forward to hearing from them in a moment.

This is a critical hearing, because it is an opportunity to draw attention to an issue that all of us face in the State and in our country, which is this epidemic of opioid addiction and overdose prescription drugs and heroin.

It has devastated communities here in Ohio. It has torn families apart. But, this is happening all over the country.

And, as we will talk about in a moment, the fact that our legislation called the Comprehensive Addiction and Recovery Act passed with a 94 to 1 vote in the United States Senate, which never happens, which is evidence of that. I do look forward to the expert testimony we are going to receive today.

And, Dan is right, I was here in this very room in a round table discussion where I learned about some of the expertise that resides right here at University Hospital and also at our other great medical institutions in town. And so, we thought this would be an appropriate place to hold this hearing.

It also happens to be a beautiful room for a hearing. You may find many Congressional hearings now coming to this room. [Laughter.]

The staff is here from the offices of Chairman and Ranking Member and they are equally impressed. So, I think they may want to come back, if you will offer it for free. [Laughter.]

I want to thank Sherrod for being here. Senator Brown and I have worked on this issue together, as we have on so many other issues for the good of Ohio.

And, this is one that crosses every line. There is no zip code that is immune from it. It also crosses every party line.

We have really tried with the CARA legislation over the last 3 years, as we developed it, to make it not just bipartisan, but nonpartisan. It is not caring where the ideas come from, but if they are good ideas, to try to promote them.

And, it is urgent. Every day we lose 120 Americans to drug overdoses. Think about that. 120 people lost every day. The rate of overdose over the last 14 years has doubled, leaving about a half a million Americans dead from overdoses.

And, the tragedy of a death from overdose, as terrible as it is, tells only part of the story. And, many people in this room are working on this issue every day and understand what that means.

But, it is about the families being torn apart. It is about that drug being more important than anything, whether it is family, work or faith. It is about communities being impacted dramatically.

When I talk to prosecutors in Ohio, they think by far most of the crime in their communities are connected directly to this issue. It is about individuals getting off track and not being able to pursue their God given purpose in life.

So, it is horrible that people are dying from drug overdoses. But, sometimes I think we forget this broader issue that is affecting everybody.

It is hitting us especially hard here in Ohio unfortunately. We are probably they say one of the top five States in the country, maybe the top State now, in fentanyl, at least heroin overdoses.

So, it is something that is appropriate for a hearing, to raise the visibility of it, and you get extra testimony.

I do not think it is getting better. And, we will hear from witnesses today about this. But, there is a troubling report this last week about a survey that was taken. It is called the Ohio Issues Poll. In 2014, they reported that two out of every 10 Ohioans knew someone who was abusing prescription drugs. In the latest poll, it is 3 out of 10. And, out of those 3 out of 10, 4 in 10 know someone who had overdosed.

Sherrod and I were talking earlier at a town hall meeting. I asked how many people have been affected, friends or family, and half the hands in the room go up. And, people look around, and they cannot believe it. They cannot believe that others are experiencing it, too.

Because there is not enough discussion about it. There is too much stigma attached to addiction. And, it is a disease. And, it is treatable. And, one of the problems in getting people into treatment is to break down that stigma, which I think is part of the reason this hearing is important.

By the way, about 5 of those 120 persons dying every day are dying in Ohio.

As Sherrod talked about earlier, drug overdoses have killed more Ohioans than car accidents, actually every year in Ohio since 2007. Overdose deaths have tripled from 99 to 2010.

We were told that 200,000 Ohioans now are addicted to opioids. 200,000. That is roughly the size of the city of Akron. We do have 20,000 overdoses a year. Several thousands will probably lose their lives again this year.

So, I do not think it is slowing down. I do not think we have any time to waste.

The U.S. Senate response has been this Comprehensive Addiction and Recovery Act—again it passed by an overwhelming vote. I think it is a critical step in the right direction. It was not just 3 years in the making. We had five conferences in Washington.

A number of the experts you will hear from today actually came and testified or talked to us on this legislation. I want to thank them for that.

Local Ohio happens to have a lot of smart people who are experts in this area. We also just have a big problem here in our State.

We made it bicameral from the start. So, it was not just not partisan, it was the House and the Senate working together. We actually introduced identical legislation.

And, the House bill, the CARA legislation in the House, has 120 plus cosponsors. So, the one reason that we believe that the House can act quickly is because they have been working with us for 3 years. We did not just take Senate ideas. We took House and Senate ideas and more importantly ideas from experts around the country. And, they do have over 120 cosponsors.

So, we are urging them to simply pass that legislation, get it to the president who will sign it and get it to our communities where it will begin to help immediately.

Are there other things we should do? Of course. And, we will hear some about that today. And, should they pass additional legislation? Of course. Should there be more funding? Of course.

All of these things can and should happen. But meanwhile, let us get this specific response, it has passed the Senate, through to our communities.

The House did move on some small bills earlier this week, and I applaud them for that.

By the way, 3 of the 12 bills are identical to CARA, language identical that is in the CARA legislation. So, again, we can work with the House on additional ideas. Well, let us pass CARA now.

Cleveland is one of the regions in Ohio that has been hard hit. The statistics are heartbreaking, and they are a call to action for all of us.

There is some city council members here. The city medical director is here. There are members of the Cuyahoga County Task Force who are here. You all have been in the middle of this.

But, as some of you know very well, from March 10, the day that the Senate passed CARA, March 10, until March 27, 29 people died of overdoses. That is one 17 day period in one city. One long weekend, 12 people died, fentanyl-laced heroin. And, we will hear some about that later today.

Attorney General (AG) DeWine has been involved in this issue as well with regard to fentanyl. And, I know the Drug Enforcement Administration (DEA) is here with us today. We appreciate you all being here. We have other law enforcement folks from the High Intensity Drug Trafficking Area (HIDTA) folks. And, we had a hearing on fentanyl this week in Washington. It is one of those issues that has unfortunately really hit Cleveland hard.

By the way, of the 12 people who died, they ranged in age from 21 years old to 64 years old, white, African-American, rich, poor. This knows no boundaries and certainly no zip code. As we talked about, it is not just a Cleveland inner-city problem. This is a problem in our suburbs and our rural areas. In fact, per capita use in the rural areas may be greater.

Fentanyl, again it is 100 times more potent than heroin. And, depending on the dose of fentanyl and how it is produced—it is a synthetic drug.

We had five people die in Cleveland from fentanyl in 2013. A 700 percent increase in 2014. More than doubled the next year. This year, probably doubling again.

So, we are just on a steep climb. I am looking at the medical director who has to deal with this every single day.

Last month, as some of you know, in Fairview Park, not far from here, you had a man overdose at McDonald's. And, it was of course immediately online and went viral.

Luckily, someone was there administering Narcan to save his life. But, there were kids there. And, this is increasingly happening in public places and in broad daylight.

We have learned a lot here in Cleveland over the last few years, again speaking with advocates, doctors, patients. I have had an opportunity to tour Rainbow Babies and Children's Hospital here and see the incredible work that doctors and nurses are doing. What compassion they have for these kids who are born with addiction.

750 percent increase in babies born with addiction in the last 12 years in our State. Whether it is at St. Rita's Hospital in Lima or

whether it has been nationwide or Cincinnati Children's Hospital, it is the same story.

And, we will hear about that today from some real experts, talking about how we can ensure that this Neonatal Abstinence Syndrome (NAS) can be addressed both in terms of prevention, education, but also with effective treatment.

Effectively these nurses and doctors take these babies, of course, through a withdrawal process. And, the long term consequences to these children we will hear more about today, but it is very difficult to know. It is such a new phenomenon. And, of course, that concerns all of us.

So, I think Cleveland has a lot to teach the country about how serious this threat is, as well as effective prevention and treatment ideas. And, that is why this hearing is important.

Again, there is a lot to do in addition to the Comprehensive Addiction and Recovery Act. And, we should continue to listen to the experts as we develop our ideas, because this issue is just too important not to.

I do think today we will hear from some really important testimony from some really compassionate and gifted people who work here in this facility and experts in the field. I look forward to hearing from them.

We also have a statement that I want to enter into the record from Senator Johnson, who is the chair of this Committee,[1] from Senator Ayotte,[2] and also testimony that has been submitted by Dr. Jason Jerry, who is with us this morning from the Cleveland Clinic.

Where are you, Doctor? There he is.

Thank you and thank you for the Clinic for being here.

I also want to thank the staff from Senator Johnson and Senator Carper. Senator Carper is the ranking Democrat on the Committee—his staff is here as well—for helping not just put this together, but also for being here and helping us substantively to pull information out of this hearing to use it for legislation.

And, again, I want to thank Senator Brown for his participation in this hearing today and for his passion for this issue. He has been involved all over the State and had hearings all over the State or round table discussions all over the State.

And, again, it is an issue that, as he will talk about, affects our entire State. And, therefore, we have to work together to solve it.

Now, I will turn it over to Senator Brown for his opening statement.

OPENING STATEMENT OF SENATOR BROWN[3]

Senator BROWN. Thank you, Rob. Thank you, Senator Portman. Thank you to UH, Dr. Simon, and all of you.

It took Rob Portman coming to my home town to get to do something in this room. I have never been in this room. [Laughter.]

I have been to UH like 25 times, including visiting family members——

Senator PORTMAN. They never let you in.

---

[1] The prepared statement of Senator Johnson appears in the Appendix on page 145.
[2] The prepared statement of Senator Ayotte appears in the Appendix on page 146.
[3] The prepared statement of Senator Brown appears in the Appendix on page 142.

Senator BROWN [continuing]. Doing hearings and doing discussions and past conferences. But, it took the other guy to come in town to get the use of this room. So, thank you, I appreciate that.

And, I thank Senator Portman to allow me to be at this hearing. Because I do not sit on this Committee in Washington. And so, I am kind of an honorary member or something today sitting in. So, thank you for that.

And, to Senators Carper and Johnson and their staffs, thank you for arranging this, for the room and the witnesses, and the second panel especially too.

Rob talked about this upcoming a couple of times. And, if you look out this window, you will see zip codes that have some of the highest infant mortality rates in the country, and certainly in the State and maybe in the country.

You will see some of the highest foreclosure rates in the country. The zip code my wife and I live in, 44105, south of Slavic Village, had more foreclosures than any zip code in the United States of America in 2007.

So, this is a public health crisis—opioid addiction—as so many of these other things are—and how related they are.

As Senator Portman pointed out, this is not a city problem, this opioid addiction.

I first started hearing a lot about this when I came to the Senate in 2007, and especially in places like Adams and Brown County of the Ohio River. Attorney General DeWine has been working on this a long time, a lot of us have.

And, it started off with Oxycontin and oxycodone and Percocet and Vicodin and legally prescribed drugs. And, it has spread obviously.

And, we know that addiction—when you think about addiction, and you think about the biases and the prejudices people have about addiction, years ago addiction, when it was confined to certain areas and certain cities, look out this windows, it was considered a character flaw or it was considered an individual problem. We know it is not.

We know addiction is—some people are just more predisposed toward addiction than others. We know it is not a character flaw. It is not a personal problem. It is an illness. And, it is a chronic disease. And, that is why this hearing is so very important.

Fundamentally—and I want to thank the people. I did not do this. I thank the people in this room who are some of the best activists, as Rob has pointed out, some of the best activists in our State fighting against this.

The numbers are just overwhelming. The availability is amazing. I have done, as Rob said—and he has, too—I have done round tables, town halls all over the State.

I remember one in Southern Ohio. I said, how easy is it to get heroin? They said, you know where the McDonald's is out on Route 23? I said, yes. They said, go out there. Walk around for 3 minutes, and you will be able to buy some.

We know what a round table I did in the Mahoning Valley—the Youngstown area. A woman, affluent, she said because of the money her family had, they could keep their son alive.

He was addicted at 14, because he went into the—I think, if I recall, they were taking care of their grandmother, as I did with home care and my brothers did some 10 years ago in Mansfield. And, there was morphine in the cabinet, because they were helping her be comfortable in her last months or last weeks and even last days. And, their 12—14 year old son began to take the morphine. And, he has been addicted in and out treatment for 12 years.

And, she talked about the family is just turned upside down, because this son has siblings. And, they are not getting the attention that they deserve and they demand and the parents and all the things that happen.

So, we know how excruciating this is in every city, county, inner-ring suburb, more far flung suburbs, every county in the State. And, that is the importance of what we do.

But, the other thing that really came through to me on this is how every community is crying out for dollars to help us on this. And, we cannot get Congress to—neither the State nor the Federal Government has come up even close to the dollars we need to scale out these programs.

Almost every community in the State, people have come together. They are very good, as Rob said earlier today, they are very good not for profits. They are very good county-funded—all the different ways we fund treatment. Those exist. But, none of them can scale up without a lot of help from Columbus and Washington.

And, when you think—because nobody predicted this opioid epidemic to explode the way it did. So, no community is prepared to scale out. It just does not have the resources to do that.

And, that is where we come in. CARA, the work that Rob has done, is very important and impressive with CARA. We need to get it through the House. He is working on that. We are all working on that.

We also though need Senator McConnell to begin to support much better funding. And, we need the Governor and the legislature to support much better funding. You just cannot do this on the cheap.

The reason though I am optimistic is, I have seen what our country has done in public health for generations. So, it was our country that led the eradication of small pox, where hundreds of millions of people in the 20th Century died of small pox. It is pretty much eradicated.

Look what we did with polio in the 1940s to 1950s—1930s, 1940s, and 1950s to eradicate polio in this country and most places around the world, almost every place. What we did with Ebola 2 years ago. When the alarmists in our country said, "thousands of people are going to die from Ebola." Well, do you know how many people died from Ebola—contracted in the United States and died here? Zero.

We are facing the public health threat of the Zika virus now. We are accelerating the research for vaccine and an antiviral for cure, for vaccine and cure. And, this is, at least for us in this State, an even bigger public health threat with opioid addiction.

So, we have risen to the occasion as a community, as a Nation. I think we will today. This hearing that Senator Portman called is a step toward that. Thank you.

Senator PORTMAN. Thank you, Sherrod, great points.

We will now go to our first panel. And, we are going to discuss here the Federal, State and local collaboration to combat opioid addiction. We have three really distinguished panelists.

First, we are going to hear from Attorney General Mike DeWine. As I said earlier, Mike DeWine has been a leader on this issue, not just focusing on the law enforcement side of it, which you might expect from an attorney general, but also on the prevention side and the community outreach. He is also going to talk about fentanyl and his effort to prevent drug abuse.

Next, we are going to hear from Carole Rendon. Carole is the acting U.S. Attorney for the Northern District of Ohio. She's gone well beyond the call of duty to actually lead the task force here in Cleveland on opioid addiction. And, I thank her for that and her continued passion.

She is going to talk about strengthening partnerships across government to address this problem in her role as part of the task force.

Finally, we are going to hear from Tracy Plouck. Tracy is the director of the Ohio Department of Mental Health and Addiction Services (MHAS). She was a key resource as we developed CARA, as you can imagine, as one of those people I talked about earlier from Ohio who actually gets it and has a lot of expertise on the ground.

She is going to talk about what the State has done to expand addiction treatment, including efforts to respond to the Neonatal Abstinence Syndrome (NAS) we talked about earlier, the addicted babies.

So, with that, I would ask all three witnesses if they are willing to stand, please, we can swear you in.

Please raise your right hand. Do you swear the testimony you will give before this Committee will be the truth, the whole truth and nothing but the truth, so help you, God?

Mr. DEWINE. I do.

Ms. RENDON. I do.

Ms. PLOUCK. I do.

Senator PORTMAN. Excellent. Let the record show that the witnesses all answered in the affirmative. And, with that, again thank all three of you for being here.

And, Attorney General DeWine, thank you for your passion and expertise on this issue. We would like to hear from you.

TESTIMONY OF THE HONORABLE R. MICHAEL DEWINE,[1] ATTORNEY GENERAL, STATE OF OHIO

Mr. DEWINE. Mr. Chairman and Senator Brown, thank you for—not just for doing this hearing today, but thank you for your long time focus on this particular issue. You have traveled the State, both of you have traveled the State extensively and really I think understand what this problem is all about.

You mentioned, Chairman, about fentanyl. There is just one statistic. In 2015, in our crime lab, it was brought in to us and we dealt with, the amount of fentanyl that year was—exceeded what

[1] The prepared statement of Mr. DeWine appears in the Appendix on page 148.

it was in our labs for five previous years combined. And, this year, 2016, we are seeing it go straight up as well. So, there is absolutely no change in that.

The number of deaths, we all cite statistics. I do not think we know exactly how many people we are losing in Ohio. I would simply say this. That if it was not for naloxone and Narcan, those numbers would just be much worse.

And, what that tells you though I think is it is not just the deaths. It is the families that are destroyed, the moms and dads who get up every day and worry about their kid all day long, because their child is now in the 22nd day of recovery, and they do not know how long that that is going to last.

You are absolutely correct, this is a very different drug epidemic. I started looking at the drug problem when I was an assistant prosecuting attorney in the 1970s. This is very different. It is everywhere. It is the rural areas, cities, and suburbs. The face of heroin is really the face of the State of Ohio. And, it does cover every single demographic group.

I do not really know why we are seeing this huge problem. But, I will note two things that I think are significant that have come together.

First of all, the marketing of heroin is fundamentally different than it has ever been before. They are much more sophisticated. It is much more user friendly or consumer friendly.

Poppies are grown generally in Mexico. The heroin is made, processed in Mexico. It comes across our Southern border. It comes into Ohio and other States.

And, the groups that are selling it really use what I call the pizza delivery system. It is very similar. The price is about the same, and you can get it just about as quickly as you can get a pizza. It is $10. It is $15. Sometimes they will give it away, because they want to get someone hooked.

It is a perfect business model, because you start off at this level of heroin for $15 a day. In 6 months or a year, you may be clear up here. Some doctors have told me the ratio could be as high as 100 to 1. So, what starts as a $15 a day habit can be a $1,500 a day habit.

Thus the comment by almost every law enforcement officer that we see around the State of Ohio, that 80, 90 percent of the crime in the county, every county, is due to this particular problem.

The second thing that I think is different today is we have a culture problem. And, I think we can do something about that.

When I was a county prosecuting attorney, you would, after a while, you would sort of get to know the drug dealers in your county. You would arrest them. And, some of them you got almost on speaking terms with.

And, after we would arrest someone, I would ask them, what drugs are you selling? Or in some cases with the user, what drugs are you using? And, they would mention a number of different things.

But, if I would ask, well, what about heroin? The answer would be, no, I am not crazy. I do not do that. That is other people. We do not do that. I do not put that needle in.

There was some psychological barrier that was there. That psychological barrier for whatever reason is just down. It is gone. And, we have to culturally resurrect that.

We cannot arrest our way out of this problem. What we do in law enforcement—we work with this every day. We have a special heroin unit that works with local law enforcement on the law enforcement side, the investigation side. But, we cannot arrest our way out of this problem.

I want to compliment you, Senator Portman, for the CARA Act, and, you, Senator Brown, for your work in support of it.

This takes a holistic approach. I think we have to have a holistic approach. We have to have education. We have to have prevention. We have to have treatment. And, we have to have the law enforcement side.

Let me just mention a couple things. The bad news is the nature of this problem and how bad it is and how horrible it is.

The good news is we are starting to see some maybe not progress in the numbers, but we are starting to see some communities that have figured out how to fight back.

When we first started looking at the pain med problem, one of the things I noticed was that the communities that who were starting to make progress in this area—and I think this still is true as well for heroin—are communities that have come together, pulled together.

It is usually led by a mom, sometimes a dad, but usually a mom of someone who has died, a boy, girl who has died. And, they sort of rise up in the local community.

And, the ones that work involve the business community. They involve the faith based community, the churches. They involve law enforcement. They involve education. And, they have to come together.

I was so impressed by this model, that a few years ago we put together a small group in our office. We now have six young ladies who work every single day to work with local communities to try and help them. Not to tell them what to do, not to tell—every community is different. But, rather to share what other communities have done.

And so, I always mention that in any group. And, we have many times people who will take us up on it. Again, we do not pretend to be experts. But, what we do know is what is happening in other places in the State and what works.

So, I would encourage us to look at this from the local point of view. Those of us at the Federal level and those of us at the State level, we can help.

Ultimately, we are not going to solve this problem. We can help. We can help give people resources. We can help give them ideas. But, ultimately, it is going to have to be done at the individual community level, which is why I put this group together.

Let me mention a couple other places. Sheriff John Tharp, the Sheriff in Lucas County, has a program that we have partnered with him. He came to me over a year ago and said, "I have an idea." And, I thought he was going to talk about law enforcement. And, he said, "No, that is not what I am taking about."

He says that we have to get people into treatment more quickly. And, we have to, once they are in the treatment, make sure they stay in treatment.

And so, what the sheriff has done with the help of local—some local money and some money that we gave him, he has a program that is over a year old now, and we begin to see some real results, where they will go out—if the emergency room is ready, when the emergency room has somebody who comes in and actually survives an overdose, the sheriff is called. The sheriff has a very small unit of dedicated people. They move. They come out.

One individual will come and see the family and see the addict and see if maybe that is a teachable moment. See if that addict is ready at that point. And, if they do, that sheriff's deputy becomes really the advocate or the sponsor of that person.

I talked to a few of the addicts who were recovering in this program a few weeks ago in Lucas County. One recovering addict pointed over across the room to the sheriff's deputy. He said, "Do you see that sheriff's deputy over there?" And, I said, "Yes." He said, "I call him five or six times a day." I said, "Why do you call him five or six times a day?" He said, "I have to in order to get through the day. But, he has always been there for me." He said, "Without him, I would not still be in recovery. I would have relapsed."

So, there are programs out there. Senator Portman, down in your area, Colerain Township, they have a similar program that is going on. So, I think there is a lot of very good things that are going on.

I do not think we can forget education. As a country, we have to do more in the area of prevention and in the area of education.

I was on President Reagan's National Commission on Drug-Free Schools when I was in the U.S. House of Representatives in the 1980s. A little different in some ways and in some ways the same—a drug problem.

The one that every expert who came in on education and drug prevention said to us is, you have to do something every single year. You have to start in kindergarten. You have to have something that is age appropriate. And, you have to go all the way through the 12th grade.

And, if you think you are going to do something in the fifth grade and the ninth grade, and that is all you are going to do, I suppose that is better than nothing. But, it is not going to really get the job done.

So, I think we have to kind of rethink how we are approaching this. We cannot put all the burden on the schools. But, we have to figure out some way, so that young people are getting the information they need in something that has been tested and we have data behind that it actually works as far as prevention.

I was in Boardman a few weeks ago and talked to school officials. They have a program there they are just starting. They took a program basically off the shelf. They bought it, a proprietary program. They have inserted it into kindergarten all the way through 12th grade. And, they are just starting it. They actually put it into their science program. So, they work with their science teachers.

So, it is a way maybe to get around the problem that we are always looking to schools to do everything. Well, let us figure out

how to put that in. They do it through their science classes. It is basically nine periods a year, in kindergarten all the way through 12th grade.

It will be a long time before we have the data. But, I think it looked very promising. And, I think that is something we need to look at in other communities.

Again, thank you both very much for holding this hearing. It is very important.

We have looked at the members of the panel, and we have looked at the people in the room. Mr. Chairman, as you said, we have a lot of great talent here.

So, thank you for giving me the opportunity to talk about what I see, how I see this problem, at least from the Attorney General's view.

Thank you.

Senator PORTMAN. Thank you, Attorney General DeWine.

Acting U.S. Attorney Rendon, we will hear from you.

TESTIMONY OF CAROLE S. RENDON,[1] ACTING U.S. ATTORNEY, NORTHERN DISTRICT OF OHIO, UNITED STATES ATTORNEY'S OFFICE, U.S. DEPARTMENT OF JUSTICE

Ms. RENDON. Chairman Portman and Senator Brown, thank you so much for the opportunity to discuss how we here in Northeast Ohio are addressing the heroin, opioid and fentanyl overdose epidemic that we are all experiencing.

Here, in Northeast Ohio, we have a really innovative program. It is the Northeast Ohio Heroin and Opioid Task Force. And, if you look out into this room, you will see many members of our task force from all different walks of life, all working together to help to solve this problem.

The rise of heroin and fentanyl and the misuse of prescription opioids threatens our communities, our families, our safety. And, these things are all interrelated and they have to be addressed together. And, that is why the Department of Justice (DOJ) and the Administration are working closely with our Federal, our State, our local law enforcement officers to fight this growing epidemic through a combination of enforcement, prevention, education and treatment. It is truly a four legged stool, and without any one of those legs, the stool will not stand.

And, this is truly a crisis in Northeast Ohio. We have heard a little bit of some of the statistics. But, let me fill you in on what we are seeing here in Cuyahoga County, and with thank you to our Medical Examiner, who I have to tell you was the first person to sound the alarm on this epidemic here in our county. So, heroin overdose deaths increased in Cuyahoga County by more than 400 percent between 2007 and 2012, when 161 people died of heroin overdoses. But, sadly, the number of heroin overdoses has increased year by year. And, recently, it has gotten dramatically worse with the introduction of fentanyl, which, as you mentioned, Chairman Portman, is incredibly potent and extremely deadly. So, according to the Cuyahoga County Medical Examiner, while there were only five overdose deaths in 2013 attributable to fentanyl, in

[1] The prepared statement of Ms. Rendon appears in the Appendix on page 151.

2014 that number rose to 37, and last year it was 91—91 overdose deaths attributable to fentanyl or a combination of heroin and fentanyl.

And, last year 228 people, just in Cuyahoga County, died of an overdose of either heroin or fentanyl—or a combination of the two. And, this year we have already seen 125 fatal overdoses in Cuyahoga County, and it is only April. So, the devastation that this is wreaking throughout our community cannot be overstated.

But, the crisis is not limited to Cuyahoga County. So, as you know, there are 40 counties in the Northern District of Ohio. And, we are seeing waves of overdose deaths everywhere in our district; Lorain, Summit, Stark, Lucas, Marion. It is everywhere throughout the Northern District of Ohio.

And so, faced with this crisis, what we did is we assembled this task force. And, it brought together a wide diverse group of stakeholders to identify and implement comprehensive solutions to this growing crisis.

And, in 2013, we held a summit to focus on the heroin epidemic. We had more than 700 people at that summit from all walks of life, from all aspects of our community; treatment providers, doctors, parents who had lost children, law enforcement, across the board.

The result of that summit was the creation of a heroin and opioid community action plan. And, let me emphasize the word community action plan.

This is the plan that guides the work of our task force. And, it addresses the heroin and opioid crisis from four different perspectives; law enforcement, health care policy, education and prevention and treatment.

I want to take a minute just to highlight a few of the successes we have had, because the news is all so grim. But, there have been some successes, and they are worth noting.

So, law enforcement. We created a heroin involved death investigation team. And, what this is, is a group of dedicated law enforcement officers who roll out to every overdose scene. And, they treat it like what it is, a crime scene, and they are there to gather evidence that we can then use in our criminal prosecutions.

To date, the United States Attorney's office has brought nine death specification indictments, which carry a 20 year minimum mandatory term of incarceration for the dealers who are killing people in our community. And, there have been a dozen more manslaughter cases brought in the State court system, because we partner, of course, with the attorney general and all of our local county prosecutors.

Health care policy. So, members of the task force, many of whom are sitting in this room, have worked to increase the physicians' use of the Ohio Automated Rx Reporting System (OARRS), which is the statewide prescription drug monitoring program. And, they have helped to develop really important increased training and education for doctors about the dangers and the unintended consequences of over prescribing opioids. And, I will note that a recent Centers for Disease Control (CDC) report showed that the total doses of opioids prescribed in Ohio decreased by 11.6 percent from 2012 to 2015, in no small measure as a result of the work of the members of our task force.

Education and prevention. Members of the task force have organized town hall meetings and presentations at schools and with labor unions and community organizations throughout Cuyahoga County. And, through this, task force members have reached literally thousands of people. And, they have also spearheaded two significant media campaigns to raise very importantly awareness of this crisis.

And then, finally, last but not least, I am looking at Dr. Jerry, treatment. So, the task force members have led the effort to expand the availability of the opioid overdose reversal drug naloxone to first responders and relatives of those who have substance use disorders. And, that work has literally saved hundreds of lives.

And, they are continuing that work, while also addressing what you mentioned, which is the critical shortage of treatment facilities in our District and throughout the United States.

These efforts, in my opinion, they are an incredible example of what we always talk about in the Department, a multi-faceted approach, that really is what we mean when we talk about being smart on crime. And, our task force, because of its success, is now a model that is being replicated at U.S. Attorney's offices all across the country.

But, while we have had some successes, we are keenly aware that this problem just continues to grow and get worse by the day. And, it is morphed, as we have discussed, from painkillers to heroin to now an incredibly deadly new drug, fentanyl.

And, as you have noted, Chairman Portman, we cannot arrest our way out of this problem. But, we have to aggressively prosecute the drug dealers who are bringing this poison into our community. And, we have to find a way to choke off the supplies of the drugs into our community.

And, of course, simply getting treatment for everyone who has suffered through addiction, that is not going to solve the problem by itself either.

But, given the number of people who we know are already addicted to opioids in our communities, we have to find a way to make treatment readily available to those who need it.

And, of course, changing prescribing practices alone, that is not going to curb the problem either. But, we have to start impacting the way that doctors are prescribing opioids.

And, we have to address the underlying incentives that cause that to happen in the first place.

And, education is critical. And, that is why the Administration is now championing a practice that requires people who are seeking a DEA registration to get specifically trained on prescription opioids and the dangers and the need to carefully prescribe.

And then, finally, every one of us has to continue to talk to our children, to our friends, to our colleagues about the dangers of opioids. Because no one is immune from this threat.

As you mentioned, Chairman, Senator Brown, opioid addiction knows no boundaries. It is an equal opportunity killer of men and women, young and old, city, suburban, rural, wealthy and poor, white, black and Hispanic. It is everywhere. And, it is killing people in our community every day. We are all at risk.

And, you mentioned, Senator Brown, Ebola and the Zika virus—sometimes I wonder if people were dropping dead at this rate of Ebola or Zika, how would we all be responding? And, would it look like the response that we are seeing to this crisis? And, if not, why not? How do we get to the stigma that underlies our failure to address this crisis with every single tool in our tool kit?

And so, from my perspective, this is going to take what we have all come to talk about as the "all of the above" approach. Everyone has to work together in concert. We have to roll up our sleeves to address what from my perspective, in my little corner of the world, is one of the worst public health crises I have ever seen and one that I hope never to see again.

So, thank you.

Senator PORTMAN. Thank you, Ms. Rendon. Director Plouck.

TESTIMONY OF TRACY PLOUCK,[1] DIRECTOR, OHIO DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

Ms. PLOUCK. I really appreciate the opportunity to present at this hearing today.

And, as you are aware, the opioid epidemic has hit all States. And, Governor John Kasich and his administration has worked tirelessly in the last 5 years with both State, local and Federal partners to curb the tide, and yet the storm just continues to rage.

I know you both share the same concerns that the Governor does. And, I would like to talk to you a little bit today about Ohio's overall efforts and where we still have work ahead of us.

Unintentional drug overdose deaths in Ohio reached an all time high of 2,482 in 2014, which is the most recent year available. That is 2,482 families that have been affected by a death related to overdose in our State just in one year. Opiate related deaths, which include both heroin and prescription painkillers, peaked at 1,988 deaths in 2014, up from only 296 in 2003. With 502 fentanyl-related drug overdose deaths in this State in 2014, fentanyl was a significant contributor to the rise in drug overdose deaths according to the preliminary data that has been released by the Ohio Department of Health (ODH). By comparison in 2013, just 84 deaths involved fentanyl. As a result, Ohio proactively requested assistance from the Center for Disease Control's EpiAid to better analyze our opiate related deaths. We are currently reviewing the recommendations and determining what should be implemented in Ohio to build on our effort. This continues to be a pressing issue for the State.

Governor Kasich has made the fight against opiates a priority and is one of the nation's most outspoken advocates on the issue. Early in his administration, the Governor announced the establishment of the Governor's Cabinet Opiate Action Team (GCOAT) to fight opiate abuse in Ohio. GCOAT is comprised of directors from multiple cabinet agencies that touch the opiate issue. And, it is designed to foster collaboration across public health, treatment, law enforcement, education and other agencies that touch some facet of this complex challenge.

[1] The prepared statement of Ms. Plouck appears in the Appendix on page 157.

I know you understand the importance of taking this issue in a multi-pronged way because of your work on CARA. Senator Portman, I would like to thank you for your sponsorship of the bill, and I would like to thank you, Senator Brown, for your support as well. CARA takes a similarly comprehensive approach and addresses on a national level several things that Ohio has demonstrated we know are working and making some progress.

I would like to talk a little bit about some specific areas. And, I am going to start with prescribing practices and prescribing guidelines specifically.

In its ongoing efforts to combat drug abuse and save lives, the Governor's Cabinet Opiate Action Team developed comprehensive prescribing guidelines for outpatient management of acute pain this past January. The acute guidelines follow previous prescribing guidelines for emergency departments, which were released in 2012, and the management of chronic pain in 2013. All three of these guidelines were developed in conjunction with clinical professional associations, health care providers, State licensing boards and State agencies. I know that CARA also addresses this issue from a national perspective. And, I applaud efforts to limit the number of opioids prescribed nationally to ensure that these powerful drugs are only used in the course of appropriate medical care.

As a result of the prescribing guidelines and the increased utility of OARRS, our prescription drug monitoring system in Ohio, the number of prescriber and pharmacist queries using OARRS increased from 778,000 in 2010 to 9.3 million in 2014. And, Ohio is making further progress.

The number of prescription opiates dispensed to Ohio patients in 2014 decreased by more than 40 million doses relative to the previous year.

The number of individuals doctor shopping for controlled substances, including opiates, decreased from more than 3,100 in 2009 to approximately 960 in 2014.

From 2013 to 2014, there was a nearly 11 percent decline in the number of patients prescribed opiates at a dose higher than the current guidelines that are recommended. Ohio patients receiving prescriptions for opiates and benzodiazepine sedatives at the same time dropped by 8 percent. So, we are seeing some progress related to these interventions.

I want to say a little bit about prevention, which has been mentioned by both of the other panelists. In 2014, the Governor and the first lady launched "Start Talking," which is a statewide youth drug prevention initiative based on the premise that youth are up to 50 percent less likely to initiate drug use if an adult who cares about them talks directly with them about this issue and the risks involved. Understanding that this is not an easy discussion to begin, the program aims to help parents and other adults communicate better with kids on these topics. "Start Talking" offers three free tools for parents and other youth leaders to approach children and young adults.

Nearly 57,000 adults are receiving these biweekly messages via e-mail to help start important conversations.

"Parents360Rx" is the second component of the program. It is a national program that Partnership for Drug-Free Kids established

that is designed to help educate adults about the dangers found in their own medicine cabinets. This is a good topical source for community meetings to help draw attention to some precautions that every household can take in the fight against the opiate epidemic.

And then, finally, "5 Minutes for Life" is a program that is led by the Ohio State Highway Patrol, the National Guard and local law enforcement in partnership with high schools. Troopers, law enforcement officers and National Guard members talk directly with students, usually student athletes, to encourage them to become ambassadors and lead peer-to-peer conversations about the importance of healthy choices. During this school year alone, over 260 events have been hosted with more than 35,000 students participating.

I want to say just a moment about criminal justice initiatives and our support for court involved individuals.

Established in 2014, we launched the addiction treatment program. This supports drug courts in establishing a program to provide addiction treatment, including medication assisted treatment, to non-violent adult offenders with dependence on opiates, alcohol or both. The first phase of the program reached 410 men and women, two-thirds of whom also had a co-occurring mental health disorder. According to a Case Western Reserve University evaluation of the program, past months drug use among program participants decreased by almost 70 percent, while crimes committed dipped 86 percent. At the same time, employment increased by 114 percent, while stable housing increased by nearly 29 percent. Among participants, 60 percent had a job, and 91 percent had stable housing upon completion of the program. This program is funded with $11 million over the current biennium in 14 Ohio counties. CARA emphasizes the importance of treatment as an alternative to incarceration, and we are seeing that work here in Ohio is effective in that regard with the drug court model.

I want to say just a little bit about expanding the availability and the use of naloxone or Narcan, as has been noted earlier.

Our department administers grants for first responders across the State. We know that through State emergency medical services (EMS) data, naloxone was administered to 18,438 patients in 2015. That is more than 18,000 deaths avoided as a result of this life-saving measure. Without this important overdose antidote, Ohio's already two large number of overdose deaths would be much higher. The most recent State budget included $1 million to purchase naloxone for first responders, including police and fire. A concerted effort has been made to convince local agencies of the importance of carrying naloxone, oftentimes as an overdose victim cannot wait for EMS to arrive. And, we have seen many communities sign on to this. CARA also addresses this issue, and we support your efforts. Naloxone use is critical to saving lives and getting people into treatment.

I would like to say a little bit about Neonatal Abstinence Syndrome. In 2013, the Kasich administration launched an effort to address the epidemic among the smallest of Ohioans, babies born to mothers who are addicted to prescription painkillers, opiates and heroin. By engaging expecting mothers in a combination of counseling, medication assisted treatment and case management, the 3-

year project is estimated to reduce infant hospital stays by 30 percent among those enrolled moms and babies. One of the goals of CARA is to improve addiction and treatment services for pregnant and postpartum women. And, we believe Ohio is developing a model that can be replicated nationally.

Across the State, I continue to hear stories of waiting lists and difficulty accessing treatment, in part due to the Federal Institutions for Mental Disease (IMD) exclusion. Treatment works, but it is not easy. I recently read of a couple who, after multiple relapses, found themselves homeless, involved in criminal justice and lost custody of their young daughter. Through treatment received through extended Medicaid benefits, they have over a year of sobriety. They have regained custody of their daughter, and they are now employed. We know that approximately 400,000 additional Ohioans were able to connect with mental health and/or drug addiction treatment as a result of the Medicaid expansion when it was extended to adults up to 138 percent of poverty. Capacity and workforce continue to be a challenge. And, the IMD exclusion poses a barrier to treatment access. I appreciate that CARA sets up a way to take a serious look at the IMD exclusion and its impact on treatment.

Thank you again for inviting me to testify on this very important topic today. I want to commend both of you on your work on this issue. And, I especially commend you, Senator Portman, on your leadership on this issue through your career. Again, as I described in my testimony and at length in my written statement for the record, a number of the provisions in the CARA bill are activities that Ohio is undertaking. And, we fully support the expansion on a more national scale of these efforts.

I stand ready to work with you as we move forward. And, we look forward to any questions that you might have.

Senator PORTMAN. Great. Thank you, Director Plouck. I appreciate it. And, we will have some questions. I am going to ask Senator Brown to go first.

I want to just make one comment that is pretty obvious to everybody in the room. If we can get CARA passed, because of the programs that all three of these panelists talked about, we will be in a good position to access some of these grants, whether it is with regard to prevention, education or treatment, medication assisted treatment or, as you mentioned, the Neonatal Abstinence Syndrome, working with pregnant women. Our veterans, of course, in Ohio are great. And, they are funded in here.

So, there is the diversion programs, drug courts. So, there is a lot of opportunity here for Ohio. We play a leading role thanks for the additional help that will come from CARA going forward.

I will ask Senator Brown to go first with questions—and I want to ask you some myself.

Senator BROWN.. Mr. Chairman, thank you.

And, Director Plouck, let me start with you. First of all, you were some years ago, in addition to what you are doing now, some years ago you were a Medicaid director in the State, right, so you know this issue pretty well.

On March 30, an Akron Beacon Journal editorial discusses the role that Medicaid expansion, when the Governor made his decision

as part of the Affordable Care Act (ACA) to expand Medicaid, and discussed in part Ohio's battle of its addiction.

I would like, Mr. Chairman, to enter into the record this editorial,[1] if I could.

Senator PORTMAN. Yes. No objection.

Senator BROWN. Folks who have health insurance are better able to access critical mental health, of course, mental health and substance abuse services, including medication assisted therapy, as we talked about.

I would like to focus on a different benefit of Medicaid expansion, if I could, because the expansion localities around the State are now able to use money they would have spent on health care for other critical services.

For example, Summit County's Alcohol, Drug Addiction & Mental Health (ADM) services board used to rely on a local tax levy to help pay for basic health costs for the disadvantaged. Now, after the expansion of Medicaid, the board can utilize these levy dollars to meet other urgent needs in Summit County. That is funding recovery coaches, Project Deaths Avoided with Naloxone (DAWN), funding detox, both to the local community.

Medicaid expansion enabled Summit County to save more than $4 million last year, and is projected to save the county more this year, money that is being used to address other urgent needs.

My question is this: The new "Healthy Ohio" plan out for comment through the Ohio Department of Medicaid, out for comment from the Senators from Medicare and Medicaid Services, would require nondisabled adults, including some pregnant women, to pay premiums for coverage that is free today, would impose new limits on how many times Ohioans can go to the doctor or get care they need each year, or require patients to pay out of pocket, as I think you know, when they go to the doctor, pick up prescriptions, on top of monthly premiums that they may face. And, additionally, if individuals cannot afford to pay the premium or they get locked out of coverage, they have to again rely on help from local counties.

Walk through, if you would, what "Healthy Ohio," if the Medicaid waiver is granted to the State from Center for Medicare, Medicaid services, how "Healthy Ohio" would affect folks who rely on Medicaid for addiction treatment?

Ms. PLOUCK. Chairman Portman and Senator Brown, I am not the lead cabinet director on this issue. And, I would want to defer to any clarification that Director McCarthy from Ohio Medicaid would want to bring to this.

I think the general philosophy behind "Healthy Ohio," when it was added into the last biannual budget, was a philosophy of personal responsibility for individuals. And, Medicaid is following the law to request the waiver that was stipulated in the budget bill.

As far as access to addiction and mental health services, those are named services in the Ohio Medicaid benefit. And if, those would be subject to the same requirements related to call sharing or anything that would be required as a part of "Healthy Ohio" waiver.

---

[1] The editorial submitted by Senator Brown appears in the Appendix on page 233.

So, I do not believe that addiction treatment is approached any differently than other Medicaid services in that regard.

Senator BROWN. Understanding you are part of an administration with the legislature that is asking for the waiver. But, does that make sense to you, when dollars that would have been available now may be used for other things, when we know how every community is starved for dollars on treatment programs?

Ms. PLOUCK. The Ohio Department of Medicaid is following the law that was enacted in the budget bill to request the waiver from the Federal Government.

Senator BROWN. And, I understand they are following the law. I want your opinion of that law. Granted I understand you are part of the administration. Does that make sense to you? If you can step in that other role, and it is probably unfair to ask you to step in the other role. But, can you kind of talk that through?

Ms. PLOUCK. As an advocate for individuals and families that are struggling with mental health and addiction challenges in their lives, I think that we should work to try to overcome any barrier to access to treatment that exists.

Senator BROWN. OK.

Ms. PLOUCK. I recognize that to an individual, the waiver, if enacted as it has been proposed pursuant to the budget bill, does create some obstacles that would need to be overcome on an individual basis depending on the resources of the individual.

Senator BROWN. Thank you. And, I ask that in part—I mean, I opposed the waiver pretty obviously.

But, I also ask in part, because the Centers for Medicare and Medicaid Services (CMS) in Washington can make a determination to choose parts of that waiver to grant and parts to deny. I think they should deny the entire waiver. I understand they may not.

And, I know that hospitals around the State are concerned about the waiver period, because they so applaud it when the Governor expanded under the ACA Medicaid, I will not speak for others. But, the ones that have talked to me think that this is backsliding and particularly with the acute needs we have now.

But, thank you for your candor there. I appreciate that.

For General DeWine and again U.S. Attorney Rendon, an easier question than I would asked Director Plouck. [Laughter.]

Senator BROWN. I just really wanted to kind of flush out some of the things you already said.

We know that the opioid crisis is not just law enforcement. Senator DeWine, you said you cannot arrest your way out of it. We have all said that. We all understand that. And, we kind of made those mistakes in the war on drugs in the past.

You cannot arrest your way entirely out of this, we know. So, we know it is not just the law enforcement. As you said, it is law enforcement, not just law enforcement.

It is not just treatment. It is a problem that requires something more comprehensive, as Senator Portman has mentioned many times with CARA overall.

But, what can regular people do to help address this crisis? And, we have some of the State's best experts here. We have people that devote much of their workday and beyond that to doing this. Talk more about the general public, what people can do?

Mr. DEWINE. Chairman and Senator Brown, I think that is an excellent question.

Because I truly believe that the success that we have achieved so far and that we can achieve in the future is going to be very much depending on what occurs at the local level.

We all have a role. We do what we do. U.S. Attorney does what they do in regard to law enforcement. We try to help with the six individuals who I told you about who will go out and help in the local community.

The communities that have started to change the culture, to change how we look at it, communities that have begun to really assist people with not only getting in treatment, but what happens when we get out of treatment, those communities—where we have seen that happen is because the local community got together.

I know you had a lot of town hall meetings. Senator Portman has had town hall meetings. I suspect you found what I found when I did this.

We did a number of town hall meetings over a year ago. And, to me the interesting thing, but also kind of scary thing was, that we would have a lot of people, a lot of just citizens who came. And, we would have a panel of experts. But, we would have a roomful of citizens. And, we encouraged just a conversation.

And, what I found was that you would get someone who would stand up on one end of the room and say, well, in this community we need such and such. We do not have that. Somebody else on the other side of the room stands up and says, yes, we do.

So, a lot of it is I think pulling people together and getting people out of their normal area where they work and communities coming together.

And, when you have a grass roots effort in the local community, what happens is, people in that community start talking to each other more. That is how we are going to do this.

I think the other thing average citizens can do is to say, hey, look, in this community, somehow we have to have education at every grade level. And, we have to work with our schools, who we ask to do all kinds of a million things. And, they are overburdened. But, we have to work with our schools. And, the community has to say to the school, this is very important.

If we are going to deal with this problem in the future, if we are going to have some success 5 years, 10 years, or 20 years from now, we have to start in kindergarten. And, we have to work all the way through.

So, I am a great believer in the local community and where the local community comes together, where the business community is involved, where the church faith based community is involved. I think we can see some progress. That is what the individual can do.

Ms. RENDON. Senator Brown, I think that is an excellent question. Because I think there are things that every single person in our community can do to help with this crisis.

And so, what you are doing here today is a huge step, because we all need to be educated about what is happening. And so, the more we get the word out, the more people know that this is out

there, the more they can figure out where their piece is, where they can help.

But, for the average citizen, what I tell people when I am at these town hall meetings, there is a ton that everyone can do.

So, you can start by going home and opening your medicine cabinet and figuring out what is in there that should not be there that you were prescribed a year and-a-half ago.

And then, on April 30, you can see my good friends at the DEA on their drug take-back day, and take that medication safely to a drug drop box and get rid of it before somebody accidentally tries it, some young kid who thinks it is safe because it is in a medicine bottle, somebody who happens to be in your home.

You can do that on a daily basis in many of our police stations. And, I know some of our pharmacies are now starting to agree to have drug drop boxes in the pharmacy, which I think is phenomenal. So, that is something you can do.

You can talk to your kids, to your family, to your friends. My oldest son is here. And, he can tell you, I think maybe because of my career, I have been talking to my children about the dangers of drugs since they were toddlers.

So, just as we have taught all of our children to buckle their seat belt and not smoke cigarettes and not drink and drive, we have to have on that list, do not use drugs. You do not know, that first time that you take it, you have no idea how it is going to impact you. And, then we all have to look at ourselves in the mirror and figure out when we became a culture that has to be pain free at all times. Right?

So, when I had my wisdom teeth out, I got Tylenol, and I think I got to stay home from school for a day. Now, you take your children to get their wisdom teeth out, and they want to give you Percocet. Percocet. We as parents, we as citizens, need to stand up and say, no. I am not taking that prescription. I do not need that prescription.

My husband had his elbow operated on—not removed. We do not need a 60 day supply of Vicodin. I want three. Right?

But, I found out you can do the same thing at the pharmacy. So, if they do give you the prescription for 30 Vicodin, you do not have to take 30 Vicodin. You can talk to your pharmacist and say, how many of these do I actually reasonably need to address this problem? And, they will tell you, two, three. And, you can walk home from the pharmacy with just what you need.

So, it has to start with each one of us in our homes with the things that we care about, with our commitment to this next generation and the future of our community. And so, there is a role for every single person in our community to help with this. And, getting the word out is the first step.

So, thank you.

Senator PORTMAN. Thank you. Thank you, Senator Brown.

I could not agree you with more. And, tragically, we are going to hear from a witness in a little while about wisdom teeth extraction and the specific issue that you raised and how that led to an addiction and eventual overdose and death.

But, and you are right, everybody has a role. One of the things we tried to do in this legislation, drop boxes, for instance, we do

provide for them to be at pharmacies and at long term care facilities and in hospitals that have pharmacies.

I must tell you, I have a frustration on the prevention and education side, because, 22 years ago, I started this group in Cincinnati. Officially, we were having our 20th year anniversary I think in a couple weeks. I founded it. I chaired it for the first 9 years. I was on the board until I joined the Senate.

It is called Coalition for a Drug-Free Greater Cincinnati. Now, it is called Prevention First. And, we are considered a model coalition. I was the author of the Drug Fee Communities Act of 1997. We have spawned 2,000 coalitions throughout the country.

As all three of you have acknowledged, we are still not able to persuade so many of our fellow citizens, not just kids, this is not just about young people, of the dangers. And, the best research shows that it is this recognition of the danger that kept those people from trying heroin. In the 1990s when we started our coalition, it was not an issue. Now, we have 13 year old kids in Ohio trying heroin, first time, shooting up.

Parents, all the evidence shows parents or other caregivers, when there is not two parents at home—which unfortunately is the case in many of our communities. And, in many situations you do not have a parent who is available, even if the parent is in the family. But, parents make a huge difference.

The single largest difference as a parent, when I had three teenagers, well, all three are passed teenagers now barely, you kind of wonder sometimes. But, it is incredibly important, as you say.

But, on the issue of community coalitions and this whole issue of prevention and education, we are going to hear from Rob Brandt later, who has become an expert on this by necessity.

But, what should we be doing differently? The CARA program starts a national awareness campaign, specifically on this issue of the connection between prescription drugs and opioid addiction, and the fentanyl and the heroin connection.

Because four out of five people who are addicted to heroin start on prescription drugs. That is what they say. And, we need to—people do not know that. So, they do not know when they go to have a relatively small procedure that they should not be asking for the Percocet. Instead they should be asking for the Toradol or the Tylenol. So, that specifically is in here.

But, what would you say? And, Attorney General DeWine, again you have been active on this, Ms. Rendon and Director Plouck, if you would like to jump in. But, what would you do differently in terms of the prevention and the education side of this, something different and new?

Mr. DEWINE. No. You go ahead.

Ms. RENDON. Well, so one of the things that I think is an example that is really incredible to me from our task force here in Northeast Ohio is the partnership between law enforcement, treatment, education and regular community members, which has allowed us in some respects to get a little bit ahead of the curve.

So, I talked earlier about our Medical Examiner (ME) sounding the alarm on this problem as it came on the horizon. So, they were the first to see fentanyl in pill form in our district. They sent out an alert, and it came to us, because we are on this task force.

And so, it went immediately to the DEA. And, within weeks, the DEA had made a massive seizure of fentanyl in pill form, just shy of 1,000 pills. And, we were able to charge that individual in Federal court within days and address this problem and get the word out very publicly.

And, what was so important about that is the fentanyl pills were shaped and dyed to look like oxycodone. And so, if you are an oxycodone user, and that is what you think you are taking, and it is fentanyl, it is an overdose waiting to happen. I mean, every one of those pills was an overdose waiting to happen.

But, we were able, because of this group that we have together and the constant communication that we have, both when we are sitting together in our office and then also on a regular basis by e-mail and phone, we were able to sound a really loud alarm bell and get the word out to the drug using population.

Joan Synenberg was here earlier. She is a common pleas court judge. She has one of the drug courts. There she is, back there. She is a member of our task force. And, told us a really heart-breaking story of one of her graduates—I was at the graduation—who 2 days after graduation overdosed and died.

And so, that caused us to realize that we have to get to her graduates as they are walking out the door to make sure that they understand how dangerous the world has become while they have been sober.

Because the heroin users do not know how deadly and dangerous the fentanyl is. And, when you are taking an illegal drug, unlike a drug that you get at the pharmacy, you have no idea what it is you are about to put in your mouth.

And so, unless you can get the word out, really actively, really publicly through the media, through one on one meetings, through this combination of people working at all levels, you cannot impact the problem.

But, all of us together, that is why the stool has to have the four legs, all of us together, we can make a difference. And, we are. It is disheartening when it is not going in the direction that you want it to. But, I am telling you every day we are saving lives and will continue to do so.

Mr. DEWINE. I have a couple of comments. Mr. Chairman, you are absolutely right. There is a natural progression from opiates to heroin.

One of the things that we partnered with Governor John Kasich's office, right after he took office and I took office, was to really crack down on doctors who are really nothing more than drug dealers.

We have taken, and I say we, because we are the lawyers for the State Medical Board, and we pushed this. But, the State Medical Board has really stepped up. For many years they were not frankly doing what they needed to do.

They have taken I believe 70 doctors' licenses in the State of Ohio. I was involved in some of the raids. And, I will not take your time to tell you the horror stories. But, we had one doctor who was on the circuit, basically. He would spend one day—and he had 10 offices around the State.

And so, that—if we can stop people from—change the culture regarding an opiate, we are going to see some progress in the heroin as well. Because one flows, one flows from the other.

We had a real pendulum swing, in regard to the culture of prescribing pain meds. And, if you recall, 15 years ago or so, the concern was that doctors were not treating pain. And, that was probably a correct comment, that we needed to do a better job, particularly people who have long term retractable pain. But, we went too far the other way. We are now starting to move back.

But, I will tell you, I had the same experience as I have experienced with a granddaughter who had her wisdom teeth taken out and was given dozens and dozens of pills. That was what the prescription was. Our daughter, we told her not to take any of them. She did not take any of them.

So, we are not there with changing the culture with the medical community. We have come a long way.

As to the second thing, I will go back to what I said, Mr. Chairman and Senator Brown, we have not done a very good job in this country in regard to education. I think you have to be—we have to be careful, is what some of the experts will—I do not intend to be an expert. But, will tell me is, there is some things we do—we could be doing that we might think is the right way in education, and it may be exacerbating the problem. So, I think whatever we do, it would have to be evidence based. And, we have to have that tested.

But, you all will remember when I was about leaving, and when Senator Brown was about coming, I think, in the Senate, you were in the House, but, killed the national funding. It was not very much in education. But, every school got some of it. Every school got something. And, that just went away. I lost that fight. And, those who were fighting on our side also lost. We lost that.

So, I think we have to look at that more and see what the Federal Government can do. I think candidly we have to do something in this State, so that we are doing something with education K through 12 every year. Nothing less than that is acceptable. Nothing less than that is going to begin at least to deal with this problem.

We are not doing that. And, I am not blaming anyone. But, we have to start doing that again.

Senator PORTMAN. Thank you.

I have so many other questions. And, I am going to continue the discussion with all three of you and then with Senator Brown on these issues.

But, we do have another panel that is patiently waiting. And, I want to get them up here, too.

Thank you to all three of you for not just coming today and sharing your views with this distinguished group of people who are in the trenches, but for what you do every single day to help to save lives and to pull lives back together. So, we look forward to continue to work with you. And, thank you for your testimony.

Ms. RENDON. Thank you.

Senator PORTMAN. I would now like to call the next panel up, if we could, please. Dr. Michele Walsh, Dr. Kotz, Emily Metz and Rob Brandt.

OK. We are on to the next panelists here. I would like to get started. Why do we not start by swearing in the panel, since this is the custom of this Committee to do this. So, please stand and raise your right hand.

Do you swear the testimony you will give before this Committee will be the truth, the whole truth and nothing but the truth, so help you, God?

Thank you. Let the record show that all the answers were in the affirmative.

We appreciate each of you coming today and look forward to the opportunity to hear from you and also to get some questions in.

I was probably negligent in not mentioning for the last panel that we are asking for five minute opening statements. And, I know you all know that. But, try to stick to 5 minutes, if you can, because that will give us more time to have interaction between yourselves and we will be able to ask you direct questions.

Again, we have an amazing group here. First, is Dr. Michelle Walsh, who is right here. I mentioned earlier the Rainbow Babies and Children's Hospital work. It is incredible. She has given the opportunity to tour it a couple times, I think, maybe a few times, but more recently with regard to this issue of babies who are born with Neonatal Abstinence Syndrome. So, thank you for being here.

Dr. Michele Walsh is division chief of neonatology right here at UH. She will talk about that issue. After Dr. Walsh, we will hear from Dr. Nancy Young. Dr. Young is an expert in the issue of substance abuse and its impact on children. She is going to expand on the broader impact of the Neonatal Abstinence Syndrome we mentioned earlier.

In particular, Dr. Young is going to discuss the correlation of substance abuse and children entering the child welfare system. Again these are areas that she has testified about before. In fact, she came to our Finance Committee, where Senator Brown both and I serve, and testified before the U.S. Senate. I appreciate her willingness to come here to Cleveland.

Dr. Margaret Kotz is here. Dr. Kotz is an addiction expert. She is a specialist right here at University Hospital. And, she told me this in our round table discussion last year. We got to talk to her about some of her work.

And, she is going to discuss the merits of medication assisted treatment. That is one we did not get a chance to get into as deeply as I wanted to in the first panel. We look forward to that.

Emily Metz is here from project DAWN. She is going to speak about the work in the community to get naloxone out to prevent these overdoses. We talked a lot about that today.

I think I am going to be with you later this afternoon and be able to see some of your good work directly at the free clinic. And, also I know you work with MetroHealth, their facility here in Cleveland. So, we look forward to hearing from you.

And then, last but not least, Rob Brandt is here with us. And, I was looking at Rob when there was discussion about this issue of prescribing to our kids prescription drugs that are addictive, in the case of a wisdom tooth extraction.

And, unfortunately, Rob is an expert. He is a business leader. He got involved with prevention because of his family—his son, Robby.

He has a group called Robby's Voice. They are awesome, because they are out there in the schools. We talked about doing it at young ages. He is there in the elementary schools. And, he works to bring the message of drug education and drug prevention to students and families.

So, again, thank you all for being here.

And, Dr. Walsh, we look forward to your testimony.

TESTIMONY OF MICHELE WALSH, M.D.,[1] DIVISION CHIEF, NEONATOLOGY, UH CASE MEDICAL CENTER, UH RAINBOW BABIES AND CHILDREN'S HOSPITAL

Dr. WALSH. Thank you, Chairman Portman, Senator Brown and distinguished guests. I am Michelle Walsh. I am the Chief of Neonatology here at Rainbow. I thank the Committee for holding this field hearing in Cleveland. And, we are proud to host you at the UH Case Medical Center. I thank the Committee for holding this field hearing in Cleveland. And, we are proud to host you at the UH Case Medical Center. I have been privileged to care for the tiny babies of Northeastern Ohio for over 25 years. And, I appreciate the opportunity to speak on their behalf.

Never have I seen a public health epidemic of the severity of the current opioid epidemic among our citizens. And, as others have said, Ohio unfortunately has the unfortunate distinction of being among the lead in the entire country. We must focus our efforts on a cohesive national strategy that attacks every facet of this complicated problem. In the same way, as Senator Brown alluded, that we came together as a nation to combat Acquired Immunodeficiency Syndrome (AIDS) and more recently Ebola, the same urgent epidemiologic methods and prevention are needed to combat this scourge. The Comprehensive Addiction and Recovery Act championed by you, Senator Portman, and so many others is exactly the right direction to address the complexities of addiction treatment, the inadequate numbers of programs, inadequate numbers of trained physicians and addiction specialists and the critical shortage of facilities to address this exploding issue.

As others have highlighted before me, and I will not repeat, the epidemic is staggering. And, I entered into the record data on the explosive growth from 2001 to 2011 of the number of citizens in Ohio. Which the data from the Ohio multi-agency community report documented that in 2001, there were only eight counties that had a significant problem with opioid addiction. But, by the last available report in 2011, there were only eight counties——

Senator PORTMAN. That will be entered into the record.

Dr. WALSH [continuing]. That was not at the highest levels of addiction.

The fentanyl problem is exploding. And, unfortunately, the epidemic among adults has led to a corresponding epidemic among newborns. A recent publication from Tennessee analyzing Medicaid data indicated that 27 percent of pregnant women were prescribed one or more opiates during their pregnancy.

So, it does have to start with education, not just of our children, but also more education of physicians. And, as has been high-

[1] The prepared statement of Dr. Walsh appears in the Appendix on page 170.

lighted here, it is not just physicians. It is dentists. It is emergency room physicians who in the interest of being compassionate are over prescribing these drugs.

The tragic occurrence of a newborn addicted to narcotics causes a syndrome similar to what is seen in adults—jitteriness, fever, diarrhea, poor feeding, and, if not treated, seizures.

About half of the babies that are narcotic exposed in the womb require pharmacologic treatment. The problem is that the strategies were largely unstudied. And so, there is huge variation in the amount of drugs used and the duration of the treatment.

Governor Kasich challenged Ohio children's hospitals to work together to come up with a better approach to this. And, we were able to publish our research that showed a significant improvement in the treatment of the newborns. Working together, we identified best practices for caring for the family and the infant and improving the integration of care between obstetricians, neonatologists and addiction medicine specialists.

From the earliest days of our work in 2011 to today, we have decreased the number of opiate-exposed newborns who received opiate treatment from 60 percent to 45 percent—and decreased the length of their treatment from 25 days to 16 days and the total hospitalization from 31 days to 19 days.

As we took that, we moved from the six children's hospitals, and with funding from the Ohio Department of Medicaid, we moved this into our statewide Ohio Perinatal Quality Collaborative (OPQC). And, I am privileged to lead that group. And, we are now active in all 105 maternity hospitals in Ohio. And, in fact, on Monday, we will have our third learning session where over 500 health professionals will meet together to share lessons learned and further improve our treatment course.

While embracing the cohesive approach that you have heard from the first panel, we are just beginning to see the tide turn on the amount of narcotics prescribed in Ohio. And, for the first time, the data comparing 2012 to 2014, the amount of opiates prescribed decreased for the first time. And, we hope that this will be a harbinger that as prescribed opiates decrease, the epidemic of addiction will decrease as well.

I believe Ohio's approach to be a model for the Nation. And, I respectfully urge additional approaches like the CARA Act to continue efforts to educate physicians and dentists and all other prescribers on appropriate pain treatment, especially the limited role of narcotics in acute pain and the science of addiction.

All of the efforts limiting illegal prescribing practices and requiring the mandatory use of our OARRS prescription platform is beginning to make inroads.

We do need to create new programs within our opioid maintenance clinics, encouraging mothers to focus on their recovery and consider delaying pregnancy until the mother's health and dependence are improved.

We also, as has been emphasized, need to enhance programs that encourage women to seek prenatal care and avoid criminalizing pregnant women with narcotic addiction. Some States have criminalized using opiates during pregnancy. And, what we are seeing, as some of those States are adjacent to us, we are seeing

increasing numbers of those women seeking care in Ohio, rather than seeking care in their home State.

We need to create incentives for new methadone treatment providers to enter into the field and eliminate barriers to prescribing Suboxone replacement therapy during pregnancy, which will decrease the severity of newborn withdrawal and allow certified providers to increase the number of patients they are treating.

Lastly, we need additional residential treatment programs that welcome both the mother and her infant and can comprehensively support the recovery.

Pregnancy is a teachable moment, where women are highly motivated to change and improve their lives and the lives of their children. And, among all of those who are treated for addiction, the success rates are higher in pregnancy than they are in other populations.

And finally, as was alluded by Senator Brown, we need to fund research at the National Institutes of Health (NIH), as we do not know what the long term consequences to these infants are going to be, and whether there are going to be impacts on their intellectual development in the future or in their vulnerability to addiction themselves in the future.

Thank you again for the opportunity to testify. And, I stand ready to support your efforts in any way possible. Thank you.

Senator PORTMAN. Thank you, Dr. Walsh, you already have. Dr. Young.

TESTIMONY OF NANCY K. YOUNG, M.D.,[1] DIRECTOR, CHILDREN AND FAMILY FUTURES, INC.

Dr. YOUNG: Thank you. And, thank you, Senator Portman and Senator Brown, for having the hearing and your continued support on these issues and the CARA Act.

Each year the number of infants who have been prenatally exposed to illicit drugs, binge drinking and heavy alcohol is about 360,000, the population of Butler County, each year.

I would like to emphasize four points from my written statement.

In the past three decades, our country has experienced at least three major shifts in substances of abuse that have had a dramatic impact on children and families, but particularly on the child welfare system.

While the increase of opioid misuse has been described as having the worst effects, unfortunately, as reported in governing just last week, we have to begin to anticipate the synthetics, such as bath salts and spice, which are beginning to kill people in a very different way than the overdose, but are increasingly being manufactured, marketed and used.

The point is that irregardless of the drug of the decade, child welfare agencies see some of its worst effects. And, despite the history and the known cost of substance use disorder on child welfare, the response has not been systemic. It has not been with funding changes to adequately address the problem. Instead, we have offered demonstration grants and pilot programs.

---

[1] The prepared statement of Dr. Young appears in the Appendix on page 173.

While worthwhile, to understand what works, we need to be at that systemic level of understanding how to take these initiatives statewide.

My second point is that the current opioid crisis, as is all too well-known in Ohio, means that young people are dying at astonishing rates too often leaving young children. Grandparents and other kinship providers are taking in these children—sometimes with little support or assistance.

We recently analyzed the Federal Adoption and Foster Care Analysis and Reporting System (AFCARS) data set and found that children who were placed in protective custody, because of their parent's alcohol or drug problem, are most frequently placed in kinship placements, rather than other type of foster care or group homes.

Another effect of opioids on child welfare services is the alarming increase in infants who are coming into protective custody. In 2014, 45,000 infants were placed in protective custody, the most recent year that data are available.

Specific to opioids, thank you again for your support of protecting our Infants Act. I understand the report to Congress is underway in the administration.

But, the Federal law intended to protect these infants, the Child Abuse Prevention and Treatment Act (CAPTA), requires medical providers to notify child protective services of infants identified as affected by prenatal substance exposure. However, it is not consistently implemented. And, child welfare agencies do not have clarity about how best to meet these families' needs.

Last week, the Administration on Children, Youth and Families (ACYF) issued program instructions for States to more fully describe their State laws and policies and then procedures for these infants. Clearly a view of the current legislation and funding mechanisms to provide safe care for these infants is now essential.

But, we also need to recognize that CAPTA funding for this provision is approximately $25 million nationwide, which in some States, it is about half of one State employee.

The response to the effects on these infants is essentially an unfunded mandate that to date has not been implemented and in the wake of increasing NAS no longer seems adequate.

The urgent policy issues here are clarifying how to implement the CAPTA law, expanding treatment access by appropriating funds for CARA, for example, and most important, ensuring that child welfare financing is flexible enough to allow keeping infants with their families whenever possible by ensuring treatment access and in-home preventive services.

My third topic is the good news on what we know about what works. Federal investments over the past decade have tested collaborative strategies in nearly 100 communities. And, those investments consistently produced better outcomes for these families.

To simplify, we have determined that there are seven core common strategies implemented in communities which lead to improved outcomes in five Rs.

Recovery. The children remain at home. They reunify. We have dramatic decrease in recurrence and decrease of return to care,

about a third of standard services. These positive results are detailed in my written statement.

Implementing these priority strategies is underway in Ohio as a result of a grant from the Department of Justice's Office of Juvenile and Delinquency Prevention (OJJDP) as a grant to the Ohio Supreme Court. OJJDP selected five States to show how these ingredients of better practice can be implemented on a larger scale by creating systems change throughout the juvenile court docket.

I have been privileged—I feel like Ohio is my second home. I am here about every other month and on the phone every week with a State team that is devoted to expanding these kinds of practices across the State, with 12 communities that have been selected as pilots.

And, over this past 18 months, we have been focused on implementing these seven key ingredients and working on the data systems to monitor outcomes. Next spring, Ohio will be one of those five States that will compete for funds for full implementation of the plans that they have made in the last 2 years. Finally knowing that Federal investments have generated a knowledge base of effective approaches and demonstration grants, pilot programs and Title IV–E waivers, we now have clear policy choices.

Improving data collection and monitoring. Building on the lessons from the prior Federal investments to take these initiatives to scale in the States. Solve the current gap in timely treatment access.

Funding CARA, as you know, is critical, as well as providing child welfare with the resources they need to pay for substance abuse and mental health treatment for parents, including those families with a baby affected by prenatal substance exposure.

And, preventing future crises and costs as substance abuse patterns change over time, by providing the flexible funding that is needed by child welfare to meet the needs of families before infants are removed. When we assure timely access to effective treatment, families recover, kids stay safe at home, and we save money. Now, we can and we must move beyond these pilots and demonstrations and take these lessons into systemic changes across agencies for all of our children and families.

Thank you so much for your time.

Senator PORTMAN: Thank you, Dr. Young. Dr. Kotz.

TESTIMONY OF MARGARET KOTZ, D.O.,[1] DIRECTOR, ADDICTION RECOVERY SERVICES, UH CASE MEDICAL CENTER, UNIVERSITY HOSPITALS

Dr. KOTZ: Chairman Portman and Senator Brown, thank you for the privilege of being here today.

I am an addiction psychiatrist at University Hospitals. And, my background is, is that I have been in the field of addiction psychiatry for over 30 years. Recently, I have been heavily involved with national agencies, such as the Substance Abuse and Mental Health Services Administration (SAMHSA), and Center for Substance Abuse Treatment and recently spoke with Agent Jess, and worked

[1] The prepared statement of Dr. Kotz appears in the Appendix on page 201.

with professional organizations to develop regulations and guidelines, as well as policies for treatment of opioid disorders.

I share the concerns of all of our previous speakers and legislations that opioid addiction is destroying the lives and communities of many Ohioans.

You have heard previously, too, that this disease was previously thought to mainly affect impoverished males in inner-cities. However, the current epidemic affecting suburban women, well to do professionals and adolescents in privileged environments has reminded us that the disease of addiction does not discriminate.

I would like to discuss the role of medication assisted treatment. Studies show that when heroin addiction is treated only with abstinence and psychosocial treatment, that most fail.

Our 50 years of experience with methadone to treat heroin addiction confirms that counterintuitively the use of a selected opioid to treat opioid addiction results in decreased unemployment, criminality and infectious diseases such as Human Immunodeficiency Virus (HIV) and hepatitis C.

However, while effective, methadone is not an option for the overwhelming majority of patients with opioid addiction. It requires daily visits to specially licensed facilities, typically only found in large urban locations. It is completely inaccessible to rural patients and relatively so to those living at a distance in the cities, especially when transportation is limited. The daily visits are a barrier to employment.

Since the Drug Addiction Treatment Act of 2000 (DATA 2000), Office Based Opioid Treatment (OBOT), has been available, the partial opioid agonist buprenorphine can be prescribed by qualified primary care providers, by a physician, in the patient's neighborhood, making it significantly more accessible. Daily visits are not needed, so that the patients can work more easily.

Research demonstrates that it is as effective as methadone and far safer in case of overdose or child exposure. Even so, access remains severely limited, due to inadequate numbers of physicians prescribing buprenorphine.

An alternate medication based strategy for treatment relies not on opioids, but rather an antagonist medication that blocks opioids. Only one—naltrexone—is currently available as a daily pill or a monthly injection. While less acceptable to many patients than buprenorphine, for those willing to take it or who have monitored administration, it can be a valuable tool for increasing long term sobriety.

Although opioid agonist and antagonist medications are important additions to our treatment armamentarium, they are not in and of themselves sufficient for successful treatment. This is especially true when a primary care provider has 15 minutes to provide addiction treatment, while also complying with requirements to ensure that other issues, such as vaccinations and colonoscopies are up to date.

So, what we need is support for extended office visits and for associated behavioral services to be and to have essential favorable outcomes.

It is imperative that we train more doctors to include medication assisted treatment, and that we ensure that there is payment for both medical and behavioral services.

In Northeast Ohio, there are simply not enough facilities or behavioral services to treat addiction for those who need it. And, when space is available, insurance often fails to pay for it. Or, perversely, patients are required to fail a level of care or a medication before the appropriate treatment will be considered.

In summary, a current epidemic, our current epidemic is having a catastrophic impact on many lives in our communities. We are fortunate that both of our Ohio Senators are taking action to address this scourge. Senator Portman was a co-author of the act. And, Senator Brown has been a ferocious supporter of it.

I am a proud member of our Heroin Task Force in Northeast Ohio. However, I also think that it is likely that an approach at the Federal level will be necessary to stem the tide of opioid addiction.

Thank you.

Senator PORTMAN: Thank you, Dr. Kotz. Ms. Metz.

TESTIMONY OF EMILY METZ,[1] PROGRAM COORDINATOR, PROJECT DAWN

Ms. METZ: Senator Brown, Chairman Portman, fellow speakers, and guests, thank you for allowing me to speak to you regarding the opioid epidemic and its devastating impact on Cuyahoga County. The MetroHealth System is an essential hospital system committed to leveraging its expertise, resources, and relationships to respond to this public health crisis. I serve as Program Coordinator for MetroHealth Cuyahoga County Project DAWN, a lifesaving overdose prevention program sponsored by the health system, the Alcohol, Drug Addiction and Mental Health Services Board of Cuyahoga County and the Ohio Department of Health (ODH). I am also speaking to you as a member of the Cuyahoga County Opiate Task Force and our local U.S. Attorney Opiate Action Plan Committee.

These committees convene many local experts, such as Project DAWN Medical Director, Dr. Joan Papp, the Cleveland Clinic's Dr. Jason Jerry, County Drug Court Judges David Matia and Joan Synenberg, Dr. Gilson, our County Medical Examiner, and even Erin Helms who manages recovery housing in our community and many others in order to address this crisis by collaborating with government, law enforcement, education and prevention and addiction experts.

Our country is in the grips of an opiate addiction and overdose epidemic. We are at risk of losing a generation of Americans to disease that devastates lives, families and entire communities. In 2014, 2,482 Ohioans died as a result of a drug overdose, where 80 percent of these fatalities involved an opioid. In large part, our country's epidemic is iatrogenic. Our liberal prescribing of opioids has created a generation of Americans who are addicted to opioids and require help. As a nation, we must mobilize to curb and fix this crisis.

[1] The prepared statement of Ms. Metz appears in the Appendix on page 211.

At Project DAWN, we work to reduce opioid overdose mortality by helping to expand community access to the opioid overdose antidote naloxone. We train community members on risk factors for overdose, how to recognize an overdose and how to respond to an opioid overdose. The most critical aspect of our program is the free provision of naloxone to our patients. Since Dr. Joan Papp founded our county program in March 2013, we have provided over 3,300 kits to community members resulting in over 430 overdose rescues that we are aware of alone.

Ohio's streets are saturated with fentanyl-laced heroin, which has contributed to the loss of 502 Ohioans during 2014, as compared to 84 during 2013. Because fentanyl is an opioid that is up to 50 times stronger than heroin, the dose of naloxone needed to revive the victim must be increased. This development is impacting our intervention efforts and budget because it is increasingly necessary to provide additional take home doses to our patients.

We and other alcohol, drug and mental health service providers in our country do not have the adequate resources to meet the emerging needs of communities struggling with substance use disorders. Cuyahoga County Project DAWN is actually considered one of the largest Project DAWN programs in Ohio. We have expanded to include 3 to 4 hour walk-in clinics 3 days a week. And, also, started to provide naloxone kits in other community settings, such as the county jail, MetroHealth emergency departments and the Free Medical Clinic of Greater Cleveland's syringe exchange program. Without these strong community collaborations, we would not be able to save as many lives. Currently Project DAWN's efforts are shouldered by one full-time employee, me. In Ohio, we are one of 37 Project DAWN programs in a State of 88 counties. The reality is that many of these programs do not have full-time staff members, and some are only able to operate once a month. And, often, there are programs that run out of funds to purchase naloxone before the year's end.

Project DAWN programs are essential to curbing opioid overdose mortality at the community level, because we equip those most likely to witness an overdose with the proper lifesaving tools. While we strongly support increasing access to naloxone for first responders, including police, fire and EMS, we know that the most likely individuals to witness an overdose are actually drug users, their family and their friends.

We strongly support the Comprehensive Addiction and Recovery Act and request funding be considered to help lay responders who are connected to Project DAWN models. This investment will sustain and expand community based naloxone programs that have a proven track record in reaching people in the community before they intersect with the first responder system.

We applaud our Congressional leadership for recognizing that increasing naloxone access in our country does not alone fix the opioid epidemic. The CARA legislation is promising, in that it promotes evidence based and innovative strategies, interventions and treatments at the community level. Project DAWN welcomes Federal funding in support of community networks focusing on connecting treatment, housing, education and employment opportunities to those struggling with addiction.

Finally, the stigma that is present in our country for individuals, as you have heard from others, is no small issue to tackle. We commend CARA's focus on public awareness campaigns, which would educate the public on the risk of prescription drugs and heroin abuse. We hope these campaigns will also educate the public that addiction is a chronic disease. And, we should support those in recovery, just as we rally behind those who face other diseases. Individuals with substance use disorders are not bad people trying to get good. Instead they are sick people trying to get well.

Thank you for your time and allowing me to serve on this panel.

Senator PORTMAN. Thank you, Ms. Metz. Mr. Brandt.

TESTIMONY OF ROB BRANDT,[1] FOUNDER, ROBBY'S VOICE

Mr. BRANDT: So, I want to thank Senator Brown and Senator Portman for the opportunity to present this testimony today, as well as for your work on the CARA legislation.

On October 20, 2011, my son Robby passed away from a heroin overdose. His addiction started with a prescription for pain medication after he had his wisdom teeth taken out. It grew because of the availability of prescription pain medications in school. And, it ultimately led to his addiction to heroin. As a family, we battled the disease as best we could. But, we lacked information. We lacked education. We lacked awareness to the resources that may have been available that may have helped us save his life. But, our deficit of education really began well before his addiction. And, it began with the lack of education in the schools, to the students, where they do not fear the drugs or that the stigma is not scary, and the lack of awareness at the community level, which allows us as parents to continue to live under the false pretense that it is not going to be our kid.

In May 2012, we started Robby's Voice in an effort to raise awareness at schools and efforts to raise awareness in the communities. And, since then, we have spoken to over 75,000 people in the schools, in communities, in rehabs. And, we are currently working on turnkey programs for schools, as well as developing a center for continued recovery for post treatment.

But, the reality of it is—it is not why we started Robby's Voice. We started Robby's Voice because it was his dream. We started Robby's Voice because, when we went on this road of addiction, we had no clue. We did not know what to do. We did not know where to turn. We did not know how to deal with it.

And, it does split the family. And, the only thing worse than living with an addict is the death of a child. And, you cannot fix that.

So, today, I speak to you as a parent who has lived with an addict, as a parent who has lost a child, and as a parent who has been on the front lines for the past 4 years fighting the battle. Robby did not want to be an addict. He said it over and over. He could not escape it. We could not protect him. And, in the end, we lost him. And so, because of that, we believe strongly that prevention is the ultimate answer. Prevention strikes at demand. Law enforcement strikes at supply. Prevention strikes at demand. If there is no buyer, there is no one for the seller to sell to.

[1] The prepared statement of Mr. Brandt appears in the Appendix on page 214.

Prevention means that we have to take a good hard look at causation—things like pain as a vital sign. Pain is subjective. And, pain can be traced back to the beginning of this epidemic. We have to look at things like the Affordable Care Act and the payment structure that promotes prescribing because of patient satisfaction surveys. We have to be able to sever payment from pain.

Prevention addresses the concepts of choice and consequence. And, it is going to allow us to escape this epidemic, and it is going to allow us to avoid the next one. To that, education is the cornerstone of a prevention strategy. Education will drive a critical change in culture. And, education will drive the change in the stigma that we deal with every day in society. Education has to be comprehensive. It has to be Kindergarten through 12th grade. It has to expand beyond just science in other classrooms and other curriculums. It has to extend to the teachers. It has to extend to the support staffs. It has to extend to the parents who are the missing link in this.

We speak at schools all the time. And, what we hear is, we do not have the time, because we have standardized tests. We do not have the money. We do not have the resource. And, as a result, most of the schools that we speak in do not have comprehensive sustainable education plans. We have to educate across the spectrum. We have to educate in the communities. We have to educate in law enforcement.

We still get mixed messages from the police department. Are the police departments in the arrest and prosecute mode or are they in the treatment mode? And, it is mixed in the communities. We only have 46 police departments in the State of Ohio that are carrying Narcan. And, I can tell you it is not because of just the cost. I have had police officers look me in the eye and tell me, we just do not know if we should save these people.

We cannot miss our opportunity to educate at the point of origin, whether it is the point that the prescription is written or at the point of dispense at the pharmacy. We also have a 70 to 90 percent failure rate in treatment. And, that frankly is a support issue.

As a society, we provide support for chronic diseases like cancer and diabetes and obesity. Yet with addiction, we do not have the necessary resources, nor the necessary funds to provide the support that is needed to sustain sobriety. And, as a result, we unknowingly continue to enable relapse.

Support also has to extend beyond the addict to the family. We call addiction a family disease, yet we focus our treatment and our treatment dollars solely on the addict, while the families are at home enabling relapse, enabling addiction.

So, the question really becomes is what can the Federal Government do to help us? And, in our opinion, we believe the Federal Government can help us not only create, but employ a comprehensive strategy. This is a national issue. And, you have a national perspective. But, more importantly than that, we believe that the Federal Government can help us move with the sense of urgency, a sense of purpose. The cost of addiction we measure in billions of dollars. But, the cost of addiction is not the dollars. It is the cost of the community, and it is the cost to the fabric of our families.

We are going to lose 120 Americans today. We are going to lose 120 Americans every day until we move. And, we measure that statistic as well. See, that is not a statistic. But, those 120, they are moms and dads. They are brothers, they are sisters, and they are sons and daughters. And, that is what has to stop.

Thank you.

Senator PORTMAN. Thank you, Mr. Brandt. I really appreciate your willingness to be here and channel your grief that you and your family have experienced into something so constructive. I am going to start with a question about these kids. And, Dr. Walsh, you talked about the fact that we need more research into what the long term effects are.

Do you agree that we also need more research into how to try to avoid those long terms effects?

In other words, although I know your neonatal unit here is at the cutting edge—one of the best in the entire world—I have also been at other hospitals that do not have that expertise, here, in Ohio. And, I know you have been generous to bring in babies from not just this region, but from around the State and, indeed, across State lines.

But, what do you think needs to be done in terms of the research, first, to determine what the long term impact is, and, second, how to avoid these impacts?

Dr. WALSH. Well, Chairman Portman, as usual you ask the salient question. The babies are the downstream. They are just the tiniest part of this horrible epidemic. And so, prevention is what it is all about. And, moving upstream to have more comprehensive treatment programs is, I think, the appropriate method. And so, using public health language, a primary prevention strategy through education in the schools. But, also then, if a woman has a substance abuse disorder, urging a life planning process, so that they avoid pregnancy while they are seeking treatment and in recovery.

The research that we need on the infants, obviously, is long term. So, we need to understand how are they doing in early childhood and at school age. It is not difficult.

Sadly, we have way too many babies in Ohio to be able to do this study. In the 18 months that we have been working throughout the State, we have treated over 4,000 newborns with opiates for NAS. And, another 4,000, who we were able to manage without opiate exposure.

The bigger question that concerns me is that, if you have a genetic predisposition to addiction—and the baby shares those same genetics as the mom—are these infants then—have they been changed, in the womb, to even enhance that genetic predisposition? And, that is going to take even decades of research to be able to answer that question.

Senator PORTMAN. As you say, this is only, not, relatively, a new phenomenon—and it is overwhelming in our neonatal units. But, it is time for us to do this research, immediately, to be able to save these kids. So that they do not have to go to school unable to concentrate or to learn, which is some of what I hear, anecdotally, from some of the teachers—elementary school teachers—who are

experiencing these kids coming into their classrooms. And, how do we help with that?

Dr. Young, you talked a little about this. And, one of the things that has always concerned me is this coordination you mentioned in your testimony between child protective services and the neonatal abstinence syndrome. Just to be clear, because I am not sure I understand this, are child protective services (CPS) contacted when there is a child who comes out of the hospital and has been diagnosed with neonatal abstinence syndrome?

Dr. YOUNG. The Child Abuse Prevention and Treatment Act, it says that they are to. But, we know that there are vast discrepancies in how that is implemented.

Last week was the first time that there were program instructions to ask the child welfare agencies to describe what their policies and procedures are once that referral is made.

We have six States with the National Center on Substance Abuse and Child Welfare (NCSACW)—six States that we are working with, specifically, on this coordination between hospitals, obstetricians, child welfare agencies, the courts, and treatment agencies. And, we have detailed some of the reasons that obstetricians, in particular, and hospitals tell us, in terms of why those reports are not made.

Two States—New Jersey and Virginia—are in the process of surveying all of their birthing hospitals in order to get a better handle on what those issues are, as to why infants are either not detected or not referred or not followed up with.

So, there is a host of issues. And, I would be happy to follow up with some of those details from those States that we are working with.

Senator PORTMAN. We would love to see that data.

CARA, as you know, authorizes and reauthorizes some programs in this area for pregnant women and postpartum women. And, I know you have been supportive of that. And, you have testified about that, and even in the Senate Finance Committee. But, it seems to me, this is an opportunity, I guess, to go past—to not just provide——

Dr. YOUNG. Right.

Senator PORTMAN [continuing]. More of those services, but more research into those.

Dr. YOUNG. Right.

Senator PORTMAN. Because we have a real problem. And, I agree with what Mr. Brandt said about prevention and education. Again, I have been at this for many years. But, we have these kids.

Dr. YOUNG. Right.

Senator PORTMAN. And, they are moving their way through the system right now.

Dr. YOUNG. Correct. Several years ago, we looked at the independent living programs, because we know that these are kids that are at a substantial higher risk of developing their own substance use disorder. And, sadly, we did not find information about addiction, about being the child of a person with a substance use disorder in the independent living programs.

So, I think foster youths tell us over and over, first I wish you would have helped my parent. And, second, I did not know what I was dealing with.

So, much of what we are looking at when communities come together and actually try and work across these systems is parent/child interventions that address both of those issues.

Senator PORTMAN. Try to keep the child in the home, ultimately?

Dr. YOUNG. Keep the child in the home. But, also, after unification—or if they are at home—that the parenting class is a two generation program. That it is prevention for the child at the same time that it is a parenting program for the parent.

And, if I could just follow up on the long term consequences. It is an area that I looked at pretty extensively, previously. And, most of the research would say that alcohol and tobacco are the two substances that have the most long term developmental consequences, particularly related to alcohol related neurodevelopmental disorders.

So, when you hold those things constant, even the things that we thought were going to happen with cocaine and methamphetamine—and the prior research from the prior heroin epidemic in the 60s followed kids up to about 5 and 6 years old. And, when you controlled for those other substances, poverty and change in out of home placement, it does not look like there is an effect of that substance in and of itself.

What we have to be mindful of are first substances and the neurodevelopmental effects of alcohol. And, second, what that postnatal environment is, and the continuity of care for the postnatal environment, particularly for kids who are placed in out of home care and the frequent changes in foster care placements.

Senator PORTMAN. That data is needed. I have heard this as well. That fetal alcohol syndrome has had more——

Dr. YOUNG. Oh, yes.

Senator PORTMAN [continuing.] Evidence of long term——

Dr. YOUNG. Oh, yes.

Senator PORTMAN [continuing.] Impacts on brain development.

Dr. YOUNG. We know that clearly now——

Senator PORTMAN. Attention span and so on.

Dr. YOUNG [continuing.] From all the prenatal exposure studies that were done during the cocaine epidemic, in particular.

Senator PORTMAN. That might be a slice of better news, and the ability to really be able to——

Dr. YOUNG. Right.

Senator PORTMAN [continuing.] Post-withdrawal to be able to get these kids in the right environment.

Dr. YOUNG. Correct.

Senator PORTMAN. And, to be able to make their lives full.

Dr. YOUNG. Right.

Senator PORTMAN. In a lot of bad news, that is the relatively better news.

I have a couple other questions. But, I am going to ask Senator Brown if he would want to ask some questions. I know he has another commitment, as do all of you I am sure. But, again, thank you all for being here. I may come back for a second round.

Senator BROWN. Thank you.

And, Ms. Metz, I loved your comment—not bad, not trying to get good, but, simply, trying to get well.

Mr. Brandt, I think the real heroes in our society are those who have lost so much, as you have. And, we do not want that to happen to other families. And, you devote much of your life to that, so thank you for that. And, what you said about the satisfaction surveys in the Affordable Care Act, I am hopeful that with the new president next year that we can go back and begin to instead of having votes to repeal the Affordable Care Act or not, whichever side you vote, that we can actually go back and begin to make changes against. Anything that broad obviously has some shortcomings. And, that is, certainly, one of the things that we will look at, the satisfaction surveys and the impact that has on pain medication. Thank you.

Mr. Brandt, what do we get wrong in our conversations about addiction? And, as you answer that, elaborate on some of the work you have done to help change that dialogue.

Mr. BRANDT. I think one of the biggest things we get wrong is this perception. We just had this conversation the other night. When you look at the news coverage of addiction—and it is on every day—what do we see? We see death. We see crime. We see arrests.

And, it continues to paint the picture of these addicts as bad people—bad kids. And, they are not. These are good people. These are good kids that are being driven to these actions out of a sense of desperation—driven by a disease that they could not comprehend—that has changed their brain chemistry and that is driving this desperation. So, we create this stigma in society. And, as a result, it drives our perceptions. And, that is, I think, one thing that is critical.

Then, the other thing is, again, it is cohesion strategy. It is parent involvement. I was at an event last night in a community of 10,000 people. About 200 plus people showed up—really good showing. We had Drug Abuse Resistance Education (DARE) officers from multiple communities there.

And, you know who was not there? Not one single representative from the schools. Not one. So, we lack some cohesion relative to our strategies.

But, I think really one of the biggest deficits we have are the parents. We did a parents event in a community one evening. And, we had two parents show up. The next day we did the high school. And, nine kids went to guidance and asked for help. That is a disconnect. So, we have to do a better job of getting the information out.

So, relative to the work we do, we spend a lot of time going into schools—whether it is elementary schools or high schools. And, we have a program for the schools that focuses on choice and consequence and information.

We are working on sustainable messaging, because it cannot be one time hits. It cannot be once a year. So, we are developing posters, things that the students can do to have student leadership. We do the same thing with parents organizations.

But, really our big focus right now is recognizing that we have a massive relapse rate. We have a massive relapse rate.

So, we are in the process of jumping on board with the recovery communities and looking at a center for continued community, where we can allow recovering addicts to have a place to come where they fit, where they feel comfortable. They are not sitting at home alone. Where we can help them with that, secondary education, post secondary education, coping skills, goal setting schools, resume writing, dressing for interviews, interview skills. We want to get down the road to develop sober employees. And so, much of that is just linked to helping communities lift the stigma off through education.

Senator BROWN. Thank you.

Dr. Walsh, thank you for the work you do at Rainbow—one of the great hospitals in the State.

You have said something so obvious and so important—that we should avoid criminalizing pregnant women. What do we do to encourage pregnant women to get help?

Dr. WALSH. So, through the Ohio Perinatal Quality Collaborative (OPQC), we worked with an advertising firm that only does public health messaging. And, we have created a number of informational pieces that are directed at the pregnant women and encouraging them to seek help.

And, we have some messaging that we are partnering with the treatment programs, maintenance treatment programs to have that information there, and say, this is where you are entitled to free prenatal care. This is how you can sign up for Medicaid, for coverage. Because it is Medicaid that covers over 85 percent of these births. And, just reaching out to encourage them to get into care.

The States that have made that criminal have seen about a 60 percent drop in the number of women seeking prenatal care. And so, now you have only the hit of substance exposure, but now you do not even have the routine prenatal care and prevention that any pregnant woman would have. And so, those babies are doubly affected.

Senator BROWN. Thank you.

Dr. Kotz, as I have done these round tables around Ohio and listened to the—you heard people talk about the difficulty of getting access to treatment, both on the provider side and from the patient side—and especially the families—I, primarily, hear two things.

One is that it is just a dollar figure—they cannot scale up enough. The other I hear is that the limit that Congress put on providers, on the number of patients they could have. That might have made sense a decade and-a-half ago, but does not make sense now.

That is what we are trying to do with the Recovery Enhancement for Addiction Treatment (TREAT) Act. We hope we can fix that, particularly, in centers where they have had a history of providing care. And, doctors can go do more than 30 the first year and 100 the second and beyond. But, could you just—if you would give me your thoughts on what more do we do to address treatment options I would appreciate it.

Dr. KOTZ. I think it is a complex situation. And, I was at the Senate hearing that I think, in 2003, asked that the limit be moved from 30 to 100.

The problem is that over half of the physicians in this country, who are waivered and eligible to prescribe, are not. And, that is based on several reasons.

One, is that there are not behavioral services that are paid for to go along with it.

And, the other thing is, for a primary care physician—again, as I said, if they are to get involved with medication assisted treatment, like buprenorphine, they have to be able to, one, refer, which is not happening. And, two, they have to be able to be paid for the time that they are taking to do it. So, again, I think addiction treatment is terrifically underfunded. And, that is why there is such a huge barrier to access.

My opinion in some of the professional national organizations I am involved with that have been working with the Federal agencies—there has to be a sensible number.

The numbers that have been thrown out there, like one physician to be capped at 500, I think is going to lead to a lot more diversion. And, one—even one physician without an infrastructure cannot take care of 100 patients.

So, when you are talking about increasing the cap or the limit, currently I think the Department of Health and Human Services (HHS) is—what they are proposing is increasing it to 200.

I think that even a tiered approach, where if you are a physician that has an infrastructure with nurse practitioners and with counselors and behavioral services, then you could definitely take care of perhaps more than 100. But, if you do not have that infrastructure, then you are not really going to be providing evidence based care. So, I think there needs to be a reasonable approach to it.

Senator BROWN. I mean, that is the difficulty in picking a number. But, I mean, I have been to clinics, treatment centers around the State which clearly have the, as you say, the infrastructure to be able to do—if they had the dollars. Some do. Some have more than others. But, to scale up because they have all the ancillary services.

And, that is a difficult way to write the law or regulation that way. But, we have to figure it out. Thank you.

Senator PORTMAN. Just a quick follow up on that. I think you are right, I think it is a complex issue.

I was at a treatment center in Dayton, Ohio on Friday talking about this issue. It was a methadone clinic with some suboxone, so it was not one of these physicians. But, I think there is a concern about diversion. And they, as you know, take very careful steps at these treatment centers, including here in Cleveland, to avoid that diversion. But, there is plenty evidence of that happening.

So, we do want to continue that, that discussion with you. And, it is not part of the legislation as a result.

We do have a study on the issue of how many beds in a residential treatment center, which is another issue I think that needs to be addressed, and we need to expand that. But, the question is bringing in the extras—and that is something that again needs discussion.

On medication-assisted treatment, you did not mention Vivitrol or the difference between, sort of, methadone, Suboxone, and Vivitrol—and what works and what does not work.

Do you have thoughts on that? Have you had experience with Vivitrol?

We have about 12 pilots around Ohio now. And, some of the drug courts are using it. And, from what they have told me, some have had very good experience.

I have also been at round tables with recovering addicts who have acknowledged to me that they have used Vivitrol—and then used other substances—not opioids, but, specifically, cocaine—and it did not work for them. What are your views as an expert?

Dr. KOTZ. So, when I mentioned agonist, that included methadone and buprenorphine. And, the antagonist I mentioned was naloxone, which is the injectable form of Vivitrol.

Senator PORTMAN. Yes.

Dr. KOTZ. So, I think, Vivitrol is definitely a good alternative to agonist therapy. I think it should be used more widely.

Again, a lot of it originally had to do with cost. The cost when I first started giving Vivitrol was $1,500. And, most insurances were not paying for that.

And, more recently, payers have said that you have to fail oral naloxone before they will consider giving you Vivitrol. So, the preauthorization hassle is enormous. And, also, even the preauthorization for buprenorphine has gotten to be an enormous burden to prescribers.

Senator PORTMAN: Actually, I know that it is still considered more expensive. Although, when it is once a month as an injection—if it works—it could arguably be less expensive.

And, the timeframe obviously the average time on methadone, for instance, is much longer than Vivitrol. But, on the other hand, it is new. So, we do not have a lot of experience.

I appreciate your input on that.

And, Ms. Metz, I know we are going to have a chance to talk about this later, and I look forward to seeing your work firsthand. But, this whole issue of Narcan has been talked about a lot today. And, as you know, naloxone, Narcan is a part of this legislation. In other words, not just the firefighters and our police officers, but your organization would benefit from some of the trainings and some of the grants to provide more immediate assistance to save lives. And, that is important.

The one thing that troubles me—and I went to Kroger. They asked me to come for their announcement that Kroger was going to go to over-the-counter. And, all I asked them was, "Well, what are you doing in terms of the consultation or providing people with some information on treatment options?"

Mr. Brandt talked about frustration he hears from some police officers. And, he did not say this, but I will tell what you they tell me, which is that, sometimes, they are administering it to the same person three, four, or five times. And, their thought is, "How do you get the person into treatment?"

That, to me, is the good intention here. How do you actually shift from the safety net—we talked about the guy at McDonald's within a few miles from here. How do you get that person motivated to go into a program to get the treatment—to get the long term recovery that is needed? How do you respond to that?

Ms. METZ. Sure. So, that is definitely a valid question.

With regard to relapse, unfortunately, relapse is a part of addiction. So, if people do not survive their relapse, they could never have the opportunity to get into recovery. From my personal experience with this program for about 3 years, most of my patients actually end up saving their friends, who are also drug users. Sometimes I do see, maybe, some folks who have overdosed multiple times.

But, most of my patients, when I see them, they are asking me, "Where do I go for detox and treatment?" And, that is information that I have readily available for folks. The problem is, the treatment waiting list for detox—for inpatient are months long. And so, we are going to expect people to continue to have an overdose. We want to make sure that they survive to get to that point.

We also see folks who are getting out of inpatient treatment programs and are having a relapse almost immediately after getting out of treatment. Because, as Rob mentioned, some of our programs are failing our patients. The relapse rate from inpatient treatment is 90 percent. Now, that is a very high risk individual for overdose and overdose death, because they have no tolerance anymore.

If it is heroin that they are going to have an overdose on—perhaps, it is heroin that they use when they have a relapse—but all too often it ends up being fentanyl. So, that is something that we are continuing to be concerned about. And, unfortunately, as I said, relapse is a part of this disease.

With regard to our pharmacies, I was involved in actually training all of our Discount Drug Mart pharmacists, who are now carrying naloxone. It is mandated as part of the law for pharmacists to be able to furnish naloxone, that they go through the training similar to what we do.

And so, one of the important things that I emphasize in that training is, you want to have all of these treatment resources available to folks. Because, especially with the syringe exchange patients I see, I might be their first entry into the health care system. They might never have been comfortable with asking someone for help. And, they see someone like myself who sees them as an individual and has that information available to them.

So, I think that we are actually going to find more opportunities for folks when they go into the pharmacies to be able to ask for treatment. And so, they should be ready with that information. So, I hope that answered your question.

Senator PORTMAN. It does. And, I commend you for that. And, I am glad that in your training that, you help them to find the local treatment and detox center information. And, as you said, one of the big issues we have in Ohio is some of our detox centers do get filled up.

Having, ridden with the police officers on this issue, from their perspective, that is their big issue often is that they do not have anyplace to send people. They do not want to arrest our way through this issue. On the other hand, they have to find a place for these people who they pick up who have overdosed.

And then, if you are not doing what you are doing, which is to provide these options, I think we are really missing an opportunity. We talked a lot about teachable moments today. That is a teachable moment. And, I have talked to many recovering addicts, who

have told me that is when it happened for them—when they overdosed—and two people told me they died. They literally feel like they died. And, I guess in some respects, medically, they might have.

One guy told me he saw his father in heaven and came back. And, when he came back, that is when he finally decided he needed to seek treatment.

So, I thank you for doing that. And, I hope that we will have a chance to see it today later, but I think that is really important to interact with their pharmacists. I have so many other questions. And, again, I will continue in touch with everybody here.

But, just one final one for you, because you have mentioned this. I am not sure everybody picked up on it. But, to use Narcan in its normal dose for fentanyl is not always effective, is that accurate?

Ms. METZ. Yes. The problem with fentanyl, because of its extreme potency, the onset of the overdose is quicker. So, overdoses can occur up to 2 hours or so after somebody uses an opioid with fentanyl. You hear of folks, unfortunately when we have lost our community members, you will hear the needle was still in their arm, something like that. That is a case when it is more likely that it is a fentanyl overdose. Because, literally, the person falls out into the overdose immediately. And so, the response time needs to be quicker. All too often in most cases, the dose of the naloxone must be increased.

So, typically sometimes we will find that one or two doses of our two milligram intranasal naloxone might revive somebody who is having just a heroin overdose. We have seen people that need 10 doses of this medicine. Now, that is very important for our program, because we are already stretched in our funding. And, I have patients pretty much every day that I have decided this person is an extremely high risk, they should have more doses.

We are at risk of running out of funds through our program now. If you think of a rural community, it takes a long time for the ambulance to get there, if a person is even willing to call 911. Because there is that fear of being arrested or being charged with a drug charge or maybe even being charged with manslaughter, that they supplied that drug to their friend or family member. So, it is an increasing concern for us.

Senator PORTMAN. Well, it is a new challenge. At least, it is a greater challenge than it used to be—particularly, here in Cleveland—and in other areas that have been specifically targeted with fentanyl.

And, again, I thank all the witnesses. This is great information here today. I think we have learned two things. One, the comprehensive approach is the only approach.

And, I appreciate the fact that many of you helped us get to this point on this one bill, CARA—into our communities quickly. It will help. It will help Emily. It will help Dr. Kotz and Dr. Walsh with what they are doing. It will certainly help Mr. Brandt in what he is courageously doing. And so, we have to get that done.

But, then, there is more to do. And, funding has to follow. We did a good job in sort of providing evidence based grant making. But, now you have to have funding that actually follows it. And,

I think that is going to be successful this year. But, we have to just keep the pressure on.

And, as with every issue, again, I started working on this many years ago—the substance that is being abused will come and go—as is talked about by the experts here today. We tend to take our eye off of the ball. We will never solve the problem entirely. The tide continues to come in. And, to turn that tide requires consistency. So, I got that today, too.

And then, finally, the sense that this is a crisis. This is not just we are talking theoretically about stuff we should be doing. This is stuff we have to do in order to save lives and repair our communities and get families back together.

So, thank you very much for your testimony. Thank you University Hospital and all of us who are still here for allowing us to use this beautiful room, which will now become the official hearing room for the United States Congress. Thank you.

This hearing record will remain open for 15 days until May 7 at 5 p.m. for the submission of statements and questions for the record. And, the hearing is adjourned.

[Whereupon at 12:35 p.m., the Committee was adjourned.]

APPENDIX

Opening Statement of Senator Portman
"Examining the Impact of the Opioid Epidemic in Ohio"
April 22, 2016

Thank you all for joining me in this critical field hearing, and for helping to call attention to the need to address the epidemic of drug addiction that is devastating so many communities in all of our states.

Every day, we lose more than 120 Americans to drug overdoses. Nationally, from 2000 to 2014, the rate of overdose deaths doubled, leaving nearly half a million Americans dead from drug overdoses.

Unfortunately, it is especially hurting us right here in of Ohio.

I read some deeply saddening news in the Cincinnati Enquirer last week. According to Interact for Health's annual Ohio Health Issues Poll, in 2014, two out of every 10 Ohioans knew someone who was abusing prescription drugs; in the latest poll, it's three in 10. And out of those three in 10, four in 10 know someone who has overdosed. These percentages have been increasing across age groups, across education levels, and across income levels.

About five of those 120 Americans we lose every day are Ohioans. Since 2007, drug overdoses have killed more Ohioans than have car accidents. Statewide, overdose deaths more than tripled from 1999 to 2010, and we're told that about 200,000 Ohioans are addicted to opioids right now. More than 20,000 will overdose this year, and several thousand may lose their lives.

This epidemic is not slowing down. Our response cannot slow down. We don't have time to waste.

The Senate has done important work so far. The Comprehensive Addiction and Recovery Act, or CARA, which the Senate passed 94 to 1, is an indispensable step in the right direction. CARA will make improvements in prevention, education, and treatment alike. It will make the naloxone that has saved thousands of lives in Ohio more available and train our first responders on how to

use it. I have repeatedly urged my colleagues in the House to pass CARA, and I will continue to speak out, even if that means going against leaders in my own party.

We're here in Cleveland, which is arguably one of the regions in Ohio that is hardest hit. The statistics are heartbreaking, and they are a call to action for us as legislators. In Cleveland, from March 10—the day the Senate passed CARA 94 to 1—to March 27, 29 people died of overdoses. That's just one 17-day period in just one city.

In one long weekend, eight men and four women died of overdoses. Twelve Ohioans. That includes a 21 year old and a 64 year old. Some of the victims were white; some were African-American. This is affecting all of us.

And increasingly overdose deaths are being driven by fentanyl, which we're told can be up to 100 times more potent than heroin. In 2013, 5 people in Cleveland died of overdoses of fentanyl. In 2014, that number increased more than 700% to 37. The next year, that number more than doubled, to 89. These rapid increases are alarming, and there does not appear to be any sign that they are slowing down.

In Fairview Park, which is not far from here, we had one case last month where a man overdosed at a McDonalds—in a public, busy place. I thank God that someone was able to save his life with naloxone. But it just shows the extent of the problem: this is happening in broad daylight, and in places where children are present.

I've spent a lot of time in Cleveland speaking with advocates, doctors, and patients. My wife, Jane, and I have toured the Rainbow Babies and Children's Hospital right here. We saw firsthand babies who were born to mothers who are addicted, babies who were addicted in the women and were born addicted. They're so small that they could fit in the palm of your hand, and they have to go through the drug withdrawal process. Doctors don't fully know the long-term consequences of this process.

Cleveland has a lot to teach the country about how serious the threat of addiction is, as well as about effective prevention and treatment.

There is still much more to do after CARA. We ought to inform our future efforts by listening to the experts. That is the approach we took to developing CARA, and that is why it is such an effective piece of legislation.

Cleveland has suffered so much from this epidemic, but also possesses some of the best doctors, nurses, and caregivers, some of the most passionate advocates, and some of the most effective coalitions with whom we could consult, so I am grateful for this field hearing. That includes, especially, some of the compassionate and gifted people who work in this facility.

I look forward to hearing from our witnesses, who represent a broad spectrum of experience and backgrounds- we will hear more about neonatal abstinence syndrome, fentanyl related overdoses, medication-assisted treatment, the use of naloxone, and what we can do to prevent drug abuse in the first place.

Opening Statement of Senator Sherrod Brown
"Examining the Impact of the Opioid Epidemic in Ohio"

Friday, April 22, 2016

As prepared for delivery:

Thank you, Senator Portman, for inviting me to be an honorary member of the Homeland Security and Government Affairs Committee for the purposes of this field hearing today.

Thank you also to Senator Carper and Senator Johnson and their staffs for their help in organizing this important hearing on the Opioid Epidemic in Ohio.

But thank you most of all to those of you who are spending your Friday mornings here with us to testify on an issue about which you know all too well.

It's about time members of Congress come together in a bipartisan way and take action on the opioid addiction epidemic that is devastating communities across our country.

We have failed to sufficiently invest in mental health care and treatment for addiction and substance abuse for too long. Now that we are experiencing a record number of fatal overdoses, it is impossible to ignore these issues any longer.

As everyone here knows all too well, in one year alone, nearly 2,500 Ohio families lost a loved one to addiction – and thousands more continue to struggle with opioid abuse or with a family member's addiction.

Addiction isn't an individual problem or a character flaw – it's a chronic disease. And right now, it's placing an unbearable burden on our families, our communities, and our health care system.

This issue has hit every community across the country, but it is particularly acute here in Northeast Ohio.

Last year in Cuyahoga County, at least one Ohioan died every day from a drug overdose.

While deaths related to heroin decreased, deaths as a result of Fentanyl [fen–tan–ill], a powerful synthetic opiate, increased.

We cannot continue to make progress against one drug but have another more dangerous and more lethal version pop up in its place.

And as we work to fight against this epidemic, we cannot afford to forget the human cost of inaction.

I am proud that we are starting to tackle this epidemic at the national level, and I am encouraged by the Senate's passage of Senator Portman's bill – the *Comprehensive Addiction and Recovery Act* (CARA), which included a provision I authored with Senator Toomey from Pennsylvania.

But CARA – even if it gets passed into law – is not enough. This bill, which we are all hopeful the House will take up soon, is just a first step.

On its own, this legislation is not nearly enough to put a dent in this epidemic.

The initiatives in CARA are going to mean very little without additional funding to back them up.

We need to ensure our communities have access to affordable naloxone, which reversed 166 heroin- or fentanyl-related overdoses in Cuyahoga County in 2015.

This requires funding, yes. But to truly fight this epidemic, we need to do more.

We need funding but we also must build upon the community-based structures and supports that already exist to do more prevention, educate our children on the danger of these drugs, give our health providers the tools they need to fight pain without opioids, and – most importantly – increase access to treatment.

I have held several roundtables around the state of Ohio to learn from communities and health professionals on what they need to make progress in this fight.

During a roundtable I held in Chillicothe, Ohio, we heard over and over how important funding is for prevention. The community organizations and local governments are already stretched thin – in both time and resources – dealing with the increasing number of residents who struggle with addiction.

They don't have the time or the resources they know that they need to educate their communities about prevention.

We need real investment in prevention programs. We need real investment in treatment options that help patients not just get clean, but stay clean.

In public health emergencies, we are somehow always able to come up with the necessary money – whether it's Swine Flu or Ebola. Hopefully, we will now provide money to address the emerging Zika virus.

But while we support these important efforts, we must recognize that addiction is also a public health emergency. You can't look at the spike in the number of deaths and conclude anything else.

I am disappointed that Congress has been unwilling to come together to invest in this epidemic and give our communities the support they need to fight this epidemic.

It's time for us to get serious, and call this what it is – a public health crisis that demands real, immediate investment.

We look forward to hearing the witness testimony today so that Senator Portman and I can bring back your stories and suggestions to our colleagues in Washington and urge them to do more.

Thank you.

Opening Statement of Chairman Ron Johnson
"Examining the Impact of the Opioid Epidemic in Ohio"
Friday, April 22, 2016

As prepared for delivery:

During this congress, the committee has spent a great deal of time uncovering and defining the problems occurring at our borders. Today will mark our 17th hearing on border security and our fourth hearing focusing specifically on the rising heroin and opioid epidemic across this country. These topics are closely related, as one root cause—perhaps the primary cause—of our unsecure border is America's insatiable demand for drugs.

The information our committee has gathered from all this work indicates that America's borders are not secure. The declining price of heroin—from a nationwide average of $3,260 per gram of pure heroin in 1981 to as low as $100 per gram on the streets of Milwaukee today—is a metric that proves the point. Today, the committee will explore how our unsecure southwest border has become a gateway for drug traffickers to distribute illicit drugs across the country.

I want to thank Senator Portman, a trusted and valuable member of the committee, for proposing and organizing this very important hearing in Cleveland. Ohio stands at the center of the heroin and opioid epidemic. In 2014, unintentional drug overdoses continued to be the leading cause of injury-related death in Ohio, ahead of motor vehicle crashes—a trend that began in 2007. Unintentional drug overdoses caused the deaths of 2,744 Ohio residents in 2014—the highest number of deaths on record from drug overdoses. The increased illicit use of a powerful opioid, fentanyl, was a significant contributor to this rise in drug overdose deaths.

My home state also has been greatly affected by this epidemic. While Wisconsin averaged only 27 heroin deaths a year from 2000 to 2007, by 2014 there were more than 250 heroin-related deaths. In Milwaukee County alone, 109 heroin-related deaths occurred in 2015. In fact, last November, six people died in Milwaukee in a 24-hour period due to prescription medication or heroin overdoses.

During a committee hearing last week in Wisconsin, we heard from not only a former addict, but from a sister, father, and two mothers, reminding us that drug addiction harms not only those who use the drug, but also their friends and family.

Today the committee will hear very important local perspectives defining the opioid epidemic in Ohio. This hearing will provide a voice for those that do not have one: babies born physically addicted to heroin due to their mothers' use. This phenomenon is known as neonatal abstinence syndrome (NAS), and Ohio has seen a 740 percent increase in it since 2004. Today's witnesses will describe how the rising heroin and opioid epidemic in this country is giving rise to NAS cases.

I thank the witnesses for their willingness to provide these important insights. I would also like to again extend a special thanks to Senator Portman for his leadership on this issue and for convening a hearing to examine much needed solutions to this growing public health crisis.

U.S. Senate Committee on Homeland Security and Governmental Affairs

"Examining the Impact of the Heroin Epidemic in Ohio"

April 22, 2016

Senator Kelly Ayotte Statement for the Record

I want to thank Senators Portman and Brown for holding today's hearing to discuss the most urgent public health and safety issue facing my home state of New Hampshire—the fentanyl, heroin, and prescription opioid abuse epidemic. I know this is an issue of grave concern to Ohio, as well, and I am pleased that the committee has again taken its work on the road to hear from those who are being directly affected by this public health and safety crisis.

Last September, we held a field hearing in Manchester, New Hampshire, and invited top federal officials from Washington to hear first-hand from members of our treatment community, local law enforcement, and families affected by this epidemic. I especially appreciated that Commissioner Kerlikowske traveled to New Hampshire to also take part in that hearing.

In New Hampshire, the number of drug overdose deaths is staggering: In 2015, there were over 430 drug overdose deaths —159 of which could be attributed to fentanyl alone. These tragic statistics are more than just numbers. They are family members, friends, and neighbors. I've had too many families tell me that they've lost a daughter, or a son, or mother – this epidemic is touching every community in our state.

Solving this crisis requires a comprehensive approach. Over the past two years, I've spent a lot of time meeting with families, treatment providers, law enforcement, first responders, health professionals and individuals in recovery to better understand what they're seeing and to identify ways that we can help at the federal level.

Whether it's speaking with families, hosting community forums, or riding along with first responders when they respond to overdose calls, these experiences have all served to reinforce my commitment to work with anyone to find effective solutions to this problem. That is why I was proud to join Senators Portman, Whitehouse, and Klobuchar in introducing the Comprehensive Addiction and Recovery Act—bipartisan legislation that has the support of over 130 groups across the nation, including the National District Attorneys Association, the Major County Sheriffs'

Association, Community Anti-Drug Coalitions of America, and the National Association of Attorneys General.

The Comprehensive Addiction and Recovery Act would expand opioid abuse prevention and education efforts, expand the availability of naloxone to first responders and law enforcement, support additional resources to identify and treat incarcerated individuals struggling with substance use disorders, expand drug take-back efforts to promote safe disposal of unused or unwanted prescriptions, strengthen prescription drug monitoring programs, and launch a prescription opioid and heroin treatment and intervention program.

CARA would be a strong step towards combatting this epidemic, both in my state and across the country. Last month, the Senate passed the legislation by a vote of 94-1, and I am hopeful that the House of Representatives will pass this legislation quickly.

Finally, I want to touch on the role of fentanyl in drug overdose deaths. Fentanyl continues to cause more drug overdose deaths in New Hampshire than heroin. Eric Spofford, CEO of the Granite House and New Freedom Academy in New Hampshire, has said that fentanyl is a "serial killer." It should be treated as the deadly drug we know that it is.

In September of last year, I introduced the Stop Trafficking in Fentanyl Act to reform trafficking penalties for fentanyl, ensuring that the law appropriately reflects the potency of this drug—which is estimated by the DEA to be up to 50 times more powerful than heroin—and takes into account its increasing prevalence in drug overdose deaths.

Law enforcement is working tirelessly to take these drugs off the streets. But we can't simply "arrest our way out of" this problem. I've heard from law enforcement in New Hampshire that key pieces they need to confront this public safety issue are more prevention efforts, more treatment options and more support for individuals in recovery. CARA would address all of these priorities.

I thank Senator Portman for his strong leadership on this issue and for convening this field hearing.

TESTIMONY AS PREPARED
OHIO ATTORNEY GENERAL MIKE DEWINE
U.S. SENATE COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS
CLEVELAND, OH
APRIL 22, 2016

Thank you, Senator Portman, for presiding over this very important field hearing today, as we discuss the opioid epidemic in Ohio.

Ohio is facing the worst drug epidemic I've seen in my lifetime. Every county, city, and village in Ohio is affected by the opioid problem. Quite candidly, the face of Ohio is becoming the face of heroin.

According to the Centers for Disease Control, nearly half a million persons in the United States died from drug overdoses between 2000 and 2014. But, in 2014 alone, 47,055 Americans died from drug overdoses, which was the highest number than in any prior year on record. For perspective, almost that same number of Americans -- 47,434 -- died in battle during the Vietnam War.

Since 2007, drug overdose deaths in Ohio surpassed deaths from motor vehicle crashes. The Ohio Department of Health reports that 2,482 Ohio residents died from unintentional drug overdoses in 2014. This is the highest number of deaths from drug overdoses on record – a number that reflects a 17.6 percent increase over the 2,110 drug overdose deaths in 2013. Opioids, whether it's heroin or a prescription opioid, are involved in the majority of these deaths.

Tragically, we are seeing the impact of the drug epidemic in babies born to moms addicted to heroin or other opioids. The Ohio Hospital Association reported in 2013 that nearly $100 million in healthcare related costs and 25,000 days in Ohio hospitals were connected to treating newborns impacted by neonatal abstinence syndrome.

We've also seen the evidence as it comes in to my office's state crime lab – the Bureau of Criminal Investigation (BCI). Heroin cases began increasing dramatically in mid-2012, and since then, we've experienced an unprecedented number of heroin submissions. In fact, one out of every four cases coming through BCI lab involves testing for heroin.

The psychological barrier that stops someone from taking heroin is simply gone. And, the drug Mexican drug cartels have created the perfect business model to make it all the easier to feed someone's addiction. Their door-to-door delivery system makes calling for and getting heroin easier and cheaper than ordering a pizza!

True impact of our heroin epidemic is measured in lives lost, families devastated, and communities diminished. That's why my office is trying to combat the problem on several fronts.

In 2013, we established a heroin unit in my office that includes lawyers, investigators, and community outreach liaisons. We restructured some existing resources, added others, provided our law enforcement partners with new tools, and expanded our community prevention and education outreach.

Our community outreach team works with law enforcement, prosecutors, grass roots organizations, schools, clergy, and other citizens to help form a plan specific to that community to address the drug problem. This team helps communities identify needs and give recommended resources to address those needs. Recommendations include anything from implementing a school based prevention program that's working in another area of the state, accessing naloxone, or connecting the community with state resources.

Additionally, my office provides grants for law enforcement officers for drug use prevention education programs in schools. However, in most cases, limits on grant dollars and manpower usually allow these programs to be in one or two grade levels at most. In the 1980s, I served on President Reagan's National Commission on Drug Free Schools. The experts we had contact with routinely told us that repetitive, comprehensive, school-based education was necessary to successfully combat drug addiction.

Some schools today have implemented alternative programs, such as the National Institute on Drug Abuse's "Brain Power" curriculum in science courses or Generation Rx from the Cardinal Health Foundation and Ohio State University College of Pharmacy. I'm encouraged by these efforts and support the expansion of evidence-tested school-based prevention education programs. Our hope is that we can help put that psychological barrier back up so our children will understand the dangers of drug abuse.

Many addicts got hooked on heroin by first misusing prescription opioids. To address this issue, we partnered with the Ohio Department of Health and Drug Free Action Alliance to provide free drug collection bins to a number of local law enforcement agencies. We've also gone after those doctors who overprescribe painkillers. Since I took office in 2011, a total of 73 doctors and 22 pharmacists have had their licenses revoked or permanently revoked for violations involving improper prescribing or handling of controlled substances or illegal drugs.

I've also been very supportive of expanding access to naloxone for first responders. Naloxone was administered at least 74,000 times in Ohio between 2003 and 2012. More than 17,000 doses were administered in just the past two years. I'm pleased to report to you that we've renewed our agreement with Amphastar Pharmaceuticals, Inc. -- a manufacturer of naloxone -- to provide rebates to consumers, such as police departments and other non-federal government agencies that distribute the drug in Ohio. So far, almost 60 Ohio agencies have applied for more than $151,000 in rebates.

In 2015, the law changed in Ohio to allow pharmacies to sell Naloxone over the counter without a prescription. Since then, we worked with several Ohio retail stores, including CVS, Kroger and Walgreens, who have agreed to sell Naloxone. This will also help families and friends who know someone who is addicted by letting them keep this life-saving medication on hand.

As Ohio's Attorney General, I am proud to be one of 38 Attorneys General who signed on to support passage of your 2016 Comprehensive Addiction and Recovery Act (CARA). As you know well, there is no magic bullet solution, but CARA's comprehensive approach would be a tremendous help to address the heroin problem in our state.

Government can't solve the heroin problem. And, we know that we cannot arrest or convict our way out of it, either. The truly effective solutions will come from citizens on a county by county, village by village, congregation by congregation basis. My office will continue to support families, schools, law enforcement, the faith-based community and others to bring hope and healing to those who struggle with substance abuse and addiction.

Thank you for the opportunity to testify here today. I'm happy to answer any questions.

Department of Justice

STATEMENT OF

CAROLE S. RENDON
ACTING UNITED STATES ATTORNEY
NORTHERN DISTRICT OF OHIO

BEFORE THE

COMMITTEE ON HOMELAND SECURITY AND
GOVERNMENTAL AFFAIRS
UNITED STATES SENATE

FOR A FIELD HEARING IN CLEVELAND, OHIO
ENTITLED

EXAMINING THE IMPACT OF THE OPIOID EPIDEMIC

PRESENTED

APRIL 22, 2016

Statement of Carole S. Rendon
Acting United States Attorney
Northern District of Ohio
Committee on Homeland Security and Governmental Affairs
United States Senate
Cleveland, Ohio
April 22, 2016

Chairman Johnson, Ranking Member Carper, and Members of the Committee, thank you for the opportunity to discuss the most pervasive drug problem facing the Northern District of Ohio today: the heroin, prescription opioid, and illicit fentanyl overdose epidemic. I appreciate the opportunity to testify today to discuss how we, in Northeast Ohio, are addressing this crisis through our innovative Northeast Ohio Heroin and Opioid Task Force.

The rise of heroin and the misuse of prescription opioids in Ohio – and across the United States – is one of our biggest challenges to public health and safety. It threatens our communities, families, and children. Heroin use and the prescription drug misuse are intertwined and both must be addressed. Although a small percentage of those prescribed opioids misuse them, 80% of new heroin users previously misused prescription pain medications.[1] The Department of Justice and the entire Administration are working closely together with our federal, state, local, and tribal partners to fight this growing epidemic through a combination of enforcement, prevention, education, and treatment.

This is truly a crisis in our community in Northeast Ohio. Several years ago, we identified and began responding to a health care and law enforcement crisis that has impacted every corner of our state, but was first apparent to us here in Cuyahoga County. Heroin overdose deaths increased in Ohio's largest county by more than 400 percent between 2007 and 2012, when 161 people died as a result of heroin overdose, in addition to another 111 who died from overdose of other opioids. By 2013, that number had increased again, to 194 fatal heroin overdose deaths. In 2012, people living in Cuyahoga County were more likely to die from a heroin overdose than a car accident or homicide. Sadly, the number of overdose deaths has continued to increase, particularly with the introduction of fentanyl, which has proven to be incredibly deadly. According to the Cuyahoga County Medical Examiner, while there were only five overdose deaths in 2013 involving fentanyl, in 2014 that number rose to 37, and in 2015 to 91. In 2014, we lost 177 people to heroin overdoses, 16 to fentanyl overdoses, and 21 to a combination of heroin and fentanyl. In 2015, heroin alone resulted in 137 overdose deaths, while fentanyl spiked to 44 deaths, with an additional 47 people dying of a combination of heroin and fentanyl. In 2016, we have had 125 fatal overdoses from heroin and fentanyl in Cuyahoga County alone, and it is only April. We were overwhelmed by a death a day in the early part of

[1] Muhuri, P. et. al., *Associations of Nonmedical Pain Reliever Use and Initiation of Heroin Use in the United States*, CBHSQ Data Review (August 2013), retrieved from http://www.samhsa.gov/data/sites/default/files/DR006/DR006/nonmedical-pain-reliever-use-2013.htm.

the year. Then, in March, we started to see an average of two overdose deaths a day. The devastation is undeniable.

This crisis, however, is not limited to Cuyahoga County. We are seeing waves of overdoses, both fatal and non-fatal, in Lorain, Summit, Stark, Lucas, and Marion Counties. No part of our District is safe from this epidemic. Nationally, there were over 47,000 overdose deaths in 2014, or approximately 129 per day; 61 percent of those deaths involved either a prescription opioid or heroin. These are our family members, friends, neighbors, and colleagues.

Faced with this crisis, we assembled the Northeast Ohio Heroin and Opioid Task Force (Task Force). This Task Force brought together a wide and diverse group of stakeholders to identify and implement comprehensive solutions to this growing crisis. There was a lot of positive work being done in our community already; our goal was to build upon and expand on it.

A summary of Task Force members speaks to both the breadth of the partnerships as well as the multifaceted nature of the problem that we face. Led by the United States Attorney's Office for the Northern District of Ohio, members are leaders from all of our major healthcare institutions, including: University Hospitals; Cleveland Clinic and MetroHealth Medical Center; Cuyahoga County Sheriff's Department; Cuyahoga County Common Pleas Court; the Cuyahoga County Prosecutor's Office; Ohio Attorney General's Office; judges from Geauga and Ashtabula counties; Robby's Voice; Orca House; WKYC Channel 3; Cleveland Division of Police; Drug Enforcement Administration, Federal Bureau of Investigation; Department of Justice's Organized Crime Drug Enforcement Task Forces (OCDETF); Ohio State Medical Board; Ohio State Pharmacy Board; Cuyahoga County Board of Health; Cuyahoga County Medical Examiner; Alcohol Drug Addition & Mental Health Services Board; Westshore Enforcement Bureau; educators; clergy; treatment providers; faith leaders, and others.

Having hosted a Prescription Pill Summit (Summit) in the Spring of 2012, the Task Force quickly decided that we needed to host a second community-wide summit to focus on solutions and raise awareness of the problem of heroin and opioid abuse in our community. It seems hard to believe now, but in 2013 there were many people who were either unaware of the scope of the problem or in denial that it was happening in their community. Our goal was to use the Summit to create a concerted, coordinated effort to address the problem from multiple fronts and stem the tide of death and destruction wrought by heroin and opioid addiction.

We brought together more than 700 community members and leaders of Northeast Ohio's top institutions, including: doctors from all of our hospital systems; federal, state, and local law enforcement; addiction specialists; pharmacists; the medical examiner; parents of children who died from heroin or other opioids; educators; and people in recovery. The result of the Summit was the creation of a Heroin and Opioid Community Action Plan to guide the work of our Task Force. The Action Plan was not set in stone, but was designed to serve as a guide, with goals and action items that would and could change as we achieved successes or needed to address new problems.

The Heroin and Opioid Community Action Plan addresses the heroin and opioid crisis from four perspectives: 1) law enforcement; 2) healthcare policy; 3) education and prevention; and 4) treatment. Here are just a few examples of success we have achieved by implementing this comprehensive plan:

- The Law Enforcement Subcommittee: Working with the Cuyahoga County Sheriff and Prosecutor, and the Cleveland Division of Police, we created a Heroin-Involved Death Investigation Team. Fatal heroin overdoses are now treated as crime scenes, with investigators going to every scene to gather evidence that we can use in potential criminal prosecutions of the drug dealers who are poisoning our community. To date, the United States Attorney's Office for the Northern District of Ohio has filed "death specification" indictments against nine drug dealers, and dozens more manslaughter charges have been filed in state court. This law enforcement model is now being replicated in Lucas County.

- Healthcare Policy Subcommittee: Members of the Task Force, particularly doctors from University Hospitals, Cleveland Clinic, and MetroHealth Medical Center, have worked to increase physician use of Ohio Automated Rx Reporting System (OARRS), the statewide prescription drug monitoring program, and have helped develop increased training and education for doctors about the dangers and unintended consequences of overprescribing opiates. A recent Centers for Disease Control and Prevention (CDC) report noted that in 2015, the total doses of opioids prescribed in Ohio decreased to 701 million from a high of 793 million in 2012, a decrease of 11.6 percent.[2] While that decrease is the result of many factors, we believe the work of the Task Force certainly helped in that effort.

- Education and Prevention Subcommittee: Members of the Task Force have organized town hall meetings and presentations at schools and community organizations attended by thousands of people throughout Cuyahoga County. Task Force members also have spearheaded two significant media campaigns to raise awareness of this crisis. The Ohio Attorney General is also leading an effort to get a science-based drug education program into our middle school curriculum.

- Treatment Subcommittee: Dr. Joan Papp, Dr. Jason Jerry, and other Task Force members led the effort through administrative and state legislative action to expand the availability of the opioid overdose-reversal drug naloxone to first responders and relatives of people with substance use disorders. Dr. Papp's Project DAWN (Deaths Avoided with Naloxone) has provided overdose prevention training and naloxone kits to persons with opioid use disorders and their loved ones throughout Cuyahoga County. Their work has literally saved hundreds of lives. They are continuing that work while also addressing the critical shortage of treatment facilities in our region.

---

[2] Spies, E., et. al., *Undetermined Risk Factors for Fentanyl-Related Overdose Deaths,* EpiAid 2016-003, Trip Report – Epi2 (March 2016), retrieved from http://www.healthy.ohio.gov/~/media/HealthyOhio/ASSETS/Files/injury%20prevention/Ohio%20PDO%20EpiAid%20Trip%20Report_Final%20Draft_3_18_2016.pdf.

The Heroin and Opioid Action Plan that serves as the master plan for Northern Ohio's attempt to address this crisis, and the sustained Task Force efforts to implement that plan, are excellent examples of what it means to develop a multi-faceted approach that is smart on crime. Our Task Force model is now being replicated in United States Attorney's Offices throughout the country, including in Georgia, Illinois, Minnesota, New Mexico, Montana, Maine, and Kentucky.

While we have had many successes, the Task Force is keenly aware that the death rate has only increased as the threat has morphed from prescription painkillers to a combination of heroin and fentanyl. A recent CDC report further examines the increase in unintentional fentanyl-related drug overdose deaths in Ohio and notes the dangers of injection drug use.[3] Rather than discouraging us, the on-going crisis has underscored the need for all aspects of our community to come together and continue to implement a comprehensive approach to this problem.

These efforts have had an impact on local communities. Thanks to Task Force member Dr. Papp and Project DAWN, the number of people who died last year from heroin and fentanyl was nearly half as high as it otherwise would have been (228 dead vs. 398 without DAWN) in Cuyahoga County. Similarly, our Medical Examiner recently sounded the alarm in a widely issued press release on the appearance of fentanyl in pill form, dyed blue to look like oxycodone, but far more potent and deadly. That alarm led law enforcement to focus its efforts on fentanyl, resulting in the seizure last month of more than 900 fentanyl pills and the arrest of the dealer who was selling the pills.

Nationally, to enhance synchronization and coordination of Federal efforts, in October 2015, the Office of National Drug Control Policy (ONDCP) in coordination with the National Security Council, established the National Heroin Coordination Group (NHCG). The NHCG, a multidisciplinary team of subject matter experts within ONDCP focused exclusively on working the heroin and fentanyl problem set, helps guide and synchronize the interagency community's efforts to reduce the availability of heroin and fentanyl in the United States by disrupting the global supply chain. The NHCG is the hub of a network of interagency partners who can leverage their home agency authorities and resources with the desired result of significantly reducing the heroin-involved deaths in the United States through a disruption in the heroin and fentanyl supply chains, a detectable decrease in the availability of those drugs in the U.S. market, and the complementary effects of international engagement, law enforcement, and public health efforts. The Department is also working to address this crisis. OCDETF has established a multi-agency, national heroin initiative to facilitate rapid collection and sharing of relevant information across agencies, jurisdictions, and disciplines, to maximize the effectiveness of the Department's holistic approach. DEA is using all available criminal and regulatory tools – both domestically and internationally – to combat this threat by identifying, targeting, disrupting, and dismantling individuals and organizations responsible for the illicit manufacture and distribution of pharmaceutical controlled substances. DEA also is targeting the Mexican-based criminal organizations that are supplying heroin to the United States. Finally, the office of Community Oriented Policing Services (COPS) program recently announced that it is accepting applications

[3] *Id.*

for COPS Anti-Heroin Task Force (AHTF) grants. The 2016 Anti-Heroin Task Force Program is a competitive grant program that assists state law enforcement agencies in states with high per capita levels of primary treatment admissions for both heroin and other opioids. AHTF funds will be used for investigative purposes to locate or investigate illicit activities related to the distribution of heroin or the unlawful distribution of prescription opioids.

We see a continued need to aggressively prosecute drug traffickers and disrupt the supply of illicitly manufactured fentanyl and heroin into the United States. Simply getting treatment for everyone suffering from substance use disorders will not solve the problem, because not everyone is ready to enter treatment and treatments are imperfect, but given the size of the existing population of heroin and opioid users, we must make sure we have enough treatment capacity so that when someone says enough and wants help, treatment is immediately available. Changing prescribing practices alone also will not cure the problem, but we must continue to curb the rate at which doctors are prescribing opioids and address the underlying incentives that have led to that practice. Education is a key component. That's why the Administration has supported requiring practitioners (such as physicians, dentists, and other authorized prescribers) who request DEA registration to prescribe controlled substances to be trained on responsible opioid prescribing practices as a precondition of registration. Finally, every one of us must continue to talk to our children, our friends, and our colleagues about the dangers of opioids and how no one is immune from the threat. Opioid addiction knows no boundaries. It is an equal opportunity killer of old and young, men and women, urban, suburban, and rural, rich and poor, black, white, and Hispanic. We are all at risk.

I believe it will take what we have come to call the "all of the above approach," that requires everyone to work together in concert to push back on what appears to be, at least in our corner of the world, a public health and law enforcement crisis.

Promoting wellness and recovery

John R. Kasich, Governor • Tracy J. Plouck, Director • 30 E. Broad St. • Columbus, OH 43215 • (614) 466-2596 • mha.ohio.gov

Director Tracy J. Plouck
Ohio Department of Mental Health and Addiction Services
Testimony before the U.S. Senate
Committee on Homeland Security and Governmental Affairs

April 22, 2016

Good morning Senators Brown and Portman. It is my pleasure to speak before the Senate Committee on Homeland Security and Governmental Affairs. Senator Portman, as chair of the committee today, I appreciate the invitation you extended to me. As you are aware, the opiate epidemic has hit all states hard, including Ohio, and the Kasich Administration has worked tirelessly over the last five years to curb the tide, yet the storm continues to rage. I know that you both share the same concerns about this as the Governor does. I would like to talk to you today about Ohio's efforts, including what is working and where there is work that still needs to be done.

Unintentional drug overdose deaths in Ohio reached an all-time high of 2,482 in 2014, which is the most recent year available. Opiate-related deaths, which include both heroin and prescription painkillers, peaked at 1,988 deaths in 2014, up from 296 in 2003. With 502 fentanyl-related drug overdose deaths in Ohio in 2014, fentanyl was a significant contributor to a rise in drug overdose deaths, according to preliminary data released by the Ohio Department of Health (ODH). (Note: the 502 fentanyl related deaths number is also included in the 1,988 total for heroin and prescription painkillers.) By comparison, in 2013 just 84 deaths involved fentanyl. As a result, Ohio proactively requested assistance from the Center for Disease Control's EpiAid to better analyze our opiate related deaths. We are currently reviewing the recommendations and determining what should be implemented in Ohio to build on our current effort. This issue continues to be a pressing one for the state.

Governor John Kasich has made the fight against opiates a priority and is one of the nation's most outspoken advocates on this issue. Early in his administration, the governor announced the establishment of the Governor's Cabinet Opiate Action Team (GCOAT) to fight opiate abuse in Ohio. GCOAT is comprised of directors from the multiple cabinet agencies that touch the opiate issue and is designed to foster collaborative efforts across public health, treatment, law enforcement, education, and other agencies in recognition that the problem is a complex one that needs attacked from many different angles.

One of the key documents that GCOAT has produced is a toolkit for local communities that are interested in convening their own cross-agency efforts. That toolkit can be found on our GCOAT webpage at http://mha.ohio.gov/gcoat. It outlines the best practices that every community should embrace, such as increased availability of naloxone, establishment of drug courts, and coordinated prevention efforts. At the state level, we have worked closely with communities, such as Ross and Trumbull counties, to provide assistance in bringing together local partners

and offering technical help to develop a plan to leverage local resources and collaboration to combat the crisis.

I know that you understand the importance of taking this issue on in a multi-pronged way because of your work on the Comprehensive Addiction and Recovery Act (CARA) of 2016. Senator Portman, I would like to thank you for your sponsorship of this bill, and I would like to thank you, Senator Brown, for your support. CARA takes a similarly comprehensive approach and addresses on a national level several things that we know are already working in Ohio. I encourage you in your efforts to move CARA forward, and I hope that Ohio's experience can offer additional support for passage of this comprehensive legislation to address opiate abuse on a national level.

Prescribing Practices

- Prescribing Guidelines
  In its ongoing efforts to combat drug abuse and save lives, the Governor's Cabinet Opiate Action Team developed comprehensive prescribing guidelines for the outpatient management of acute pain in January 2016. The acute guidelines follow previous prescribing guidelines for emergency departments (April 2012) and the management of chronic pain (October 2013). All three guidelines were developed in conjunction with clinical professional associations, healthcare providers, state licensing boards and state agencies. The prescribing guidelines are designed to prevent "doctor shopping" for prescription opiates, to urge prescribers to first consider non-opiate therapies and pain medications, to reduce leftover opiates that can be diverted for abuse, and to encourage prescribers to check Ohio's Automated Rx Reporting System before prescribing opiates to see what other controlled medications a patient might already be taking. I know that CARA also addresses this issue from a national perspective, and I applaud efforts to limit the number of opioids prescribed nationally to ensure that these powerful drugs are used only in the course of appropriate medical care.

- OARRS Improvements
  Ohio Automated Rx Reporting System (OARRS) is a tool created to track the dispensing of controlled prescription drugs to Ohio patients. It is designed to monitor suspected abuse or diversion (i.e. diversion of legally prescribed drugs for illicit purposes), and can give a prescriber or pharmacist critical information regarding a patient's controlled substance prescription history. This information can help prescribers and pharmacists identify high-risk patients who would benefit from early interventions such as pharmacist consultation with the prescriber regarding a patient's controlled substance use, switching to alternative non-opiate therapies, further assessment of addiction risk or mental health concerns and, when appropriate, referral to an addiction medicine specialist. While Ohio is seeing record use of OARRS, it is cumbersome for prescribers and pharmacists to switch from their computer system to OARRS to check past opiate history. That is why Governor Kasich recently invested up to $1.5 million to integrate OARRS directly into electronic medical records and pharmacy dispensing systems so prescribers and dispensers can automatically check past opiate history within the same system they use day-to-day.

- Results
  As a result of the prescribing guidelines and the increased utility of OARRS, the number of prescriber and pharmacist queries using OARRS increased from 778,000 in 2010 to 9.3 million in 2014 and Ohio is making impressive progress in curbing painkiller prescriptions, including:
    - The number of prescription opiates dispensed to Ohio patients in 2014 decreased by more than 40 million doses (5.27 percent) compared to 2013.
    - The number of individuals "doctor shopping" for controlled substances including opiates decreased from more than 3,100 in 2009 to approximately 960 in 2014.
    - From 2013 to 2014, there was a nearly 11 percent decline in the number of patients prescribed opiates at a dose higher than the current guidelines recommend to ensure patient safety.
    - Ohio patients receiving prescriptions for opiates and benzodiazepine sedatives at the same time dropped 8 percent.

Prevention Efforts

- Start Talking!
  In 20134, Governor John Kasich and First Lady Karen W. Kasich launched the Start Talking! statewide youth drug prevention initiative based on the premise that youth are up to 50 percent less likely to use drugs when their parents or other trusted adults talk with them about drug use and abuse. Understanding that this is not an easy discussion to begin, the program aims to help parents and other adults communicate better with kids. Start Talking! offers three free tools for parents and other youth leaders to approach children and young adults:
    - Know! delivers free tips and tools to parents (Parent Tips) and teachers (TEACHable Moments) to increase communication between parents and their children about substance abuse. Currently, nearly 57,000 adults are receiving these messages that help start important conversations.
    - Parents360Rx is a national program from the Partnership for Drug-Free Kids that is designed to educate adults about the dangers found in their own medicine cabinets.
    - 5 Minutes for Life is a program led by the Ohio Highway Patrol, the Ohio National Guard and local law enforcement in partnership with high schools. Troopers, law enforcement officers and National Guard members talk to student athletes to encourage them to become ambassadors who lead peer-to-peer conversations that promote healthy lifestyles. During this school year, over 260 events have been hosted with over 35,500 students participating.

- Community Based Coalitions
  In Ohio, we are seeking to elevate local drug coalitions by offering designation to local prevention coalitions as an Ohio Coalition of Excellence. The recognition illustrates that a coalition is using local data and evidence-based prevention strategies to create meaningful change in a community. Many coalitions across the state receive funding through OhioMHAS and the Substance Abuse Prevention and Treatment Block Grant. CARA places an emphasis of the importance of community-based coalitions and we support that effort because this issue is most impacted through local efforts.

- Youth Led Prevention Network
  The Ohio Youth-Led Prevention Network is a joint initiative between the Drug Free Action Alliance and OhioMHAS. It consists of youth-led substance abuse prevention providers and youth across the state who are committed to the cornerstones of youth-led prevention, peer prevention, positive youth development and community service. These teens plan an annual rally at the Statehouse to declare "We Are the Majority" – meaning that most youth live their lives drug and substance free. This year's rally is next week – April 28 – and more than 1,700 teens are expected to attend. I encourage anyone to attend – feel free to reach out to my office for more details.

Criminal Justice

- Addiction Treatment Program for Court Involved Individuals
  Established in 2014, this program supports drug courts in establishing a program to provide addiction treatment, including medication-assisted treatment, to non-violent adult offenders with a dependence on opiates, alcohol, or both. The first phase of the program reached 410 men and women, two-thirds of whom also had a co-occurring mental health disorder. According to a Case Western Reserve University evaluation of the program, past-month drug use among program participants decreased 69.4 percent, while crimes committed dipped 86 percent to 3.7 percent. At the same time, employment increased 114 percent, while stable housing increased by nearly 29 percent. Among participants, 60 percent had a job and 91 percent had stable housing upon completion of the program, compared to 27 percent and 70 percent, respectively, before enrolling in the program. The program is funded with $11 million over the current biennium in 14 counties. CARA emphasizes the importance of treatment as an alternative to incarceration, and we are seeing that work here in Ohio through the drug court model.

- Specialized Dockets Payroll Subsidy Project
  This program provides assistance to drug courts and other specialized docket programs with funding to effectively manage offenders in the community, thereby reducing commitments to Ohio's prisons and jails. The funding supports payroll for the administration of the docket, in an effort to encourage communities to create new dockets and sustain existing ones. Currently, the state is funding 136 specialized dockets.

- Recovery Services Partnership with the Ohio Department of Rehabilitation and Correction
  The most recent state budget proposed a new partnership between OhioMHAS and the Ohio Department of Rehabilitation and Correction (DRC) to improve addiction services within the state prison system. According to DRC, approximately 50,495 individuals are incarcerated within DRC facilities. Of these, 80 percent have histories of addiction. Nearly 30,000 of those incarcerated have a considerable or moderate treatment need. In order to make improvements and expand the reach of recovery services in the prisons, this initiative leverages the clinical expertise and recovery-oriented mission of OhioMHAS partnered with DRC's success in keeping recidivism rates low to provide quality addiction services to more people within the walls of the state prisons. Enhanced care inside the prison walls includes adding to the recovery services staff to provide individual and

group treatment and adding two therapeutic communities, a proven model of treatment that uses the influence of peers to promote recovery. Additional programming will encourage a seamless transition to services upon release to further lower the rate of recidivism, including a connection with the Medicaid program to ensure continued clinical services where applicable. Expanded use of medication-assisted treatment will further reduce the risk of future relapse. The program will also increase access to recovery supports, such as sober housing and employment services, upon release to ensure stable recovery and even further lower the recidivism rate.

Expanding the Availability and Use of Naloxone

- Project DAWN (Deaths Avoided With Naloxone)
  Project DAWN is an initiative of the Ohio Department of Health which encourages local programs to offer, free of charge, kits that include two doses of naloxone and training on its use to members of the public who may encounter people at risk opiate abuse for the purposes of overdose reversal. As you are aware, naloxone is effective at saving lives and is easy to administer. It is a critical tool in fighting the opiate epidemic, particularly as Ohio is seeing an increase in the very deadly illicit version of fentanyl. There are over 40 Project DAWN programs across the state with more being added soon.

- Grants for First Responders
  We know through state EMS data that naloxone was administered to 18,438 patients in 2015. Without this important overdose antidote, Ohio's already too large number of overdose deaths would be much higher. The most recent state budget included $1 million to purchase naloxone for first responders, including police and fire. A concerted effort has been made to convince local agencies of the importance of carrying naloxone, as oftentimes an overdose victim cannot wait for EMS to arrive, and we have seen many communities eager to take this on. CARA also addresses this issue, and we support your efforts. Naloxone use is critical to saving lives and getting people into treatment.

- Over the Counter Availability
  Ohio's legislature has rapidly expanded the availability of naloxone across the state by putting in place immunity for naloxone administration and making it available over the counter at pharmacies that have a standing order with a physician. Legislation recently proposed by the Kasich Administration proposes to allow facilities that regularly interact with high-risk individuals to have onsite access to naloxone. Facilities that could benefit from this measure include homeless shelters, halfway houses, schools and treatment centers.

Treatment and Supports

- Neonatal Abstinence Syndrome
  In August 2013, the Kasich Administration launched an effort to address the epidemic among the smallest of individuals – babies born to mothers who are addicted to opiate painkillers and heroin. The Maternal Opiate Medical Support Project will improve health outcomes and reduce costs associated with extended hospital stays by neutralizing the impact of Neonatal Abstinence Syndrome. Treating newborns impacted by Neonatal

Abstinence Syndrome was associated with nearly $100 million in healthcare expenses and almost 25,000 days in Ohio's hospitals in 2013, according to data from the Ohio Hospital Association. The project supports interventions and prenatal treatments that improve outcomes for women and babies while reducing the cost of specialized care by shortening length of stay in Neo-Natal Intensive Care Units. By engaging expecting mothers in a combination of counseling, medication-assisted treatment and case management, the three-year project is estimated to reduce infant hospital stays by 30 percent. One of the goals of CARA is to improve addiction and treatment services for pregnant and postpartum women, and we believe Ohio is developing a model that can be replicated nationally.

- Medication Assisted Treatment
  Work is on-going to expand the use of medication-assisted treatment across the state. It is a proven best practice. In 2011, Governor Kasich signed an executive order authorizing its expanded use and making it available through the state Medicaid program. In 2013, seed funding was put forward to establish medication-assisted treatment in Southern Ohio, specifically Jackson, Ohio.

- Recovery Housing
  CARA recognizes the importance of recovery supports, and one area in which there has been rapid expansion in Ohio is recovery housing. Recovery housing is characterized as a safe and healthy living environment that promotes abstinence from alcohol and other drugs and enhances participation and retention in traditional clinical treatment. Through a $12.5 million state investment, we have been able to increase the availability of recovery housing by over 1,000 beds statewide. Additional funds have been committed for future years and this work is being supported by Ohio Recovery Housing, an organization dedicated to the development and operation of quality alcohol and drug-free living in a community of recovery for people with substance use disorders which was created with funding from OhioMHAS.

- Medicaid/Institutions for Mental Disease (IMD) Exclusion
  As I cross the state, I continue to hear stories of waiting lists and difficulty accessing treatment, in part due to federal law. Treatment works, but it is not easy. I recently read of a couple who, after multiple relapses, found themselves homeless, involved in the criminal justice system, and lost custody of their young daughter. Through treatment received through extended Medicaid benefits, they have over a year of sobriety, regained custody of their daughter, and are employed. We know that approximately 400,000 Ohioans have accessed mental health and addiction services since Medicaid was extended up to 138% of poverty. Capacity and workforce continue to be a challenge, and the IMD exclusion poses a barrier to creating more treatment capacity across the state. I appreciate that CARA sets up a way to take a serious look at the IMD exclusion and its impact on access to treatment.

Thank you again for inviting me to testify on this important topic today. I want to commend both of you on your work around this crisis and I want to especially commend you Senator Portman on your leadership on this issue throughout your career. Again, as I described in my testimony and in length in my written statement for the record, a number of the provisions in the CARA bill are activities Ohio is undertaking and should be implemented on a national level.

That is why we support your efforts and the CARA legislation. I stand ready to work with you moving forward, particularly on the issue of the IMD exclusion. I have attached a comprehensive document that lists the state's efforts over the past few years and a timeline that highlights many of the key changes made. Thank you for your time, and I welcome any questions.

COMBATTING THE OPIATE CRISIS IN OHIO

In 2011, Gov. John R. Kasich announced the establishment of the Governor's Cabinet Opiate Action Team to fight opiate abuse in Ohio. Ohio is combatting drug abuse through many initiatives on several fronts at the state and local levels involving law enforcement, public health, addiction and treatment professionals, healthcare providers, educators, parents and many others. New initiatives were developed, then launched in 2013 or later, and it will take some time for their full impact to be reflected in reducing the number of drug overdose deaths. For more information about GCOAT, visit http://www.mha.ohio.gov/gcoat.

Law Enforcement: Cracking Down on Drug Trafficking

Interdiction by law enforcement is a necessary intervention in combatting the opioid epidemic. Yet, the opiate issue is one of the more complex drug challenges that law enforcement has ever faced. Coordination across jurisdictions and with regulatory boards is a critical step.

- 2011: Gov. Kasich signs HB 93 into law to shut down "pill mill" pain clinics that fuel Ohio's opiate crisis.
- 2011: The Ohio Highway Patrol reports that it seized more than 38,000 prescription pills and 16,400 grams of heroin in calendar year 2011.
- 2012: Ohio hosts first statewide Opiate Summit, drawing more than 1,000 addiction, law enforcement, policy and medical professionals.
- 2012: The Ohio Highway Patrol reports that it seized more than 39,900 prescription pills and 34,800 grams of heroin in calendar year 2012.
- 2013: A partnership with local law enforcement is strengthened by investing $3 million in behavioral health programs through local jails to reduce recidivism.
- 2013: Ohio Attorney General Mike DeWine establishes the Attorney General's Heroin Unit, which assists local law enforcement in investigating and prosecuting upper-level drug traffickers in Ohio.
- 2013: The Ohio Highway Patrol reports that it seized more than 54,200 prescription pills and 46,200 grams of heroin in calendar year 2013.
- 2014: Ohio Attorney General Mike DeWine awards more than $500,000 to law enforcement in Allen County to combat the flow of heroin along I-75.
- 2014: The Ohio Attorney General's Office launches Heroin Recognition and Investigation Training for law enforcement through the Ohio Peace Officer Training Academy.
- 2014: The Ohio Highway Patrol reports that it seized more than 37,900 prescription pills and 14,100 grams of heroin in calendar year 2014.
- 2011-2014: The State Medical Board of Ohio and the Ohio State Board of Pharmacy, working in conjunction with the Ohio Attorney General's Office, revokes the licenses of 61 doctors and 15 pharmacists for violations involving improper prescribing or dispensing of prescription drugs.
- 2015: The Office of Criminal Justice Services contributes $100,000 to the Heroin Partnership Project, a collaborative effort of federal, state and local agencies focused on reducing heroin and opiate overdose deaths in Ross County.
- 2015: The State of Ohio Board of Pharmacy trains local law enforcement agencies on how to conduct drug overdose investigations, including the use of the Ohio Automated Rx Reporting System.

Preventing Youth Drug Use Before it Starts

To help prevent youth drug use before it starts, Gov. Kasich launched *Start Talking!* in January 2014. *Start Talking!* is Ohio's statewide youth drug prevention initiative that brings together proven prevention strategies to promote the importance of having drug-free conversations with our youth. Research shows that children whose parents or other trusted adults talk with them about the risks of drugs are up to 50 percent less likely to use drugs. *Start Talking!* features three components designed to provide parents, teachers, guardians and community leaders with simple tools to get the conversation started: *Know!, Parents360-Rx*, and *5 Minutes for Life*. Visit the *Start Talking!* website at http://starttalking.ohio.gov for details.

Start Talking!
Building a Drug-Free Future

- 2013-14: More than 16,500 high school student-athletes participate in *5 Minutes for Life* sessions held before or after practice, during which Ohio state troopers, local law enforcement officers and National Guard members talk about responsible decision-making, leadership and encouraging their peers to live a drug-free lifestyle.
- 2014: An additional 6,400 parents, teachers and employers sign up for *Know!* tips and *TEACHable Moments* with a total reach of more than 40,000 as a result of organizations sharing the information. They join a subscriber base of more than 60,000.
- 2014-15: More than 17,700 student-athletes participate in *Minutes for Life* sessions held before or after practices.
- 2014-2015: Start Talking! awards 22 grants totaling $1.5 million to communities to help strengthen school-based prevention and resiliency programming for at-risk youth.
- 2014: An overview of *Start Talking!* was presented to approximately 500 nurses at three ODH Regional School Nurse Conferences.
- 2014: Gov. Kasich signs HB 367 into law, requiring school districts to provide education about prescription medication and opiate abuse.
- The Ohio Department of Health releases results of the Ohio Youth Risk Behavior Survey which indicates a 50 percent decrease in the number of Ohio teens who used a prescription painkiller without a doctor's prescription.
- 2015: The 5 Minutes for Life program is expanded and now available year round.
- 2015: *Start Talking!* is displayed at ODH's annual New School Nurse Orientation.

Encouraging Appropriate Use and Availability of Pain Medication

Ohio officials have worked diligently with the medical community to find the right balance between making sure pain interventions are available to patients who need it while taking important steps to limit the number of opioid prescription medications that diverted and sold on the street for illicit use.

- 2011: The Governor's Cabinet Opiate Action Team develops low dose protocol for buprenorphine and Suboxone.
- 2012: The Ohio Attorney General's Office, the Ohio Department of Health, the Ohio Department of Mental Health and Addiction Services, and Drug Free Action Alliance launch the Ohio Prescription Drug Drop Box Program by providing secure disposal bins to more than 60 law enforcement agencies.
- 2012: The Governor's Cabinet Opiate Action Team rolls out opioid prescribing guidelines for emergency room and acute care facilities.
- 2013: The Governor's Cabinet Opiate Action Team introduces prescribing guidelines for Ohio's opioid prescribers for safe management of chronic, non-terminal pain.

- 2014: ODH provides seed funding for local prescription drug overdose prevention projects in Cuyahoga County, Clermont County and the City of Portsmouth with a grant from the Centers for Disease Control and Prevention. The projects include coalition development, healthcare prescriber education and healthcare system changes for safer prescribing practices.
- 2014: The State of Ohio Board of Pharmacy adopts rules authorizing pharmacies to accept unused or expired prescription controlled substances from the public.
- 2014: The State of Ohio Board of Pharmacy receives a $386,000 federal grant to make enhancements to improve the use of the Ohio Automated Rx Reporting System.
- 2014: The number of opioid doses dispensed to Ohio patients decreased by almost 42 million from 2012 to 2014.
- 2014: The number of individuals "doctor shopping" for opiates decreased from more than 3,100 in 2009 to approximately 960 in 2014, according to data from the State Board of Pharmacy's Ohio Automated Rx Reporting System (OARRS).
- 2014: To improve care to our veterans and reduce prescription drug abuse, the State of Ohio Board of Pharmacy completed a project that allows the Veterans Health Administration (VHA) to report all prescription controlled substances dispensed from their Ohio facilities to the Ohio Automated Rx Reporting System (OARRS).
- 2014: An analysis of OARRS data shows a 10.8 percent reduction in the number of Ohio patients receiving prescription opiates (excluding Suboxone) at doses greater than the 80 mg Morphine Equivalent Daily Dose since the establishment of Ohio's opiate prescribing guidelines in October 2013.
- 2015: Governor's Cabinet Opiate Action Team releases a Health Resource Toolkit for healthcare providers to address opioid abuse.
- 2015: Use of the Ohio Automated Rx Reporting System by opioid prescribers continued to increase. In the second quarter of 2015, OARRS receives more than 2.2 million queries by prescribers compared to 156,289 for the same quarter in 2010.
- 2015: The State of Ohio Board of Pharmacy provides healthcare regulatory boards with the names of more than 15,500 clinicians who violated Ohio laws by prescribing opioids and benzodiazepines and not checking the Ohio Automated Rx Reporting System.
- 201S: Prescription Drug take-back targeted at state employees nets more than 100 pounds of unused, expired, unwanted prescription medications (roughly 95,000 pills).
- 2015: CDC selects Ohio among 16 states to receive between $750,000-$1 million a year over four years to combat prescription drug overdoses. The funding is to be used to enhance prescription drug monitoring programs; educate providers and patients about the risks of prescription drug overdose; work with healthcare systems, insurers and healthcare professionals to help them make informed decisions when prescribing pain medication; and respond to new and emerging drug overdose issues.
- 2015: U.S. Department of Justice selects the State of Ohio Board of Pharmacy to receive a $200,000 grant to develop new OARRS educational and training resources for healthcare schools, colleges and residency programs.
- 2015: Governor Kasich announces an investment of up to $1.5 million a year to integrate the Ohio Automated Rx reporting System (OARRS) directly into electronic medical records and pharmacy dispensing systems across the state, allowing instant access for prescribers and pharmacists.
- 2016: The Governor's Cabinet Opiate Action Team launches guidelines for the management of acute pain outside the hospital emergency department setting. The guidelines address treatment without drugs, non-opioid drug treatment and safe opioid drug treatment.
- 2016: Ohio Board of Pharmacy issues updated rules requiring increased use of OARRS by pharmacists prior to dispensing controlled substance medications.

Saving Lives by Expanding Access to Overdose Antidote

Ohio has taken steps to prevent drug overdose deaths through the expanded availability and use of the overdose reversal drug naloxone. Ohio's naloxone efforts also serve to educate persons who are addicted on available treatment options.

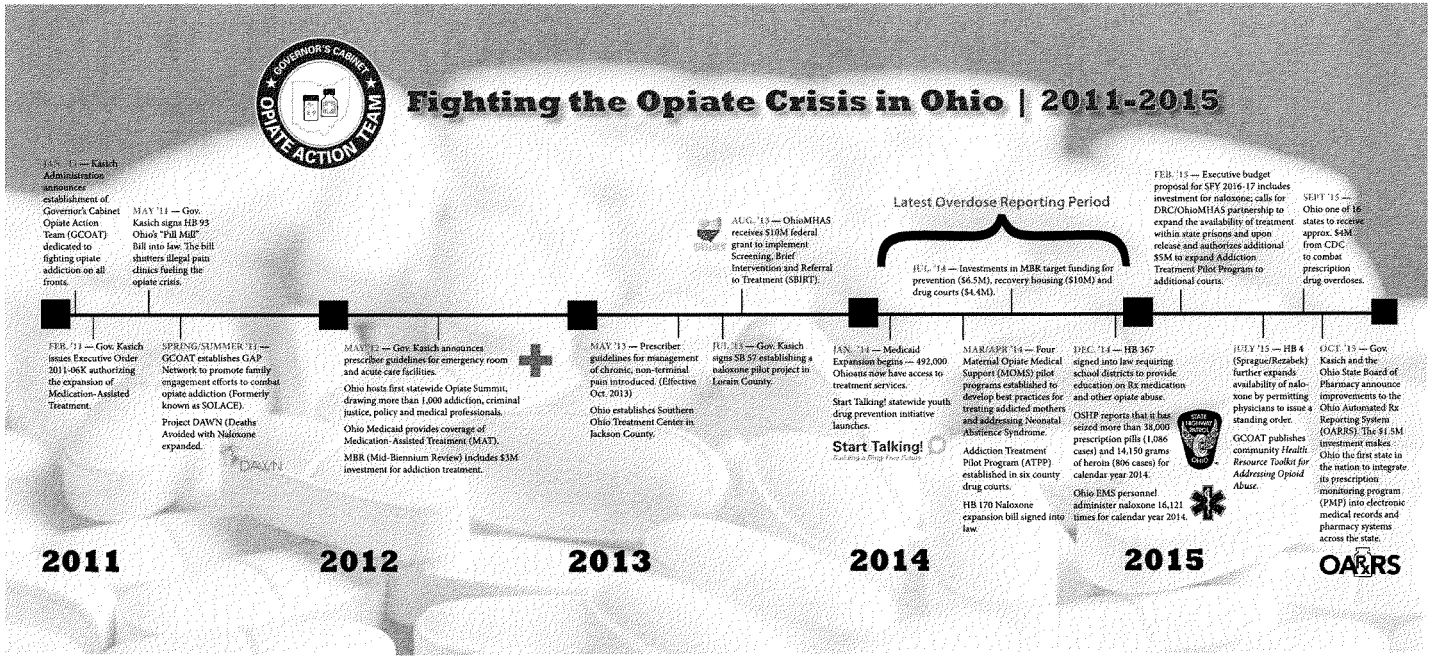
- 2012: ODH provides seed funding for a pilot naloxone education and distribution program called Project DAWN (Deaths Avoided with Naloxone) in Scioto County.
- 2013: ODH funds additional Project DAWN sites in Ross, Stark and Hamilton Counties. These sites joined existing sites in Cuyahoga, Scioto and Montgomery counties.
- 2013: OhioMHAS begins offering Project DAWN kits to patients leaving state psychiatric hospitals who are at-risk of overdose.
- 2013: Gov. Kasich signs SB 57 into law establishing a one-year naloxone pilot project in Lorain County that permits first responders to administer naloxone.
- 2014: Gov. Kasich signs HB 170 into law, expanding the use of naloxone so that first responders can administer the drug, and allowing family and friends to get prescriptions for loved ones at risk of overdosing on opioids.
- 2014: The Ohio Attorney General's Office develops an online training course for law enforcement and an educational video for the public regarding the administration of naloxone.
- 2014: Ohio EMS personnel administer naloxone 16,121 times.
- 2014: Fourteen Project DAWN programs provided 2,894 naloxone kits with 190 overdose reversals/lives saved.
- 2015: Thirty-four Project DAWN community sites operate in 27 counties, and 16 sites operate in drug addiction treatments centers and hospital emergency departments.
- 2015: Ohio Attorney General Mike DeWine negotiates an agreement with naloxone manufacturer Amphastar Pharmaceuticals, Inc. regarding rebates for public entities that purchase Amphastar naloxone.
- 2015: Gov. Kasich signs HB 4 into law, further expanding access to naloxone by permitting pharmacists to dispense without a prescription this life-saving drug that has the potential to reverse drug overdoses.
- 2015: To assist pharmacies in the implementation of HB 4, the State of Ohio Board of Pharmacy has developed a dedicated web page, www.pharmacy.ohio.gov/naloxone, which features a number of helpful resources, including a guidance document, sample protocol and a listing of all participating pharmacies. The Board is also offering printed, no-cost patient educational materials to any participating pharmacy.
- 2015: SFY 16-17 budget includes an investment of $500,000 per year to purchase naloxone for distribution to law enforcement by local health departments.
- 2016: More than 800 Ohio pharmacies in 77 counties offer naloxone without a prescription.
- 2016: The Centers for Disease Control and Prevention (CDC) issues a report based on a CDC team's visit to Ohio at the Ohio Department of Health's request to help examine the state's increase in fentanyl-related drug overdose deaths. The report recognizes Ohio's comprehensive response to combatting the opiate crisis and makes recommendations, including further expanding access to and use of naloxone.

Creating Pathways to Treatment and Recovery

Making sure that Ohioans have access to treatment – including Medication-Assisted Treatment in combination with traditional counseling – along with key recovery supports such as stable housing, employment services, relapse prevention and more has been a critical focus in Ohio.

- 2011: Gov. Kasich signs Executive Order authorizing the expanded use of Medication-Assisted Treatment (buprenorphine, vivitrol, methadone) in responding to the state's opiate crisis.

- 2012: Ohio Medicaid introduces coverage of Medication-Assisted Treatment services.
- 2012: The Mid-Biennium Budget Review includes $3 million for opiate addiction treatment.
- 2012: The Office of the Governor awards $2.1 million to Ohio's children's hospitals to fund several research projects. Of that total, $1 million was set aside for the development of a standardized treatment protocol for addressing neonatal abstinence syndrome (NAS) in newborns.
- 2013: The Ohio Department of Mental Health and Addiction Services receives a $10 million federal grant to support implementation of a screening and wellness tool for physicians called SBIRT (Screening, Brief Intervention and Referral to Treatment). SBIRT also becomes a billable service under Ohio Medicaid.
- 2013: New Southern Ohio Addiction Treatment Center is established in Jackson County, addressing a gap in local services for individuals who are opioid-dependent.
- 2014: Extension of Medicaid coverage in Ohio begins, making addiction treatment services available to more individuals.
- 2014: The Ohio Department of Mental Health and Addiction Services partners with Ohio Medicaid to launch the Maternal Opiate Medical Support (MOMS) pilot project to develop best practices for treating addicted mothers and for addressing neonatal abstinence syndrome among newborns.
- 2014: The Mid-Biennium Budget Review includes funding for drug prevention, recovery housing, and drug courts.
- 2014: The Ohio Department of Mental Health and Addiction Services launches an Addiction Treatment Pilot Project to provide Medication-Assisted Treatment to drug court participants in six counties.
- 2014: Gov. Kasich speaks to teams from across Ohio at a Judicial Symposium to encourage collaborative efforts to fight drug abuse and promote the drug court model.
- 2014-15: Ohio Attorney General Mike DeWine awards a total of $800,000 to Lucas County to develop a pilot program aimed at helping those suffering from heroin addiction get the assistance they need to move towards recovery. The University of Toledo will study and evaluate the effectiveness of the program for its potential use as a model for recovery in other communities across the state.
- 2015: The Ohio Department of Mental Health and Addiction Services participated with the Ohio Highway Patrol in successful SHIELD details by helping connect drug users intercepted by law enforcement to treatment.
- 2016-17: The state budget for the biennium calls for the Ohio Department of Rehabilitation and Correction and OhioMHAS to expand the availability of treatment within state prisons and upon release; to continue to invest in recovery housing; and provides additional funding to expand the Addiction Treatment Pilot Project to a total of 15 counties.


GOVERNOR'S CABINET
OPIATE ACTION TEAM
Fighting the Opiate Crisis in Ohio | 2011-2015
JAN. '11 — Kasich Administration announces establishment of Governor's Cabinet Opiate Action Team (GCOAT) dedicated to fighting opiate addiction on all fronts.
MAY '11 — Gov. Kasich signs HB 93 Ohio's "Pill Mill" Bill into law. The bill shutters illegal pain clinics fueling the opiate crisis.
FEB. '11 — Gov. Kasich issues Executive Order 2011-06K authorizing the expansion of Medication- Assisted Treatment.
SPRING/SUMMER '11 — GCOAT establishes GAP Network to promote family engagement efforts to combat opiate addiction (Formerly known as SOLACE).
Project DAWN (Deaths Avoided with Naloxone expanded.
DAWN
MAY '12 — Gov. Kasich announces prescriber guidelines for emergency room and acute care facilities.
Ohio hosts first statewide Opiate Summit, drawing more than 1,000 addiction, criminal justice, policy and medical professionals.
Ohio Medicaid provides coverage of Medication-Assisted Treatment (MAT).
MBR (Mid-Biennium Review) includes $3M investment for addiction treatment.
MAY '13 — Prescriber guidelines for management of chronic, non-terminal pain introduced. (Effective Oct. 2013)
Ohio establishes Southern Ohio Treatment Center in Jackson County.
JUL. '13 — Gov. Kasich signs SB 57 establishing a naloxone pilot project in Lorain County.
AUG. '13 — OhioMHAS receives $10M federal grant to implement Screening, Brief Intervention and Referral to Treatment (SBIRT).
Latest Overdose Reporting Period
JUL. '14 — Investments in MBR target funding for prevention ($6.5M), recovery housing ($10M) and drug courts ($4.4M).
JAN. '14 — Medicaid Expansion begins — 492,000 Ohioans now have access to treatment services.
Start Talking! statewide youth drug prevention initiative launches.
Start Talking!
Building a Drug Free Future
MAR/APR '14 — Four Maternal Opiate Medical Support (MOMS) pilot programs established to develop best practices for treating addicted mothers and addressing Neonatal Abstinence Syndrome.
Addiction Treatment Pilot Program (ATPP) established in six county drug courts.
HB 170 Naloxone expansion bill signed into law.
DEC. '14 — HB 367 signed into law requiring school districts to provide education on Rx medication and other opiate abuse.
OSHP reports that it has seized more than 38,000 prescription pills (1,086 cases) and 14,150 grams of heroin (806 cases) for calendar year 2014.
Ohio EMS personnel administer naloxone 16,121 times for calendar year 2014.
FEB. '15 — Executive budget proposal for SFY 2016-17 includes investment for naloxone; calls for DRC/OhioMHAS partnership to expand the availability of treatment within state prisons and upon release and authorizes additional $5M to expand Addiction Treatment Pilot Program to additional courts.
JULY '15 — HB 4 (Sprague/Rezabek) further expands availability of naloxone by permitting physicians to issue a standing order.
GCOAT publishes community Health Resource Toolkit for Addressing Opioid Abuse.
SEPT '15 — Ohio one of 16 states to receive approx. $4M from CDC to combat prescription drug overdoses.
OCT. '15 — Gov. Kasich and the Ohio State Board of Pharmacy announce improvements to the Ohio Automated Rx Reporting System (OARRS). The $1.5M investment makes Ohio the first state in the nation to integrate its prescription monitoring program (PMP) into electronic medical records and pharmacy systems across the state.
OARRS
2011
2012
2013
2014
2015

University Hospitals

Testimony of

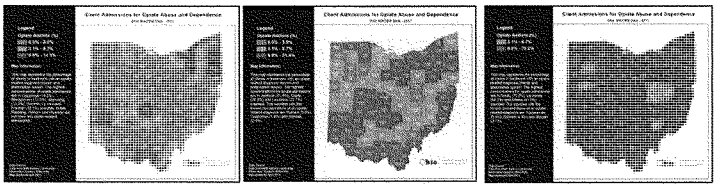
Michele Walsh, MD, Chief of Neonatology, University Hospitals, University Hospitals Rainbow Babies & Children's Hospital and Case Western Reserve University
University Hospitals Case Medical Center
Cleveland, Ohio
April 22, 2016
Before the United States Senate Homeland Security and Government Reform Committee

Chairman Portman, Senator Brown and distinguished guests, my name is Michele Walsh, M.D. I am the Chief of Neonatology at Rainbow Babies & Children's Hospital, UH Hospitals and Case Western Reserve University. I have been privileged to care for the tiny babies of North Eastern Ohio for over 25 years. I thank the Committee for holding this field hearing in Cleveland, and UH Case Medical Center is proud to serve as host. I appreciate the opportunity to speak on behalf of those babies this morning.

UH Rainbow Babies & Children's Hospital is a 244-bed, full-service children's hospital and academic medical center. A trusted leader in pediatric health care for more than 125 years, UH Rainbow Babies & Children's Hospital consistently ranks among the top children's hospitals in the nation. As the region's premier resource for pediatric referrals, UH Rainbow Babies & Children's Hospital's dedicated team of more than 1,300 pediatric specialists uses the most advanced treatments and latest innovations to deliver the complete range of pediatric specialty services for 700,000 patient encounters, annually.

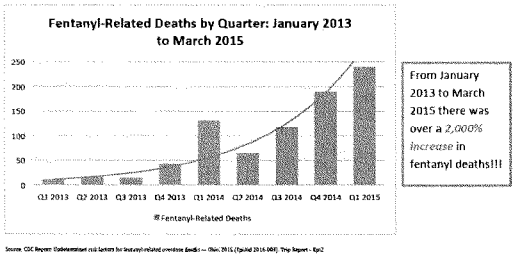
Never have I seen a public health epidemic of such severity as the current opiate epidemic among our citizens. We must focus our efforts on a cohesive national strategy that attacks every facet of this complicated problem. In the same way that we came together as a nation to combat AIDS and more recently Ebola—the same urgent methods are needed to combat this scourge. The Comprehensive Addiction Recovery Act championed by Senator Portman and others is exactly the right direction to address the complexities of addiction treatment, and the inadequate numbers of programs, trained physicians and facilities to address this exploding issue.

The epidemic has raced across Ohio and the nation. To illustrate I provide a series of pictures of the spread of individuals in Ohio seeking treatment for opiate addiction from 2001-2011.



2001 2007 2011

We are now facing a new twist that is having deadly consequences. Ohio leads the nation in seizures of illegally manufactured fentanyl: a narcotic that is 50 times more powerful than heroin or morphine. Drug dealers are mixing the fentanyl with heroin unbeknownst to their clients- and escalating the death toll.



The problems associated with abuse of prescription narcotics and the use of illegal opiates has grown and continues to get worse. Unfortunately, the epidemic of narcotics (both heroin and prescription narcotics) use among adults has led to a corresponding epidemic of narcotic-exposed newborns. This tragic occurrence is termed Neonatal Narcotic Abstinence Syndrome (NAS). NAS produces jitteriness, fever, diarrhea, poor feeding, and if not treated seizures. After narcotic exposure in the womb, NAS requires treatment in most newborns. The problem is that treatment strategies for NAS are largely unstudied, and lead to wide variations in practice, lengths of stay, and cost.

To combat the issue of disparate treatment of NAS newborns, Governor Kasich helped to create and fund a statewide collaboration of the 6 Children's Hospitals in Ohio to research NAS and determine improved courses of treatment. I am honored to lead this research initiative, and to work with my colleagues from the other Ohio Children's Hospital Association member hospitals: Akron Children's Hospital; Cincinnati Children's Hospital Medical Center; Dayton Children's Hospital; Nationwide Children's Hospital; and, Promedica Toledo Children's Hospital. Our objectives were to:

- Describe the maternal and neonatal characteristics of full term infants with NAS;
- Determine the best practice for NAS treatment; and,
- Identify variation and areas for future research.

Working together we were able to identify best practices for caring for the family, and the infant and improving the integration of care between obstetricians, neonatologists and addiction medicine specialists. From the earliest days of our work in 2011 to today we decreased the duration of opiate treatment from 60% of all NAS exposed infants to 45%, decreased length of treatment from 25 days to 16 days, and total hospitalization from 31 days to 19 days.

While embracing a cohesive statewide approach attacking all aspects of the problem, we are just beginning to see the tide turning and for the first time seeing a reduction in the amount of opiates prescribed across the state. We hope this will be a harbinger that the epidemic of addiction is slowing.

I believe Ohio's approach to be a model for the nation. I respectfully urge federal lawmakers to:

- Continue efforts to educate physicians, dentists and other prescribers on appropriate pain treatment, the limited role of narcotics in acute pain and the signs of addiction.
- Continue efforts to eliminate illegal prescribing practices.
- Require the mandatory use of state wide opiate prescribing sites before writing an opiate prescription, and link theses registries across states.
- Create new programs within opioid maintenance clinics designed to delay pregnancy until the mother's health and dependence are improved. (MOMS grant from CMS)
- Enhance programs that encourage women to seek prenatal care and avoid criminalizing pregnant women with narcotic addiction.
- Create incentives for new methadone treatment providers to enter the field.
- Eliminate barriers to prescribing suboxone replacement therapy during pregnancy which will decrease the severity of newborn withdrawal, allowing certified providers to increase the number of patients that they are treating.
- Create additional residential treatment programs for both the mother and infant. Pregnancy is a teachable moment where women are highly motivated to change and improve their lives and the lives of their children.
- Fund research at the National Institutes of Health to better understand the consequences of inutero exposure to opiates, and to further refine treatments.

Thank you once again for the opportunity to testify before the Committee this morning. I stand ready to support your efforts in any way possible, and look forward to your questions.

Strengthening Partnerships, Improving Family Outcomes

Written Testimony of

Nancy K. Young, Ph.D.
Director, Children and Family Futures, Inc.

Before the United States Senate
Committee on Homeland Security and Governmental Affairs

Examining the Impact of the Opioid Epidemic

Friday, April 22, 2016

University Hospitals of Cleveland

11100 Euclid Avenue, Cleveland, OH 44106

25371 Commercentre Lake Forest, CA 92630 714.505.3525 www.cffutures.org

Senator Portman, Senator Brown and the other Members of the United States Senate Committee on Homeland Security and Governmental Affairs:

Thank you for conducting this hearing on our nation's opioid epidemic and the effects of opioid and other substance use disorders on our nation's child welfare and foster care system. There are four primary points I would like to emphasize in this statement for the record:

1) In the past three decades, our country has experienced at least three major shifts in substances of abuse that have had dramatic effects on children and families. However, the increase of opioid misuse has been described by long-time child welfare professionals as having the worst effects on child welfare systems that they have seen.

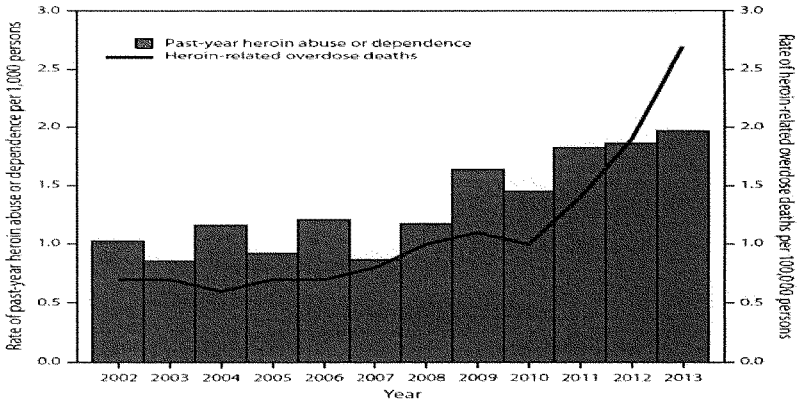
2) The current environment has at least two major differences from our prior experiences: (a) young people are dying at astonishing rates; and (b) many states report that infants are coming into protective custody at alarming rates.

3) Federal law requiring medical providers to notify child protective services of infants identified as affected by prenatal substance exposure is not consistently implemented and a review of current legislation and funding mechanisms has become essential.

4) Federal investments over the past decade testing strategies to improve outcomes for families in child welfare affected by substance use disorders have generated a knowledge base of effective programs, which means that we can no longer say we don't know what to do to address these problems.

Brief Summary of the Data

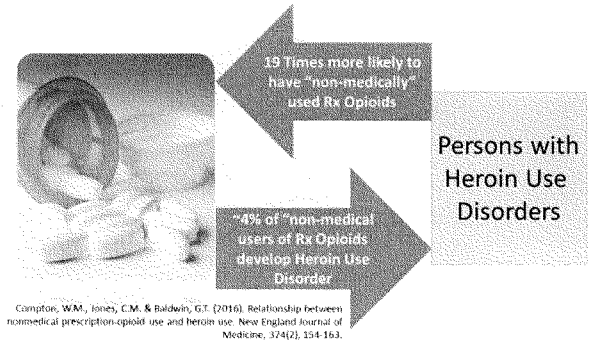
Data from SAMHSA's National Survey on Drug Use and Health show that between 2007 and 2014, the numbers of persons who misuse prescription drugs, new users of heroin and people with heroin dependence increased significantly (SAMHSA, 2014). As shown in this graph, rates of dependence on heroin has doubled and overdose deaths increased 286 percent between 2002 and 2013 (Leonard, 2015).



According to the 2014 National Survey on Drug Use and Health:

- 10.3 million persons used prescription painkillers non-medically in 2014[1]
- Approximately 1.9 million met criteria for prescription painkillers use disorder
- 4.8 million people have used heroin at some point in their lives
- 212,000 people aged 12 or older used heroin for the first time within the prior 12 months
- Approximately 435,000 people were regular (past-month) users of heroin

The pattern of initiating heroin use has changed over the past decade. Approximately three-quarters of persons who use heroin report prior nonmedical use of prescription opioids, as well as current abuse or dependence on additional substances such as stimulants, alcohol and marijuana. Conversely, a small percentage, approximately four percent, of persons with nonmedical use of prescription drugs become regular users of heroin. However, given the 10.3 million persons who reported nonmedical use of prescription drugs in 2014, this small percentage of conversion to heroin generates two hundred thousand new heroin users in a year and 435,000 regular heroin users (Compton, Jones & Baldwin, 2016).



Compton, W.M., Jones, C.M. & Baldwin, G.T. (2016). Relationship between nonmedical prescription-opioid use and heroin use. New England Journal of Medicine, 374(2), 154-163.

Among pregnant women, the highest rates of use continue to be the legal substances which have known detrimental effects on the neurodevelopment of the fetus. Among pregnant women aged 15 to 44, 5.4 percent were current illicit drug users based on data averaged across 2012 and 2013. This was lower than the rate among women in this age group who were not pregnant (11.4 percent). In the most recent year for which the data on specific substances are available, among pregnant women in 2011-2012, 18% reported using cigarettes, 9.4% used alcohol and 5% used illicit drugs; heroin use was reported by .2% of pregnant women and .9% non-medically used prescription drugs (SAMHSA, 2012).

[1] Nonmedical use of prescription drugs includes using medications that are not prescribed for these drugs or using them for the effect or feeling rather than the medical purpose for which they were prescribed

There are two aspects of parental opioid use that affect the child welfare system:
(1) prenatal opioid and other substance use exposure when it is determined that there are immediate safety factors resulting in the newborn being placed in protective custody; and,
(2) post-natal use that affects parents' ability to safely care for their children.

Each year, the number of infants who have been prenatally exposed to illicit drugs (240,000), binge drinking (108,000), and heavy alcohol (12,000) are an estimated 360,000 – the population of New Orleans.

If you add that across the years of 0 to 5, kindergartners with prenatal substance exposure total the population of the State of Nebraska.

Congress has been specific that hospital notification of cases of prenatal substance exposure is not substantiated child abuse or neglect.[2] Rather, when these children come to the attention of the child welfare system, assessment of risk and safety are to be conducted and plans of safe care instituted to ensure the newborn's well-being. Unfortunately, as the recent Reuters series made clear, often this is not happening (Wilson & Shiffman, 2015).

In April 2016, the Administration on Children, Youth and Families (ACYF), issued Program Instructions to States for their June 2016, reporting on child welfare programs. This instruction includes details on how States are to report their programs and policies specific to this population of infants who were identified with prenatal exposure in accordance with the current Child Abuse Prevention and Treatment Act (CAPTA). Future analyses of these reports will assist in determining what actions may be needed to ensure the well-being of these infants and their families. At present, data are not available to report how often infants are referred to child protective services resulting from prenatal substance exposure. Clearly however, the CAPTA State grants at approximately $25 million dollars for the entire country are inadequate to provide services and supports for this population. The policy focus should be on the need for legislative changes and sufficient funding, including links to other child welfare and treatment funding, in order to implement the congressional intent of the CAPTA legislation.

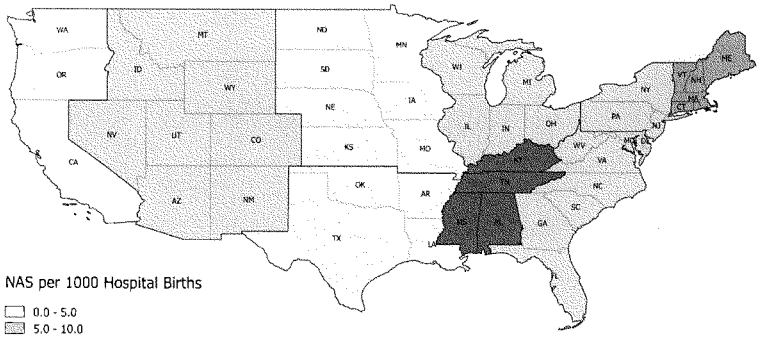
In addition, there has been a lack of clarity on the requirements and components that should be included in a plan of safe care for these infants. Our agency has issued a discussion draft to clarify how States and local communities should be addressing the implementation of plans of safe care. It includes a two-pronged approach: (1) a Governor-appointed task force that works across the multiple administrative agencies and the family courts to set State policies and (2) a local implementation committee that clarifies practice components such as screening tools, assessment, referrals and communication protocols. This draft is being circulated to gather input from multiple stakeholders to assist States and communities. A plan of safe care must address a two-generation approach to the needs of the parents and the child.

Neonatal abstinence syndrome (NAS) occurs in about half of babies with exposure to opioids during pregnancy. At this time, there are not clear data as to why babies do or do not experience the withdrawal syndrome. In a national study on the use of methadone and buprenorphine during pregnancy, researchers found that NAS did not appear to be related to

[2] The exact language is that "...such notification shall not be construed to— (I) establish a definition under Federal law of what constitutes child abuse or neglect; or (II) require prosecution for any illegal action."

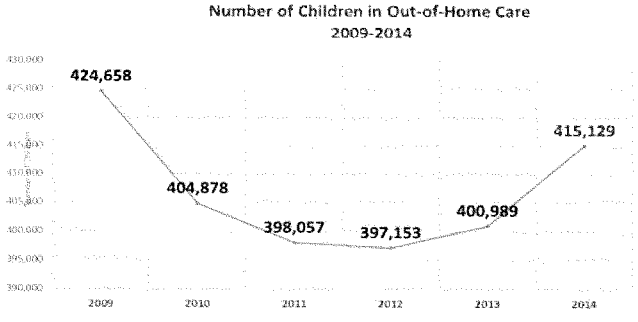
the dose of these medications that are used to treat opioid dependence. But there were data suggesting that experiencing NAS was related to mothers who also smoked during pregnancy (Jones, 2015).

Dr. Stephen Patrick and colleagues (2015) have analyzed hospital data to monitor the trend of infants who are diagnosed with Neonatal Abstinence Syndrome. There is variation across regions in rates of NAS, with the north-east and mid-south central regions experiencing the highest rates of diagnosed cases in hospital births.



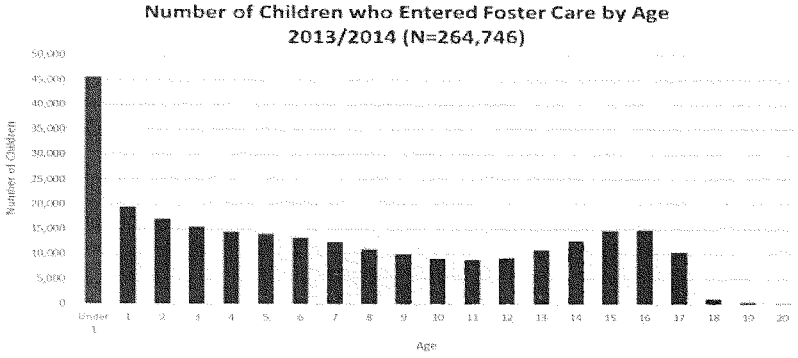
Patrick, S. W., Davis, M. M., Lehmann, C. U., & Cooper, W. O. (2015). Increasing incidence and geographic distribution of neonatal abstinence syndrome: United States 2009 to 2012. *Journal of Perinatology, 35*(8), 650-655.

While there is not a clear relationship of rates of NAS and the dramatic increase of infants being placed in protective custody, the trend of younger children in care and particularly the number of infants is alarming. After a decade of decreasing numbers of children in out-of-home care, that trend began to reverse in 2012-2013. The total number of children in care are both new intakes as well as children who are remaining longer in care.



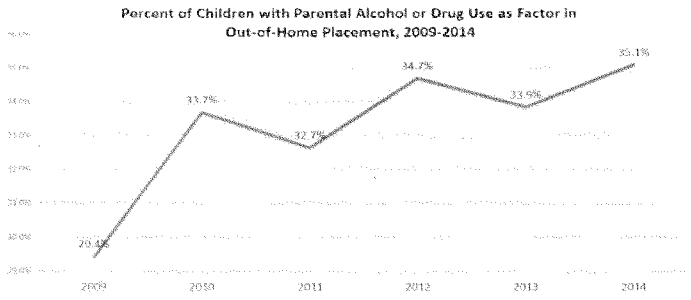
From the all-time high point in 1999 of 567,000 children, there was a steady decline until 2012 when the trend reversed

Of the nearly 265,000 children who entered care in 2014, the largest group were infants. The data are not available on the percentage of those infants who also experienced prenatal substance exposure, since they are not collected at the federal level nor by the majority of states. One might suggest however, that there are few underlying factors other than a parent's substance use disorder that would disrupt the ability of a parent to care for their infant—particularly in areas of the country that are experiencing a profound opioid epidemic.



These trends are resulting in an increasing shift toward younger children making up a larger percentage of children in out-of-home care with children under six representing nearly 40% of children in care. These data indicate a short window of time for intervention with these children and families. This alarming rate of young children coming into care is especially troubling, as children ages 0-3 are especially vulnerable. Infancy and toddlerhood is a time of rapid development across all domains of functioning. The brain of a newborn is about one-quarter the size of an adult's and by the age of three, the brain has developed to about 80 percent of its adult size (Nowakowski, 2006). It is imperative that the development of that child take place in a stable environment with a caregiver who fosters mutual attachment with the child.

Unfortunately, I cannot report reliable data that would indicate to what extent parental opioid or other substance use disorders are associated with the number of children in out-of-home care. The nation's data system to monitor these factors does not require collection of parental substance use as factors in child removal, since those are voluntary collection items in the data system. However, our agency has been monitoring the available data for 15 years, and there has been a steady increase in reports of removals due to substance use by parents. The graph on the following page shows that since 2009, states report a 19.4% rate of increase in parental alcohol or drug use as factors in the child's removal.

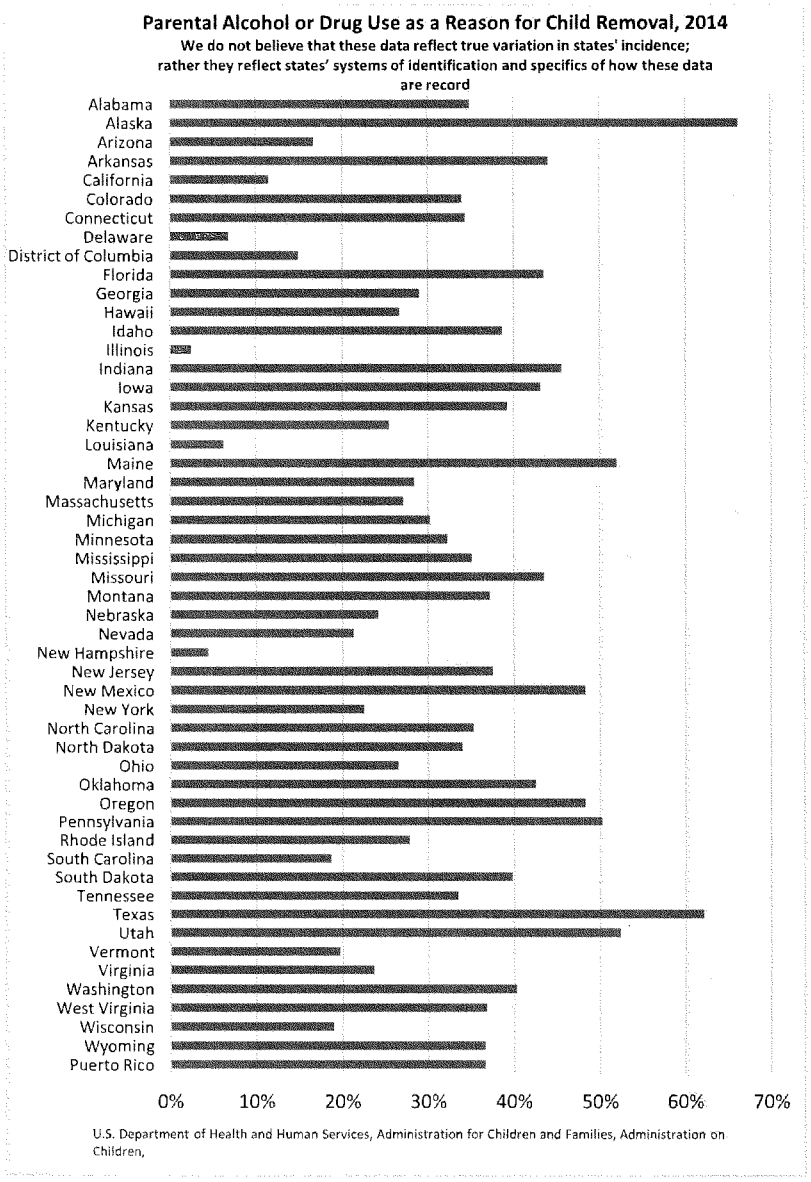


There has been an increasing trend in the percentage of child placement cases with parental alcohol or drug use as factors in the protective custody placement over the past 15 years. Due to identification and data entry complexities, there is great variability across states with States reporting less than 10% to some reporting more than 60%.

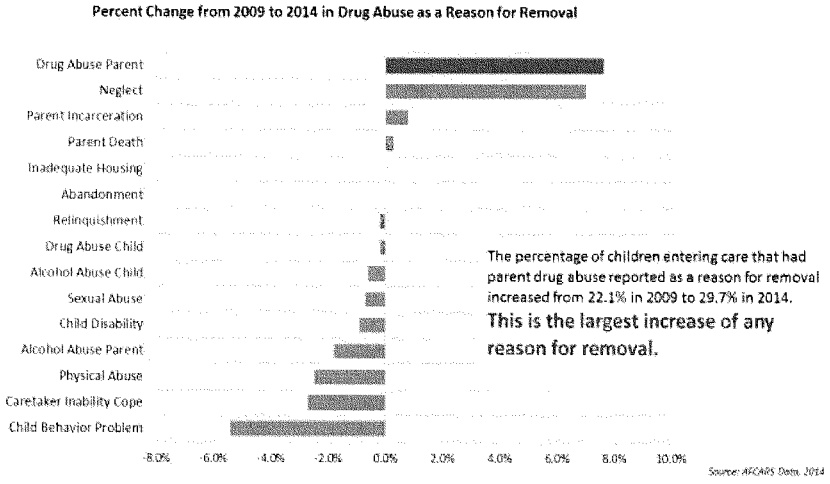
Source: AFCARS Data

However, we have been to all the States in the country and asked child welfare professionals if they believe these data represent the prevalence of parental substance use in their cases. Not a single state believes these data accurately reflect their experience and nearly all tell us that these numbers greatly understate the vast majority of cases in which a child is placed in protective custody for causes related to parental substance use disorders.

As shown in the graph on the following page, these data vary substantially across states. We do not believe that these data reflect true variation in incidence; rather they reflect states' systems of identification and specifics of how these data are recorded in each state's automated data system. Only a handful of states have a standardized screening tool that is used to detect parental substance use disorders during investigations of child abuse and neglect. Very few states have consistent policy and protocols on how the results of investigations regarding parents' substance use are to be recorded in the automated information system.


Parental Alcohol or Drug Use as a Reason for Child Removal, 2014
We do not believe that these data reflect true variation in states' incidence; rather they reflect states' systems of identification and specifics of how these data are record
Alabama
Alaska
Arizona
Arkansas
California
Colorado
Connecticut
Delaware
District of Columbia
Florida
Georgia
Hawaii
Idaho
Illinois
Indiana
Iowa
Kansas
Kentucky
Louisiana
Maine
Maryland
Massachusetts
Michigan
Minnesota
Mississippi
Missouri
Montana
Nebraska
Nevada
New Hampshire
New Jersey
New Mexico
New York
North Carolina
North Dakota
Ohio
Oklahoma
Oregon
Pennsylvania
Rhode Island
South Carolina
South Dakota
Tennessee
Texas
Utah
Vermont
Virginia
Washington
West Virginia
Wisconsin
Wyoming
Puerto Rico
0%
10%
20%
30%
40%
50%
60%
70%
U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children,

Among all reasons for child removal, drug abuse by parents showed the largest rate of increase over the past five years. In addition, child welfare professionals often tell us that neglect is the category that is checked in the data system but that neglect is almost always associated with parents' substance use disorder.



These data are reflected in statements by child welfare agency professionals from around the country. I have had the privilege to work with the State of Ohio over the past year and a half. Recently, I was told by a child welfare administrator from a county that borders Kentucky that 2015 was the first time ever that there were more children whose parents' rights were terminated than were reunified. That small county had 70 terminations attributed to parents' opioid use disorders. Child welfare officials reported that this trend is evident across the state. They report that over the past five years, parents with opioid use disorders have increased the number of children placed in care at the same time that overall resources to serve families have decreased.

To summarize:

- Infants are the largest age group of children entering foster care; however, it is not currently known how many of these infants were referred due to prenatal substance exposure
- Overall removals of children due to parental substance abuse have increased significantly as reported by the states
- Child welfare professionals across the country, particularly in the north-east and Appalachian states, report that parental opioid use disorders are having a major impact on increasing child removals, preventing reunification and increasing termination of parental rights

What Works for Families Affected by Opioid and other Substance Use Disorders

Families and child welfare agencies have been affected by multiple drug epidemics over the past several decades—cocaine in the late 1980s, methamphetamine in the early 2000s and now opioids. This month an article in *Governing* reports that the next trend in drug epidemics is on the horizon with bath salts and "synthetic marijuana," "K2" or "Spice." Synthetic marijuana is dried plant leaves that are sprayed with a synthetic cannabinoid similar to THC. Alabama in particular has reported increases in overdoses and deaths associated with these synthetics (Buntin, 2016).

During the cocaine epidemic, Congress enacted legislation to expand specialty treatment programs for women and their children and required that the Substance Abuse Prevention and Treatment Block Grant prioritize treatment admissions for pregnant and parenting women.

These evolving patterns in drugs of abuse warrant our current policy attention to:

- Ensure that the lessons from prior Federal investments are used to respond to the effects of the opioid epidemic on the child welfare system; and,
- Build the capacity of States to protect children and heal families from future changes in drugs of abuse.

During the methamphetamine epidemic, Congress made the largest ever investment in demonstration grants linking child welfare, treatment agencies, and the courts to find out what works to improve outcomes for these families and ensure child safety, permanency in caregiving relationships, and child and family well-being. A key shift in policy was that many of the communities that received these grants worked to prevent removal of children by providing services to children and their families while the children remained safely at home. States use different labels to refer to these "in-home" cases—protective supervision, for example. But they represent the majority of the caseload of families in child welfare services, often about 70% of the state's caseload.

Across child welfare programs, approximately 85% of children stay home, or go home, or in the case of children who are not reunified, they find homes when they age out of foster care or become adults and access their adoption records. These realities make evident the imperative that child welfare service agencies, substance abuse treatment providers, courts, and community partners work together to address the needs of parents to prevent placement, reunify with their children or potentially play another supportive role in their child's life.

The demonstration grants included the Regional Partnership Grant Program (RPG) and SAMHSA's Children Affected by Methamphetamine Program (CAM). The RPG and CAM programs documented a set of common ingredients and strategies leading to positive outcomes for families affected by substance use disorders. These strategies include:

1. ***Identification:*** A system of identifying families in need of substance use disorder treatment
2. ***Timely Access:*** Timely access to substance use disorder assessment and treatment services
3. ***Recovery Support Services:*** Increased management of recovery services and monitoring compliance with treatment
4. ***Comprehensive Family Services:*** Two-generation family-centered services that improve parent-child relationships
5. ***Increased Judicial Oversight:*** More frequent contact with parents with a family focus to interventions
6. ***Cross-Systems Response:*** Systematic response for participants based on contingency contracting methods
7. ***Collaborative Structures:*** Collaborative non-adversarial approach grounded in efficient communication across service systems and the courts

Implementation of these common strategies for collaborative policy and practice has shown five core outcomes, the 5Rs:

1. ***Recovery:*** Parental recovery from substance use disorders
2. ***Remain at Home:*** More children remain in the care of parents
3. ***Reunification:*** Increased number and timeliness of parent-child reunifications
4. ***Re-occurrence:*** Decreased incidence of repeat maltreatment
5. ***Re-entry:*** Decreased number of children re-entering out-of-home care

Regional Partnership Grants

The Child and Family Services Improvement Act of 2006 reauthorized the Promoting Safe and Stable Families program and provided a competitive grant program with funding over a five-year period to implement regional partnerships in states, tribes and communities to improve outcomes for children and families who were affected by parental substance use disorders.

In October 2007, the Administration on Children Youth and Families (ACYF), Children's Bureau (CB) awarded grants to 53 partnerships across the country, including 7 tribes. Family Drug Courts were part of the initiative in 21 of the grantees. The outcomes of the grants were measured in a performance measurement system focused on documenting child safety, permanency, and well-being; systems improvement; and treatment-related outcomes such as timeliness of treatment access, length of stay in treatment, and parents' recovery.

In September 2012, ACYF/CB awarded 17 new RPGs and 2-year extension grants to 8 of the 53 original grantees. This was made possible by Child and Family Services Improvement and Innovation Act (Pub. L. 112-34) signed into law in September 2011. In September 2014, four additional 5-year grants were awarded.

RPG grantee ***OnTrack*** is located in Medford, Oregon. They developed an alternative to children being placed in foster care by creating emergency shelters and residential treatment in which parents and children could stay together. Of families who participated in the program, 98% of children were reunified with families within 10 months.

After one year of program completion, only 6% of families had a subsequent removal, compared 28% of families receiving standard services—comparison group children were four times more likely to experience subsequent removal.

The original 53 grantees served a total of 17,820 adults, 25,541 children and 15,031 families. Key positive outcomes across sites include:

- Parents achieved timely access to substance abuse treatment (36.4% entered treatment within 3 days), stayed in treatment (65.2% stayed in treatment more than 90 days), and reported reduced substance use.
- The majority of children at risk of removal remained in their parent's custody – 92.0% of children who were in custody of their parent or caregiver at the time of RPG program enrollment remained at home through RPG program case closure. The percentage of children who remained at home significantly increased through program implementation from 85.1% in Year 1 to 96.4% in Year 5.
- Most children in out-of-home placement achieved timely reunifications with their parent(s)
  - 83.0% of children discharged from foster care were reunified
  - 63.6% reunified within 12 months
  - 17.9% were reunified in less than 3 months
  - 72.7% of infants reunified within 12 months.
- After returning home, very few children re-entered foster care
  - only 4.2% of children had a substantiated maltreatment within six months versus 5.8% subsequent maltreatment rate based on state data.

The RPG in the State of Kansas implemented the evidence-based Strengthening Families Program (SFP) with 367 Children and 473 adults. On average, the SFP child participant spent 190 fewer days in out-of-home care than their non-SFP counterparts. For example, at the 360-day point from start of SFP, almost half (45.0 percent) of the SFP children were reunified, compared to 27.0 percent of the comparison children. The evaluation conducted by University of Kansas researchers found that SFP saved approximately $16,340 per child in State and Federal out-of-home care costs (McDonald & Brook, 2013).

Children Affected by Methamphetamine Grants

Funded through the Substance Abuse and Mental Health Services Administration (SAMHSA), the Children Affected by Methamphetamine (CAM) Grant Program focused on expanding and enhancing services to children and their families who are affected by methamphetamine and other substance use disorders. The Public Health Service Act of 2000 Section 509 provided funding from 2010-2014 to 12 Family Drug Courts to improve the well-being, permanency, and safety outcomes of children, who were in, or at-risk of out-of-home placement as a result of parental methamphetamine or other substance abuse. The primary focus of the grant program was to provide services directly to the children and to provide supportive services for parents, caregivers, and families.

The ***Sacramento County CAM Project*** (known as Children in Focus) served children and families in the Dependency Drug Court (DDC) and the Early Intervention Family Drug Court (EIFDC). The DDC serves families in which children have been removed from parental care and the EIFDC serves children, primarily infants, who are in the care of their birth parents. The CAM grant supported family-centered services including an evidenced-based specialized parenting program for parents in recovery called Celebrating Families (CF) and the use of Recovery Specialists who conduct active engagement based on motivational interviewing and monitoring activities with parents. The project also linked participants to family resource centers and other community resources to provide recovery support during CF participation and beyond program completion.

Outcome data shows that 97.6% of children who were at home at the time of enrollment remained at home, saving an estimated $34,494 per child in placement costs. Within 6 months of program entry, only 1.5% of children experienced maltreatment reoccurrence. Higher reunification rates and shorter times in out-of-home care compared to standard services saved an estimated $12,254 per child.

Outcome data from across all 12 sites indicated that children enrolled in the CAM program services were kept safe with lower rates of repeat maltreatment than in the general child welfare population. Outcomes included:

- More than 90% of children remained in their home with their parent/caregiver throughout program participation and the majority of children exiting out-of-home care were discharged to reunification
- Over two-thirds (68.2%) of CAM children were reunified in less than 12 months
- Less than 6% of reunified children re-entered foster care within 12 months after being returned home. This is about a third of the national average with standard services.

The CAM grantees' experience increased our knowledge about the timing and type of parenting classes that should be delivered to parents in early recovery. These grantees experimented with when to start and what type of parenting classes these families need. They found that they could increase retention in treatment when they engaged parents early in their recovery in parenting programs specifically developed for parents with substance use disorders, focusing on teaching effective parenting skills, and providing opportunities for children and parents to repair their relationship.

The other good news about these projects is that they saved money. Not only did they reduce foster care costs, but they also kept parents in treatment long enough for treatment to have a lasting effect. And in the long term, these programs are keeping children out of higher-end, higher-cost mental health, special education, and juvenile justice programs when they get older. These programs proved that they could save millions of dollars, justifying the increase in enhanced services for children and their parents.

Although these grant programs operated in different drug epidemics than the current opioid wave, there is much that can be applied to today's crisis. We do know that access to medication-assisted treatment is imperative for success in today's population. But, as important as access to effective treatment has proven to be in prior eras, access to medication-assisted treatment for this population is not being provided on a timely basis. For example, months of wait lists for treatment are the norm across the country.

In Ohio last month, I was told that in a FDC model that includes facilitating treatment access, it still takes approximately one month to get access to medication assisted treatment. Without participation in the specialized drug court docket, it takes at least three months to access medications. When children's safety and well-being are at stake, parents need to access treatment much faster than that.

While some states have access to Medicaid funding for some families involved with child welfare, it's important to recognize that the health-related criteria for accessing treatment and the outcomes measured in the health care system may not always relate to the needs of families in child welfare. Medical criteria to access a certain level of care with Medicaid or private insurance does not include the safety or impact on the child as criteria for residential or intensive out-patient levels of care. Similarly, outcomes for substance abuse treatment for adults in the Medicaid or private insurance system do not typically count family safety and child well-being in their performance measures. Rather, these outcomes are the responsibility of the child welfare system in collaboration with substance abuse treatment agencies and courts.

Another factor affecting the expansion of treatment resources in a family-centered approach is the restriction on residential programming under Medicaid due to the Institutions for Mental Disease (IMD) exclusion on treatment access for individuals with a substance use disorder. We note that the Comprehensive Addiction and Recovery Act (CARA) legislation would require a GAO report on the implications of this restriction and would urge that specific attention to its impact on families involved in child welfare be included in that report.

We would suggest that referral to a wait list does not meet child welfare's legal standard of reasonable efforts, and in the case of Native American children the higher standard of active efforts, to prevent placement and to reunify children. Merely referring does not connect parents and children with services; ensuring access to treatment and treatment availability is what is needed.

In summary, we can no longer say we don't know what to do. We can build on the track record of dozens of fine, smaller-scale programs in your states and communities. That's a big difference in this epidemic, compared with prior eras. We can take what works into system change approaches, instead of helping only a few families at a time.

Opportunities to Take What Works into System-Wide Reform

The impact of opioids on children and families in the child welfare system must be placed in context of the history of parental substance use disorders, the need to comprehensively address the current epidemic, and the potential to mediate the effects of future shifts in drug use patterns from severely impacting children and their families. These efforts should focus on:

- Building on lessons from prior federal investments;
- Resolving the current gap in timely treatment access;
- Improving data collection and monitoring; and,
- Prevent future crises and costs as substance use patterns change over time.

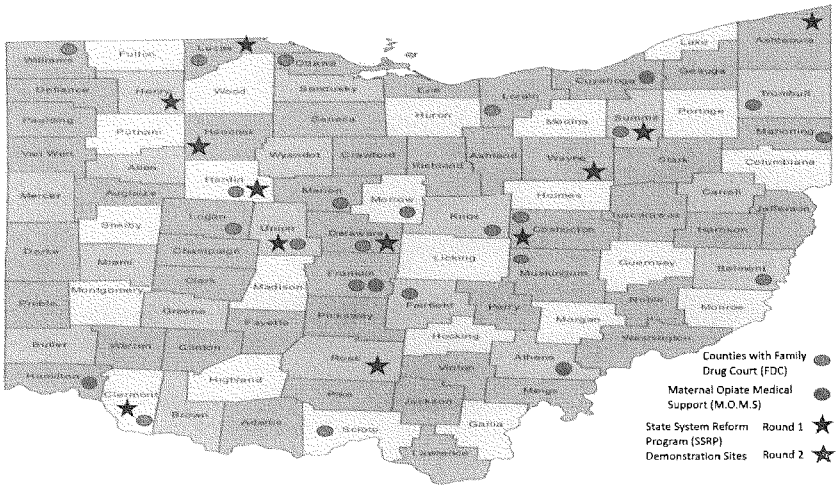
In Fiscal Year 2015, the Office of Juvenile Justice and Delinquency Prevention (OJJDP) funded five states to take the lessons from effective family drug courts and implement those on a larger scale. The states are Alabama, Colorado, Iowa, New York and Ohio. Another solicitation to add a small number of additional States is currently underway. The first round of States were awarded two years of planning grants and in 2017, it is anticipated that the States will compete for implementation awards. In addition to a grant award, each State receives significant resources in technical assistance and training through OJJDP's FDC Technical Assistance contract with Children and Family Futures.

In Ohio, an Executive Oversight Committee has been created with membership from the Supreme Court of Ohio, the Ohio Department of Job and Family Services and the Ohio Department of Mental Health and Addiction Services. The Executive Committee and its representatives are working on several key strategies:

- A Memorandum of Understanding across these agencies and the court to specify agreements related to their working together including data sharing agreements.
- Various working groups and committees are developing implementation plans on:
  - Cross-system training;
  - Data collection;
  - Resource development;
  - Expanding the number and penetration rate of family drug courts to reach more families; and,
  - Determining how to best take the components of effective practice into the larger child welfare court docket.
- Eleven performance measures have been agreed upon by the State team and a code book has been developed to assist counties in clarifying how to track parents and children in the separate data systems.
- A contract is in development that will create a data warehouse at Ohio State University so that performance measures can be monitored across the state agencies and the court; this action is necessary, since the existing data systems do not have variables to track families' progress across treatment and child welfare services.
- Counties applied and two waves of six demonstration counties have been selected. The pilot sites are being provided technical assistance via the OJJDP grant and small incentive awards are being developed to assist with some of their direct costs in participation. The demonstration sites are currently working on the following priorities:
  - Developing local governance structures with representatives from the local dependency court, child welfare and treatment agencies;

- Testing strategies to implementing universal substance abuse screening protocols for all families within the child welfare system;
- Developing standardized information sharing protocols across the three systems that include formal information-sharing agreements that address the issues of confidentiality; and
- Identifying local performance measures needed to measure outcomes for families affected by substance use disorders within the children welfare system and developing strategies to engage in data sharing across the three systems.

The map below indicates the 20 counties currently operating Supreme Court-certified family drug courts, with Cuyahoga in is the process of certification. There are 12 counties that have been selected to pilot and implement the SSRP initiative, as well as four counties that are currently pilot testing the M.O.M.S. program.



In addition to the key programmatic strategies being implemented to prevent child placement, there are system changes that are also needed to effectively monitor effects over time, ensure staff are prepared to work effectively with these families, develop state-specific financing strategies to maximize recent changes in substance use disorder treatment, fill gaps in treatment access for these families, and build collaborative efforts that cross agency boundaries and support communities. Specific system reforms that are needed include:

- **Improve data collection and reporting to monitor the effects of parental substance use disorders on the child welfare system and the outcomes achieved by addressing treatment needs.** States' information technology challenges include recording alcohol and drug use factors in case files, requiring standardized reporting of alcohol and drug use factors in federal child welfare reporting systems and requiring existing outcome monitoring to report on the differential child welfare outcomes for children and families due to parental

substance use disorders. No state at present is able to report the child welfare outcomes of all families referred to and enrolled in its treatment systems.

- **Improve access to quality substance use disorder treatment**. The need for access to substance abuse treatment cannot be over-emphasized. When we refer parents to treatment as a condition of keeping or reunifying with their children, we must make sure that the treatment is state-of-the–art, comprehensive, meets the needs of the entire family, and that treatment, including medications for opioid use disorders, is available and timely. Funding of the Comprehensive Addiction and Recovery Act (CARA) is critical, including the provisions that will expand services to pregnant and parenting women. However, it is also imperative to ensure that child welfare funding is shifted to allow children, particularly infants and young children, to remain at home with parents while their parents receive substance abuse and mental health treatment to prevent the trauma of child removal and the higher costs associated with foster care.

- **Improve collaborative practice.** This can be achieved through implementation of practical strategies, such as staff development and training programs and cross-systems communication protocols. Ensuring that these strategies include a focus on infants with prenatal substance exposure will develop a workforce that is prepared to work in today's environment. Staff training and communication protocols must provide concrete and pragmatic information, such as guidance in developing comprehensive plans of safe care that keep infants with birth families whenever possible and provide interventions to address the needs of both the infant and mother.

When we ensure timely access to effective treatment, families recover, kids stay safe at home, and we save money. Now we can and must move beyond pilots and demonstration grants and take these lessons to into systemic changes across agencies to help children and families.

References

Buntin, J. (2016). Synthetic Drugs: An Emerging, Evolving Threat. *Governing.* Accessed April 18, 2916 at: http://www.governing.com/topics/public-justice-safety/gov-synthetic-drugs-states.html

Compton, W.M., Jones, C.M. & Baldwin, G.T. (2016). Relationship between nonmedical prescription-opioid use and heroin use. New England Journal of Medicine, 374(2), 154-163.

Jones, H. (2015). Treatment of Opioid Use Disorder in Pregnancy and Infants Affected by Neonatal Abstinence Syndrome. A Webinar presented for the SAMHSA Women's Health Week. May 15, 2015. Accessed February 20, 2016 http://www.cffutures.org/files/webinars

Leonard, K. (2015). Heroin Use Skyrockets in U.S. *US News and World Report.* July 7, 2015. Accessed February 21, 2016. http://www.usnews.com/news/blogs/data-mine/2015/07/07/heroin-use-skyrockets-in-us-cdc-says

McDonald, T. & Brook, J. (2013). Description of the State of Kansas Regional Partnership Grant and Evaluation Findings. Accessed February 21, 2016. http://www.cffutures.org/files/rpgprofiles/ArrayofServicesCluster/KansasDepartmentofSocialandRehabilitationServices.pdf

Nowakowski, R.S. (2006) *Stable neuron numbers from cradle to grave.* Proceedings of the National Academy of Sciences of the United States of America. 103(33):12219-12220.

Patrick, S. W., Davis, M. M., Lehmann, C. U. & Cooper, W. O. (2015). Increasing incidence and geographic distribution of neonatal abstinence syndrome: United States 2009 to 2012. *Journal of Perinatology,* 35(8): 650-655.

Substance Abuse and Mental Health Services Administration, *Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings*, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality (2015). *Behavioral health trends in the United States: Results from the 2014 National Survey on Drug Use and Health* HHS Publication No. SMA 15-4927, NSDUH Series H-50. Retrieved from http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf (accessed February 19, 2016).

Wilson, D. & Shiffman, J. (2015). Helpless and Hooked. *A Reuters Investigation.* December 7, 2015. Accessed February 21, 2016 http://www.reuters.com/investigates/special-report/baby-opioids/

Via Email (Megan_Harrington@portman.senate.gov; Abigail_Duggan@brown.senate.gov)

May 3, 2016

Senator Robert Portman
Committee on Homeland Security and Governmental Affairs
340 Dirksen Senate Office Building
Washington, DC 20510

Senator Sherrod Brown
713 Hart Senate Office Building
Washington, DC 20510

Re: Longer-Term Effects of Prenatal Substance Exposure

Dear Senator Portman, Senator Brown, and Committee Members:

Thank you for the opportunity to participate and testify before the Committee on Homeland Security and Governmental Affairs at the recent hearing titled "Examining the Impact of the Opioid Epidemic" on Friday, April 22, 2016 at the University Hospitals of Cleveland in Ohio.

In follow-up to our discussion, I have provided a brief summary of the literature on the longer-term effects of prenatal substance exposure to opioids and other substances (i.e., alcohol and nicotine).

Introduction
According to the American College of Obstetricians and Gynecologists (ACOG), "Neonatal abstinence syndrome is an *expected* and *treatable* condition that follows prenatal exposure to opioid agonists (2012)." Neonatal abstinence syndrome (NAS) is the term used to represent the pattern of effects that are associated with opioid withdrawal in newborns (Wachman et al., 2013). The section on *Prenatal Exposure to Opioids* below provides additional information on NAS.

A complex interplay of prenatal and postnatal factors affect the developmental trajectory of the infant that is exposed to opioids. Although numerous studies have identified the various factors that can affect the long-term outcomes of children with prenatal substance exposure—whether the mother is able to access prenatal care, substance use treatment and the range of additional services that may be necessary to address the range of psychosocial, health and socioeconomic issues that the family may face—poly-substance use, particularly alcohol and tobacco, must be addressed. Use of multiple substances in itself presents a challenge, making it difficult to separate analyses of any one substance's effects.

25371 Commercentre Drive, Suite 140 • Lake Forest, CA 92630
Phone: 714.505.3525 • Fax: 714.505.3626 • Toll Free 866.493.2758
www.cffutures.org

Some studies have demonstrated that some of the long-term effects of prenatal exposure to alcohol and tobacco are independent of other risk factors. There is a growing body of evidence that suggests these long-term effects include a predisposition to developing a substance use disorder for the child with prenatal exposure (Behnke & Smith, 2013). The following table from the American Academy of Pediatrics summarizes 40 years of data examining the effect of prenatal exposure to drugs and alcohol (Behnke & Smith, 2013).

TABLE 2 Summary of Effects of Prenatal Drug Exposure

	Nicotine	Alcohol	Marijuana	Opiates	Cocaine	Methamphetamine
Short-term effects/birth outcome						
Fetal growth	Effect	Strong effect	No effect	Effect	Effect	Effect
Anomalies	No consensus on effect	Strong effect	No effect	No effect	No effect	No effect
Withdrawal	No effect	No effect	No effect	Strong effect	No effect	*
Neurobehavior	Effect	Effect	Effect	Effect	Effect	Effect
Long-term effects						
Growth	No consensus on effect	Strong effect	No effect	No effect	No consensus on effect	*
Behavior	Effect	Strong effect	Effect	Effect	Effect	*
Cognition	Effect	Strong effect	Effect	No consensus on effect	Effect	*
Language	Effect	Effect	No effect	*	Effect	*
Achievement	Effect	Strong effect	Effect	*	No consensus on effect	*

* Limited or no data available.

Across all substances, alcohol and tobacco exposure have the highest risk for poor outcomes in regard to challenges across multiple domains related to both short-term effects (e.g. birth outcomes) and long-term effects. Alcohol exposure has been found to have a strong effect across all long-term domains of growth, behavior, cognition, and achievement. Nicotine exposure has been associated with challenges across long-term domains of behavior, cognition, language and achievement.

The following summarizes various studies that examine the long-term outcomes of children prenatally exposed to opioids, alcohol and nicotine. Discussion on the short-term (e.g. neonatal abstinence syndrome) effects of opioid exposure is also provided.

Prenatal Exposure to Opioids

Some distinctions among women who use opioids during pregnancy are paramount to understand because the potential risks to the infant can vary. Generally, women who use opioids during pregnancy can be categorized within one of the following groups:

- Are receiving pain management with medications under the care of a physician.
- Are under the care of a physician and undergoing treatment for an opioid use disorder with medications, such as methadone or buprenorphine.
- Are misusing or abusing opioid pain medications with or without a prescription (e.g., obtaining pills illegally for a nonmedical use, "doctor shopping," obtaining a prescription illegally).
- Are using or abusing illicit opioids, particularly heroin.

The use of medication-assisted treatment (MAT) during pregnancy is a recommended best practice for the care of pregnant women with opioid use disorders (ACOG, 2012). The use of

MAT, in combination with counseling and behavioral therapies, and access to a range of supportive services, such as housing and employment services, assists the mother in achieving a more stable life (Newman & Kagen, 1973). MAT stabilizes the intrauterine environment and avoids subjecting the fetus to repeated episodes of withdrawal, which place the fetus at higher risk for morbidity and mortality (Kaltenbach & Finnegan, 1998; Jones et al., 2005; CSAT 2005).

Methadone has been accepted as a treatment for opioid use disorders during pregnancy since the late 1970s (Kaltenbach & Finnegan, 1998; Kandall et al., 1999; CSAT 2005). In 1998, a National Institutes of Health consensus panel recommended methadone maintenance as the standard of care for pregnant women with opioid use disorders (National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction, 1998). The use of buprenorphine for the management of opioid use disorders in pregnancy is becoming more widely used, with the emergence of data from randomized clinical trials that demonstrate its safety and efficacy (Jones et al., 2005; Fischer et al., 2006; Jones et al., 2010).

Between 2005 and 2008, A National Institute on Drug Abuse (NIDA)-supported clinical trial, the *Maternal Opioid Treatment: Human Experimental Research* (MOTHER) study, examined the use of both methadone and buprenorphine maintenance therapy during pregnancy. The study found that infants exposed to buprenorphine required shorter treatment duration and less medication to treat the symptoms of NAS and experienced shorter hospital stays when compared to infants exposed to methadone. No significant difference was found with respect to any serious maternal or neonatal adverse events, including abnormal fetal health or neurologic symptoms (Jones et al., 2010).

- Jones, H. E., Kaltenbach, K., Heil, S., Stine, S. M., Coyle, M. G., Arria, A. M., O'Grady, K., Selby, P., Martin, P., & Fischer, G. (2010). Neonatal abstinence syndrome after methadone or buprenorphine exposure. *New England Journal of Medicine*, 363, 2320–2331. Retrieved from http://www.nejm.org/doi/full/10.1056/NEJMoa1005359.

Neonatal abstinence syndrome (NAS) symptoms are affected by a variety of factors, including the type of opioid the infant was exposed to, the point in gestation when the mother used the opioid, genetic factors, and exposure to multiple substances, particularly nicotine (Velez & Jansson, 2008). Non-pharmacological treatment is the standard of care for the infant with NAS and should start at birth and continue throughout the infant's hospitalization and beyond. Both non-pharmacological and pharmacological treatment (e.g. methadone, buprenorphine, morphine) seek to soothe the infant's symptoms, while encouraging the mother–infant bond. The course of treatment required by the infant depends on the severity of symptoms and response to treatment. The mean length of hospital stay for newborns diagnosed with NAS is approximately 1-3 weeks, depending on the type of treatment (Hudak & Tan, 2012).

Sudden Infant Death Syndrome/Sudden Unexplained Infant Death

Studies have examined the association between prenatal opioid exposure and risk of Sudden Infant Death Syndrome/Sudden Unexplained Infant Death (SIDS/SUID). A study found that

smoking during pregnancy and lack of prenatal care contribute to a high risk for SIDS/SUID among women who received methadone treatment—controlling for those two factors almost *halved* the risk. Another study found the mortality rate of infants prenatally exposed to opioids via MAT for opioid dependence to be similar to that of the general population.

- Burns, L., Mattick, R.P., Lim, K., & Wallace, C. (2007) Methadone in pregnancy: Treatment retention and neonatal outcomes. *Addiction*, 102(2): 264–270.
- Kelly, L.E., Rieder, M.J., Bridgman-Acker, K., Lauwers, A., Madadi, P., & Koren, G. (2012). Are infants exposed to methadone in utero at an increased risk for mortality? *J Popul Ther Clin Pharmacol*, 19(2): e160-1655.

Developmental Outcomes

A seminal review of two decades worth of literature examining the impact of prenatal exposure to opioids found no difference in the linguistic, cognitive, social-emotional and motor skills of children who had been exposed to opioids via methadone maintenance treatment. Although some studies found differences in the motor development of infants and toddlers, potentially confounding factors—such as exposure to multiple substances, use of prenatal care, and length of participation in methadone maintenance treatment—were not controlled for and the differences could not be directly attributed to methadone exposure. The potential effect of other risk factors was also demonstrated in studies that examined the developmental outcomes of pre-school aged children. A study comparing the outcomes of three groups of children—those born to mothers who received methadone treatment; those born to mothers who used heroin during pregnancy and did not receive methadone or any other type of medication assisted treatment; and those born to mothers who did not use any substances—found comparable findings across the groups in terms of cognitive development. However, 95% of women in the methadone treatment group continued to use illicit or prescribed medications. The three groups were also comparable in terms of the presence of physical and psychosocial risk factors. These findings indicate that the degree of opioid exposure was not a factor and instead, predictors of cognitive development are much more influenced by a range of factors, including access to prenatal care, exposure to multiple substances and other risk factors related to continued substance use, and the presence of mental health issues or domestic violence.

- Kaltenbach, K.A. (1996). Exposure to opiates: behavioral outcomes in preschool and school-age children. NIDA Res Monogr, 164: 230-41.
- Kaltenbach, K., Finnegan, L. P. (1987). Perinatal developmental outcome of infants exposed to methadone in utero. *Neurotoxicol Teratol,* 9, 311-313.
- Kaltenbach, K., & Finnegan, L. P. (1984). Developmental outcome of children born to methadone maintained women: A review of longitudinal studies. *Neurobehavioral Toxicology Teratol,* 6(4), 271-275.

A 2014 meta-analysis review found no significant impairments in cognitive, psycho-motor or behavioral outcomes for children prenatally exposed to opioids. Although the review did find a trend toward poorer outcomes for children with prenatal exposure, the study did not control for whether multiples substances were involved and variation in the type of exposure (e.g. heroin or

methadone). The study discusses additional risk factors such as maternal mental health, parental attitude towards parenting, parent-child interaction and stressful life vents. It is not the sole presence of prenatal exposure to opioids or the presence of one of the other potential risk factors that contribute to poor outcomes. Instead, it is the presence of multiple and inter-related variables that cumulatively influence the infant's development.

- Baldacchino, A., Arbuckle, K., Petrie, D. J., & McCowan, C. (2014). Neurobehavioral consequences of chronic intrauterine opioid exposure in infants and preschool children: A systematic review and meta-analysis. *BMC Pscyhiatry, 14, 104.*

Visual Impairment

One study found that infants prenatally exposed to methadone are at higher risk for developing visual problems, especially infants who experience severe NAS requiring pharmacological treatment. The authors acknowledge that it is uncertain whether the visual and other issues experienced by children in the study are directly attributed to methadone exposure, or, whetber other factors, such as prenatal exposure to other substances—55% of children were exposed to benzodiazepines and 40% exposed to heroin—also contributed.

- Hamilton, R., McGlone, L., McKinnon, J. R., Russell, H. C., Bradnam, M. S., & Mactier, H. (2010). Ophthalmic, clinical and visual elegrophysiological findings in children born to mothers prescribed substitute methadone in pregnancy. *Br J Ophthalmol.* 94(6): 696-700.

Prenatal Exposure to Alcohol

"Prenatal alcohol is predictive of decreased executive functioning in early childhood that could not be attributed to environmental factor (Noland et al., 2003)*."*

Alcohol is a teratogen, meaning that it is a substance known to be harmful to human development (Kaufman, 1997). Children prenatally exposed to alcohol can suffer from serious cognitive deficits and behavioral problems as well as from alcohol-related changes in brain structure. Brain imaging studies have identified structural changes in various brain regions of children who were prenatally exposed to alcohol. The affected regions may account for the cognitive deficits experienced by affected children. Fetal Alcohol Spectrum Disorders (FASD) is an umbrella term describing the range of *lifetime* physical, mental, behavioral and learning disabilities experienced by children who are prenatally exposed to alcohol[1].

Several studies have found that the long-term effects of prenatal exposure to alcohol are *independent* of the other risk factors (e.g. environmental risk factors) that influence the development of children who are exposed to other substances. These effects are due to the changes in brain structure caused by alcohol exposure.

- Baer, J., Sampson, P. D., Barr, H. M., Connor, P. D., & Streissguth, A. P. (2003). A 21-year longitudinal analysis of the effects of prenatal alcohol exposure on young adult drinking. *Arch Gen Psychiatry*, 60(4), 377-385

[1] http://fasdcenter.samhsa.gov/educationTraining/FASDBASICS/FASDTheBasics.pdf

- Mattson, S.N., Schoenfield, A.M., & Riley, E.P. (2001). Teratogenic Effects of Alcohol on Brain and Behavior. *Alcohol Research & Health*, 25(3), 185-191.
- Merrick, J., Merrick, E., & Kandel, I. (2006). Fetal alcohol syndrome and its long-term effects. *Minerva Pediatrica*, 58(3), 211-218

Prenatal Exposure to Nicotine

Tobacco smoke contains over 4,000 different compounds, of which approximately 30 have heen associated with adverse health outcomes (Behnke & Smith, 2013). Multiple studies have demonstrated that prenatal exposure to nicotine exacerbates NAS, resulting in a higher likelihood of the infant requiring pharmacological treatment, thereby resulting in longer hospital stays. Any nicotine exposure has been found to significantly increase the risk of poor fetal growth, prematurity and low birth weight. (Bakstad, et a., 2009; Burns, et al., 2008; Choo, et al., 2004; Jones, et al., 2014; Jones, et al., 2012; Kaltenbach, et al., 2012; & Winklbaur, et al., 2009).

In addition to exacerbating the symptoms of NAS, prenatal exposure to nicotine affects the fetus in numerous ways including low birth weight and abnormalities to the brainstem—both of which are risk factors for SIDS/SUID. Up to 70% of SIDS/SUID involve brainstem abnormalities (American Academy of Pediatrics [AAP], 2011). The brainstem operates numerous functions, including respiratory and autonomic functions, both of which are related to SIDS/SUID. Exposure to tobacco smoke in the postnatal period continues to affect the infant's respiratory and autonomic development and functions, putting the infant at further risk. An estimated *one third* of SIDS/SUID cases can be prevented if smoking during pregnancy were to be eliminated (AAP, 2011).

After controlling for a variety of potentially confounding factors, studies have demonstrated the behavior effects, such as impulsivity and attention problems, of prenatal tobacco exposure to be long-term in nature.

- Fried, P.A., Watkinson, B., & Gray, R. (1992). A follow-up study of attentional behavior in 6-year-old children exposed prenatally to marijuana, cigarettes, and alcohol. *Neurotoxicol Teratol,* 14(5): 299–311.
- Kristjansson, E.A., Fried, P.A., & Watkinson, B. (1989). Maternal smoking during pregnancy affects children's vigilance performance. *Drug Alcohol Depend*, 24(1): 11–19.
- Thapar, A., Fowler, T., & Rice, F. (2003). Maternal smoking during pregnancy and attention deficit hyperactivity disorder symptoms in offspring. *Am Journal Psychiatry*, 160(11): 1985–1989

Summary

Prenatal exposure to substances is a major health concern with significant new visibility due to the current opioid epidemic. Understanding how to appropriately and effectively treat infants prenatally exposed to opioids and to develop a long-term care plan requires an understanding of:

- The type of opioid exposure: Exposure to heroin and related risk factors (e.g. HIV, hepatitis, drug-seeking behavior) demonstrates significantly poorer outcomes than exposure to medications used to treat opioid use disorders
- Access to treatment: Improved outcomes related to the use of MAT in pregnancy is associated with the concurrent use of counseling, other behavioral interventions and a range of additional supports to address the other psychosocial and health concerns faced by the family.
- Exposure to multiple substances: Teasing out the effects of specific substances is often difficult as individuals with substance use disorders generally use multiple substances, particularly alcohol and nicotine, which have been shown to have adverse consequences for children. In all situations of opioid use during pregnancy, identifying whether alcohol and nicotine are also involved is critical due to the effects of smoking on the frequency and severity of the NAS experience of the infant and the potential of lifetime challenges related to growth, behavioral, cognitive, and language development.

In closing, I would like to thank you for your interest in the opioid issues and again for the invitation to testify before the United States Senate Committee on Homeland Security and Governmental Affairs. We are happy to assist you with any questions you may have regarding this summary and to provide you with any additional information you may require regarding these critical issues.

Sincerely,

Nancy K. Young

Nancy K. Young, Ph.D.
Executive Director

cc: Laura Kilbride (Via Email Laura_Kilbride@hsgac.senate.gov)
Benjamin Grazda (Via Email Benjamin_Grazda@hsgac.senate.gov)

Referenees

American Academy of Pediatrics. (2011). Technical Report, SIDS and Other Sleep-Related Infant Deaths: Expansion of Recommendations for a Safe Infant Sleeping Environment. Pediatrics, 128(5), e1341-e1367. Retrieved from http://pediatrics.aappublications.org/content/pediatrics/128/5/e1341.full.pdf

American College of Obstetricians and Gynecologists Committee on Health Care for Underserved Women, & American Society of Addiction Medicine. (2012). Opioid abuse, dependence, and addiction in pregnancy. ACOG committee opinion no. 524. Obstetrics and Gynecology, 119(5), 1070–1076. Retrieved from http://www.acog.org/Resources-And-Publications/Committee-Opinions/Committee-on-Health%20Care-for-Underserved-Women/Opioid-Abuse-Dependence-and-Addiction-in-Pregnancy

Bakstad, B., Sarfi, M., Welle-Strand, G., & Ravndal, E. (2009). Opioid maintenance treatment during pregnancy: Occurrence and severity of neonatal abstinence syndrome: A national prospective study. European Addiction Research, 15(3), 128-134.

Behnke, M., & Smith, V. C. (2013). Technical Report. Prenatal substance abuse: short and long-term effects on the exposed fetus. American Academy of Pediatrics, 131(3), e1009-e1024.

Burns, L., Mattick, P. & Wallace, C. (2008). Smoking Patterns and Outcomes in a Population of Pregnant Women with Other Substance use Disorders. Nicotine Tob Res. 10 (6): 969-974

Center for Substance Abuse Treatment. (2005). Medication-assisted treatment for opioid addiction in opioid treatment programs: Treatment Improvement Protocol (TIP) Series 43. HHS Publication No. (SMA) 12-4214. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved from http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214

Choo, R. E., Huestis, M. A., Schroeder, J. R., Shin, A. S., & Jones, H. E. (2004). Neonatal abstinence syndrome in methadone-exposed infants is altered by level of prenatal tobacco exposure. Drug and Alcohol Dependence, 75(3), 253-260.

Fischer, G., Ortner, R., Rohmeister, K., Jagsch, R., Baewert, A., Langer, M., & Aschauer, H. (2006). Methadone versus buprenorphine in pregnant addicts: A double-blind, double-dummy comparison study. Addiction, 101, 275–281. Retrieved from http://onlinelibrary.wiley.com/doi/10.1111/j.1360-0443.2006.01321.x/abstract?systemMessage=Wiley+Online+Library+will+be+%20disruped+on+the+18th+October+from+10%3A00+BST+%2805%3A00+EDT%29+for+essential+%20maintenance+for+approximately+tw+hours+as+we+make+upgrades+to+improve+our+services+to+you

Hudak, M. L., & Tan, R. C. (2012). Neonatal drug withdrawal. Pediatrics, 129(2), e540–e560. Retrieved from http://pediatrics.aappublications.org/content/129/2/e540.abstract

Jones, H. E., Johnson, R. E., Jasinski, R., O'Grady, K. E., Chisholm, C. A., Choo, R. E., & Milio, L. (2005). Buprenorphine versus methadone in the treatment of pregnant opioid-dependent patients: Effects on the neonatal abstinence syndrome. Drug and Alcohol Dependence, 79, 1–10. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/15943939

Jones, H. E., Kaltenbach, K., Heil, S., Stine, S. M., Coyle, M. G., Arria, A. M., O'Grady, K., Selby, P., Martin, P., & Fischer, G. (2010). Neonatal abstinence syndrome after methadone or buprenorphine exposure. New England Journal of Medicine, 363, 2320–2331. Retrieved from http://www.nejm.org/doi/pdf/10.1056/NEJMoa1005359

Jones, H. E., Heil, S. H., Baewert, A., Arria, A. M., Kaltenbach, K., Martin, P. R., Coyle, M.G. , Selby, P., Stine, S.M., & Fischer, G. (2012). Buprenorphine treatment of opioid-dependent pregnant women: A comprehensive review. Addiction, 107, 5-27.

Jones, H. E., Dengler, E., Garrison, A., O'Grady, K. E., Seashore, C., Horton, E., Andringa, K., Jansson, L.M., & Thorp, J. (2014). Neonatal outcomes and their relationship to maternal buprenorphine dose during pregnancy. Drug and Alcohol Dependence, 134, 414-417.

Kaltenbach, K.A. (1996). Exposure to opiates: behavioral outcomes in preschool and school-age children. NIDA Res Monogr, 164, 230-41.

Kaltenbach, K., & Finnegan, L. (1998). Prevention and treatment issues for pregnant cocaine-dependent women and their infants. Annals of the New York Academy of Sciences, 846, 329–334. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/9668419

Kaltenbach, K., Holbrook, A. M., Coyle, M. G., Heil, S. H., Salisbury, A. L., Stine, S. M., Marin, P.R., & Jones, H. E. (2012). Predicting treatment for neonatal abstinence syndrome in infants born to women maintained on opioid agonist medication. Addiction, 107, 45-52.

Kandall, S. R., Doberczak, T. M., Jantunen, M., & Stein, J. (1999). The methadone-maintained pregnancy. Clinics in Perinatology, 26(1), 173–183. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/?term=The+methadone-maintained+pregnancy.+Clinics+in+Perinatology%2C

Kaufman, M.H. (1997). The teratogenic effects of alcohol following exposure during pregnancy, and its influence on the chromosome constitution of the pre-ovulatory egg. Alcohol Alcohol, 2(2):113-28.

National Consensus Development Panel on Effective Medical Treatment of Opiate Addiction. (1998). Effective medical treatment of opiate addiction. Journal of the American Medical Association, 280 (22), 1936–1943. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/9851480

Newman, R. G., & Kagen, J. G. (1973). The New York City methadone maintenance treatment program after two years: An overview. Proceedings, National Conference on Methadone Treatment, (1):794–801.

Noland, J. S., Singer, L. T., Arendt, R. E., Minnes, S., Short, E. J., & Bearer, C. F. (2003). Executive functioning in preschool-age children prenatally exposed to alcohol, cocaine, and marijuana. Alcoholism: Clinical and Experimental Research, 27(4), 647-656.

Velez, M., & Jansson, L. M. (2008). The opioid dependent mother and newborn dyad: Nonpharmacologic care. Journal of Addiction Medicine, 2, 113–120.

Wachman, E. M., Hayes, M. J., Brown, M. S., Paul, J., Harvey-Wilkes, K., Terrin, N., Huggins, G. S., Aranda, J. V., & Davis, J. M. (2013). Association of OPRM1 and COMT singe-nucleotide polymorphisms with hospital length of stay and treatment of neonatal abstinence syndrome. Journal of the American Medical Association, 309(17), 1821–1827.

Winklbaur, B., Baewert, A., Jagsch, R., Rohrmeister, K., Metz, V., Jachmann, C. A., Thau, K., & Fischer, G. (2009). Association between prenatal tobacco exposure and outcome of neonates born to opioid-maintained mothers: Implications for treatment. European Addiction Research, 15(3), 150-156.

Testimony of

Margaret Kotz, DO, Director of Addiction Recovery Services, UH Case Medical Center
University Hospitals Case Medical Center
Cleveland, Ohio
April 22, 2016
Before the United States Senate Homeland Security and Government Reform Committee

Chairman Portman, Senator Brown and distinguished guests, my name is Margaret Kotz, D.O. I am the Director of Addiction Recovery Services at University Hospitals Case Medical Center. I thank the Committee for holding this field hearing in Cleveland, and UH Case Medical Center is proud to serve as host.

University Hospitals is a Cleveland-based super-regional health system that serves more than 1 million patients in 15 Northeast Ohio counties. The hub of our 18-hospital system is University Hospitals Case Medical Center, a 1,032-bed academic medical center that encompasses University Hospitals Rainbow Babies & Children's Hospital; UH Seidman Cancer Center; UH MacDonald Women's Hospital and a medical-surgical complex boasting world-renowned excellence in every specialty.

As we are all aware, the disease of addiction has reached epidemic proportions. One need only turn on the television or open a newspaper on any given day to see reports of the alarming increases in opioid pain medication and heroin use and associated overdoses and death. Opioid pain medication addiction and more recently, heroin addiction, have skyrocketed with the death rate for opioid pain medication increasing 3.4-fold and heroin deaths increasing 6-fold from 2001 – 2014. Nationwide, 78 people die of opioid or heroin overdose each day. Right here in Cuyahoga County we saw heroin and fentanyl kill 12 people in a matter of 6 days, just last month. Although we may see heroin and opiate addiction in the headlines these days, the rate of alcohol dependence has remained steady. It is estimated that 17 million Americans over the age of 12 are actively addicted to alcohol and more than half of households in the United States are affected by an alcoholic family member. Beyond the flashy statistics and the headlines, we must always remember that each number represents a person and a family suffering every day from this horrible disease. The only effective remedy for this enormous public health problem is adequate treatment for addiction.

I want to commend Senator Portman for his diligent work in drafting and working to pass the Comprehensive Addiction Recovery Act. I am confident that many provisions in the bill will help address the current shortfalls in treatment options and get more people the help they need. I

am pleased it had such strong support in the United States Senate and hope the House of Representatives swiftly moves to pass the bill.

It is a simple fact that the vast majority of individuals who need addiction treatment do not get it. According to the National Survey on Drug Use and Health (NSDUH) conducted by the Substance Abuse and Mental Health Service Administration (SAMHSA), only about 11% of individuals who needed treatment for alcohol or drug use problems in 2013 received treatment at a specialty facility (defined as inpatient hospital stays, inpatient or outpatient drug or alcohol rehabilitation facilities, or mental health centers). This translates to approximately 20 million people who needed treatment for alcohol or drug use problems but did not receive it in 2013 alone. The most common reason given by individuals who recognized a need for treatment but did not receive it was a lack of health coverage or the ability to afford it, comprising 37% of respondents. This reason was followed by not being ready to stop using (24.5%), not knowing where to go for treatment (9%), health coverage did not cover treatment costs (8.2%), and a lack of convenient transportation (8%). It is imperative that we make treatment more accessible and widely available to people of all socioeconomic statuses and improve insurance coverage and costs for addiction treatment.

The stigma attached to alcohol and drug addiction continues to loom large in society. Often, it is heard "just lock them up in jail, treatment doesn't work anyways." This less than humane attitude about people needing treatment for a chronic and often fatal disease is not only entirely inaccurate, this sentiment has contributed to a sense of shame where one's disease is depicted as criminal. Shame about one's alcohol or drug use affects the individual's decision to seek treatment or not, as well as recovery and relapse rates. Individuals with addiction are more likely to have higher levels of shame compared to the general population as well as individuals with other mental health conditions. Early intervention on shame is a worthy goal, as children who are more shame-prone may be more likely to use drugs by age 18, compared to lower shame-prone children. Shame is associated with poorer functioning in multiple domains, including recovery from alcohol and drug addiction. Higher levels of shame about one's past drinking is associated with higher relapse rates, more severe relapse, as well as worse physical health in general.

Despite typically having a faster course of illness and more severe physical and mental health consequences, women are less likely to go to addiction treatment compared to men. This is particularly alarming as women are among the fastest growing groups to be afflicted by addiction. The rates of overdose death from prescription painkillers among women have risen 400% from 1999 – 2010. We have seen a 100% increase in heroin use among women from 2002 – 2013.

The most common barriers to treatment for women are issues related to childcare. The stigma associated with substance use is one contributor, with research indicating that mothers who abuse substances are judged more harshly by the public and even by healthcare providers. On a practical level, women often fear that reporting problems with alcohol or drugs and entering treatment would jeopardize custody of the children. Women who are primary caretakers of their children often do not enter treatment at all, and among those who do, many leave treatment early due to childcare constraints. When addressing the addiction epidemic in this country, we must also include the very real concerns and barriers to care for women with addiction.

Treatment must include the use of state of the art medications, prescribed by properly credentialed physicians. It must also include evidence-based behavioral and psychosocial treatment (in conjunction with proper medications) to be effective and to assist patients in maintaining long term abstinence. Further, we must educate the public, including healthcare providers that evidence-based addiction treatment is effective and essential. Research has shown that individuals in treatment, over extended periods of time, will stop using drugs, decrease their criminal activity, and improve their occupational, social and psychological functioning. At the same time, it is important for patients and family members to have a realistic view of the chronic nature of this disease and the associated, expected treatment outcomes. Relapse does occur in the treatment of addiction. However, relapse should not be deemed a "failure". Relapse rates for addiction resemble those of other chronic diseases such as diabetes, hypertension, and asthma. If relapse occurs, this does not indicate failure. Rather, it indicates the need for treatment to be adjusted, or that alternate treatment is needed.

Specialized programs certified by their State's accrediting body have the most positive outcomes. Unfortunately, there is a dearth of treatment programs and addiction specialists in the United States providing evidence-based treatment. In order to adequately address the growing addiction epidemic, it is imperative that treatment be available and readily accessible by those who need it.

Beyond saving lives and healing families, treatment is quite simply cost effective. Alcohol and drug addiction yield an enormous financial burden on society, with costs of up to $600 billion per year. Conservative estimates indicate that every dollar invested in addiction treatment programs yields $4 - $7 in reduced drug related crime, criminal justice costs, and theft. As mentioned above, in lieu of treatment, addicts often end up in jail. In addition to the questionable morality of this practice, treatment is much more cost-effective than incarceration. For instance, on average, a year of medication for opiate or heroin addiction (methadone) costs approximately $4,700, compared to $18,000 for imprisonment. If for no other reason, investing in drug and alcohol treatment is a cost-saving measure in the United States.

Drug and alcohol addiction does not discriminate based on race, gender or socioeconomic class. In a time and country filled with great medical and technological advances, it is tragic that overdose death rates are not only rising, but rising at a tremendous rate. We whole-heartedly endorse the passing of the CARA as it will serve to make treatment more available to those in need. For too long, there have been insurmountable barriers for many to receive adequate treatment. CARA is an important step towards addressing this growing public health concern which devastates lives and families.

Margaret Kotz, DO, Ashley Braun-Gabelman, PhD., Ray Isackila, LPCC, LICDC
April 22, 2016

As we are all aware, the disease of addiction has reached epidemic proportions. One need only turn on the television or open a newspaper on any given day to see reports of the alarming increases in opioid and heroin use with associated overdoses and deaths. Addiction to opioid analgesics and more recently heroin, has skyrocketed with the death rate for prescription opioids increasing 3-fold and heroin deaths increasing 6-fold from 2001 – 2014 (NIDA, 2015). Nationwide, 78 people die of opioid or heroin overdose each day (CDC, 2016). In Cuyahoga County Ohio, heroin and fentanyl killed 12 people in a period of 6 days this March (MacDonald, 2016). Beyond the attention-grabbing statistics and headlines, it is essential to remember that each number represents a person and a family suffering every day from this disease that destroys lives long before it ends them. The remedies for this epidemic include education, interdiction, and especially treatment of those already afflicted.

The vast majority of individuals who need addiction treatment lack access to it. According to the National Survey on Drug Use and Health (NSDUH) conducted by the Substance Abuse and Mental Health Service Administration (SAMHSA), only about 11% of those who needed treatment for alcohol or drug use in 2013 received specialty treatment, leaving 20 million people without care in 2013 alone. The most common barrier cited by individuals who recognized a need for treatment but did not receive it was financial. This affected 37% of respondents. This reason was followed by "not ready to stop using," (24.5%) "did not know where to go for treatment," (9%) "health coverage did not cover treatment costs," (8.2%) and "no transportation/inconvenient" (8%). It is imperative that treatment be made more accessible to people at all socioeconomic levels.

Beyond saving lives and healing families, treatment is cost effective. Alcohol and drug addiction is an enormous financial burden to society, with costs of up to $600 billion per year (NIDA, 2012). Conservative estimates indicate that every dollar invested in addiction treatment yields $4 - $7 in reduced crime and criminal justice costs (NIDA, 2012). Without treatment, individuals with addictive disorders often end up in jail. This has a disastrous effect on the lives of the offenders and falls disproportionately on minorities. It also represents a mal-allocation of funds. On average, a year of medication treatment for addiction (with methadone) costs approximately $4,700, compared to $18,000 for imprisonment (NIDA, 2012). If for no other reason, investing in drug and alcohol treatment is a cost-saving measure.

The stigma attached to alcohol and drug addiction continues to loom large in society. A common attitude is, "Just lock them up in jail; treatment doesn't work anyway." This response is not only inhumane, it is factually incorrect. It contributes to the shame and self-loathing that impede treatment-seeking. Those with addiction are even more likely to experience shame than are those with other mental health conditions (O'Connor, Berry, Inaba, Weiss, & Morrison, 1994).

Despite typically having a faster progression of illness and more severe physical and mental health consequences, women are less likely to receive addiction treatment than are men (Greenfield, Brooks, Gordon, Green, Kropp, McHugh et al., 2007). This is particularly alarming as women, historically less likely to become addicted, constitute a large portion of the population afflicted by the opioid epidemic. The rates of overdose death from prescription opioids among women have risen 400% from 1999 – 2010 (CDC, 2013). There has been a 100% increase in heroin use among women from 2002 – 2013 (CDC, 2015).

The most common barriers to treatment for women are scarcity of treatment facilities, lack of funding for treatment, and unavailability of childcare. The stigma associated with substance use is one cause of treatment avoidance, as addicted mothers are judged more harshly by the public and by healthcare providers than are men. (Castillo & Waldorf, 2008). Additionally, women often fear that entering treatment may cost them custody of their children (Greenfield, Back, Lawson & Brady. 2010.) Women who are primary caretakers of their children often do not enter treatment at all, and of those who do, many leave treatment early due to childcare constraints (Castillo & Waldorf, 2008). When addressing the addiction epidemic in this country, we must also include the very real concerns and barriers to care for women with addiction.

Treatment must include state of the art medications, prescribed by properly credentialed providers. Studies show that when heroin addiction is treated only with abstinence and psychosocial treatment, most fail. Our 50 years of experience with methadone treatment of heroin addiction confirms that, counter-intuitively, the use of a selected opioid to treat addiction results in decreased unemployment, criminality, and infectious diseases such as HIV and hepatitis.

However, while effective, methadone is not an option for the overwhelming majority of patients with opioid addiction. It requires daily visits to specially licensed facilities, typically only found in large urban locations. It is unavailable to rural patients, and relatively so to those living at a distance in the cities, especially when transportation is limited. The daily visits are a barrier to employment.

Since DATA 2000, Office Based Opioid Treatment has been available. The partial opioid agonist buprenorphine can be prescribed by a qualified primary care physician in the patient's

neighborhood, making it significantly more accessible. Daily visits are not needed, so that patients can hold jobs. Research demonstrates that it is as effective as methadone and far safer in overdose or accidental child exposure. Despite this, access remains severely limited due to inadequate numbers of physicians prescribing buprenorphine.

An alternate medication based strategy for treatment relies not on opioids, but on agents (antagonists) that block them. Only one, naltrexone, is currently available as a daily pill or monthly injection. While less acceptable to many patients than buprenorphine, for those willing to take it or who have monitored administration, it can be a valuable tool for increasing long term sobriety.

Although both opioid agonist and antagonist medications are important additions to our treatment armamentarium, they are not sufficient for successful treatment. This is especially true when a primary care provider has 15 minutes to provide addiction treatment while complying with requirements to ensure that other issues, such as vaccinations, colonoscopies, and mammograms are up to date, that state prescription drug monitoring data has been checked, that urine drug testing is current, etc. It is apparent that support for extended office visits and for associated behavioral services is essential for favorable outcomes. It is necessary that more physicians be trained in medication assisted treatment of addiction and that there is sufficient payment for requisite medical and behavioral services.

In Northeast Ohio, there are simply not enough facilities to treat addiction for those who need it, even if they could afford it. Perversely, patients may be required to fail a level of care or a medication before the recommended treatment will be reimbursed.

We have focused on treatment of substance use disorders; however, it goes without saying that this is only part of a group of essential strategies. We have learned from cigarette

addiction efforts that a national educational campaign can save many lives. We have learned that focusing on a criminal justice approach to the problem is largely ineffective, yet has costs that greatly exceed those of treatment.

In summary, the current addiction epidemic is having a catastrophic impact on many lives and communities. We are fortunate that both of our Ohio senators are taking action to address this scourge by supporting CARA. It is likely that an approach at the federal level is necessary to stem the tide of opioid addiction nationally.

References

Castillo DT, Waldorf VA (2008). Ethical issues in the treatment of women with substance abuse. The book of ethics: Expert guidance for professionals who treat addiction, 101-114.

Centers for Disease Control and Prevention. Understanding the epidemic. (2016, March). Retrieved on April 14, 2016 from: http://www.cdc.gov/drugoverdose/epidemic/index.html.

Centers for Disease Control and Prevention (CDC). Prescription painkiller overdoses: a growing epidemic, especially among women (2013, July.) Retrieved April 11, 2016 from http://www.cdc.gov/vitalsigns/PrescriptionPainkillerOverdoses/index.html

Centers for Disease Control and Prevention (CDC). Today's heroin epidemic infographics (2015, July). Retrieved April 15, 2016 from: http://www.cdc.gov/vitalsigns/heroin/infographic.html

Greenfield SF, Back SE, Lawson K, Brady KT (2010). Substance Abuse in Women. Psychiatric Clinics of North America, 33: 339 – 355.

Greenfield SF, Brooks AJ, Gordon SM, Green CA, Kropp F, McHugh RK., ... Miele, G. M. (2007). Substance abuse treatment entry, retention, and outcome in women: A review of the literature. Drug and alcohol dependence, 86(1): 1-21.

MacDonald, Evan (7 April, 2016). Cuyahoga County heroin, fentanyl overdoses kill 12 in six days. *Cleveland.com.* Retrieved on April 15, 2016 from: http://www.cleveland.com/metro/index.ssf/2016/04/cuyahoga_county_heroin_fentany.html

National Council on Alcoholism and Drug Dependence (2015, July). Facts about alcohol. Retrieved on April 15, 2016 from: https://ncadd.org/about-addiction/alcohol/facts-about-alcohol

National Institute on Drug Abuse (2012). Principles of drug addiction treatment: a research-based guide (3rd edition). Retrieved on April 14, 2016 from: https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/drug-addiction-treatment-worth-its-cost

National Institute on Drug Abuse (2015, December). Overdose death rates. Retrieved on April 15, 2016 from: https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates

O'Connor, L. E., Berry, J. W., Inaba, D., Weiss, J., & Morrison, A. (1994). Shame, guilt, and depression in men and women in recovery from addiction. Journal of substance abuse treatment, 11(6), 503-510.

Substance Abuse and Mental Health Services Administration, Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014.

Substance Abuse and Mental Health Services Administration (2014). National Survey on Drug Use and Health (NSDUH). Table 5.8A—Substance dependence or abuse in the past year among persons aged 18 or older, by demographic characteristics: Numbers in thousands, 2013 and 2014. Retrieved on April 15, 2016 from: http://www.samhsa.gov/data/sites/default/files/NSDUH-DetTabs2014/NSDUH-DetTabs2014.htm#tab5-8a

Stuewig, J., Tangney, J. P., Kendall, S., Folk, J. B., Meyer, C. R., & Dearing, R. L. (2015). Children's proneness to shame and guilt predict risky and illegal behaviors in young adulthood. Child Psychiatry & Human Development, 46(2), 217-227.

MetroHealth

Statement Of

EMILY METZ, MPH
Program Coordinator
Cuyahoga County Project DAWN (Deaths Avoided With Naloxone)
The MetroHealth System
Cleveland, Ohio

For a Field Hearing

Before The
United States Senate
Committee on Homeland Security and Governmental Affairs

"Examining the Impact of the Opioid Epidemic"
Friday, April 22

MetroHealth

Chairman Johnson, Senator Baldwin, Fellow Speakers and Guests:

Thank you for allowing me to speak to you today regarding the opioid epidemic and its devastating impact on Cuyahoga County. The MetroHealth System is an essential hospital system committed to leveraging its expertise, resources, and relationships to respond to this public health crisis. I serve as Program Coordinator for MetroHealth Cuyahoga County Project DAWN, a life-saving overdose prevention program sponsored by the health system, the Alcohol, Drug Addiction & Mental Health Services Board of Cuyahoga County, and the Ohio Department of Health. I am also speaking to you as a member of the Cuyahoga County Opiate Task Force and our local U.S. Attorney Opiate Action Plan Committee.

Our country is in the grips of an opioid addiction and an overdose epidemic. We are at-risk of losing a generation of Americans to a disease that devastates lives, families, and entire communities. In 2014, 2,482 Ohioans died as a result of a drug overdose and 80% of these fatalities involved an opioid. In large part, our country's epidemic is iatrogenic; our liberal prescribing of opioids has created a generation of Americans who are addicted to opioids and require help. As a nation, we must mobilize to curb and fix this crisis.

At Project DAWN, we work to reduce opioid overdose mortality by helping to expand community access to the opioid overdose antidote naloxone. We train community members on risk factors for overdose, how to recognize an overdose, and how to respond to an opioid overdose. The most critical aspect of our program is the free provision of naloxone to our patients. Since the founding of our county program in March of 2013, we have provided over 3,300 kits to community members resulting in over 400 overdose rescues.

Ohio's streets are saturated with fentanyl-laced heroin, which has contributed to the loss of 502 Ohioans during 2014 as compared to 84 during 2013. Because fentanyl is an opioid that is up to 50 times stronger than heroin, the dose of naloxone needed to revive the victim must be increased. This development is impacting our intervention efforts and budget because it is increasingly necessary to provide additional take-home doses to our patients.

We and other alcohol, drug, and mental health service providers in our country do not have the adequate resources to meet the emerging needs of communities struggling with substance use disorders. Cuyahoga County Project DAWN is considered one of the largest Project DAWN programs in Ohio. We have expanded to include three-to-four hour walk-in clinics, three days a week and also provide naloxone kits in other community settings such as the County Jail, MetroHealth Emergency Departments, and the Free Medical Clinic of Greater Cleveland's syringe exchange program. Without these strong community collaborations, we would not be able to save as many lives. Currently, Project DAWN's efforts are shouldered by one full-time employee, me. In Ohio, we are one of 37 County

MetroHealth

Project DAWN programs in a state of 88 counties. The reality is that many of these programs do not have full-time staff members, some are only able operate once a month, and often there are programs that run out of funds to purchase naloxone before the year's end.

Project DAWN programs are essential to curbing opioid overdose mortality at the community level because we equip those most likely to witness an overdose with the proper life-saving tools. While we strongly support increasing access to naloxone for first responders including police, fire and EMS, we know that the most likely individuals to witness an overdose are drug users, their family and friends.

We strongly support the Comprehensive Addiction and Recovery Act (CARA) and request funding be considered to help lay responders who are connected to Project DAWN models. This investment will sustain and expand community-based naloxone programs that have a proven track record in reaching people in the community before they intersect with the first responders system.

We applaud our Congressional leadership for recognizing that increasing naloxone access in our country does not alone fix the opioid epidemic. The CARA legislation is promising in that it promotes evidence-based and innovative strategies, interventions, and treatments at the community level. Project DAWN welcomes federal funding in support of community networks focused on connecting treatment, housing, education, and employment opportunities to those struggling with addiction.

Finally, the stigma that is present in our country for individuals with substance use disorders is no small issue to tackle. We commend CARA's focus on Public Awareness Campaigns, which would educate the public on the risk of prescription drug and heroin abuse. We hope these campaigns will also educate the public that addiction is a chronic disease and we should support those in recovery just as we rally behind those struggling with other diseases. Individuals with substance use disorders are not bad people trying to get good, instead, they are sick people trying to get well.

Thank you for your time. I welcome questions from the committee.

ROBBY'S Voice
Break the Silence

EXAMINING THE IMPACT OF THE OPIATE EPIDEMIC
Testimony
Presented by
Robert Brandt, Founder ROBBY'S VOICE
Friday, April 22, 2016

Mr. Chairman and members of the committee, thank you for the opportunity to present testimony this and thank you for your focus on this issue. I also want to thank Senator Portman and Senator Brown for their efforts relative to the CARA legislation. Once this legislation is passed, it will make a significant difference for so many families.

Before I proceed to my testimony, I want to provide a brief overview of our family's experience, and our organization. Five years ago this October, my son, Robby, passed away from an accidental heroin overdose. His addiction began with the prescribing of prescription pain medication after the extraction of his wisdom teeth, and ultimately led to his addiction to heroin. As a family, we battled this disease as best we could. However, we lacked information, we lacked education and we lacked the understanding of resources that may have been available; resources that may have saved his life. This included things like a real understanding of medication assisted treatment, the probability of relapse, and the role of the family in enabling recovery versus addiction. But the real deficit began prior to his addiction. The lack of education to students and parents, the lack of community awareness, and the abundance of stigma which cast a dark pall over every family struggling with this disease. What scares me to this day is that even if there were more awareness, more education, I do not know that I would have escaped the "not my kid" mentality that so many parents operate under.

Our journey with heroin addiction lasted six months. When it ended, it left a wake of devastation behind it and darkness ahead. We watched this young man, our son, struggle with this disease. We witnessed the battle, and we saw the pain in his eyes as he would say over and over "I did not ask for this, I don't want this." We watched as the relationship he had with his brother and sister deteriorated, blocked by the drug, by the addiction. We watched as he did unthinkable things; lying, stealing, manipulating, things that were just not who he was. We watched as our home was wrought with chaos, divided by differences that stemmed from our lack of education and understanding.

Robby passed away on October 20th, 2011, 68 days before his 21st birthday, 18 days before leaving on deployment to Afghanistan. In the wake of his death, our family has been left forever impacted, forever incomplete. As parents, we carry the guilt of not being able to save him, questioning every decision we made along the way, wondering how we allowed this to happen to our son, why we did not see this earlier. His sister lost her best friend. She struggles continually with the guilt of knowing he was struggling, but as a good sister does, she kept his secret because he asked her to, and because of the

lack of education in our schools, she just did not understand the true impacts of addiction. His brother lost his idol, the person that he, as little brothers always do, emulated and wanted to be like. To this day, Nolan always has something of Robby's with him, and he often talks about not being able to have a best man at his wedding. The impact of loss is deep, and it is permanent.

A few weeks after his death, Carla and I were cleaning up Robby's room, and we found a journal that outlined his plan to make a difference. He wanted to speak in schools and he wanted to create an on-line support group for recovering addicts. His idea was called Live Free. We knew that we traveled this road in darkness, confused and unsure of what to do, and we knew we could never let another family experience the same thing we had. After reading Robby's journal, we knew that we had to become his voice and at that moment, ROBBY'S VOICE was born.

ROBBY'S VOICE officially launched in May of 2012 with a mission to bring awareness to schools and communities. Over the past four years, we have spoken to over 70,000 students and parents. We have worked to raise awareness in our communities and we have worked with those communities to develop plans to attack the epidemic that has been attacking them. We have worked in private with families that have been impacted by this disease, and with families that have suffered the ultimate loss from this disease. We continue to develop resources for schools with the goal of delivering a turn-key program that makes education on this issue easy and meaningful. We continue to provide resources for parents, and have launched our own family support group called Family Matters. We have also announced our intention to develop a Center for Continued Recovery which will be a post treatment resource center for those in recovery that focuses on helping them develop the skills and relationships to allow for a quicker assimilation back into normal life, increases the opportunity for sustained recovery and provides a place where recovering addicts are able to fit in. Our place in the world of addiction lies in prevention, both on the front end prior to addiction, and what we call prevention part 2, the prevention of relapse.

In the invitation to testify, there were two main points we were asked to address; the role the Federal Government can play, and how we may improve prevention, education, treatment and support. I have delineated my thoughts on these subjects in the following testimony, thoughts that are based in part on evidence based research done by others, interaction with industry experts as well as families that have personal experience, and our personal experience both with addiction and in all the encounters we have had through ROBBY'S VOICE.

As I prepared this testimony, I was challenged to determine how best to articulate my thoughts and to convey these thoughts as well as the hearts and souls of those who shared their thoughts with me. I will frame this testimony with the following story;

Last Friday, I had the honor to speak at my alma mater, Padua High School. Robby wanted to look at going to Padua, but we discounted that because of cost and distance. Today, we question that decision. What if, what if we had said yes; would we be in a different place today? We question every decision we made along the way, we carry the guilt of every decision we made along the way because those

decisions ultimately were not the right ones. We failed to protect our child. We failed to save our child, and we carry that every day. Welcome to our world. Welcome to the world of addiction.

In our opinion, prevention is the key element because those that don't use don't get addicted, and those that are not addicted are not at risk for the consequences of the disease. Prevention touches many areas, but the foundation of prevention is education which I will discuss later. Yet there are other elements that will allow us to be more successful relative to prevention.

- Supply vs. Demand; Some want to attempt to strangle supply, get the drugs off the street. While we have been mildly successful at reducing the availability pf prescription pain medication, we have not been successful in reducing the availability of illegal drugs. Prevention strikes at demand. It does not matter what the product is, if there are no buyers, the seller ultimately loses.
- Pain as a vital sign; Prevention means we look at causation and one cause that needs to be addressed is pain as a vital sign. Pain is the only subjective vital sign, and that subjectivity is exploited by those who continue to abuse prescription medications. Additionally, it forces our providers to administer care in a different manner. The adaptation of pain as a vital sign is aligned with the beginning of our current epidemic.
- Affordable Care Act; Along with the exploitation of pain as a vital sign is the impact of the Affordable Care Act and the focus on patient satisfaction. Pain is the largest driver of poor survey results which impact the reimbursements to healthcare providers. We will and we must increase education to Residents, increase the use of automated tracking of prescriptions, and adopt prior authorization guidelines. These are outlined in CARA and will undoubtedly help. However, until we separate the relationship between pain and payment, our providers will continue to write. It may be in smaller quantities, but they will continue to write in order to not be penalized.
- Funding; If prevention is to be successful, then it has to be a priority and it has to be funded. The current funding allocations provide the lion's share of funding to treatment. That funding is essential and critical, but it also takes money from prevention. We need to fund prevention so that we are able to ultimately spend less on treatment. Yes, we need expanded treatment today, but ultimately, we need less addicts.

Within prevention lies the concepts of choice and consequence. Today, we focus on prescription pain medications as well as heroin, but there will always be another drug, there will always be the next drug. The concepts of prevention, honest education about choice and consequence, will allow us to have an impact not just on this current epidemic, not just on the next potential dangerous drug, but on all the different issues facing our kids (bullying, sexting etc.).

Today, we face a new danger that is far greater than heroin; fentanyl. Virtually no one saw this coming, but the devastation is far greater, far more dramatic than anything we have dealt with. A foundation in prevention, a real foundation would have allow us to minimize the impact of this drug. A real foundation in prevention will allow us to minimize the impact of the next fentanyl.

Education is the cornerstone of a prevention strategy, and to be effective, must extend to all segments of society, all age groups and it must be sustained.

We have learned that in order for education to be effective, it must have the following elements;

- Sustained over time
- Maintain a frequency that salutes the importance of the subject matter
- Variation of in how it is delivered

These factors reinforce the importance of the information, account for different learning modalities, and enhance the probability of delivering the message at a time when it needs to be heard.

Education also drives change in two other critical areas; culture and stigma.
We have created a take a pill feel better mentality, and a culture that glorifies drug use. We may say that we don't, but we do, and we deliver these messages to our youth through movies, television, music and societal expectations (concert behavior or the "college experience."). We have taken the stigma of use and experimentation out of the picture. Education will allow us to change that.

Stigma still exists across society, and impacts the addicts ability to re-engage into a normal life and drive long term sobriety. In my community, Medina, many had worked to bring more treatment options forward. It was received with open arms, until it came down to selecting a location. Then, stigma, driven by uneducated but understood beliefs slowed the process. Education will allow us to overcome stigma. It will help us recognize addiction as a disease entity, and will allow families to more openly deal with addiction an engage in treatment earlier. It will assist in sustaining recovery through community acceptance and the development of options like sober employers.

Education must be comprehensive.

Schools – K-12 science based with adjuncts to different curriculum elements allows us to build student's knowledge year over year, it answers the questions why, and how. When we speak at schools, students agree that addiction is a bad thing, yet they struggle to articulate how addiction happens. They also do not associate their image of an addict (usually a dark, dilapidated image) with themselves, their families or their peer groups. This disassociation supports the "It won't happen to me" attitude. K-12 education allows us to answer the key questions of how and why, providing a knowledge base for decision making. Yet schools struggle to deploy consistent education as they are faced with economic challenges as well as the burden of performance test scores. We hear regularly, "we don't have time." Most schools are now conducting cursory education, but most that we deal with truly don't have a comprehensive approach.

Included in this, we must not forget teachers and support staff. These teams interact with students on a daily basis and have an opportunity to identify a behaviors that fall in line with addiction, as well as understanding the impact that addiction in a family has on other children within the household.

Parental Education – probably the largest gap we see is within the parents groups. These events have notoriously low turn-out, so information dissemination is a struggle. We find parents believing that they either know the information or that it won't be their kid. We as parents live under false impressions, yet, I understand it. Honestly, even if all the awareness that exists today were available when Robby was first struggling, I am not certain that I would have been open to it happening to "my kid." Utilizing social media tools and a targeted educational campaign, we have the ability to push information to parents on a regular and consistent basis. Messages from programs like "Let's Talk" here in Ohio are being adopted by schools and used in parental communication. The keys, once again, are sustainability and frequency, coupled by the ability to provide incremental resources to parents. Just like students, parents need a "why" to get engaged.

Medical Community – Increased training at all levels of healthcare providers. CARA will address part of this. We must ensure that our Doctors receive the training they need both on prevention as well as the impacts of dispensing. Here are a few examples of what needs to change;

- My wife underwent a surgical procedure. She was prescribed 60 Percocet post operatively, took about 20. At her follow-up visit, the Surgeon asked her about pain and medication. She told him that she had 40 left, and he still wanted to write another prescription "just in case."
- A friend's daughter recently had her wisdom teeth extracted. She was prescribed enough OxyContin for two weeks.
- A friends daughter, a recovering addict, recently gave birth. She told the Doctor that she was in recovery and did not want pain medication. The Doctor replied "it will be administered through your IV so it won't affect your recovery." She continually declined, and the Doctor continually pushed.

Law Enforcement – When law enforcement officials say to me, "I don't know if those people are worth saving," then I know more education is needed to assist our officers in understanding addiction, the addicts perspective and what is driving their behavior, the family impact, and the critical nature of Narcan.

Communities – We focus on failure. Follow the media and we are bombarded by stories of overdoses and crime. This perpetuates the stigma associated with addiction and directly impacts efforts to re-acclimate to the community and working toward sustained recovery. Part of the education approach must be to help society as a whole understand two key elements;

- We must understand the impact that society has relative to influence and messaging to kids. This includes the glorification of substance use on television, in the movies, and in music.
- We must help society understand the disease of addiction

We will always deal with addiction, and as such, we will always need treatment. I will leave more detailed testimony to the treatment experts, but I will share a few thoughts based on our experience. We must recognize areas that are having success versus areas that provide treatment. Areas like Scioto County Ohio, led by Ed Hughes that had dramatic turn arounds should serve as models to be adapted as standards. We must;

- Recognize the differences in opiate addiction and other addictions and adapt treatment accordingly. THE LCADA WAY in Lorain is a great example of an organization that has developed different treatment options and extended treatment to deal with this particular addiction.
- Utilize evidence based treatment, allowing us to identify treatment facilities that produce results, either globally or within a certain substance group and/or demographic. Our partner, MAP, has developed an algorithm which allows them to identify the best treatment options based on historical data married to the specifics of a given addict. Utilizing this type of data allows us to not only to save lives, but to reduce the overall cost of treating the disease.
- Availability – Treatment availability is critical, and we should look at multiple options to increase access. These options include creative modalities like ambulatory detox. Additionally, funding of treatment continues to be a challenge. Private payors do not treat addiction like other chronic diseases, leaving the burden of funding on the parents, and in Ohio, even with the expanded Medicaid coverage there is still a gap in those that have private insurance that no longer covers treatment or covers short periods of treatment.

Finally, the need to focus on support directly impacts the relapse rate which ranges between 70% - 90%. This begs the question; where is the issue, treatment or support? While we must improve treatment availability our relapse rate is directly relative to our post treatment support as well as family support. Post treatment support is prevention part 2.

Post Treatment support lacks in many areas, but is critical to reducing relapse rate. We see in recovery communities improved outcomes driven by the support that continues to wrap addicts in the support that carries them through the time it takes to recover the natural chemistry of the brain and reestablish or establish the skill sets needed to manage everyday life.

This concept of post treatment support provides a pathway to;

- Continuing sobriety through support groups and connectivity to peer support.
- Tele-medicine
    - Utilization of MAP or other tele-medicine providers to provide on-going support and early relapse identification
- Development Life Skills
    - Coping skills
    - Goal setting and accomplishment
    - Personal Finance
    - Parenting
- Education

    - Secondary completion
    - Post-secondary access
- Employment
    - Resume's
    - Interview skills
    - Dressing for success and grooming
    - Employment connections and the development of sober employers
- Additional Concepts
    - Networking
    - Nutrition
    - Cooking
    - Fitness

The concept of continued recovery communities is providing the needed continuing support to assist addicts in defeating this chronic disease which we currently treat as acute.

The second element of support that must continue to evolve is family support. Addiction is a family disease, but we focus our treatment efforts on the addict while families often fend for themselves. The continuing development of resources as well as awareness of those resources will allow families to cope with the stigma of addiction, as well as learning how to enable recovery versus addiction. Family support is built upon;

- Education to empower the family
- True support group functions
- Connectivity to other resources

Through our experience in deploying Family Matters, we have uncovered two additional areas where we see a need for increased support'

- Expanded support for children and siblings
    - Targeted at ages 7-15, developing teen leaders to assist in generating discussion and easing the fears of younger members.
- Expanded support for children of addicts living with relatives
    - Primary focus is on educating the family members on how to deal with the situation

As a society, we provide support for other chronic diseases like cancer, diabetes and obesity. Yet, with addiction, we lack the necessary continued support to sustain sobriety, and through that, we unknowingly enable relapse.

The final point to address is the statement in the invitation to testify that reads "focus on the role of the Federal Government and the importance of a cohesive national strategy..." In my view, we lack a cohesive national strategy. In fact, we lack cohesive state and local strategies and as such, we need the Federal Government to lead in this arena. This epidemic is a national epidemic, and as such requires a

national approach. As we have worked within the field of addiction, we have encountered many organizations, both public and private sector, that are working diligently to address this issue. However, within that same element, we are seeing a lack of cohesion and repetitive efforts across the state. Our experience has revealed a disjointed effort in the following areas;

- Schools
    - Focus is on standardized testing and the statement is far too often "we don't have time."
    - Schools don't have the financial ability to deploy Preventionalists or Resource Officers
    - Schools that do provide education don't have a sustained strategy; usually a one-time speaker, health class and the D.A.R.E program.
    - Lack of a K-12 approach and a lack of funding for programs like the NIDA program.
- Law Enforcement
    - Community perception that their law enforcement is focused on arrests and punitive action and others that are engaged in treatment versus jail
    - Police Departments that are on-board with Narcan and others that either don't have the resources or the desire to carry Narcan
- Physician differentiation relative to prescribing and managing pain.

These are some areas where we see disjointed efforts and inconsistent messages to our communities. The Federal Government has an opportunity to bring all parties to the table and to build a national strategy that does not focus on walls and enforcement, but rather on a strategic approach with tactical execution across the spectrum of players in this field. A coordinated strategy that identifies best practices and has education, healthcare, law enforcement and communities all on the same page will improve our treatment outcomes, lower costs and lay the groundwork to prevent such epidemics in the future.

We need to focus on a migration of funding from treatment to prevention. We need to support treatment, but we must increase focus and funding toward prevention and support. A reduction in active addicts, both first time and those who suffer from repeated relapse will have a natural reduction in those that need treatment. We have to fix the issue as opposed to treating the symptom if we hope to reduce the financial burden and most importantly the human cost of addiction.

Most important, we need to move with a sense of urgency, and the Federal Government has the ability to drive that urgency. We lose an America every thirteen minutes, an Ohioan seven times per day. This is the greatest healthcare crisis in modern history, and we must act with urgency; lives depend on it.

ADDENDUMS

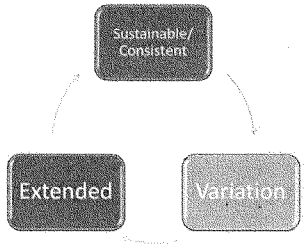
The following addendum outline the current efforts of ROBBY'S VOICE as it pertains to our education based programing.

ROBBY'S Voice
Break the Silence

ROBBY'S VOICE EDUCATIONAL PROGRAM OVERVIEW

Education Tenants

Our approach to education at the school level is based on the following three principles;
1. Sustained Consistency
2. Variation
3. Extension



Sustained Consistency

Due to the pressures facing schools to perform on standardized tests and cover the social issues facing students, we only skim the surface of education relative to drugs and addiction. The education surrounds three or four factions;

DARE (4^{th}/5^{th} Grade) ⟹ 9^{th} Grade Health ⟹ Prom

If education on this topic is not sustained on a consistent level, the message we deliver is simple; it is important, but not that important. In order to change and create a culture that focuses on good decision making, education on this issue must be sustained consistently over the students' academic career. We need to acknowledge that accidental overdose is the leading cause of accidental death in our state and country, and that the first age of usage are;

- Marijuana; 12 years old
- Pill abuse; 14 years old
-

Our (RV) approach emphasizes a K-12 curriculum as follows:
K-12; NIDA pre planned curriculum. This program was developed by educators for educators and is a pre-planned science based curriculum. It is adaptable outside of science to create education throughout the school year and in different classes. Additionally, the program is age appropriate, answers the question "WHY," and provides visual support materials to support the classroom lessons.

Core Curriculum Related Classroom Activities – RV is developing classroom based activities which tie to the states adaptation to the common core. The activities will provide opportunity in creative writing (grammar/research), debate, and physical education. grammar, research. Debate,

Sustaining the consistency of education allows each year to build upon the previous year and creates a platform for positive decision making based on facts and information.

Variation

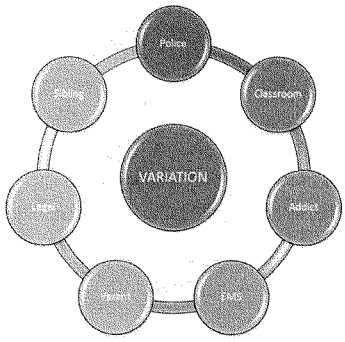
Variation of messaging is another facet that we view as important. Recognizing that exposure, influence, experience and timing vary by student, we can't predict which message will resonate with which students. For example, we have spoken to students who were very engaged with the DARE program while others stated that DARE made them want to experiment with drugs. Variation provides the following benefits;

Relatability; Provides a wider variety of relatable messaging to students as well as staff members that may be listening.

Reinforcement; variation improves attention. The same message from the same sources tends to tuned out over time. Hearing the same message from different sources allows for a stronger attention span as well as reinforcement of the message.

Differentiation; Variation provides opportunity for perspective and for discussion in the classroom after the program as to similarities and differences. Also another opportunity for education based activities.

Perhaps the best reason for variation lies in bringing reality to the discussion. NIDA is a classroom activity, but by utilizing outside sources, the classroom application may be applied to real life. This again allows for vigorous classroom discussion or assignment. Even more critical is the ability to empathize and relate, potentially seeing friends or family members reflected in the speaker and triggering a call out for help. We have experienced engagements where we are not approached by students afterwards, approached by three to five students with legitimate questions and challenges, and having up to nine students seeking assistance from guidance after the presentation.



EXTENTION

Classroom education, while critical for its ability to influence choices, is not enough. Education must extend beyond the school to be reinforced and emphasized. With addiction, the extension is even more critical as we know that early intervention has a greater success rate relative to treatment and recovery. Yet we know that far too many parents are truly not aware of the scope, deviance and information needed to understand this epidemic.

We view staff and parents as the key focal points of this activity.

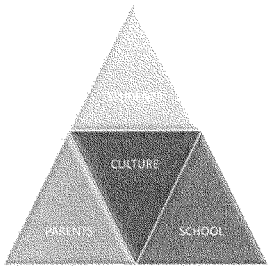
STAFF – With the educational and social issues facing teachers, keeping up with addiction education is a challenge. Most efforts are targeted within the health department, and that knowledge doesn't matriculate beyond that. We also need to aknwoledge "staff" t include bus drivers, maintenance, cafeteria and so on. All of these Teams are exposed to the student environment and should have at least a base understanding of;

- Warning signs
- Terminology
- Paraphernalia

Furthermore, all staff should have a clear understanding of the tools available through the school system and what steps to take if they uncover anything that may present a danger to the students in the school. Finally, the forgotten ones in this epidemic are siblings. Staff, especially teachers, should understand when siblings are facing challenges at home so they may assist in the support network.

PARENTS – We believe that parental education should be mandatory each school year. Again, to create a culture, educating parents should have a cadence of consistency which demonstrates the importance of the issue. Parents need to be provided with the tools to detect warning signs within their children as well as their children's friends, and that education must continually be updated. The awareness campaign may be conducted in a way that allows for interaction between parents and students as well as providing information and support to assist in having these discussions in the home.

By extending the educational umbrella, we improve the support for the students, improve early detection, and support a strong creation of culture. Let us also not forget that the staff of each school are also parents, grandparents and members of the community and we should not assume that because they work in the school that they are more educated and aware on this issue.



THE ROBBY'S VOICE PROGRAM

The RV program is a multi-faceted approach to providing resources and support to our schools in an effort to provide more sustained education with greater variation extending beyond the classroom.

RV Support a choice consequence model that extends beyond the "opiate" issue to encompass drug usage and addiction overall with values that may be applied to other challenges such as bullying, sexting etc.

Our program is age appropriate and reality based utilizing a multi-media, interactive format to keep the students engaged. This is not a scared straight approach, but it also does not shirk the realities our kids must understand.

We are currently working to develop a turn-key portfolio which allows schools to access different elements to support their educational efforts. We support our model as follows;

SUSTAINED – CLASSROOM

- K-12 NIDA Program
- 7th Grade Booster with "Anti-Venom"
- RV tools including posters and CAP cards

- Developing a weekly "Break The Silence" program for school announcements. This may be potentially aligned with the 40 developmental attributes.
- Common Core alignment is under development

We are currently involved with student based focus groups to gain a deeper understanding of where we may be able to more effectively connect with students. Our common core activities are being developed by Teachers.

VARIATION – SPEAKERS

- ROBBY'S VOICE
    - Currently adding additional speakers to include recovering addicts that are established speakers.
- Network of partners in law enforcement, medical and treatment. We have presented multi-dimensional programs when requested.

EXTENTION

STAFF

- Staff education presentation
- Conducted an annual seminar utilizing Operation Street Smart for an 8 hour educational program.
    - Currently investigating an annual staff certification via the on-line application.

PARENTS

- Traditional parents presentation
- Alignment of school program to parents with interactive activities
- Utilization of our web site and Facebook as resources
- Contributions to the monthly school newsletter
- Developing a parents workshop
- Developing a parents support guide
- Support programs like Hidden In Plain Site

ROBBY'S VOICE SPEAKING PROGRAM

- Multi-Media
- Interactive
- Action orientation

- First Segment
    - Introduction to "why" we are talking
    - Gain student involvement
    - Address societal influences (messaging, TV, movies, music)
    - Review what an addict looks like – help them understand it could be anyone and build attention to the remainder of the program.
    - Consequences; Students provide and RV reviews using real life young people and their path ways.
- Second Segment
    - Video from Tyler's Light
        - Addresses starting with alcohol and marijuana
        - Leads to discussion about choice of friends
        - Links to the power of addiction
    - The brain and addiction
        - Answer how this happens
        - Message to physiological changes and loss of personal choice
    - Robby's Story; brings reality closer
- Third Segment
    - Focuses on Action
    - CAP
        - Choices and Consequences
        - Awareness
            - Illegal, Prescription, Marijuana
            - Warning Signs
        - Plan
            - Personal Plan for who to call for help
            - Three phrases to get to safety
            - What to do if a friend is in trouble
    - Importance of Breaking the Silence making a difference for others
- Post Program
    - Encourage classroom discussion
    - Options Include
        - CAP Card at school or home
        - Engaging parents with phone blast and web site connection
        - On-going activities and suport

ROBBY'S VOICE is working to close the loop relative to schools, parents, students and tools. Accordingly, we are also have a drug testing partner and a philosophical approach to rewards based testing programs.

Finally, our experience has led us to begin the development of a school checklist. We utilize this list (below) to have discussions with school leaders relative to resources they either have and deploy, are under-utilized (tip lines), or may want to consider.

We are also developing a School/Police program to address parties where underage drinking and substance abuse takes place. This will include a hand-out for parents to help them understand their responsibilities.

ROBBY'S Voice

Break the Silence

SCHOOL PROGRAM CHECKLIST

OPPORTUNITY	DESCRIPTION	OWNERSHIP
District policy for identification and management of drug use	Identify the school districts policy on identification and management of drug use, inclusive of parental notification and resource support.	School
Prevention/Addiction Resource Support	Identification of district resources for prevention education including Resource Professional, Preventionalist, D.A.R.E. deployment, Guidance Department	School
Staff Education	Education of Teachers, Coaches,	School

	Trainers, Nurses, Bus Drivers and other district personnel	
District Educational Curriculum	Identification of the curriculum the district deploys for the students focusing on age groups, frequency, consistency and variation of the message	School
Staff Education	RV supported education including RV presentations, Operation Street Smart and D.A.R.E. for the Staff. Create a Teachers organization responsible for staff education.	School and RV
Student Education	Grade Appropriate RV presentations to present the issue.	RV
Student Education	Curriculum review of the DRUG AWARENESS & PREVENTIO program providing K-12 curriculum	RV Affiliate. Program has an implementation and training expense dependent upon scope of deployment
Sustained Messaging	Collaborate on sustained messaging for the students, working with RV Team, Administration and Student leadership.	RV
RV Poster Messaging	Quarterly deployment of an RV poster providing different messaging to the students. This will be supported by a weekly message that Student Leadership may deploy	RV – Poster Program under development
"Break The Silence" Fridays	Provides sustainable messaging within the schools by allowing the students to define the themes on Fridays to re-enforce the anti-addiction message	RV/Schools Utilization of RV approved family stories are available for this program
Volunteer Drug Testing	Program focuses on volunteer drug testing in the High School. Program is funded either by private sponsorship or by students/parents. Student reward programs need to be identified within the individual school for those passing the test.	RV/School RV will assist in the identification of a testing organization. Parental contract/student contract is under legal review
Rewards Program	Working with the County and local Prosecutor, a portion of	RV/Administration/Community

	seized items from drug raids are provided to the schools as a reward program. Works well in conjunction with the voluntary drug testing program. Additionally, community businesses and school offer rewards which may include merchandise, discounts an special privileges like bonus points, popcorn lounges etc.	
Tip Submit	Program to allow teachers and students to submit information anonymously regarding drug use. This is a program that becomes cultural over time, and saves lives. It is a smart phone app so it fits the new generation	RV
RV Web Site	Utilization of the RV web site as an educational tool. RV videos may be used by teachers and parents to communicate with their students about the issue in a more in depth manner. Videos are pulled from different sources to provide a spectrum of perspective	RV Scripts are in development
T-Shirt Program	Create awareness through apparel. The students are able to develop their own messaging and shirts to enforce the messaging.	School
Mentoring Program	Development of a student mentoring team which is deployed to younger grades in order to provide messaging on drugs and other key issues as well as support for students struggling with issues in the younger grades	School
Parents Program	RV presentation specifically designed to educate parents on the issue of addiction	RV
Boot Camp	Parents program that is more focused on helping parents learn the tools of prevention	RV

PTA Messaging	Coordinate with the school's PTA for inclusion in the district newsletter, providing information to the parents of the district	RV

Submitted for the record by Sen. Brown:

How the Medicaid expansion helps in addressing the heroin problem
By the Beacon Journal editorial board
Akron Beacon Journal
Published: March 30, 2016 - 06:48 PM

John Kasich has received some campaign knocks for his decision to expand Medicaid. To his credit, the governor has not backed away. The numbers are compelling, with roughly 600,000 newly eligible Ohioans enrolling in the public health-care program. Emergency room traffic has declined as visits to primary care doctors have increased. Those with little means struggle less to pay for necessities such as food and housing.

There is another benefit of much significance. The Medicaid expansion has aided efforts to address the heroin problem touching so many Ohio communities.

How so? Consider Summit County. Before the expansion, the county Alcohol, Drug Addiction and Mental Health Services Board used local money, generated through a property tax levy, to help pay for basic health costs of the disadvantaged. With the expansion, Medicaid now picks up much of the expense. That allows the ADM board to route levy dollars to meet other urgent needs.

All told, the money newly available totaled $4.2 million last year and is projected to be $5.4 million this year. Not all of those funds go to combating heroin addiction. The county Opiate Task Force has routed resources to recovery coaches, for instance. The coaches play a crucial role, helping those in recovery to navigate the system, accessing aftercare, housing, even employment.

Such support can be decisive in beating an addiction. That is especially so with recovery housing beds, those afflicted residing in a more encouraging environment and more likely to stay clean.

Similar thinking applies to detox beds, the ADM board working with such partners as Oriana House and the Community Health Center. Local levy dollars help ease the strain driven by the need. The money also supports Project Dawn, an initiative to train family members and friends about how to recognize and respond to overdoses. That includes administering naloxone, a medication that reverses overdoses and saves lives.

The local effort involves a drug prevention component for the long term, spurred by roughly $800,000 per year. For example, these levy funds support equipping teachers with skills to improve management of child behavior in the classroom. Already some teachers in the Akron and Coventry schools are using the techniques. Evidence from elsewhere shows positive results — fewer disruptions leading to more learning and a greater likelihood of success in school and beyond.

On Tuesday, President Obama highlighted the need for the federal government to do more to help communities overcome the heroin epidemic. The U.S. Senate, with Rob Portman of Ohio at the front, recently approved additional resources for the effort. Now the House must act, though the bill still does not do enough to meet the size of the problem.

What already has made a difference in Summit and other counties with local levies is the expansion of Medicaid. In that way, not only do more Ohioans have health-care coverage. Communities have resources to push back against heroin with proven strategies.

Dr. Jason Jerry, M.D.

Staff Physician, Alcohol and Drug Recovery Center

Assistant Professor of Medicine, Lerner College of Medicine

Cleveland Clinic

United States Senate Homeland Security and Government Affairs Field Hearing

"Examining the Impact of the Opioid Epidemic in Ohio"

April 22, 2016

Chairman Johnson, Ranking Member Carper, Senator Portman, and members of the Committee, thank you for coming to our community to discuss the opioid and heroin addiction epidemic that is plaguing many of our communities throughout Ohio and across the nation. On behalf of the Cleveland Clinic, we appreciate the opportunity to provide a firsthand account of the impact of opiate addiction, as well as the approaches we are taking to address this crisis.

As an Addiction Specialist at the Cleveland Clinic, as well as Chair of the Treatment Sub-Committee for the U.S. Attorney's Heroin and Opiate Task Force Group, I have advised on community, clinical, and policy solutions to this crisis. The Task Force was an outgrowth of an Opiate Summit hosted by Cleveland Clinic and the U.S. Attorney's office in 2013. Since then the Cleveland Clinic has been dedicated to addressing the opiate and heroin abuse and addiction crisis in Northeast Ohio. Through the Heroin and Opiate Task Force, we collaborate with government, local law enforcement, and addiction experts - including from our partners at University Hospitals and MetroHealth Medical Center - to address the epidemic in local communities. The Task Force has been instrumental in developing and implementing community-based approaches to combat this crisis, such as increasing access to naloxone through Project Dawn and establishing "drop-box" programs with local municipalities to dispose of unused prescription drugs.

Yet it is hard for clinicians to discuss opiate and heroin abuse in Ohio without addressing pain. Research has shown that 75% of current heroin addicts were introduced to opiates through prescription narcotics. An increased focus on the aggressive treatment of pain has led doctors to prescribe narcotics for indications where they would never have been considered twenty years ago.

The rise in opiate addiction, including addiction to prescription pain killers and street drugs such as heroin, is influenced by a complex interaction of physical, social, emotional, and economic factors. While it is tempting to try to solve the problem with simple actions such as limiting access to prescription pain medications, longer-term solutions must address all of the contributing causes.

However, over-prescribing opioids has been implicated in substance abuse patterns across the United States. Ohio's Cuyahoga County has recently experienced a dramatic increase in heroin mortality as well as a rise in prescription narcotic mortalities. An analysis of 2012 deaths indicates that approximately 67% of overdose victims had at least one prescription for a scheduled drug and that more than 50% had at least one prescription for an opioid analgesic.

Here is where we need help from our federal policymakers. While the connection between increase in use of opiate prescription drugs and the rise in opiate addiction state is clear, the Center for Medicare and Medicaid Services (CMS) Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient satisfaction survey includes broad queries about pain management, setting the expectation that control of pain, by any means, is essential to patient outcomes and quality. The surveys used by CMS ask a total of 25 questions. These surveys are tabulated and the results impact Medicare payment rates for that institution.

The two pain related measures questions read as follows:

13. During this hospital stay, how often was your pain well controlled?

14. During this hospital stay, how often did the hospital staff do everything they could to help you with your pain?

These questions are helping to drive increased patient expectations that pain can and will be eliminated by physicians. If the patient's expectations are not met, providers could lose significant reimbursement based in part by negative responses to these questions. In an op-ed that Dr. Joan Papp, M.D. and I recently wrote for the American Medical Association (AMA) Wire, we highlight the practice of CMS utilizing patient satisfaction scores that include specific questions regarding pain management to help determine hospital reimbursement. (Papp J and Jerry JM. When patient satisfaction is bad medicine. *AMA Newswire.* March 18, 2016.)

Rather than tying payment to "pain free" care, isn't it more important that the patient understand their pain and their role in helping to control it? Isn't the critical issue that a patient knows how their pain is going to managed to optimize healing and minimize addiction?

Along with your colleagues in Congress, the members of this Committee can make a difference here. We call on you to work with CMS and clinical experts to consider how the pain management questions can be revised to better reflect the patient experience and quality of care provided, while still holding providers and caregivers accountable for the most responsible care possible.

Cleveland Clinic authored legislative policy alongside the Ohio State Medical Association, and members of the Ohio Assembly to encourage CMS to revise the HCAHPS survey questions that are related to patient pain management. Just last week

this state resolution (HCR 16) was passed unanimously by the state Senate and is currently awaiting the Governor's signature.

Addressing the issue of patient satisfaction surveys and pain management will no doubt help us tackle this opioid epidemic. Cleveland Clinic would welcome the opportunity to partner with you in this effort.

Opiate addiction is a chronic, lifelong illness that requires ongoing treatment and follow up. Addressing the addiction epidemic that continues to grow and spread throughout Ohio and across the country requires strategies that hit at it from all angles. Just this month, our Ohio Attorney General, Mike DeWine called together community and faith leaders for an Opiate Summit. I spoke on behalf of the Cleveland Clinic, but despite having become an expert on the issue of substance abuse and addiction, I was touched by the stories and was inspired by the commitment of the community to overcome this destructive killer.

From a clinical perspective there is much we can do to help treat those who are addicted to heroin or prescription opiates. We have known for decades that evidence-based treatment - specifically, medication-assisted behavioral treatment - is effective in keeping this illness in remission but is too seldom employed. Widespread misinformation, stigmatization, and, in some cases, poor delivery of these evidence-based treatments has guided many addicts to seek help in abstinence-based programs that are only successful in about 10-20% of cases. Opiate addiction simply cannot be effectively treated in 28 days. In addition to the well-documented lack of efficacy of the acute-care abstinence-based residential programs, is a secondary tragedy—individuals returning home from such programs are at increased risk of overdose as their physiologic tolerance to opiates has returned to pre-addiction levels.

Our best strategy is to stop addiction before it starts. On January 1 of this year, Cleveland Clinic became one of the few health systems in the US to adopt system-wide randomized drug testing of all caregivers. Much like when we established a policy to not hire smokers, we determined that for patient safety and caregiver health it is imperative to have a drug-free workplace. As part of our pledge to deliver safe, reliable care, Cleveland Clinic recognizes that impairment caused by chemical dependency and substance abuse/misuse can adversely impact patients and the lives of our caregivers. Coping with overwhelming job stress and having access to controlled substances puts healthcare workers at increased risk for substance abuse. But admitting there is a problem with substance abuse is the first step to overcoming it. In fact, we encourage caregivers who believe they have a substance abuse problem to seek help before they are selected for random testing.

We are grateful for the leadership exhibited by Senator Portman, Senator Sherrod Brown, and members of the Ohio congressional delegation in advancing legislative policies to expand access to evidence-based, life-saving addiction treatments, including broad availability of Naloxone to help assist those experiencing opiate-related

overdoses. Senator Portman, your bipartisan legislation, the Comprehensive Addiction and Recovery Act (CARA), is one example and a much-needed step in the right direction. We support the bill and are hopeful it can be passed by both Chambers in Congress and signed into law. Together with Senator Brown, you have worked tirelessly to ensure the federal government provides the resources necessary to fight this addiction epidemic head on.

Cleveland Clinic, together with our the leaders testifying at this hearing, helped drive policy at the state level to curb the number of opioid-based drugs prescribed in Ohio. This work led to the passage of legislation mandating physicians in the state use Ohio's Automated Rx Reporting System (OARRS), which resulted in a 6.5% decrease -- nearly 50 million doses (6.5%) -- in the number of prescription opiates dispensed to Ohio patients in 2015 compared to 2014.

Senator Portman, members of the Committee, thank you for your leadership and commitment to solving this public health emergency.

○