

THE OPIOID EPIDEMIC IN APPALACHIA: ADDRESS- ING HURDLES TO ECONOMIC DEVELOPMENT IN THE REGION

(115-31)

HEARING BEFORE THE SUBCOMMITTEE ON ECONOMIC DEVELOPMENT, PUBLIC BUILDINGS, AND EMERGENCY MANAGEMENT OF THE COMMITTEE ON TRANSPORTATION AND INFRASTRUCTURE HOUSE OF REPRESENTATIVES ONE HUNDRED FIFTEENTH CONGRESS FIRST SESSION

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CONTENTS		Page
Summary of Subject Matter		iv
TESTIMONY		
PANEL 1		
Hon. Harold Rogers, a Representative in Congress from the State of Kentucky		3
PANEL 2		
Hon. Earl Gohl, Federal Cochair, Appalachian Regional Commission		6
Barry L. Denk, Director, The Center for Rural Pennsylvania		6
Nancy Hale, President and Chief Executive Officer, Operation UNITE		6
Jonathan P. Novak, Esq., Former Attorney for the Drug Enforcement Administration		6
PREPARED STATEMENTS SUBMITTED BY MEMBERS OF CONGRESS		
Hon. Tom Marino of Pennsylvania		28
PREPARED STATEMENTS SUBMITTED BY WITNESSES		
Hon. Harold Rogers		31
Hon. Earl Gohl		35
Barry L. Denk		42
Nancy Hale		48
Jonathan P. Novak, Esq.		54



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U.S. House of Representatives
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December 8, 2017

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SUMMARY OF SUBJECT MATTER

TO: Members, Subcommittee on Economic Development, Public Buildings, and Emergency Management
FROM: Staff, Subcommittee on Economic Development, Public Buildings, and Emergency Management
RE: Subcommittee Hearing on "The Opioid Epidemic in Appalachia: Addressing Hurdles to Economic Development in the Region"

PURPOSE

The Subcommittee on Economic Development, Public Buildings, and Emergency Management will meet on Tuesday, December 12, 2017, at 10:00 a.m. in 2167 Rayburn House Office Building, for a hearing titled "The Opioid Epidemic in Appalachia: Addressing Hurdles to Economic Development in the Region." The purpose of the hearing is to examine the impact of the opioid crisis on efforts in Appalachia to spur economic development and growth in distressed communities, to explore possible solutions to the crisis, and to examine the role of federal economic development programs, such as the Appalachian Regional Commission (ARC), in addressing this epidemic. Witnesses include the ARC and state and private sector experts.

BACKGROUND

The Subcommittee has jurisdiction over ARC, the Economic Development Administration (EDA), the Denali Commission, the Delta Regional Authority (DRA), the Northern Great Plains Regional Authority, Southeast Crescent Regional Commission, Southwest Border Regional Commission, and Northern Border Regional Commission. These entities provide federal assistance to economically distressed areas for the creation of long-term employment opportunities and economic growth. These economic development agencies leverage federal dollars with state and local funds to attract private investment in distressed communities. Support under these programs can assist in planning, technical assistance, job training, and the physical infrastructure needed to attract employers and jobs in communities to spur economic growth.

The ARC, specifically, was created in the *Appalachian Regional Development Act of 1965*. The primary function of ARC is to provide economic development assistance to a 13-state region. The region includes all of West Virginia and parts of Alabama, Georgia, Kentucky, Maryland, Mississippi, New York, North Carolina, South Carolina, Ohio, Pennsylvania, Tennessee, and Virginia. ARC is a federal-state governmental agency consisting of the governors of the 13 Appalachian states and a federal co-chairman. Project proposals must originate in, and be approved by, a state. The Commission allocates the level of funding to each state.

DISEASES OF DESPAIR AND THE OPIOID CRISIS

This year, the ARC commissioned two reports specifically examining potential health challenges to economic development in Appalachia. In August 2017, ARC issued “Health Disparities in Appalachia” and “Appalachian Diseases of Despair.”¹ These reports detail the health disparities in Appalachia and, more specifically, the impact of the opioid crisis in Appalachia. Specifically, the reports noted:

- The household income in Appalachia is 80 percent of the U.S. average and 17 percent of Appalachians live below the poverty level.²
- Nationally, the majority of drug overdose deaths involve opioids and, since 1999, the number of overdose deaths involving opioids quadrupled.³
- Between 1999 and 2014, while the overall mortality rate in non-Appalachian states decreased by 10 percent, the overall mortality rate in Appalachia increased by 5 percent. By 2015, the overall mortality rate in Appalachia was 32 percent higher than in the non-Appalachian regions of the United States.
- In 2015, among 15 to 64 year olds in Appalachia, there were 5,594 overdose deaths – 65 percent higher in Appalachia than to the rest of the Nation. The disparities were greatest among people 25 to 54.
- In 2015, 69 percent of the overdose deaths were caused by opioids.
- In comparing the mortality rates for diseases of despair within states with Appalachian portions and non-Appalachian portions – the differences were stark. For example, in 2015, the mortality rate in Appalachian portions of Maryland were 63 percent higher than in non-Appalachian portions. In Pennsylvania, the difference was 28 percent and in Kentucky it was 26 percent.

The reports highlight that when examining specifically overdose deaths, those individuals who are 25 to 44 years old experienced mortality rates 70 percent higher than the non-Appalachian states. Typically, this group includes those in their prime working years which has created a significant challenge to economic development in the region. For example, the Pennsylvania Chamber of Business and Industry, citing a report released in September 2017,

¹ See *Appalachian Diseases of Despair*, Prepared for the Appalachian Regional Commission, The Walsh Center for Rural Health Analysis, NORC at the University of Chicago (2017); *Health Disparities in Appalachia*, The Cecil G. Sheps Center for Health Services Research, the University of North Carolina at Chapel Hill (2017).

² Data Snapshot, Income and Poverty in Appalachia, Appalachian Regional Commission.

³ See Record Overdose Deaths, Opioid Overdose, Centers for Disease Control and Prevention: <https://www.cdc.gov/drugoverdose/epidemic/index.html>

noted that opioids are responsible for 20 percent of the workforce decline for men and 25 percent for women.⁴ The Pennsylvania Chamber further noted that addressing the opioid epidemic is an integral component of workforce strategy.⁵ As a result, the opioid crisis has created challenges to spurring economic development and job creation in already distressed communities.

The hearing will examine the impact of opioids in Appalachia on economic development, and what role economic development programs can have in addressing the problem.

WITNESS LIST

Panel I

The Honorable Harold Rogers (R-KY)
Member of Congress
U.S. House of Representatives

Panel II

The Honorable Earl Gohl
Federal Co-Chair
Appalachian Regional Commission

Mr. Barry L. Denk
Director
The Center for Rural Pennsylvania

Ms. Nancy Hale
President and Chief Executive Officer
Operation UNITE

Mr. Jonathan P. Novak, Esq.
Former Attorney for the Drug Enforcement Administration

⁴ “Where Have All the Workers Gone?” Alan B. Krueger, Princeton University, September 2017.

⁵ Gene Barr, President and CEO, Pennsylvania Chamber of Business and Industry testimony Before the Center for Rural Pennsylvania, October 26, 2017.

THE OPIOID EPIDEMIC IN APPALACHIA: ADDRESSING HURDLES TO ECONOMIC DEVELOPMENT IN THE REGION

TUESDAY, TUESDAY, DECEMBER 12, 2017

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON ECONOMIC DEVELOPMENT, PUBLIC
BUILDINGS, AND EMERGENCY MANAGEMENT,
COMMITTEE ON TRANSPORTATION AND INFRASTRUCTURE,
Washington, DC.

The subcommittee met, pursuant to call, at 10:01 a.m., in room 2167, Rayburn House Office Building, Hon. Lou Barletta (Chairman of the subcommittee) presiding.

Mr. BARLETTA. The subcommittee will come to order.

The purpose of today's hearing is to examine the impact of the opioid crisis on economic development in Appalachia. The opioid crisis has touched the lives of countless Americans. This public health emergency has taken the lives of far too many of our Nation's citizens, and has had significant adverse effects on our economy and labor force participation. As a subcommittee with jurisdiction over a number of economic development agencies, including the Appalachian Regional Commission, we are specifically focusing today on the ways the opioid crisis has affected the Appalachian workforce, and efforts to promote economic development in the region.

The opioid epidemic has profoundly affected all of our districts and uprooted the lives of so many of our constituents. Ninety-one Americans die every single day of an opioid overdose. In my home State of Pennsylvania, 4,642 drug-related overdose deaths were reported in 2016. In 2015, there were 5,594 overdose deaths in Appalachia—a drug-related death rate 65 percent higher than the rest of the Nation. Sixty-nine percent of those deaths were caused by opioids. An overwhelming majority of these deaths throughout Appalachia were individuals between the ages of 25 and 44, people who were in their prime working years. These troubling statistics makes it clear that the opioid crisis is not only destroying lives, it has created a significant challenge to workforce expansion and economic development throughout Appalachia.

This crisis is economically disastrous for our Nation. This past month, the White House office of economic advisers released a report that estimated the opioid epidemic cost our Nation \$504 billion in 2015. That is an important number to remember as we begin today's hearing, because it points to the lost potential for economic

activity and productivity in communities battling opioid addiction. That is our focus here today.

To that end, I remind our witnesses and my fellow Members that this subcommittee's jurisdiction is economic development programs in the Appalachian Regional Commission. We have no oversight of the Department of Justice or the DEA. Our goal is to have a hearing that this subcommittee can use to inform our committee's decisions regarding agencies within our jurisdiction. Therefore, I would ask that all testimony and questions be confined to the issues within our jurisdiction. Further, I would like to reiterate that today's hearing is meant to be bipartisan. The opioid crisis does not recognize political parties. I think that we can all agree, Republicans and Democrats alike, that the priority here is to finding solutions for the communities and the families who are being devastated by this epidemic, not playing politics with people's lives.

Just a few days ago, the Transportation and Infrastructure Committee showed what it can accomplish when we work in a bipartisan fashion. We unanimously approved the Disaster Recovery Reform Act because of the good work that was started here in this subcommittee. Let's continue to work in that same fashion here today to look for solutions within the programs and agencies under our jurisdiction.

It is my hope that today we can come together to examine the impact of opioids in Appalachia and the ways in which existing Federal economic development programs can help States and communities address and combat this growing epidemic. I am sure our witnesses today will help us answer those questions. I thank you for being here.

I now recognize the ranking member of this subcommittee, Mr. Johnson, for a brief opening statement.

Mr. JOHNSON. Thank you, Mr. Chairman. Good morning, and I would like to thank Chairman Barletta for holding this very important hearing on the opioid epidemic in Appalachia and how it is impacting adversely and severely the lives of our brothers and sisters in Appalachia.

Since the formation of the Appalachian Regional Commission in 1965, Appalachia has made significant progress in executing its mission of addressing persistent poverty and economic despair. However, the progress made in attracting industry to Appalachia and reducing poverty has been threatened by the current opioid epidemic sweeping the Nation.

According to the Centers for Disease Control and Prevention, the CDC, drug overdoses are now a leading cause of death in the United States resulting in approximately 52,000 deaths in 2015. Fifty-two thousand deaths in 2015, or 142 deaths every day. In Appalachia, the problem is even worse. In 2009, the mortality rate in the Appalachian region was 24 percent higher than the non-Appalachian United States. By 2016, the mortality rate was 37 percent higher than the rest of the Nation.

The opioid epidemic also happens to strike in the most devastating way men and women between the prime working ages of 25 and 44. Although the mortality rate is lower in the Georgia counties in my congressional district covered by the ARC, I think there can be important lessons learned for the Southeast Crescent

Regional Commission, another economic development commission that I introduced legislation reauthorizing earlier this year.

This is a full-blown crisis that demands the attention of Congress. The high rates of substance abuse and mortality in Appalachia compared to the rest of the United States is a serious impediment to sustained economic growth. Employers are seeking a healthy workforce when making decisions about where they will locate their businesses. High rates of substance abuse and mortality make it difficult for employers to find and hire qualified candidates. The ARC in its mission to promote economic development in the region has understood the great threat of opioid addiction to the economic viability of the region.

In 2017, the ARC commissioned two reports that clearly outlined that men and women of prime working ages are beset with high rates of substance abuse and mortality. I support ARC's conclusion that increased access to treatment services, prevention, and overdose medications to address the opioid epidemic are necessary. I am pleased that the approach to the opioid epidemic in all of ARC's commissioned reports discuss this problem in the context of it being a public health issue as much as it is a law enforcement issue. We must not repeat the mistakes of the past where drug abuse was overcriminalized as it was during the crack cocaine epidemic of the 1980s. The Government's response to drugs in the 1980s did not have the effect of easing the problem, but instead, only intensified the severity of the problem.

Hopefully, we have learned some things from our past. Today, the comprehensive reports and testimony before this committee make clear that the genesis and driving force for this epidemic starts with the proliferation of prescription drugs. I am glad that we will have a former DEA official talk about how changes in the law and policy at DEA contributed to the explosion in prescription pills in Appalachia. There is no silver bullet to solve the opioid epidemic, but I look forward to hearing from today's witnesses on how a comprehensive multifaceted approach can address this crisis.

And with that, I yield back.

Mr. BARLETTA. Thank you. The Chair now recognizes the ranking member of the full committee, Mr. DeFazio.

Mr. DEFazio. Thanks, Mr. Chairman. I won't delay things here. I am here in the hope of hearing from the witnesses before I have to leave.

Thank you.

Mr. BARLETTA. OK. I am pleased to welcome on our first panel, our colleague, Representative Harold Rogers of Kentucky. I ask unanimous consent that our witness' full statement be included in the record. Without objection, so ordered.

For our witness, since your written testimony has been made a part of the record, the subcommittee would request that you limit your oral testimony to 5 minutes.

Representative Rogers, you may proceed.

**TESTIMONY OF HON. HAROLD ROGERS, A REPRESENTATIVE
IN CONGRESS FROM THE STATE OF KENTUCKY**

Mr. ROGERS. Thank you, Mr. Chairman. And thank you, members of the committee, for holding this hearing and for allowing me

to be here to introduce a constituent who will be testifying immediately after me.

It is a pleasure to introduce Nancy Hale. She is the president and CEO of a group called Operation UNITE. My area was impacted most severely at the very outset. It is where this epidemic began.

Mr. BARLETTA. Excuse me. Can you pull that microphone a little bit closer to you?

Mr. ROGERS. Is that OK?

Mr. BARLETTA. Yep.

Mr. ROGERS. Unbeknownst to anyone, I am talking 2002 or so, the State newspaper had this banner headline saying that eastern Kentucky is the painkiller capital of the world. It is where OxyContin got its start, in the coalmine fields of east Kentucky. I didn't know what to do. This is completely out of the blue. No one knew or suspected that this was going on. So I called together, over several weekends, people from all walks of life, from all professions: preachers, doctors, orators, judges, social workers, you name it. And we barnstormed, what in the dickens can we do to stem the tide? Kids were dying in the hospitals every night.

And out of that came this organization called UNITE. Unlawful Narcotics Investigations, Treatment and Education. Holistic three-pronged attack. You can't arrest your way out of the problem. You can't treat your way out of the problem alone. And you can't educate your way out of it. You got to do all of them at the same time, across the board, in every community, with everyone involved. And you got to involve the public. So the public pressure comes to bear on judges, prosecutors, the law enforcement community, the medical community, the education system and the like. And so, there are 32 counties in Operation UNITE. We had 35 undercover agents that could work in those 32 counties. So far, they have arrested and convicted some 4,300-and-so pushers.

But now with this Operation UNITE program, we have got treatment centers. We have got counselors in schools. We have got drug courts in every county, every community. And we have got law enforcement that is now pushing and pushing and pushing.

So the operation is a success. Is it solving the problem? No. We are still going up in drug use. It has shifted a lot from prescription pills to heroin laced with fentanyl, meth, and other substances. I am sure all of you have the same problem in your own districts back home. All of us in Congress have been touched, in some way, by opioid abuse. As the flames of addiction have fanned across communities small and large, my area spanning Kentucky's Appalachian region, the very heart of Appalachia, has been acutely impacted.

While I was first initially skeptical of that newspaper story about the widespread abuse of OxyContin, it didn't take me long to find out it was true. The overprescription diversion of painkillers was wreaking havoc on our small towns. Addiction was pervasive and deadly, with overdoses tragically far too common. Something had to be done.

But addressing this issue, the misuse of illegal drugs, was far from black and white. And that is how we came by the Operation UNITE organization.

I don't want to steal Nancy's thunder when she testifies in a few minutes, but I want to emphasize that this organization is the national leader now in combating opioid addiction at the regional level. UNITE has taken this holistic model to the national stage by hosting and putting on the National Prescription Drug Abuse and Heroin Summit, now in its seventh year. We will meet again in April in Atlanta. We will have all of the agencies there: The DEA, the FBI, Department of Justice. Last year, we had the President come. We will have the head of the CDC, NIH, DEA, the drug czar, you name it. And I hope a number of Members of Congress. The chairman graced us with his presence a couple of years ago. And, Mr. Chairman, we want all of you back again next April.

I know today, given the jurisdiction of your subcommittee over the Appalachian Regional Commission, you are focused on finding solutions in this geographical area which has been a bellwether for national trends in the opioid's space.

Let me state that ARC has been a valued partner. And Mr. Gohl answered the call when UNITE asked for support for this summit 8 years ago. And, Mr. Gohl, we are grateful for your support for the ARC summit, and we would not be where we are today without you.

But I also believe that the opioid epidemic is indelibly tied to the future economic development of Appalachia, and that ARC could be doing more to help organizations like UNITE tackle the challenges associated with substance abuse. UNITE has found creative ways to do more with less as funding has become more difficult to come by. But I believe, Mr. Chairman, a vision without funding is a hallucination. Without additional Federal support, UNITE simply cannot maintain the level of service that will be necessary to save lives in our region and in communities around the country.

As a long-time appropriator, I understand better than most that ARC has a broad mission and limited resources. However, one thing is painfully clear. The continuation of our addiction crisis and a vibrant Appalachian economy cannot coexist. The need for more targeted action is urgent as innocent children are left behind in the wake of deadly overdoses, and as more employers search for a drug-free workplace, both in Appalachia and across the country.

I think today's hearing, Mr. Chairman, is an important first step, and I am grateful that you have made it a priority. I stand ready to assist the members of your subcommittee and you in any way as we work together to find solutions to this crisis.

So thank you, Mr. Chairman, for allowing me these minutes and for your hospitality towards Nancy Hale, who is on the next panel.

Thank you, and I yield back.

Mr. BARLETTA. Thank you. Thank you for your testimony. Your comments have been very helpful to today's discussion.

We will now move to our second panel.

Mr. BARLETTA. On our second panel, we have the Honorable Earl Gohl, Federal Cochair of the Appalachian Regional Commission; Mr. Barry L. Denk, director, The Center for Rural Pennsylvania; Ms. Nancy Hale, president and chief executive officer, Operation UNITE; and Mr. Jonathan P. Novak, former attorney for the Drug Enforcement Administration.

I ask unanimous consent that our witnesses' full statements be included in the record. Without objection, so ordered.

For our witnesses, since your written testimony has been made a part of the record, the subcommittee would request that you limit your oral testimony to 5 minutes.

Chairman Gohl, you may proceed.

TESTIMONY OF HON. EARL GOHL, FEDERAL COCHAIR, APPALACHIAN REGIONAL COMMISSION; BARRY L. DENK, DIRECTOR, THE CENTER FOR RURAL PENNSYLVANIA; NANCY HALE, PRESIDENT AND CHIEF EXECUTIVE OFFICER, OPERATION UNITE; AND JONATHAN P. NOVAK, ESQ., FORMER ATTORNEY FOR THE DRUG ENFORCEMENT ADMINISTRATION

Mr. GOHL. Thank you, Mr. Chairman, and members of the subcommittee for holding this hearing examining the impact of opioids in Appalachia. I also want to acknowledge Congressman Rogers whose leadership has challenged us all to look at how opioids are holding Appalachia's economy back.

My name is Earl Gohl. I serve as the Federal Cochair of the Appalachian Regional Commission. ARC is a partnership between the Governors of the 13 Appalachian States and the Federal Government. The Commission was created by Congress to help Appalachia achieve socioeconomic parity with the rest of the Nation. ARC has a broad mandate to foster and support economic growth across the region's 420 counties.

Mr. Chairman, opioid abuse poses a major threat to the economic prosperity of Appalachia. It is not just a public health and public safety issue. It is an economic issue. It drains the region's resources, both human and financial. It shatters Appalachia's families and communities. It would be understandable if this scenario led to a narrative of defeat.

But my narrative, based on 8 years of intensive engagement, working with communities, partnering with a variety of groups and interests and making hundreds of friendships is not a tale of woe. It is, rather, a narrative of proud Americans who are resilient, determined, and full of grit. There is an army of Appalachians with ambition and hopes who get up every day and work incredibly hard to make their communities better places for their kids and their grandkids.

Today, these folks bring energy and innovation and determination to many communities. They are focused on the challenge of a stronger, new, and diverse local economy. It is a story of groups like SOAR in eastern Kentucky, Coalfield Development Corporation in West Virginia, the Foundation for Appalachian Kentucky, the Pennsylvania Wilds, and the West Virginia Hub, the list goes on, who are incredibly focused on writing the narrative of Appalachia's future.

But we also know the studies, the data, the roundtables, the focus groups, the discussions, the casual conversations with friends and partners make it clear. Opioid addiction is a significant barrier preventing Appalachian communities from reaching their economic potential. Mayors tell me that prospective employers ask about the state of opioid addiction in their communities. Law enforcement understands they are confronting a disease. Friends and partners,

employers will pull you aside and say, this is touching every family, with the emphasis being on “every.”

In 2008, ARC published a research report by the Walsh Center for Rural Health Analysis that showed Appalachian hospital admission rates for abuse of prescription painkillers were more than twice those in the rest of the United States. It showed the rate rising, both nationally and regionally, but it was rising faster in Appalachia. The ARC study was the first to document that Appalachia was being disproportionately harmed by the growth of prescription drug abuse.

This fall, the President released the opioid commission report that outlined the challenges of opioid abuse nationwide. ARC recently published another study from the Walsh Center that described the extent of the opioid challenge in our region. It put opioid-related drug abuse in context with two other diseases of despair, suicide and alcoholic liver disease, and showed that the region’s mortality rate for all three combined is 37 percent higher than the rest of the Nation. The same study also illustrates that the gaps between Appalachian and non-Appalachian mortality rates are highest among people in their prime working years.

In 2015, overdose-related mortality rates for Appalachia’s 25-to-44-year-old age group were more than 70 percent higher than the same age group in the country’s non-Appalachian areas. Seventy percent of all the data points. This is the one that all of us need to focus on. It is the one that will have the greatest impact on the economic growth—economic opportunities of the Appalachian region.

You probably already know that Appalachians are not folks who are going to stand by and wait for someone to tell them what to do when there is a problem that impacts their families and their community. Appalachians recognize that the opioid challenge requires everyone’s engagement and commitment. They understand that ARC can partner with them and—to help them take on the region’s toughest challenges.

You will hear from Nancy Hale. The story of UNITE is an example of what Appalachian communities can accomplish. ARC is very proud to call ourselves a partner of Operation UNITE. We have all heard about the heroics of the Huntington, West Virginia, city emergency responders who have been on the front line of this opioid crisis. ARC is currently supporting the work of the Cabell-Huntington Health Department to expand its opioid harm reduction services from one site to six, making the program available countywide.

Organizations like FAHE [Federation of Appalachian Housing Enterprises] in Kentucky recognize that they can contribute to this effort by partnering with service providers to develop recovery housing and employment support for individuals. ARC has invested \$1 million in our POWER [Partnerships for Opportunity and Workforce and Economic Revitalization] Initiative that targets coal-impacted communities to help FAHE establish three treatment and recovery facilities in Kentucky.

Using the ARC funds, the Center for Rural Health Development in Hurricane, West Virginia, is strengthening the healthcare indus-

try in a 15-county region by providing business development systems to care providers.

At its core, each one of these examples is about creating job opportunities in Appalachia, which is what ARC's core mission is.

ARC believes that supporting the workforce and creating new jobs and businesses are strategically important in solving the region's opioid crisis. Over the past 5 years, ARC's investments have helped create and retain over 100,000 jobs. Each of these jobs gives someone hope, a reason to get up every day, and make the region a better place for their kids, their grandkids, and themselves.

Mr. Chairman, thanks so much for this opportunity.

Mr. BARLETTA. Thank you for your testimony, Chairman Gohl.

Mr. Denk, you may proceed.

Mr. DENK. Thank you.

Good morning, Chairman Barletta, Ranking Member Johnson, and members of the House Subcommittee on Economic Development, Public Buildings, and Emergency Management. I appreciate the opportunity to be with you today. I am Barry Denk, the director of The Center for Rural Pennsylvania. The center is a bipartisan, bicameral legislative research agency serving the Pennsylvania General Assembly. For those who may not know, Pennsylvania has the third largest rural population in the Nation with 3.5 million rural residents. Rural Pennsylvania comprises 75 percent of our Commonwealth's land area.

The center began sponsoring a series of public hearings in July 2014, on the issue of what we now know is the public health epidemic of substance use disorder due to heroin and opioid addiction. We conducted our 13th hearing just this past October of 2017. The Center for Rural Pennsylvania received testimony from over 150 professionals totaling over 35 hours, all viewable on my chairman's website as well as their written testimony. We heard firsthand from the attorney general, from police officers, district attorneys, judges, EMS professionals, coroners, doctors, superintendents, business leaders, treatment providers, Federal and State government officials, and we heard from families who have lost loved ones to addiction, and we heard from persons in recovery.

One of the individuals who testified at two of our hearings, the most recent being in October of 2017, is the president and CEO of the Pennsylvania Chamber of Business and Industry. He noted a Princeton economist, Alan Krueger, who released a report in September 2017 that analyzed how the opioid crisis has contributed to workforce challenges. By comparing county level data for opioid prescription rates, and labor force data for the periods of 1999 to 2001, and from 2014 to 2016, Dr. Krueger concluded that opioid prescriptions accounted for a 20-percent decline in the workforce participation among men, and a 25-percent decline among women.

The Pennsylvania Chamber of Commerce also commissioned a survey of its members in 2016 about their experiences and expectations concerning the workforce. Over 400 of the members responded to the survey, and they painted a daunting picture. A combined 52 percent said it is very, or extremely difficult to recruit qualified candidates to fill the workforce needs for their companies. Over 61 percent said finding qualified applicants has become much

more difficult within the past 5 years, and over 57 percent expect that same situation to play out over the next 5 years.

Over 20 percent of the respondents said the job applicants or potential new hires very often, or somewhat often, failed to pass a drug test. He also stated that it is becoming increasingly evident that addressing the prescription drug and opioid epidemic must be an integral component of any workforce development strategy.

We are also aware of a study that was completed in two Appalachian counties in Pennsylvania, namely Allegheny, where Pittsburgh is located, and Westmoreland County. The Allegheny Institute for Public Policy released its report in May 2017, stating that their estimate is that there are 16,000 opioid medicine abusers in Allegheny County, and over 5,000 heroin abusers/users in Allegheny County coming at a cost for healthcare, crime, and lost wages and benefits estimated at \$472 million for those opioid medicine users and over \$350 million for heroin users.

For Westmoreland County, the costs were placed at \$102 million for opioids, and \$108 million for heroin. We are also aware of a study by the National Bureau of Economic Research that surveyed 35 Appalachia counties known for a high propensity for heroin use. It found that, as unemployment increases by 1 percent, there is a 3.6-percent increase in opioid-related deaths, and an over 7-percent increase in emergency room visits for opioid-related health crises.

These are just a few examples, given the time today, to help document the impact that the heroin and opioid epidemic is having on our workforce and our economy in Appalachia, and, specifically, in rural Pennsylvania.

A few closing comments. Specifically, I will provide a quote from my chairman, Senator Gene Yaw, who testified before the Pennsylvania Senate Health and Human Services Committee in May of 2017. And his quote is this: "Today, 13 Pennsylvanians will lose their lives to a drug overdose. This week, over 1,000 people will die of an overdose in the United States. By comparison, the Vietnam War, a period that spanned 10 to 12 years, claimed more than 56,000 American lives. We are now approaching that level of lives lost every year due to drug abuse and misuse, and estimates are that these numbers will continue to surge."

The Center for Rural Pennsylvania since 2014 has been investigating this issue. But our work addressing rural Pennsylvania and the challenges and opportunities that face those residents in those communities dates back to 1987.

I will leave this final comment with you: While the heroin and opioid crisis is an unbelievable impact for our communities and our citizens, it is also important to put it in the context of much broader challenges that are ongoing and systemic in rural Pennsylvania, and, I would offer, in rural Appalachia.

Two things are constant, regardless of what we are talking about: geographic isolation, and lack of density population. And that makes it extremely challenging to aggregate, to get return on investment, and to provide goods and services that can move the economies for rural Pennsylvania.

One of the maps that I provided for you in my written testimony shows the per capita income gap between urban and rural Pennsylvania. That gap in 1970 was just under \$5,500. That income gap,

adjusted for inflation in 2015, increased to over \$12,000, a per capita income gap. That means an awful lot of things for how rural Pennsylvania can do a lot of things, invest in a lot of programs, whether it is drug treatment or whether it is economic development programs. Those are constants that remain in rural Pennsylvania and speak to the broader picture of some of the challenges, but also, some of the opportunities that can turn things around for our Commonwealth.

Chairman, thank you so much for the privilege to be here.

Mr. BARLETTA. Thank you for your testimony, Mr. Denk.

Ms. Hale, you may proceed.

Ms. HALE. Good morning, Chairman Barletta, Ranking Member Johnson, and members of the subcommittee. Thank you for giving me the opportunity to speak with you. I am Nancy Hale, president and CEO of Operation UNITE.

UNITE stands for Unlawful Narcotics Investigations, Treatment and Education. Operation UNITE was launched in 2003 by Congressman Hal Rogers, after the Lexington Herald-Leader published a report on addiction and corruption. Per capita, we were the top painkiller users in the entire world. UNITE pioneered a holistic approach that has become a model for other States and the Nation. Eastern Kentucky's economy has been hard hit by the rising rate of substance abuse among its residents. Local employers are losing skilled workers to substance use and are unable to find qualified employees who can pass a drug test.

So how is UNITE addressing the problem? UNITE's enforcement effort has resulted in the removal of more than \$12.3 million worth of drugs from the street, 4,400 arrests with a conviction rate of more than 97 percent, and nearly 22,000 calls to our tip line. But we realize that we cannot arrest our way out of this epidemic.

We staff a statewide treatment line to connect people to resources, and have supplied vouchers to help more than 4,000 people enter long-term rehabilitation. In addition, the number of drug court programs has increased from 5 to serving all 32 counties in our region. But prevention is paramount. UNITE has reached more than 100,000 students through our drug education programs.

A National Center for Injury Prevention and Control study estimated that prescription opioid abuse cost the economy \$78.5 billion in 2013. That did not include factors like lost productivity. We have provided State-certified, drug-free workplace training to more than two dozen companies which benefit from reduced workers' compensation insurance premiums, safer workplaces, increased productivity, and reduced absenteeism. UNITE focuses on addiction, the signs of drug use, the effects in the workplace, and how to find support services. We also help with employee assistance programs. We have implemented many evidence-based solutions. The good news is that these programs can be replicated. The bad news is they require funding.

You have already heard Congressman Rogers say a vision without funding is a hallucination. Operation UNITE received Federal appropriations in the early 2000s for enforcement efforts. SAMHSA helped provide treatment vouchers. Through our AmeriCorps program, students show a more than 50-percent growth in math knowledge and drug education knowledge. Our achievements would

not have been possible without these appropriations, many of which are no longer available. We seek private and State investments, and continue to explore opportunities through the competitive grant process. Our unique regional holistic structure does not fit many funding models.

The Appalachian Regional Commission has been invaluable. Please refer to my written testimony for those details. I would like to focus today, though, on the National Prescription Drug Abuse and Heroin Summit. Congressman Rogers asked UNITE to create a summit where stakeholders could collaborate, cooperate, and discover data-driven solutions to the epidemic. The ARC agreed to serve as educational partner for the first summit in 2012. Its investment of \$50,000 paid for travel expenses for more than 200 leading experts and the ability to offer continuing education credits.

Since inception, attendance has more than tripled, attracting nearly 2,400 people in 2017. The Institute for the Advancement of Behavioral Healthcare now promotes and stages the summit. UNITE remains active as the educational adviser. In 2016, UNITE received ARC funding for effective sustainable social media strategies. UNITE implemented a campaign to raise awareness of the summit, and received training from Oak Ridge Associated Universities, enabling us to build a strong regional presence and increase Facebook followers by 24 percent.

In 2017, ARC provided funding to share social media best practices at the summit; to expand our media presence in the Appalachia region; to assist with the CDC's campaign to prevent prescription opioid abuse; and, create a strategic plan, a sustainability roadmap.

Unfortunately, many people are unaware of how to replicate our initiatives, and UNITE has endured drastic funding cuts. UNITE and organizations utilizing our model are desperate for Federal support to keep the doors open. We hope we can maintain and expand upon our partnership with ARC and other Federal agencies. UNITE helps ARC fulfill its mission. And ARC support has enabled UNITE to create hope and change the culture, not only in southeastern Kentucky or Appalachia, but on a national stage. By supporting a national dialogue through the Rx summit, ARC is creating positive changes well beyond its service area. But we need the ARC to do more. Funding and expansion of our drug-free workplace training would help economic development in Appalachia. In addition, we need funding to support medical symposiums on prescribing addiction, alternative treatments, and recovery.

UNITE looks forward to working with other communities across the Nation to address our Nation's opioid epidemic. And thank you for giving me the opportunity to share today.

Mr. BARLETTA. Thank you for your testimony, Ms. Hale.

Mr. Novak, you may proceed.

Mr. NOVAK. Good morning, and thank you for the honor of speaking here today.

From 2010 through 2015, I had the great honor to serve as an attorney for the Drug Enforcement Administration. My work was focused almost entirely on enforcement actions against doctors,

pharmacies, distributors, and manufacturers of opioid controlled substances, all registrants under the Controlled Substances Act.

For several years, with an eye on protecting the public health and safety, DEA shut down pill mills and practices run by greedy, immoral drug dealers in lab coats, all betraying not only their duties under the CSA, but their ethical obligations to their fellow human beings. I watched as DEA fought hard against the rising tide and struggled not to drown as the opioid epidemic swelled around us.

The opioid epidemic was a slow burn fire. Traditionally, many opioids used to treat pain included acetaminophen, a drug which, if taken long term, caused severe liver damage. So in the 1990s, a pharmaceutical company decided to remove the acetaminophen and start promoting the use of opioids for long-term pain management. Their proposal was backed by claims that opioid medicines are rarely addictive. Too late. We now know that this is not true.

As these drugs were marketed, the very people selling the pills went about changing hearts and minds about the dangers of opioids. Soon, opioid phobia was replaced with frowny-faced pain measurement and a general misunderstanding by many physicians of what exactly they were prescribing. Over the course of time, opioid usage was normalized in America and heralded as a wonder drug. Opioids were digging in everywhere across the country, especially in blue collar and poorer areas, where those seeking a prescription felt validated by the fact that their drugs came from a doctor and where those seeking a buck found incredible profits in sharing their stash. Unemployment and disability numbers rose, and the number of employable members of the workforce diminished.

As DEA endeavored to help the people of this country, we began broadening our investigations and enforcement actions to look at the role of distributors and manufacturers in this threat of opioid addiction. Then, for no readily apparent reason, DEA began to slow down, not ramp up, its enforcement. And DEA became afraid to use its strongest enforcement tool: the immediate suspension order.

The ISO was a tool for immediately halting the shipments of opioid controlled substances sent by a distributor to a pharmacy. During my time at DEA, it seemed to me that these larger pharmaceutical corporations and industries were not interested in doing the right thing, at least until their profits were hurt and their names were being tied to the opioid epidemic in the headlines.

Soon after, DEA began losing more and more attorneys recruited over to represent the industry. When these attorneys left for the industry, they brought with them an intense and brilliant understanding of DEA regulations and case law. I believe this brilliance and understanding, now representing some of the largest DEA registrants in the country, was what DEA began to fear. This was, to my understanding, what caused much of the slowdown in DEA enforcement.

It was, to my knowledge, a former DEA attorney who drafted the Ensuring Patient Access and Effective Drug Enforcement Act which stripped DEA of the ISO. While DEA attorneys feared that a bad decision in Federal court might strip DEA of the ISO, Congress effectively legislated the ISO away, ostensibly in the name of

ensuring patient access to opioid controlled substances. Without the ISO in its tool belt, DEA will likely have little effect enforcing regulations against manufacturers, distributors, and large pharmacy chains who, in my experience, only ever seem to listen when it hurt their bottom line. Ensuring patient access is a misleading description painting the picture of an altruistic industry only concerned with saving lives and easing pain.

While we may not consider corporations to be people, there is simply no such thing as an altruistic corporation. And by limiting DEA's ability to enforce its regulation and the CSA against these pharmaceutical corporations, we have effectively condoned the poisoning of our populous, and ushered in the loss of an entire generation to highly addictive and deadly drugs.

According to the CDC, 80 percent of heroin users in America today got their start on opioid painkillers. Overdose deaths in America are at an all-time high, making the heroin epidemic of the 1970s and the cocaine epidemic of the 1980s look tiny in comparison. We are killing our own people, and DEA is falling down on the job. This is an epidemic that focuses on no race, no gender, no socioeconomic classification, because it affects them all.

Everyone has a story of a loved one injured on the job now living a life of addiction, pain management, and unemployment, because their doctor kept increasing their prescribed dosage, or of a student injured in a high school football game prescribed opioids by a well-intentioned physician, and now in jail for possession of heroin or dead of an accidental overdose.

Significant damage has been done not only to those who now are addicts, but to our communities, our workforces, and our economies. Old methods of treatment are failing in the face of this long-term physical and biological addiction. And yet, these pills seem easier and easier to find and harder and harder to avoid. We need to focus on changing the laws, restoring DEA's ability to enforce, and looking at funding to educate our population, and to help those already addicted to fully recover and become productive members of our society again. We need to focus on local law enforcement and legal actions by States and counties. All of this starts with effective enforcement to shut off the overflow of opioids into our communities.

And thank you very much for this opportunity today.

Mr. BARLETTA. Thank you for your testimony, Mr. Novak.

I will now begin the first round of questions limited to 5 minutes for each Member. If there are additional questions following the first round, we will have additional rounds of questions as needed.

Mr. Denk, The Center for Rural Pennsylvania has done a lot of work for the Pennsylvania General Assembly. It seems the impact of the opioid crisis on the workforce is significant.

From the information the center has gathered, can you highlight how opioid abuse has created barriers for attracting jobs? And how will the general assembly use the information you have collected to address this issue?

Mr. DENK. We have heard from a number of testifiers, particularly those in recovery, where prior felony convictions still linger for them, not just in employment opportunities, but with regard to

housing itself. And so I know my boss, Senator Gene Yaw, is looking at that issue.

There is concern that those felonies, while committed because somebody was addicted to a substance, need to be looked at. And at some point in time, maybe that can be removed from their record.

We heard from one young individual in Greensburg, Pennsylvania. Started the path into drugs at age 13 because of her home environment. And she eventually went to heroin. She committed two felonies by the age of 20. That woman turned her life around completely. She now has a master's degree, and she now works for the Allegheny Health Network as an addictions counselor, helping individuals. Those two felony convictions still linger on her record. And she has been turned down for housing because she reports, yes, I have been convicted of two felonies.

So we have heard that. We have heard from employers, particularly in the gas industry, which is important to Pennsylvania's economy with the drilling, of individuals who fail to pass some drug tests. We heard at one of our hearings in Williamsport where the local single county authority, the agency that provides treatment services, they are meeting with employers and developing a list of employers who are willing to give a second chance to an individual who may have had a substance use disorder, may have had some kind of criminal activity as a result of that.

We also heard from a number of judges about the effects of drug courts and how helpful they are, and somebody who has committed a crime but needs to turn their life around. And so we are looking to expand drug courts across the Commonwealth.

Currently, out of 67 counties, only 38 drug courts exist in those counties. There are a number of things that are being looked at to further document the question that you raise and take a look at from a legislative standpoint as to what might be done.

Mr. BARLETTA. Thank you.

Ms. Hale, Operation UNITE has done a lot in eastern Kentucky and has become a resource for other communities.

What types of programs have you found to be the most impactful in addressing the opioid crisis? And are there models that other States like Pennsylvania can use?

Ms. HALE. I think our education prevention programs have had the greatest impact. We have seen and heard anecdotal evidence from some of our summer interns who were students in college share that, on their college campus in attending frat parties and sorority parties, where there, unfortunately, is a great deal of alcohol and drugs being used at the parties, the students have noted that there are a number of students who do not engage in those activities, and then they begin noting that those students were from eastern Kentucky, and have grown up for the last 10 to 12 years hearing about substance abuse, being trained in making healthy choices and things such as that. We are seeing an impact on that generation.

Also, we are seeing an impact in our program in working with the administrative office of the courts through our drug court programs. We are learning that drug courts do work. There are many people who are in recovery who make excellent employees because

of what they have endured, what they now understand, the structure that has been brought into their lives through the drug court programmings.

Education and prevention. We have a mobile prevention unit that we target 7th and 10th graders. That has had a huge impact. The University of Kentucky compiles the data from the pre- and post-surveys with that program. We also have programs that we are taking into the elementary schools where we are introducing young people at an early age to the dangers, the harms, preparing them with knowledge, helping them make healthy decisions, even as early as third grade.

And then, of course, our AmeriCorps program. We have 54 AmeriCorps members serving in 13 counties in our district. And those AmeriCorps members work primarily on math tutoring. But they also are introducing a Too Good for Drugs curriculum that impacts the parents, the staff, and the community in prevention initiatives.

Mr. BARLETTA. Thank you.

The Chair now recognizes Mr. Johnson for 5 minutes.

Mr. JOHNSON. Thank you, Mr. Chairman.

Mr. Denk, you have testified that alcohol and drug treatment funding has been cut by 25 percent, while requests for service have quadrupled since 2014.

Mr. DENK. Yes, sir.

Mr. JOHNSON. Have you identified either Federal or State funds that could reverse those cuts in future fiscal years?

Mr. DENK. That testimony came from one of the single county authority directors, who specifically gave those statistics. There is hope that at the Federal level, there might be some funds that would be earmarked, additional funds that would be made available. The CURE's [Commonwealth Universal Research Enhancement program] grant. Pennsylvania received about \$26.5 million under the CURE's grant from the Federal Government to deal with drug addiction and treatment services. Also, the Pennsylvania General Assembly, our budgets are extremely strapped, but I know there is interest in looking at expanding treatment options. There was over \$30 million provided in the State budget to set up what we are calling Centers of Excellence around the Commonwealth. So there has been new money provided at the Federal and State levels to support treatment programs.

Mr. JOHNSON. Well, are you fearful that the passage of the tax cut bill that is pending before Congress now will have an adverse impact on the ability of the Federal Government to fund these grants that have been insufficient in the past?

Mr. DENK. I really can't speak to that, sir, quite honestly, in terms of not knowing all the details of the tax cut bill. I think, you know, priorities need to be made in terms of what works best for the Nation as a whole. But, quite honestly, I have not looked at the specifics of the tax cut bill.

Mr. JOHNSON. Well, let me ask you this question.

Mr. DENK. Sure.

Mr. JOHNSON. Do you anticipate that future healthcare cuts based on changes in Federal healthcare laws and regulations, such as the repeal of the Affordable Care Act, also known as Obamacare,

do you think that that could have an impact on the ability of those seeking treatment to get drug treatment?

Mr. DENK. If funds are cut serving Medicaid-eligible individuals who are in need of drug treatment, then there will be challenges that present themselves for those individuals. We have found community foundations and others stepping up to the plate and helping out in terms of providing services for indigent individuals. Time will see as to what impacts at the Federal level that filter down to the State play out for those audiences, sir.

Mr. JOHNSON. Well, thank you.

Ms. Hale, in your testimony, you state that the second pillar of addressing the opioid epidemic is treatment.

Has the Affordable Care Act, also known as Obamacare, affected the ability of residents of Kentucky to get treatment for drug addiction?

Ms. HALE. Has it affected the ability? I probably can't address that properly.

Mr. JOHNSON. Let me ask it this way then: Have there been opportunities for people to get treatment in Kentucky for drug abuse and drug addiction, because they had access to the healthcare system through the Affordable Care Act, and the State's expansion of Medicaid under the Affordable Care Act?

Ms. HALE. There have been opportunities, I am sure, that that has resulted. One of the things that UNITE did before is, in providing the vouchers for people who did not qualify, did not have private insurance or Medicaid, to enter long-term rehabilitation.

Mr. JOHNSON. Well, do you worry that a withdrawal of Federal resources from social services can adversely impact the ability of people to get treatment for drug abuse in Kentucky?

Ms. HALE. I think our communities are rallying, our State is rallying around to fit those needs. What I would be concerned about is if the system could handle all of that.

Mr. JOHNSON. I know it is a political football, but we got to get away from politics and start looking at how we help people, and whether or not Federal policies are helping.

Now, Mr. Novak, what is the historic role of the DEA in stopping the flow of suspicious drug shipments in Appalachia?

Mr. NOVAK. Historically, that was exactly the purview of what DEA was doing nationwide. Appalachia was especially hard hit. And, you know, the problem is the suspicious orders are to be monitored and reported by registrants. DEA has historically been, you know, reactive, not proactive, because there are suspicious orders going into West Virginia, in a town of 925 people, that is getting 9 million oxycodone pills, and that is not reported to DEA. DEA then finds out about things like that, and can go in and try to shut them down.

But, you know, that is exactly what DEA relies on in putting together its cases and trying to have a registrant, like a distributor or a manufacturer, monitor what is going out. Unfortunately, historically, we found that they weren't and they were just pushing orders of that size into regions with no concern whether or not that order was suspicious.

Mr. JOHNSON. Thank you. My time has expired.

Mr. BARLETTA. Again, just a reminder that our committee's jurisdiction is not a healthcare policy or DEA enforcement. We want to find solutions that we can act on as this committee.

The Chair now recognizes Mr. Mast for 5 minutes.

Mr. MAST. I want to thank you for the time, Mr. Chairman.

This epidemic is something that greatly affects my region in Florida, as well as it does many other areas of the country. I have three beautiful children. I literally couldn't imagine this being something that affects my family. I have a very good old military friend of mine I speak to reasonably often, and he lost his son. So it is something that touches close to home for me.

I just want to ask a couple of questions quickly, just a little bit of fact-based questions here. What are the quantity of opioids that are obtained legally versus those that are obtained illegally that are relating to whether an overdose or an overdose resulting in death? What are the statistics that we are looking at comparatively, whoever can answer that?

Mr. NOVAK. I can at least start with that. The problem that we are seeing in this epidemic is that you can't get the pills, for the most part—every pill that is getting out on the street was prescribed by a doctor, filled by a pharmacy.

The problem is the people who are overdosing aren't just people abusing. The directions for taking your oxycodone, it is not a one-size-fits-all. Addiction can be caused as quickly as after a 10-day program of opioids. There is a 20-percent chance you are addicted a year later.

The overdoses are happening, not just from abuse, but from standard use, because I don't believe that our medical community is nearly as informed about the dangers of these or the potential for overdoses as they need to be.

Mr. MAST. Certainly. But do you have a number saying this is how many opioid deaths or overdoses that were treated that are as a result of somebody that filled the prescription that was assigned to them, or somebody that purchased it secondhand from somebody else? That is what I am asking.

Mr. DENK. Sir, I am not aware that that information is available in Pennsylvania.

One of the challenges would be is, who collects that data. If it is stolen medication or taken out of a house, whether law enforcement gathers that information, the county coroner upon autopsy or a hospital, there could be a number of organizations involved in dealing with that death from an overdose. And, so, the data analytics on that is challenging to get.

I have one statistic for you, but it doesn't distinguish your specific question. This is from the U.S. Drug Enforcement Administration in a report in July of 2017 for Pennsylvania.

"In 2016, the presence of an opioid, either illicit or prescribed by a doctor, was identified in 85 percent of drug-related overdose deaths." So whether it is illicit or actually prescribed, opioids are still a major, major player, obviously, in overdose deaths in Pennsylvania.

Mr. MAST. Very good. Thank you for your response.

What is the most commonly used opioid for overdose? Is it methadone? Oxycodone? Hydrocodone? Fentanyl? What ranks as the

number one drug within this epidemic, or number two. You can give me a couple.

Mr. DENK. In Pennsylvania, it is a mix. Oxycodone. But we are seeing because of Pennsylvania now has in force for a couple years, our prescription drug monitoring program, which is cutting back dramatically on opioid prescriptions out on the streets, illicit or otherwise. The presence of fentanyl, increasing deaths in Pennsylvania due to fentanyl.

Mr. MAST. So are you saying that filled the gap that was created by enforcement elsewhere?

Mr. DENK. I am not sure that it filled the gap. I think those that are in the drug-dealing business can make more money by mixing fentanyl into their heroin. The person who uses it has no idea of the purity of that heroin. And that, because of the PDMP [Prescription Drug Monitoring Program] being in place and controlling opioids, it was predicted that we would see a rise in heroin use and overdose deaths. But now with the influx of fentanyl, what we are seeing is a major cause of overdose deaths now in certain counties.

Mr. MAST. Thank you for your responses. This is undoubtedly something that we all need to find the absolute best way to work together on this across the States, across the Federal Government, across every locality to combat this.

I thank you for your responses, and I yield back, Mr. Chairman.

Mr. BARLETTA. Thank you. I ask unanimous consent that members not on the subcommittee be permitted to sit with the subcommittee at today's hearing and ask questions.

The Chair now recognizes Ms. Norton for 5 minutes.

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

I thank you for calling this hearing. Of course, it focuses on Appalachia. We know that opioids are a problem throughout the United States. It is interesting how drugs tend to find their favorite places, and the link between opioids and heroin and how that is playing out. But this is particularly bothersome, because we find opioids here in Appalachia where there is, to begin with, poor education, low income, often rural areas, the last place that needs this kind of epidemic. It is really heartbreaking. Opioids, of course, the difference between opioids and heroin is that ain't nobody prescribes heroin. Initially, opioids are prescribed and then they become a kind of rogue drug.

What interested me was to note that the Chamber of Commerce in Pennsylvania has seen a link between employability and the skills gap and this opioid crisis. And I am wondering, in light of a survey that has been cited to us, for example, that businesses find that over 20 percent of applicants, or their potential new hires, often fail a drug test.

So I am interested, Mr. Denk, in what your legislature is doing, given what appears to be an effect on the economy itself and on getting people who might otherwise be employed a job.

Mr. DENK. There has been no legislation with regard to the issue of the business and industry with employers in terms of their right to issue, you know, drug tests on individuals. That—

Ms. NORTON. I understand their right, but they are having to do it because they suspect so many of those who are applying for jobs have been caught up in this crisis. And I wonder if the legislature

has found any way to address this problem of employability with an ultimate effect on your economy——

Mr. DENK. Sure.

Ms. NORTON [continuing]. In Pennsylvania.

Mr. DENK. Ma'am, no short-term answers. No quick fixes. I think it has been recognized, certainly from the public hearings that we have held across the Commonwealth, education on prevention, and education starting at the lowest levels. And we heard this from the UNITE program. That has been seen as the long-term fix in this long-term crisis.

Ms. NORTON. So if people are better educated, or they are not caught up in this opioid crisis, and they can pass the drug test, and it is basically poor people that are involved. If it is a question of education, is the link between education and employability such that you can get a hold of these people once you try to get them off of the drug and deal with the education problem at the same time?

Mr. DENK. Yes, ma'am. Pennsylvania implements what is called a PAYS study. Pennsylvania Youth Survey. It is done every year. And that measures attitudes, behaviors, influences of youth in 6th and 10th and 12th grades.

We are seeing individuals coming from family members where parents are approving marijuana use. They would rather them do that, or they would rather them drink in the home as opposed to going outside. So with this whole education, it is getting in early and changing attitudes and behaviors and mindsets. It is going to be a long-term solution.

Ms. NORTON. I want to ask this before my time runs out.

Mr. DENK. I am sorry.

Ms. NORTON. I appreciate that answer. I want to ask Mr. Novak a question. Because I am wondering, why this problem has grounded itself in areas like Appalachia, whether or not the DEA had a role in stopping this kind of entrenchment at any time, and when did it become so entrenched, and why did it become so entrenched in an area like this?

Mr. NOVAK. First of all——

Ms. NORTON. I want to know all I can to keep it from becoming entrenched in the big cities.

Mr. NOVAK. And, you know, what we are seeing now is it is becoming entrenched everywhere, or rather, it has become entrenched everywhere. It is a problem that we didn't recognize until it was far too late. Poor areas or isolated areas, they found a market for these kinds of drugs, because they seem to be valid because a doctor is prescribing you. And if a doctor is prescribing it, it must be good for you. But it is also, you know, that almost gave people a pass. "Well, I am not abusing, I am just using what my doctor prescribed to me for my pain management."

DEA, again, you need to look at the fact that there are divisions around the country and the larger an area and the bigger the population and the more funding that that division has, you know, the more proactive they could be. And unfortunately, some of the worst problems I saw at DEA were cases coming out of areas that nobody cared about until it was too late.

I know Florida, for instance, got hit devastatingly with all of this, but it was always in the smaller towns, a little farther away. You know, it wasn't Miami, it was Oviedo. And that is where this all took route. It took route with the populous that, you know, could get these drugs for much cheaper at the time, and then felt validated in using them. Again, it is staggering how addictive these things are, and 2 months of being on an opioid, suddenly you are addicted. And it just escalates and escalates.

Ms. NORTON. Thank you, Mr. Chairman.

Mr. BARLETTA. Thank you. The chairman now recognizes Mr. Faso for 5 minutes.

Mr. FASO. Thank you, Mr. Chairman. I appreciate the witnesses being here today on this topic.

I am wondering, Ms. Hale, if you could tell us what you think it would take to replicate the type of program that you are operating in Kentucky around the country, and what kind of funding streams have you been able to—you or others—been able to postulate? Maybe even Mr. Denk may have some ideas in that regard as well.

Ms. HALE. To replicate the holistic approach that Operation UNITE, when we first began, when Congressman Rogers launched the program, we had Federal grants from the Department of Justice working, starting out with about \$12 million and in receiving other grants, you know, like our AmeriCorps grant, funding from ARC, that sort of thing.

Mr. FASO. So, in other words, you would cobble together, whether they were specific appropriations that Mr. Rogers was able to secure, or specific funding streams from other agencies, cobble that together to run your program?

Ms. HALE. Correct. The State support that we receive now allows us to keep our doors open somewhat. One of the things that we have done is developed community coalitions within every one of our 32 counties. These are people in that county who are volunteers who serve. They have their own nonprofit status, and they are working to secure grants and funding. We have several drug-free community grants in our area that we are working with those areas as well.

Mr. FASO. So I guess our task is to find out how we can maybe combine some existing Federal funding streams together with perhaps some new efforts in order to attempt to replicate these efforts around the country.

You had mentioned that you had also been able to fund vouchers, you said, I think, 4,000 vouchers, for people to get substance abuse treatment. I guess that would be short- and/or long-term.

Ms. HALE. No, sir, we only fund long-term treatment.

Mr. FASO. Long-term. And so where did you get the money for that?

Ms. HALE. Starting out, that money came from SAMHSA. The Commonwealth of Kentucky supports that. We use the proceeds from the National Prescription Drug Summit. We also had a lot of buy-in from businesses and organizations, such as Kentucky River Properties gave us \$500,000, because they understood the need for helping their employees who were suffering from substance abuse, get into long-term treatment.

Mr. FASO. Yeah, I would think, in line with what you just said, that it would be important for us to try to not just simply let people think that there is one source of funding for this from Washington, but combining sources from States, localities, but also the private sector. Because I think that if everyone has some skin in the game—Mr. Denk, did you have something to add in that regard?

Mr. DENK. Not on the scale of Operation UNITE, but there is an entity in Williamsport, Pennsylvania, called Project Bald Eagle. Similar concepts, doing a lot in the area of prevention and education, nothing in the area of treatment.

Their core funding came from higher education, the healthcare system and the Chamber of Commerce. They all kicked in \$25,000 apiece to jump start what's called Project Bald Eagle. So I think there is local money to be had. There is community foundation funding. I think as long as there is a solid game plan, local investment can occur, and certainly, if that can be piggybacked and parlayed with other moneys, Federal, State, I think you get a greater return on investment.

The investment, as has been demonstrated, must be owned at the local level.

Mr. FASO. Yes. And I think that is a very important point that you just made.

Now back to you, Ms. Hale. Again, you mentioned that you conduct drug-free workplace training that is a State-certified training, I think you said. How prevalent is that among the States? Do all 50 States have such programs or is this unique to your area?

Ms. HALE. I don't know if all the other States have that program. It has been unique to our area in Appalachia, simply because before UNITE, we weren't aware of any drug-free workplace training that was taking place.

Mr. FASO. Thank you. I think, Mr. Chairman, the fact is that we are seeing, right now, among the lowest workforce participation rates of able-bodied people between 18 and 65. And this, in line with what the Pennsylvania study suggested, is really a prevalent problem that exists all across the country.

In my district, I have counties that have under 60 percent workforce participation rates of people between 18 and 65, and I think opioid and drug abuse is a major part of that. And I appreciate your convening this hearing, and I appreciate the witnesses being here today on this topic. And I yield back.

Mr. BARLETTA. The Chair recognizes Mr. Smucker for 5 minutes.

Mr. SMUCKER. Thank you, Mr. Chairman, for the time. I appreciate it.

Mr. Denk, thank you for your testimony. Welcome to Washington, DC.

Mr. DENK. Thank you. My pleasure.

Mr. SMUCKER. It is great to see you.

Mr. DENK. Thank you.

Mr. SMUCKER. As you know, I am also from Pennsylvania, served in the legislature and State senate for 8 years, and so I am familiar with the work of your organization. You have been a tremendous resource to the legislature in Pennsylvania. And, Senator Yaw, the chairman, is a good friend. In fact, I sat next to him in our caucus

for much of the time that I spent there, so really great to hear from you.

Mr. DENK. Thank you.

Mr. SMUCKER. Senator Yaw, I know, and your organization did a lot of work, hearings all across the State, really bringing an awareness to this issue a number of years ago when you started the work that was so valuable to all of us. And we have had a lot of conversations in caucus in the State senate in regards to how we can respond. And, you know, just the magnitude of this is hard to imagine at times. And just repeating what you said in your testimony, 4,642 Pennsylvanians died in 2016 as a result of a drug overdose with thousands more affected by addiction, either personally or through family, friends, coworkers, employees or neighbors. That was an increase of 37 percent from 2015 when, as you mentioned, 13 people died each day of a drug-related overdose.

Just specifically, my area in 2016, my district includes portions of three counties, Lancaster averaged 22.3 deaths per 100,000 people; Chester County averaged 19.4; and Bucks County, 28.4 overdose deaths per 100,000 people. It is just absolutely devastating to our communities.

One of the takeaways that I always heard from Senator Yaw, and you mentioned here this morning, is there are no simple short-term solutions. In fact, there is no silver bullet here to solve this. And, you know, we think it can be solved but it will take a number of solutions, a broad range of solutions, from enforcement to treatment to—you mentioned drug courts, which have been particularly effective in my area.

We did a number of pieces of legislation at the State level as a result of the hearings that you have done. One of those you mentioned was a prescription drug monitoring program. And as with any new program there was pushback. It, of course, was additional work for every party, you know, including medical doctors, pharmacies and all. But I am curious, how well do you think it is working, and are there ways that we should improve a program of that type?

Mr. DENK. Thank you. The office of the PDMP is right next door to my office, so I do meet with them on a regular basis. It is working in Pennsylvania. I don't have the figure in front of me, but I know that the director has talked on numerous occasions about the thousands of pounds of opioids that have been stopped because of the PDMP and the doc shopping that was occurring. And so that has been critical.

There is interest in revisiting the prescription drug monitoring program to tighten it up a little bit. We had one doctor who oversees a residency program, and he would like language that allows someone to query the querier, kind of a checks and balance as to who is checking into the system and using it, that type of thing. Some comments that we have heard that dentists should be required to subscribe to that. Dentists prescribe opioids. And from a medical standpoint, often opioids are not what is needed to deal with pain from a dental procedure.

So there is interest in reopening it. As you know so well, you open any piece of legislation, and it is ripe for a lot of other things to be taken a look at.

Mr. SMUCKER. And sorry to cut you off, but I am running close to the end of my time.

I am curious, from your perspective, what is it that we could do at the Federal level to help? What would be your number 1, number 2 things that we should be—specific actions that we can do to help communities combat this?

Mr. DENK. The public face of this epidemic, I think the Federal Government can play an even greater role in recognizing that it is an epidemic affecting all segments of our society, and has direct impact on the economy, on infrastructure, you name it.

I think a much stronger face and getting Federal agencies, and I see this in Pennsylvania, and State agencies, to really work together. Unfortunately there is still too much siloing in our work to address this epidemic.

Mr. SMUCKER. Thank you. Mr. Chairman, I have additional questions. Do you want me to wait for the second round?

Mr. BARLETTA. Yeah, sure.

Mr. SMUCKER. Thank you.

Mr. BARLETTA. I will now recognize each Member for an additional 5 minutes of questions.

Mr. Gohl, the ARC is a Federal economic development agency. How did the problem of opioids get on your radar, and do you think ARC's programs are good templates for other Federal economic development agencies, such as the EDA, and if so, how?

Mr. GOHL. Thank you, Mr. Chairman. I think that, a couple things. In our work within the region, this clearly became an issue within several communities.

And you know, part of the work of Operation UNITE has a little bit of magic about it, because it is not just the money, but it is the leadership, and the long-term leadership. And the effort and the work that Congressman Rogers has put into growing Operation UNITE is a lot of the reason for its success and its recognition.

And not every community has a Harold Rogers to be there all the time pushing, pushing, pushing, challenging people like me. And that is an important part of it. So, you know, giving money to folks is one thing, but having leadership pays huge dividends.

In terms of our experience, in one of the research projects that we did back in 2008, the data showed that Appalachia was leading the Nation in the hospitalization as a result of prescription drugs. And that really was a surprise to us. That really got our attention. In working and talking with Congressman Rogers and his staff around an agenda, we got to a point of developing and working with Operation UNITE to do a national prescription drug abuse summit and to take a role in terms of education—the extended education—as our contribution to the summit.

And I think that really, for us, put us in a position where we weren't just supporting a conference, but we were supporting education and the development and strengthening of the workforce. That is where we felt pretty comfortable. And clearly, as you look at our plans and look at our strategies, developing and strengthening the workforce is a critical area of our work.

The other thing I would say is that we currently have a partnership with NIDA, the National Institute on Drug Abuse, where we, with CDC and a couple agencies—but NIDA is really the lead—are

working in five different communities, or five different initiatives around the region to focus on community-based solutions to treatment and prevention of substance abuse.

And we are very hopeful that that evidence-based work would really provide some direction and some really strong guidance for going forward.

Mr. BARLETTA. And what would help ARC's work on opioids be more effective?

Mr. GOHL. You know, I would say that a seat at the table is probably the most effective thing that works in this town, that when ARC is part of the discussion, or ARC is part of the development and ARC is part of hearings like this, it makes sure that the rural voice is heard. And oftentimes, I think you just heard one of the witnesses talk about that nobody really knew. Well, it is collecting data and making sure that the rural communities are part of the discussion is often the biggest part of the challenge. And so, it is hearings like this; it is being a part of initiatives and work, not only in the Appalachian region, but to partner with other folks who are doing work outside the region is very helpful. I think that our partnerships with CDC, and NIDA in particular, over the last few years, has given us, not only resources, but it has also given us a place and a voice to raise the issues of Appalachia and the challenges that we have.

Mr. BARLETTA. And what is the role of ARC in helping to address the opioid problem?

Mr. GOHL. I think we have several roles. I think that it is important for us to work with our State partners who really are the agenda setters for the Commission in terms of investment of dollars, to work with them and make sure that the issue of opioids in the workforce and how it affects communities is a challenge that they focus on and that they use the resources to invest in.

I think that we need to continue to work around community organizations and being able to empower them and give them the tools. I think it is important for us to invest in initiatives like NIDA as a way of really getting to strategies that work. There is no reason to invest in strategies that don't work.

I think part of the ongoing effort right now is around social media, and how do you use social media as part of this? Social media just consumes us all, and it is a way of communicating. It is a way to share challenges and issues. And I think as you go forward, we are going to learn more about effective strategies for how do we communicate. Groups like Operation UNITE can engage their communities. It is not just a matter of "just say no." It is really a matter of these are the reasons, these are the challenges we face, and to be able to drill down and get people to understand the challenges and the dangers that they are facing.

And I think one of the other issues that we really need to focus on is making sure that people understand that this is a disease and that we need to treat it like a disease. And, you know, this country has faced a lot of diseases over the years with polio, or small pox, or the flu, or HIV/AIDS, and we defeated each one of those. And the challenge is to look at the history and look at what has worked in the past and how do we move forward to make sure that we defeat this disease as well.

Mr. BARLETTA. Thank you. The Chair now recognizes Mr. Johnson for 5 minutes.

Mr. JOHNSON. Thank you. Mr. Gohl, given the Appalachian Regional Commission's efforts to address the opioid epidemic in Appalachia, if the President's fiscal year 2018 budget recommendation to eliminate the ARC were affirmed by Congress, what other Federal agency would be able to meet the needs of Appalachia?

So in other words, if the Appalachian Regional Commission ceases to exist, as is called for under President Trump's 2018 budget, what would be the effect on Appalachia, and on the drug epidemic that ravages America and Appalachia?

Mr. GOHL. You know, ARC over the last number of years has been very focused on creating opportunities, changing the level of education, working, you know, very deliberately for the region to be on parity with the rest of the Nation in terms of socioeconomic—

Mr. JOHNSON. Well, let me ask you the question this way. I really want to get a yes or no, a quick answer.

Will the defunding and the removal of the Appalachian Regional Commission from the Federal budget, that would hurt Appalachia, wouldn't it? Yes or no?

Mr. GOHL. Mr. Johnson, I have a great deal of respect for you, and I appreciate your work—

Mr. JOHNSON. And I really just want to get—I am not trying to be political. I am just making a point. I think it is a fair point. Because what we do up here, the Federal policies that we enact up here have an impact back at home, back on the streets. People pay taxes, people deserve a fair deal. When they pay in, they should get a return on it.

So when we start talking about giving tax cuts to wealthy individuals, multinational corporations and the like, it has an impact on people on the street who are paying taxes. And when we have a proposal to eliminate the Appalachian Regional Commission because we are spending too much money and the Federal Government has to cut its deficit and debt, so we sacrifice the Appalachian Regional Commission because we want to give tax cuts to the wealthy. I mean, that is a fair point, I think, for me to make and for me to ask you. And I am just asking you what the impact of that policy would be on the Appalachian region? And this is what I was talking about in terms of us being honest and not playing politics, and let us really look at the impact of our policies on how it affects people in Appalachia. That is the only thing I am trying to do.

And I know that you don't want to answer the question. It is hard to—the truth hurts. And that is the bottom line.

Mr. GOHL. Sir, I would say this: Every year we release a document that talks about what we did. And the document talks about the number of folks we educate, the number of jobs we help folks create, and if ARC isn't here, we are not going to issue that report any longer.

But in all fairness, Mr. Johnson, the support that was vocalized in March of this year by a bipartisan group of Members about ARC, which was really very impressive, and what we did was we got to work on doing our jobs, of taking the funds that the Con-

gress provided us, and worked diligently every day to focus in on our work and what Congress told us to do.

Mr. JOHNSON. Well, if those funds went away, it would hurt the people of Appalachia, who I really feel for, suffering and pain and no hope about the future. And I believe that there is something that the Federal Government can do, should do, and must do in order to help the people of Appalachia and the people throughout this country who are suffering and looking for a better deal from their Government. And with that, I will yield back.

Mr. BARLETTA. The Chair recognizes Mr. Smucker for 5 minutes.

Mr. SMUCKER. Thank you, Mr. Chair.

Ms. Hale, impressive program, it sounds like, in your community. For the benefit of our communities who are interested in similar initiatives, how important were the coalitions that you built within the community, and who should be at the table for that?

Ms. HALE. The coalitions are really the foundation of Operation UNITE. Those people within those communities from all sectors, whether it is education, law enforcement, treatment, faith-based. Every one of them lives in those communities, they understand the problems and they are looking for the solutions themselves. They are the ones who are motivated to work within their communities. They are the ones who are motivated to look for sources of funding and not depend totally on the Federal Government. However, the Federal Government has done things, just like CARA has brought a renewed sense of hope into our Commonwealth. We are looking at programs that will allow us to be more proactive rather than, as Mr. Novak said, you know, we have had to react for so long.

And so those coalitions are the grassroots of what we are doing in Operation UNITE, and throughout the Commonwealth.

Mr. SMUCKER. How do you measure success? And maybe talk a little bit about how success for your program has been. What are some of your key performance indicators, if you will?

Ms. HALE. Well, one of the ways that we measure success is taking, for example, the vouchers that we have provided to over 4,000 residents, and looking at the followup, coming back, you know, when they are coming out of long-term recovery, moving back into their communities. UNITE follows that with looking at how we can support them, how can we work with our administrative office and the courts to help them find jobs, to build the economy.

The University of Kentucky is helping us collect data on each one of our programs to show the success. Some of our success has been anecdotal, but then, we are looking at developing those programs, our educational programs that we can use, evidence-based, we are using evidence-based programs to find those solutions.

Mr. SMUCKER. I will ask the same question I asked Mr. Denk. What is it that we could be doing at the Federal level to better help? I know funding is one. Is there anything else?

Ms. HALE. I think looking at programs that will be proactive. One of those that Kentucky is looking at this year with our legislators is developing an essential skills bill. We are working with the Kentucky Chamber of Commerce, our business and industry, and our education system to develop K through 12, helping young people develop those skills that they are going to need for them to be effective members of the workforce. And included in that essential

skills bill is going to be a huge prevention component in educating them on how to be drug free.

Mr. SMUCKER. Thank you. It sounds like you are doing great work. I really appreciate all of you taking the time to share with us the good things that are happening in your communities.

Mr. BARLETTA. Thank you. I ask unanimous consent to enter into the record a statement of Congressman Tom Marino. Without objection, so ordered.

[The statement of Congressman Tom Marino is on pages 28–30.]

Mr. BARLETTA. Thank you all for your testimony. If there are no further questions, I would ask unanimous consent that the record of today's hearing remain open until such time as our witnesses have provided answers to any questions that may be submitted to them in writing, and unanimous consent that the record remain open for 15 days for any additional comments and information submitted by Members or witnesses to be included in the record of today's hearing.

Without objection, so ordered.

I would like to thank our witnesses again for their testimony today. If no other Members have anything to add, the subcommittee stands adjourned.

[Whereupon, at 11:36 a.m., the subcommittee was adjourned.]

Statement of Congressman Tom Marino (PA-10)
Transportation and Infrastructure Subcommittee on Economic
Development, Public Buildings, and Emergency Management.
The Opioid Epidemic in Appalachia: Addressing Hurdles to Economic
Development in the Region
Tuesday, December 12, 2017 at 10:00 a.m.

Chairman Barletta, Ranking Member Johnson and other esteemed colleagues, thank you for offering me the opportunity to submit a statement for the record today on my legislation, the *Ensuring Patient Access and Effective Drug Enforcement Act*.

As this Committee is aware, I was nominated to be the next Director of the Office of National Drug Control Policy, or ONDCP. Following an expose by the Washington Post and a report on 60 Minutes, I withdrew my nomination so that I would not be a distraction to this Administration in the fight against the opioid epidemic. I am here today to correct the record on these reports filled with flat out untruths and false statements.

One particular detail that 60 Minutes failed to inform their audience of is that one of their star sources, Jonathan Novak, who is testifying today, currently works as a lawyer handling “DEA Regulatory and Compliance Consultation and defense.” At the bare minimum this shows a severe conflict of interest and a disturbing bias.

In 2012 I visited with pharmacies in my district where I learned that it was becoming difficult for legitimate patients to access needed medication. I directed my staff to do some research on the issue and find out more regarding the supply chain. I wanted to learn more about why the opioid problem was worsening and yet individuals suffering with pain were unable to access medications.

One problem I identified was that the term “imminent danger” was not defined in the Controlled Substances Act. The Government Accountability Office (GAO) in 2015 also issued a report stating that there needed to be more clarity regarding DEA authorities. Utilizing this vague, undefined language the Drug Enforcement Agency’s Office of Diversion Control overzealously utilized suspension orders and ran roughshod over the will of Congress and Justice Department leaders.

In particular, the leader of the Diversion Control Office, had shown a particular cavalier disregard for the rule of law. In a public setting, when asked specifically what the Controlled Substances Act term “imminent danger to the public health and safety” meant, his response was “whatever I think it means.” I found this to be a completely irresponsible and unreasonable answer.

In response to these concerns, in the 113th Congress I introduced the *Ensuring Patient Access and Effective Drug Enforcement Act*. This legislation for the first time aimed to define “imminent danger to public health and safety,” similar to other laws like the *Mine Safety Act*, where the term is well defined.

Following introduction, the House Energy and Commerce Subcommittee on Health held hearings, the Energy and Commerce Committee reported the bill by voice vote to the House of Representatives, and it was passed by the House of Representatives by voice vote.

In the 114th Congress I again introduced this legislation. The Energy and Commerce Committee held a hearing, it was reported favorably to the House of Representatives, and passed the House of Representatives by a voice vote.

In the 114th Congress, Senators Hatch and Whitehouse introduced their version of the legislation. The bill was reported out of the Senate Judiciary Committee, passed the Senate by unanimous consent, passed the House by unanimous consent, and was signed into law by President Obama.

My legislation defined “imminent danger to the public health or safety” as a “foreseeable risk of serious adverse health consequences or death,” which would have had little impact on DEA enforcement. In the Senate version, which became law, this language was changed to a “substantial likelihood of an immediate threat that death, serious bodily harm, or abuse of a controlled substance will occur,” a much higher burden. This change was made at the request of the DOJ.

Throughout the entire process my office and Senator Hatch’s office worked closely with the Department of Justice and the Drug Enforcement Agency to find acceptable language. When the legislation was finalized in the Senate, both the DOJ and the DEA had signed off on the final language. After the legislation was passed, there was no objection by the White House or any Agency and the bill was signed into law.

Several Congressman and Senators have come forward and attacked my motives and integrity following the media reports. Every single Member of Congress had plenty of opportunity to provide input or stop this legislation when it was going through the regular legislative process, nobody said a word. Instead, they voted in favor of this legislation.

Before becoming a Congressman for the 10th District of Pennsylvania I served as a prosecutor for 18 years, first as a District Attorney for Lycoming County and then as U.S. Attorney for the Middle District of Pennsylvania. I worked tirelessly to prosecute drug dealers and producers, putting them behind bars and preventing them from destroying lives. I worked closely with community and local leaders to start drug treatment and prevention programs. I have dedicated my life to protecting Americans from the scourge of illegal drugs. I have been involved with and supported law enforcement throughout my life. I would never introduce or support legislation that would make it easier for dangerous drugs to proliferate.

In an October 25 hearing before the House Energy and Commerce Committee, Mr. Neil Doherty, the Deputy Assistant Administrator in the Office of Diversion Control for the DEA, testified regarding this law. In his testimony, Mr. Doherty stated that between 2011 and 2016, prior to passage of my legislation, the number of immediate suspension orders reduced substantially. Following passage of my legislation, immediate suspension orders have actually increased and the quantity of opioids distributed has decreased. He went on to say that the data doesn’t show

that this legislation fueled the opioid epidemic and that the DEA recommended to President Obama that he sign this legislation into law.

Since so far all we have heard from the media is a disgruntled former DEA official with a vested interest pushing his narrative, I look forward to hearing what the current DEA and DOJ have to say regarding this legislation and the effect on their ability to execute their mission. The data shows that there has been no impact and if anything the DEA has been able to issue more immediate suspension orders while having more legal clarity.

**Chairman Hal Rogers
Opening Statement**

**Committee on Transportation & Infrastructure:
Subcommittee on Economic Development, Public Buildings and
Emergency Management**

**Hearing on
The Opioid Epidemic in Appalachia:
Addressing Hurdles to Economic Development in the Region**

**Tuesday, December 12, 2017
2167 Rayburn House Office Building
10 a.m.**

Thank you, Chairman Barletta, Ranking Member Johnson and members of the subcommittee for inviting me to testify this morning. It is my distinct honor and pleasure to introduce one of my constituents and a national leader in combatting opioid abuse – Nancy Hale, the President and CEO of Operation UNITE. Though national awareness of this epidemic has only piqued in recent years, Nancy and Operation UNITE have been on the front lines in Eastern Kentucky for nearly two decades – implementing a holistic strategy that incorporates a three-pronged approach to save lives: investigations, treatment and education. I am certain that all of you in this room will benefit from her testimony and that you will leave this morning wondering how you can replicate UNITE in your congressional district. Thank you for inviting her to participate.

All of us in Congress have been touched in some way by opioid abuse as the flames of addiction have fanned across communities small and large. My area, spanning Kentucky's Appalachian region, has been acutely impacted – identified in 2003 as the “per capita painkiller capital of the nation” by a prominent state-wide newspaper. While I was initially skeptical of this declaration, I soon came to understand the sad truth: the over-prescription and diversion of painkillers was wreaking havoc in our small towns. Addiction was pervasive and deadly, with overdoses tragically far too common. Something had to be done.

But addressing this issue – the misuse of a legal drug – was far from black and white. So I called together people from all walks of life who had felt the impacts of this scourge: parents, teachers, preachers, judges, doctors, law enforcement, elected officials – anyone who was interested in finding a solution. Operation UNITE was ultimately born from those conversations.

I don't want to steal Nancy's thunder, but I want to emphasize that this organization is THE national leader in combatting opioid addiction at the regional level. UNITE has taken its holistic model to the national stage with the National Rx Drug Abuse and Heroin Summit – now in its seventh year. It is the lessons learned at this summit, the relationships

forged by professionals of every imaginable discipline – that are going to help our country turn the tide of the opioid epidemic.

I know today, given the jurisdiction of your committee over the Appalachian Regional Commission (ARC), you are focused on finding solutions in this geographical region – which has been a bell weather for national trends in the opioids space. Let me state that ARC has been a valued partner, and Mr. Gohl answered the call when UNITE asked for support for the Rx Summit several years ago. Earl – we are grateful for your support and the Rx Summit would not be what it is today without your engagement.

But I also believe that the opioid epidemic is indelibly tied to the future economic development of Appalachia, and that ARC could be doing more to help organizations like UNITE tackle the challenges associated with substance abuse. UNITE has found creative ways to do more with less as funding has become more difficult to come by, but I believe, “A vision without funding is a hallucination.” Without additional federal support, UNITE simply cannot maintain the level of service that will be necessary to save lives in our region (and in communities around the country).

As a long-time appropriator, I understand better than most that ARC has a broad mission and limited resources (though Congress has, on a bipartisan basis, fought to robustly fund the agency in light of recent economic challenges). However, one thing is painfully clear: the continuation of our addiction crisis and a vibrant Appalachian economy cannot coexist. The need for more targeted action is urgent, as innocent children are left behind in the wake of deadly overdoses, and as more employers search for a drug-free workforce, both in Appalachia and across the country. I think today's hearing is an important first step and I am grateful that you have made it a priority. I stand at the ready to assist the members of this subcommittee in any way as we work together to find solutions to this crisis.

Thank you for your time, and for your hospitality towards Nancy Hale. I yield back.

Statement of Earl Gohl
Federal Co-Chair, Appalachian Regional Commission
Before the House Subcommittee on Economic Development, Public Buildings and
Emergency Management
House Committee on Transportation and Infrastructure
December 12, 2017

Mr. Chairman and Members of the Subcommittee:

My name is Earl Gohl, and I am Federal Co-Chair of the Appalachian Regional Commission (ARC). ARC is a partnership between the federal government and the Governors of the 13 Appalachian states, created by Congress to help Appalachia achieve socio-economic parity with the rest of the nation. The Commission has a broad mandate to foster economic and community development across the region's 420 counties. I applaud the subcommittee for focusing attention on the opioid epidemic through an economic development lens.

Opioid abuse poses a major threat to the economic prosperity of Appalachia. It's not just a public health and public safety issue; it's an economic development issue. It drains the region's resources, both human and financial. It shatters the fabric of Appalachia's families and communities. It ravages the workforce, slowing productivity and making the region less competitive. In short, as a result of all of its other terrible consequences, opioid abuse diminishes regional economic opportunity.

That's why ARC, as an economic development agency, has been focusing on the opioid issue for several years. The Commission understands that Appalachia cannot have a vibrant and competitive economy without a healthy workforce, and we know that this epidemic disproportionately affects our region. ARC's broader efforts to help build a strong regional economy—through investments in basic infrastructure, in strengthening entrepreneurship, in expanding transportation options—cannot achieve maximum success if the region does not have a healthy workforce. Indeed, fostering a healthy, skilled, and ready workforce is one of the five goals of the agency's strategic plan.

A practical application of the economic development consequences of the opioid problem was recently described to us vividly by Washington County, Tennessee Mayor Dan Eldridge. He has recounted to the Commission that when companies consider locating to his county, they often ask specifically if the workforce can routinely pass drug tests. This is sadly a routine question asked in communities across the country.

In October, the President, through his direction to declare a national public health emergency, underscored the challenge the opioid crisis poses nationally. ARC research¹ found that the problem is even more severe in Appalachia, with opioid-related overdose deaths being 49 percent higher in Appalachia than in the rest of the United

¹ Appalachian Regional Commission. 2017. *Appalachian Diseases of Despair*, p. 17. Retrieved from https://www.arc.gov/assets/research_reports/AppalachianDiseasesofDespairAugust2017.pdf

States. This disparity is particularly striking for northern and central Appalachia. According to recent ARC-sponsored research, Appalachian Pennsylvania has an opioid-related overdose rate 50 percent higher than the rate found in the non-Appalachian portions of the nation. The Appalachian parts of Kentucky, Maryland, and Ohio all have opioid-related overdose rates more than twice as high as that found in the non-Appalachian U.S. West Virginia has a rate over three times as high as the rate for the non-Appalachian United States.

Appalachia was among the first areas to experience the widespread consequences of prescription opioid drug abuse, perhaps the result in part of well-intentioned efforts by physicians to address the pain associated with mining-related injuries.

An ARC-commissioned study back in 2008 revealed that Appalachian hospital admission rates for abuse of prescription painkillers were more than twice those of the U.S. In addition, it showed that the rate was rising, both nationally and regionally, and that it was rising faster in Appalachia than in the rest of the country. This ARC study was the first to document the fact that Appalachia was being disproportionately harmed by the growth of prescription drug abuse. It confirmed the alarming reports ARC was hearing from local economic development leaders and elected officials.

Unfortunately, more recent ARC-funded studies paint a similarly disturbing picture of the disproportionate impact opioids are having on our region, with major implications for Appalachia's workforce. In August, ARC released a study that suggests the extent of the prescription drug abuse challenge in our region. *Appalachian Diseases of Despair*, conducted by The Walsh Center for Rural Health Analysis at the University of Chicago, focused on three "diseases of despair": drug abuse, suicide, and alcohol-related liver disease. It concluded that the Region's mortality rate for all three diseases combined was 37 percent higher than the rate of the rest of the country.²

Even more troubling, from ARC's economic development perspective, the relative gaps between Appalachian and non-Appalachian mortality rates are highest among people in their prime working years. In 2015, overdose-related mortality rates for Appalachia's 25-44 year old age group were more than 70 percent higher than for the same age group the country's non-Appalachia areas. Moreover, in Appalachia, the overdose mortality rate was 78 percent higher among 35- to 44-year-old men and 72 percent higher among 25- to 34-year-old men compared to non-Appalachian men of corresponding age range.³ Likewise, the overdose mortality rate for Appalachian women ages 35 to 44 was more than double the rate for women in the non-Appalachian U.S., and among 25- to

² Appalachian Regional Commission. 2017. *Appalachian Diseases of Despair*, p. 6. Retrieved from https://www.arc.gov/assets/research_reports/AppalachianDiseasesofDespairAugust2017.pdf

³ Appalachian Regional Commission. 2017. *Appalachian Diseases of Despair*, p. 14. Retrieved from https://www.arc.gov/assets/research_reports/AppalachianDiseasesofDespairAugust2017.pdf

34-year old women, the Appalachian rate was 92 percent higher.⁴ The highest overdose mortality rate for Appalachia women was among the 45- to 54-year-old age group.⁵

Across Appalachia, workers in their prime productive years are dying – stunting our economic potential by creating a doughnut-hole in our workforce. This can be preventing our Region, and in turn, our nation, from reaching its economic potential.

But premature mortality is not the only issue that comes along with opioid abuse. For those suffering with addiction, holding down any sort of steady employment is a nearly impossible endeavor. Though we don't have data specific to the Appalachian region on the number of work days lost due to opioid abuse, we do know that mental and physical health challenges in general contribute to the significant workforce issues facing Appalachia. Another report (*Health Disparities in Appalachia*) recently released by ARC (and conducted in conjunction with the Robert Wood Johnson Foundation and the Foundation for A Healthy Kentucky) examined the number and frequency of mentally and physically unhealthy days throughout the region. Taken together, the average Appalachian resident feels unhealthy 12 more days per year than the average American. Feeling physically or mentally unwell may lead to any number of workforce issues: absences, lower productivity, and an increased risk of accidents and injuries.

The challenges facing efforts to support a healthy Appalachian workforce are compounded by a proportionately fewer number of health professionals in the region. The *Health Disparities* study found that the region is already behind the rest of the nation in the number of available physicians, mental health providers, and other relevant health care workers needed to help address Appalachia's opioid crisis. For instance, the number of mental health providers per 100,000 population in the Appalachian region is 35 percent lower than the national average. The supply of mental health providers in counties defined as economically distressed by ARC's classification index is six percent lower than in the region's non-distressed counties. The study also found that, while between 1990 and 2013 the number of primary care physicians per 100,000 population grew faster in Appalachia compared to the nation as a whole (31 percent v. 27 percent), there were still 13 percent fewer primary care physicians per 100,000 population in Appalachia in 2013 than in the nation as a whole.

ARC is not the only organization pointing out the connection between opioid abuse and the workforce. The Federal Reserve Bank of Richmond has recently looked at opioid prescription rates and drug overdose deaths throughout its footprint, which, includes the ARC states of Maryland, North Carolina, South Carolina, Virginia, and West Virginia, as well as the District of Columbia. A November 2017 Richmond Fed publication stated that "increased opioid use does appear to be contributing to adverse workforce trends," citing preliminary national research that suggests the increase in opioid prescription

⁴ Appalachian Regional Commission. 2017. *Appalachian Diseases of Despair*, p. 15. Retrieved from https://www.arc.gov/assets/research_reports/AppalachianDiseasesofDespairAugust2017.pdf

⁵ Id.

rates from 1999 to 2015 could account for approximately 20 percent of the decline in the U.S. labor force participation of prime age men during that period.⁶

Federal Reserve Board Chair Janet Yellen, responding to a question in testimony earlier this year before the Senate Banking Committee, likewise suggested a relationship nationally between opioid abuse and the decline in the labor force participation rate, though she cautioned that she didn't know whether there was a causal connection or whether one reflected a symptom of the other. She did note, however, that the issue seemed to be "particularly affecting workers who have seen their job opportunities decline." Creating jobs and economic opportunities can be important parts of a comprehensive strategy to help address the opioid crisis.

A study by the White House Council of Economic Advisers (CEA), released last month, echoes these themes for the nation. The report estimated that the nonfatal cost of the opioid crisis in 2015, including related healthcare and substance abuse treatment costs, criminal justice costs, and productivity losses, was \$72.3 billion.

ARC has augmented the quantitative research about the incidence of opioid abuse with qualitative assessments specific to the region. Earlier this year, ARC partnered with the Centers for Disease Control and Prevention's (CDC's) National Center for Injury Prevention and Control (NCIPC) and the Oak Ridge Associated Universities (ORAU) to explore how the opioid epidemic is specifically affecting a range of Appalachian communities. To do this work, ORAU convened twelve focus groups in four Appalachian communities (London, Kentucky; Kingston, Tennessee; Oneida, Tennessee; and Princeton, West Virginia). Participants, who were in their prime working age, included people who are in recovery from addiction as well as those who have never taken opioids.

A consistent theme across all the interviews was a deep concern about the impact the crisis is having on the region's economic health, be it an underperforming workforce, challenges of recruiting drug-free workers, or a high rate of worker turn-over. In addition, focus group participants cited various stories about companies and industries reluctant to do business in the region due to a compromised workforce. What these groups were describing was the clear cyclical relationship between the Appalachia's economic challenges and the opioid crisis.

The interviews also make clear that the hard data fail to adequately capture the devastating impact of the opioid crisis on communities, particularly in rural Central Appalachia. Quite simply, it touches almost everyone in the community. When ARC leaders visit Appalachian communities, it's not unusual for community members to approach them and to say, unsolicited, "This drug problem affects everybody in the community." It's personal for them.

⁶ Federal Reserve Bank of Richmond. 2017. Fifth District Footprint: The Opioid Epidemic in the Fifth District. Retrieved from https://www.richmondfed.org/media/richmondfedorg/publications/community_development/5th_district_footprint/2017/footprint_201711.pdf

ARC's response to Appalachia's opioid epidemic has ranged from conducting research to better understand the extent of the problem, to supporting community-based solutions, to funding treatment centers that focus on the re-entry into the workforce.

We are currently partnering with the National Institute on Drug Abuse at the National Institutes of Health, along with the CDC and the Substance Abuse and Mental Health Services Administration (SAMHSA), to cosponsor research on the implementation of evidence-based practices for the prevention and treatment of opioid overdose, HIV, and hepatitis in Appalachia. This is a multi-site effort and to our knowledge the only large-scale research effort to establish best practices that the region's communities can deploy to address critical public health threats within Appalachia's unique and varied contexts.

In recent years, ARC has supported a variety of community-based intervention efforts, often in partnership with other federal agencies, such as the Office of Rural Health Policy at the Health Resources and Services Administration, SAMHSA, and CDC, to help educate local health officials about federal resources and best practices.

One effective local organization, with which ARC has had an ongoing relationship for a nearly a decade, is Operation UNITE, which stands for Unlawful Narcotics, Investigations, Treatment and Education. UNITE provides a multi-faceted, community-based response to the prescription drug epidemic in Eastern Kentucky. Through the work of UNITE, \$12.6 million in illegal drugs have come off Kentucky's streets over the past 15 years. Since 2012, UNITE has coordinated the National Rx Drug Abuse and Heroin Summit, now the nation's largest annual gathering of health care professionals, community leaders, and law enforcement officials to address opioid abuse. ARC has sponsored the Summit since its inception.

Addressing the economic impacts of substance abuse is one of the elements of ARC's POWER initiative, under which special funding is targeted to communities that have been adversely affected by the decline in the coal industry. Earlier this year, for example, we made a \$1 million POWER grant to the Federation of Appalachian Housing Enterprises (FAHE) to finance three community recovery facilities that will support residents' recovery from addiction, provide needed health services, and create job opportunities in Kentucky's coal-impacted communities. One component of this grant will work with patients for 2-3 years and focus on transitioning them from the center's care directly into an internship or job.

ARC recently provided a grant to the Cabell-Huntington Health Department in Huntington, WV, to expand its pilot program of opioid harm reduction services from one site to six sites, making the program available throughout the county. Huntington's 26 overdose cases in just four hours last year made national headlines. Services provided under the program include risk reduction, prevention education, counseling and referral, and community-based naloxone education and training. The services are integrated with primary care and behavioral health providers, and with other social services supports.

The UNITE, FAHE, and Cabell-Huntington projects emphasize the importance of a rich network of supports to help those who have become addicted to drugs and to help prevent addiction in the first place. The importance of this approach was underscored by the report of the President's Opioid Commission. ARC's recent study of health disparities found that Appalachia's social association rate—the number of business, civic, labor, political, professional, religious, and sports organizations per 100,000 population—is 33 percent higher than that of the nation overall.⁷ This suggests a strong foundation of local organizational resources and a strong sense of community that could be leveraged to support regional strategy to turn the corner on the region's opioid problem.

Addressing the opioid crisis will itself create job opportunities in the region. As the report of the President's Commission on Combating Drug Addiction and the Opioid Crisis observes, more health care workers are needed to help address the nation's opioid challenges. Our *Health Disparities* study documents that Appalachia has proportionately fewer of these workers than the rest of the nation.

The Commission believes one way to address the acute and immediate need for more health care and mental health care providers in Appalachia is to invest in strengthening the health care job sector. Last year, an ARC grant of roughly \$360,000 to the Center for Rural Health Development in Hurricane, WV helped capitalize a revolving loan fund designed to strengthen the health care industry in a 15-county region in central West Virginia and helped support the provision of technical and business development assistance to existing health care providers. The fund has already had conversations with potential borrowers seeking funding for opioid treatment centers, though no formal loan applications have yet been submitted. We anticipate this grant will both foster the creation of new health care jobs and strengthen the entrepreneurial environment.

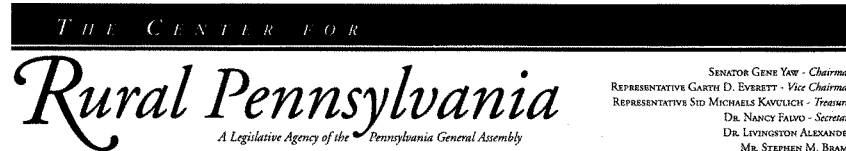
Earlier, I mentioned ARC's "diseases of despair" study. Despair signifies the absence of hope, and given the correlation between economic distress and negative health outcomes seen throughout the Region, it is unfortunately an appropriate label for the opioid crisis facing Appalachia—from both a public health and an economic development standpoint. It also underscores the importance of work undertaken by organizations such as ARC.

ARC's focus is to grow the economy and expand opportunity for the Appalachian Region, which includes creating jobs and preparing our workers to be competitive in a 21st century global economy. Between FY 2012-FY 2016, over 101,000 jobs were created or retained by ARC investments. In FY 2017 alone, ARC investments will help create or retain over 21,000 jobs and train over 30,000 students, workers and leaders in new skills. Each one of these jobs gives someone a reason to get up every day and make the region better for themselves, their kids and their grandkids. And each one these jobs is a reason to be optimistic about Appalachia's future.

⁷ Appalachian Regional Commission. 2017. *Health Disparities in Appalachia*, p. 310. Retrieved from https://www.arc.gov/assets/research_reports/Health_Disparities_in_Appalachia_August_2017.pdf

Helping create economic opportunities—jobs—in those areas struggling with opioid abuse and other diseases of despair is one key component to what must be a multi-pronged approach to recovery, at both the individual and the community levels: hope.

ARC believes that supporting the workforce and creating new jobs and businesses in the health care sector for Appalachia are strategically important in solving the nation's opioid crisis. These strategies will also help Appalachia achieve socioeconomic parity with the nation.



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Public Hearing on The Opioid Epidemic in Appalachia:
 Addressing the Hurdles to Economic Development in the Region

Presentation to the U.S. House Subcommittee
 on Economic Development, Public Building and Emergency Management

Barry L. Denk, Director, The Center for Rural Pennsylvania
 December 12, 2017

Good Morning Chairman Barletta, Ranking Member Johnson and members of the House Subcommittee on Economic Development, Public Building and Emergency Management.

Thank you for the opportunity to be with you today to discuss the heroin/opioid public health crisis affecting Pennsylvania and, in particular, the 52 counties in Pennsylvania that are part of the Appalachian Regional Commission territory.

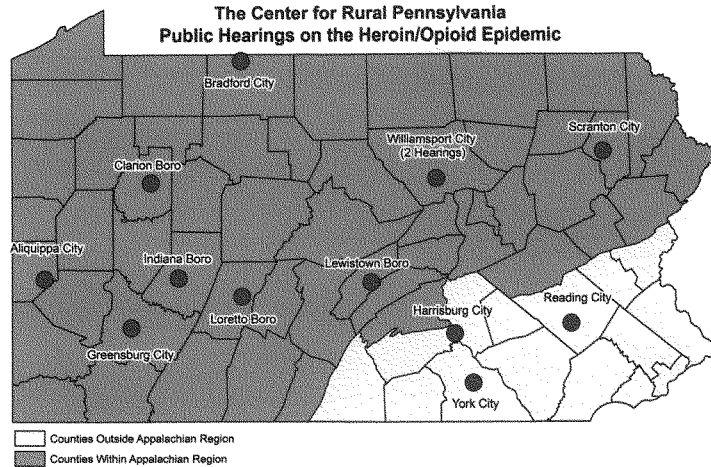
I am Barry Denk, Director of the Center for Rural Pennsylvania. The Center is a bipartisan, bicameral legislative research agency of the Pennsylvania General Assembly. The Center was created by the Rural Revitalization Act of 1987. We are the second oldest state-level rural research agency in existence and the only rural-focused state agency under the jurisdiction of the State Legislature.

Our mandate is to sponsor research and develop and maintain a database on rural trends and conditions. That research and data analyses help to inform and educate the legislature so that when it is considering public policy issues, it understands the potential impact on our state's rural population.

For those who may not know, Pennsylvania has the third largest rural population in the nation, behind Texas and North Carolina. We have, with 3.5 million rural residents, 27% of the state's population. Rural Pennsylvania comprises 75% of the state's land area.

In the spring of 2014, the Center's Chairman, Senator Gene Yaw (R-23rd Senatorial District) was asked by a colleague if the Center could look into the issue of heroin/opioid use in rural Pennsylvania. The rural parts of that legislator's senatorial district had experienced overdose deaths of four young individuals over a short period of time.

That meeting led to the Center sponsoring a series of 13 public hearings, held from July 2014 to October 2017, on the issue of what we now know is the public health epidemic of substance use disorder due to heroin and opioid addiction.



Our hearings were held across the Commonwealth as indicated by the map above.

Through these hearings, the Center for Rural Pennsylvania heard from more than 150 professionals, family members, and people in recovery about the heroin/opioid epidemic, about what's working, and about what needs to be expanded, improved and put in place. We learned that this crisis is not going away anytime soon and there is no simple short-term solution.

We heard firsthand testimony from recovering addicts, parents who have lost a child to an overdose, and grandparents who have been thrust into the role of full-time parent once again. We have heard from Pennsylvania Attorneys General, police officers, District Attorneys, judges, EMS professionals, coroners, doctors, school superintendents, business leaders, treatment providers and federal and state government officials.

We learned how all segments of our society are being impacted by this epidemic. For example, we heard from: recovering individuals, their parents, and grandparents about the financial, insurance and treatment challenges they have faced and continue to face; from Single County Authorities, who are the county-level organizations charged with providing treatment services, about the challenges they are encountering with limited staff, limited funding and limited treatment beds for those seeking recovery; from law enforcement organizations about the deluge of heroin and illegal prescription drugs that are flowing into our communities and the challenges they face with limited staff and funds; from treatment professionals who need more staff, including psychiatrists, counselors, and doctors who are trained to handle treatment medications like methadone, buprenorphine, and naltrexone, and how to treat heroin/opioid addiction, often with a dual mental health diagnosis; and from county judges and district attorneys who spoke about the need to expand county drug courts, which have been shown to be cost effective and efficient.

The hearing agendas and the testimonies of presenters are available on Senator Yaw's website (www.senatorgeneyaw.com). The Pennsylvania Cable Network filmed and televised the hearings across its statewide system and the more than 35 hours of testimony can be viewed through Sen. Yaw's website (www.senatorgeneyaw.com/heroin-combating-this-growing-epidemic-in-rural-pennsylvania/). Summary reports from the 2014 and 2015 hearings are also available on the Center's website (www.rural.palegislature.us/documents/reports/heroin_report2014.pdf and www.rural.palegislature.us/documents/reports/HerionReportFinal2015.pdf).

Overall, we learned that the heroin/opioid crisis has affected all segments of our communities, from the personal to the professional, from health care to law enforcement, and from education to our economy.

In response to today's hearing, we can tell you about the impact the crisis has had on our workforce. In October, the President and CEO of the Pennsylvania Chamber of Business and Industry presented testimony at the Center's public hearing on how the heroin/opioid crisis is impacting many Pennsylvania Chamber members, employers and employees. He noted that a Princeton Economist, Alan Krueger, released a report in September 2017 that analyzed if and how the opioid crisis has contributed to workforce challenges, especially among working age Americans who are unemployed and not looking for work. By comparing county-level opioid prescription rates and labor force data from 1999 to 2001 and 2014 to 2016, Dr. Krueger concluded that opioid prescriptions accounted for a 20 percent decline in the workforce participation among men and a 25 percent decline among women.

In 2016, the PA Chamber also commissioned a local research firm to conduct a survey of Pennsylvania employers about their experiences and expectations concerning the workforce. The more than 400 Pennsylvania employers who responded painted a daunting picture. A combined 52 percent said it is very or extremely difficult to recruit qualified candidates to fill the workforce needs of their company. Most believed that finding qualified applicants has gotten more difficult over the last five years (61 percent) and most also believed it would become more difficult over the next five years (57 percent). A mere 2 percent of respondents said it would get easier. More than one in five respondents also said that job applicants or potential new hires very often or somewhat often failed to pass a drug test. The Chamber CEO concluded his testimony by saying that reversing these broad workforce trends will require a long-term, multifaceted strategy involving employers, educational institutions, parents, students and others to help narrow the skills gap and improve employability. He stated it is becoming increasingly clear that addressing the prescription drug and opioid epidemic is an integral component of this workforce strategy.

At the Center's hearings, we also learned how the epidemic is impacting the treatment workforce as several testifiers noted the need to build that workforce. In 2014, Single County Authority administrators for drug and alcohol treatment said that treatment funding has been cut by 25 percent over the past few years while requests for services have quadrupled. An Executive Director of a treatment facility said he was seeing an experienced and effective workforce dwindling, noting the long hours, low wages, burnout and retirement of seasoned counseling professionals. He added that the experience and training requirements necessary to replenish the field were causing potential candidates to pursue other careers.

While information documenting the economic impacts of the epidemic was not provided during our hearings, we do know of a study completed in Pennsylvania, specifically focusing on the Appalachian

counties of Allegheny and Westmoreland. In May 2017, the Allegheny Institute for Public Policy released its report, *The Economic Impact of Opioid Abuse Locally*. The report puts the number of opioid medicine abusers in Allegheny County at 16,000, and the number of heroin abusers at 5,000. The costs for health care, crime, and lost wages and benefits are \$472 million for opioid medicine abuse and \$350 million for heroin. For Westmoreland County, the costs are placed at \$102 million for opioid medicines and \$108 million for heroin. It is important to note that all the estimates are just that although they are likely to be reasonable approximations of actual costs. They will diverge from actual costs depending on the degree of accuracy of the national findings in the studies used to estimate the local impact.

Another study from the National Bureau of Economic Research surveyed 35 Appalachia counties, with known high propensity of heroin use. It found that as unemployment increases by 1%, there is a 3.6% increase in opioid-related deaths and a 7.07% increase in Emergency Room visits for opioid-related health crises. This positive relationship between socioeconomic status and illicit drug use is indicative of the disproportionate impact that opioids have on low-income communities. The study noted that this claim is supported by a study performed by Dr. Alejandro Badel of the Bureau of Labor Statistics, which suggested that “those who are unemployed or otherwise out of the labor force may face financial hardship or simply have more unstructured time, either of which can result in a higher propensity to consume these substances, everything else held constant.”

A 2017 report released by the White House Council of Economic Advisors noted that the opioid epidemic has cost the U.S. economy more than \$500 billion in 2015. This amount is considerably higher than what previous studies have identified. For example, a study published in the October 2016 journal, *Medical Care*, estimated the total economic burden of prescription opioid overdose, misuse, and addiction at \$78.5 billion in 2013.

A 2016 report released from Altarum (<https://altarum.org/>), a health care research organization, noted that the benefits of putting an end to the opioid crisis exceeded \$95 billion in 2016. Some suggest that the White House estimate is much higher as it took a total societal welfare loss associated with the opioid epidemic.

While these few examples help to document the impact of the heroin/opioid epidemic on our workforce and our economy, there may be more that have not yet been published. Anecdotally, I’m sure that all of our states have stark examples of how this epidemic has changed our communities, especially in the number of lives that have been lost.

A July 2017 U.S. Drug Enforcement Administration report titled, “Analysis of Overdose Deaths in Pennsylvania, 2016,” reported that 4,642 Pennsylvanians died in 2016 as a result of a drug overdose, with thousands more affected by addiction, either personally or through, family, friends, co-workers, employees, or neighbors. This was an increase of 37 percent from 2015, when 13 people died each day of a drug-related overdose. In 2016, the presence of an opioid, either illicit or prescribed by a doctor, was identified in 85 percent of drug-related overdose deaths.

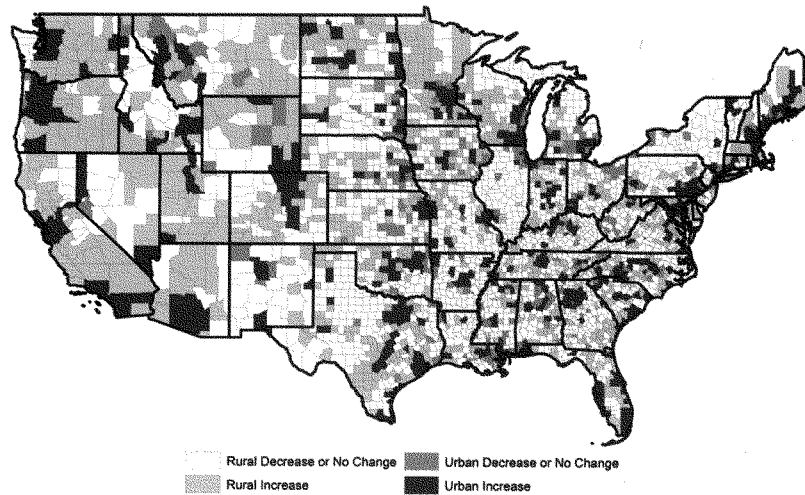
In a public hearing held by the Pennsylvania Senate Health and Human Services Committees in May

2017, the Center for Rural Pennsylvania's chairman, Senator Gene Yaw, made the following statement: "Today, 13 Pennsylvanians will lose their lives to a drug overdose. This week, over 1,000 people will die of an overdose in the United States. By comparison, the Vietnam War, a period that spanned 10 to 12 years claimed more than 56,000 American lives. We are now approaching that level of lives lost every year due to drug abuse and misuse, and estimates are that these numbers will continue to surge."

The Center for Rural Pennsylvania, as part of its role in serving the General Assembly, is continuing its work in addressing this public health crisis affecting our commonwealth. Three years ago we held the first public hearing on this epidemic, but our work to address all issues affecting rural Pennsylvania has been ongoing since 1987. While this public health crisis of heroin/opioid addiction is now on the national stage, it is important to put it in the context of ongoing challenges faced by rural America. As part of this written testimony, I am including some additional information for your consideration as it relates to the systemic challenges facing rural Pennsylvania and rural America.

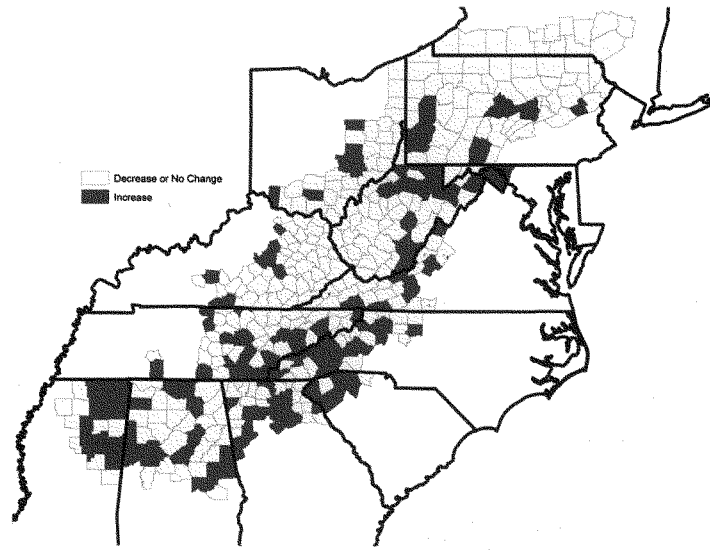
Thank you for the opportunity to speak with you today.

Change in Rural and Urban County Employment, 2007 to October 2017



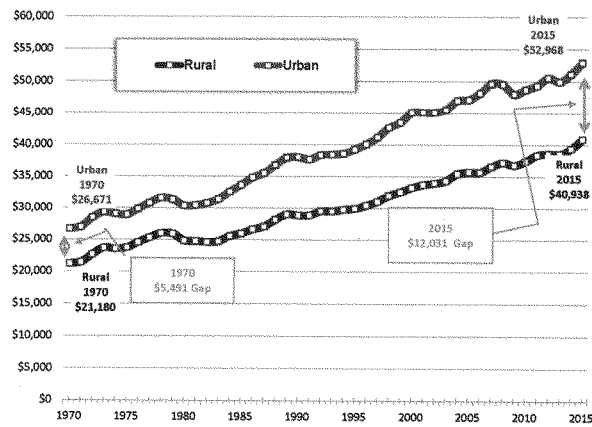
Data not seasonally adjusted. 2007 data are average annual, October 2017 data are preliminary. Data source: U.S. Bureau of Labor Statistics. Map by the Center for Rural Pennsylvania.

Change in Employment in Appalachian Region Counties, 2007 to October 2017



Data not seasonally adjusted. 2007 data are average annual. October 2017 data are preliminary.
Data source: U.S. Bureau of Labor Statistics. Map by the Center for Rural Pennsylvania.

Per Capita Personal Income in Rural and Urban Pennsylvania, 1970 to 2015 (Adjusted for Inflation)



Data adjusted for inflation using the CPI-U with 2015=100. Data source: U.S. Bureau of Economic Analysis. Graph by the Center for Rural Pennsylvania.

**Testimony of Nancy Hale
President & CEO, Operation UNITE**

**Subcommittee on Economic Development, Public Buildings, and
Emergency Management
December 12, 2017**

Good morning, Chairman Barletta, Ranking Member Johnson, and members of the subcommittee. Thank you for giving me the opportunity to speak with you today. I am Nancy Hale, president and CEO of Operation UNITE.

UNITE stands for Unlawful Narcotics Investigations, Treatment and Education.

Operation UNITE was launched in 2003 by Congressman Hal Rogers shortly after the *Lexington Herald-Leader* published a special report, "Prescription for Pain," that exposed the addiction and corruption in southern and eastern Kentucky.

Many of us were shocked to learn that, per capita, we were the top pain killer users in the entire world.

Congressman Rogers and other local leaders feared that if we did not take swift and decisive action, an entire generation would have been wiped out. We held community meetings to find out the scope of the problem and what should be done. Teachers, preachers, parents, judges, cops. Everyone with whom he spoke had stories – personal stories. And they were ready for action.

Operation UNITE then pioneered a holistic approach in our 32-county service area that has become a model for other states and the nation. This comprehensive method involves law enforcement, treatment, and education/prevention initiatives working together. We create strategic partnerships. We provide leadership. We promote education. We coordinate treatment. And, we support law enforcement.

Why are we so concerned? Of the 32 counties in our service region, the Appalachian Regional Commission has identified 27 as being "distressed" and 3 to be "at-risk." UNITE's initiatives are focused on improving the education, knowledge, skills and health of residents to work and succeed.

Eastern Kentucky's economy has been hit hard by the rising rate of substance abuse among its residents. This is especially true for local employers – including those with existing, open jobs, and those who would create new jobs. These employers are losing skilled workers to substance use, and are unable to find qualified employees who can pass a drug test, hampering their ability to run successful, growing businesses.

So how is UNITE addressing the problem?

The first pillar is Investigations/Enforcement.

UNITE has removed more than \$12.3 million worth of drugs from the street, arrested more than 4,400 bad actors, achieved a conviction rate of more than 97 percent, and processed nearly 22,000 calls to our drug tip line.

But we have also long recognized that we can't arrest our way out of this unique epidemic.

That is why Treatment is our second pillar.

Getting justice is only part of the equation. Getting into long-term recovery is what transforms substance users into healthy and productive members of their families and communities.

We staff a statewide treatment help line to connect people to resources, and have supplied vouchers to help more than 4,000 low-income people enter long-term rehabilitation. Each month our team responds to more than 1,000 inquiries from people with substance abuse disorders and their families who don't know where to turn.

In addition, with UNITE's assistance, the number of Drug Court programs increased from five to now serving every county in our region.

The final pillar is Education/Prevention.

We must not only cut off the supply of drugs, we must also decrease the demand. Our education programs introduce youth and adults to a life without drugs. We have reached more than 100,000 students through drug education programs and summer activities, and tens of thousands of community members have volunteered their time and resources.

In addition, through private donations, we provide \$1,500 scholarships to youth who have been actively involved in UNITE programs or have been impacted by substance abuse in their families.

We also provide state-certified Drug-Free Workplace training – a necessity to attracting, retaining, and growing jobs. Certified employers benefit from reduced workers' compensation insurance premiums, safer workplaces, increased productivity and reduced absenteeism.

A federal study by the National Center for Injury Prevention and Control conservatively estimated that prescription opioid abuse cost the economy \$78.5 billion in 2013, but that did not capture the broader effect on businesses from factors like lost productivity.

A 2015 study by Castlight Health found employers spend nearly twice as much in medical expenses on opioid abusers annually than on non-abusers. Leading lab services provider Quest Diagnostics analyzed more than 10 million workforce drug tests in 2016 and found that 4.2 percent of these tests came back positive.

UNITE's Drug-Free Workplace training educates both employees and supervisors about addiction, the signs and symptoms of drug use, the effects and costs of substance use in the workplace, and how to find treatment or other support services in the area. In addition, our staff will review existing – or help to create – an Employee Assistance Program. UNITE has provided this training to more than two dozen different companies.

According to information released in August from the Appalachian Regional Commission, overdose and opioid-related overdose mortality rates for ages 15 to 64 are 52.1 per 100,000 people in Appalachian Kentucky. That is the second highest in Appalachia and more than **DOUBLE** the amount for the non-Appalachian areas of the United States.

Unfortunately, our problem is not unique. Many communities are facing the same consequences from this epidemic. That is why UNITE's efforts must continue: the enemy is evasive and persistent.

Operation UNITE has implemented many evidence-based best practices and solutions. The good news is that these programs can be replicated. The bad news is that implementing these solutions requires funding.

Support for Solving the Epidemic

As Congressman Rogers often says, "A vision without funding is a hallucination." Operation UNITE received funding in the early 2000s through the federal appropriations process for important enforcement efforts. SAMHSA helped provide treatment vouchers.

And through AmeriCorps, we have 54 people who provide math tutoring, teach anti-drug and wellness curricula, and sponsor anti-drug UNITE clubs. The results are dramatic: Last school year, students showed an average 56.5 percent growth in math knowledge and a 51.3 percent growth in drug education and healthy decision-making knowledge.

Our achievements would not have been possible without these investments, though many of them are no longer available. We continue to explore funding opportunities through the competitive grant process but nothing specific seems to match up to our mission.

In addition to seeking private and state investments, opportunities through the Appalachian Regional Commission have been invaluable. The ARC has supported us in targeted ways that have planted seeds that are yielding fruit beyond our grandest plans. Let me share with you several key examples.

Lord's Gym

Throughout most of its existence, UNITE and its Community Coalitions have interacted with programs funded by the Appalachian Regional Commission. That relationship strengthened in 2008, when UNITE received funding to renovate an old elementary school gym and purchase equipment to create the Lord's Gym of Jackson County – one of its most at-risk counties.

Modeled after a similar project in another UNITE county – which also received ARC funding for facility repairs – the Lord's Gym provided a healthy, drug-free environment for youth to receive tutoring in mathematics, reading and science; provide organized physical activities for health; and support future generations to make positive decision in their lives through mentoring opportunities.

Kentucky Medical Communities UNITED

In late 2009, our region was rocked by the murder of Dr. Dennis Sandlin, who had refused to provide pain medications to a drug-seeking patient. This was a wake-up call for our organization, as great emphasis had not been placed on engaging health care providers and medical professionals in seeking workable solutions to the drug problem.

A series of regional educational forums was conducted involving the Kentucky Office of Drug Control Policy, state law enforcement, the Kentucky Pharmacists Association, the Kentucky Hospital

Association, and state legislators. This collaboration ultimately resulted in sweeping legislative changes in the prescribing and monitoring of controlled drugs, regulation of pain clinics, and mandated use of the Kentucky All Schedule Prescription Electronic Reporting system.

There was a great deal of confusion about these legislative changes, so UNITE partnered with the Kentucky Office of Drug Control Policy to stage a series of four regional training symposiums across Kentucky in early 2013. The Appalachian Regional Commission financed these forums to provide Continuing Education credits across multiple disciplines.

National Rx Drug Abuse & Heroin Summit

Perhaps ARC's greatest and most fruitful investment in Appalachian anti-drug efforts was its early support for the National Rx Drug Abuse & Heroin Summit. In 2011, Congressman Hal Rogers recognized the need for "a coordinated national effort" to find data-driven solutions to the nation's prescription drug epidemic. Congressman Rogers asked Operation UNITE to organize a first-of-its-kind Summit, where all impacted stakeholders could collaborate, learn from others' successes, and foster better understanding and cooperation.

Acutely aware of the impact that substance abuse and diversion was having across Appalachia – devastating families, burdening communities, and undermining employability of the workforce – UNITE approached the Appalachian Regional Commission seeking support. Recognizing the importance of bringing the nation's foremost experts together, the ARC agreed to serve as "Educational Partner" for the first National Rx Drug Abuse Summit, held in April 2012.

The ARC's investment of \$50,000 – double what was originally requested – has enabled UNITE to pay travel expenses for more than 200 of the country's leading subject matter experts and leading advocates, provide audio-visual services, and offer Continuing Education credit hours each year. Attendees have been given an opportunity to learn from state and national leaders, law enforcement officials, medical professionals, community advocates, treatment experts, educators, private industry leaders, and others.

More than 700 participants – representing 45 states, the District of Columbia, and 3 other countries – attended that first Summit. The conference has grown every year since, attracting nearly 2,400 people in 2017. Registration for next year's 7th annual Summit is currently trending 12 percent ahead. Because of ARC's continued partnership, additional educational sessions have been crafted each year to address emerging threats and attendee demand.

Social Media Support

In 2016, UNITE received additional funding from ARC to design and implement a robust and sustainable communication and social media strategy, one that increased the capacity of Appalachian organizations to use social media effectively as they pursue substance abuse prevention and treatment activities.

As part of this initiative:

- UNITE contracted with StoryCorps to film on-site interviews. I am happy to say that one of these interviews – featuring neonatal abstinence syndrome pioneers – aired on National Public Radio earlier this year. All segments have been promoted on UNITE's social media channels.

- UNITE provided audio-visual services for the Centers for Disease Control and Prevention to conduct a Pre-Summit Workshop on “Using Digital and Social Media to influence the #RxProblem.” This was the second-most attended workshop.
- UNITE contracted for a social media campaign on Facebook and Twitter to raise awareness of the Summit.
- UNITE contracted for a social media coordinator to assist with communications both during and after the Summit. This coordinator responded to more than 110 media requests and facilitated more than 18 on-site interviews with local, regional and national media.
- UNITE worked with Oak Ridge Associated Universities and ARC to provide technical assistance and training services to support and enhance social media needs throughout the Appalachian Region. The results of this collaboration has enabled UNITE to maintain a strong social media presence. Our number of Facebook followers has increased 24 percent since the training.

In 2016, as the Summit continued to gain national and international recognition for its quality programming and experience attendance growth, UNITE entered into an agreement with Vendome Healthcare Media to assume responsibility for promoting and staging future Summits. UNITE continues to serve as Educational Advisor and is heavily involved in steering discussion to address today's most urgent issues.

In 2017, the ARC provided funding for UNITE to:

- Share information about media best practices at the Rx Summit, and develop promotional materials so other communities can learn about UNITE initiatives they could replicate;
- Enhance and expand its social media presence in the Appalachian Region;
- Collaborate and assist with community engagement sessions for the CDC's new national campaign to prevent prescription opioid abuse; and
- Create a Strategic Plan and a roadmap for short-term and long-term sustainability.

The ARC understands that improving the education, knowledge, skills, and health of residents to work and succeed requires finding ways to reduce deaths from drug overdose, increase public drug awareness and education, increase access to treatment, and reduce diversion of prescription pills.

Without ARC's involvement, the National Rx Drug Abuse & Heroin Summit would not have become the place where solutions are formulated, stakeholders convene, and change begins. UNITE has been able to showcase its unique, holistic model and position itself as a national leader in addressing substance abuse and misuse issues.

Unfortunately, there are still many people who are not aware of UNITE's initiatives or what services we have available to share. Drastic funding cuts have forced UNITE to maintain a high level of services with a bare-bones staff, and implement strategies for long-term survival. UNITE, and other organizations trying to replicate our model, are desperate for federal support to keep the doors open. As Congress and the federal government coalesce around solutions to this epidemic, we are

hopeful that we can not only maintain, but also expand upon, our partnership with ARC and other federal agencies to continue our support for individuals and communities in need.

Conclusion

In conclusion, UNITE, a collaborative model striving to prevent abuse of drugs and facilitate recovery, has been able to help ARC fulfill this part of its mission. And, support from the Appalachian Regional Commission – both financially and through collaborative partnerships – has enabled UNITE to create hope and change the culture, not only in our corner of southeastern Kentucky, not only across Appalachia, but on a national stage.

But we need the ARC to do more. UNITE believes funding an expansion of its Drug-Free Workplace training program would help expand economic development opportunities in Appalachia and provide valuable information to employees and their families. In addition, UNITE believes we need to push for more medical symposiums – specifically relating to prescribing, addiction, and alternative treatments.

And, of course, by supporting a national dialogue through the National Rx Drug Abuse & Heroin Summit, ARC is creating positive changes well beyond its primary service area.

Thank you allowing me time this morning to share the good things that are being accomplished in Kentucky. UNITE looks forward to working with other communities to address our nation's opioid epidemic.

United States House of Representatives
Committee on Transportation and Infrastructure
"The Opioid Epidemic in Appalachia:
Addressing Economic Hurdles to
Economic Development in the Region"

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From 2010 through 2015, I had the great honor to serve as an attorney for the Drug Enforcement Administration. My work was focused almost entirely on enforcement actions against doctors, pharmacies, distributors, and manufacturers of opioid controlled substances, all registrants under the Controlled Substances Act. For several years, under amazing leadership and with an eye on protecting the public health and safety, DEA shut down pill mills and practices run by greedy, immoral drug dealers in lab coats, all betraying not only their duties under the CSA, but their ethical obligations to their fellow human beings. I watched as DEA fought hard against the rising tide, and struggled not to drown as the opioid epidemic swelled around us all.

The opioid epidemic was a slow burn fire. Traditionally, many opioids used to treat pain included acetaminophen, a drug which, if taken long-term, can cause severe liver damage. So in the 90s, a pharmaceutical company decided to remove the acetaminophen, and start promoting the use of opioids for long-term pain management.

Their proposal was backed by claims that opioid medicines are rarely addictive. Too late, we now know this to be untrue.

As these drugs were marketed, the very people selling the pills went about changing hearts and minds about the dangers of opioids. Soon, "opioidphobia" was replaced frowny-face pain measurements and a general misunderstanding by many physicians of what, exactly, they were prescribing. Over the course of time, opioid usage was normalized in America, and heralded as a wonder drug. Opioids were digging in everywhere across the country, especially in blue collar and poorer areas, where those seeking a prescription felt validated by the fact that their drugs came from a doctor, and where those seeking a buck found incredible profits in sharing their stash. Unemployment and disability numbers rose, and the number of employable members of the workforce diminished.

As DEA endeavored to help the people of this country, we began broadening our investigations and enforcement actions to look at the role of distributors and manufacturers in

the spread of opioid addiction. Then, for no readily apparent reason, DEA began to slow down, not ramp up its enforcement.

A new section chief arrived, and with him, inexplicable new standards for charging cases were put into place. Soon, attorneys for DEA were being shut down. Draft pleadings would go through farcical rounds of edits and re-edits, almost as if the section chief and his second-in-charge were simply stalling cases rather than charging them. Attorneys began to be singled out and put into the crosshairs of the section chief, who seemed intent on making things difficult for those attorneys who questioned his rationale. New policies were drafted and enacted unilaterally by the section chief, declaring higher standards of proof, unfounded new demands on field investigators, an increased need for the use of expert witnesses, and, more so, an almost palpable fear of utilizing DEA's strongest tool for enforcement: the immediate suspension order, or ISO.

The ISO was a tool for immediately halting the shipments of opioid controlled substances sent by a distributor to a pharmacy. During my time at DEA, it seemed to me that these larger pharmaceutical corporations and industries were not interested in doing the right thing; at least until their profits were hurt and their names were being tied to the opioid epidemic in headlines.

When this new section chief began running my section, discussions turned to an almost palpable fear that, if DEA utilized the ISO and a corporation challenged the ISO, DEA could receive a "bad ruling" against it in a federal court, which could ultimately take away DEA's ability to utilize the ISO at all. This fear appeared to be based, largely, on the fact that DEA began losing some of its best, brightest, most driven, and most talented attorneys. A former section chief was hired into private practice to represent one of the largest opioid distributors in the country. Soonafter, DEA began losing more and more attorneys, recruited over to represent the industry.

When these attorneys left for the industry, they brought with them an intense and brilliant understanding of DEA regulations and case law. I believe this brilliance and understanding, now representing some of the largest DEA registrants in the country, was what DEA began to fear. This was, to my understanding, what caused much of the Slowdown in DEA enforcement actions.

During this Slowdown, I witnessed a staggering drop in morale at DEA, based in part on the feelings of futility and downright absurdity in the face of the ever-increasing death toll related to the opioid epidemic. And more so, morale continued to plummet as employees from all parts of DEA began "switching sides." Not just attorneys, but special agents, group supervisors, and in many cases, management would resign or retire, only to immediately take a job with a pharmaceutical manufacturer or distributor.

I understand the idea behind this revolving door. But for me, there was a downright confusion when the very special agent who referred to the distributors and manufacturers as

"evil" and "the bad guys" happily took a position employed with one of those bad guys just two weeks after his retirement.

It was, to my knowledge, a former DEA attorney who drafted the Ensuring Patient Access and Effective Drug Enforcement Act, which stripped DEA of the ISO. While DEA attorneys feared that a bad decision in federal court might strip DEA of the ISO, Congress effectively legislated the ISO away, ostensibly in the name of ensuring patient access to opioid controlled substances. Without the ISO in its toolbelt, DEA will likely have very little effect enforcing regulations against manufacturers, distributors, and large pharmacy chains who, in my experience, only ever seemed to listen when it hurt their bottom line. "Ensuring patient access" is a misleading description, painting the picture of an altruistic industry only concerned with saving lives and easing pain.

While we may now consider corporations to be people, I laugh at the idea of an altruistic corporation. And by limiting DEA's ability to enforce its regulations and the CSA against these pharmaceutical corporations, we have effectively condoned the continued poisoning of our populace and ushered in the loss of an entire generation to highly addictive and deadly drugs.

According to the CDC, 80% of heroin users in America today got started on opioid painkillers. Overdose deaths in America are at an all-time high, making the heroin epidemic of the 70s and the cocaine epidemic of the 80s look tiny in comparison. We are killing our own people, and DEA is falling down on the job. This is an epidemic that focuses on no race, no gender, no socioeconomic classification - because it affects them all. Everyone has a story of loved one, injured on the job, now living a life of addiction, pain management, and unemployment because their doctor kept increasing their prescribed dosage. Or of a student, injured in a high school football game, prescribed opioids by a well-intentioned physician, and now in jail for possession of heroin, or dead of an accidental overdose.

Significant damage has been done not only to those who are now our addicts, but to our communities, our workforces, our economies. Old methods of treatment are failing in the face of this long term physical and biological addiction. And yet these pills seem easier and easier to find, and harder and harder to avoid.

DEA has been hobbled by legislation intended to defang the agency, and communities are now suffering the consequences of this drug epidemic with a long, arduous road ahead. The influence of the pharmaceutical manufacturers and distributors, the very ones who promoted and profited from the widespread, dangerous use of opioids, have influenced legislation in order to further limit DEA's ability to enforce its laws. And while this battle between the agency, the industry, and the lobbyists continues, American people keep dying.

We need to focus on changing the laws, restoring DEA's ability to enforce, and looking at funding to educate our population and to help those already addicted to fully recover and become productive members of society again.