Congressional Testimony

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Combatting the Opioid Abuse Epidemic: Professional and Academic Perspectives," April 23rd 2015

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Mr. Chairman, Members of the Committee, thank you very much for inviting me to speak with you today about treatment for opioid addiction. Dr. Murphy, before I start, I'd like to say that as a psychiatrist specializing in addiction , I am particularly appreciative of the clinical awareness you have imparted to the Helping Families in Crisis Act, which will focus resources on helping our patients. I am board-certified in general psychiatry, addiction psychiatry, and forensic psychiatry, and I serve as President of the American Academy of Addiction Psychiatry, the professional organization for psychiatrists who specialize in the treatment of Addiction and other Mental Illnesses. My primary professional focus is on the clinical treatment of addicted people: I trained at Bellevue Hospital, where I worked for many years and continue to teach, and I treat people addicted to opioids in my offices in

Manhattan, and in New Jersey, where I live. I know this committee understands the absolutely lethal nature of opioid addiction, so you don't need me to tell you about that. My main goal in speaking with you today is to underline what you have already heard: ***opioid-addicted people need access to a broad range of treatments for opioid addiction. This must include access to medication assisted therapy and treatment for co-occurring psychiatric disorders.***

I have treated homeless heroin-injecting senior citizens, college students who snort OxyContin, and practicing attorneys who must take an opioid pill every few hours in order to continue seeing their clients. The death and destruction I have seen due to opioid addiction is profoundly disturbing but, thankfully, with appropriate treatment, the more common return to health, the workplace, and family is what keeps most of us doing the clinical work which assists addicted people in their search for recovery.

Part of that clinical work includes full treatment for what is ailing the addicted person. Research demonstrates that the opioid-using person often has a co-occurring mental illness like Major Depression, Bipolar Disorder, or PTSD. Sometimes the opioid-user is self-medicating uncomfortable mood states, or anxiety, or just has difficulty soothing him-or-herself. All of these circumstances can increase the risk for relapse, and

require sophisticated and individualized psychiatric evaluation and treatment. Research shows that prescribing the appropriate effective medication to help the patient with craving along with “talk” therapy and treatment for a co-occurring psychiatric disorder give the addicted person the best chance for recovery.

That sophisticated treatment system must include access to well-trained clinicians who can select between the available psychosocial treatments like Relapse Prevention Therapy and Cognitive Behavioral therapy, medications like buprenorphine, methadone and naltrexone, and mutual support groups like Narcotics Anonymous. For many, mutual support groups like AA and NA can be extremely helpful, but they are not treatment – nor do they claim to be. They are support groups which can be life-saving for some, and not so much for others. As you have heard, the available research has not provided us with a silver bullet that works for all opioid addiction. Rather, the data tell us that some treatments work for some opioid addicts, some of the time. Others may respond to a very different approach. That is one reason we clinicians must have all available arrows in our quivers - we must have the skills and training for a broad array of approaches to meet the treatment needs of each patient. Quite often using a team approach that includes psychologists, social workers, nurses and counselors is critical to therapeutic success.

The wide variety of personal choices addicted people make about treatment is yet another reason for supporting the full spectrum of treatment possibilities, from medication-assisted treatment with buprenorphine and methadone, to opioid blockers like naltrexone, to Relapse Prevention Psychotherapy. Some patients demand to be treated without medications, while others clearly want and require medications to control their craving, and may also require more specific psychiatric treatment for any co-occurring disorders.

The use of buprenorphine and methadone, which are both opioids like heroin, can be controversial. When I talk to opioid-addicted people and their families, I sometimes – but not always – recommend tapering or maintenance with buprenorphine or methadone. The question is not whether the medication has side effects (all medications do) but whether the risk is worth the benefit. Patients and their families need to know that detoxification treatment and "drug-free" counseling are associated with a very high risk of relapse. As with other medical conditions, the relevant question about whether a medication is worth the risk is the following:

"Compared to what?'

Is taking buprenorphine or methadone better than dying from an overdose? Better than contracting HIV or hepatitis? Flunking out of school? Losing a marriage? Losing a job? One

size treatment does *not* fit all, and different patients may need different treatments. But the very good news in this situation is that people who are able to stop their use of illicit drugs – whether through psychotherapeutic interventions, medications, and/or help from Narcotics Anonymous, or most likely, some combination of the above – return to vibrant and productive lives. It is that return to physical and emotional health, which I find so gratifying, and empowers me to help my patients keep trying.

Before I stop, let me reiterate my main point, and what I know you have heard from others: ***Opioid-addicted people need access to a broad range of treatments for addiction. This must include medication-assisted treatment and treatment for co-occurring psychiatric disorders.***

Thank you for inviting me today.