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

THURSDAY, MARCH 26, 2015

House of Representatives,

Subcommittee on Oversight and Investigation

Committee on Energy and Commerce

Washington, D.C.

The Subcommittee met, pursuant to call, at 10:15 a.m., in Room 2123 of the Rayburn House Office Building, Hon. Tim Murphy [Chairman of the Subcommittee] presiding.

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

Staff present: Sean Bonyun, Communications Director; Leighton Brown, Press Assistant; Noelle Clemente, Press

Secretary; Brittany Havens, Legislative Clerk; Charles Ingebretson, Chief Counsel, Oversight and Investigations; Chris Santini, Policy Coordinator, Oversight and Investigations; Alan Slobodin, Deputy Chief Counsel, Oversight; Sam Spector, Counsel, Oversight; Jeff Carroll, Democratic Staff Director; Chris Knauer, Democratic Oversight Staff Director; Una Lee, Democratic Chief Oversight Counsel; Elizabeth Letter, Democratic Professional Staff Member; and Tim Robinson, Democratic Chief Counsel.

Mr. {Murphy.} Good morning.

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

What is striking about these statements is not the dismal picture they paint, but rather, that these remarks were published over 100 years ago in 1911. Back then, of course, we did not have the scientific or government involvement that we have today. Back then, there was no National Office of Drug Control Policy--the NODCP--and there was no Department of Health and Human Services, no Substance Abuse and Mental Health Services Administration, and there was no National Institute on Drug Abuse. Yet despite all of our science and public health agencies, and despite the

billions of federal dollars devoted to fighting the opioid problem, the situation is no better than it was 100 year ago. Indeed, many would say the situation is far worse.

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

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

Something is desperately wrong with our Nation's

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

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

No federal agency has a more central role in this ongoing epidemic than the Department of Health and Human Services. HHS and its Substance Abuse and Mental Health Services Administration, otherwise known as SAMHSA, are tasked with leading our Nation's public health response to opioid and heroin abuse and addiction. SAMHSA regulates our country’s 1,300 opioid maintenance--formerly known as methadone clinics--and is responsible for certifying the

26,000 physicians who prescribe the semi-synthetic opioid buprenorphine. According to testimony provided by SAMHSA before this subcommittee in April of last year, nearly 1.5 million people were ``treated''--and I put ``treated'' in quotes--with these opioids in 2012. That is a five-fold increase in the last 10 years. Now, I might add, I will not call this treatment. It is addiction maintenance.

Buprenorphine can more safely maintain a person's dependence by reducing the need for illegal opioid use, such as heroin, and thereby the risk for overdose. But make no mistake, buprenorphine is a highly potent opioid, which according to SAMHSA, is 20 to 50 times more potent than morphine. So it is worth considering that our national strategy to combat substance abuse is to maintain addiction by either prescribing or administering a heroin-replacement opioid. When you consider research from the National Institute on Drug Abuse documenting that almost everyone who stops taking buprenorphine relapses to illicit opioid use within a matter of weeks, it is deeply concerning we don't have the best solutions for addiction recovery. According to the Drug Enforcement Administration, when police conduct a prescription drug bust, the third most frequently seized drug by law enforcement is buprenorphine--more than methadone, more than morphine, more than codeine. And unlike clinics

that administer methadone, there are no requirements for buprenorphine clinics to offer or even discuss non-addictive treatment alternatives with patients, no requirement to develop treatment plans, no requirements to protect the public against it being diverted for illicit use. Meanwhile, the CDC reports that buprenorphine is the most frequently cited prescription drug in poisonings of children, accounting for nearly 30 percent of all opioid-related emergency department visits and 60 percent of emergent hospitalizations among children.

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

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

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

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

Compounding this crisis is the lack of evidence-based treatment to end opioid addiction, not merely replace an illicit drug with a government-sanctioned one. Evidence-based treatment includes decisions based on scientific studies with quantitative data, and is distinguished from those relying on anecdotes and subjective observations.

Only about 10 percent of persons with a substance abuse disorder will get any form of medical care. Of those who are lucky enough to get care, only 10 percent of them will get evidence-based treatment for the disease of addiction. Yet most medical professionals are not sufficiently trained to

diagnose or treat the disease of addiction, and most providing addiction care are not medical professionals and are not equipped to provide the full range of effective treatments.

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

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

[The prepared statement of Mr. Murphy follows:]

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Mr. {Murphy.} And with that, I now recognize Ms. DeGette of Colorado.

Ms. {DeGette.} Thank you very much, Mr. Chairman, for convening this hearing today.

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

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

Recent advances in science have shown us that addiction is a disease of this brain. This demands that we approach the problem not only as a public safety issue but also as a public health issue. Yes, we must stop drug smugglers and crack down on pill mills, but we also must work with

prescribers to educate them and prevent the over-prescription of opioids for pain management. And most importantly, we must improve our ability to identify and treat people with substance abuse disorders.

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

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

Despite this track record, in 2013, MATs were available in only 9 percent of substance abuse treatment facilities nationwide. Even more troubling are reports that some treatment facilities that adopt an abstinence-based approach to drug treatment do not allow patients to take MATs while enrolled in their programs. According to experts, a high percentage of opioid addicts in abstinence-based treatment return to opioid abuse within 1 year, and as you said, Mr. Chairman, even within a few weeks. Given the limited success of these programs in promoting long-term recovery in opioid addicts, we must ask some hard questions regarding how we

should be spending our limited resources for treatment.

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

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

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

communities, and we need to have them help us inform the national discussion.

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

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

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

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

And with that, Mr. Chairman, I just want to let the witnesses know, this committee has a bill on the Floor right

now, so I have to run down and make a statement on the Floor. I am leaving us in the capable hands of Mr. Kennedy, and I will be back after my statement. Thank you.

[The prepared statement of Ms. DeGette follows:]

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Mr. {Murphy.} I thank the gentlelady, and thank you for your comments--very pointed.

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

The {Chairman.} Well, thank you, Mr. Chairman.

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

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

I know personally a number of families that have been

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

As we continue to mourn the loss of all these lives, testimony from you all today will provide us an effective approach making a real difference in fighting this awful abuse. This is a great opportunity for this committee, on a bipartisan basis, to help improve the federal government's response to this epidemic. I am especially pleased to welcome one of today's witnesses, my good friend Vic Fitz, the Cass County Prosecutor and the President of the Prosecuting Attorneys Association of Michigan. He has 31 years of experience in prosecuting drug cases, and will certainly share his insights today as he has done with me over the past number of years and with other fellow

prosecutors in Michigan on this issue. I would note that the heroin dealer who sold the heroin that killed Amy Bousfield was caught, convicted, and sentenced to 10-1/2 to 40 years in prison. We appreciate the work of Vic and his fellow prosecutors who have held dealers accountable to the law, and helped addicts straighten out their lives. I thank him and all of you for your service, and for participating at today's hearing, and I yield the balance of my time to Mr. McKinley.

[The prepared statement of Mr. Upton follows:]

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

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

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

today.

Thank you, and I yield back my time.

[The prepared statement of Mr. McKinley follows:]

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

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

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

Back home in the 4th District of Massachusetts, there is not an event that I go to where this topic does not come up.

Communities like Fall River in Taunton have been particularly hard-hit. Local leaders are working tirelessly to respond.

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

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

According to CPAC, the New England Comparative Effectiveness Public Advisory Council, 133,000 people in New England abuse or are addicted to opiates. Of those, 70 percent meet the criteria for treatment but cannot access it. We know that this is a problem with no single solution. We are working to chip away at it, and I am proud to have joined Representative Whitfield this morning in reintroducing legislation to reauthorize the NASPER program, the National

All Schedules Prescription Electronic Reporting program. The program is designed to provide grants to states for the establishment, implementation, and improvement of prescription drug monitoring programs. We know that timely access to patient records and high standards of interoperability are successful with PDMPs, and this legislation will give providers the tools that they need to identify and treat at-risk behavior.

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

Let me just say I first became aware of the scope of this addiction and the scope of this problem as a prosecutor in local communities in Massachusetts, finding young men and women that were breaking into 15 cars in a night, five, six homes over the course of the weekend, undercover agents that were putting themselves at great risk to try to keep our communities safe. So for those of you in law enforcement that are here, I look forward to hearing your ideas. From

those folks back home that I have talked to, they have profound recognition that we will not arrest our way out of this problem, but very much look forward to hearing your solutions as to what we can do going forward, and I yield back my time.

[The prepared statement of Mr. Kennedy follows:]

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

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

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

[Witnesses sworn.]

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

We will call upon you each to give a 5-minute summary of

your written testimony. We will start off with Mr. Fred Wells Brason, and Mr. Hudson of North Carolina will introduce the witness.

Mr. {Hudson.} Thank you, Mr. Chairman.

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

Mr. {Murphy.} Mr. Brason, you are recognized--is it Brason or Branson?

Mr. {Brason.} Brason.

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

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

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^TESTIMONY OF FRED WELLS BRASON, II

} Mr. {Brason.} Thank you very much. Chairman Murphy,

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

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

and so forth, that they have a safety net so that they are not just pushed into the heroin or they are not pushed someplace else.

A community has to address all of those facets, and we began by addressing, you know, first community awareness and community education so that individuals receiving a prescription can take it correctly, store it securely, dispose of it properly, and never share. Unfortunately, those are common practices that go on in our community with the right prescription for the right person but when it is in the home, the family is feeling like, well, it is okay because the doctor wrote it. Those are some of the public health reversals that we need to do. Then we work with our prescribing community to, you know, look at how to best manage chronic pain, how to manage acute pain, how to appropriately prescribe but then also how to assess patients, how to determine they are at risk, you know, possibilities, but then also looking within the community, and if there is a risk of something already has developed, who can I have the warm handoff to for the treatment that is necessary to them, whether it is an abstinence program, whether it is a medication-assisted treatment, whether it is a methadone or a buprenorphine or naltrexone. There isn't one treatment that works for everybody but there is treatment that works for

everybody, so we have to make sure our communities have accessibility for all of that, and that is what we look for in our community and we are able to do that by education.

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

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

population groups, all ages from a public health perspective to reverse the behaviors, the misconceptions, and the problems that arise from that but ensuring that those that need it can receive it, those that need treatment can receive it and have it.

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

others, law enforcement are saving lives, and that is what it is important to them. So it is a safety factor to do that.

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

Thank you for your time.

[The prepared statement of Mr. Brason follows:]

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Mr. {Murphy.} Thank you very much.

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

Mr. {Griffith.} Thank you very much, Mr. Chairman.

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

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

Mr. {Murphy.} Dr. Melton, you are recognized for 5 minutes.

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^TESTIMONY OF SARAH T. MELTON

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

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

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

Overall, more funding is needed form the federal level to provide expanded graduate medical education opportunities for training in the identification, referral and treatment of substance use disorders. As changes in federal funding

allocated for graduate medical education are currently being discussed, it is an opportune time to assess how funding can best address training in addiction medicine.

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

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

in the clinical setting. We are going to be sending letter to all pharmacists in the Commonwealth in the next month.

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

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

With regard to treatment, medication-assisted treatments with methadone, buprenorphine and naltrexone have become an essential component of a comprehensive treatment plan for opioid use disorders. The issue that we have now is that we need a modernization of federal law to further expand access to these lifesaving medications but we need specific best

practice requirements and recommendations for prescribers and insurers such as Medicaid and Medicare to make sure that certain patients are receiving comprehensive care by competently trained healthcare providers. Also critical is reimbursement for parts of these programs such as urine drug screens and the necessary psychotherapy that accompanies the medication treatment.

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

buprenorphine, of course, is reported to the State prescription drug monitoring programs that allow us more monitoring for safety and appropriate use.

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

[The prepared statement of Ms. Melton follows:]

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Mr. {Murphy.} Thank you.

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

Mr. {McKinley.} Thank you, Mr. Chairman.

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

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

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

Mr. {Murphy.} Doctor, you are recognized for 5 minutes.

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^TESTIMONY OF STEFAN R. MAXWELL

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

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

So at the time, we really were not understanding the whole impact of what was happening in the State. So we--I

missed a meeting and became chairman of the substance abuse committee, I have to say, and I was given that responsibility, and over the next ensuing 3 years or so, we tried to figure out what was the prevalence of this problem in our State, and so we embarked upon the umbilical cord tissue study, which looked at eight hospitals through the State, scattered throughout the State. We collected as many umbilical cord tissue samples as we could as sort of a pilot over a month-long period. We ended up collecting almost 800 samples, and then we realized that one in five of those samples was positive for a substance, many of them being polydrug abusers, which included opiates, marijuana and so forth.

So this was obviously a daunting problem, and so at the Perinatal Partnership we decided to try to be proactive rather than reactive, and by that, I mean we wanted to see if we could reduce the numbers of babies with neonatal abstinence or at least reduce the severity of the neonatal abstinence syndrome at the end of the pregnancy. So we embarked upon a project that we called the Drug-Free Mothers and Babies Project whereby we sent out requests for proposals, got four or five in, and now have established four or five programs that are in the process. This project basically--the aspects of this project are, one, we screen

all women at the first antenatal visit, whether we do it using biological specimens like urine or we do it with screening tools such as what we call SBIRT screening, brief intervention, referral and treatment. And then once we have identified a woman, a pregnant woman, who is using an opiate specifically, we then refer them to an addiction counselor and behavioral medicine, and try to follow them throughout that pregnancy with a goal to reducing or first of all converting the substance they are using to another drug that we can probably wean throughout the pregnancy with a goal to reducing the amount of drug that the baby is exposed to during the pregnancy and ultimately get them either off the drug or on a very small dose so that the severity of neonatal abstinence would be that much reduced.

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

on throughout the pregnancy.

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

Thank you for the opportunity, Mr. Chairman.

[The prepared statement of Dr. Maxwell follows:]

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Mr. {Murphy.} Thank you.

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

Mrs. {Brooks.} Thank you, Mr. Chairman.

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

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

Mr. {Murphy.} Thank you.

You are recognized for 5 minutes. Thank you.

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^TESTIMONY OF RACHELLE GARDNER

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

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

The abuse of opiates continues to rise in central Indiana. According to the Indiana University Center for Health Policy, the number of adolescents receiving treatment for opiate dependence has risen 9 percent over the last 5 years. One of the most staggering statistics is that since 1999, the number of opiate-related deaths has quadrupled in

Indiana. Over the last 18 months, Fairbanks has admitted 360 young people ages 15 to 23 who indicated opiates as their primary drug of choice.

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

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

In the United States, 80 percent of students relapse from recovery upon returning to their high school following primary treatment for substance abuse. Fairbanks was seeing this same trend and in response, opened Hope Academy in 2006. Hope Academy is a public charter school sponsored by the Mayor of Indianapolis. We serve students in grades 9 through 12 who are seeking a safe, sober and supportive environment. We are committed to small class sizes with highly qualified

teachers who are well trained to educate and support students in recovery from drug and alcohol addiction. Most of our students struggle with co-occurring behavioral and mental health issues as well, yet because of the expertise of our staff, we are able to address these issues.

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

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

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

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

empowering our local communities. The passage of legislation is critical to helping our youth, our families and our communities who are fighting this epidemic on a daily basis.

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

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

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

[The prepared statement of Ms. Gardner follows:]

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Mr. {Murphy.} Thank you, Ms. Gardner.

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

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^TESTIMONY OF VICTOR FITZ

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

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

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

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

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

I know the Congressional representative from Colorado

spoke earlier about the 8,000 heroin deaths in the United States, and allow me just for a moment to personalize that from a prosecutor's perspective, from a law enforcement perspective. We had about 2 years ago in Cass County and Bering County in southwest Michigan, our two counties, we had a heroin death that occurred, or suspected heroin death. In Michigan we now have a law that indicates that if you deliver heroin or any drug and that causes the death of that person, it is the equivalent of a second-degree murder charge. Unfortunately, because of the newness of this statute, law enforcement not having protocols, did not seize upon the opportunity to investigate in that fashion initially. So as the investigation did take forward once my office became aware of it by the exhumation of the body, which I can tell you was something that was quite traumatic to the victims of the teen who had been killed from suspected drug activity. While that investigation was going on, in an effort to show that the death came from the use of heroin and other drugs that were supplied, this individual was still out on bond and he again delivered to another person, who also died from a heroin overdose. I can tell you that the pain and the agony is palpable for the victims and for those families.

On Monday of this week, I was talking to another family of a homicide situation, didn't happen to be drugs, but I can

tell you when it is a violent death, when it is a death from a drug overdose, the pain never leaves the family. Again, these are real. The number 8,000, as mentioned earlier, every one of those is a tragedy for the family and for the community and for the friends.

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

If I could have just one moment, I want to mention very briefly our prosecutor from Wayne County in the Detroit area.

Kim Worthy asked me this morning to just pass on a couple things very quickly that again this is again not just a rural issue, it is also an urban issue, and they have excessive pill mills, violent crime, robbing of pharmaceutical vehicles going through their neighborhoods, murders occurring from these situations, and she again emphasizes we need to attack it on both the supply and the demand end.

Thank you very much.

[The prepared statement of Mr. Fitz follows:]

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Mr. {Murphy.} Thank you very much.

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

Mr. {Mullin.} Thank you, Mr. Chairman.

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

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

Mr. {Murphy.} You are recognized for 5 minutes.

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^TESTIMONY OF MICHAEL GRIFFIN

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

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

Narcotics investigators within the Tulsa Police Department know that a large majority of individuals currently addicted to heroin began their drug abuse by abusing prescription drugs. The Tulsa Police Department currently has 751 sworn police officers. TPD believes the focus of drug investigations should be on those individuals who are responsible for trafficking drugs into and through our community rather than on those individuals who are merely addicted to drugs. This is because of our belief that resources are best utilized at the source of the problem

rather than on the symptoms of a problem. With that goal in mind, of the 751 sworn officers working for TPD, one investigator is assigned to investigate prescription drug cases within the city. One lone prescription drug investigator spent the last 20 years investigating prescription drug cases. He believes that Oklahoma has one of the best prescription monitoring programs in the United States. Oklahoma's PMP is real time and allows doctors and pharmacists to quickly access an individual's prescription drug history to evaluate if they are possibly doctor-shopping to gain access to prescription drugs.

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

Heroin trafficking in Tulsa is operated by Mexican drug trafficking organizations. Similar to other drug investigations conducted at the local or State level, the individuals most often arrested and prosecuted are the local dealers and operation leaders. However, the individual profiting most from the illegal distribution of heroin resides in Mexico and is usually beyond prosecution at the State level.

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

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

than does Mexico. The FBI states that each of the four major drugs of abuse are either produced in or transported through Mexico before reaching the United States.

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

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

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

international borders and finding their way into communities across the United States.

[The prepared statement of Mr. Griffin follows:]

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Mr. {Murphy.} Thank you, Corporal. I appreciate your testimony.

Last but not least is Dr. Banta-Green, Senior Research Scientist at the Alcohol and Drug Abuse Institute at the University of Washington in Seattle.

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

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^TESTIMONY OF CALEB BANTA-GREEN

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

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

Washington State so that they can respond to the overwhelming impacts of opioid abuse and overdose in their communities. That funding is from the SAMHSA block grant to our State substance abuse agency.

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

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

ones who use heroin that are necessary to provide lifesaving services.

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

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

Switching to those using opioids for chronic pain, realistic expectations about pain relief need to be discussed, including the fact that long-term opioid use may not lead to good pain control and in fact may reduce functioning. Washington State has led the nation by implementing chronic pain management guidelines in 2007 which have subsequently been codified in State law. Key points of these guidelines include: a dosing threshold trigger for consultation with a pain specialist; patient evaluation

elements; periodic review of a patient's course of treatment; encouraging prescriber education on the safe and effective uses of opioids; and the use of medication-assisted treatment if a person is not successfully tapered off of opioids and has an opioid use disorder.

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

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

and intervention simultaneously.

Thank you very much.

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

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

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

Ms. {Melton.} That is a great question and a point of controversy in the clinical setting. Of course, to me the goal of medication-assisted treatment is to provide a treatment for the patient where they are able to do the hard work and become productive members of society. And so the way I think of it as a patient who has addiction has constant craving and constant thoughts of where am I going to get my next opioid. When they are prescribed methadone or buprenorphine, the craving is relieved and they are able to focus their efforts on doing the really hard work that is necessary, and that is the psychotherapy, group, 12-step programs, et cetera. So the overall goal is for the patients to receive the treatment for a limited period of time. We usually tend to think of it as 2 years, one year for them to

become stable and do the hard work and perhaps a year to taper off of it. However, there are some patients that are wanting to have this maintenance for life. We know we have seen that in some patients, but the goal is eventually for them to be productive members of society and not to be maintained long-term.

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

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

Mr. {Murphy.} So there is an incentive, and isn't it--with regard to--are there incentives because there are cash transactions in many cases and what you describe, they become pill mills? Is that what it has become?

Ms. {Melton.} Yes. We are seeing that, and it is devastating in many circumstances. There is a dearth of

access to good treatment, and by ``good treatment,'' I mean patients being seen frequently, getting urine drug screens at nearly every visit, if not every visit, requiring 12-step programs, group counseling, and not co-prescribing with other drugs of addiction such as benzodiazepines.

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

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

Mr. {Brason.} Getting patients off--

Mr. {Murphy.} Yes, off drugs.

Mr. {Brason.} A comprehensive approach and determining and assessing that individual of what the best treatment modality may be. Some can walk right into a 12-step abstinence program. Others who have been using for even longer then do need that maintenance therapy in order to give them that stability so that you can work on their entire life. Now, somebody who is getting the methadone or the buprenorphine can receive that, and that takes maybe--if they are getting daily dosed--an hour and a half a day. What happens to the other 22, 23 hours of that person's life when

they had gone from 24/7 of looking to use, getting to use and figuring out where they are going to, you know, obtain that? It takes community support. You have got to have the life systems around that individual so that if they are getting the right maintenance therapy or the right 12 steps, they have got the counseling, they have all of those in place, but what happens when they go home? You know, you talk about a rural community. They leave their house or they go to detox and they leave detox during the same home, same environment, same friends. You know, if there is no other support around that to help them stay strong in that environment, then they fall back into the same situation.

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

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

Mr. {Murphy.} And in simple words too, Ms. Gardner, is

there hope? Can you give someone hope that they can get off drugs?

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

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

Mr. {Murphy.} Thank you.

Ms. {Gardner.} And we need to focus on the hope.

Mr. {Murphy.} Thank you.

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

Ms. {DeGette.} Thank you very much, Mr. Chairman.

Dr. Banta-Green, I was very interested in your testimony

that when somebody becomes addicted to opiates, there are actually changes in their brain. Is that right? And I am assuming, Dr. Melton, you would agree with that as well from your testimony. You need to answer.

Ms. {Melton.} I agree, yes.

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

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

Ms. {DeGette.} Right.

Mr. {Banta-Green.} We need a menu of things. Different things work for different people.

Ms. {DeGette.} And would you agree with that, Dr. Melton?

Ms. {Melton.} I also agree, yes.

Ms. {DeGette.} And so what we have learned is, and we have been referring to this, there was a recent article that said that abstinence-based treatment only works in about 10

percent of opiate addicts. Would you agree with that, Dr. Banta-Green?

Mr. {Banta-Green.} I am not sure it is exactly 10 percent. What I--

Ms. {DeGette.} But it is a low percentage, right?

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

Ms. {DeGette.} Okay.

Mr. {Banta-Green.} There are different paths for different people.

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

Mr. {Banta-Green.} Absolutely. There is no question about that.

Ms. {DeGette.} And were you aware that the MAT treatment was only available in about 9 percent of all

substance abuse treatment facilities nationwide?

Mr. {Banta-Green.} I know that it is a very low proportion.

Ms. {DeGette.} And Dr. Melton, were you aware of that too?

Ms. {Melton.} Yes.

Ms. {DeGette.} Okay. And Mr. Brason?

Mr. {Brason.} Yes.

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

Ms. {Melton.} That is correct.

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

Mr. {Brason.} That is correct also, yes.

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

Banta-Green?

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

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

Mr. {Banta-Green.} No.

Ms. {DeGette.} Okay.

Mr. {Banta-Green.} I would say that the goal is for the person to do well, and for some of them, that is going to be to go off the medications immediately. They are not going to do well on those medications. For other people, they are going to have a short period. For people who have been involved in addiction and a lot of their life has been wrapped around it for 10, 15, 20 years, that is going to take

a long time to work through and it is going to take a longtime for them to recreate that life. So some people may need to be on them long term, some not at all, some short term.

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

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

Ms. {DeGette.} Okay.

Ms. {Melton.} But for some people, it will be a lifetime, as I said.

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

Ms. {Melton.} Some people are able to do abstinence.

Ms. {DeGette.} And you agree with that too, Mr. Brason?

Mr. {Brason.} Yes, I do.

Ms. {DeGette.} Thank you very much, Mr. Chairman.

Mr. {Murphy.} Thank you, Ms. DeGette. I now recognize Mr. McKinley for 5 minutes.

Mr. {McKinley.} Thank you again, Mr. Chairman.

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

Dr. {Maxwell.} I will try, sir. The pay-for-success model I was introduced to last year when I attended as one of the representatives for our State at Readynation.org meeting in Charlotte, which was their first meeting, and they have brought this pay for success or social impact bond concept to the United States based on Great Britain's experience a few years ago looking at recidivism rates for juveniles going

back into jail, and they had some success in Great Britain. The program was brought here by Robert Dogle and some other members of the ReadyNation organization, and I think--I can't tell you exactly how many States but Virginia, North and South Carolina, I think New Jersey have implemented some of these programs. Some are actually social impact programs, some are pay-for-success programs looking at early childhood education and so forth.

I was intrigued when I heard of the model, and the model, I will have to read it for you because it makes a little bit more sense if I read it. Under this model, an investor finances the implementation of a proven or evidence-based social intervention program that is expected to improve social welfare and save government money in excess of the program implementation cost. So the government at the end repays the investment only after the program can measurably reduce state expenditures as a result of its successful implementation. So I thought that looking at our drug-free moms and babies model, that if it in fact is successful, that we could have this end up in a pay-for-success program because you identify women early in pregnancy using a screening tool, and as I said, urine is not a very good screening tool because if the woman has not done a substance in 2 or 3 days, then the urine will be negative, especially

for alcohol, but for narcotics, you know, I think that if they use it within a 24-hour period of time prior to the test that the urine will be positive. But the urine is never--it is not universally positive. And so we depend upon another tool. In West Virginia, we are using a tool that we call SBIRT. There are other areas. People in Chicago, Dr. Chasnoff and his people are using the Five Piece Plus model, which is trademarked and so forth, so it is expensive.

So we use the SBIRT model, and there are people who train others to use this screening tool because the questions have to be asked in a specific way in order to get the answers. And so once you have screened them and you realize that they are positive, then we hope that we can get them into addiction counseling, and I have found looking at the programs that we have had in place now for the last 2 years or so, that addiction counseling and rehabilitation using behavioral medicine specialists seems to be the way to go because pregnancy is a unique opportunity, I think, to address addiction, and we find, I believe, that there is a very positive motivating force that occurs when you are pregnant because a woman really wants to deliver a healthy baby, believe it or not.

And so I have found that if we can intervene early in pregnancy, that throughout that pregnancy we might be able to

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

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

Mr. {McKinley.} Thank you very much. I yield back my time.

Mr. {Murphy.} Thank you. Mr. Tonko, you are recognized for 5 minutes.

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

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

Mr. {Murphy.} Without objection.

[The information follows:]

********** COMMITTEE INSERT **********

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Mr. {Tonko.} Thank you.

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

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

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

But having said that, I am on the Governor's Advisory Council for Substance Abuse in West Virginia. Governor Tomlin established this probably 3, 4, years ago now, and we have an advisory council that oversees the work of task forces within the State. We have split the State into six

different areas, and each area, each of those six areas has a task force, and the task force has meetings every month or bimonthly at the community level where they get information from the people. And then they bring that to the advisory council and we meet once or twice a year to collate all that information in terms of access to care, who is getting what and so forth, and where treatment centers are needed, et cetera, and we have had some success. The first year we had $7 million to spend, and we advised the Governor how to spend that money by identifying areas within the State that needed a treatment center, or because I am biased and, you know, it was for women and pregnant women treatment, but--so we are working on that problem. I don't have all that information with me but I can get it to you.

Mr. {Tonko.} Thank you. That would be most helpful.

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

Mr. {Banta-Green.} Thank you for the question. So just to be clear, methadone maintenance is done in large treatment facilities, generally in larger cities, and there actually is

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

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

doing addiction treatment. So those are some of the barriers that are faced in terms of having enough physicians step up to prescribe at the same time is really important. There are reimbursement issues and then there are also those geographic issues as well.

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

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

Mr. {Tonko.} Especially with it being a gateway to the addiction, heroin addiction.

I thank you very much. I see my time is exhausted, and

I yield back, Mr. Chair.

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

Mr. {Griffith.} Thank you, Mr. Chairman. I appreciate that very much.

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

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

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

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

Mr. {Griffith.} I recently wrote a bipartisan letter with 22 of my colleagues here in the House calling on the Administration to develop practices for naloxone use and reprogram existing funds to provide naloxone to medical providers. I think that is a good idea. You have mentioned here in your earlier testimony Senator Kaine's bill that provides Good Samaritans with some immunity from liability unless they are acting grossly negligently or maliciously. What else do you think that we can do to promote this from a Congressional standpoint and make sure that the public is aware of it?

Ms. {Melton.} Well, I think one issue is, I think we are getting the awareness going across the country now but access to it, patients being able to afford it is a difficulty. It really needs to be mandated coverage by

insurance companies so we are able to access it easily at the pharmacy. Virginia's new legislation will allow pharmacists to, through a collaborative practice agreement, write prescriptions for patients that come in and ask for it and train them on the spot, which I think is a huge step forward, so that will increase access, but again, the payment issues are a barrier.

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

Ms. {Melton.} I agree.

Mr. {Griffith.} Yes, ma'am.

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

Ms. {Melton.} Okay. So as I stated in my testimony,

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

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

Do either of the folks want to add something?

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

Mr. {Griffith.} Very good.

Dr. Maxwell?

Dr. {Maxwell.} From West Virginia, yes, we have recently passed legislation for pharmaceutical tracking, et

cetera.

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

Mr. {Griffith.} Yes, sir. I appreciate it very much.

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

Mr. {Murphy.} Thank you, Mr. Griffith.

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

[Recess.]

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

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

Mr. {Mullin.} Thank you, Mr. Chairman, and Mike, thank

you again for taking the time to come up here and give your professional opinion.

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

Mr. {Griffin.} So the barrier, or the goal, of course, in all our drug investigations is, like I said earlier, we are not targeting individuals addicted to drugs. We are going after the people that are hurting other people by supplying drugs and ruining those people's lives. So when you think of methamphetamine, cocaine, heroin, things like that, you are always working up the ladder, so to speak, to get to the biggest drug dealer we can find and almost always that leads us back to the U.S. border with Mexico. Different from that is prescription drugs where in those situations--I

hate to use the word ``dealer'' but the dealer in that situation is a doctor or a pharmacist. Ninety-nine-plus percent of those people are law-abiding people doing the right thing for all the right reasons. A very small percentage of them may be taking advantage of the situation.

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

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

Mr. {Griffin.} Yes, sir.

Mr. {Mullin.} Are you being successful at that?

Mr. {Griffin.} We are very successful at it. We have a great relationship with other law enforcement agencies in the area to include DEA and FBI. We are constantly working on cases that cross State boundaries. We are working a very big case right now. Hopefully we will really start moving further down the road within the next week or two, and we already know that that case is an international case that has

been operating for a long, long time, not only in the United States but in Oklahoma, and that is a case we will work all the way into Mexico with the help of federal law enforcement agencies.

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

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

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

Mr. {Mullin.} Corporal Griffin, you have a tremendous

amount of knowledge about meth too.

Mr. {Griffin.} Methamphetamine is just the biggest drug facing Oklahoma right now.

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

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

Mr. {Fitz.} There is a large percentage, but again, that is just the tragic reality of drug activity is not only

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

Mr. {Mullin.} Corporal Griffin, Mr. Fitz, thank you so much. Thank you, Mr. Chairman.

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

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

I have actually been a defense attorney. I have been a United States attorney. I was at our State's community college and have dealt with individuals with addiction but nothing really touched me as much as when I went and visited the Hope Academy and saw a recovery high school and realized that that is the type of program--because I have been involved in the take-downs of the big cartels and organizations in our community in the southern district of Indiana, but we have to stop it. There is always going to be a supply but I want to focus a bit on the demand and what we are doing on the demand side, and I really appreciate you being here, Ms. Gardner, and want to ask about those recovery supports that are so important and what are some of the things--I would like you to talk a bit more about how the high school works and about what--because there are only 35 in the country but yet you have had really very wonderful results. You have alumni who are involved. You have--

Fairbanks Hospital has brought the community together, but I have to tell you, when I sat in the circle with kids who had the support group, and when a young girl said to the group she was turning 17 the next day and it was her first birthday in 4 years that she would be sober, it broke my heart.

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

Ms. {Gardner.} So a little bit about the school. We are a high school so we are 9th through 12th grade, public education, so it is a tuition-free school. It looks a little different at our school. They start a little later. They--we have--what we have in the school is called recovery coaches. So, you know, it is about--it is a dual recovery. It is about gaining better grades so that they can go on to higher education but it is also about helping them to stay in long-term recovery. Sometimes that is a daily battle. Some kids have been there that have been there, you know, that have 6 months to a year sober. Some have 30 days. They come to us from treatment centers. They come to us from private therapists. They come to us from jails, from probation. So we are dealing with a wide variety of young people. But the whole goal is to help them be in a safe, sober environment and to be able to go on to graduate and be successful.

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

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

Ms. {Gardner.} So we have talked a lot about law enforcement, we have talked a lot about medication. We have talked--treatment is--access to treatment is a problem across the country. The Affordable Care Act has allowed the ability for more people to get it. My opinion in Indiana currently, our young people don't get to stay long enough in treatment. We look at young people like we look at adults. They don't have the--their brains haven't developed the ability to make informed decisions and so you are looking at a young person who is addicted but also having to be an adolescent and grow--help them grow with their development. They need longer

times away from those people, places and things, and their ability to access recovery supports, be it schools, be it things within a traditional school, be it long-term aftercare kinds of programs, which aren't funded.

Mrs. {Brooks.} Thank you for that.

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

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

But again, it is a balance because we recognize that if they don't get clean, that we need to continue to protect the public because even drug addicts sometimes do very

unfortunate things--child abuse, sexual abuse, thefts, things of that sort, crimes of violent. So it invasive species balance but prosecutors do see a need for more treatment.

Mrs. {Brooks.} Thank you. I yield back.

Mr. {Murphy.} Thank you, Ms. Brooks.

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

Ms. {DeGette.} I will follow up on what Ms. Brooks was just asking Mr. Fitz.

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

Mr. {Fitz.} I don't.

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

Mr. {Fitz.} Yes.

Ms. {DeGette.} I mean, it is a terrible problem. So one reason they have started drug courts is so that we can find a way to do the different kinds of treatment that all of the experts here talked--every single expert said, you know, it is not just a one-shot deal with people who get addicted to these opiates. Since it changes your brain, different

people need types of treatment. But something that is unique about drug courts is that they are trying to send these offenders to programs. They are not just saying to folks, okay, now go get clean. I mean, they send them into programs, right?

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

Ms. {DeGette.} Right.

Mr. {Fitz.} --daily drug testing, the things they need to get on the straight and narrow, so to speak.

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

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

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

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

Ms. {DeGette.} Right.

Mr. {Banta-Green.} --would be a nice partnership and maybe a win-win both for the--well, for the community in terms of having a lot less crime--

Ms. {DeGette.} And you might see less recidivism too.

Mr. {Banta-Green.} Absolutely.

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

Mr. {Murphy.} Sure. Without objection.

[The information follows:]

********** COMMITTEE INSERT **********

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

Mr. {Murphy.} Thank you. The gentlelady yields back.

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

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

But I want to ask one follow-up question. On that first issue of dealing with healthcare professionals who over-prescribe, some doctors have told me that now as they are

rated by patients, one of the things they are rated on is, you know, the comfort level and managing pain, and of course, a physician who is looking to boost their ratings doesn't want that patient to leave their office in pain. So there is an incentive there, again, one of these bizarre incentives we have to over-prescribe. Any of you have any comments on that and how we deal with that aspect of things? Mr. Brason.

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

And then coupled with that, the FDA has been approving abuse-deterrent formulations to make them available to individuals so that they can't crush and they can't snort and they can't inject. So when you are combining that federal-level work with the local prescriber, you can still prescribe but then it is a much safer product.

The problem we have is the coverage in order to pay for

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

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

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

Dr. Banta-Green.

Mr. {Banta-Green.} I would just mention so the University of Washington in terms of trying to limit opioid use and treat pain well, and again, as you mentioned, the JCAHO is actually focused on pain as the fifth vital sign, and we think that is part of what has led a lot of visits. It is easy to quickly treat pain with an opiate, and what we

are seeing is that, as I mentioned earlier, it may lead to a lot of dysfunction, but if pain is your measure, if symptom relief is your pure measure, you are in trouble, because what we really care about is functioning, and that is really the idea that we are moving towards. There is a nice computer-based support for physicians called the Pain Tracker that among other things really helps that patient focus every visit on what is their functioning, not just their pain level, but really, what is their functioning.

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

So as a person who has dealt with folks with substance abuse, as a person who has lived with someone with substance

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

Ms. {Gardner.} Yes, sir.

Mr. {Murphy.} That is awesome.

Ms. {Gardner.} Thank you.

Mr. {Murphy.} We wish him the best. And all of you, thank you for your frontline work.

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

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

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