MEDICAL EXPERTS: INADEQUATE FEDERAL APPROACH TO OPIOID TREATMENT AND THE NEED TO EXPAND CARE

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C O N T E N T S

MEDICAL EXPERTS: INADEQUATE FEDERAL APPROACH TO OPIOID TREATMENT AND THE NEED TO EXPAND CARE

Wednesday, June 19, 2019

HOUSE OF REPRESENTATIVES
COMMITTEE ON OVERSIGHT AND REFORM
WASHINGTON, D.C.

The committee met, pursuant to notice, at 10:03 a.m., in room 2154, Rayburn House Office Building, Hon. Elijah Cummings (chairman of the committee) presiding.

Present: Representatives Cummings, Maloney, Norton, Clay, Connolly, Krishnamoorthi, Raskin, Rouda, Hill, Wasserman Schultz, Sarbanes, Welch, Speier, Kelly, DeSaulnier, Khanna, Ocasio-Cortez, Pressley, Tlaib, Jordan, Amash, Massie, Meadows, Grothman, Comer, Cloud, Gibbs, Higgins, Norman, Roy, Miller, Green, and Steube.

Chairman CUMMINGS. The committee will come to order. Without objection, the chair is authorized to declare a recess of the committee at any time. The full committee hearing is convening to hear from medical experts regarding the Inadequate Federal Approach to the Opioid Treatment and the Need to Expand Care.

I now recognize myself for five minutes to give an opening.

First of all, I want to thank all of you very much for being here this morning. We're honored to have some of our Nation's most accomplished medical experts and practitioners working on the frontlines, and they are here to testify today.

Today, the committee will be examining legislation that could significantly increase access to treatment across the country for those suffering from substance use disorder. Substance use disorder is a generational health crisis, but most people suffering from it are not able to get the evidence-based treatment that they so urgently need.

More than 270,000 Americans died from drug overdoses from 2013 to 2017. Despite this staggering loss of life, a study based on the National Survey on Drug Use and Health found that those who have substance use disorder, and I quote, "Only 10.8 percent receive specialty treatment."

The National Academies of Science, Engineering, and Medicine reported earlier this year that in 2016 just 36 percent of the specialty treatment facilities offered any form of FDA-approved medication for opioid use disorder. It concluded, "Only six percent of facilities offered all three medications" approved to treat this disease.

The National Academies also warn, and I quote, "Efforts to date have made no real headway in stemming this crisis, in large part

because tools that are already in existence, like evidence-based medications, are not being deployed to maximum impact."

The response of the Administration and Congress has been woefully inadequate. For the entire first two years of the Trump Administration the President failed to issue a national drug control strategy, even though it was required by law.

Finally, in this past January, the Administration released its first strategy, but it failed to meet even the most basic requirements of the law. Even more shocking, its stated goal is to reduce the overdose deaths by only 15 percent over the next five years. And ladies and gentlemen, I'm convinced that we can do better than that. Not only can we do better than that, we must do better than that, because these are people's children, their mothers, their fathers, their classmates, who are dying. And there are so many in the pipeline to die.

And so, let me put all of that into context. Even if the Administration reaches its stated goal, more than 200,000 Americans will still die of overdoses by 2022. Congress has also failed to act with the urgency this crisis demands. Last year, Congress passed a support act. Although that bill took small steps to expand treatment, it only nibbled at the edges of this generational health crisis.

Meanwhile, nearly 200 Americans continue to die every single day during this epidemic. The CARE Act offers a comprehensive evidence-based approach to getting people the treatment they need to save their lives. And it is endorsed by the medical professionals across the country. The CARE Act is co-sponsored by more than 100 members of the House, including every single democratic member of this committee.

Even the Trump Administration's director of the Office of Drug Control Policy, Jim Curiel, has commended, and I quote, calling it "The heart and the spirit of this legislation," is something that he likes.

The CARE Act would apply the proven model we've adopted on a bipartisan basis to fight HIV, the AIDS epidemic. I can remember when people questioned whether or not we would be able to address AIDS, and we have done an effective job. Is there more to do? Yes. But we didn't just throw up our hands and say, "Let folk die." We said we were going to do something about it.

So, the CARE Act would authorize $10 billion for a year to provide states and local communities with stable funding to build robust treatment infrastructure. And what we're talking about is effective and efficient treatment. I'm not talking about people that throw up a shop on the corner, like I see some places in my town, and distribute certain types of medications, and then call themselves giving people treatment. I'm talking about real evidence-based treatment.

And it would expand access to medication assistant treatment, and the wraparound services that are necessary. It would incentivize states to adopt model standards for treatment programs and recovery residences. It would provide $500 million per year to buy the overdose anecdote Naloxone, and distribute it to first responders, public health offices, and the public. The CARE Act has been endorsed by more than 200 organizations. For example, the American Medical Association has endorsed the CARE Act, noting,

"The CARE Act is intended to fill the current funding gap. It sets up a framework to do so."

The American Society of Addiction Medicine supports the CARE Act, because it will, "Help communities of all shapes and sizes, provide critically needed and evidence-based addiction prevention, treatment, engagement, and recovery services."

The American Psychological Association endorsed the CARE Act, noting that, "The CARE Act acknowledges that a fundamental requirement for successfully addressing the drug overdose epidemic is treating the whole person."

Finally, the National Nurses United endorse the CARE Act, and wrote, "In order to effectively combat this horrible epidemic and save the lives of our patients, it is necessary for this committee and Members of the Congress in full to commit to fully fund the response to the opioid crisis. We urge you to support and pass the Comprehensive Addiction Resources Emergency Act of 2019, and look forward to working with you to do so."

I've often said that, at 68, I've been seeing this drug problem a long time. The first person that I've ever heard of dying of an overdose was somebody who died in my neighborhood when I was eight years old. And I didn't even know what an overdose was. But the fact is that I've seen many people die over the years.

But we have not come here just to speak for those who have died. We've come to speak for the living and the dead. There are so many people who have been in so much pain that they didn't even know they were in pain. There are so many people that were suffering from psychological problems, and did not realizes how much trouble they're in.

Even in my neighborhood, I can see people sometimes at three at night chasing death, trying to get drugs, trying to again put themselves out of pain. And so, we cannot look at them as collateral damage. We have to address them. Again, these are our neighbors, these are our friends, these are our church members. These are our fellow students. These are our fellow workers.

And so, I am looking forward, and I want to thank all of the associations that have joined us today. We can do this. And again, I thank you. And now we will hear from distinguished ranking member of our committee, Mr. Jordan.

Mr. JORDAN. Mr. Chairman, thank you. I know you care passionately about this, and we appreciate that, the commitment to dealing with this crisis. And this is one of the most trying issues of our time. And this committee has rightfully treated the ongoing epidemic as an issue of the utmost importance. Chairman Cummings and I both represent states that have been severely affected, and the situation, as the chairman described, is nothing short of heartbreaking.

Our home state of Ohio has the second worst opioid overdose death rate in the country. In Ohio more people die from overdoses than from car accidents. Over the course of a single year Ohio has witnessed almost 5,000 fatal drug overdoses. That's nearly 14 deaths every single day.

As all too many of you know, this staggering death toll does not begin to capture the devastation inflicted on families and communities. Today, we will discuss the sad fact that many Americans

suffering with addiction are not able to access evidence-based treatment options. The witnesses her today, who help us understand the extent of this problem, how we can get to the solution. And I appreciate you all being here, and look forward to hearing what you have to say.

This is an issue deserving of Congress's attention, and I'm pleased that this committee has made it a priority. I'm also encouraged the Trump Administration is fully committed, fully committed to addressing the problem. As we have heard during two recent hearings with Office of National Drug Control Policy, the Administration has a plan to reduce opioid demand, cutoff the flow of elicit drugs, and save lives by increasing access to treatment.

The plan is producing results. Since President Trump took office there has been a 34 percent decrease in the total amount of opioids that pharmacies dispense monthly. Also, the number of patients receiving a form of medication-assisted treatment has increased dramatically.

Monthly prescribing of lifesaving Naloxone, as the chairman talked about, has increased 484 percent. The Trump Administration has invested $500 million in the HEAL Initiative to bring new non-addicted pain med management therapies to patients in need. And this Administration is making great strides to enforce parity rules so more insurers are providing the services that their members are entitled to.

Last year, President Trump signed into law legislation that allocates $6 billion specifically dedicated to combatting the crisis. This crisis does not strike each community in the same way. What prevention and treatment efforts may be effective in one area may not work as well in another? What we know for sure is that this is not a problem that funding alone can solve. We need to thoughtfully empower communities to address their unique needs to reduce the supply of drugs, prevent drug use, and provide access to needed treatment.

It would also be a mistake not to address one of the root causes of the opioid crises. We should consider securing our borders, a necessary part of this effort to deal with this problem. Earlier this year enough Fentanyl was seized in one drug bust, in one seizure, enough Fentanyl to kill 57 million people. It's scary to think of how much is getting through.

I'm grateful for medical processionals who are with us this morning. You are on the front lines battling this problem daily. Thank you. Thank you for taking the time to be here to discuss this health crisis.

And I should just point out, too, that there are a number of important things going on this morning. This one is certainly one of them, but there's a reparation's hearing next-door. There's a former White House adviser upstairs in a deposition. And I'm supposed to be at all three places at the same time. So, I will be in and out, but I do look forward to hearing from what you have to say. Other members will be in that same position.

But, again, Mr. Chairman, thank you for this hearing. And, again, I want to thank our witness for being here. And I yield back.

Chairman CUMMINGS. I want to thank you, Mr. Ranking Member.

Now I would like to welcome our witnesses. Dr. Susan Bailey is the President-elect of the American Medical Association. Dr. Yngvild Olsen is the Vice President of the American Society of Addiction Medicine, and Medical Director of the Institutes for Behavior Resources, Inc., REACH Health Services, in Baltimore. Dr. Arthur C. Evans, Jr., is the Chief Executive Officer and Executive Vice President of the American Psychological Association. Ms. Jean Ross is a registered nurse, and is the President of the National Nurses United. And Ms. Angela Gray is a registered nurse, and is the nurse-director of the Berkeley-Morgan County Board of Health, in West Virginia. Dr. Nancy Young is the Executive Director of Children and Family Futures.

If you all would please rise, and raise your right hand, and I will begin to swear you in.

Do you swear or affirm that the testimony you are about to give is the truth, the whole truth, and nothing but the truth, so help you God?

You may be seated. Let the record show that the witnesses answered in the affirmative.

Let me just let you know that the microphones are very sensitive. Make sure that they're on when you speak. We will hear from each of you, and understand that we have your testimony. And basically, what we're looking for you to do is summarize it.

As you can see, we've got a—this is a pretty big panel. Usually we only have four people. So, we just ask that you stay within the five-minutes. Of course, you're familiar with the lighting system. If you see a red light you might want to wrap it up. Okay?

Dr. Bailey?

STATEMENT OF SUSAN R. BAILEY, PRESIDENT-ELECT, AMERICAN MEDICAL ASSOCIATION

Dr. BAILEY. Good morning. Chairman Cummings, Ranking Member Jordan, committee members, the American Medical Association commends you for holding today's hearings. My name is Dr. Susan Bailey, and I am president-elect of the AMA. I'm a practicing allergist immunologist from Ft. Worth, Texas, and I thank you for this opportunity to testify today.

The nation's epidemic of opioid-related overdoses and deaths continues to worsen. Nearly 20 million people in the United States have a substance use disorder, putting them at a greatly increased risk of early death from overdose, infectious diseases, trauma, suicide, and more than 92 percent of these patients receive no treatment.

According to the National Institute on Drug Abuse more than 130 people per day, we heard the chairman say upwards of 200, die in the United States every day from an opioid-related cause.

If there's any good news in this epidemic is that we know what works. There is clear evidence that medication-assisted treatment, commonly referred to as MAT, is a proven medical model that supports recovery, saves lives, reduces crime, and improves quality of life. Methadone, buprenorphine, and Naltrexone are approved medications to treat this disorder.

The bad news, however, is that only a small portion, maybe about a third of people with opioid use disorder, receive any type

of treatment, and only a small set of those receive MAT. So, if we know what works——

Chairman CUMMINGS. Wait a minute. Hold——

Dr. BAILEY [continuing]. why is it so hard for people to get the treatment?

Chairman CUMMINGS. Hold up. Hold up. Hold up. We've got to keep those doors closed. I can barely hear what you were saying.

Dr. BAILEY. Thank you.

Chairman CUMMINGS. All right.

Dr. BAILEY. So, if we know what works, why is it so hard to get treatment? There are several reasons that I would like to highlight.

First, there are administrative barriers imposed by payers and pharmacy benefit management companies on MAT drugs, such as prior authorization and step therapy. The AMA calls on all payers, both private and public, as well as PBMs, to end these administrative burdens for the treatment of opioid use disorder.

In addition, MAT should be available on the lowest cost-sharing tier to promote affordability as well as promote availability. There is no clinically valid reason to deny or delay access to these life-saving evidence-based medications.

A second reason for limited access to treatment is the lack of enforcement of mental health and substance use disorder parity laws. Very high rates of mental disorders coexist among patient with opioid use disorders, as well as among patients with chronic pain conditions, leading to an increased risk of suicide.

More than 10 years after the passage of the Mental Health Parity and Addiction Equity Act, huge gaps in treatment for substance use disorder and mental health disorders are simply unacceptable. The AMA continues to call on policymakers to enforce the parity laws provisions. Insurers need to be held accountable for not complying with their obligations required by law.

Insurers must have addiction medicine and psychiatric physicians in their networks, and the networks have to be accepting new patients, as well as have mental health and SUD coverage that is on par with surgical and medical benefits.

A third reason for the gap in treatment is funding and infrastructure. There is an enormous need for long-term funding and policy to build a robust, flexible, evidence-based public infrastructure that can handle the opioid epidemic, and prepares us to treat other growing concerns, including the increased use of methamphetamine, which brings me to the CARE Act.

Its funding level is a substantial increase and in keeping with the enormity of the subject. At the patient level, the bill would provide grant preferences to states that have prohibited prior authorization and STEP therapy for NIT. Overall, the bill will help create the nationwide infrastructure needed to address this and future epidemics, and the AMA is pleased to support it.

Thank you.

Chairman CUMMINGS. Thank you very much. Dr. Olsen?

STATEMENT OF YNGVILD K. OLSEN, VICE PRESIDENT, AMERICAN SOCIETY OF ADDICTION MEDICINE

Dr. OLSEN. Thank you. And good morning, Chairman Cummings, Ranking Member Jordan, esteemed members of this committee.

And thank you so much for inviting me to participate in this important hearing.

My name is Dr. Yngvild Olsen. I'm a general internist, board certified in addiction medicine, and care for patients with addiction in the state of Maryland. I'm also the vice president of the American Society of Addiction Medicine, or ASAM, a national medical society representing over 6,000 physicians and other clinicians who specialize in the treatment and treatment of addiction.

And I'd like to start with a story of one of my patients, whom I will call Andy. In 2011, Andy walked into my office and told me was addicted to heroin. His life was in shambles, and his mother and ex-wife were unwilling to let him see his two children.

Andy began taking methadone and receiving counseling in our clinic. And slowly he began to escape Heroin's grip. Previously, he had struggled for years to maintain a job while suffering with addiction. But since starting treatment, he has stopped problematic substance use for long periods of time, has been able to work, has been able to pay child support, and has been able to support himself and his new wife. And he is an involved father in the life of his children.

However, out of his 11 close high school friends, Andy is the only sole survivor. The others have all died of drug overdose. And I think of Andy and his high school friends every time I see the statistic in the 2016 surgeon general's report that only about one in ten people with addiction receive specialty treatment.

And inspired by Andy, and by many of my patients, who have overcome incredible challenges in their lives to achieve recovery, I've three points to make to you today.

First, everywhere we look we are missing opportunities to save lives. Evidence-based addiction treatment reduces crime, increases employment, and reduces the transmission of infectious disease. And specifically, we have medications for the treatment of opioid addiction that reduce the risk of fatal overdose by half or more.

Yet, we can leave this hearing room today together and visit emergency departments and jails across the country, where we will find people with addiction unable to start treatment meeting generally accepted standards of care. And we can walk together around cities, towns, and rural areas in every single one of your districts, and we will find people using drugs without hope for the future, and without access to lifesaving care.

And second, to end the addiction and overdose crisis, we must pay for it. I deeply appreciate that Congress has appropriated several billion extra dollars in the last few years to support efforts in every state. And there's no question that these investments have saved lives. But about 70,000 Americans each year are dying from drug overdose.

Far more resources are necessary in the interventions shown to have the most impact to save more lives. It requires more than more funding. It requires smart funding. Paying to save lives starts with comprehensive insurance coverage, including private insurance, Medicare, and Medicaid.

My patient Andy is covered by Medicaid. He relies on that coverage not only for the care I provide, but also for mental health

treatment that has allowed him to overcome a terrible legacy of trauma related to childhood sexual abuse.

But payment for treatment alone is just the beginning. Communities need additional resources to create systems of care and social services that give every individual the opportunity to achieve and sustain recovery. And one terrific model is the Ryan White Care Act. Ryan White is the act of Congress that has made it possible for our national goal today to be the end of the HIV epidemic.

We need a similar investment so that we can one day achieve the national goal of ending our addiction and overdose crisis. And that's why ASAM supports the CARE Act. This legislation, modeled on the Ryan White Care Act, authorizes $100 billion over the next decade to help communities of all shapes and sizes provide critically needed and evidence-based addiction prevention, treatment, harm reduction, and recovery services.

And third, ending the addiction and overdose crisis requires more than new resources. It requires a new attitude. Because drug addiction is not a moral failure. It is a complex and chronic disease. And people with addiction deserve care and support, not stigma and ostracism. All practitioners who care for patients should learn to identify and treat patients with addiction, and take pride in doing so.

Police departments should measure success by fewer overdoses and less crime, not by the number of arrests of people who have a disease. And instead of only focusing on some people with addiction, based on address, or class, or race, or ethnicity, we should embrace the following, that everyone with addiction deserves the opportunity for treatment and recovery.

Because looking back more than a century, historians have called opiate addiction the American disease. It's time to write the final chapter of this history. It's time for the United States to take a compassionate, humane, and public health approach to this crisis.

So, thank you for the opportunity to testify today, and I look forward to your questions.

Chairman CUMMINGS. Thank you very much. Dr. Evans?

STATEMENT OF ARTHUR C. EVANS, JR., CEO AND EXECUTIVE VICE PRESIDENT, AMERICAN PSYCHOLOGICAL ASSOCIATION

Dr. EVANS. Chairman Cummings, Ranking Member Jordan, and members of the Committee on Oversight and Reform, thank you. I'm Dr. Arthur C. Evans, chief executive officer of the American Psychological Association, which has a membership of over 118,000 psychologists and affiliates.

Mr. Chairman, psychologists are on the front lines of providing clinical services, conducting research, developing policy, and providing education to help combat the opioid crisis. I want to convey two key points today.

The first is that successfully treating opioid and substance use disorders really requires a whole-person approach, articulated by SAMSO. Second, we need to incorporate non-pharmacological pain management in dealing with the opioid epidemic.

So first, let me talk about the whole-person approach. Substance use disorders are very complex. They have behavioral, biological, and social underpinnings. Research indicates that you have to ad-

dress all of these areas if we're going to be effective in treating and helping people to achieve long-term recovery.

My understanding of these conditions is informed by 30 years of work in the field, including as a clinician, as a researcher doing treatment studies, a faculty at medical schools training psychologists and physicians, and as a program director overseeing treatment programs for people with opioid dependency.

I also spent 20 years of my career as a policymaker in the state of Connecticut and in Philadelphia overseeing large behavioral health treatment systems.

One of the things that I've learned in my career is that we must based our practices and policies on the best available research. And the research is clear that the most effective treatment for opioid use disorders include psychosocial interventions in combination with medications. In other words, medication-assisted treatment means medications are used to assist in the treatment process, not be the treatment.

This is important, because as a former director of a medication-assisted treatment program, I know how easy it is to give short shrift to psychosocial interventions, and in doing so we are not giving people the best opportunity for long-term recovery.

Our policies and funding strategies should ensure that people have access to the full range of services and supports that they need. This is why APA supports the CARE Act, because it embraces this whole-person approach. Grantees would be able to use CARE Act funding to provide a wide range of treatment, as well as recovery support services, including those that have helped people to access education, housing, and job training.

People could receive these services through multiple pathways, including faith-based organizations, vocational rehabilitation agencies, housing agencies, and community-based entities.

Turning to my second point. We need to make non-pharmacological pain management more available to people, because this is critical if we're going to help reduce the misuse and dependency on opioids.

Research has shown that pain involves a complex interaction of physiological, psychological, and social factors. Psychologists have been at the forefront of using this research to develop interventions that help people more effectively manage their pain and approve their functioning. However, these interventions are not as widely used as they should be. So, we were pleased to see the Administration's Pain Management Best Practices Interagency Task Force report just released last month. The report notes that the importance of—notes the importance of psychological interventions and the management of pain, and recognizes the importance of non-pharmacological interventions in the Nation's overall strategy to address the opioid crisis.

Finally, one thing that I've learned in my 20 years as a policymaker, that if you see one treatment system, you've seen one treatment system. What communities need depends on a variety of factors. Depends on the population of the community, depends on the nature of the treatment system, depends on the nature of the epidemic within the community. And it depends on the non-treatment resources that are available to help people in their recovery.

So, the unique mix of each community is going to be different. The CARE Act recognizes this by targeting resources to those hardest hit communities, and giving them the flexibility to address their unique needs. And that's why we are supportive of this legislation.

Thank you for this opportunity to testify today on behalf of America's psychologists and the people whom we serve. And I look forward to working with you on moving this legislation through Congress, and welcome any questions that you might have.

Chairman CUMMINGS. Thank you very much. Ms. Ross?

STATEMENT OF JEAN ROSS, PRESIDENT, NATIONAL NURSES UNITED

Ms. ROSS. Good morning. Thank you, Chairman Cummings, Ranking Member Jordan, and the rest of the members of the committee for inviting me to testify at this very important hearing today.

I've been a registered nurse for over 40 years, and I am president of National Nurses United, the largest union of bedside nurses in the United States, representing over 155,000 members.

Registered nurses take care of people with substance use disorder and opioid use disorder specifically every single day across this country. We provide care to them while they undergo treatment and when they overdosed. Far too often we are next to them and their families when overdose kills them.

We also witness how barriers to accessing much needed treatment and prevention services has caused and exacerbated the opioid epidemic. We witness how poverty, income and equality, racism, and unethical profiteering by the pharmaceutical and health insurance industries all have contributed to this horrible crisis.

I want to make three main points in my testimony today, which summarize the detailed testimony I've submitted for the written record.

First, there is an abject lack of access to treatment, prevention, and harm reduction services for patients with or at risk of opioid use disorder. Across the country there are far too few or no local providers who offer medication-assisted treatment. Harm reduction services are far too rare. And in many communities early intervention programs and recovery services are non-existent.

NNU nurses across the country have observed how a lack of these services means that patients do not have access to treatment for underlying health conditions, and only get care when overdosing.

For example, in Stark County, Ohio, such services are rare, and the county has lost several mental health and acute care facilities. Stark County has almost twice the rate of opioid overdose deaths than the U.S. as a whole.

Second, inequality and specifically health inequity is a main driver of the opioid epidemic. Although the epidemic impacts every segment of our Nation, it has grown exponentially in our most vulnerable communities, where safety net services are underfunded, under resourced, or simply nonexistent.

Health inequity can drive people who have pain, whether physical or psychological, toward substance use disorders. Patients may be unable to afford comprehensive services whether or not they

have health insurance. Research has shown that unemployment increases opioid fatalities by 3.5 percent.

Moreover, longstanding healthcare inequities in communities of color are reflected in how our Nation currently addresses the epidemic. Opioid overdoses in African-American communities are rapidly increasing, faster than other groups. The way in which our country has thus far approached the crisis serves to perpetuate and exacerbate health inequality.

It is critical that the Federal Government moves away from law enforcement and criminalization, and instead responds to all substance use disorders through public health interventions.

Third, despite well-meaning steps forward, the national response to the opioid epidemic is inadequate, and it must be sufficiently increased to ensure that people receive the care that they need to treat and prevent substance use disorder. In order to address the massive scale of this epidemic, it is necessary to invest a significant amount of financial resources into a dramatic scale-up of treatment, prevention, and harm reduction services.

Medical science has given us the treatments we need to prevent disorder from killing our patients, but high prices and lack of resources are preventing us from saving lives. The CARE Act of 2019 provides us multipronged approach to slow and halt the epidemic.

Most importantly, it would appropriate an adequate and sustained financial commitment that would allow our Nation to sufficiently address the scale of the epidemic. The approaches prioritized in the CARE Act would drastically reduce overdoses, increase access to treatment for patients, and provide the services necessary to help people manage their pain. It puts funds into the hands of the communities impacted by this crisis, like the Ryan White Care Act did so successfully for HIV AIDS.

While we fully support the CARE Act, it's important to note that in order to address the fundamental health inequities that pervade and fuel the opioid crisis, we must adopt a guaranteed healthcare system. This is why National Nurses United supports Medicaid for all.

I urge all the members of this committee to work to pass the CARE Act, and adequately scale-up the Federal response to this crisis.

Thank you, Mr. Chairman. Thank you to all the members of this committee for hearing our concerns.

Chairman CUMMINGS. Thank you very much. Ms. Gray?

STATEMENT OF ANGELA GRAY, NURSE DIRECTOR, BERKELEY-MORGAN COUNTY BOARD OF HEALTH

Ms. GRAY. I'd like to thank Chairman Cummings, and Ranking Member Jordan, and the committee for giving me the opportunity today to share my front-line experience. I am the Nurse-Director of the Berkeley-Morgan County Board of Health. I cover Berkeley County, which is the second largest county in West Virginia, of about 118,000. And then the neighboring county of Morgan is a smaller county of about 18,000. So, I have a good perspective on rural and urban. I am a Robert Wood Johnson public health nurse leader. There are 25 of us in the Nation.

My state is hemorrhaging, and without long-term funding, and commitment, and plan, we will continue to bleed. We are appreciative of the funding that we are getting, but we need infrastructure support. To this date, none of the SOR money has hit the community level. I have not seen one penny.

In March I was asked to put an order in for Naloxone. Our state has the highest number of overdoses in the country. I've yet to see one dose of that Naloxone from the million dollars that's at the state level for it, that was supposed to cover from March of this year to March of next year.

I'm getting local support. Our county commission and our city commission has supported us in helping get a harm reduction program up and running in Berkeley County before the state had funding from the Federal level, or any guidelines on it.

Our Medicaid expansion has been crucial. Before that we were unable to link people to care. However, it still has many gaps. Providers won't accept it, and those who do, it creates a financial burden because there are three to four months getting reimbursement.

There's huge gaps in the MAT. We have more providers trying to get waived, but a lot of our providers are very leery, because it requires a waiver. But OxyContin and Percocet doesn't require them a waiver to prescribe.

And when you get them linked to MAT it doesn't stop there. I get a couple to MAT. They give me a call and say, "Hate to bother you, you've helped me so much, but I can't get my prescription, because I don't have a valid ID." So, I meet them at the pharmacy, and use my personal ID, so they can get their medications, and then link them to nonprofits that will help them get through the process of getting their ID.

The tentacles of this crisis and epidemic reach every level of our community. And with what we know about the adverse childhood experiences, we are perpetuating generations of addiction and substance use disorder.

In President Trump's State of the Union address he said that there was a plan to end domestic HIV within the next 10 years. I literally responded back to the TV and said, "Not an attainable goal with the way we are addressing the opioid epidemic." West Virginia has always been a low-incident state for HIV, and we have 52 new cases in Huntington, West Virginia right now, all linked to injection drug use.

My colleague explained and gave an analogy of substance use disorder the best I've ever heard it. Imagine a carousel spinning around. We offer support before people enter by prevention and trying to prevent our children from first drug use. We offer support at the end, when people need recovery, although there is much more work that needs to be done. But as you're spinning out of control and you're the most vulnerable we do not intervene at all. And that's where in harm reduction programs, with syringe access, can intervene and are vitally important of reducing the spread of disease such as HIV, Hepatitis A, B, and C, and other things such as endocarditis, abscesses that's costing our healthcare dollars billions.

"Those who do not learn from history are doomed to repeat it," so said President Roosevelt. Have we not learned from the HIV and

AIDS epidemic that's slow to respond and putting the money in the funding, and the resources where it's needed, it does work. Ryan White has proven that. I support this CARE Act to help heal our communities and give the actual funding that's needed to address substance use disorder and mental health in our country.

Communities are letting their morality and lack of education get in the way of harm reduction programs and syringe access. I was raised Pentecostal, and I remember my Bible stories from when Jesus walked this earth. And when he did, he did not seek the rich, and the kings and the queens. He would seek the poor. He sought out the leper, those of disease, and the prostitutes. And I have no doubt today that if Jesus walked this earth right now he would be working and alongside the harm reduction clinics, because I do God's work every day, and so does the staff, my small staff, that works so hard to help accomplish that.

This is very personal to me, because our state has been riveted, and we lost our family members, people we went to high school with, our children. You can see the data, and it's very important, but beyond the numbers, at the local level we see the faces every day.

I would like to invite you. I'm not far away from you. Less than two hours. Come visit my clinic. See what the front lines look like. Arrange a meeting that you can sit down with the 30-plus community partners that meets, and work, and try to manipulate the systems and the barriers to get people help.

We need force multipliers. There's not enough of us. We need real infrastructure, and I'm sure that's why the SOR money hasn't even touched the community level yet. They're just floundering at the state level, and we are at the community level, too.

Besides myself, there are two other nurses that are trying to do this for 118,000 population. We need help, and I'm asking you please to support this CARE Act and give the real funding that's needed to address substance use disorder and mental health in this country.

I hear people say, "Well, don't you just think you've got to wait for this generation to die out before the opioid epidemic will be over?" And my response is, "Which generation. I'm seeing three now, and more are coming on every day." Our children being born right now in West Virginia are at a high risk of having substance use disorder because of the ZIP Code that they live in. How sad is that?

I've a great nice who's a year-and-a-half year old who is just the joy of my family, and I want to change this before she gets to middle school and becomes at higher risk.

Thank you for the opportunity for me to speak today. And please do the right thing for the people who are suffering in my state as well as others.

Chairman CUMMINGS. Thank you very much. Dr. Young?

STATEMENT OF NANCY YOUNG, EXECUTIVE DIRECTOR OF CHILDREN AND FAMILY FUTURES

Dr. YOUNG. Thank you, Ms. Gray for the work that you and your colleagues are doing.

Ms. GRAY. Thank you.

Dr. YOUNG. Chairman Cummings, Ranking Member Jordan, two months ago I had the opportunity to spend the afternoon in Coshocton County, Ohio, Mr. Gibbs' district. I was there to visit the family treatment court. And my time included about an hour with a young woman, I'll call her Monica, who graduated from the family treatment court. And she shared her family's story to opioid addiction and her recovery.

Opioids entered her life when her husband had a work accident that almost severed his leg. He was sent home from the hospital with a large supply of opioid-based pain medication. Today, in hindsight, healthcare professionals might recognize that supplies too many pills for his prescription, but his brain became triggered, and he became dependent on that supply of semi-synthetic opioid pills.

Later, Monica had her first baby by a C-section, and she, too, was sent home from the hospital with many opioid pain pills, and her family was forever changed.

As the committee knows, much progress has been made across the country in restricting the availability of prescription drugs over the past several years. But that restriction has been filled by other forms of opioids. For Monica, a young mother in Coshocton, who is struggling with an opioid use disorder, the birth of her third baby brought child protective services into her life, and she found her way to the county's family treatment court.

I don't know all the details of her case, but what happened for Monica is the goal of child welfare services. She was able to keep her children in her custody while she worked her program of recovery through the Coshocton County Family Treatment Court.

Monica is not unlike other mothers who have gotten trapped in opioid addiction, but it's all too rare for them to have services like Coshocton and the 30 other Ohio counties with family treatment courts, or the 31 counties with the Start Program in Ohio, or 13 counties in Maryland where Start is available to them. These are good programs, and they are helping some parents and children who desperately need them. But I want to make clear that these are still patchworks, not systems.

The most recent estimate of babies who are diagnosed with neonatal abstinence syndrome is from 2014 data, 8 babies per 1,000 hospital births, or about 30,000 babies per year. This is a dramatic increase from a decade ago. There are not clear data available that would connect these infants with NAS to the increasing number of infants who are being placed in child welfare services, but in 2017, out of the 269 children placed in protective custody, just over 50,000 were infants.

Why can't all parents who need treatment like Monica obtain it? It's not news to anyone on this committee that for decades our country has neglected the infrastructure of the substance us and mental health treatment systems. The National Office of Volunteers of America recently completed a national inventory of residential facilities that can accept parents with their children. And there are 362 programs in the country. The painful reality is that there hasn't been a national effort to expand parent and children programs since the cocaine epidemic.

There's been a tremendous effort to provide service dollars over the past couple years, and ongoing support is needed, but maybe we need an infrastructure we can, Congress, that's about building infrastructure of substance use and mental health facilities for families. The infrastructure just isn't there.

In the child welfare arena, even though Title 4E funds are being made available for children to remain with their parents in treatment, there remains an enormous infrastructure gap of bricks and mortar, as well as professional staff who can work across substance use, child welfare, and courts with families.

Have the responses from the Administration and Congress been adequate? No. Every single one of us can do better, from churches, and community groups, to local governments, states, Federal officials, and private enterprises, we all have a role.

I also believe it's critically important that new funding build on the existing planning, licensing, and certifications of state and local governments. Often, those are the barriers to building those new facilities. I've had the opportunity to work with various grant programs from Federal and state governments over the past 25 years, and what I know is that grants often don't go to the communities of greatest need. They go often to the community who is able to hire the best grant writer. From my perspective connecting funding through existing planning and operational methods makes the most sense for evaluation of programs and for long-term sustainability.

At the end of my conversation with Monica, I told her that from time to time I have the opportunity to make recommendations to state and Federal officials. And I asked her what she would want me to tell them. She said, "Tell them that the drugs are still here, that there's still a lot of diversion of pills, and even meds for treatment of opioid addiction."

Of course, I wasn't able to hear that, as I'm sure members of this committee are not. But she also said, "Tell them there's not enough support for people who are in recovery." So, Monica would say she's in recovery, the family treatment court helped save her, but families like hers still need more help to sustain the recovery. And I would add more help is needed to heal the trauma for her children, and to focus on both generations. That support will need to be there a day at a time for the rest of her life, and our job is to make sure that the community support is there, as well as the front-line treatment in an organized system, not a patchwork of fragmented programs.

Thank you very much.

Chairman CUMMINGS. Thank you very much. And I yield myself five minutes to ask a few questions.

Ms. Gray, I'm going to take you up on your offer. I'm going to come visit. Sometimes I think that we——

Ms. GRAY. Yes.

Chairman CUMMINGS [continuing]. forget that drug addiction has no boundaries. And I want to thank you for, all of you for what you're doing. And I'm going to thank you, in particular, because I know it must be very difficult trying to address this problem with very limited resources.

A lot of people will say that you don't—I think a lot of people have gotten to the point where they've become kind of cynical, Dr. Bailey, about drug treatment. They've seen people relapse. And then they combine it with it's more failing, and they say it's their fault.

So how do we deal with that? Because, you know, one of the things up here in Congress, the first thing you'll hear is, you know, we're going to be wasting money. I didn't mean to say it like that, but that's basically what the result is.

So how do we deal with that? Do you follow what I'm saying? In other words, what do we—how do we guarantee as best as we can something that works?

And Dr. Olsen, you may—any of you may chime in. When we were putting together the CARE Act, we tried to take all of that into consideration, but I'd like to see your viewpoint.

Dr. BAILEY. Thank you, Mr. Chairman. The stigma around substance use disorder is pervasive in our society. And I think all of us need to re-set our thinking that it's not a moral failing. Substance use, opioid use disorder is a brain disorder. It is a disease that requires treatment. Unfortunately, it's a disease that features frequent relapses. And the treatment aspect of it is very, very difficult, but it can be successful. And I think that the more success that society sees, the less we'll have to deal with the stigma and the judgment surrounding the treatment.

Chairman CUMMINGS. I think one of you all said, remind who it was, said that when people do get treatment, and I've seen this research, that they have less problem. They're able to keep a job. Who talked about that? Dr. Olsen, would you talk about that?

Dr. OLSEN. Absolutely. So, thank you for the question. You know, we have a long history in this country of misunderstanding around addiction and what addiction is, and what it's not. And you are absolutely correct that it is not a moral failing.

Over the past 50 years we have really developed an understanding of addiction as a chronic brain disease that is complicated. It involves interactions between genetics. So, 40 to 60 percent of the risk of developing a substance use disorder is genetically based.

It also involves interactions between our environments. There was mention of the adverse childhood experiences. So early childhood trauma increases the risk of developing a substance use disorder.

In any one individual it is not entirely clear to what extent the genetics versus the environment and other psychiatric conditions that also increase the risk, exactly how do those all play into together to develop—how some people develop an addiction while other people don't.

And the stigma around what this is and what it's not is still very profound. But what we know through decades of research is that medications, treatment, particularly when we're talking about an opioid use disorder that medications such as Methadone, Buprenorphine, and injectable naltrexone reduce crime, increase employment, reduce the risk of HIV and hepatitis C transmission by six-fold, and improve quality of life.

And I think particularly now, with the number of overdoses that we're seeing, it reduces mortality. In fact, there's a study from Bal-

timore City that looked at the expansion of access to Buprenorphine and Methadone treatment several years ago that found that it reduced the overdose from heroin-related deaths by over 50 percent, between 50 and 75 percent.

So, we know what to do. We know that this works.

Chairman CUMMINGS. Do all of you agree that the majority of Americans who have a disorder are not getting the treatment that they need? Anybody disagree with that?

Dr. EVANS. No.

Voice. No.

Chairman CUMMINGS. Do you agree that the Federal Government, including both the Congress and the executive branch, could be doing more to address this generational public health crisis? Anybody disagree?

And third, do you agree that we need a comprehensive Federal approach to expand access to treatment and wrap-around services, the kind of approach that's laid out in the CARE Act? All of you agree. Dr. Young?

Dr. YOUNG. I would say for most things it's a Federal, state, and local partnership. I mean states and local government play a role in most public policy, and particularly when it comes to healthcare——

Chairman CUMMINGS. Yes.

Dr. YOUNG [continuing]. delivery, and social service delivery. So, I would hope that Congress would be seeking help from NGA and NCSL. Most grant programs that takes a partnership at the state level to ensure sustainability, so I'm sort of making an assumption that the Congress has already sought their advice in this. And I'm hopeful that that partnership could be made, so that it is all three, state, and local, and Federal Government.

Chairman CUMMINGS. I want to just ask you, Ms. Gray, there are—we have a situation where I think you and others mentioned, children, and our children are affected. A lot of times we don't see the impact on its surface. I mean we think about the drug-addicted adult.

Ms. GRAY. But they were children, and they started when they were children.

Chairman CUMMINGS. Yes. So, what impact do you see on their children? You follow what I'm saying?

Ms. GRAY. Yes.

Chairman CUMMINGS. And somebody else might want to address that, too.

Ms. GRAY. Go ahead.

Ms. ROSS. I would just say I think we sometimes forget about the effects of the families of that member, including the children. So, when we talk about getting that money, and getting it to the local areas so you don't have to go through the state and Medicaid red tape, when we talk about that, some of the things that those—the substance users have to deal with is time off work. It's childcare. And, again, that's where the child is affected.

It's just such a huge array of things that is needed in that treatment. And so, children are affected in that respect, too.

Chairman CUMMINGS. You know, when we talk about wrap-around services, we had Elizabeth Warren in my district and we

were talking about the CARE Act, and we had all these experts to come in, and they were talking about the kinds of things that you're talking about today.

And then at the end of the, at the end of the session, a gentleman got up, and he says, you know, he says, "I've got a drug problem." He said, "I'm 62 years old." And he said, "All those programs are nice. All the stuff you're talking about is nice," but he asked this question, and it really made me think. He said, "How am I going to get there?" He said, "How am I going to get there?"

Voice. Exactly.

Ms. ROSS. Yes.

Chairman CUMMINGS. I mean, and it's—would you please turn cell phones off, please?

He asked the question, "How am I going to get there?" In other words, going back to these wraparound services, I mean—and I guess that's one of the good things about the flexibility of the CARE Act.

Dr. EVANS. Could I speak to that?

Chairman CUMMINGS. Yes.

Dr. EVANS. I think that is a critical point. You know, it is really clear that, as I said in my testimony, that substance use disorders are very complex. They affect a lot of parts of people's lives. They affect their ability to hold employment. Most of the people who are at the late stages of their addictions have lost not only their family, they've lost their job, they have lost their housing.

And the basic things that people need in order to live are just as important, in fact, more important than the treatments that we can give them. Many people that I've seen we've provided treatment after treatment, but what has really helped them is to get into stable housing, for example.

When I was in Connecticut, the commissioner in Connecticut, we had a program called the basic needs program. So we were providing treatment services for people, but what made the difference in terms of people being able to engage in long-term recovery were things like giving people money so that they could get a haircut, so they could go and do a job interview, helping people to get from point A to point B, giving people small grants so that they could start a business, so that they could take care of themselves, and they wouldn't be dependent on state aid.

Those small things can make a tremendous difference, and it's one of the reasons why I think as we talk about this issue, we can't simply talk about evidence-based treatments, we have to talk about the whole range of services that people need.

Chairman CUMMINGS. Thank you very much. I am going to have to—let me go to Mr. Higgins. But I wanted to just throw out a series of questions as I did, and you may want to—in answering other people's questions you may want to chime in and bring—but I want to get to Mr. Higgins now.

Mr. Higgins?

Mr. HIGGINS. Thank you, Mr. Chairman. And I thank the gentleman and the ladies for being here today. It's an important subject.

Dr. Young, let me jump straight into drug courts, if I could. In Louisiana, the state that I'm proud to represent, we have 49 pro-

grams state-wide. Thirty-seven have been in existence for 10 years or longer, drug courts, adult and juvenile drug courts.

The difficulties in drug courts, in reality, as compared to the programs that are created by, passed by bureaucrats, and well-meaning administrators that are not necessarily deeply rooted in the street, create these programs that include expenses for the offender that is sometimes quite difficult or even impossible for the offender to meet.

And as well-intentioned as the diversion programs are, and the drug court is something I support, I've seen it work very well, and I've seen it work horribly, but the percentages are alarming of failures in the first phase of drug court, and overall, through the phases of graduation through drug court, we're running, in 2018, 1,747 admitted into the programs in Louisiana, 829 graduated. But, of course, this is graduating through all phases. The first-phase failure rate is much higher.

In Louisiana there is a requirement for $100 a month for 15 months, plus restitution. If there's some ancillary crime attached to the drug conviction, through the diversion program, the offender has to pay restitution, if there was a burglar involved, criminal damage, et cetera.

They have to essentially maintain a job or the effort to find a job. They are frequently very challenged to earn any money. And I've seen men actually driven to crime in order to pay the drug court costs, and fees, and expenses, because of the difficulty being employed.

Would you please share with America what are the success rates for drug courts, and what do you think the major problem is, especially in the first phase? And what can we do as a nation to respond to that realistically?

Dr. YOUNG. Well, I apologize that I am not an expert on the adult criminal drug court model. I'm much more focused on the family treatment court model that operates in the child welfare arena.

Mr. HIGGINS. They're very similar. Please use that as your expertise.

Dr. YOUNG. In the family treatment court arena, we do see much higher rates of reunifications. And the biggest outcome is that the children don't come back into foster care with long-term studies. There's a meta-analysis that I included the results in my written statement that looked at, I believe it was 16 evaluations of family treatment courts that says in the written statement that this is a model that should be used in child welfare for——

Mr. HIGGINS. So, you see the family preservation and intervention courts, I don't mean to interrupt you, but we're limited on time——

Dr. YOUNG. I understand.

Mr. HIGGINS [continuing]. as having a higher success rate than traditional adult drug courts diversion programs.

Dr. YOUNG. And I think, as Dr. Evans said, when you see one treatment system, you've seen one treatment system. And we know that there's a lot of variability in adult drug courts as well as in family treatment courts.

Mr. HIGGINS. Let me jump into the—perhaps Dr. Bailey or Dr. Evans can respond regarding treatment options. I think as a nation we have to explore this treatment options for opioid abuse other than medication-assisted treatments.

Which alternatives would you doctors recommend, perhaps Dr. Evans and Dr. Bailey, to medication-assisted treatments? What do you recommend for opioid and substance abuse programs, including through drug court?

Dr. EVANS. So, the research is pretty clear that opioid treatment is—that medications are very effective in treating opioid addiction. But if you look at the way the regulations and the way those programs are designed, they're really designed, as I said in my testimony, to be medication plus psychosocial interventions. And in the absence of psychosocial interventions embedded within those programs are not going to be as effective. And let me give you a few reasons why.

Many of the people who come into medication-assisted treatment programs have occurring mental health conditions. And so, you have to have the capacity to treat those conditions effectively.

Second, many of the people who come into those programs are using other substances. I ran a medication-assisted treatment program, and I will tell you that most of the people, the overwhelming majority of people who come into those programs are not only using opioids, but they're using alcohol, they're using cocaine, they're using a lot of other substances. And if you're only using a medication to address the opioids, you're missing the opportunity to address the other conditions which actually keep people from engaging in long-term recovery.

And finally, as I said in my testimony, these are very complex conditions. And even if we can arrest people's symptoms, we can help people through the acute phase of their withdrawal so that they are physically stable, if they don't have proper housing, if they have family situations that are very problematic, one of the things that we know from the research is that one of the best interventions for people is helping them with family interventions.

If you can imagine someone who's living in a family, who the family system has gotten accustomed to that person as a person who is not in recovery, when that person goes into recovery, it throws the family system off, and families can unwittingly undermine people's recovery. That is something that is not very well known, but it's something that we know from the research. But more specifically, outside of medication-assisted treatment, there's contingency management, which is an evidence-based treatment approach. There's cognitive behavioral therapy. There's multidimensional family therapy. All of those have been shown to be effective in treatment opioid addiction.

Mr. HIGGINS. Sir, thank you for your answer. It was very thorough. I thank the chairman for indulging, and perhaps, Mr. Chairman, the remaining panelists can submit an answer regarding alternatives to medication-assisted treatments. Perhaps they could submit in writing, Mr. Chairman.

Chairman CUMMINGS. Very well.

Mr. HIGGINS. My time has well expired. Thank you for indulging.

Chairman CUMMINGS. Very well, Mr. Higgins. Thank you, Mr. Higgins. Ms. Maloney?

Mrs. MALONEY. Thank you, Mr. Chairman. Dr. Bailey, in 2017 there were over 70,000 deaths in the United States due to drug overdose, with the majority, over 67 percent due to opioids.

In your testimony you mentioned the importance of taking individualized approaches and responsibility in prescribing opioids. And does your research show evidence that certain prescribing practices can be helpful in preventing addiction to or abuse of opioids.

Dr. BAILEY. Thank you. I am not aware of any research that shows differences in prescribing practices making a difference. We know what works. Using medication-assisted therapy works, but other things need to be studied, and that's one reason why we support the CARE Act, to provide the funding and the infrastructure, so that we can find out what makes a difference, what can prevent addiction, what can treat it, and what works the best on the local level.

Mrs. MALONEY. Thank you. Now Dr. Olsen, in the district I represent in New York City, it's home to some of the leading medical research institutions in the country. And education and training in treatment addiction is an important component. And I'd like to ask you about certain proposals that have come forward. One is from Representative Schneider. He's introduced the Opioid Workforce Act, which would increase the number of graduate medical education slots for residency positions and addiction medicine programs.

And also, the chairman has introduced the CARE Act with Senator Warren, which would provide considerable funding for programs, and also training. And it would give preference in awarding this funding to projects that would train providers to provide substance and disorder treatment to underserved groups.

How would Baltimore and other communities benefit from efforts to expand the work force in addiction treatment?

Dr. OLSEN. Thank you for that question. The work force currently that we have across the country, not only in Baltimore, but elsewhere, is woefully inadequate to address not only the current opioid epidemic, but really, the future addiction epidemics or other public health issues related to addiction. So, we need to build the infrastructure, and we need to really build it now in terms of increasing that work force.

Medical schools, nursing schools, pharmacy schools, health professional schools across the country, as well as graduate medical education, and even faculty education, one of the important pieces of the CARE Act also focuses not just on the students themselves, and making sure that they receive the appropriate education in terms of not only diagnosing addiction, but treating it, but the CARE Act also provides for funding to shore up the faculty that are needed in order to actually train all those students.

So ASAM is extremely supportive of any legislation, including the CARE Act that would really be able to do that.

Mrs. MALONEY. Thank you. Ms. Gray, I was very moved by your testimony, and I'd like to hear your comments on the challenges

you face in staff retention at your clinics in West Virginia, and would like to join the chairman in visiting your clinic.

But what was really compelling to me were the obstacles that you put out there that are systematically put in front of you in order to stopping you from giving the treatment you want. I'd like your comments specifically on, if anybody wants information and treatment options to assist someone who's over 18, they can't give it to you. It has to go to the person, which is sometimes hard to coordinate. That's an obstacle.

And then you mentioned that the MAT accessibility is difficult. A provider is not required to have a special waiver to prescribe opioids like Oxycontin, but you have to get a waiver to prescribe the treatment, such as the MAT thing. And the accessibility, you said, is difficult. I find that startling. Why would we have obstacles to getting treatment options?

Ms. GRAY. And those are just a few. Like I said, you come to visit, and meet the other 30 partners that I work with, we will just unload on you. But yes, I mean we have very few MAT providers in either of the counties that I work in. Actually, in Morgan County, we have one, and they only see people one day a month. So yes, it's pretty rough.

Mrs. MALONEY. But your providers can't prescribe that, but they can prescribe an opioid.

Ms. GRAY. Right. But they can prescribe——

Mrs. MALONEY. What is the logic of that?

Ms. GRAY. From my knowledge it comes from legislation that's from the early 1900's, that maybe you guys can look at and change.

[Laughter.]

Mrs. MALONEY. Maybe we should update that legislation.

Ms. GRAY. Yes. Yes. And it makes them very leery. And also, when we talk about the next epidemic, people are talking about the next epidemic as meth. I wish Representative Jordan was in the room, because he talked about, you know, hitting the supply, and how much Fentanyl and things, it is pure Fentanyl. They're not shooting heroin in Berkeley County or Morgan County. It's pure Fentanyl. We've tested. It's pure Fentanyl.

But it's time that we put as much funding and effort into the demand as we do the supply, because you hit the supply all you want, and you haven't dealt with the addiction. I can trace it in my clinic, whenever there's been a hit on the opioid or heroin supply, it's going to be a heavily meth clinic, because they have to—you haven't addressed the addiction, so they have to move to the next drug that keeps them going.

And you can make meth in your home. You can make it in a backpack. So, unless we really put some serious effort into treating addiction, you can hit that supply all you want. I'd love to know how much goes in the criminal justice system that hits that supply.

Chairman CUMMINGS. Mr. Gibbs?

Mr. GIBBS. Thank you, Chairman. Thank you to the witnesses for being here.

I'm from Ohio, and Ohio is unfortunately is one of the problem states, challenging states. And last year I held half-a-dozen or so roundtables around my district, brought in faith-based community,

all the stakeholders, medical, first responders. And it was very educational and very helpful.

But I think we've made some progress. I think this is the first step, but you've got to have—awareness and education is a problem. And I think at all levels of government, local, state, and Federal, I think we've crossed that hurdle. So that's the first corner of addressing this. So, I think we're probably all in agreement that we're in a lot better place we were a couple years ago. Hopefully, the trends start going the right way.

But one thing I did learn, and I've had this confirmed by numerous doctors in these hearings, and even the Cleveland Clinic pain specialists, a physician, I was amazed to learn that some people can get addicted to these opioids after maybe three days of taking them.

And I just think about my wife when she broke her kneecap 10 years ago, and we had surgery, and she left the hospital. I think she had like two weeks of Oxycontin. She only took it for a day. I had no idea. And so, the medical community takes a lot of blame, you know, I think in prescribing.

So, I want to talk about, I know, Dr. Olsen, you talked about current guidelines for opioid prescribing. And I understand you've been teaching appropriate prescribing as early as the 2000's. Do you recommend revisiting the guidelines for surgical procedures?

Dr. OLSEN. Thank you for that question. So, it is clear, so the CDC in 2016 came out with prescribing guidelines for chronic pain targeted at primary care physicians. And those guidelines are very comprehensive. They are guidelines, and they are actually the first guidelines that also include a recommendation for primary care physicians to be able to identify and treat opioid use disorder in their clinic and in their patients when they find it.

There are currently also efforts in various different states, including in my state of Maryland, the Johns Hopkins School of Medicine, where there are surgical specialties, from orthopedics to neurosurgery, that are really looking at very specific guidelines for different surgical techniques, and various different procedures. And so, having those types of guidelines is going to be very important.

Mr. GIBBS. When I had my roundtables last year, I saw a lot—some of the counties, or pretty much all my counties, but some were doing maybe a little bit better job of getting out a person that was overdosed, and they get, you know, stabilized. And I learned that if they could get out and get to them in the next week, and get them into treatment, had fairly good success.

So, does anyone want to comment about where we are? It seems like to me that the treatment, 'cuz you've got to give them the treatment, and then with un-treatment, I think that's where the faith-based community can play a huge part. But then also, hopefully, when they get out of treatment, and they're going up the right path, having them be employable, or else they're probably going to revert back to where they were.

So, does someone want to comment about where we are at the treatment centers? You know, we've done a lot on education, the different stakeholders I've mentioned, getting money out there. But where do we stand on treatment centers and the status, I guess. Go ahead, Ms. Ross.

Ms. ROSS. One of the things I would like to say, and this is why I talked about a guaranteed healthcare system, since we don't have a system. Hospitals, clinics, centers are open and closed depending on profit. They aren't set up in the areas in which people need them. One of the things we do as nurses is protest every time they close a community hospital. So, we have too few of them to start with, and then they get closed down. The treatment isn't there for the people when they needed it. That's one thing we have to guard against.

And then before I stop here, I just wanted to kind of put in a plug, because many of us nurses, when we became aware of this crisis that we're in now, said to ourselves, and I was one of them, "Oh, no, they're going to go overboard, and the people who really do need these opioids aren't going to get it." And we do see signs of that happening right now.

So, the education has to include the fact that there are chronic disorders, certainly hospice care, where those drugs are necessary.

Mr. GIBBS. I'm almost out of town, but you're talking about community hospitals. I'm not so sure I——

Ms. ROSS. And treatment centers.

Mr. GIBBS. Yes. Treatment centers.

Ms. ROSS. And treatment centers.

Mr. GIBBS. I think someone mentioned Stark County. That's one of my counties, my largest county. And CommQuest, they are doing some good thing there, getting those people into treatment. And I know Senator Portman and myself, we've visited there numerous times, but that's key. And then getting them employable, and getting them, you know, back into a job. So, it goes far beyond what I would expect a community hospital to do.

So, I yield back my time.

Chairman CUMMINGS. Thank you very much. Mr. Clay?

Mr. CLAY. Thank you, Mr. Chairman. You know, by the latest estimate, last year opioids took the lives of over 70,000 Americans. And I want you all to stop and think about that startling number.

The opioid war has taken more lives than the Vietnam War, when you think about the—and across my home state of Missouri, over 1,500 people died last year. More than those who lost their lives in traffic accidents. And opioid abuse is an equal opportunity killer. It does not respect geography, race, religion, age, or educational level. So urban and rural, we're all in this mess together.

And let's not kid ourselves. Only with a substantial increase in Federal support and a national commitment to expanding community-based treatment will we have even the basic tools to combat this epidemic.

So, let me start with Dr. Evans, and I'd like to ask you, when a person is suffering from a substance use disorder, is that typically their only health issue, or do they often have other health issues?

Dr. EVANS. It would be the exception if a person had a substance use disorder and didn't have other health or mental health conditions. And it's the reason why it's really important to have a holistic whole person approach to treatment. And I can't stress that enough, because if you listen to the debates right now——

I should step back just for a moment and say, prior coming to APA I was a commissioner of behavioral health in Philadelphia. And before I left, the mayor asked me to chair a task force to look at the opioid epidemic. And one of the things that we did before we started that work is we looked around the country to see all of the other recommendations that had been done on this issue.

And if you do that, what you will find is that there are no set of recommendations. And frankly, I believe that we have oversimplified this problem. It is a tremendously complex problem. And you will hear often, "Well, if we can just get people medication-assisted treatment," and what people mean by that, if we can just give people medication, we will solve this problem. That is not the case. We have to deal with all of the other issues that people bring into their addiction, if we're going to be successful.

And so treating people's health conditions, making sure that they are stable from a social standpoint. All of those things are necessary to increase the likelihood that people are going to have long-term recovery.

Mr. CLAY. I see Ms. Gray is shaking her head in agreement. Would you like to add?

Ms. GRAY. I think the hashtag 'holistic treatment' behind me is definitely the key. You need to look at the whole of the family. We have families where multiple people are injecting in the same home. How do you even start there? And do we want to continue this route? Absolutely not. So, we definitely need to look at the whole of the family.

In my neighboring county, Jefferson County, they've started what's called a circles program. And it was designed for moms and babies just through pregnancy to help so babies aren't born and withdraw. But they found that the moms loved the support so much they wanted to stay in their groups even after delivery. And they look at the whole of everything, the childcare, getting clothes and their hair done, so they can go to job interviews. They're bringing in—the grandma comes with them. So, then you're getting in that next—above generation, who is also abusing drugs.

Mr. CLAY. Let me ask you. So do people with substance use disorder often have other significant challenges in their lives, like homelessness——

Ms. GRAY. We expect more out of——

Mr. CLAY [continuing]. and unemployment?

Ms. GRAY [continuing]. out of substance—people who suffer from substance use disorder than we do any other disease that we treat. If someone comes in in a diabetic coma, I'm not going to scold them because they ate so much sugar that they ended up in the hospital four times that month. But yet, if somebody comes in and has overdosed and relapsed, we shame. The way we approach people, we keep people from getting care.

People will come through my lobby when they first engage with us, grown men will walk out with tears running down their face, because they haven't been treated like a human being before.

Mr. CLAY. Let me ask Dr. Olsen real quickly, do you see those similarities, too?

Dr. OLSEN. Absolutely. And I think that is one of the reasons why we also need to be very cognizant of what the goals are in

treatment. Initially, the goal, particularly for opiate use disorder, is we want to help keep people alive. And that is where medications have such an important role. And so, the National Academies actually came out with their recent report calling medications and treatment with medications medication-based treatment. And then you wrap all these other things also kinda around that to address all those other conditions that have been mentioned.

I also just wanted to reference one thing, which is that in terms of the question around treatment and treatment standards, you know, you've heard that hospitals, emergency departments, that people show up in different places. They're not necessarily walk into an addiction treatment clinic immediately.

So, we need to have healthcare professionals who are educated to be able to start treatment wherever the person walks in the door. And we need to be able to standardize the treatments across the specialty treatment settings, so that when people go to a specialty addiction treatment center, whether it is residential or outpatient, the people, not only the individuals themselves, but their family members, and payers, and others, know what it is they're going to be getting. And that is another really key part of the CARE Act, is that it speaks to standardizing the care that is provided.

Mr. CLAY. Thank you. And Mr. Chairman, my time has expired. I appreciate it.

Chairman CUMMINGS. Ms. Miller?

Mrs. MILLER. Thank you, Mr. Chairman. And thank you all for being here today. And I want to give a special shout-out to Ms. Gray. I'm from Huntington, West Virginia. I understand, and we've been dealing with a lot of this since the 1990's, really.

Because of some of the comments that have just been made I'm going to go off some of my questions, and immediately go to the holistic aspect. And I'd like quick, short answers from the entire panel.

Is faith-based recovery utilized to its full potential? Any one of you can give me quick answers?

Dr. EVANS. I'll jump in. I think faith-based is very important. You know, one of the things we know from the research is that different things work for different people. And even if we say that there is a treatment that is the gold standard, I will tell you that gold standard does not work for everyone.

I have seen, as a medication-assisted treatment program, a provider, and as a detox provider, people have gone through treatment after treatment after treatment, and what really helped them was to get involved into a faith community that really supported them. And that was what made the difference.

So, I think as treatment professionals, particularly as scientists, we ought to be open to all of the pathways that people find to get recovery. I'm agnostic to that, to some degree. What I really care about is at the end of the day that people are well.

Mrs. MILLER. Go ahead.

Dr. OLSEN. And I would just also add that those individualized needs and what every person is going to need is going to be different.

Mrs. MILLER. Absolutely.

Dr. OLSEN. That starts with a very through needs assessment, and that can identify what have people tried in the past, what has worked, what maybe hasn't worked, and what all the options are, including medications, as well as other mutual support services, counseling services, other medical and psychiatric services, so really getting to that whole person.

Mrs. MILLER. That's my whole point, is often we're afraid to mention that, but I have found in my experience that every single piece can make a difference.

Go ahead.

Ms. GRAY. Yes. Very important. And the faith-based community is at my table with the 30 that I keep refereeing to.

I think, though, that we know with the way the dopamine rides so high with the opioid that abstinence-based programs are about 90 percent fail rate. So, I see the medically assisted treatment getting them stable, functioning back into normal society, linking them to the counseling, and to the group sessions, and that type of thing, that will help lead them to those things, and the faith-based programs, and stuff.

There's a few people in the movie that was done on addiction in West Virginia where they were MAT for four years, and now they're faith-based programs, so——

Mrs. MILLER. The recovery is so very important that, you know, we've—it's like throwing spaghetti against the wall, and trying to see what sticks. But recovery, to me, is the key.

Let's see. Dr. Young, on Sunday we had a 60 Minutes session, which I'm sure you have at least watched on your phone, if you didn't watch it on T.V. I've worked closely with the police department, and... very aware of what has gone on. What is your opinion? What are the best practices that you see?

Dr. YOUNG. I was preparing for this hearing, and I'm sorry, I haven't seen the 60 Minutes——

Mrs. MILLER. You need to.

Dr. YOUNG [continuing]. from this week. I will make a—I will watch that. I am somewhat familiar with what's going on in Huntington, West Virginia, however. But maybe you could——

Mrs. MILLER. Well, we now have an addiction specialist meeting with the police, talking to them directly. So, you can watch it on YouTube. It really is fantastic.

Dr. YOUNG. Great. Great.

Mrs. MILLER. Okay. I'll switch my question to you about drug courts, because I think drug courts are very, very important. Tell me what you think of their success rate.

Dr. YOUNG. I certainly would refer to any DCP for the overall success rate for the adult drug courts, but we know that they've been very successful when they follow the standards that have been set. And I'm very pleased that family treatment court standards will be announced next month at the annual conference. So, we have enough research now to say what kinds of standards should these courts be following?

Mrs. MILLER. Thank you. And one other thing is, we've been very lucky to have Lily's Place in West Virginia. What patterns do you see can help emerge from this, with the neonatal abstinence syndrome?

Dr. YOUNG. There are many hospitals that are testing different strategies for non-pharmacological based kinds of treatments, and certainly kinds of things that are keeping moms and babies together, in stepdown nurseries, or even in the hospital, in non-NICU kinds of settings that are keeping moms and the babies together, are certainly being tested in lots of places, and we're very encouraged by that.

Mrs. MILLER. I just read in the paper that we now have new program for babies from six weeks to two years, very much what you all have been talking about, having the mothers to be able to get their hair done, and involving the whole family. And I just feel that it's so important, because this neonatal abstinence syndrome, the principals are seeing kids that are five and six years old coming into school, and they're not able to cope. Their mechanisms are, anger very quickly.

Dr. YOUNG. Right.

Mrs. MILLER. There's just so many aspects that I'm sure we could all sit around for a month and talk about, and share ideas of what's important.

Dr. YOUNG. I would say every time we talk about treatment for an adult, we need to say 'and the children, and the children' every single time along the panel and in the questions.

Chairman CUMMINGS. Thank you very much.

Mrs. MILLER. Thank you.

Chairman CUMMINGS. Mr. Welch?

Mr. WELCH. Thank you, Mr. Chairman. Thank you so much for this hearing, and for your proposed legislation. We've been having in Vermont a series of roundtables all around the state, inviting in folks like you who, in Vermont, are providing frontline services. But also, everyone from the police, who is incredibly involved at walking that fine line between enforcement and dealing with a person who's got a medical problem, to grandparents who are raising their grandchildren, because their child is in the grip of opioid addiction, to community volunteers.

And just yesterday we had a hearing in Morrisville, and two parents who lost their daughter to a recent opioid overdose are starting a local treatment facility, buying up, hopefully, the Catholic Church to provide some help to people who are in the grip of this addiction.

And as incredibly challenging and heartbreaking as this issue is, and several of my colleagues have mentioned, this knows no boundaries. There's no political favorites here. I think it's really tougher even in rural areas and urban, but it knows no boundaries, whatsoever.

The experience I've had in Vermont is also inspiring, because if we're going to address the one by one challenge, and Congresswoman Miller, you were speaking about that very eloquently, it has got to be done in the community. That is where it has to happen.

And what I've seen, and I'd be interested in your reaction on this, is there's such pressure, especially in our rural communities, where a lot of local institutions are really under attack, or they're fraying. Our local hospitals are having a hard time keeping the doors open. Many of our schools in rural communities are closing. The rural economy is under an immense amount of stress.

And so many of the people that are on the frontlines tell me that oftentimes this decision to start going to opioids is just a decision of hopelessness, a lack of hope. So, I view our role here federally fundamentally as getting the resources back to the communities, and it's only in the communities where the work can be done. And in Vermont it's being done. I know in West Virginia it's being done.

But this is why I think, Mr. Chairman, your bill is so important because it acknowledges our role is to get taxpayer resources. And by the way, that money belongs to the people we all represent. This is no big deal for us. This is us getting resources back to the people who sent it here in the first place, so they can do the important work in their communities. So that, as I see it, is our role.

Dr. Evans, you were talking about all of the above, you know, whether it's faith-based, or community-based, or a local parent helping a friend. So much of this is whether that individual gets some hope through, I believe, a human connection of any kind. And absent that, and I'll just ask you for your comment on that, as somebody who's been so much involved in the treatment.

Dr. EVANS. What you're saying is so important and critical, and I'm so glad that you brought that into this discussion, because we're talking about all the technical aspects of treatment. But I will tell you that what makes the difference for most people is that human connection.

I sort of joke when I'm talking to providers, and I say, "You know, when you ask people what helped them in treatment, rarely do they say, 'You know, doc, it was the paradoxical intervention that you did on the third session that made all the difference.'"

[Laughter.]

Dr. EVANS. They rarely say that. You know what they say when you ask them that question? They will say, "You called me sir."

Mr. WELCH. Right.

Dr. EVANS. "You called me mister."

Mr. WELCH. Dignity.

Dr. EVANS. You treated me with respect. That is a critical ingredient. We are talking about all of the other aspects, but if treatment doesn't have that aspect——

Mr. WELCH. Right.

Dr. EVANS [continuing]. I can tell you it doesn't work. And the reason it doesn't work is that people will not come back, they will not engage, and they will not do the work that they need to do.

Mr. WELCH. Thank you. Ms. Gray, I'll ask you. I went to West Virginia with my colleague, Congressman McKinley, and I've gotta say I was pretty impressed with the people in your state, and I know folks are facing challenging times there. Same question to you.

Ms. GRAY. I'll give you an example of something in my clinic. I was walking through the lobby one day, and a gentleman that was in his 50's stopped me, and he said, "Do you know that girl back there, that short girl with the short black hair?" And I said, "Yes." And it happens to be my daughter, because I'm bringing in anybody I can to help us, because we're in that much need working the program.

And I said, "Yes. I know her." And he said, "She gave me a hug last week." And I said, "Oh, she did." He said, "You don't know

what that meant to me. I haven't had a hug for over three years." So, I walked around and I gave him another one, and I said, "Well, you're getting one today." So, when he comes back every week, that's what he gets.

We have just, as a society, we have isolated ourselves more. We're not interacting more, and we are definitely interacting with people with substance use disorder as they are human beings, and how they need. It's very important. Relationship building is everything.

Mr. WELCH. Well, thank you. My time is up, but I do just want to reemphasize the importance of your bill, that we get this money back to folks in the communities, in all our communities that are doing this hard work. Thank you.

Chairman CUMMINGS. Mr. Comer?

Mr. COMER. Thank you, Mr. Chairman, and I wanted to just first say this. I'm a big believer in faith-based recovery programs. In fact, yesterday, in my district, stopped in Washington County at the Isaiah House, really impressive faith-based recovery center that I think has a tremendous business model of trying to not only help people recover from drug addiction, but to get back into society.

Helps them find employment. Takes them to work. Helps them make sure that when they leave there, if they have bills, like child support, outstanding child support payments, to try and help them get on their feet, to where when they leave, they're debt free, and even with a little money in the bank.

I think that's an important part of recovery, helping people get back into society. So, I wanted to mention that.

The other thing, and what my question is, I'm a believer in alternative sources of pain relief, because we have people in America that truly have pain. The business model, and I've said this many times, for treating pain, the old business model, where you prescribe opioids, has been a disaster in rural America. And part of my district covers the western part of Appalachia, and I have all of Southern Kentucky, all the way to Western Kentucky.

So, my question for Dr. Bailey and Nurse Ross, what are the barriers to patients having access to non-opioids to manage pain?

Dr. BAILEY. Thank you. There are many barriers. Even if a patient is employed and has insurance, many of those therapies are not covered, or if they are covered, extensive prior authorization and approvals are needed. And that's one of our biggest points that we'd like to make today is removing the barriers, like prior authorization. That's just not just for drugs. It's also for procedures. It's for therapies.

And these things need to be studied. We don't really—pain is such a pervasive part of our culture and our being a person, and the notion that life should be completely pain free, and that the ultimate state of pain is a zero pain is not necessarily very realistic. And we need to have research, but we need to limit the barriers.

There's also still not parity between mental health services, and, say, surgeries and medications, and we need the funding and the infrastructure to make all these things work.

Mr. COMER. Okay. Great.

Ms. ROSS. I would agree with everything that the doctor said, and I would also point out, as we've mentioned several times, you know, it's—all right. Let's just have an example of someone that could use PT. Physical therapy——

Mr. COMER. Right.

Ms. ROSS [continuing]. works for a lot of people right off the bat. It depends on your circumstances. So, you start with whether or not you have insurance. Then you go whether or not it's covered. Then how many sessions are covered. If the doctor says it's going to take you this many weeks, and at least 16 treatments, let's say you're living out of your car. Poverty has an effect on that.

Mr. COMER. Mm-hmm.

Ms. ROSS. It's often the things that do work, but they work over time——

Mr. COMER. Right.

Ms. ROSS [continuing]. that are more difficult to get insurance companies to pay for, and the patients to participate in. Then sad to say there is some awful things, like you've got a work-related injury, and from the employer's perspective, it's quicker to give you some pills that work fast, as opposed to being out of work longer. So, all those things have an effect.

Mr. COMER. And I agree, and hopefully, we can come together on this committee in a bipartisan way to make it easier for patients to have access to alternative sources of pain relief that work.

Mr. Chairman, I have a little bit of time left. I'd like to yield to my friend, Dr. Green.

Dr. GREEN. Thank you, Mr. Chairman. And thank you, Mr. Comer. As an ER physician, I see these patients both in the seeking role and in the crashing role, whether it's withdrawal, or, you know, an overdose. And I have a unique perspective on it, but I want to say first to anyone in the room, or who's watching, who may be struggling with this issue, if you've gotten victory over it, you've done the hardest thing that a human being will ever do in their life.

I've done hard. I'm an ex-army ranger, combat veteran, cancer survivor. If you have overcome addiction, you have done the hardest thing that a human being will ever have to do. If you're struggling with it now, and you're watching on television, get help. You can do it. You can overcome it. But please seek help.

One quick couple things from a physician's perspective. We need to always question the data. When I was in residence, I was told, and the literature said, that a six-day prescription of opioids will not cause addiction. Now that we know that three days for some people who are genetically predisposed, will cause addiction.

That also means that we need to push the advancements in genetic research on metabolizing medications, and physicians need to prescribe, based on that genetic profile in the future.

CMS needs to approve abuse-deterrent drugs, so that physicians can give these things that will prevent patients from abusing. I want to say about Narcan, it saves lives. Narcan availability needs to be everywhere. It needs to be in restaurants. It needs to be in schools. It needs to be on rigs. It needs to be on policeman. Narcan saves lives, and we need to use it, and we need to distribute it.

Thanks for talking about neonatal abstinence syndrome. We don't want to forget those children. I will, if I have just a second more, Mr. Chairman, just a second more, and I appreciate the indulgence.

We've also got to make sure that physicians get to make these decisions about medications, because the pressure from administrators in hospitals to make patients satisfied creates an incentive for physicians to just write the prescription, make the patient happy, and the patient's satisfaction scores go up. We have to be aware of this dynamic in medicine, and make sure that the physician gets to make the call.

Thank you, Mr. Chairman.

Chairman CUMMINGS. Thank you. Thank you very much.

Voice. Amen.

Chairman CUMMINGS. Mr. Connolly?

Mr. CONNOLLY. Thank you, Mr. Chairman. And I want to pick up where Dr. Green just left off, because I think there's a burden on physicians as well. I mean my experience, frankly, is that physicians are all too ready to prescribe opioids, and look at you kind of funny as a patient if you object.

If you're a patient in a hospital, it is more likely you're actually going to go to battle with the physician, the attending physician, after surgery, with an accident, in which you do have acute pain. And their focus correctly is on trying to make sure the patient can sleep and recover. If you're in acute pain you're not going to do either one of those two things.

Pain management is tricky, but I don't think it's yet in the heads of a lot of physicians that, you know, there's a real risk here if I prescribe this, or if I prolong its use in an IV drip. And I just want to know if you might comment on that, because I—yes, maybe there's administrative pressure on physicians to have happy customers, but I also think that there's a Hippocratic compulsion, all motivated for good reasons, to keep a patient out of pain, which is why we ask them on a scale of one to ten, "How you feeling today?" And we try to address it.

Leaving people in acute pain is not the answer to this crisis. And I wanted to give you an opportunity, especially Dr. Bailey and Dr. Olsen to comment on that.

Dr. BAILEY. Thank you very much. The, I think we actually have made a good deal of progress changing the mindset of the medical community. Opioid prescribing went down 33 percent between 2013 and 2018.

Mr. CONNOLLY. But can I just interrupt you, Dr. Bailey. That sounds impressive. But we were so overprescribing, it had to come down. I mean in and of itself that doesn't tell us a lot. And if you have patient experiences, you know, with the medical community, I mean I don't know whether I want to describe it as overprescribing, but a quick readiness to tell you, "This is good for you, you need to take it, it won't hurt you," continues to, in my experience, dominate much of medical opinion in interaction with patients, motivated for good—I mean the motivation's good, but the outcomes are very, very risky.

Dr. BAILEY. I actually have often the opposite reaction from my patients when I prescribe medications for asthma. Very often,

many of my patients do not want to take things. They don't even want to take an aspirin. They don't want to take an antihistamine.

Mr. CONNOLLY. Right.

Dr. BAILEY. So, there are a lot of patients out there that will push back against that. But I think the 33 percent decrease in prescribing is significant, because it's going in the right direction. It may have started way too high, but it's going in the right direction. And I think the greater use of prescription drug monitoring programs around the country has increased. An incredible amount of education has been delivered.

The AMA, and ASAM, and other organizations are being very active in prescribing from the medical student level, on up, focusing on the treatment of pain, and non-drug modalities that treat pain.

Mr. CONNOLLY. I have to interrupt you, only because I'm running out of time, but thank you, Dr. Bailey.

Dr. Olsen, let me ask you a question about treatment. Criticism, if you read Beth Macy's book, Dope Sick, a lot of rehab, you know, people put out a shingle saying, you know, "Addiction Rehab Center Here." They're not licensed, or they're not really permitted. And two-third of them still practice no drugs allowed here at all.

And the experience with opioid addiction is that is almost guaranteed to lead you to another addiction, probably heroin. It doesn't work, and neither does cold turkey. And neither does faith-based alone rehab, which Mr. Comey talked about. I wish they did, but they don't, and I want to give you an opportunity to comment a little bit about what we're dealing with in terms of rehab, and what works, and what doesn't.

Dr. BAILEY. Great. Thank you so much.

So, you know, I think that this is an issue that ASAM is working extremely hard on, and making sure that we have standards, that we have generally accepted medical standards. This is a medical disease, so, therefore, we really need to be approaching this as the medical disease that it is. That means medications. That means a trained work force of physicians, nurses, psychologists. It takes a multidisciplinary team, as I think you've heard today on the panel. But it also means that we do have 50 years of robust scientific evidence that shows that medication-based treatment saves lives and improves lives. So, we talked a little about that earlier. And making sure that we then actually have those standards. ASAM——

Mr. CONNOLLY. If I can interrupt you here, too, and I thank the indulgence of the Chair, but this is so important for people to hear. We still have two-thirds of the rehab centers in this country saying otherwise, saying "no drugs here at all."

Dr. OLSEN. Right. Right.

Mr. CONNOLLY. And that is—we know that does not work. We know, in fact, it condemns people who are sincerely seeking treatment to a relapse.

Dr. OLSEN. Yes. Yes.

Mr. CONNOLLY. Because the brain chemistry is changed to the point where they can't control that.

Dr. OLSEN. Yes.

Mr. CONNOLLY. And so, you've got to have stepdown drugs.

Dr. OLSEN. Yes.

Mr. CONNOLLY. I'm sorry.

Dr. OLSEN. No. You're absolutely correct. And I think, you know, there has been newspaper articles, there have been public awareness campaigns really demonstrating that people, when they come out of residential treatments, or incarceration settings, where there is no access to those medications, people die.

The death rates from and the risk of overdose—relapse and overdose from now Fentanyl is upwards 20 times higher in people who are coming out of settings like the residential treatment facilities, like incarcerated settings, where there is no access to those medications.

And so, therefore, I think the CARE Act really speaks to evidence-based effective treatments need to be available and standardized across the board.

Mr. CONNOLLY. Which is why I support this, Mr. Chairman. Thank you.

Chairman CUMMINGS. Mr. Roy?

Mr. ROY. Thank you, Mr. Chairman, I appreciate that. Thank you to all the witnesses. You've taken time out of your day to be here and appear before the panel. More importantly, thank you for what you do on a daily basis on the frontlines in a way that most of us don't understand or comprehend what you're facing, and the good that you're doing, and appreciate that all your commitment, both from a medical and also from a faith perspective.

And appreciate very much your testimony about faith, and about your appropriate recognition of what Christ would teach us to do today, and what he would do today. And appreciate your statement in saying that.

Let me ask you all a question, if I can go down the table. How overwhelmed are we, as a society, clinics, and all the hospitals, and all the front lines in terms of dealing with this crisis? If you can just go down the table and just kind of give me just a—I've got limited time. I'd like sort of a 10 second synopsis of how overwhelmed you would characterize our current situation.

Dr. BAILEY. I would say very overwhelmed, and any barrier that's placed between the physician, or the treating provider and the patient is just going to make that logarithmically worse.

Mr. ROY. Thank you. Dr. Olsen.

Dr. OLSEN. Our emergency departments, our hospitals, our police, our EMS, I mean everywhere we are overwhelmed, but we know what to do. We have the evidence and the science, and we can actually get people started in treatment in so many different places.

Mr. ROY. Thank you. Dr. Evans?

Dr. EVANS. I would say two things are really important. One is that we have to talk about attitudes, about substance use, and substance users, that it will make a big difference in our policies. And I think the other thing is that we have to use the whole body of research, and not narrow parts of the research to make sure that we're using all of the tools that we have available to us.

Mr. ROY. Thank you. Ms. Ross?

Ms. ROSS. I think we are overwhelmed, but we are not helpless, and we are not hopeless, which is why we support this bill. When Representative Cummings mentioned the AIDS epidemic, we didn't

just throw up our hands. We got to business and did something. We can do that here, too.

Mr. ROY. Ms. Gray?

Ms. GRAY. I would say we are busting at the seams. Every public service area there is is overtaxed. Our first responders, they've been out there for the last 10 years on their own, walking in while children are doing CPR on their families. It's affecting them in their trauma.

Mr. ROY. Thank you. And Dr. Young?

Dr. YOUNG. Our welfare system, I would agree that they've documented that this is straining the child welfare system completely.

Mr. ROY. Thank you. Well, I appreciate that. I know there's been a lot of conversations here back and forth to the members of the panel and you all about the cultural problem, and that that is a significant part of that. And I'm not sure that the bill necessarily, you know, obviously hits that head-on, but I do think that is a critical part of what we're talking about.

The other thing that I—it will not surprise my colleagues that I will bring up, as I'm wont to do when we're talking about the opioid problem, is the crisis at our border, and the extent to which that the flow of elicit Fentanyl into our country is driving a significant portion of what we're dealing with, in terms of what you all were just describing, in terms of being overwhelmed.

If you look at the data, and you look at the charts, this chart, which, forgive the pen-drawn addition there, because I don't have the chart from 2017, but you're seeing the spike in the red, and the numbers are going up of that portion being the elicit Fentanyl that we are now seeing spiking over the last two or three years. And I note a lot of head nodding.

This portion, which is now truly drowning us in the numbers of people, is something that I think we as a country need to at least recognize the problem at the border. And I would implore my colleagues on the other side of the aisle to recognize that problem, and not to bury one's head in the sand about what we're facing as a nation as a result of our failure to secure the border.

Mr. CONNOLLY. Would my colleague yield just for a question on that?

Mr. ROY. I would be glad to yield——

Mr. CONNOLLY. Thank you.

Mr. ROY [continuing]. for a brief question from my colleague.

Mr. CONNOLLY. Just what percentage of the illegal Fentanyl coming into the United States is crossing the border versus from China?

Mr. ROY. I don't have that data right in front of me, but happy to have that conversation.

Mr. CONNOLLY. I think that's an important conversation before——

Mr. ROY. It is.

Mr. CONNOLLY [continuing]. you get us to agree with your analysis of the border.

Mr. ROY. Taking my time back.

Mr. CONNOLLY. Take it back.

Mr. ROY. What I would suggest to you is that a significant amount of that coming from China data shows is coming through

Mexico. And the 144 pounds that was caught by border patrol between the ports of entry, a data, a fact we have in hand, is ample evidence of the significant amount of opioids that is flowing across our southern border into my home state of Texas, devastating communities locally in Texas, because this body fails to do its job to secure the border.

I yield back.

Chairman CUMMINGS. Let me just ask you one thing, and you all can incorporate this in your answers, and perhaps it would be best, Dr. Olsen. Do we have a shortage of physicians that are trained to do what you do? Because it seems like we haven't touched on that, whether the stigma with regard to doctors who say, "I don't want to be bothered with that type of patient." You can answer that. You can answer it very briefly now, but then we'll go on to Ms. Hill.

Dr. OLSEN. Yes. So, thank you for that question. And, you know, we know there are surveys that have been done of physicians, not only in training, but also post-training that identify that the regard that they have for people with substance use disorders is much lower than the regard that they have for people with other chronic conditions, such as diabetes, or high blood pressure. And that even among the substance use disorders there is lowest regard for people who have an opioid use disorder.

What is, I think, inspiring, at least for me now, is that we are seeing a younger generation of trainees, of graduate medical students, residents, who are really starting to embrace their role as treatment providers for people with substance use disorders. Where I work, we have an agreement with the Johns Hopkins Addiction Fellowship. We have an agreement with the urban and pediatric residencies. We have an agreement with the school of nursing.

So, we have students who rotate through with us, and really see that people can and do recover. And that is, I think, one of the biggest pieces. If we can help students and other healthcare professionals see that people can and do recover, their attitude changes dramatically. And so we need the funding to actually then be able to expand the graduate medical education fellowships to really standardize and to get medical education on not only pain, but also addiction, into all medical schools, into all nursing schools, pharmacy schools, so that we really have a robust and qualified work force to treat individuals now and for the future.

Chairman CUMMINGS. Ms. Hill?

Ms. HILL. Thank you, Mr. Chairman. And thank you all so much for the work that you do and for being here.

I actually used to be more on your side of things. I was the executive director of a large homeless services organization, and oversaw one of the only harm reduction facilities for veterans experiencing homelessness in Los Angeles.

And what I saw over and over again was the number of people who needed that kind of help so far exceeded the capacity that we had, and that any program had. My teams would do outreach. They would go out to people who were experiencing homelessness, and you would build a relationship so that once someone is finally ready to get help, once they're finally saying "This is the moment. I saw a friend die from a heroin overdose,", or, you know, they know that it is time, they are ready to get treatment, and you

can't. That moment passes, and before, you know, the months' long waiting lists are open, then they've died, or they've disappeared.

I want to address a couple of things in terms of what my colleagues have talked about. One is that we've mentioned the stigma around it. And I think we have only recently, relatively recently started kind of universally referring to addiction as a disease. Can you talk a little bit more about how not understanding addiction as a disease impacts this treatment gap, and whether you think that the work that we're doing with this bill will help to close that?

This is really to anyone who feels like answering it.

Dr. OLSEN. So, thank you for that. And I think that, you know, the stigma is real. The stigma is profound. We have a lot of work to get around that. I do think that all of the pieces of this bill really together and collectively are going to help reduce that stigma.

Because the bill includes focus on education of healthcare professionals, so that they really see it as their role, and they understand what to do when people walk through their doors, that there are resources for local service agencies and counties in coordination with states, and their state, single-state agencies, so that everything is also coordinated, that, really then, are able to provide the resources needed for all those wraparound services, so that we can support people in their recovery, and in their remission.

But also, as you pointed out, that we can then get people and identify them when perhaps they're actually not quite ready for treatment, because we know that this is a disease, much like other chronic conditions, where people are—it's a chronic thing that people have to accept that they have the condition, and then actually want to be able to—and be ready to receive the help that they need.

It doesn't mean that we should just kind of, you know, put people in jail, and to throw our hands up and say there's nothing we can do. We really absolutely can have the harm reduction and the preventions efforts to help engage people, keep them alive, keep them as healthy as possible before we also then kind of move along that continuum. And all those pieces are in this bill.

Ms. HILL. So, I want to followup with Mr. Connolly said, which is that so many of the facilities and the programs that treat—that are intended to treat addiction really are this zero-tolerance policy. They're based on the AA model, which I think has a role, but it places the responsibility entirely on the person suffering with the addiction.

I think that one of the reasons that the AA model is so proliferate is that it's the only free and largely universally accessible kind of program. And so, there are many programs that just don't—they don't feel like they can release a patient into the world when there's no other followup that they can say other than to join your local AA/NA.

Can you talk about how——

Mr. CONNOLLY. Would my friend just yield for a second?

Ms. HILL. Sure.

Mr. CONNOLLY. The data shows, I believe, that that model, the AA model, has only a 10 percent success rate, whereas the step-down drug——

Ms. HILL. Right.

Mr. CONNOLLY [continuing]. has a 30 percent-plus.

Ms. HILL. Right. No. Correct. Correct. And I think that's what I wanted to get at was with the—with the expansion such as that is covered in this bill, do you believe that it will expand the access of MAT, and of these stepdown programs. Do you think we can have regulations in place that will make it so that more facilities need to adopt these evidence-based practices, and that we will have the resources to provide that aftercare, so that when someone leaves an in-patient setting, the answer isn't just, "Go to your local NA."

Dr. EVANS. If I could answer that. I was a policymaker commissioner for 20 years, and my last position I managed a $1.5 billion budget. So everyday we spent $2 million approximately of taxpayer money. And as someone trained as scientist, I was very concerned that we were spending money on the things that we knew from the science what was working, so much so that we created an evidence-based practice and innovation center, because I know, as having been a practitioner, that if you don't, and if you're not intentional about helping providers to incorporate what the science says, they will not do it. That's No. 1.

No. 2, in the addictions field more than probably any other field that I've been affiliated with, there is a very strong philosophical bent that is sometimes not open to data, facts, science, and I think we have to be very intentional about making sure that if we're going to use taxpayer money that we need to ensure that people are using what the science says about what works.

So, the point you're raising is a good one. I will tell you that it is not easy to change clinical practice. A lot of these programs have been in existence for decades. The people who are running those programs are often people who went through those programs, and have gotten into their recovery that way. And so, they believe that the only way that people can get into recovery is to go through that same process.

So, it's very difficult, and I really believe that—you know, I mentioned we spent somewhere between 1 and $2 million every year on trying to retrain providers. You know, my strong recommendation is that we not only provide new resources for communities, but we also provide the resources to help people with the implementation of those new practices, because it won't happen otherwise.

Ms. HILL. Yes. So, with this Act we really need to have the—not just the enforcement mechanisms, but the regulations that say you have to have the evidence-based practices involved. It's not just money going out there. It needs to be evidence-based, and it needs to be——

Dr. EVANS. Well, I would be very careful about regulations. As someone who's worked on both sides as a policymaker and as a provider, I think that the model is more about how you create resources and technical assistance so that people can actually make the practice change.

One of the providers in Philadelphia that was a very strong, what we call concept program, they were very philosophically bent toward sort of the AA model. We thought would be one of the last programs to incorporate evidence-based training programs, but with a fairly significant investment with consultants and trainers,

they turned out to be one of the shining stars. So, it's possible, and I personally believe that using a hammer is not as effective as using other kinds of strategies.

Ms. HILL. I agree. I was on the provider side, too, so——

Dr. EVANS. Okay.

Ms. HILL. Thank you so much. I yield back.

Chairman CUMMINGS. Mr. Grothman?

Mr. GROTHMAN. Yes. Can anyone guess, say, in the last five years the amount that we have spent on treatment nationwide? Anybody have a stab at it? Oh, guess. It's a rhetorical question almost. Can somebody just take a wild stab? Nobody knows how much we're spending on treatment in the country.

Dr. BAILEY. It's gotta be billions.

Mr. GROTHMAN. Billions. It's a lot. And the thing that bothers me, you know, a lot of people, particularly because the treatment community gets involved in this stuff, say the answer is to spend billions more. But things keep getting worse. And if things keep getting worse no matter how much we spend on treatment, it seems to me the problem overwhelmingly is not to spend more money on treatment, but to focus on what type of treatment works and what type of treatment doesn't.

I'll give you another general question. We are told that there was a lot of heroin usage in Vietnam. I don't know if it's true, but we're told it's true. And nevertheless, when all these guys came back from Vietnam there were very few people who wound up addicted to heroin.

Can you take a stab as to why that's true? Anybody want to take a stab as to why that's true?

Dr. OLSEN. So I'd like to actually address a couple of your points, one of which is believe that the White House Office of, I can't remember exactly what the office is, has put forth that we've spent—in 2015 we had spent a total of about $500 billion on addiction and the opioid addiction crisis. So, I think that's an important number to just keep in perspective when we're talking about the $100 billion that has been put forth in terms of the CARE Act.

And in terms of the——

Mr. GROTHMAN. And it hasn't worked, right?

Dr. OLSEN. Well, actually, that was my second point.

Mr. GROTHMAN. You could say it could be worse, I suppose.

Dr. OLSEN. So, the second point is that we actually now have—so the latest data from Maryland, for the first quarter in 2019 we saw a 15 percent decline in opioid-related overdose deaths. And so, we are seeing that. And in Rhode Island they have seen a reduction in overdose deaths, especially when they expanded access to medications in all of their correctional settings.

So, we are seeing that there are now the beginnings of kind of a decline in these overdose deaths, and hopefully, we'll be able to kind of have those continue.

The third point, in terms of the Vietnam experience, so Dr. Jerry Jaffe was the physician, he was a psychiatrist, who actually was hired by Nixon to really study the problem of the Vietnam vets who were coming back. You know, one of the things—so he works at the Defense Research Institute in Baltimore, and I've had some conversations with him about this.

One of the things that he says is that probably the biggest missed opportunity from a scientific perspective with that experience was not having done sufficient studies on the people who actually stopped using heroin once they came back to the U.S.

However, what we do know is that because the 40 to 60 percent of the risk of developing opioid use disorder is genetically based, that the presumption is that the men who continued to use substances probably had a different genetic predisposition to developing that addiction, as well as perhaps some of the other factors that we know about, traumatic childhood experiences, they may have had other psychiatric conditions. But there certainly is a difference between the population of people who develop an addiction when they are exposed to substances, even if that substance is heroin, versus those who don't.

Mr. GROTHMAN. So, you're saying the reason we were so much more effective during the Vietnam era without doing anything, than compared to today, is because the original data bases of people who used heroin, today the people who use heroin are more genetically predisposed than to the average soldier in Vietnam.

Dr. OLSEN. So, I actually wouldn't even say that we didn't do anything with Vietnam. Jerry Jaffe was appointed by Nixon to actually establish the first opioid treatment programs back then, called methadone maintenance programs. After several studies in Lexington, Kentucky, and in New York, had demonstrated that methadone had tremendous efficacy in reducing crime, in reducing relapse to heroin. So, it was Nixon really who actually established the first treatment programs.

Mr. GROTHMAN. Okay. But I am under the impression that most people stopped using heroin when they came home from Vietnam without a program. They just quit. Is that accurate?

Dr. YOUNG. And there were detox programs that were set up. One of my——

Mr. GROTHMAN. But most people, that's the question I'm trying to bring up.

Dr. YOUNG. And most people who take prescription opioids now don't develop a heroin problem, but for some people, they do convert to an opioid use problem, and may convert to heroin use disorders when those prescription drugs. So, it's not 100 percent of people who take prescription opioids convert to heroin use disorders. I think that's what Dr. Olsen is saying. It's not 100 percent, but for some people, they do.

Chairman CUMMINGS. Thank you very much. Ms. Wasserman-Schultz?

Ms. WASSERMAN SCHULTZ. Thank you, Mr. Chairman. And I want to thank the panel for joining us to help address this really crisis-proportion issue.

I want to ask unanimous consent to enter this article from The New Yorker in 2013, if that's okay, Mr. Chairman.

Chairman CUMMINGS. Without objection, it's ordered.

Ms. WASSERMAN SCHULTZ. Thank you. In it it describes the joint commission which is responsible for establishing pain management criteria, and accredits health facilities' issues, and they issued pain management standards in 2001 that instructed hospitals to measure pain.

And this was really the elephant in the room, I think, that we aren't addressing in terms of a solution, because essentially, we're on a hamster wheel. I mean we can really find strategies to help people get off of their addiction to opioid abuse, but we keep replacing them with more people who become addicted, because this pain scale that was established in 2001, that this is the smiling-to-crying faces scale, the joint commission essentially instructed hospitals to prioritize its use, and the treatment of pain with narcotics.

As Elizabeth Zoni, a spokeswoman for the Joint Commission, told the author of the article that, "Standards were based upon both the emerging and compelling science at that time, and upon the consensus, a broad array of professionals." Yet, Perdue, according to a report issued by the U.S. Government and Accountability Office, helped fund a pain management educational program organized by the Joint Commission, a related agreement allowed Perdue to disseminate educational materials on pain management. And this, in the words of the report, "May have facilitated its access to hospitals to promote OxyContin."

So essentially these pharmaceutical companies bought their way into the official medical guidance committees. And in 2007, Perdue Pharma, and three of its top executives, pleased guilty to criminal charges that they had misled the FDA, clinicians, and patients about the risks of OxyContin addition and abuse by aggressively marketing the drug to providers and patients as a safe alternative to short-acting narcotics.

The elephant in the room, to me, is that this pain scale still exists. My husband just had emergency back surgery a little over a week ago, and I can't describe to you the number of opioids he left the hospital with. Now we are very well aware of how cautious you have to be, but many aren't. And people have a different level of—different levels of pain tolerance.

But Dr. Bailey, and any of the other experts on the panel, I'd like to know what steps are being taken and should they be taken to eliminate or dramatically alter this pain scale, and the whole idea that as soon as you walk in the door someone's immediately asking you, "On a scale of one to ten, describe your pain." And no one wants to be in pain. We all understand we should stay ahead of pain. But the entire focus of a hospital stay is on pain, and that's important, but it's become an obsession. And if we don't change it, and if we don't change the amount of pills that people are sent out the door with, then we are never going to get a solution, then a resolution to this problem.

Dr. BAILEY. Thank you. The treatment of acute and chronic pain is a very complex area. The AMA has been very involved in educating physicians about the use of opioids——

Ms. WASSERMAN SCHULTZ. Okay. But I want to specifically ask you if you believe that the pain scale and its use, the smiley-to-crying faces scale, and the entire focus of the way people have pain addressed in a hospital setting, in a medical setting, after an injury, or any other type of pain situation, needs to be altered.

Dr. BAILEY. I think there's no question that there's an overemphasis on measuring—trying to quantify pain. The physicians undoubtedly have been encouraged by their hospitals, by those that——

Ms. WASSERMAN SCHULTZ. Pharmaceutical companies.

Dr. BAILEY [continuing]. provide patient satisfaction surveys, you've got to treat pain, you're got to treat pain, and I think part of that was what helped create this problem.

Ms. WASSERMAN SCHULTZ. But you do think it needs to be changed.

Dr. BAILEY. Yes.

Ms. WASSERMAN SCHULTZ. Okay. I hope, since you are the president of the AMA, that you would lead that effort. Yes, Dr. Olsen? Or I'm sorry. Dr. Evans?

Dr. EVANS. I think this is a really good point that you're raising. There are more sophisticated ways to figure out who's going to be more likely to be susceptible to opioid addiction. In many hospitals now you have what are called clinical health psychologists who are embedded within surgical units and other units within hospitals who do sophisticated psychological assessments of people prior to an operation to determine whether they are more likely to engage in opioid misuse.

That's very effective in helping to identify people who are more likely. Those psychologists are working with physicians to help alter the protocols around how they're going to manage pain. And not enough of that's done.

I talked about the importance of non-pharmacological interventions for pain management. And the reality is that pain is not only physiological, it's psychological. And we have completely ignored the psychological aspects of pain. We're not treating it.

And my colleagues who work in this area will tell you that there are a lot of effective ways of helping people to not only manage pain, but to improve their daily functioning. And we have to incorporate more of that into our healthcare system.

Ms. WASSERMAN SCHULTZ. Mr. Chairman, could Dr. Olsen just answer?

Chairman CUMMINGS. Dr. Olsen, and then we'll——

Ms. WASSERMAN SCHULTZ. Thank you so much.

Dr. OLSEN. So, thank you. So, I agree with——

Ms. WASSERMAN SCHULTZ. What he said.

Dr. OLSEN [continuing]. Dr. Evans. What he said.

[Laughter.]

Dr. OLSEN. That essentially that really doing broad education, not only of physicians and other healthcare providers, but also the community, so that we really can get to a point where the pain scale that you reference, that may have a role in terms of kind of an acute episode of pain, where we want to actually decrease the pain, but particularly in people who have chronic pain, or acute chronic pain, that really is not the best way to look at the outcomes and the appropriate outcomes for people who have chronic pain.

Ms. WASSERMAN SCHULTZ. Thank you. Thank you. Mr. Chairman, I hope we can change that. Thank you so much.

Chairman CUMMINGS. Mr. DeSaulnier.

Mr. DESAULNIER. Thank you, Mr. Chairman. I just want to thank the panel. This is both incredibly depressing and frustrating, and also inspiring, your work, and gives me hope, as somebody who has dealt with behavioral health issues personally. My dad had substance abuse problems, and he ended up committing suicide.

But 30 years ago, when that happened, this support system, and his substance abuse was not heroin, we have come so far. Part of the frustration is we know the neuroscience. We know what the evidence-based research is. As you have said so well, you know it works.

And having been in San Francisco in the 1970's and 1980's, having been in the restaurant business, and had employees and friends pass away because of AIDS and HIV, knowing people at UCSF, who were supported by NHS funding, that did remarkable things, that now keeps friends alive, who are HIV positive, this is an example of we know both the policy and the politics to implement it. And we're overcoming the stigma, and the blame, and the denial slowly but surely that I was impacted through my dad's experience.

But I can't tell you how frustrating it is, and you share this, about the lives we're losing and the money we're wasting. So, sort of going on a cost benefit should be pretty clear, both by the research and anecdotally, that passing that bill, implementing this kind of investment, insisting on the best practices, insisting on support services, as you've all settle on with the medication.

And then last, to followup with what Congressman Wasserman Schultz said, what Perdue Pharma, and I appreciate my colleague's concern about the border, but it should be proportionate here, and effective, what Perdue Pharma did was clearly criminal and morally unethical. I think every penny that all of these states, county lawsuits are not—most of it should go back into the system. We should punish them, obviously, but I hope it doesn't go off in the general funds in local and state government.

So, if you had those kind of resources, do you think you'd have the same outcomes that we had when we were dealing with AIDS and HIV? Dr. Olsen? Dr. Bailey? Dr. Evans? And how quickly could we see that?

Dr. OLSEN. Yes.

Mr. DESAULNIER. Could we save generations, like we did with HIV?

Dr. OLSEN. I would believe so. You know, I think that we have started to see, as I mentioned, kind of a little bit of a dip in some of the overdose, the opiate-related overdose deaths. But I think as you mentioned, that, you know, that opioids are kind of—that's today.

Mr. DESAULNIER. Mm-hmm.

Dr. OLSEN. Tomorrow, it is probably going to be methamphetamine.

Mr. DESAULNIER. Yes.

Dr. OLSEN. We're seeing that coming down the line. Alcohol kills more people in the U.S. every year. 88,000 people lose their lives every year to alcohol, and alcohol is a slowly progressing killer.

So, you know, really being able to have a trained work force that is multidisciplinary, but that includes physicians, and nurse practitioners, and others that are really able to recognize when people have a substance abuse disorder or a risk for that, being able to then make that diagnosis and treat it. That, and then getting people into wherever they are, whatever door they walk into, really having those opportunities.

You know, as I mentioned in my testimony, whether it's in jails, or emergency departments, or hospitals, specialty treatment clinics, primary care, we really need that continuum of services, and we need to standardize it. We know that there are effective evidence-based interventions for opiate-use disorder. We have——

Mr. DESAULNIER. Dr. Olsen, can I just jump in——

Dr. OLSEN. Sure. Yes.

Mr. DESAULNIER [continuing]. because I want to—if we have time to respond.

Dr. OLSEN. Yes.

Mr. DESAULNIER. But you triggered another thing. I've had psychologists, behavioral health people come and tell me because of the ACA and parity, we have a 75 percent increase in people seeking services. We know the numbers here aren't very good, one in ten. But they've also told me that they have a 25 percent decrease in young people going in other fields. So, in the context of what we just said, we're not providing the infrastructure that would save lives.

Dr. OLSEN. Correct. Correct. And so, we need the infrastructure. We need the resources. We need to teach it, standardize it, and really cover it.

Mr. DESAULNIER. Dr. Bailey?

Dr. BAILEY. Thank you. The money that has been invested in this crisis is undeniably just tremendous, but I'd like to give an example of what the state of Virginia was able to do with their Medicaid 1115 waiver funds. They established a program to increase reimbursement to physicians for the treatment of substance use disorder patients. They provided training for medically assisted therapy, and they provided incentives to the patients for behavioral health. So, they kind of went all the way around.

And they found that there was an increase in Medicaid enrollees that had had medication-assisted therapy. There was a dramatic decrease in the number of ER services that were needed by that patient population. Too early to say anything about overdose deaths, but I think—and the punchline is that the program basically broke even. They saved as much money as they spent. So, I think that there are ways that we can invest wisely.

Mr. DESAULNIER. Thank you, Mr. Chairman.

Chairman CUMMINGS. Ms. Tlaib?

Ms. TLAIB. Thank you, Mr. Chairman. Thank you all for your incredible work. I think everything you're saying is to be true. This is a multifaceted kind of approach, from holistic to the mental health, to the wraparound, talking about community-based or faith-based. I think it's a combination of all of those things.

I do want to share a story, if I may, chairman, that's happening in my district. Janet, she's a social worker and a recovery coach at Covenant Community Care, a federally accredited clinic in 13th congressional District. She's relentless at her job. Ellis, he's about a middle-aged man, the same age as many of my colleagues here in this chamber, and was addicted to heroin.

They met at a local church, where Ellis went for free meals, and Janet reached out to him at the church and offered to help him. They had come up with a pact that when he was ready, because he wasn't ready at that moment, that he put his thumb up. And

one Sunday he finally did that. He put his thumb up, and Janet and Covenant Community Care was there for him, and their role at community health center, and the opioid treatment center played a really, really incredible role. Because it was very local level, and frankly, they need more resources, and that's why the CARE Act is so critically important. So, I thank the chairman for his leadership on that.

According to the 2018 report to Congress from the Medicaid and CHIP Commission, it said that many areas of the country simply lacks substance use treatment facilities, and we talked about this. I want to take a deeper dive in that, because in the report it said roughly 40 percent of counties do not have an out-patient substance abuse disorder treatment program.

Ms. Ross, in your experience, are there areas of the country that have a high number of residents with substance abuse disorders, but lack the adequate treatment facilities?

Ms. ROSS. I actually think that's all over.

Ms. TLAIB. Yes.

Ms. ROSS. They're just plain aren't enough of them. And as I mentioned before, we've had some close. So, unless there's something like this CARE Act, that's what you're going to see. And so yes, we do need more of them, and they need to stay open.

Ms. TLAIB. No. And I agree. And I think there's always this constant debate whether we need—and it always is people pause, because it costs money, I mean a lot of money in resources to combat something like this that has to come from—you know, from different kinds of forms.

Ms. Gray, are there people in your community who have overdosed because they were waiting for access for treatment?

Ms. GRAY. Currently, we are driving people four to six hours away to get treatment. There is no in-patient treatment center anywhere near us. We even have grassroots people like the Hope dealers, who are moms who just got up and got tired of watching their children die, and they're driving the people to the treatment programs.

Hopefully, that will change in my community this fall, because we're working on an in-patient treatment program, but that is definitely a huge gap. I mean even when they're ready there was nowhere to take them. That's how I actually got into this and harm reduction. People were literally coming into my clinic for other services, and crying on my lap because they wanted help, and I had nowhere to send them. Six-month waiting list on behavior health units.

And I'm glad that you have talked about peer recovery coaches, because that is key. Peer recovery coaches in my clinic are amazing human beings. And if you want to see that there's life in recovery, come visit them, because they just really—it's a huge piece of this. It really is. And every person that walks through my clinic I think, "Are they going to be my next peer recovery coach?"

Ms. TLAIB. Yes. And it's because they offer love and respect.

Ms. ROSS. They offer love.

Ms. TLAIB. All of you have said some sort of form of, if it wasn't in the form of a hug, a form of—and, you know, a lot of this is creating this extended family——

Ms. ROSS. Yes.

Ms. TLAIB [continuing]. that you have, and this is my family in Congress, by the way. You feel less alone.

But I do want to share something. Congressman Raskin had kind of a sub-hearing around this issue of addiction. And it was one father who lost his daughter to—lost his son to addiction. His son described it as like mosquito in his head, that he just kept wanting to scratch, and it just was constant. It was very powerful, but one of the things that was consistent is every single—all three that testified were all from different income and education backgrounds.

I think his son has like a master's degree, and another person, you know, just graduated from high school, was in the service industry, and so forth. Is the fact that we need to change this culture and this image, that I think, you know, media, and I think mainstream, like TV, and all this, have created this image of somebody that suffers from addition looks like, and where they come from.

And I think that is something that is critically important for us to push up against. Because I've met people from all different social backgrounds, all different education backgrounds, come from all communities, not just mine, that are suffering from addiction, because of the lack of funding and resources that is being provided here in the CARE Act.

So, thank you so much, Mr. Chairman. I yield the rest of my time.

Chairman CUMMINGS. Ms. Ocasio-Cortez?

Ms. OCASIO-CORTEZ. Thank you. Dr. Olsen, in your book you discuss the history of opioids in the United States. And you describe how the United States has a unique history with opioids, if there's a way in which manifests as a uniquely American disease. And that the U.S. has kind of cycled between making opioids widely available and then trying to restrict their use between treating addiction as a crime, and then criminalizing it—and criminalizing it, and then treating it as a disease.

So, this is not the first time we've gone through this pendulum swing. This is how America has gone from criminalizing to treating opioids, and then going back again.

So, opioids were first used during the U.S. Civil War to ease wounded soldiers' pain, and then in the decades after the war, they were actually widely prescribed to middle-and upper-class women. You wrote, "By the early 20th century, with estimates of habitual users of opioids as high was 250,000, concern about the overprescribing of opioids led to a tightening of restrictions." That was in the early 1900's, is that correct?

Dr. OLSEN. Correct.

Ms. OCASIO-CORTEZ. And then eventually Congress passed the Narcotics Control Act in 1956, which, "Included the first mandatory minimum sentences for a first conviction of possession, as well as the death penalty for drug trafficking."

And then after that crackdown—after that crackdown, we found that heroin use surged. It didn't reduce. It surged during the Vietnam War, leading Nixon to send a message to Congress about the tide of drug abuse that swept America in the last decade, is that correct?

Dr. OLSEN. That's correct.

Ms. OCASIO-CORTEZ. And as you kind of indicated earlier, Nixon's first instinct was actually to treat opioids as a disease. This was before the war on drugs really manifested. And, in fact, he established a network of clinics that offered treatment with methadone.

So, my question is, how do we move from Nixon's first approach of treating this as a disease to the war on drugs that was unleased just a few years later, in the 1980's, and waging this war on drugs in communities of color?

Dr. OLSEN. Yes. So, thank you for that question. You know, I think the—we have a lot to learn from history, obviously, as you've—kind of as we indicate in our book. And, you know, part of what happened in the early 1970's is that treatment became available, effective treatment became available, and then kind of that swing back to, "No. This is moral issue. No. These are—the people who have substance abuse disorders are criminals." I don't think we've ever really, as a society, wrapped our heads around what really is this, looking at the science, and understanding the science.

And the difference I think between the early 1900's and even 1970 and 1980 is that we now understand so much more about the brain, and about the disease, and what influences the development of an addiction, what effective treatments are, and why.

Ms. OCASIO-CORTEZ. Mm-hmm.

Dr. OLSEN. And that, unfortunately, it really took, you know, decades of the war on drugs, decades of really—you know, the cocaine epidemic and the crack epidemic hit communities of color unbelievably hard, but rather than seeing it as, no, these are individuals who have a chronic health condition, that we criminalized those individuals.

Ms. OCASIO-CORTEZ. So here we've seen, kind of you think of this pendulum shift. And it starts with the U.S. Civil War, we made opioids widely available. Then they started impacting upper middle class, you know, upper middle-class people. And so, then we decided to criminalize it in 1956. We cracked down immensely, and then we find that that resulted in another surge of abuse during the Vietnam War.

So, then we go back to Nixon's initial approach, which is treating it as—using it as a treatment again.

Dr. OLSEN. Mm-hmm.

Ms. OCASIO-CORTEZ. And then we hit the war on drugs, where we criminalize communities of color for their use. We go back to the criminalization. Then we go back to the 1990's, where we treat pain management as a widespread disease, correct?

Dr. OLSEN. Mm-hmm.

Ms. OCASIO-CORTEZ. So, then we decide that, doctors decide that pain management needs to be aggressively—needs to be aggressively treated, and now we're back to an opioid crisis again.

So, we have it—we're at an inflection point, where we could potentially criminalize this again, or we could potentially treat the opioid crisis as a health issue——

Dr. OLSEN. Yes.

Ms. OCASIO-CORTEZ [continuing]. correct? So, my question, my last question would be, how do we stop this pendulum shift, and how do we just end——

Dr. OLSEN. Right.

Ms. OCASIO-CORTEZ [continuing]. our addiction as a national crisis?

Dr. OLSEN. Yes. So great question. And, you know, partly I think we look to the science. We really look to the past to learn from what happened, and learn from our mistakes. And as I said in my testimony, I think that we really have to embrace the saying and the concept that everybody, no matter where they come from, no matter what class, race, ethnicity, address they have, that everybody deserves the chance for treatment and recovery.

Because addiction, as others have said, addiction knows no boundaries. But really trying to understand where any one individual is coming from, treating people with dignity and respect, no matter who they are, that's really important. And I've had—you know, I've heard police commissioners say, "We are not going to be able to arrest our way out of this." We really need to have treatment. We need treatment on demand. We need to be able to provide services when and where people are ready.

Chairman CUMMINGS. Ms. Norton.

Ms. NORTON. Thank you very much, Mr. Chairman. This is a very important hearing for all of us. I am concerned, very concerned that we are experiencing the single highest rates of overdose deaths in the history of our country, and we still don't have—we still haven't gotten ahold of it.

Indeed, this committee is concerned that if you were to ask us what is the national drug control strategy, I think we would be—we would not have an answer. And in the absence of a strategy from the Administration, they did issue a document in January, which nobody would call a strategy, I think this committee has to come to grips with what the strategy should be, and enact one.

Dr. Olsen, I'm concerned with how patients continue, particularly in the absence of a strategy, because in your testimony you mentioned a patient, Andy, and he was the only one of his 11 friends to survive addiction, and that that person, Andy, is on Medicaid. So, I need to know whether Medicaid is a program of last resort, or whether essentially these patients are essentially on Medicaid. And is private insurance just out of the picture for most of them? And is Medicaid the program of first and last resort for many, or if not, most of them? We need to know that in order what to do about Medicaid funding, which the President's budget, nobody pays much attention to a president's budget, no matter who he is, will cut Medicaid funding by 1.5 trillion over 10 years.

What is your response to how important or not Medicaid is as compared to private insurance?

Dr. OLSEN. So, Medicaid and Medicaid expansion in the state of Maryland has absolutely saved hundreds of my patients' lives. It is extremely important. Seventy-five percent of the patients that I see are enrolled in Medicaid.

Ms. NORTON. So, most of your patients?

Dr. OLSEN. Yup. We do——

Ms. NORTON. Are most of those essentially middle-class people?

Dr. OLSEN. Some are. Yes. And they are, what happens when people get into treatment and recovery is, they then can get hired for jobs. They are stable enough that they actually then go back to work. And when they go back to work, sometimes they go back to

work in places where their employer is able to provide them with health insurance. In other places, they now make too much money, just too much money to qualify for Medicaid, and so now being able to actually get insurance through the health insurance market through the ACA has been helpful for them. And so, we see fluxes between people who are enrolled in Medicaid, and then no longer enroll in Medicaid. But if they then lose their job, if they get laid off because the job market shrinks, then they really need to have that support and that safety net of Medicaid to be able to continue their——

Ms. NORTON. Yes.

Dr. OLSEN [continuing]. lifesaving treatment.

Ms. NORTON. The ACA, of course, and Medicaid. Let me ask about the steps Congress is taking, to see what we should do. The 21st Cures Act, we call it CARA, and a package of opioid bills that we passed last year, Dr. Olsen, in your written statement you noted that while the steps Congress has taken have saved lives, that more needs to be done. And you said more funding and smarter funding. Would you clarify that, please?

Dr. OLSEN. Absolutely. So, thank you for that question. So by smarter funding, we really mean that funding, as we've kind of talked about today, that funding really needs to be targeted toward those interventions that we know work, that we have evidence for as being effective, and supporting the education and the standardization of treatment, and providing those standards of care across a treatment setting, so that when people walk into a treatment facility, that they know what to expect, no matter whether they're in Maryland, in Virginia, in California, in Ohio, in West Virginia, and that what they are getting is evidence-based.

Ms. NORTON. Thank you. Mr. Chairman?

Chairman CUMMINGS. Thank you very much. Ms. Pressley?

Ms. PRESSLEY. Thank you, Mr. Chairman, and thank you for holding this important hearing. My father, like millions of Americans, as someone who battled heroin addiction, opioid addiction, and was in and out of the criminal justice system, committing crimes to support that addiction. Ultimately, during his time, while incarcerated, he was able to get on a path to healing. And I do believe that was also because that was at a time when there was access to behavioral health supports and mental health. My father was someone, like many who were self-medicating because of a series of life traumas.

And I would love to at some point talk about what is the course of treatment, or what are we doing for those behind the wall. I was at Alameda County, Santa Rita Jail, in Oakland, California, this weekend, a women's jail, and the majority of those that were there were there for poverty crimes, and/or crimes to support their addiction.

And so, I do want at some point know what we're doing behind the wall, because that's about the health and wholeness of those being able to bring their full contribution to the world, which now my father is doing as a professor of journalism and a published author.

But we know many of them will recidivate. And so, I would love to have that conversation at some point. And I'm grateful that we

are at a point in the pendulum switch shift here that we are looking at this as a public health crisis and epidemic, which we did not do with crack cocaine.

I'm reminded in my time on the Boston City Council, where I was a part of a hearing around safe injectionsites, which I support. And there was a woman who said, "I'm sick, and my life matters, and I don't want to die in a McDonald's bathroom." And, you know, that is what this is really about, the pain and seeing the dignity and humanity of people, but also recognizing that it's not just about that one person, but the impact on entire families this is destabilizing, and decimating whole communities.

I was recently appointed as the vice chair on the Taskforce of Aging and Families, and I just was at that taskforce before coming here, lifting up the growing challenge of grandparents raising grandchildren, because of this public health problem and epidemic.

So, we have to move holistically. We have to move with urgency, and I do believe we need not only on-demand treatment, but it need to be culturally competent, it needs to be gender specific and responsive, and it needs to be trauma informed. But, again, we're here to talk about not only the problem, but, again, the fixes.

And so, I wanted to talk about the importance of harm reduction services, which I do think many of those models do lift up some of the practices that I just asserted and offered up.

Ms. Gray, your testimony, you used a really fascinating analogy on our current addiction intervention approaches, which you likened to a spinning carousel. You say we intervene at the point of entry of this carousel, but supporting prevention efforts to avoid—by supporting prevention efforts to avoid drug use, and then at the end, to provide supports and linkages to recovery options. However, very little is done to aid people throughout addiction, or in keeping with your analogy, the point at which the carousel is spinning out of control.

So, Ms. Gray, how has this current approach exasperated HIV and hepatitis outbreaks in communities across the country, specifically harm reduction strategies like syringe services, and in West Virginia, where you practice? How has this exasperated HIV and hepatitis outbreaks?

Ms. GRAY. If you look at the vulnerability study that the CDC did that showed the top 5 percent of counties in this entire nation that are at risk for an HIV and hepatitis C outbreak, out of those 220 counties, there are almost—about 40 are in West Virginia. And both of my counties are identified. Berkeley County is 204, or 205, and Morgan County, the smaller rural county, is 44. It's in the top 50 percent.

Ms. PRESSLEY. Okay. I'm sorry. Just to reclaim my time. So, opponents of syringe service programs have argued that these approaches fuel drug use rather than reduce the risk of disease.

Ms. GRAY. Yes.

Ms. PRESSLEY. So, for the record, do you agree with that assessment?

Ms. GRAY. Sorry. No, they do not.

Ms. PRESSLEY. Okay. Thank you. All right.

Ms. GRAY. They engage people.

Ms. PRESSLEY. Absolutely. Thank you. In my district there are four syringe service programs. Ms. Gray, can you explain how Berkeley County syringe service programs and others like those, surveying vulnerable communities in the Massachusetts 7th, help to reduce the transmission of HIV and other infectious diseases?

Ms. GRAY. Yes. We have over 30 years of evidence, based upon the HIV AIDS epidemic that harm reduction programs do work to reduce HIV, hepatitis C, and hepatitis B.

Ms. PRESSLEY. Okay. Short on time. Just reclaiming my time.

Dr. Bailey, does the American Medical Association have a position on the use of supervised injectionsites as a way to prevent opioid deaths and disease transmission?

Dr. BAILEY. Yes, Congresswoman, we do. And I don't have the details of that policy with me right now, but I'd be happy to provide it for the committee as soon as possible.

Ms. PRESSLEY. Okay. Does anyone else on the panel have any thoughts on what research has shown relative to save or supervise injectionsites as another form of hard reduction?

Ms. ROSS. They work.

[Laughter.]

Ms. PRESSLEY. Great. And how do these outcomes compare to cities and communities that do not maintain these types of syringe service programs or supervise injectionsites?

Ms. GRAY. That's what I have been talking about is we have 52 new cases of HIV in Huntington now. We are not getting supported for syringe exchange in our state. People just don't, they don't understand it. They thing we're enabling, but that's not what it is.

And if you look at the New England Journal of Medicines' article in this past May, it will compare those 220 counties that I was talking about, where there are syringe exchange programs, and we're not heeding the warnings. There's not enough harm reduction programs that match those counties that are in dire risk.

Dr. OLSEN. Syringe exchange programs have really been found to reduce the risk of HIV and hepatitis C transmission. Baltimore City has had one for a very long time, and it is now extremely rare for HIV or hepatitis C to actually be transmitted in people who use drugs.

Chairman CUMMINGS. Ms. Gray, let me just ask you this. What would happen in West Virginia if the Medicaid expansion were rolled back?

Ms. GRAY. We'd be back to the days where we couldn't link anyone for any of their care and recovery. We might as well just—I'm not a person who gives up very easily, but without the Medicaid expansion, we're done.

Chairman CUMMINGS. All right. Mr. Jordan.

Mr. JORDAN. Thank you, Mr. Chairman. I just wanted to thank our panel for coming and testifying today, but more importantly, thank you for the work you do. I especially appreciated what Ms. Gray said in her opening statement, when she referenced the fact that Jesus didn't come to save the perfect people, he came to help all of us who have problems.

And what you are doing is truly a ministry, and we appreciate that, and we appreciate the chairman's commitment to helping get a solution, and help people who are trapped in this. We've got a

little difference sometimes, I think, in how that should play out, but the goal is a good goal, and you are doing the Lord's work, and we appreciate that. And thank you for being here today.

Chairman CUMMINGS. Thank you. Thank you. And I, too, want to thank all of you for being here today. I ask unanimous consent to enter into the record written statements from Smart Recovery and Faces and Voices of Recovery. So, ordered without objection.

Chairman CUMMINGS. I want to thank all of you for being here. This is a, as you all have described it, a very significant problem that's been going on a long time. And what we tried to do with the CARE Act is try to figure out every possible way that we could effectively and efficiently deal with it, and trying to really dig down to the core, so that we're not doing the same things over and over again, and getting the results that are not satisfactory.

So, we are going to work together. I'm going to push very hard on this. This proposal has been endorsed by so many, and your groups, we want to thank you all for standing up for it. And again, we want to thank you for working with us. And we're going to continue the battle.

So, again, thank you. All members will have five legislative days within which to submit additional written questions for the witnesses—to the chair, which will be forwarded to the witnesses for their response. I ask our witnesses to please respond as promptly as you can.

Thank you very much. Meeting adjourned.

[Whereupon, at 12:57 p.m., the committee was adjourned.]

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