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United States House Committee on Oversight and Government Reform
"A Sustainable Solution to the Evolving Opioid Crisis:
Revitalizing the Office of National Drug Control Policy"
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Testimony of

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Chairman Gowdy, Ranking Member Cummings, and distinguished Committee members, thank you for the opportunity to appear before the House Committee on Oversight and Government Reform today to discuss an issue of significant importance to the lives of the American people, the opioid epidemic. State and territorial health agencies are on the front lines responding to the current crisis of substance misuse, addiction, and drug overdose. As a public health official and as a practicing physician for nearly 25 years, I have witnessed the consequences of this crisis in the form of overdose deaths, substance-related interaction with the criminal justice and welfare systems, HIV and hepatitis, prenatal substance exposure effects, and the burden on the healthcare system.

The nation is in fact suffering from the twin challenges of the overprescribing of prescription opioids for pain and a growing use of heroin, often adulterated with fentanyl. Every day, more than 115 people in the United States die from opioid overdose. That's one American almost every 12 minutes, mostly comprising of the working age population. In fact, the misuse of and addiction to opioids such as prescription medications, heroin, and synthetic opioids like fentanyl, not only constitutes a public health emergency but is also unweaving the very fabric of our society. Unlike any epidemic before it, this crisis is impacting the entire life cycle of our society.

In West Virginia, we continue to experience the highest rate of overdose fatalities in the nation at 52 per 100,000 in 2016, 33 percent higher than the rate of the second highest state, Ohio. Moreover, preliminary data from 2017 indicate an additional 20 percent rise in overdose deaths. West Virginia is also enduring a surge in the rate of Neonatal Abstinence Syndrome (NAS) among infants, a condition in which babies are born drug-dependent and begin to suffer the terrible consequences of withdrawal. Currently, one in 20 babies are diagnosed with NAS and one in six expecting mothers are found to have intrauterine exposure to drugs. Children are being placed into foster care at a higher rate than ever before, causing a tremendous demand on social and early childhood services.

In fact, we estimate that there is an additional cost of at least $1 million for each baby born with a NAS diagnosis. Our state is not alone; the number of babies born in the United States with a drug withdrawal symptom has quadrupled over the past 15 years.

The price of this epidemic is staggering. In November 2017, the White House Council of Economic Advisers estimated that in 2015, the economic cost of the opioid crisis was $504 billion, or 2.8 percent of gross domestic product (GDP) that year. This is over six times larger than the most recently estimated economic cost of the epidemic. This means that the cost of the opioid crisis to West Virginia's economy may have been as much as $8.8 billion or 12 percent of the state's GDP in 2015. Princeton University economist Alan Krueger recently estimated that the increase in opioid prescriptions could have caused 20 percent of the observed declines in labor force participation (LFP) among men and 25 percent among women in the United States. Over the last 15 years, LFP fell more in counties with higher opioid prescription rates.

Collectively, states and territories recognize the opioid crisis as a public health emergency. As with any emergency, we must respond with the resources necessary to sustain a full continuum of care and ensure that proven prevention, treatment, and recovery services are used consistently. To do that, we need to work with other government agencies, healthcare providers, law enforcement, as well as local, state, and national organizations to counteract stigma and view addiction as a chronic health condition that affects the brain. Just like asthma or diabetes, if we apply appropriate, evidence-based strategies, addiction is both preventable and treatable. My public health colleagues and I firmly believe that preventing the misuse and addiction of opioids and other substances in the first place is the best way to end our nation's epidemic. We need to look "upstream" and intervene in areas that will support our efforts.

In November 2017, the West Virginia Bureau for Public Health sought public input and engaged a panel of national and regional experts to develop a strategic plan to address the opioid epidemic. This process involved more than 500 public comments, a public meeting, and engagement of a broad array of stakeholders. Throughout this initiative, there was significant support for reducing the harms of overprescribing, improving access to evidence-based treatment, and increasing use of naloxone and other harm reduction strategies. This strategic plan, delivered to the Governor and the State Legislature on January 30, 2018, included twelve high priority, short-term recommendations. (Appendix A)

Soon after the release of the plan, Governor Jim Justice sponsored legislation to advance several of the recommendations. The Governor's proposal aimed to limit initial opioid prescriptions in emergency rooms and outpatient settings for all prescribers including physicians, dentists, optometrists, and veterinarians. It also backed the expansion of medication-assisted treatment by removing unnecessary state-level regulatory barriers and creating an exemption from state-level registration for practitioners treating no more than 30 patients. In advance of the recent advisory issued by Surgeon General Jerome Adams Advisory on Naloxone and Opioid Overdose, the proposal included a mandate for first responders to carry the opioid antagonist rescue kits and authorize the State Health

Officer to prescribe opioid antagonist on a statewide basis by one or more standing orders. With broad bipartisan support, on March 27, 2018, Governor Justice signed the Opioid Reduction Act with all of these provisions into law.

The new legislation represents a major step in the right direction for West Virginia. Yet, our public comment process also revealed that substantial stigma on opioid use disorder and its treatment remains. For every comment that stated something like, "When someone decides to go [into treatment] we need them in right now not two weeks from now," there was one that stated something like, "Anyone requiring an antidote should be sent to a psychiatric hospital for a minimum of 30 days. The hospital is not a resort; let them see what it is like to be locked up." Clearly, more than treatment is needed to address this crisis.

To develop sustainable solutions to this contemporary challenge, we must have authentic national leadership that can envision and coordinate a robust and wide-ranging cross-cutting support from multiple federal agencies, national organizations, and state and local governments to develop an evidence-based comprehensive response strategy. The White House Office of National Drug Control Policy (ONDCP) provides this leadership. As the Committee explores the reauthorization of ONDCP, its position should be strengthened, resourced, and allowed the expertise to develop robust leadership potential. ONDCP has done more in recent years to narrow the divide between public health and public safety than any other agency. Two programs supported by ONDCP include the Drug Free communities and the High Intensity Drug Trafficking Areas (HIDTA). Drug-Free Communities in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA) provides grants to community coalitions to reduce local youth substance use. The HIDTA program provides assistance to state, local, and tribal law enforcements agencies operating in areas determined to be critical drug-trafficking regions of the United States.

The opioid crisis is evolving—illicit fentanyl and other synthetic opioids are the major driver of overdose deaths in many parts of the country now. While the opioid crisis is not just a criminal justice issue, we must support and strengthen the role of law enforcement to address the supply of illicit fentanyl, as well as other emerging illicit drugs. Overdose deaths are increasingly being associated with methamphetamine, indicating that a comprehensive approach to all illicit substances, that includes law enforcement and health agencies, is needed. ONDCP can provide the leadership for that coordination, and through funding of the HIDTAs, can facilitate coordinated responses at the state and local levels.

This collaboration among ONDCP, local jurisdictions and state level responses are saving lives. As an example, in West Virginia we received notification at our medical examiner's office of several overdose deaths in a southern part of the state. We immediately issued an advisory to hospital emergency rooms and other healthcare partners to monitor for a fentanyl laced heroin batch. However, it was HIDTA that through its law enforcement relationships contacted confidential informants, arrests were made, and the deaths stopped. We also have a public health expert embedded in Appalachian HIDTA. Thus,

states like ours cannot afford to lose this resource and critical law enforcement partnerships.

ONDCP was created to provide broad-based policy direction on drug policy, and to serve as the single agency Congress could identify as responsible for understanding the many facets of drug policy, from the public health aspect to international and supply reduction efforts. What the House Oversight and Government Reform Committee should consider is whether ONDCP has been equipped adequately to fulfill that mission. Is ONDCP empowered to provide overarching policy direction to the federal government and guidance to the states? Does ONDCP have the authority to hold federal government agencies accountable?

State and territorial public health departments must have sustained and predictable sources of federal funding to improve monitoring and surveillance; expand and strengthen evidence-based prevention and education strategies; manage access to opioids and improve access to and use of effective treatment recovery and support. Additionally, in order to fully address this epidemic, as well as substance abuse and misuse disorders as a whole, we must move further upstream to address the exposures during the life course that can lead to addiction such as toxic stress in infants and adverse childhood experiences. We must bolster efforts to work with schools and school-age children, build resilient communities, and increase investments in programs that work to address the social determinants of health. Prevention programs like ONDCP's Drug-free Communities help ensure that this work is done – but such programs including those at CDC and SAMHSA must also be expanded and strengthened. I'm also very excited to see that under the leadership of Commissioner Dr. Scott Gottlieb, the Food and Drug Administration (FDA) is already leading the way by fostering the development of novel pain treatment therapies and appropriate prescribing by providers. However, opioid addiction affects a wide array of individuals, from high school athletes to blue-collar rural workers, yet stereotypes about those afflicted with addiction still exist. Stigma can lead to a lag in seeking addiction assistance and support from friends and family. As people get help, they often need to rebuild their lives which includes four components: personal health, home and family, community re-integration and relationships, and finally, finding and following a purpose in life.

Congress and states must work towards further expanding access to evidence–based treatment. We know there are a number of barriers in accessing treatment including stigma, homelessness, and poverty. However, we know also that we cannot exclusively treat our way out of this problem, just like we cannot exclusively jail our way out of this crisis. Individuals often need ancillary services such as housing, recovery support, employment assistance/training, childcare support, and others. Therefore, we should consider establishing a program to provide treatment and services to individuals with substance use disorders, modeled on the Ryan White program, which provides treatment for AIDS patients. With that in mind, I urge you to ensure that any changes in statute are building upon the existing system and programs that currently exist without creating undue burden to state and local communities.

Public health must ally with law enforcement agencies to improve health outcomes. This includes developing partnerships with quick response teams that help connect non-fatal overdosed individuals to treatment and prioritizing treatment of inmates. Similar to Rhode Island, which showed more than 60 percent reduction in opioid overdose deaths among those who were recently incarcerated after medication-assisted treatments were offered, West Virginia is aiming at helping prison and jail inmates who are struggling with addiction. One pilot program, being expanded statewide this summer, gives assisted treatment to inmates with an opioid medication upon their release and then helps connect them to longer term care in the community.

As the Committee considers evidence-based approaches to the opioid crisis specifically, I strongly urge you to refrain from a narrow focus on "opioids." While the opioid epidemic is a crisis of the moment, in many states other drugs such as methamphetamine, cocaine, and benzodiazepines, often in combination with opioids, are the emerging predominate causes of substance abuse and misuse among some populations. This is in addition to the long-standing challenge of alcohol misuse and addiction.

The opioid crisis and substance misuse will not be solved by an individual agency or a single state. Instead, we need a comprehensive science-driven approach that combines the efforts of local, state and federal agencies, organizations, and industry. I implore the Committee to take swift action to expeditiously coordinate the implementation of these solutions. I applaud your commitment and I look forward to working with you and your committee to help address this public health emergency.

Appendix A
Opioid Response Plan for the State of West Virginia
High Priority Short-Term Recommendations

Prevention	1. West Virginia should expand the authority of medical professional boards and public health officials to address inappropriate prescribing of pain medications. 2. West Virginia should limit the duration of initial opioid prescriptions.
Early Intervention	3.West Virginia should expand awareness of substance use disorder as a treatable disease by developing a public education campaign to address misinformation and associated stigma. This campaign should also support access to treatment through 1-844-HELP4WV. 4. West Virginia should expand promising law-enforcement diversion programs, such as the Law Enforcement Assisted Diversion (LEAD) model, to help people experiencing a substance use disorder access treatment and achieve sustained recovery. 5. West Virginia should strengthen support for lifesaving comprehensive harm reduction policies, by removing legal barriers to programs that are based on scientific evidence and by adding resources.
Treatment	6. Reflecting the need for all patients to have access to multiple options for treatment, West Virginia should require a statewide quality strategy for opioid use disorder treatment and remove unnecessary regulatory barriers to the expansion of effective treatment. 7. West Virginia should expand access to effective substance use disorder treatment in hospital emergency

	departments, other healthcare settings, and the criminal justice system to reach people at key moments of opportunity to enter care.
Overdose Reversal	8. West Virginia should require all first responders to carry naloxone and be trained in its use, support community-based naloxone programs for initial responders, and authorize a standing order for naloxone prescriptions to improve insurance coverage. 9. West Virginia should require hospital emergency departments and Emergency Medical Services to notify the Bureau for Public Health of nonfatal overdoses for the purpose of arranging for outreach and services.
Supporting Families with Substance Use Disorder	10. West Virginia should expand effective programs that serve families, including Drug Free Moms and Babies, home visitation programs, and comprehensive services for the families of children born with Neonatal Abstinence Syndrome, such as Lily's Place. 11. West Virginia should expand access to voluntary, long-acting, reversible contraception and other contraceptive services for men and women with substance use disorder in multiple settings.
Recovery	12. West Virginia should continue pursuing a broad expansion of recovery supports, including peer-based support services, families, and allies.

Source: Opioid Response Plan for the State of West Virginia
https://dhhr.wv.gov/bph/Documents/ODCP%20Response%20Plan%20Recs/Opioid%20Response%20Plan%20for%20the%20State%20of%20West%20Virginia%20January%202018.pdf