Opening Statement of the Honorable Tim Murphy
Subcommittee on Oversight and Investigations
Hearing on "Combatting the Opioid Abuse Epidemic: Professional and Academic Perspectives"
April 23, 3015

(As Prepared for Delivery)

Less than one month ago, on March 26, we held the first in a series of hearings to "Examine the Growing Problems of Prescription Drug and Heroin Abuse." During that brief span of time, according to the best estimates from the Department of Health and Human Services, at least 3,374 Americans will have died from drug overdoses, with opioids being the most common cause. That's 3,374 overdose deaths in less than one month. Indeed, during the time we spend in this hearing, another 10 lives will be lost.

The headlines out of Pittsburgh last week sent shock waves throughout my district: 10 heroin overdoses in a single 24-hour period. On the 2 who died were found stamped bags marked either "Chocolate" or "Chicken/Waffle." This is what we are up against. This is what is killing our sons and daughters; brothers and sisters, fathers and mothers.

Let me state clearly so as to leave no room for doubt: Our current strategies are failing and I am not going to stop until we start moving in the direction of success defined not just as getting individuals off of street drugs and onto a government-approved opioid, but getting them to the point of drug free living.

About three weeks ago, on the very same day this Committee held our first hearing on this issue, the Department of Health and Human Services released its long-awaited three-part plan to reverse this epidemic. Elements of the plan make sense; however, I am puzzled and amazed to read one particular priority included in their press release (and I quote):

- Exploring bipartisan policy changes to increase use of buprenorphine and develop the training to assist prescribing.

We are in desperate need of innovations to reverse the current trend, and not merely maintain it. Why would we focus only a single opioid replacement program rather than the full range of FDA-approved treatments for opioid addiction? Why the fixation on one pharmaceutical product?

According to testimony presented to this Committee last year by the Director of SAMHSA's Center for Substance Abuse Treatment, nearly one million people were prescribed buprenorphine in 2011. We know that number is much higher today, probably closer to 1.5 million people or more.

Think about that. Success by federal government standards for addiction disorders is 1.5 million people prescribed synthetic opioids. Yet, consider the sad fact that states have not seen their investment in prescription clinics reverse the opioid epidemic. States like Maryland, Vermont, Massachusetts and others that have made massive investments in buprenorphine maintenance have not seen reductions in overdose deaths. On the contrary, things have only gotten much much worse:

- According to the DEA, buprenorphine is the third most confiscated drug in law enforcement activities in our country today. More than morphine, more than methadone, more than codeine.
- "Patients" are routinely getting buprenorphine prescribed as "heroin helper" – meaning they get a month's supply of buprenorphine to use whenever they can't get heroin. It tides them over, enabling them to remain in their active addiction. This should more accurately be called "addiction maintenance" not just the euphemistic, "opioid maintenance."
- Some addicted to methamphetamines go to local "bupe mills" and get a 30-day supply that they promptly sell to buy their drug of choice.

- In the field of addiction treatment, the “enabler” is part of the problem – helping intentionally or unintentionally to keep a family member as an alcoholic or drug addict. Here, the U.S. government is the biggest enabler of them all.
- Some clinics operate cash-only businesses for writing 30-day supplies of buprenorphine at the highest permissible doses (usually 32 milligrams) knowing full well patients will sell at least of half of the pills in order to pay for their “treatment” or other illicit drugs.

At our last hearing, Professor Sarah Melton at East Tennessee University noted that that there are methadone clinics operating on a cash basis handing out methadone without any other treatment, or buprenorphine “pill mills.” It is not acceptable that federal taxpayer money be used to support programs that hand out these drugs for cash. Worse, Professor Melton testified that there was a dearth of good treatment programs. And what happens after the patient leaves the treatment program? What is being done to follow-up with patients to prevent relapses and put them on a path of real recovery?

I fully recognize the importance of medication assisted treatment as a transition from street drugs and to prevent overdose from heroin. But relying on this as the one and only solution shouldn’t be the strategy. As I recently heard Dr. McLellan, the former Deputy Director of ONDCP say, while there is an appropriate place for “medication assisted treatment” we should not turn a blind eye to the fact that there is also a tremendous amount of “medication assisted addiction.” It is not acceptable for federal taxpayer money to be used to support treatment programs that lack evidence of effectiveness, or that define “success” merely as an individual with an addiction disorder using heroin fewer times per week than before treatment.

I am calling for a patient-centered initiative with a goal of matching patients with the most appropriate care coupled with a focus on transition not just off of street drugs but eventual transition from opioids altogether. I hope to modernize our existing opioid addiction treatment system to ensure that the right patient gets the right treatment at the right time. It simply isn’t true to present buprenorphine and methadone as opioid-free treatment. We do a tremendous disservice to those living with addiction disorders when we advance disingenuous double-talk and not state outright that buprenorphine and methadone are highly potent opioids.

We are not going to end this opioid epidemic by increasing the use of opioids. We need an exit strategy that enables Americans to become opioid-free altogether. We can do better than addiction maintenance. We can and we must. I look forward to working with my colleagues and HHS as we explore new innovations for detoxification and treatment models to transition individuals off of all opioids into evidence-based counseling with non-addictive, non-narcotic behavioral and medication treatments.

We don't do enough to help those addiction disorders. I believe in recovery. I believe in lives being restored so that every individual may live to their full God-given potential and do so drug free. I consider opioid maintenance as a bridge to cross over in addiction recovery, not a final destination. At this point, we’ve simply stopped building the bridge. We’ve not yet fully helped move those with addiction disorders beyond opioid maintenance. I seek to lay out a vision for recovery that includes complete withdrawal from opioids as an option. Once we lay out those goals, we can then move forward with research and clinical efforts, and boldly declare that we are no longer satisfied with the status quo of opioid maintenance only.

To assist us today, the Subcommittee will hear from some of the nation’s foremost professional and academic experts in the field of opioid addiction. Among the questions we hope these experts will address are: What can be done to incentivize individual compliance with prescribed treatment plans and reduce the risk of relapse? What should be the aim of treatment for opioid addiction: reduce the intake of illicit drugs by these individuals to more moderate levels? Or should the aim be to place patients on a path to detoxification and ultimately a full recovery, ending all illicit uses and removing the need for life-long opioid maintenance recovery? To what extent is the increased prescribing of methadone for pain contributing to more overdose deaths? Are Medicaid and Medicare payments for the treatment of pain incentivizing doctors to prescribe opioids like candy for the treatment of pain?

Today we have assembled some of the leading opioid addiction experts to get your thoughts about how to reverse this epidemic. We thank you for your expertise and look forward to hearing your testimony.

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