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HIF104140

AN EPIDEMIC WITHIN A PANDEMIC:

UNDERSTANDING SUBSTANCE USE AND MISUSE IN AMERICA

WEDNESDAY, APRIL 14, 2021

House of Representatives,

Subcommittee on Health,

Committee on Energy and Commerce,

Washington, D.C.

The subcommittee met, pursuant to call, at 10:29 a.m. via Webex, Hon. Anna Eshoo [chairwoman of the subcommittee], presiding.

Present: Representatives Eshoo, Butterfield, Matsui, Castor, Sarbanes, Welch, Schrader, Cardenas, Ruiz, Dingell, Kuster, Kelly, Barragan, Blunt Rochester, Craig, Schrier, Trahan, Fletcher, Pallone (ex officio); Guthrie, Upton, Burgess, Griffith, Bilirakis, Long, Bucshon, Mullin, Hudson, Carter, Dunn, Curtis, Joyce, and Rodgers (ex officio).

Also Present: Representatives Tonko, O'Halleran; and Latta.

Staff Present: Joe Banez, Professional Staff Member; Jeff Carroll, Staff Director; Waverly Gordon, General Counsel; Tiffany Guarascio, Deputy Staff Director; Perry Hamilton, Deputy Chief Clerk; Mackenzie Kuhl, Digital Assistant; Aisling McDonough, Policy Coordinator; Meghan Mullon, Policy Analyst; Kaitlyn Peel, Digital Director; Tim Robinson, Chief Counsel; Chloe Rodriguez, Deputy Chief Clerk; Kimberlee Trzeciak, Chief Health Advisor; Caroline Wood, Staff Assistant; C.J. Young, Deputy Communications Director; Sarah Burke, Minority Deputy Staff Director; Theresa Gambo, Minority Financial and Office Administrator; Grace Graham, Minority Chief Counsel, Health; Caleb Graff, Minority Deputy Chief Counsel, Health; Nate Hodson, Minority Staff Director; Olivia Hnat, Minority Communications Director; Peter Kielty, Minority General Counsel; Emily King, Minority Member Services Director; Clare Paoletta, Minority Policy Analyst, Health; Kristin Seum, Minority Counsel, Health; Kristen Shatynski, Minority Professional Staff Member, Health; Michael Taggart, Minority Policy Director; and Everett Winnick, Minority Director of Information Technology.

*Ms. Eshoo. The Subcommittee on Health will now come to order. And due to the COVID-19, today's hearing is being held remotely. All members and witnesses will be participating via video conferencing.

As part of our hearing, microphones will be set on mute to eliminate background noise. Members and witnesses need to remember to unmute your microphone each time you wish to speak. Documents for the record should be sent to Meghan Mullon at the email address that we provided to your staff, and all documents will be entered into the record at the conclusion of the hearing.

The chair now recognizes herself for five minutes for an opening statement.

According to recently-reported data from the CDC, overdose deaths spiked after the start of the pandemic. From September 2019 through August 2020, there were over 88,000 overdose deaths, with 2020 being the deadliest year for overdoses on record. These are really stunning numbers. So we are in an addiction crisis during a COVID crisis.

In 2016 Congress passed the 21st Century Act and CARA, C-A-R-A, and the SUPPORT Act in 2018 to stem the tide of addiction and the devastation that the opioid crisis has created. Congress also provided over $8 billion -- with a B -- to address opioid use and mental and behavioral health care through the American Rescue Plan in the fiscal year 2021

Appropriations Act.

Yet despite our legislative efforts to increase access to evidence-based treatment, according to a National Academies of Science Report, more than 80 percent of the two million people with opioid use disorder are not receiving medication-assisted treatment.

Today we are going to hear from the acting director of the Office of National Drug Control Policy about where and why previous efforts have fallen short, and what the Biden-Harris Administration believes we need to do to save lives.

We will also consider 11 bills, many bipartisan, to address the opioid crisis. According to the CDC, three in five people who died from overdose had an identified opportunity for care or other lifesaving actions.

And we know that Representative Tonko and Trahan's bipartisan bills will ensure more doctors are trained and able to prescribe the medication-assisted treatment that we know saves lives.

Those who are released from prisons and jails are 12 times more likely to die of an overdose than the general public, because they often have no access to treatment upon release. The bipartisan Medicaid Reentry Act addresses these inequities by extending Medicaid eligibility to incarcerated individuals 30 days before release.

And lastly, we are considering bills to address the

upcoming expiration of the temporary placement of all fentanyl-related substances in schedule 1. Despite the temporary scheduling, deaths from fentanyl analogues rose by 10 percent. So clearly, scheduling is not the silver bullet, and Congress has to consider alternatives to stop synthetic opioids.

[The prepared statement of Ms. Eshoo follows:]

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

*Ms. Eshoo. I now yield the rest of my time -- I don't know how much is left -- to the sponsor of the Stop Fentanyl Act of 2021, Representative Annie Kuster.

*Ms. Kuster. Thank you so much, Chairwoman Eshoo. As we are all too well aware, the pandemic has exacerbated the already dire addiction and mental health crisis in our country. From August 2019 to August 2020, 88,000 Americans died of an overdose, the highest number ever recorded over a 12-month period.

But we also know the addiction and overdose crisis in this country did not occur overnight. It has devastated communities in my state of New Hampshire and across the U.S. for decades. What began as an opioid crisis has evolved to an epidemic that knows no bounds. It impacts every community, no matter the race. It is cross-regional and inter-generational.

The complexity of this epidemic is urgent. Overdose deaths due to synthetic opioids such as fentanyl and fentanyl analogues have continued to rise. And what we have learned in New Hampshire is there is no silver bullet. It is an all-hands-on-deck approach, and any serious solution must look at comprehensive reforms to both public health and our criminal justice system.

And that is why I am so pleased to see my bill, the Support, Treatment, and Overdose Prevention of Fentanyl Act,

included in today's hearing. I look forward to discussing it more, and thank you, Chairwoman Eshoo, for this time, and I -- including my bill to support public health and public safety efforts into responding to fentanyl. It will be a real game-changer.

[The prepared statement of Ms. Kuster follows:]

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

*Ms. Kuster. And I yield back.

*Ms. Eshoo. Well, thank you, Annie, you have been and continue to be an important leader on the whole issue of opioids, and we are all very grateful to you.

The chair is now pleased to recognize Mr. Guthrie, the ranking member of the Subcommittee on Health, for five minutes for his opening statement.

Good morning to you.

*Mr. Guthrie. Good morning. Good morning, Chair Eshoo, and thank you for holding this important hearing today.

It is devastating that we have lost more than 550,000 Americans due to COVID-19. Sadly, we have another epidemic that has claimed around the same number of lives over the past two decades: the opioid crisis. We are hearing from public health providers that the COVID-19 pandemic has exacerbated this crisis. The CDC recently reported that -- over 88,000 overdose deaths over the past year, ending in May of 2020, which is the highest number of overdose deaths in a 12-month time.

In 2019 addiction and substance use disorders affected over 20 million Americans, 10 million of which experienced opioid misuse. Last year we sadly saw that number increase even more. According to the CDC, we have had three waves of the opioid epidemic. First we saw the rise in prescription opioids. Then in 2010 we began to see the rise in heroin.

And currently we are in the third wave, which includes the rise of synthetic opioids, which often includes deadly forms of fentanyl.

My home state of Kentucky has seen some of the highest numbers of substance use disorder deaths. One Kentucky substance abuse provider group that my office spoke to shared that they have lost more patients to overdose during the pandemic than they had in the last five years. CDC compared the death by drug overdose rates over a 12-month period between August 2019 and August 2020. In August 2019, Kentucky and 1,307 overdose deaths; one year later, that number was 1,874. Unfortunately, Kentucky is not alone with these increases.

This committee has worked in a bipartisan way to authorize many programs to decrease overdose deaths. But more work needs to be done. Specifically, the Energy and Commerce Committee authorized the 21st Century Cures Act, the Comprehensive Addiction Recovery Act, and the SUPPORT Act for patients and communities -- Communities Act to combat the opioid epidemic. Included in the final SUPPORT Act was my bill, the Comprehensive Opioid Recovery Act Centers of 2018, which authorized the creation of comprehensive opioid recovery centers throughout the nation. This program is currently being implemented, and provides evidence-based comprehensive care for those with substance use disorders.

Overall, these laws continue to provide critical funding and authorizations to help address substance use disorder treatment, recovery, and prevention.

I think it is important for us to look back and fully examine these laws, and evaluate where we are and where we are headed. And while we have 11 new bills before us today, we must also examine current authorizations.

One of these current authorizations is the extension of the temporary emergency scheduling of federal analogues. Synthetic opioids, which includes fentanyl analogues, were involved in 744 deaths in Kentucky in 2018. Fentanyl analogues are very dangerous, due to their potency, and often come across our borders illegally only to harm Americans. Just last month a two-year-old in Kentucky died from exposure to fentanyl. One health care provider group who treats patients with substance use disorders told my office that almost all of their patients have some sort of fentanyl in their system. Many of the patients are not aware of it themselves. I recently heard from another local health care provider in Kentucky who said it is almost rare to have an overdose that does not have some traces of synthetic opioids, such as fentanyl.

This provider also shared that they have certain individuals using substances in their own parking lot, in case they overdose, or anything were to happen, because they

know the provider is equipped with Narcan.

We must protect Americans from these harmful drugs and -- that ruin lives and families. I look forward to continuing the bipartisan work to combat the substance abuse disorder crisis in America. I appreciate this hearing, and the witnesses before us, and the members present.

[The prepared statement of Mr. Guthrie follows:]

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

*Mr. Guthrie. And, Madam Chair, I will yield back.

*Ms. Eshoo. The gentleman yields back, and I thank him for his opening statement.

The chair is now pleased to recognize Mr. Pallone, the chairman of the full committee, for his five minutes for an opening statement.

*The Chairman. Thank you, Chairwoman, and thanks to the ranking member, as well.

This committee has a long history of working on a bipartisan basis to combat the threat of opioids and substance use and misuse. And together we are making significant progress.

But unfortunately, the COVID-19 pandemic and the resulting economic downturn over the last year has weighed heavily on the American people, and has only exacerbated substance use and misuse. And so today we are continuing our work to address the epidemic within the pandemic, essentially.

The statistics are alarming. In 2019, prior to the pandemic, more than 20 million Americans experienced a substance use disorder, and half of those involved opioids. Tragically, there were nearly 71,000 drug overdose deaths. And recent data shows that the pandemic has accelerated overdose deaths. From August 2019 to August 2020, 88,000 overdose deaths were reported, the highest ever recorded in a

12-month period.

The primary driver of these deaths was a dramatic increase in the availability of synthetic opioids derived from fentanyl. These low-cost substances can be 50 to 100 times more potent than morphine, and are frequently mixed into other drugs like cocaine and methamphetamine.

To combat the opioid epidemic the committee advanced major pieces of legislation that became law. These laws expanded critical substance use disorder services and supports for communities around the country. But our efforts have not ended there. And since the beginning of the pandemic we pushed for the inclusion of funding aimed at the dual public health threats of the virus and rising rates of overdose deaths, substance use and misuse, anxiety, and depression. And I look forward to hearing from our panelists about the implementation of these laws, how the pandemic is impacting people suffering from substance use, and what more can be done to help aid in response to these threats.

Now, on our first panel we will hear from the acting director of the White House Office of National Drug Control Policy, or ONDCP, who recently released the Biden Administration's first-year drug policy priorities. And I commend the Administration for taking an evidence-based public-health approach to the drug epidemic. I also applaud them for their plans to expand evidence-based treatment,

reduce youth substance use, enhance recovery services, and advance racial equity. Their work falls squarely within the jurisdiction of this committee. I look forward to hearing more from ONDCP about how we can work together.

And our second panel is composed of experienced providers, public health experts, advocates for justice, and federal law enforcement professionals. This group is on the front lines of the epidemic, and their insight on the impact of federal policy is invaluable. And I thank all the witnesses for their selfless dedication to this cause.

Now, throughout our discussion it is important to remember that substance use disorder is complex, but treatable. Regardless of a patient's personal history or health care coverage, they deserve compassion and help, just like any other patient with a diagnosable disease. And we have to approach this substance use epidemic as a public health crisis, and take the lead on de-stigmatizing effective treatments.

The 11 pieces of legislation we are considering today to tackle the epidemic in multiple ways, and many of them take a public health approach. And we have considered some of these policies before, and they remain a critical component of a comprehensive response to the crisis. So we have to continue our work in a bipartisan fashion to combat the epidemic. Millions of lives depend on it.

And I commend the sponsors of these bills for their leadership, and look forward to our continued work to address this devastating epidemic in the months ahead.

[The prepared statement of The Chairman follows:]

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

*The Chairman. Thank you again, Madam Chair. I think this is a very important hearing, and I yield back.

*Ms. Eshoo. Thank you, Mr. Chairman.

The chair now is pleased to recognize the ranking member of the full committee, Representative Cathy McMorris Rodgers, for her five minutes for an opening statement.

*Mrs. Rodgers. Good morning, everyone. Thank you, Chair Eshoo, and thank you to our witnesses.

America remains in the midst of two national emergencies, COVID-19 and the substance use disorder crisis. Experts, including law enforcement, the DEA, and local leaders in my community are raising the alarm.

We are losing more people to the depths of despair. The social isolation, economic shutdowns, stress, fear, loneliness has taken a severe toll. According to the CDC, 88,000 people died of overdose in the last 12 months leading up to August 2020. That is a 26.8 percent increase. And that comes after the CDC released May data that we had the highest number of overdose deaths in the history of our country. This is how one mental health expert in eastern Washington put it to me, "A situation such as 2020 that really stressed even the strongest will among us, it can really impact how they are feeling, and it can increase their need for a substance use as a way to protect themselves, as a way to find the comfort they are used to having.''

People need hope, hope to overcome fear, change their lives, provide for their families, and thrive, and that is what is on the line as we work to address this epidemic within the pandemic, head on.

While I have some concerns with some of the bills, I am pleased that we are coming together to improve prevention, increase access to treatment, and offer support to those in recovery. All of this will build on our historic bipartisan work on the comprehensive Addiction and Recovery Act, Cures, and the Support for Patients and Communities Act.

Energy and Commerce has a rich history of leading on the most significant efforts against addiction crisis, and today I am hopeful that we can move more of those solutions across the finish line. That includes stopping the scourge of fentanyl coming across our southern border from Mexico, and also China. Nearly all states are seeing a spike in synthetic opioid deaths, with 10 western states reporting more than a 98 percent increase.

In Washington State it is even worse. The fentanyl positivity rate increased by 236 percent. Washington State is the highest in the nation. Last fall we lost two teenagers in eastern Washington to potential fentanyl exposure. We have had close calls with police officers who barely came in contact with fentanyl, just a few milligrams. What can fit on Lincoln's ear on a penny is lethal. The

analogues are often times more potent. If it is reaching our streets in Washington State in deadly quantities from Mexico, I can assure you that the scourge is everywhere.

That is why DEA created a temporary scheduling order for fentanyl analogues, placing these dangerous substances in the schedule 1. Previously, drug traffickers could slightly change the chemical structure of fentanyl, so the novel formula was not considered prohibited. The DEA would then have to individually schedule each variant. Once one analogue was scheduled, a new one would emerge, creating this game of Whack-A-Mole for drug control efforts.

With wide class scheduling, any dangerous variant of fentanyl is controlled under schedule 1. This allows law enforcement to combat all fentanyl-related substances and protect the public. For example, one recently-encountered substance was approximately eight times more potent than fentanyl. A scheduling order is set to schedule in less than a month.

Given the House schedule, Speaker Pelosi must make this a priority for this week or next. I fear that, like last year, the majority may wait until the last minute. We should work with DEA and other agencies to make this scheduling permanent, like with Mr. Latta's FIGHT Fentanyl Act.

We should also look for reforms that encourage the scientific research. If the majority will not act on a

permanent solution, then we must temporarily extend it. Judiciary Republican Leader Jordan and I are leading a one-year extension to buy us time. The clock is ticking. If this is allowed to expire, Customs and Border Protection will lose their authority to seize these substances at ports of entry, and drug traffickers regain the incentive to push deadlier and deadlier drugs on our streets.

There is no excuse to let May 6th come and go without us doing our job to keep people safe, break the cycle of despair, and build a more prosperous future for America.

[The prepared statement of Mrs. Rodgers follows:]

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

*Mrs. Rodgers. With that I yield back.

*Ms. Eshoo. The gentlewoman yields back. The chair would like to remind members that, pursuant to committee rules, all members' written opening statements will be made part of the record.

I would now like to introduce our witnesses for our first panel. Regina LaBelle is the deputy director of the White House Office of National Drug Control Policy, and is currently the acting director of the agency, serving as the principal adviser to the Biden-Harris Administration on drug policy matters ranging from substance use, prevention, treatment, and recovery, to drug interdiction.

Acting Director LaBelle previously served as the chief of staff of the ONDCP during the Obama Administration, where she oversaw the federal government's initial efforts to address the opioid epidemic. And before returning to the agency, she served as a distinguished scholar and program director of the Addiction and Public Policy Initiative at Georgetown University's O'Neill Institute for National and Global Health Law, and was also a director of the graduate school's master of science program in addiction policy and practice.

So we have a seasoned professional representing the agency.

And Acting Director LaBelle, you are recognized for five

minutes. Please remember to unmute, and I recognize my -- I will recognize myself for questions after your testimony.

STATEMENT OF REGINA M. LABELLE, ACTING DIRECTOR, WHITE HOUSE OFFICE OF NATIONAL DRUG CONTROL POLICY

*Ms. LaBelle. Thank you, Chairwoman Eshoo, Ranking Member Guthrie, Chairman Pallone, Ranking Member McMorris Rodgers, members of the subcommittee. Thank you for inviting me to testify today. It is my pleasure to discuss the Biden-Harris Administration's drug policy priorities for our first year, and the activities of the Office of National Drug Control Policy. Thank you for holding this hearing so early in the 117th Congress. It reflects the urgency of addressing the overdose and addiction epidemic.

ONDCP coordinates federal drug policy by developing and overseeing the national drug control strategy and the national drug control budget. We develop, evaluate, coordinate, measure, and oversee the international and domestic drug-related efforts of executive branch agencies, and work to ensure those efforts complement state, local, and tribal drug policy activities.

In this role I advocate for people with substance use disorder and their families, for a balanced approach to drug policy that includes public health and public safety, and for greater inclusion and equity in our efforts to tackle the addiction and overdose epidemic. These responsibilities are evident in the work ONDCP has undertaken since President

Biden took office.

On April 1st, ONDCP delivered the Biden-Harris Administration's statement of drug policy priorities for the first year to Congress. These seven priorities have two overarching themes: first, immediately getting services to people most at risk for overdose; and second, building the addiction infrastructure necessary to meet the needs of the more than 20 million people in this country who have a substance use disorder.

Our policy priorities include a focus on preventing substance use initiation, including through our drug-free community support program, and expanding access to quality treatment and recovery support services. It also includes supporting harm reduction services. This is especially important during this time when illicitly manufactured fentanyl is present in so many drugs. Harm reduction services include distributing the lock zone and fentanyl test strips, and expanding syringe services programs. These programs build connections, reduce people's chance of overdose, and give them the opportunity to receive services and engage them in health care, including treatment.

As the epidemic continues, the shifting dynamics require us to adapt and meet people where they are. I have an example. I recently read about a 60-year-old woman in Miami who had untreated opioid use disorder. After many years she

received services finally through a mobile service provider. She engaged in treatment, now has an apartment, and is able to spend time with her children and grandchildren.

Also included in our policy priorities is racial equity in drug policy, both in criminal justice and health care. Our priorities include the entire continuum of care, and seek to reduce the stigma of addiction.

We also recognize the need to reduce the supply of illicit drugs in the United States. Illicitly-manufactured fentanyl, fentanyl analogues, cocaine, methamphetamine, and other drugs enter our country through our ports of entry or through the mail, including express couriers. Our efforts to disrupt drug trafficking networks include working with domestic law enforcement through ONDCP's High Intensity Drug Trafficking Areas Program, and we appreciate Congress's strong support for this program.

We are also working closely with countries such as Colombia, Mexico, and China to disrupt drug-trafficking networks and stem the flow of drugs coming into this country. On this issue Congress is facing a deadline of May 6 to extend the temporary fentanyl class scheduling bill. The Administration is asking Congress to extend this law while we work with the Departments of Justice and Health and Human Services to address legitimate concerns regarding mandatory minimums and research provisions involved in class

scheduling.

Beyond extending temporary class scheduling, Congress has an important role to play in addressing the overdose and addiction epidemic. Already, Congress has provided needed resources through the American Rescue Plan, and the President's budget request calls for a substantial investment of $10 billion. This funding will help build the type of infrastructure the nation needs to reduce overdose deaths in the short term, while laying the groundwork for a system of care that is long overdue. These funds will be guided by science and evidence, and we hope this budget request informs your work.

Addressing the addiction and epidemic is an urgent issue, and the Biden-Harris Administration's drug policy priorities are intended to bend the curve and save lives. And working with our members -- with Members of Congress, ONDCP will take quick action to implement them.

Thank you for your time, and I look forward to your questions.

[The prepared statement of Ms. LaBelle follows:]

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

*Ms. Eshoo. Thank you very much, Acting Director LaBelle, for being with us.

So how many days have you been on the job?

*Ms. LaBelle. So I was sworn in the afternoon of Inauguration Day, so it is 85 days, I guess.

*Ms. Eshoo. Well, congratulations to you.

*Ms. LaBelle. Thanks.

*Ms. Eshoo. You have a weighty portfolio. Now, based on the early data, 2020 is the deadliest year for overdoses, with 88,000 deaths counted so far, 88,000 in 2020.

Now, as members stated in their opening statements, our subcommittee and the full committee have done a lot of work. We have passed packages of bills. The first big effort, I think, was something like 53 bills. I think every single one of them was bipartisan. We have put money to this.

Something isn't working, something isn't working. We are not putting a dent in this. And I don't know -- I know that you were part of doing a report before you came to head up the agency. What instructions do you have for the subcommittee about what we need to change, what we need to do more of, what is not working, and also the bills, the 11 bills that we have before us? Can you comment on this?

It is very disturbing to me that we all think we have done very important work. And I still think that we have. But 88,000 deaths? I mean, that -- we just -- it seems to me

that we are not making -- to put it mildly, I don't think we are making progress.

*Ms. LaBelle. Right. So thank you, Chairwoman.

I think the issues are very complex, but I think that we can't see immediate results over a problem that has evolved for decades. You know, we have had overdose deaths increasing since the 1970s. They did go down in 2018, but fentanyl, illicit fentanyl that is getting into the drug stream, it is getting into coke, methamphetamine, heroin, that is really what is driving a lot of these overdose deaths.

So there are things -- I mean, there are bright spots. The money has not been wasted. We have seen an increase in the number of providers who are -- provide Buprenorphine, one of the three forms of medication treatment. We have made efforts. It is not enough yet. And that is why our policy priorities stress what it does: harm reduction, prevention, recovery supports, because this is a chronic disease, and we need the full continuum of care.

*Ms. Eshoo. On the soon-to-expire temporary scheduling of the fentanyl-related substances, what is your agency's suggested policy on this?

*Ms. LaBelle. So we are going to -- we have been having discussions with HHS and the Department of Justice and DEA. We just got the GAO report that had -- that was required as

part of the federal scheduling extension from two years ago. We are going to be looking closely at what the results have been of that and, you know, come together to make sure we have a whole-of-government approach to this issue.

*Ms. Eshoo. And what kind of timeframe are you thinking of here, to get the job done?

*Ms. LaBelle. So we are, you know, engaged in continuous conversations about this. We understand the urgency. It is not going to happen before May 6th, but we are going to work as quickly as possible after that.

*Ms. Eshoo. And what is your response to the criticisms that class-wide scheduling leads to disproportionate incarceration of Black and Brown people, many of whom -- who don't receive the treatment they need while they are in jail or prison?

But of course, we have an excellent bill that -- before us that addresses that. But can you comment on that, please?

*Ms. LaBelle. Yes. So the mandatory minimum issues are much broader than this bill. But when we work with Department of Justice, we are going to look exactly at that. What are the effects of this legislation on the fentanyl scheduling, on mandatory minimums?

But the -- you know, but the mandatory minimum issue is a much broader issue that involves all forms of drug, as well as other sentencing.

*Ms. Eshoo. Well, thank you very much for agreeing to testify today, and we need to -- you know, we need the agency to really operate in top gear, because this number of deaths says to me that we are not making progress, and we have to change that. We have to change that. So thank you very much to you.

And now I will recognize Mr. Guthrie, the wonderful ranking member of our subcommittee, for his five minutes of questions.

*Mr. Guthrie. Thank you very much. And thank you, Director, for being here. I really appreciate it.

One, one of my prepared questions, by not meeting the May 6 deadline, we have to make, you know, some important decisions -- or not having information for us -- and I know you have a lot of the experts. I think you said -- you said that fentanyl analogues are driving the overdose deaths. And I would -- and I said in my opening statement that almost all of my providers are saying that everybody with an overdose death has some fentanyl analogue.

And I would agree it is not just a criminal justice issue, but I think it is a criminal justice issue, but not just. And this committee has responded with the CARES Act, SUPPORT Act, and hopefully we will have a chance to look at all of that, and see how it is making a difference. But I think it is both, we have to deal with both. And any

disparities in the laws being enforced absolutely need to be dealt with, as well. But I would -- it would be nice to have information before May 6, or a position from the Administration. But I appreciate it.

I know you had -- you put out your priorities for the year one report, and I really want to work with you to achieve your seven goals that you set. And specifically, I would like to focus on evidence-based treatment, and how you plan to address holistic treatment for those with co-occurring substance use disorders. Are you willing to work with me and the committee on fully evaluating current programs that are authorized or funded for substance use disorders?

*Ms. LaBelle. I am sorry, can you repeat the last part of your question? I had a hard time hearing.

*Mr. Guthrie. Okay, are you willing to work with me and the committee on fully evaluating current programs that are authorized or funded for substance use disorders?

*Ms. LaBelle. Yes, absolutely, Congressman Guthrie, thanks for your question. That is -- you know, we want to make sure that it is quality treatment that is evidence-based. And so we intend to work across, you know, all the HHS, SAMHSA to make sure that the programs that the federal government is funding are effective. And so we have to put those standards into place.

*Mr. Guthrie. Okay, thank you for that.

And then, additionally, I believe we need to ensure that the Office of National Drug Control Policy is addressing polysubstance abuse, not just opioids, but also stimulants and alcohol abuse. Can you please share how you plan to address this, and while also taking a wide lens on what programs we are already funding, and how we can make sure they are best serving those with substance use disorders?

*Ms. LaBelle. Yes --

*Mr. Guthrie. So kind of more emphasis on your --

*Ms. LaBelle. Sure --

*Mr. Guthrie. You sort of answered a little bit, but just a little broader on what you just answered.

*Ms. LaBelle. Sure, thanks. So polysubstance use is, obviously, as you point out, a huge problem. People are not just using one substance, they are using multiple substances. And we can't kind of have blinders on that we are only going to deal with one drug at a time.

So our policy priorities call for a holistic approach, starting with prevention of all substances -- as you mentioned, youth alcohol use -- and then treatment, making sure the quality treatment is available where people live, harm reduction, and recovery support services. Those don't have -- there are certainly medications that work for certain drugs, but we need to make sure that we are responsive to all

forms of substance use disorder.

*Mr. Guthrie. Great, thank you. And then I will just say again that, when we were looking at all the CARES Act, SUPPORT Act, and all the others that we worked on, I know -- and I had to change some of my attitude. Mine was coming from a pure -- not pure, but strong emphasis on the criminal justice side, that that is illegal, and people use it illegal. And as you really delve into this, some people commit crimes because of their drug habit. If you could deal with the substance abuse disorder, you could solve the criminal problem.

But some people are criminal, and they are out to -- and a lot of them aren't users. That is -- if you read some of the books that you read about, that they avoid using because it takes away from their ability to do business. And so my -- I would be really concerned if we start de-scheduling, or not allowing these types of drugs to go forward, particularly that -- you have said, and I have witnessed or heard from people who practice in this, that fentanyl analogues are a big driver in the overdose and overdose deaths.

We had a -- I mentioned in my opening statement -- a little -- I have a couple of -- few seconds -- but a two-year-old, we felt -- they believe touched and handled his mother's fentanyl, and her opioid, which had fentanyl in it, and that is why the two-year-old passed away.

And so this is just something that -- we need to really look at this as we move forward, and try to work together. So I really appreciate your time, and I will yield back to the chair.

*Ms. LaBelle. Thank you.

*Ms. Eshoo. The gentleman yields back. The chair now recognizes the ranking member of the full committee -- pardon me?

*Voice. Mr. Pallone.

*Ms. Eshoo. Oh, I am sorry. The chairman of the full committee first.

Mr. Pallone?

*The Chairman. Thank you, thank you, Chairwoman. I wanted to ask the director about this drug policy, first-year drug policy report that you just released.

I know your jurisdiction puts you in a unique position, because you collaborate with public health and public safety agencies to drive the direction of drug policy, not only in the U.S., but around the world. And what we discussed today and what we do in the months to come is really an issue of life and death, so it is very serious.

But your office recently released the Biden Administration's first-year drug policy priorities. I want to applaud the bold approach in that to reducing overdose deaths, and the urgency in which you intend to act. But I

wanted to focus on the first priority, which is expanding access to evidence-based treatment.

Acting Director LaBelle, the statement of drug policy priorities places expanded access to evidence-based treatment at the top of the list. So what actions are you going to take in year one to achieve that specific goal, if you would?

*Ms. LaBelle. Sure, thanks. So it is important that we look at the full continuum of care, but also that we look at the types of FDA-approved medications. So it is buprenorphine. We will be looking at how we can reduce barriers to buprenorphine access.

We are also looking at how can we modernize our methadone treatment that is available to people. So there is -- there are many steps that we have to take to look for how to update today's treatment approaches, and not be stuck in approaches that we had 15 to 20 years ago.

*The Chairman. Well, you know, only a fraction of the patients with substance use disorders have access to these evidence-based treatments. And as part of expanding access for evidence-based treatment, the statement noted that the Biden Administration will "remove unnecessary barriers to prescribing BUP, and identify opportunities to expand low-barrier treatment services.''

Just discuss a little further the barriers the Administration sees currently to prescribe BUP, and the steps

that the Administration plans to take to address those barriers, if you will.

*Ms. LaBelle. Sure. So the research shows that some of the barriers to people -- to prescribers prescribing buprenorphine include -- so they don't necessarily feel comfortable treating patients with addiction, so there is stigma attached to that.

There is also a lack of training in many medical schools. We don't do a good job of building out the addiction workforce. That is a second piece we will be working with medical schools to talk about that.

And then lastly, we have an -- interagency working groups going on that are looking at the X-waiver, specifically, which is the eight-hour training for doctors, and a 24-hour training for nurse practitioners and physician's assistants. So we are looking specifically at that issue, as well, at how we can remove barriers to the X-waiver, what we can do administratively, what requires legislative action.

*The Chairman. Well, that is great. That is very important, and I appreciate your answer.

Last question. Any other steps that Congress or the Biden Administration can take to ensure that providers are equipped with the tools that they need to diagnose or treat patients with substance use disorder?

*Ms. LaBelle. Sure. I think -- so many of the authors of the appropriations have helped to expand our addiction workforce. We need to look where there have been things authorized and money has not yet been appropriated, because we really need to expand the number of physicians and nurse practitioners and health care providers who feel competent to not only treat addiction, but to screen for it. Because the earlier we can identify someone who might have an emerging substance use disorder, the easier it will be to treat those people before their condition becomes chronic.

So Congress can help us, you know, expand awareness about the importance of medical training and nurse -- nursing training on addiction.

*The Chairman. Well, thank you. You know, I heard Chairwoman Eshoo, you know, repeatedly point out how, you know, this scourge of overdose deaths, and the rising rates, particularly now during the pandemic -- so we really look forward to working with ONDCP and the Biden Administration to reduce this.

I mean, it is just -- I think the ranking member, Mrs. Rodgers, you know, talked about, you know, this essentially double dose of problems between the pandemic and the opioid abuse and misuse. And so we really want to get to the bottom of it. Thank you for being here.

Thank you, Madam Chair.

*Ms. LaBelle. Thank you, Congressman.

*Ms. Eshoo. Thank you, Mr. Chairman.

Now the chair recognizes the ranking member of the full committee for her five minutes of questions.

*Mrs. Rodgers. Thank you. Thank you, Madam Chair and Mr. Chairman. And I too just want to join in saying that we, on the Republican side of the aisle, look forward to working with you, continuing to work with you. This is a huge issue all across the country. And I think, without a doubt, the last year has been a difficult year, with COVID and everything that it has meant, as far as lockdowns, and isolation, and fear, and uncertainty.

But there is this other crisis underway, and the deaths of despair has really been on my heart, and I know it is on a lot of people's hearts, with the increased substance abuse, increased suicides. And I absolutely believe that this is an area that we must take action. We must continue to identify what is going to work, what is going to be most successful in ensuring that individuals and families get the support and the treatment that they need.

But I also think there is more that Congress needs to be doing.

And I just wanted to start by asking the acting director, LaBelle -- and I appreciate you being with us today -- just -- I would like to ask you, do you believe that

Congress should extend this -- the temporary scheduling order for fentanyl-related substances before it expires on May 6th?

*Ms. LaBelle. We are asking Congress to give us more time to -- I mean, it can be extended. We need more time to -- before it is extended further. So we -- as I said, I don't think we -- there is any way we can come to you with new legislation before May 6. So we need -- we are asking Congress to extend the time so that we have time to come together and present you with another proposal.

*Mrs. Rodgers. So just so I understand, so would you support the temporary extension, while we work on a more permanent solution?

*Ms. LaBelle. We are looking to Congress to extend this for a period of time. We don't have a period of time in mind yet, because we have to get our interagency together to talk about this. But we support and we are asking Congress to extend this -- the fentanyl scheduling bill for a short period of time.

*Mrs. Rodgers. Okay, great. I wanted just to highlight to the committee that when ONDCP Assistant Director Kemp Chester testified before the Senate Judiciary Committee, he stated that codifying the scheduling emergency order and making it permanent is a "critical, most important first step that we have to take.''

And to the Acting Director LaBelle, is it still the

position of ONDCP that the scheduling order be made permanent?

And would you just speak if the position is changed?

*Ms. LaBelle. Sure. So I think we just got the GAO report. We are working with DEA to see what the results of this fentanyl scheduling act has been so far.

One thing that we know about the drug environment is that it is ever changing. And sometimes legislation that we put in place two years ago doesn't address today's issue. But the biggest challenges we face are synthetic drugs, and those are morphing over time. We want to make sure that the solutions we put into place and that we ask Congress to put into place address today's problems, not yesterday's problems.

*Mrs. Rodgers. Okay. The chairman of -- the chair of the subcommittee highlighted the 88,000 deaths this last year. I would just like to reiterate to the committee that I believe Congress must act, either this week or next, to prevent the spread of deadly fentanyl variants by making it permanent, and extending DEA's class-wide scheduling order.

You know, I would just highlight, when you compare the first quarter of 2021 -- so January to March, 2021, the seizure of fentanyl at the southwestern border by CBP has increased, just in this quarter, by 233 percent from last year, 2020 quarter 1. And so I think what we are seeing is

that we do have a crisis on our hands, and we are seeing a huge increase.

If -- so if you compare first quarter of 2020 to this quarter, January to March, 2021, seizure of fentanyl at the southwestern border, it has increased by 233 percent. So we need to make sure that we are providing the support necessary at the border and throughout the country, so that people are protected, and that we do not allow the continued negative impacts and destruction of lives and families due to fentanyl in America.

With that, I will yield back. Thank you, Madam Chair.

*Ms. Eshoo. I thank the gentlewoman. Yes, there has been the increase coming in from Mexico, but thank God we -- the reason we know the figures that you just stated is because it was seized. And -- but we need, really, a refreshed plan on this, because we can't gather a year from now and have statistics saying this is what happened in 2021, and it is more lives lost.

The chair now recognizes the gentleman from North Carolina, Mr. Butterfield, for your five minutes of questions.

Good to see you.

*Mr. Butterfield. Thank you so very much, Madam Chair, for convening this hearing --

*Ms. Eshoo. I think you are -- I can't hear you.

Can everyone else hear Mr. Butterfield?

No, they are shaking their heads no. There is something wrong with your microphone. We can't hear you.

*Mr. Butterfield. Does that work?

*Ms. Eshoo. Yes, there you go.

*Mr. Butterfield. Okay, I had my earpiece plugged in. That messed it up.

Thank you. Thank you very much, Madam Chair, for convening this very, very important hearing this morning. And thank you for your leadership. It has been nothing less than stellar. Thank you so very much. And thank you for the direction that you are taking this subcommittee. And thank you to the witnesses, the one witness on this panel and the witnesses on the next panel. Thank you for taking the time to join us today.

Director LaBelle, let me just start here. I am hoping that you can help us better understand the ways in which the federal government benefits from your office. This is simply a continuation of what Mr. Malone was -- Pallone was talking about a few minutes ago.

I understand that your office leads and it coordinates the nation's drug policy with the goal of improving the health and lives of our constituents. So my question is, your priorities seem to intersect with both public health and public safety. I want to talk about that intersection, if I

can. How does your office -- what is your office's role, and how does it differ from that of HHS and DEA?

*Ms. LaBelle. Sure. Thanks, Congressman. So the Office of National Drug Control Policy is, obviously, a unique office situated in the Executive Office of the President. And the purpose -- our purpose of our office is to bridge the gap that often occurs between public health and public safety.

So we bring Drug Enforcement Administration in, the Department of Justice in, as well as with our colleagues from HHS, from all of the various components of HHS, to discuss issues like fentanyl scheduling, because there are different -- the X-waiver is a perfect example. Law enforcement has a different perspective and a different goal sometimes. I mean, all of our goals is to reduce overdose deaths. But our charges are different.

So the Office of National Drug Control Policy, we have about 65 full-time staff, about 35 additional staff detailees, and they bring these sides together so we can find solutions that serve both needs. So that is really the unique role that ONDCP plays.

*Mr. Butterfield. Well, in that light, in what way do you coordinate and/or convene the other relevant agencies in your work?

*Ms. LaBelle. Sure --

*Mr. Butterfield. Do you coordinate with the other agencies?

*Ms. LaBelle. Yes. So we often have convenings. We have -- I mean, I think someone gave me data about the number of meetings we have had across the interagency just since the end of January. It has been about 78 meetings, where we work with other White House components. We work with HHS, DOJ, and we talk about these issues that we -- our goal is to make things move quicker, and -- so that we don't have to -- and build those bridges, so that we are not separately talking to Congress, for example, so that we can come together with one approach on an issue.

*Mr. Butterfield. You know, during the presidential campaign, Joe Biden announced a very robust and comprehensive drug policy agenda, and I hope that he will continue to pursue that agenda. How will the Administration leverage your office -- if you know, how will the Administration leverage your office to carry out its drug policy agenda?

*Ms. LaBelle. Sure, thanks. So I think the one unique role, again, is that we have public health and public safety experts together in the same agency. That doesn't occur anywhere else.

I am very engaged and aware of all the Biden-Harris campaign pledges that were made. Those are areas that -- we are going to take them one by one, and look at how we can

implement those over the next couple of years and, again, by having our convening authority, which helps to have one voice on these issues.

*Mr. Butterfield. Thank you for those responses, and thank you for your incredible work. I realize that you were just installed the day after the inauguration, whatever date you announced, but it seems like you have hit the ground running. And just thank you so much for what you are doing, and what you are going to do. I look forward to working with you as the Administration advances its priorities in this space. So thank you, thank you, thank you.

I yield back.

*Ms. LaBelle. Thank you.

*Ms. Eshoo. The gentleman yields back, and I appreciate your very kind comments, Mr. Butterfield.

It is a pleasure to recognize a former chairman of our full committee, the gentleman from Michigan, Mr. Upton, for your five minutes of questions.

*Mr. Upton. Well, thank you, Madam Chair. And I just want to share, Ms. LaBelle, this is so personal to all of us. I mean, every one of us on both sides of the aisle have many personal stories on this. We have family members. It is indeed close to our heart, as we try to do our very best to resolve this major issue that continues to plague virtually every one of our communities, families across the country.

So I appreciate your leadership.

You and I, of course, both sit as members of the Commission on Preventing Synthetic Opioid Trafficking, as appointed by our respective leaders. And though we had our first meeting just a week or so ago on Zoom, certainly I just want to commit and definitely look forward to working with you and other members of the Commission on ideas to help curb this terrible scourge that plagues our nation.

Can you briefly share your thoughts on how the Commission could be most impactful on stopping this trafficking?

*Ms. LaBelle. Thank you, Congressman. And the Synthetics Commission, we -- as you mentioned, we just had our first meeting. We are just organizing it. I think it is charged with a very -- with very specific -- it has a very specific charge. I think what it -- the best part about the Commission is it has external experts, it has a bipartisan approach, including Congressman Trone, yourself, Senator Markey, and Senator Cotton.

So what I think the Commission will be best able to do is to look at these issues, the international synthetics landscape, and come up with some -- take the time to come up with some specific approaches that Congress can take up, that we can do by executive order or administratively. So it is going to be a real focused effort that I think is going to

help with this issue.

*Mr. Upton. So I want to -- well, thank you. I want to echo our Republican leader, Cathy McMorris Rodgers, in terms of her question on why don't we make this permanent, the class-wide scheduling for fentanyl, rather than an extension. I think that makes a lot of sense.

You sensed, as we get -- close in on this deadline, again, that perhaps the Administration, if Congress fails to act, knowing that we are only in session this week and next, that they might pursue an executive order to try and extend that?

*Ms. LaBelle. So, Congressman, I think I would have to check to see if we have the authority by executive order. I am not sure that we can do it.

What DEA can do is, you know, ask for -- by -- analogue by analogue, to schedule it. That they certainly could do. I am not sure the executive order would -- could make it -- could extend it, however.

*Mr. Upton. So we know that much of the fentanyl issue is coming from China, right? Tell us what you are doing to try and close that door.

*Ms. LaBelle. Sure, thanks. So what we are seeing right now, as I said, these issues are very dynamic, and drug traffickers are, obviously, very crafty. And so what is happening -- what Congress did over the last several years is

pass several pieces of legislation that allowed our Customs and Border Patrol to identify this -- the drugs that were coming through the mail.

Now -- and China acted to schedule fentanyl as a class. So now a lot of the drugs are going in through Mexico. We are working with Mexico to make sure that they are working on interdiction, so that it never even comes to the border, that they are working on identifying labs so they can seize these labs. And then lastly, working at their ports of entry to identify and seize these substances. So we have a good working relationship with Mexico on these types of issues, and our law enforcement partners can work together on it.

*Mr. Upton. I don't know -- I don't have the clock on my screen. Do I have a lot of time left, Anna?

Wait, I didn't hear you.

*Voice. You have 50 seconds.

*Ms. Eshoo. You have a minute.

*Mr. Upton. Okay, one of the things that we discovered in the last Congress was that our postal inspectors, frankly, didn't have the resources.

So, as you know, I am from Michigan. Much of our mail in west Michigan actually goes through the Grand Rapids postal facility. You know, we learned that, at the time, they had one postal inspector to really look through all of these different packages coming through. I know Dr. Burgess

was up to New York and saw just a number of these facilities. There has been a lot of documentation on that on TV, in terms of the issues there.

What are we doing on more resources to try and stop this from coming in using FedEx, UPS, as well as the Postal Service, things that would seem pretty routine to you and me?

*Ms. LaBelle. So I will quickly answer that. So, number one, we saw that there was a decided drop in mail coming from China that had fentanyl in it. So that was a success over the last year.

However, Congress did provide additional resources to the U.S. Postal Service, Inspection Service, to identify these drugs. And there were other pieces of legislation passed to make it easier to identify something that might be coming from a chemical company that could have fentanyl in it.

*Mr. Upton. Thank you, I yield back.

*Ms. Eshoo. We thank the gentleman.

It is a pleasure to recognize the gentlewoman from California -- and she is a gentlewoman -- Congresswoman Matsui.

*Ms. Matsui. Thank you very much, Madam Chair, and thank you for holding this very important hearing.

And Ms. LaBelle, welcome to the committee, and thank you for your testimony and the very important work that you are

doing.

Now, we know that the lack of access to timely, high-quality behavioral health treatment continues to be a significant challenge. And that is why I have long supported the expansion of Certified Community Behavioral Health Clinics, CCBHCs, which provide a comprehensive range of mental health and substance use disorder services to vulnerable individuals, including 24/7 crisis response and care coordination.

Addiction treatment is a core component of CCBHCs' required service offerings. And as a result, all 340 clinics across 40 states, D.C., and Guam have either launched new addiction treatment services, or expanded the scope of their addiction care. And well over half of CCBHCs provide same-day access to medication-assisted treatment for patients with opioid use disorder. This model is really well-placed to respond to the pandemic's expected long-term impact on behavioral health needs, and Congress has recognized its value by extending support to the program in recent COVID relief bills.

Ms. LaBelle, how does the Biden Administration plan to leverage existing treatment networks like CCBHCs expand access to recovery support services?

*Ms. LaBelle. Sure, thank you, Congresswoman. You raise a really important point about recovery services.

As we recognize that addiction is a chronic condition, we need to have recovery support so that we can sustain people's recovery over a period of time. CCBHCs received about $420 million in the American Rescue Plan, and that includes -- they are required to have recovery support services within them.

Peer support services are incredibly important, as you point out. They have to be provided throughout communities. As some Member of Congress mentioned, one of our highest rates of overdose death are among people -- the reentry population, people leaving jails and prisons. It is important that recovery services reach them to help them sustain their recovery, so that they don't overdose, and that they can go on to live full lives.

So we look forward to working with you further to determine how to integrate recovery services throughout all of our treatment programs.

*Ms. Matsui. Well, I look forward to that, thank you very much.

You know, in 2018 Congress included in the SUPPORT Act a provision requiring DEA to issue regulations around a special registration process to expand remote prescribing of controlled substances. While in the past year the public health emergency has eased historic barriers to certain telehealth services, including allowing providers to initiate

treatment for opioid use disorder over the phone and via video chat, the DEA has still not completed its statutory requirement to stand up the special registration process for remote prescribing.

Ms. LaBelle, can you expand a bit on the framework ONDCP is using to evaluate whether to make permanent the emergency telehealth provisions related to MAT prescribing?

*Ms. LaBelle. Thanks for asking that. So we -- you know, we have this included in our policy priorities. There are researchers at NIDA who are funded by the National Institute on Drug Abuse who are looking at exactly how effective the regulatory changes that were made during COVID have been. We are going to be looking at that, and determining if it is administrative changes that need to be made, are there legislative changes, and how can we -- what we have heard is a lot of anecdotal information that is really positive about how telehealth has helped people who are already in treatment be retained in treatment.

So we want to be guided by science and evidence, and we are working with our colleagues at the National Institute on Drug Abuse to inform those policies.

*Ms. Matsui. Well, thank you very much, because I have been working with many providers in my community, and -- whether it is at the hospital or the community health centers, they have had an increase in the telehealth with

their patients, and found very much that it was almost immediate, as far as the prescriptions, and all of this, and the sense of being able to, in fact, walk people through some of these crises as they have occurred.

So I really do encourage that you really look at this, and I would be happy to work with you as we do this, too. So thank you very much, very much for being here today.

*Ms. LaBelle. Thanks.

*Ms. Matsui. I yield back.

*Ms. Eshoo. The gentlewoman yields back. It is a pleasure to recognize the gentleman from Texas, Dr. Burgess, for his five minutes of questions.

*Mr. Burgess. I thank the chair. I thank our witness for being here.

Ms. LaBelle, it is great to make your acquaintance. I have worked with your predecessor, James Carroll, while we -- in two Congresses ago, when we worked on the SUPPORT Act. So this ongoing work is critically important.

Just to pick up on one of your answers to Ms. Matsui's question about telehealth, do you sort of foresee telehealth, you know -- that was a big deal in getting people to continue doing their treatment because they lost the in-person care that they were at one point receiving during the pandemic. So how do you see this working, as we come on the other side of the pandemic?

Will telehealth continue to be complementary to the treatment available?

*Ms. LaBelle. Yes, thank you, Congressman. I think that telehealth will always be an essential piece, going forward.

I don't think it is going to replace in-person care, but it certainly makes it a lot easier for people who may be some distance from a treatment provider. What we want to do is increase interventions at every single point. And so, if we can remove the barrier that people face -- it might be transportation, it might be child care -- telehealth can help remove those types of barriers to get people to be retained in treatment.

*Mr. Burgess. Yes, and I was interested in your testimony, because it actually talked a little bit about the methadone treatment programs. Obviously, that is -- by definition, that is in person, because the methadone is administered and has to be taken on site, literally.

I actually worked in a methadone clinic when I was a senior medical student on an elective, but this was back in 1975, so it has been some time. But methadone -- you are right, I don't think the methadone availability or methadone clinics have quite kept pace with what is available, technologically. And I do think that is an important part that we need to include.

*Ms. LaBelle. Yes, sure. And that is -- I think that is one thing we found, again, anecdotally -- the research will follow soon, hopefully -- is that, particularly for patients early in their methadone treatment, I mean, that is a long haul for many people to get to a methadone clinic, as you know. And so allowing them to have take-home doses, and be able to have telehealth, is a really -- a great way to remove a barrier for someone who might otherwise not be able to continue in treatment, and might be subject to overdose.

*Mr. Burgess. Right. But the risk for diversion is significant with methadone, and that has to be borne in mind.

Let me just ask you -- and I appreciate you providing the Biden-Harris Administration policy priorities. One of those listed is reducing the supply of illicit substances. And clearly, that is absolutely critical. And many of us have spent some recent time down on the -- I represent a district in Texas. I am not on the Texas border with Mexico, but there is a lot of activity, and a lot of illicit activity, a lot of contraband, as, of course, as well as people that are coming across the border.

So how do you see what your task in preventing that is, in disrupting the supply of illicit substances? How do you see that working?

*Ms. LaBelle. Sure. So we have ongoing conversations with the Government of Mexico, and with our law enforcement

partners through something called North American Drug Dialogue. We are working with Mexico on interdiction in their own country to prevent those drugs from even getting to the border, identifying and disrupting their labs, lab production, which is how the fentanyl is produced, or heroin, and then also their ports, which is where the precursor chemicals come. So that is kind of what -- you know, some of the steps we are taking to make sure that it never even gets to the border. And that is a partnership that we have had, a long partnership with Mexico.

*Mr. Burgess. Well, good luck. But, I mean, if you have ever been down to the Texas-Mexico border, particularly that sector in the lower Rio Grande Valley, it is very, very difficult to provide those -- that interdiction. And, of course, you couple that with the human toll that is coming across the border, and our Customs and Border Protection are tied up having to administer to them, it creates a diversion where additional supply can pretty much come across uninterrupted. So please don't take your eye off of that. That is absolutely critical, that we bring that under control. And that is certainly part of the Biden-Harris agenda that I would support, is interdicting that illicit supply coming into the country.

*Ms. LaBelle. Right --

*Mr. Burgess. Thank you, Madam Chair, I will yield

back.

*Ms. Eshoo. The gentleman yields back. Those are excellent points.

And now it is a pleasure to yield to the gentleman from Maryland, Mr. Sarbanes.

[Pause.]

*Ms. Eshoo. I saw Mr. Sarbanes.

There you are. Are you -- Mr. Sarbanes? Can you hear us?

Mr. Sarbanes, you need to unmute.

*Mr. Sarbanes. Sorry, Madam Chair.

*Ms. Eshoo. You looked like you were studying something very hard there.

*Mr. Sarbanes. Yes, I appreciate --

*Ms. Eshoo. You are recognized.

*Mr. Sarbanes. Yes, thank you very much for the hearing.

Many of us, it is clear from our comments already, are focused on the impact of this opioid crisis on our particular states, the districts that we represent. I am no different from my colleagues in that respect.

In Maryland, since 2017, we have seen over 2,000 opioid-related deaths each year, and the numbers have gotten worse, as we have been discussing today, during the coronavirus pandemic. In the first three quarters of 2020 there were

more opioid-related deaths in Maryland than in the same time period in prior years. So we are seeing that acceleration. I think that goes to the heart of your opening comments about what do we need to do to really get our arms around this.

I had the opportunity to serve on Energy and Commerce back in 2018, when we were crafting a legislative package to address the crisis that resulted, as you will recall in H.R. 6, the SUPPORT for Patients and Communities Act, which included bills addressing a wide range of substance use disorder issues.

Workforce issues are a very important part of the conversation, in terms of reversing this opioid epidemic. And the package back in 2018 included a bill which I had worked on, the Substance Use Disorder Workforce Loan Repayment Act, which would help increase the number of health care professionals working in addiction treatment and substance use disorder programs. It would provide loan repayment for individuals who provide direct patient care at opioid treatment programs in high-need areas.

Director LaBelle, in your testimony you discuss staffing shortages in the behavioral health occupations. Could you describe some of the challenges that you are seeing in this area, in particular, and how it relates to our ability to address this crisis?

*Ms. LaBelle. Sure. Thank you, Congressman. And the

loan repayment program is a good example of a solution.

You know, we know how much colleges -- medical school costs for people. And it might be -- there are many communities around this country where they don't have access to any type of addiction treatment. Buprenorphine-waived doctors are not available. Methadone clinics are not available. Doctors don't know how to treat addiction or screen for it.

So the workforce piece is something we are looking at very closely, and actually have had conversations with Johns Hopkins about how we work to encourage more medical schools, more health care providers, health care professional schools to include addiction in their curriculum, so that when people come out they are prepared to screen and identify folks for substance use disorder. The workforce issue is so important because, as we -- Congress has been very generous in giving a lot of money to the states. But unless we address those workforce shortages, we are not going to be able to put that money to good use across the country.

*Mr. Sarbanes. Can you be a little more specific about some of the actions you plan to take in this space in the coming months?

I mean, do you have a kind of prioritized list when it comes to boosting the workforce?

And then, how can we help? I mean, how can Congress

help support those efforts in concrete ways?

*Ms. LaBelle. Sure, thanks. So a couple of things.

One is that there are fellowships that are available that have been funded by -- in HRSA by HHS that are not filled yet. So we are going -- we plan first to just make sure that people know that these fellowships, addiction fellowships, are available that can help build the addiction treatment workforce.

Secondly, we plan to talk once again with our colleagues in medical school, medical schools, nursing schools, about what they can do to make sure that, for example, all of the -- their residents are DATA-waived. That is one step they can take.

So those are two things that we plan to take on right away. And again, we are going to work closely with Johns Hopkins on several of these issues.

*Mr. Sarbanes. Thank you very much.

Madam Chair, I yield back my time.

*Ms. Eshoo. The gentleman yields back. It is a pleasure to recognize the gentleman from Virginia, Mr. Griffith, for your five minutes of questions.

*Mr. Griffith. Thank you very much, Madam Chair.

Director LaBelle, I first want to say that I greatly appreciate the work that the Office of National Drug Control Policy does, and the role it plays in combating abuse of

controlled substances.

In fact, you mentioned one of the programs that was very helpful in my district. In fact, they would like it expanded, and that is the HIDA program.

Former Director Jim Carroll traveled to the district a little over a year ago, and we visited with the folks in a far southwest corner of Virginia, where the opioid epidemic has hit particularly hard, although it is spread across the district. And prescription opioid abuse has been a major problem, as it has been in many districts. But for many years, the nation's highest per-capita prescribing rates for opioid pain pills occurred in two of the localities in my district. One, it was 306 pills per person, and in another it was 242. So obviously, we can do better, and we are doing better, and I appreciate your work on this, as well.

And we have more than our share of illegal drugs trafficked in from China and Mexico.

But the question is, how does the ONDCP approach to data collection and recommendations differ between schedule one and schedule two substances?

*Ms. LaBelle. So I think -- I am sorry, can you repeat the last part of the question?

*Mr. Griffith. Sure. What is -- what are the differences between schedule one and schedule two, when it comes to your data collection, and then the recommendations

you make?

*Ms. LaBelle. So the National Survey on Drug Use and Health is one of our tools that the Health and Human Services Department uses to collect data on drug use. And it has -- it asks questions about lifetime drug use, substance use. It includes alcohol, it includes schedule one and schedule two drugs. And they added a lot about scheduled two -- I am sorry?

They added quite a few questions about schedule two drugs in the last couple of years, because, as you said, we can't keep our eye off the ball of other types of substance misuse.

What we are trying to do in our strategy, in our policy priorities, is look at this from a holistic standpoint, that it is not just about one drug, it is about all drugs. It is about polysubstance use. And that can include alcohol use, as well, because we know that that is a substance that young people first start with, including alcohol and marijuana.

So those are our issues. We work closely with HHS through their National Survey on Drug Use and Health to inform our policies.

*Mr. Griffith. And I appreciate that. And I appreciate recognizing that all substances may have a problem. I come from a family with some history of substance abuse, and so I have chosen throughout my life not to use any of the

substances, including alcohol and marijuana.

All right, new subject, Director LaBelle. In 2019 a federal interagency work group led by ONDCP recommended the use of permanent classified scheduling for fentanyl-related substances, along with legislative modifications to allow for easier rescheduling of any fentanyl-related substances with low or no abuse potential. This would allow rescheduling to happen in a more timely manner, and it would make it easier to conduct research on schedule one substances. And I am big on research.

I understand that ONDCP is re-evaluating permanent scheduling, but does ONDCP still stand by these recommendations to make conducting research for medical purposes easier?

*Ms. LaBelle. So we are talking to HHS about exactly what the barriers are to research with the fentanyl scheduling legislation as it currently stands. We will be engaging with them in the future. We can build off of what was done and have that inform our work, but we need to make sure we are talking to them about the issues they are facing today.

*Mr. Griffith. Because, I mean, I think this is an important issue, and I think we need to do research because, while some of this stuff is the nastiest stuff out there and has no benefit whatsoever, sometimes things have medical

capabilities that we are just not aware of. And if we don't allow our research facilities and our medical teams to experiment, and try to figure out how to -- how do you solve these problems, then we will still be in the dark 20 years from now.

*Ms. LaBelle. Right.

*Mr. Griffith. So I would hope that you all would allow more research, even on schedule one, and figure out ways to make it so that it is practical and effective and efficient.

And I have got a little bill that will help you do that, but -- that Dan Crenshaw and I are carrying. But I am encouraged by your comments, and I yield back.

Thank you, Madam Chair.

*Ms. LaBelle. Thank you.

*Ms. Eshoo. I thank the gentleman, and especially for being willing to express what your family and extended family have dealt with. That is to your credit. And I think it is important for, not only Members, but the American people hear you express that, Mr. Griffith.

Now I would like to recognize the gentleman from Oregon, Mr. Schrader, for your five minutes of questions.

*Mr. Schrader. Thank you very much, Madam Chair.

And Director LaBelle, thanks for being here. I appreciate it very, very much. I am encouraged by the interest shown by ONDCP in pursuing mental health parity. We

try and do that in Oregon. It is a huge benefit at minimal cost, and I would argue it saves millions of lives and a lot of money in the long run.

Just like we have been talking about here, access to treatment is a huge issue. And while payers can't create more providers, ensuring that, you know, they cover the ones that exist is one piece of the puzzle.

And so, in that regard, what policies is ONDCP considering to encourage the growth of substance use disorder providers?

*Ms. LaBelle. So what we are doing is making sure, obviously, that there is quality treatment. As you mentioned, the parity work, we did quite a bit of that when I was here at ONDCP last. We need to catch up to see where the barriers still exist to parity. We need to work with Department of Labor, as the agency that administers and enforces the Parity Act. So we will be working with them to determine what the gaps -- where the gaps continue to be.

*Mr. Schrader. Very good, very good, excellent.

And others have spoken about this, too, but, you know, the -- last March, millions of Americans that were getting treatment for alcohol, cocaine, methamphetamine, marijuana, fentanyl, heroin addictions basically lost access. There have been some creative opportunities through telehealth to help in that regard.

And so, given the constraints that we have encountered with the in-person care, has ONDCP given any consideration -- the field -- the FDA cleared and regulated products called Prescription Digital Therapeutics that use software to treat serious unmet medical health needs? And if so, how so?

*Ms. LaBelle. Sure. Thank you for asking that. So clearly, there are lots of innovations that have come out across the country to address this need.

I mean, there are -- technological innovations kind of abound, which is great because, as I said before, our policy priorities is about increasing interventions at every single point, and removing barriers. And technological advances such as the one you identified, that is something I need to look into a little bit further, and I would be happy to talk to you about that more.

*Mr. Schrader. Well, that would be great. I would like to have you work with the committee on the opportunities that are there.

My understanding is that the products actually have accountability and support features built into them, which are both very, very important, in terms of follow through. So I want to make sure that, while these apps and opportunities are there, they are actually doing what we want them to do, and can register improvement from our patients. So if you will work with us, I would appreciate it.

*Ms. LaBelle. Sure, thank you.

*Mr. Schrader. Thank you.

And Madam Chair, I yield back.

*Ms. Eshoo. Thank you. The gentleman yields back.

It is a pleasure to recognize the wonderful Mr. Bilirakis.

*Mr. Bilirakis. Thank you very much. I appreciate it, Madam Chair --

*Ms. Eshoo. -- members on our committee.

*Mr. Bilirakis. Thank you so much, it is appreciated.

Madam Chair, the United States remains in an overdose epidemic. I know you know that. Sadly, according to the CDC, drug overdose deaths rose from 2018 to 2019; 70,630 lives lost in 2019, sadly. And with deaths involving synthetic opioids, primarily fentanyl, there was a continued increase with more than 36,359 lives lost in 2019. It is just terrible.

DEA temporarily scheduled fentanyl analogues as controlled substances three years ago. Last year Congress passed a temporary extension that continued to criminalize fentanyl analogues until May 6, 2021. Locally, we have seen that fentanyl has been a major problem, even with the schedule being in place. Madam Chair.

For example, Pasco County in my district has already had 48 people die from overdoses since January of this year. And

Pasco is not alone, as you know. Many communities throughout the country are experiencing the same overdose increases as the pandemic has only exacerbated the mental health and addiction crisis in our country. If this scheduling ban expires, we expect far more fentanyl to flood our streets, and many more lives to be tragically lost. We cannot allow that to happen.

While we have made meaningful bipartisan strides to address this scourge, we are certainly far from being out of the woods. It is critical that we remain engaged in the fight to save the communities we are charged to represent, and the lives of our neighbors too often cut short.

Director LaBelle, thank you for being here. Thank you for your testimony. Can you discuss our working relationship with China to prevent the entry and sale of fentanyl and its analogues?

And then, given the dynamics of the current U.S.-China relationship, what is the level of transparency and information-sharing with law enforcement agencies, please? Thank you.

*Ms. LaBelle. Sure, thank you, Congressman. I will start with your first question first.

So our office, the Office of National Drug Control Policy, has a regular conversation with our embassy in Beijing, where we discuss these very issues that you raised.

China has a very large chemical industry, much of it which is unregulated. So we are discussing with them on a regular basis about just the issues that we have discussed, how to control the chemical industry so the precursor chemicals that are used in the manufacturing of fentanyl and fentanyl analogue are more controlled.

And then the second -- your second question concerned, you know, what -- going forward, what we can do. Again, you know, it is making sure that -- there were several pieces of legislation put into place that -- so we could have our Customs and Border Protection and the U.S. Postal Service make sure they are getting the chemicals that are coming in, the fentanyl analogues that are coming in through the mail or express couriers, so they can seize those.

And then also, I think it was good in -- a couple of years ago when China -- working with China to make sure they were -- they scheduled all of their fentanyl. So that did reduce the amount of fentanyl coming in directly to the United States from China.

Unfortunately, a lot of that -- the chemicals are now going to Mexico, where we are working with Mexico on the problem.

*Mr. Bilirakis. Thank you.

You know, Madam Chair, while China's step to designate fentanyl and all its related analogues as controlled

substances is certainly helpful, if COVID-19 has taught us anything, it is that we ought to remain skeptical, and not rely on the goodwill of the Chinese Communist Party.

A permanent American solution is necessary, as you know, and I encourage my colleagues to review and consider a permanent ban for these deadly analogues under H.R. 1910, the FIGHT Fentanyl Act, or continuing the temporary ban under H.R. 2430, the Temporary Reauthorization of the Emergency Scheduling Fentanyl Analogues Act.

Thank you very much for holding this very important hearing, Madam Chair, and I will yield back. Thank you.

*Ms. Eshoo. I thank the gentleman, and he yields back.

I don't see Dr. Ruiz, so I am going to go to the gentlewoman from Michigan, Mrs. Dingell.

You are recognized.

[Pause.]

*Ms. Eshoo. Unmute.

*Mrs. Dingell. I know --

*Ms. Eshoo. Now we can hear your voice.

*Mrs. Dingell. I am sorry. Thank you, Chairwoman Eshoo and Ranking Member Guthrie, for convening this important hearing on the opioid crisis, which, as we have all talked about this morning, remains one of the defining public health challenges of our time. And thank you, Acting Director LaBelle, for the leadership you and your team have already

put forward at the Office of National Drug Control Policy.

As we know, substance abuse disorders are complex, but they are treatable diseases. And it is good to be part of a committee that has recognized that, and sees this as a public health problem.

Despite all of our work over the years, the nation is still experiencing a significant treatment gap, and I would like to ask you to expand on how we can work together to reduce barriers to treatment, particularly for patients who receive methadone. By law, only certain treatment programs can dispense methadone for the treatment of opioid use disorder. Patients who receive methadone as part of their treatment must also receive the medication under the supervision of a practitioner.

Could you -- Director LaBelle, could you -- the Administration's drug policy priority states that you plan to review policies relating to the methadone treatment, and develop recommendations to modernize them. When will this review begin, and when do you expect to develop recommendations?

*Ms. LaBelle. Thank you for your question. And methadone is, obviously, a proven medication for opioid use disorder, as you have recognized. We are -- we have not yet begun that review. I can't give you a timeline. We do know how urgent it is.

Methadone regulations and rules haven't been reviewed in some -- for some time. So we need to -- you know, our policy priorities were issued on April 1st. We are now looking for what the best venue is to review that. So as soon as we know that, I will make sure our office stays in touch with your staff about it.

*Mrs. Dingell. Thank you. During the pandemic SAMHSA and other agencies have made exceptions to rules around treatment for opioid use disorder. But some restrictions around methadone remain in place, such as requiring new patients that are treated with methadone to complete an in-person medical exam. Does that in-person requirement exist for other forms of opioid use disorder treatment?

Can this requirement be a barrier for patients seeking treatment?

*Ms. LaBelle. So the methadone -- the way -- and again, I am a lawyer, not a doctor, so I don't want to step into clinical recommendations. But as I understand it, one of the issues with methadone is making sure you get the right dose, which is why it is so important to have the in-person piece.

Those are issues that we need to make sure are reviewed, and that we have clinicians who can discuss that very issue, because we know methadone works, and we want to remove those barriers.

*Mrs. Dingell. One way to -- thank you for that. One

way to reduce barriers to treatment is to find ways to meet patients where they are. Your priorities include finalizing a rule related to methadone treatment vans. Can you talk to -- talk us through how these would work, and why they might be important for both rural and urban communities?

*Ms. LaBelle. Great, thank you. So methadone treatment vans have been -- we haven't had new ones for almost a decade now, and so that is why it is so important to get these methadone rules out. The mobile methadone vans can be useful. I feel very strongly they can be useful in -- across the country in jails that may not have their own opioid treatment program. A methadone van could provide those services to those individuals.

I also think that it is important -- and I talked about the, you know, the mobile treatment availability. It is -- that is important for rural areas, but it is also important in urban areas, as well, where you might have the same type of -- or similar issues with transportation. So I am a strong proponent of mobile methadone vans, and we are working diligently to make sure that those get out as soon as possible.

*Mrs. Dingell. Thank you, Director LaBelle. As we have heard today, the trend in drug overdose death statistics is really alarming, and we know that increasing the availability of treatment will ultimately save lives.

I lost my sister to this, so it is an issue that remains very personal. My father was an addict, too. So thank you for all the work you are doing, and we also have to remove this stigma attached to it, so we can get out there and really treat the problems. Thank you.

I yield back, Madam Chair.

*Ms. Eshoo. The gentlewoman yields back. And I would also add to Mr. Griffith's personal testimony, I think that it is really rather courageous of Members coming forward, as Mrs. Dingell has, to let the American people know that we are all just as human as the rest of the people in our country, and that these terrible, terrible drugs have impacted so many Members in -- obviously, in a very personal way. So thank you to you.

The chair now recognizes the gentleman from Missouri, the one, the only Congressman Long.

*Mr. Long. Thank you, Madam Chair, and I appreciate it very much. And I remember being on a trip to Turkey with you a few years ago, right around the start of the Syrian War. And we had some refugees from Syria in our roundtable discussion, so we were there a week, and really trying to drill down. And at one point you leaned back and you said, "What a mess.'' And that, I think, is what we are faced with here again today. What a mess.

I never came home growing up and had my parents tell me

that one of their friend's children had deceased from drugs. And just within the last month I have had the fourth child that is the same age as my children, and grew up with them, that deceased from opioid abuse, I guess you would call it. And all four of those cases, all four, are personal friends of mine that have lost children. They had had them -- they were all middle -- up or middle-class and above. They had all done everything humanly possible for their children, had them in rehab facility, rehab facility, after rehab facility. One died, they found him in the bushes of the rehab facility with a needle still stuck in his arm.

So thank you very much, Madam Chair, for holding this very important hearing today. It is titled, "An Epidemic Within a Pandemic: Understanding Substance Use and Misuse in America.'' And I hope we can understand how to break the addiction for these kids, because in all four cases in our -- you knew what was going to happen, you knew how the book was going to end, how the story was going to end. And it did. And I don't know what the breakthrough will be, with a drug company or with someone to come up with something to break this horrendous addiction, and -- that brings so much death to families across America.

I was in Kansas City a couple of years ago, visiting a drug facility where, when the cops pick you up, instead of taking you to jail, they take you to this facility. And the

first thing that they do is they test you for drugs. And they have got this guy in there, the cops brought him in, and instead of taking him to jail, bringing him to the rehab facility, brought him in, and they said, "What are you on?''

And he said that he was on opioids, and they tested him, and they said, "You don't have one opioid in your system. You have fentanyl.''

He said, "What is fentanyl?''

So, again, I, you know, just want to thank you for holding the hearing.

And Ms. LaBelle, for years Missouri had one of the worst problems in the country with meth labs. And that trend has, thankfully, gone down. But unfortunately, these bigger manufacturing operations are filling the void.

We tend to think of meth as the small lab's business. And when I was an auctioneer, I would go out to book a farm, a real estate auction, and there would be a black trash bag on the ground with, like, smoke coming up. It wasn't smoke. I don't know exactly what it was, but somehow I guess you can put meth in a black plastic trash bag. But -- so we tend to think of it as small labs in basements or out in the fields, I guess. But it is clear that the meth production has turned into a highly industrialized operation.

And last week a Missouri State Highway Patrol trooper found 88 pounds of meth in a car during a traffic stop. And

this was following a similar traffic stop in Missouri the week before, where they discovered 75 pounds in a cooler in the back of a car.

Last year, in March, we had a hearing on substance use disorder, and I asked Admiral Brett Giroir, the assistant secretary of HHS at the time, about methamphetamine. He noted the cartels were manufacturing and then distributing hundreds of thousand pounds of pure methamphetamine. And he characterized methamphetamine as the fourth wave of substance abuse.

Director LaBelle, last year's hearing was right before the COVID pandemic and everything that came with it. Fast forward a year. What are you now seeing, in terms of availability, manufacture, and distribution, and use of methamphetamine?

*Ms. LaBelle. Thank you, Congressman. So I think, as you said, it is not yesterday's meth. Meth that is being -- now it is manufactured in Mexico, and it is coming in to the United States across the border. So -- and we are seeing it where -- I grew up in New England, but lived in Washington State for a long time. Never heard of it in New England. Washington State had a lot of meth labs. Now we are seeing more meth availability in the Northeast and across the country.

And so I think that that is getting much more attention.

We know there are treatment programs that work, and will be working with HHS on making sure that, again, the barrier to effective treatment for meth use disorder is something that we take up.

*Mr. Long. Okay, I only have 47 more questions, but I am out of time. So, Madam Chair, I yield back.

*Ms. Eshoo. The gentleman yields back. I think that it is worth noting that when -- with a sweeping schedule one designation, it is very difficult for there to be the development of new drugs to be administered to people that would benefit from them, because in that sweeping schedule one it eliminates the possibility of some of these substances to be used to the -- for the benefit of individuals. So I think we need to keep that in mind.

Let me recognize the gentleman from California, Dr. Ruiz, for his five minutes of questions.

*Mr. Ruiz. Thank you, Madam Chair, and thank you, Acting Director LaBelle, for providing an update on the Administration's drug policy priorities.

One issue I would like to address today is access to treatment, and how that is directly related to the amount of education and training of providers. In other words, also the physician shortage that we see, not only in all aspects and all specialties, but specifically with addiction medicine.

As an emergency physician myself, I have cared for countless individuals in the emergency department who were actively overdosing, and have resuscitated many, and intubated them, et cetera, given them the appropriate medications when appropriate, and saved their lives. And there is an obvious opportunity in the emergency department to help an individual get help by seeking long-term treatment.

However, many patients with substance use disorders also come to the emergency department for completely different reasons. And being able to identify the more subtle signs of substance use disorders can be a critical tool to help more individuals get access to the treatment they need. In other words, identify those at risk, give them the treatment before they come in blue and not breathing.

And this is not just for emergency physicians. The more providers in all specialties that can help identify the signs, the more opportunity we have to open doors for our patients to seek care and improve their lives. A National Academies paper issued last April found that, "despite the impact and pervasiveness of the opioid epidemic, most clinicians cannot confidently diagnose and treat patients with substance use disorder.''

So Acting Director LaBelle, just talk to me about whether or not additional education and training around

substance use disorders improve provider confidence in diagnosing and treating substance use disorders and, therefore, increase access to treatments for individuals with substance use disorders.

*Ms. LaBelle. Thank you, Doctor. I couldn't agree more about the importance of all providers, all health care providers, being able to identify early stages of a substance use disorder before it becomes chronic, when it is much harder to treat, as you know.

So we are working with the National Academies. We will continue to work with the National Academies, the American Medical Association, pediatricians. These are all important parts of the answer to this, is to make sure that they get the training that they need in medical school, but also, you know, during residency, so that they understand how to identify and refer people to treatment. That is a key element of our strategy.

*Mr. Ruiz. Thank you. And you also note in your testimony that the nation's addiction workforce is experiencing staffing shortages. In what way does the Biden-Harris Administration plan to support, diversify, and expand the addiction workforce?

*Ms. LaBelle. Thank you, an important point about diversifying the addiction workforce.

There are fellowship programs, minority fellowship

programs in particular, that would help diversify the workforce. I don't think we are there yet. And I want to work with your office to identify how better to address those issues, because I think there have been workforce approaches that have been authorized but not appropriated. We need to work with HHS to identify what those are, and expand them, and particularly in areas where there is a high need.

*Mr. Ruiz. Director LaBelle, I helped start a medical school in one of the -- California's most under-resourced areas that faced high health disparities, our senior -- founding senior associate dean at the UC Riverside School of Medicine. And one of our missions was to develop a workforce that comes from the under-served communities. In other words, it is -- diversity was very important.

The best way to do so is to create pipelines from those communities into those specific targeted specialties that you need for that region. And so I am more -- and I developed pipelines, not only through my pre-med mentorship programs from those under-served communities, but also developing residency, because the best predictors of where a person will practice is where they are from, and where they last train. So you need to develop pipelines and create residencies in addiction medicine in those under-served communities.

And so with that, I want to thank you. I want to make myself available to you as we address this pandemic the right

way.

And I yield back my time.

*Ms. LaBelle. Thank you.

*Ms. Eshoo. The gentleman yields back. It is a pleasure now --

*Mr. Guthrie. Excuse me, Madam Chair?

*Ms. Eshoo. Yes?

*Mr. Guthrie. Hey, it is Brett Guthrie. Hey, you made a comment between the last two questioners about research and fentanyl. And I am not speaking for every single Republican, I think, but for our side is that we just want to say we want to do research, but we don't think they are mutually exclusive, that you can have scheduling -- and there is a bill that I think Mr. Griffith and Mr. Crenshaw have allows for research to go forward, too.

So I just wanted to -- I know we don't have a chance to respond to that comment, I just wanted to respond to what you said between the last two.

*Ms. Eshoo. Yes, it is not a hit on anyone. I think there is bipartisanship on the -- always on the development of new drugs to --

*Mr. Guthrie. Absolutely.

*Ms. Eshoo. -- suppress whatever it is that is serious out there.

*Mr. Guthrie. Right.

*Ms. Eshoo. I thought it was, you know, important just to mention, and thank you for raising it.

*Mr. Guthrie. Thank you, I appreciate that.

*Ms. Eshoo. We can be for -- we can certainly be for both, and I believe that we are, and bills address it.

I now would like to recognize the gentleman from Indiana, Dr. Bucshon, for his five minutes of questions.

Great to see you. Look at that big smile. You make me happy, just looking at my screen.

*Mr. Bucshon. Yes, well, thank you, Madam Chairwoman. I very much appreciate it. And thank you to the panel.

I was a cardiovascular and thoracic surgeon before, so I have been in health care for over 30 years, and this is really a critical subject.

But before I get to my questions, I would like to share my concerns regarding one of the bills being considered today. Buprenorphine can be effectively administered by properly educated and trained providers who counsel and educate patients. However, the vast majority of individuals currently receive little or no counseling.

I have been working in Congress to implement prescribing limits and increased prescriber education for buprenorphine and other medication-assisted treatment to mitigate the practice of only treating people with medication-assisted treatment, but not continuing on with a more comprehensive

treatment plan.

However, not everyone agrees with this, and some of my friends continue to work on expanding the scope of practice to allow almost anyone, regardless of their qualifications and/or training, to prescribe buprenorphine. In my opinion, that is exactly what H.R. 1384, the Mainstreaming Addiction Treatment Act does. It removes education requirements and limits, making it easier to prescribe the medication known to be one of the most highly-diverted drugs in the country.

This bill will only expand access to medication, not real and effective treatment for individuals with substance use disorder. Everyone who is legitimately involved in the medication-assisted treatment space to treat people who are addicted recognize the importance of a comprehensive treatment plan. The last thing Congress should do is relax the requirements for prescribing and dispensing narcotic drugs such as buprenorphine because, as I mentioned before, expanding the use of medication-assisted treatment is not going to be effective unless we have a comprehensive treatment plan in place. So I would like to voice my opposition to this legislation.

Pivoting now to another topic, pain management is real, and people have chronic pain, and we must look -- all of us -- to finding non-opioid alternatives to use to help individuals that suffer from pain daily. Director LaBelle,

recently eight states have passed non-opioid directives that ensure non-opioid options are considered for the treatment of pain management. These directives are voluntary, and are intended to spur discussions between patients and providers around alternative ways to alleviate pain.

Does the White House support establishing a federal -- my question is, does the White House support establishing a federal, non-opioid directive to further empower patients and providers across the country to engage in important conversations around the need for non-opioid alternatives?

And are we -- also I would request that the White House consider reimbursement as an issue, as opioids are cheap, and new medicines are expensive. And what advice might you have to Congress in addressing that particular issue?

*Ms. LaBelle. Thank you, Congressman. So, on the first one, I think we could -- we would be happy to work with your office to get more information on that issue, on the directives.

On the second issue, the reimbursement rates certainly, you know, are something that we would have to speak with CMS about. And as we go forward in our national drug control strategy, which we will issue next year, we can certainly take a look at that.

*Mr. Bucshon. Yes, because that is one of the most important barriers for hospital systems or clinics, is,

again, opioids are very cheap, potentially new non-opioid alternatives are expensive. And when you look at, you know, bundled payments that -- based on diagnostic-related groups and other ways providers are reimbursed, it doesn't make a lot of economic sense, in many cases, to use non-opioid alternatives, and we need to fix that, because, whether we like it or not, in health care financial incentives drive the ship many times.

*Ms. LaBelle. Right, right.

*Mr. Bucshon. And so we need to address that. So I appreciate that.

You can also not properly combat the opioid misuse epidemic without addressing one of its root causes: again, as I just mentioned, inadequate pain management. HHS has included improving pain management as one of their pillars of the opioid strategy. What is ONDCP's position on improving pain management, provider education, and patient access to non-opioid therapies?

And that is just an extension of what I just mentioned.

*Ms. LaBelle. Sure. I think it is really important that we make sure that people who are -- have pain are treated properly, whether that is -- and what the alternatives are, that is an important issue that I know that the National Institutes on Drug Abuse have looked at, as well as the rest of HHS and CDC. So it is a very important issue

that we will look at, going forward.

*Mr. Bucshon. Thank you. I can -- I had a personal experience with my father, who has now passed away, had substantial back issues that, really, there was nothing they could do for him -- he was in his late 70s, early 80s -- other than opioids, unfortunately. And all of us are fighting the opioid epidemic. But what happened to him is -- in his home state -- is it became more and more difficult to acquire his medication, even through his primary care provider, because of things put in place at the state level.

So I just want to mention the pain -- chronic pain management is an issue. We need good opioid alternatives.

With that, Madam Chairwoman, I yield back. Thank you.

*Ms. LaBelle. Thank you.

*Ms. Eshoo. The gentleman yields back. It is a pleasure to recognize the gentlewoman from New Hampshire, certainly not a newcomer to this issue, offered really important insights and leadership on the whole issue of opioids, Ms. Kuster.

You are recognized.

*Ms. Kuster. Thank you so much, Chairwoman Eshoo, and thank you to Director LaBelle for joining us today. I am pleased to see that this Administration's priorities focus on evidence-based approaches that holistically address prevention, support, and treatment for those battling with

substance use disorder. And I think you can appreciate today, for many of us, this is a personal issue in our families, as well.

My legislation, the Emergency Support for Substance Use Disorder, was included in the American Rescue Plan to ensure smaller organizations on the front lines of the addiction crisis would receive support for their harm reduction services during COVID-19. I look forward to working with you.

I want to commend Representative Tonko's bill today about treatment at the end of incarceration, and I would like to meet with you about treatment during incarceration, so that we can break this terrible recidivism cycle that we are engaged in.

This is deeply personal. And New Hampshire has consistently had one of the highest rates of overdose deaths in the country. In 2019 my state ranked third for the most overdose deaths per 100,000 people. And we had the highest rate of fentanyl overdose deaths per capita in the United States for many years. In 2020 about 65 percent of the overdoses in New Hampshire were caused by fentanyl, or a combination of fentanyl and other drugs, as we have heard today.

But we know this is not just happening in my state. My colleagues all have similar stories about how the opioid

crisis has evolved into an overdose crisis at the hands of synthetic opioids.

Now, at the same time, the Drug Enforcement Agency has had the ability to go after the proliferation of fentanyl-related substances through emergency class-wide scheduling. Despite this tool, we have seen the continued upward trend of overdose deaths related to fentanyl and its analogues. And that is why I have introduced, with my good friend and colleague, Congresswoman Blunt Rochester, the Stop Fentanyl Act to provide a comprehensive, balanced public health approach.

Director LaBelle. You have said the Administration is supportive of this short-term extension, but could you explain, as specifically as you can, how another temporary extension is necessary to explore a more comprehensive and effective approach to fentanyl-related substances?

*Ms. LaBelle. Sure. Thank you, Congresswoman, and thank you for your work on this issue.

I think that we need the extension because we need a little bit more time to -- you know, we have only been in this position for about 85 days. There are many people who aren't even in place yet. This is a critically important issue, and we want to do it right. So we need the time to look at the mandatory minimum implications of this legislation, as well as the research implications that have

come up several times on both sides of the aisle. So that is why we need the extension of time.

*Ms. Kuster. And if I could press you a bit further, what is the plan to use that time effectively, so we won't be back in this same situation if we grant a seven-month extension?

*Ms. LaBelle. Sure. I mean, so the plan is that, you know, it is a process plan, which is we get our colleagues together from the Department of Justice, we get our colleagues together from HHS, and we hash this out. We have had a couple of meetings already. We are going to have more, and we are going to come together and have a resolution of the issues.

*Ms. Kuster. And how can we work with you to make sure that we address the issue of racial equality?

I am very concerned, as many of us are on both sides of the aisle, about the disparate impact on race with these mandatory minimums. How can we do a better job with a public health approach, rather than being so focused on mandatory minimums, when we know we are not getting the treatment into the jails and prisons across this country?

*Ms. LaBelle. Yes, so we know that incarceration rates are higher for poor Black Americans, and the work that has to be done in jails across the country, we are getting there. Certainly, New Hampshire has medication, most of the New

England states do. There is a lot more work that needs to be done.

I am encouraged by the Congress's help, though, to provide funds through the Department of Justice to expand access to treatment in jails.

*Ms. Kuster. Well, we would love to meet with you. I will set that up. We have game-changer legislation that would eliminate the exclusion of Medicaid during incarceration. And I think it would really change the scope. We would be talking about treatment. We would be talking about support services, and we would help people get back on their feet and lead much more productive lives.

So with that, I yield back, and thank you.

*Ms. Eshoo. The gentlewoman yields back. I would like to recognize the gentleman from Georgia, Mr. Carter, our favorite pharmacist.

*Mr. Carter. Thank you, Madam Chair. I appreciate that very much. And thank you for being here. We appreciate this very much, this is extremely important.

I wanted to mention, first of all, that I understand we don't have jurisdiction over the border in this committee. But I do want to bring up the border crisis, as it is impacting this epidemic. And I know that because I was there last week. I was there last Friday.

The GAO has reported that Customs and Border Patrol data

at U.S. ports of entry at the southern border show seizures of fentanyl and its analogues have gone up more than 200 percent in the last couple of years.

Ms. LaBelle, is it correct the majority of fentanyl and its analogues come through the southern border from Mexico?

*Ms. LaBelle. Most -- well, much of fentanyl certainly is seized at the border. We are getting some that comes through couriers. So mail systems, that is much reduced, but much of it comes -- is seized at the southern border.

*Mr. Carter. Well, from my investigation of it, my studies of it, what I have seen is there is enough fentanyl coming across the southern border to kill every American several times over. So I think it is really a stunning problem.

Again, I want to allude back to my visit this past Friday to the border, and what I witnessed there, because, listen, these cartels, they are not dumb. In fact, they are very smart. And what they are doing is flooding the border in one area so that it takes the attention of Customs and Border Patrol agents, and then they are just bringing drugs across at another point. It is causing us to have even more of a problem.

Obviously, we have got a humanitarian crisis down at the border, with what is going on with the illegal immigrants. But we have also got another problem, and that is a national

security problem with our -- with all of these drugs that are coming across this border. We have got to get this under control.

You know, it would be easy for all of us just to sit back and think, oh, what is happening down there is just a problem at the border, and those poor people down there. But it is much more than that, because when we talk about fentanyl, when we talk about illegal drugs, those drugs that are coming across that border, they are going to be in your community next. Whether you are in Georgia, whether you are in the northern United States, or the northeast, or the northwest, it is going to be impacting you.

And that is why it is such a big problem. It is killing people in our communities. Just this past week, in Georgia, we had two incidents of fentanyl overdoses, one in Richmond County near Augusta, one in Chatham County near Savannah, where my district is. And that is a problem that we have got to deal with, and it is a problem that is being exacerbated by the fentanyl that is coming across the southern border, and coming across from Mexico.

I wanted to ask you, Ms. LaBelle, would you agree that you have an obligation to advise the President, as he must get the border under control, because the epidemic that we are discussing today has gotten much, much worse -- have you discussed with the Vice President or the President the harm

an open border is having on the opioid epidemic, specifically the trafficking of fentanyl?

*Ms. LaBelle. So we are working very closely with all of our White House colleagues on this issue. We are separating the migrant issue from the drug issue. And that is where we have ongoing conversations on a monthly basis with the Government of Mexico and with our law enforcement partners, to make sure that they are doing everything they can to interdict the synthetic drugs that are coming from China into Mexico. So certainly these are ongoing conversations, and particularly with the National Security Council.

*Mr. Carter. So I want to make sure I heard you right. You said these are monthly conversations, that you only discuss them once a month?

*Ms. LaBelle. With Mexico.

*Mr. Carter. With Mexico. But in the Administration, with the Vice President --

*Ms. LaBelle. Oh, no, we have --

*Mr. Carter. That was --

*Ms. LaBelle. I am sorry, sir. We have ongoing conversations with our colleagues throughout the White House on this issue on a daily basis.

*Mr. Carter. We were told last week when we were down there that over $400 million of illegal drugs crossed that

border last month, that we know of. That, to me, is substantial. And I think to everyone in America it would be substantial. Don't you feel like this deserves more immediate attention than what it is getting at the White House right now?

*Ms. LaBelle. I think that everyone is paying very close attention to the issue. Certainly, the issue of how many drugs are coming through can be a matter of enforcement, because that is what we are seizing. That is not necessarily -- it is hard to tell what it is when --

*Mr. Carter. And that is why I mentioned $400 million of what we know of, because what is happening is the Customs and Border Patrol agents, as you know, are having to be in the processing facility, and they are not able to monitor the borders. Therefore, we are not catching as much as what is coming across. So we don't really know the true number, but we know it is more than 400 million.

Okay, well, listen, this deserves immediate attention, Ms. LaBelle.

*Ms. LaBelle. Yes, sir.

*Mr. Carter. I hope you will go back to the White House immediately. And listen, we have got to get this stopped.

Thank you, Madam Chair, and I yield back.

*Ms. LaBelle. Thank you.

*Ms. Eshoo. The gentleman yields back. It is a

pleasure to recognize the gentlewoman from Illinois, Ms. Kelly.

*Ms. Kelly. Thank you, Madam Chair. The Biden-Harris Administration's statement of drug policy priorities for year one, published by the Office of National Drug Control Policy, stated, and I quote, "Black individuals generally entered addiction treatment four to five years later than White individuals. And this effect remains when controlling for socioeconomic status.''

Have plans been identified on how to ensure that Black people have more timely access to evidence-based care that includes prevention, harm reduction, treatment, and recovery services?

*Ms. LaBelle. Thank you, Congresswoman. So we included that in there in order to make sure that we can work with HHS to look at the data, to look at the research, just what we identified in our policy priorities, and then put in place specific programs that can handle -- that can tackle those issues.

We want to do more than just a program that sounds good, or looks nice. We want to put in programs and policies that are really going to make a difference once and for all on this issue. And it is not going to happen overnight.

I mean, one of the first steps is making sure that we acknowledge this is an issue, and then we are going to work

with HHS to put plans in place that are going to make a difference on it.

*Ms. Kelly. Thank you. In the HHS OIG report titled, "Geographic Disparities Affect Access to Buprenorphine Services for Opioid Use Disorder,'' 40 percent of counties in the United States did not have a single waivered provider, and waivered providers were not necessarily found in areas where the need for the treatment is most critical.

How can we ensure equity of access for geographic locations, and is telehealth a tool that we can use to ensure provider equity?

*Ms. LaBelle. Thank you. So this raises the issue that we talked about before with methadone clinics, that -- you know, so you can go to an office and get your buprenorphine, a doctor's office. If you are going to a methadone clinic, you are probably standing out in the street corner, waiting to get in. So much less private, much less personal care.

Certainly, there are a lot of great opioid treatment programs around the country that provide methadone, but it is a different form of care.

So how we tackle this is, number one, removing barriers to buprenorphine treatment to expand the number of providers -- not just physicians, but nurse practitioners and physicians' assistants -- so that we can reduce those barriers to care that occur around the country.

*Ms. Kelly. And can you give more insight on why providers must receive a waiver to provide medication to treat opioid use disorders, but not to prescribe the medications that have gotten us to where we are today? This seems counterproductive.

*Ms. LaBelle. Sure, thank you. So I think the issue is that we have -- as we have spoken about, we really have minimal training and education in addiction in the health care services. And so, in order -- and so, you know, people who are prescribing buprenorphine are required to go through that training, the eight-hour training, because they may not have ever really encountered or have a lot of knowledge about the treatment of addiction.

So I think what we really need to do is expand the number of people in our health care system who understand how to screen and treat and help people recover from addiction, as opposed to hinging it all on this one medication.

*Ms. Kelly. Okay, thank you so much. And Madam Chair, believe it or not, I will yield back.

*Ms. Eshoo. The gentlewoman yields back, and now I have the pleasure of recognizing the gentleman from Florida, Mr. Dunn, for your five minutes of questions.

*Mr. Dunn. Thank you very much, Madam Chair. You know, the increase in fentanyl throughout the United States, including Florida, is deeply troubling. Sadly, this has been

a growing problem in my district, too.

Just last month the Panama City Police Department arrested a man with 90 grams of fentanyl. That is more than 43,000 lethal doses of this drug. And for perspective, that is enough to kill over half of the population of Panama City.

On the other end of my district, the Ocala Police Department seized 177 grams of fentanyl in a single bust just last fall, and the police chief there said that that was enough fentanyl to kill, with overdose, every person in Polk County, man, woman, or child.

When using fentanyl for medical purposes, a typical dose would be 25 micrograms. That is 25 millionths of a gram. Doctors always use this drug very, very cautiously, with extreme care, because even the medical formulation of fentanyl is extremely potent and potentially hazardous.

Florida law enforcement is doing a heroic job getting it off the streets, putting traffickers behind bars. However, they need help. Fighting fentanyl requires a team effort among the trade and shipping industries, law enforcement, health care professionals, community leaders, and lawmakers.

And I want to associate myself with the comments made by my colleague, Dr. Bucshon, regarding the dangers of making access to Buprenorphine and Suboxone too easy. Because honestly, these are drugs that are used -- Buprenorphine is the single most common cause of opioid overdose in northern

Europe. So we have to be careful. We have to get this in the hands of skilled people who know how to use it safely.

And I do have some questions, but I will be submitting those to the second panel of witnesses. So with that, Madam Chair, I yield back. Thanks so very much.

*Ms. Eshoo. The gentleman yields back, and I thank him for his questioning, and it is a pleasure to recognize the gentlewoman from Delaware, Ms. Rochester Blunt -- Blunt Rochester, I am sorry. You need to unmute.

[Pause.]

*Ms. Eshoo. You need to unmute. Lisa?

[Pause.]

*Ms. Eshoo. We will get this one of these days, right?

*Voice. I don't think she can hear you.

*Ms. Eshoo. I don't think she hears us, so I think I will go to -- Angie Craig?

*Voice. Angie Craig.

*Ms. Eshoo. We will go to the gentlewoman from Minnesota, Angie Craig, for her five minutes of questions, and then circle back with -- I hope Ms. Blunt Rochester's staff is listening, but we will -- Ms. Craig is -- Representative Craig is recognized for her five minutes of questions.

Are you with us?

No?

*Voice. Schrier.

*Ms. Eshoo. All right, then we are going to go to another doctor, the gentlewoman from Washington, Dr. Schrier.

It is great to see you.

*Ms. Schrier. Well, great to see you, and I am now unmuted. I was just texting Lisa to see if I could let her know. Thank you, Madam Chair, and thank you to Ms. LaBelle for sharing how the White House is going to be focusing on these issues.

You have already heard that Washington State has been hit hard by this opioid epidemic. For over a decade, our state has lost about 700 people per year from overdoses, mostly from opioids. And sadly, we saw a 40 percent increase in mortality due to opioid use in 2020.

So we know fentanyl, in particular, has become an increasingly dangerous threat in my state and, as we have heard, across the country. In 2019, three students in my district died because the Oxycodone that they thought they were taking, which is bad enough already, was laced with fentanyl. And two were students in the high school just down the street from my house.

Then, two days ago, in a conversation with another parent, I heard about a bring-your-own-pill party, where a group of high school seniors in my town all brought whatever pills they had to a party: Ritalin, Adderall, Oxycodone,

Vicodin, whatever. They dumped it in a bowl like M&Ms, and then helped themselves without even knowing what they were taking. And this is barely one year after the two deaths that I just mentioned.

So, Ms. LaBelle, you mentioned in your testimony that one of your strategies to mitigate drug abuse and death is support evidence-based prevention efforts to reduce youth substance abuse. And as a pediatrician, I know how important it is for pediatricians to talk with their patients, and parents to talk with their children. I wonder if you could just talk briefly about the most effective ways to prevent these risky behaviors from starting, and then these tragedies.

*Ms. LaBelle. Thank you very much, Congresswoman, for asking that important question. I want to raise one issue about the pressed pill issue that you raised. I think all of us need to be aware that this is a trend. CDC has sent alerts about these pressed pills. That is a lot of what we are seeing. This is pure fentanyl, and people have no idea what they are getting. And this is why the Administration has put out the fentanyl test strips, so people who -- can test what it is that they are getting. I am not talking about that for youth use, but that is important for -- to prevent overdose deaths.

So for youth use, the National Institute on Drug Abuse

has some great tools. SAMHSA -- I am a parent myself. I probably drive my son crazy by talking to him about these issues so much, because he has a genetic predisposition to this. So I -- you know, you have to -- there is a -- SAMHSA has a "you talk, they listen'', which is a great tool. And actually, the University of Washington has some great prevention programs, and one of the preeminent prevention researchers in the country is there.

So there -- we can't -- we think that kids won't listen. Certainly, they are going to roll their eyes, but they will listen to you when you talk to them.

The other piece that we want to do on prevention is preventing adverse childhood experiences that lead to risky behavior, and that includes substance use. So that is an area that we will be working more with the Centers for Disease Control and Prevention on, particularly with our drug-free community coalitions.

*Ms. Schrier. I really appreciate you bringing all those things up. Can I ask just a quick follow-up question on the fentanyl test strips?

Are those -- are the pills -- do they contain fentanyl only on the outside, or throughout?

I mean, is this something we have to crush a pill to test strip it, or can you just rub it on the outside of a pill?

*Ms. LaBelle. You could -- you wet the test strip, and you can rub it on the outside of the pill.

Again, these are -- you know, these are -- there are various forms of this, but in many cases it is pure fentanyl.

*Ms. Schrier. Okay. It is devastating. Thank you.

Also, with the limited time I have left, you know, one of the barriers to care that we have all talked about is simply not having enough access to providers who are trained and confident in treating substance abuse disorder. In particular, most pediatricians have no experience with medically-assisted treatment. And I was wondering what ONDCP's role is in ensuring that there is a broad provider network that is adequately trained, and where pediatricians might fall in that plan.

*Ms. LaBelle. So the pediatrician association actually encourages, as you are probably aware, screening for all of their patients. So we want to work with them again on expanding that work.

*Ms. Schrier. And screening is standard. Treatment, not so much --

*Ms. LaBelle. Right --

*Ms. Schrier. -- pretty intensive appointments. Do pediatricians generally get the special training?

*Ms. LaBelle. No, they don't. So we need to -- we will be happy to work with you on that issue.

*Ms. Schrier. Thank you, I yield back.

*Ms. Eshoo. The gentle doctor yields back, and it is a pleasure to recognize the gentleman from Pennsylvania, Mr. Joyce, for your five minutes of questions.

*Mr. Joyce. Thank you, Chairman Eshoo, and thank you, Ranking Member Guthrie. This is an important discussion that we have, specifically discussing the epidemic that we face within the pandemic.

In Pennsylvania, where I represent, the availability of illicit drugs, and specifically fentanyl, is a crushing blow to our local communities. In joining this COVID-19 pandemic, this epidemic has spiraled further out of control. In 2020, Blair County, my home county, we have seen an 80 percent increase in overdose deaths, 80 percent.

Coroner Patty Ross, she can rattle off these statistics in a breath, and she will tell you that fentanyl can be 100 times more potent than morphine. Coroner Patty Ross knows how many families have been torn apart, how many children have suffered from drug-related circumstances. She has witnesses -- she has been a witness to tragedies firsthand. She talks about addressing families, talking to them as she relays the tragedy of the death of a loved one, talking to them about these loved ones who have just come out of rehab.

In Pennsylvania and around the country, Coroner Ross and other local leaders, they are desperate for Congress to get

serious about combating fentanyl and illicit drugs, providing support to the brave Americans in recovery, and advocating for communities with the widespread ramifications of substance abuse and addiction, and addressing what we need to address: the stigma of drug abuse. We need to be taking action right now to keep our communities safe. But also, we need to expand lifesaving treatments for those who have substance abuse disorders.

Director LaBelle, shortly before leaving office, the previous director of ONDCP, James Carroll, announced new practice guidelines for the administration of Buprenorphine for treating opioid use disorder. And these guidelines were intended to make it easier for practitioners to prescribe Buprenorphine. As I understand it, on January 14th the Biden Administration made a statement saying that those guidelines were issued prematurely, and could not be sustained.

Director, could you please tell us why these guidelines were pulled?

*Ms. LaBelle. Sure, thank you, Dr. Joyce. These are important issues that you just raised. We all want to expand access to evidence-based care. The practice guideline that was rescinded by the Administration, or that is being reconsidered, and making sure -- what we don't want to do is to issue a practice guideline that would not be upheld, or would not withstand legal scrutiny.

So we are taking a look at it to make sure that anything else that is issued can withstand any kind of legal challenge to it. So that is where we are at right now.

*Mr. Joyce. And what is the current status of your evaluation for renewing these guidelines?

*Ms. LaBelle. We are taking a look with our lawyers on it to make sure that it gets issued. So we are working on it. I can't give you a precise timeline right now.

*Mr. Joyce. The previous Administration came up with rural guidelines addressing substance abuse. In the rural communities throughout America, as you pointed out, as well as in the metropolitan areas, these substance abuses still exist. And we are looking forward to having the answers to when these guidelines will be reissued.

Can you assure us, so I can take back to the corners, to the leaders who are facing these issues, that this is of utmost concern to you, as the acting director of the ONDCP, as it was to your predecessor?

*Ms. LaBelle. Absolutely, sir.

*Mr. Joyce. Can you provide for us additional guidance of what we should be doing, from a legislative point of view, to aid you in making this decision?

*Ms. LaBelle. So I think that what we want to make sure is that, when it is released, that it is lifted up.

But we can't stop there. We have a lot more work to do.

Our policy priorities lay out our expansive approach to this, because it can't -- we can't just look at one tool. We have to look at all the tools available to address every form of addiction, not just opioid use disorder. So we are looking forward to working with you on the totality of the addiction epidemic.

*Mr. Joyce. I thank you for your hard work, and I look forward to seeing the guidelines on the administration of Buprenorphine for treating opioid disorders. Thank you for being here today.

And again, thank you, Chair Eshoo and Ranking Member Guthrie.

*Ms. Eshoo. The gentleman yields back.

And I apologize to you, Dr. Joyce. I think it is very important, when recognizing our physician members, that it -- that that always be stated. So apologies to you.

*Mr. Joyce. Not necessary, Chair. Thank you, though. I appreciate that.

*Ms. Eshoo. We are very happy to have you as a member of our subcommittee.

*Mr. Joyce. It is an honor, thank you.

*Ms. Eshoo. Oh, you are very nice. You are such a gentleman.

And now I recognize with pleasure, from Delaware, Congresswoman Lisa Blunt Rochester.

I am sorry that you didn't hear us earlier.

*Ms. Blunt Rochester. Thank you so much, Madam Chairwoman. And forgive me, I am on two screens at the same time, so please --

*Ms. Eshoo. Not to worry, not to worry. We see you and hear you now.

*Ms. Blunt Rochester. Thank you so much. And I want to thank you, Ms. LaBelle, for joining us as well, and for your work and dedication.

Under the previous Administration, the approach towards fentanyl-related substances was handled through policies that more promoted decriminalization and not public health. And evidence shows us that that isn't the most effective approach.

The U.S. Sentencing Commission's January 2021 report on fentanyl and fentanyl analogues found that, in fiscal year 2019, a greater proportion of fentanyl and fentanyl analogue offenders were Black, and over half of the total offenders were convicted of an offense with a mandatory minimum penalty. But less than 10 percent of offenders knowingly sold fentanyl and fentanyl analogues as another substance.

I am seriously concerned that our efforts are targeting minimally-involved individuals, instead of the higher-up traffickers and cartels. What is the Administration's plan to stop illicit fentanyl from coming into the country, so we

are targeting the drug traffickers that are manufacturing fentanyl and placing it into the drug supply?

*Ms. LaBelle. Thank you, Congresswoman, for that important question.

So, you know, when -- the Office of National Drug Control Policy works a lot on international issues. I would say it is probably half of the time in our office. And so we are working with China to look at their regulatory controls over their vast chemical industry. We are also working closely with Mexico on their interdiction efforts inside Mexico, as well as destroying and using evidence from their labs, their lab takedowns, and then -- as well as working with them on how to identify some of the precursor chemicals that are coming from China into their ports.

So those are numerous -- a number of issues that we are dealing with with China and Mexico right now to stop it from ever coming into the country.

*Ms. Blunt Rochester. And can you be more specific about the length of time that you would need to come up with the permanent solution of -- because I know a couple of people have asked this, and because time is of the essence, it would be really good if we could get a clearer picture of the specific length of time that you would need.

*Ms. LaBelle. Yes, thank you for asking that. It is urgent. We know it is urgent. I can't give a timeline. As

I said, you know, we have been here about 85 days, and there are plenty of people at DOJ who aren't in place yet. So I can't give a timeline, but know that we are working diligently on this issue.

*Ms. Blunt Rochester. And thank you. I know that you are aware that overdose deaths involving synthetic opioids like fentanyl continue to rise, and from 2017 to 2018 rose as high as 10 percent. If we don't pursue a public health approach as part of the solution for addressing fentanyl-related substances, as Representative Kuster and I are suggesting, what would be the impact on people with substance use disorder, and how will their access to evidence-based treatment change?

*Ms. LaBelle. So the public health approach that we have laid out in our policy priorities identifies the specific actions we can take, as -- such as harm reduction programs that can prevent people from overdosing.

I am very concerned that, if we don't expand access to evidence-based treatment throughout the country, especially in areas of high risk for overdose, that these rates are just going to continue to climb. And I have been working on this issue since 2009, when it first started. And it is -- and the steps that we are taking are -- every day counts at this point.

*Ms. Blunt Rochester. Yes. Will ONDCP commit to

working with Congresswoman Kuster and I on a comprehensive public health approach to addressing the overdose epidemic?

*Ms. LaBelle. Yes, we look forward to working with you, absolutely.

*Ms. Blunt Rochester. Thank you so much, and I yield back my time.

*Ms. Eshoo. The gentlewoman yields back. It is a pleasure to recognize the gentleman from Utah, Mr. Curtis, for your five minutes of questions.

*Mr. Curtis. Thank you, Madam Chair. I enjoyed the interchange between you and Dr. Joyce. I am wondering if there is a title that we should use for those of us that have put children through medical school. Maybe we could work on that. And you are on mute, so I am just going to keep going, Madam Chair.

Director, four in 10 adults -- and this is as reported by the Huntsman Institute of Mental Health -- have reported new symptoms of anxiety and depression disorder, which is a fourfold increase since last year. And so, to state the obvious, this hearing couldn't be more important, couldn't be more timely, and the work that you do.

I am grateful for Representative Scott Peters of San Diego. He and I recently reintroduced a bill, H.R. 2051, which would declare meth an emerging drug threat. And I want to thank Congressman Peters for his leadership on this issue.

It is an important issue to both of us in our districts, and we view it as the first of many steps in continuing to fight substance abuse.

The legislation would require the Office of National Drug Control Policy, you, to develop a strategy to prevent the sale and use of this drug. We have touched on meth a little bit in this hearing. Can you just share, from your perspective, where this fits in with the larger picture of what you are seeing across -- with meth across the United States?

And specifically, what can Congress be doing to help you?

*Ms. LaBelle. Sure. Thank you. So our policy priorities include contingency management, and looking at the barriers to expanding access to contingency management therapy, which is an effective tool to use for people with meth use disorder.

Our policy priorities also include an emphasis on prevention. So that is another tool that we need to use to reduce meth use.

And then also, our policy priorities include disrupting the drug supply coming in from Mexico, which is where much of our methamphetamine is sourced. So all of that is part of our priorities for us that we will be looking at in the first year.

As far as what Congress can do, I think that we may be coming back to on contingency management, to see if there are legislative barriers to expanding that. I think the most important thing that Congress can do is making sure that we have sustainable funding for a lot of these programs, particularly for prevention and treatment, so that the states are not reliant and local communities are not reliant on one-time grants that may not help them address the totality of the issue.

*Mr. Curtis. Thank you, a very good answer.

I have listened, as my colleagues have all expressed -- many have expressed close loved ones and people they know who have been impacted by this tragic problem. It came home to me and my wife with not only some of our loved ones, but this summer, when we purchased a home, we kind of randomly did a meth test that -- we were purchasing a home from a couple that had passed away in old age, and we were surprised to find out the home had been used as a meth lab. And I think that is just a small indication of what is going on across the United States.

Quickly, I represent a very rural community with very limited resources, particularly for law enforcement, a vast geography, very, very difficult for law enforcement to cover it, which poses a challenge to crack down on this. Are there ways that we can leverage machine learning?

Have you spent any time on this, by using data collected by law enforcement agencies and public health agencies on drug overdose in certain communities to help augment the local authorities in rural areas?

*Ms. LaBelle. So ONDCP funds ODMAP, which gets information from local law enforcement that helps kind of identify trends. That is in all 50 states, but it is not universal. That is one tool.

We also should be working with our partners at the Bureau of Justice Assistance and the COPS program to look at exactly those issues that you just raised, because we know law enforcement in rural areas is stretched thin.

Our High Intensity Drug Trafficking Areas Program works with a lot of law enforcement in rural areas, and that is a force multiplier for a lot of rural efforts.

*Mr. Curtis. Yes, thank you for appreciating the special needs in rural.

It has been touched on a lot today, so I am only just going to mention -- not ask the question, but just -- I want to reemphasize the conversations we have had today about telehealth, how important it is in these rural parts of my district.

And with that, Madam Chair, I yield my time.

*Ms. LaBelle. Thank you.

*Ms. Eshoo. I agree with you on telehealth. I think

that -- and I think other members believe that it should be made permanent. So we have our work to do on that.

I don't think there are any other Republicans that need to be recognized. I see Mr. Latta, but I know that you are interested in panel two, is that correct?

Okay, so we have two Democrats, and then we are going to go to -- or we might have another one, I don't know, but I have two lined up right now.

And then, members, we do have a second panel with five witnesses that are waiting in the wings for us. So I will recognize the gentlewoman from Minnesota, Ms. Craig, for her five minutes.

*Ms. Craig. Well, thank you so much, Madam Chair.

Acting Director LaBelle, thank you very much for your testimony today. Your experience and your expertise is greatly appreciated.

As many of you aware, over 20 million Americans struggle with substance use disorder. A significant portion of them have an opioid use disorder. Moreover, many overdose deaths involve opioids such as illicit fentanyl and fentanyl-mixed substances. The DEA recently cited fentanyl-mixed cocaine and meth as an accelerant of overdose deaths, due to its widespread availability. This trend is reflected in my home state of Minnesota, where an overwhelming majority of opioid overdose deaths involve synthetic opioids. Unfortunately, it

is likely we are going to see a record increase in those deaths from 2020.

I recently hosted a roundtable in my district that addressed veterans' access to mental health services, and the disproportionate rate of substance use disorder among veterans. One of the barriers to care raised by stakeholders is the stigma that often surrounds substance use disorders, an issue I know is not limited just to this nation's veterans.

It is critical to remember that substance use disorders a treatable disease. People with substance use disorder deserve compassion and adequate access to affordable, quality care. The problem won't be solved in jails and emergency rooms. It will take a shift in attitudes by many of the stakeholders involved.

So Acting Director LaBelle, how does ONDCP hope to reduce stigma associated with substance use disorders through its drug policy priorities in year one?

*Ms. LaBelle. Thank you for asking that important question, Congresswoman.

So the first step we took, and that happened during the transition, was hiring people, bringing people on who are in recovery. Our chief policy adviser is a person in long-term recovery. Our outreach director is a person in long-term recovery.

And we are expanding a lot of our work on talking about recovery and making -- because really, when you look at our policy priorities, all of these barriers really go back to stigma, the stigma that is attached to addiction. Why don't people want to treat addiction? There is stigma attached to it. Why don't people want to seek out help? Because there is stigma attached to it.

So the first step we can take, as ONDCP, is setting an example, and involving people who are in recovery in the policy-making process.

*Ms. Craig. Thank you so much. And I know stigma is one part of this that you are focused on, but also folks face barriers due to lack of access to coverage. So what levers is your office using, can you use, to address the access to care in the long term?

*Ms. LaBelle. So there are lots of pieces to this. One is we are going to focus on parity to make sure that coverage, insurance coverage, is -- that people are complying with parity.

The other access-to-care pieces are -- involve workforce. How do we improve the workforce access throughout this country, and then also identifying, you know, the barriers to treatment with Buprenorphine, methadone treatment, and contingency management services.

*Ms. Craig. Let me ask you what you think Congress can

do to build on the previous legislation that we put forward, particularly around reduction of stigma. What are the most important couple of things that we could be focused on that helps you reduce stigma when it comes to this particular disease?

*Ms. LaBelle. Thanks. So I think one thing we can do is to make sure that Congress, by looking at this as an ongoing issue -- this is not a -- these are chronic conditions, not acute conditions, that require sustainable funding over the long term. So if we -- by having Congress make sure that we are recognizing that these are not acute conditions, that people don't go into treatment and then 20 days later they are cured, that recovery services are part of the continuum of care, and continuing to emphasize recovery services is important.

*Ms. Craig. Well, thank you so much, Director LaBelle, and I look forward to working with you and the Biden-Harris Administration.

Madam Chair, with that I will yield back.

*Ms. Eshoo. The gentlewoman yields back, and we thank her, and we now will go to the gentlewoman from Massachusetts, Mrs. Trahan, for your five minutes.

And thank you for your patience. You have been with us from the very -- as most members -- from the very beginning of today's hearing.

*Mrs. Trahan. Well, thank you --

*Ms. Eshoo. And it is now afternoon.

*Mrs. Trahan. Yes. But it is such a critically important hearing, and I thank you for convening us on this topic. Certainly my thanks to Director LaBelle for being here today. And we all look forward to working closely with you and ONDCP in the months and years ahead to push policies that take a multi-pronged approach to curb overdoses.

You know, the substance use disorder epidemic has claimed too many lives in all of our districts, red and blue alike. And over the last 20 years our nation has lost more than 750,000 lives due to drug overdoses. The latest CDC data suggests that the coronavirus pandemic has triggered an acceleration in lives lost to overdoses.

Now, anyone with a loved one who has suffered from this terrible disease knows how powerful addiction can be. It can appear to have an unbreakable hold on those in its grip. My heart certainly goes out to those suffering from substance use disorder. You know, I have met with too many moms who have lost a child, the worst thing a parent can even imagine, and they and their families deserve our compassion and acceptance, free from judgment.

But we also owe it to all of our constituents, particularly our young people, to do more to defeat SUD through greater attention to preventative measures, and

safer, effective treatment options. The Medication Access and Training Extension Act, legislation I have introduced with Representatives Kuster, Carter, Trone, and McKinley would ensure that most DEA-licensed prescribers, at a minimum, have the baseline knowledge to treat and manage their patients with substance use disorder.

So Director LaBelle, in your written testimony you say that the origins of the overdose epidemic began with prescription opioids. Current CDC data shows that overdose deaths involving prescription opioids more than quadrupled from 1999 to 2019. How does prescription drug misuse continue to contribute to the overdose and overdose death epidemic in our nation today?

*Ms. LaBelle. Thank you, Congresswoman, for asking that. So it continues to be part of the issue. As I said, our policy priorities focus on the addiction epidemic. And so there are certainly specific prevention tools that we can use for each substance. So in that regard, prescription opioids as a driver is -- of later substance use disorders is important.

But we are really taking the entirety of the addiction epidemic, and looking at it from how do we prevent, treat -- have quality treatment, provide harm reduction services, and help people recover. So that is really our -- the extent of our continuum of care that we are looking at implementing.

*Mrs. Trahan. So many prescribers must take some sort of, say, prescribing education, but few take substantial education on how to identify, treat, and manage their patients with opioid and substance use disorder. You know, Dr. Ruiz said it himself, that many patients with SUD enter medical offices and emergency rooms for separate medical reasons. And so the ability of physicians to identify the more subtle signs of SUD is critically important.

Does the Biden-Harris Administration believe that it is the responsibility of all prescribers with a DEA license to know how to identify, treat, and manage their patients with opioid and substance use disorder?

And would this education increase access to care?

*Ms. LaBelle. Yes, if we recognize that addiction is a chronic disease, then it is up to the health care community providers, health care providers, to be able to recognize it, screen for it, and treat it, or at least refer people to treatment. But if they can't identify it, they are not going to screen it or treat it.

So I think that that is something that we have long emphasized is the importance of addiction training in medical schools for DEA-licensed providers. And I think it is something we need to look at.

*Mrs. Trahan. And certainly one of the best things that we could do to, as Congresswoman Craig said, accelerate the

end of stigma associated with addiction.

Thank you, I yield back the remainder of my time.

*Ms. LaBelle. Thank you.

*Ms. Eshoo. The gentlewoman yields back. It is a pleasure to recognize the gentlewoman from Florida, Ms. Castor, for your five minutes of questions.

*Ms. Castor. Well, thank you, Madam Chair, and thank you so much for your leadership on this very important issue. I know you have seen today that all of the members, we are really interested and concerned about substance use and misuse.

And thank you, Acting Director LaBelle, for spending some very -- a lot of quality time with the committee today. And thank you for your leadership. I want to -- I have two real quick questions. One is going back to Dr. Schrier's attention to prevention, especially among young people.

And one of the bills that is on our list today is the Drug-Free Communities Pandemic Relief Act. You identified in the -- in your -- the national drug control strategy that this is an essential element to prevent and reduce drug addiction misuse among young people. The -- that bill would waive the local matching requirement during the pandemic, because many of these local community groups simply haven't been able to make that local match.

Can you share with me why that is important at this

time, and what you are hearing from drug-free communities across the country?

*Ms. LaBelle. Sure. Thank you, Congresswoman. So the Drug-Free Community Coalition is -- one of the great things about them is that they are community-based, and -- but they rely upon in-kind contributions. In-kind contributions that we found in the last year during COVID have been -- there have been shortfalls in that. And so helping Drug-Free Community Coalitions in that regard is very important. They -- we know that Drug-Free Community Coalitions reduce youth substance use, and that is an important tool that we can use to reduce addiction, overall.

*Ms. Castor. Thank you very much. And that is what I hear from folks back home, as well. The issues that are so complex these days -- but there has been a drop-off on community support, and I think this would go a long way to helping keep all of those coalitions moving forward and focused on youth drug use prevention.

So my second question is a much broader one on the American Rescue Plan. We are so proud of the depth and breadth of the American Rescue Plan recently signed into law by President Biden. It provides, just in this area, $4 billion to SAMHSA and HRSA for a lot of the issues that your office will oversee.

Give us a good thumbnail sketch on what you are working

on right now, in coordination with those agencies and our local partners, to ensure that those dollars get to communities and families that need them. Will -- we -- are you coordinating the guidance that will be issued from the agencies, and what can we expect?

*Ms. LaBelle. Thank you. So the -- HHS, SAMHSA, the Substance Abuse Mental Health Services Administration, we are working closely with them on what this is going to look like, because, I mean, the good thing is that this funding can be spent over a period of time so that states aren't going to get this huge influx of money that they have to spend in a year. So there will be a more sustainable funding source for them.

So we are talking to SAMHSA about, you know, what are the gaps, what is missing, who are the vulnerable groups. That is -- so because this money is going through the block grant, it will be easier to facilitate that funding. So it is a great opportunity to really make a difference on this issue.

*Ms. LaBelle. I agree. We are all so proud of what we have been able to do in the American Rescue Plan. And a lot of folks are focused, of course, on vaccinations and the stimulus payments, and kids in school safely. But there are very significant dollars for our local communities when it comes to behavioral health. So thank you so much, and we

will look forward to working with you in future months.

*Mrs. Trahan. I yield back.

*Ms. Eshoo. The gentlewoman yields back. It is a pleasure to recognize a fellow Californian, Mr. Cardenas, for his five minutes of questions.

*Mr. Cardenas. Hello, can you hear me?

*Ms. Eshoo. Yes, very well.

*Mr. Cardenas. Okay, can you see me?

*Ms. Eshoo. I can see you, and you look very well, too.

*Mr. Cardenas. Okay, thank you so much, because earlier today during gavel I was not recognized as being seen, so I had to wait and --

*Ms. Eshoo. Oh, I am sorry.

*Mr. Cardenas. -- my questions, so --

*Ms. Eshoo. Sorry. How does that happen?

*Mr. Cardenas. Sorry about that.

*Ms. Eshoo. Oh, my.

*Mr. Cardenas. We will hopefully get a better system within the committee to make sure that that doesn't happen again to any of us as we all try to be here at gavel --

*Ms. Eshoo. Is that the technological difficulty with the committee's technology, Tony?

*Mr. Cardenas. Well --

*Ms. Eshoo. No?

*Mr. Cardenas. I don't know what happened, because I

saw myself on the screen, I heard you clearly, I saw you, I saw a bunch of my colleagues and the witnesses, or what have you. But anyway, that is housekeeping. We can take care of that later.

*Ms. Eshoo. Okay, good.

*Mr. Cardenas. But thank you so much --

*Ms. Eshoo. I apologize.

*Mr. Cardenas. -- Madam Chair. No, that is okay.

*Ms. Eshoo. What happened?

*Mr. Cardenas. I want to talk a bit about health disparities. And when it comes to pandemics, when it comes to addiction, when it comes to incarceration, all of these kinds of things are issues. So I would like to know, how does that fit into what the dynamic of the Administration's efforts are on the topic we are talking about today when it comes to opioid -- the opioid pandemic and -- epidemic excuse me, it is a pandemic, sort of -- and when it comes to assisting with making sure that we treat it more as an illness, not as something that is just -- we treat it as a punitive matter.

*Ms. LaBelle. Right. Thank you, Congressman. So the disparities in treatment, we have identified some of them in our policy priorities. They include kind of a two-track system that we have seen. Certainly, some people get health care, treated through the health care system, and others are

incarcerated. And what the President has committed to is reducing rates of incarceration, and having -- not having it so that people are incarcerated for drug possession alone, because we know that often people who have low amounts of drugs in their possession are -- often have a substance use disorder themselves. So there is a couple of things that we want to do.

Number one, we need to make sure that we have better data sources on this. And I know that sounds like it is not an immediate issue, but it is not something that we have a great deal of granularity on, you know, where the disparities exist and how exactly are we going to address those disparities. So that is one step that we have to take.

The second thing that we need to do, we talked a little bit about before, is make sure that our workforce reflects the people that are served. And that is something we will work closely with HHS on.

And then also -- so we also will be looking at, you know, criminal justice reform, writ large. The drug piece is a part of that, so we will be looking at that, as well.

*Mr. Cardenas. Thank you. And you mentioned something that -- my question is how are the departments going to work together?

Because when there is this presumption that in poor communities -- White communities, as well, poor White

communities, poor Black and Brown communities, Native American reservations, et cetera, where all of a sudden policing seems to be the fortified method of trying to address the issue of drug addiction and drug abuse in those communities. I think it is important that the departments understand that the amount of resources that we allocate at the federal level, local level, et cetera, needs to be proportional to how we are going to -- be honest with ourselves about how it should be addressed.

Are you working with other departments to make sure that we are all on the same page?

*Ms. LaBelle. Yes, we work closely with our law enforcement partners, as well as our health department partners.

And I think what you raised is an important piece. I think that some of this is because -- that is why we talked about harm reduction programs in our policy priorities, because that is -- provides an alternative intervention point for people who may not otherwise be able to get treatment, and may end up in law enforcement's hands in the criminal justice system. So that provides an alternative intervention point.

*Mr. Cardenas. Yes, because I would venture to say -- I am in Los Angeles, and in my community, where I grew up in Pacoima, law enforcement seemed to be the answer to treating

people with addictions, or addressing the issue of people with the addictions.

But yet, just a few miles away in Beverly Hills, I would contend that there is just as much drug use going on with teenagers and adults and seniors in those households as it is in households in Pacoima, in a different zip code, only the difference is, in those other communities like Beverly Hills, "Oh, my gosh, you know, little Johnny is addicted. We got to get Johnny some help. We got to put him in a program,'' et cetera, which I believe is the proper, humane way to deal with these issues.

But yet, just a few miles away on the other side of town, book him and book him, send the cops in, get the DEA to do a crash unit or something, and all of a sudden you have people on one side of town who are behind bars, not addressing the issue of addiction. But on the other side of town, the other person is actually getting support.

Do you believe that that has been going on in America far too much?

*Ms. LaBelle. I think we have two bifurcated systems of how we treat addiction. And I think that has been with us for a very long time, and we are going to work on that.

*Mr. Cardenas. Okay. Well, I look forward to speaking to you in the future, and --

*Ms. LaBelle. Yes.

*Mr. Cardenas. -- and also working with you --

*Ms. LaBelle. Yes.

*Mr. Cardenas. -- both as a legislator and as two Americans, to make sure that we get a system that is much more appropriate for addressing issues for all of us.

Thank you so much, I yield back.

*Ms. LaBelle. Thank you, sir.

*Ms. Eshoo. The gentleman yields back. We now have two members that have waived on to our subcommittee, and we welcome you. It is always a pleasure to have our colleagues from the full committee be a part of our subcommittee.

So the chair will recognize the gentleman -- and he is a gentleman -- from New York, Mr. Tonko, for his five minutes of questions. And he has been very active on the issue of opioids, especially, as I recall, fighting for more beds so that patients would really get the care that they need.

You are recognized.

*Mr. Tonko. Thank you, Madam Chair. Can you hear me?

*Ms. Eshoo. I can. Talk a little louder, though.

*Mr. Tonko. Okay, thank you, Madam Chair, and thank you for allowing me to waive on.

I am indeed thankful to hear about the leadership already put forward by the Biden-Harris Administration, and want to express gratitude to you, Acting Director LaBelle, for agreeing to testify today, and thank you for your

leadership.

I am a proud sponsor of two pieces of legislation being considered today, including the Medicaid Reentry Act and the Mainstreaming Addiction Treatment, or MAT, Act. These two bipartisan bills are considered some of the most effective policy actions that we can take at reducing opioid overdoses.

The Medicaid Reentry Act would empower states to restore Medicaid eligibility for incarcerated individuals up to 30 days before their release to ensure those transitioning will have immediate access to critical services, including mental health support, addiction treatment, and COVID testing. Granting states the ability to jumpstart Medicaid coverage for these individuals will mean they are not only able to receive lifesaving treatment for mental health, substance use disorders, and other conditions; it will also help them stay out of our already-overburdened hospitals, and on the path to recovery and rebuilding their lives.

As ONDCP identifies ways to reduce the increasing number of overdose deaths, and to strengthen access to evidence-based substance use disorder treatment services and medications, would passage into law of the Medicaid Reentry Act help to achieve these important goals?

*Ms. LaBelle. Thank you, Congressman, for your leadership on these important issues.

So I am a strong believer that we need to make sure that

people, regardless of their circumstances, have access to evidence-based treatment. And providing incarcerated populations access to treatment before they leave is one way to do that.

We also need to make sure that we follow up, that there are re-entry tools available to help people with their recovery. And actually, upstate New York has a lot of great examples. Buffalo MATTERS is one good example.

So this is a high-risk population that we need to get services to.

*Mr. Tonko. Thank you so much. And I heard your earlier comments about giving your undivided attention to some of the issues concerning the X-waiver. So I also ask for your commitment to prioritize the elimination of the X-waiver in order to deliver on President Biden's promise to expand access to medication-assisted treatment. I ask that you examine all actions you can to take on this -- support passage of our Mainstreaming Addiction Treatment Act, the MAT Act, in order to accomplish this goal.

So a couple of questions. Are you aware that, after France took similar action to make Buprenorphine available without a specialized waiver, opioid overdose deaths declined by some 79 percent over, I believe it was, a 4-year period?

*Ms. LaBelle. Yes, I am familiar with the research, thanks. Yes.

*Mr. Tonko. Yes. And again, I thank you for your attention to this matter.

Are you aware that in 2020 the number of waivered physicians accounted for only 5.9 percent of the total active physicians?

*Ms. LaBelle. Yes, sir.

*Mr. Tonko. And are you aware that, in 2018, 40 percent of counties in the U.S. did not have a single waivered provider?

*Ms. LaBelle. Yes.

*Mr. Tonko. And are you aware that providers can already prescribe Buprenorphine without additional training, but only when treating pain?

The X-waiver training to prescribe Buprenorphine only applies to providers treating patients with opioid use disorder.

*Ms. LaBelle. Yes.

*Mr. Tonko. Okay, so today I would like to submit a letter for the record signed by a number of groups, including the Association for Behavioral Health and Wellness of the Kennedy Forum, Shatterproof, Mental Health America, National Association of Attorneys General, the National Alliance on Mental Illness, the National Council for Behavioral Health, and many other groups.

And I would indicate that they write -- and I quote --

"The existence of the X-waiver sends a terrible message to practitioners and the public alike, that treating OUD with Buprenorphine requires separate, stigmatizing rules, and that Buprenorphine is inherently more dangerous than the powerful opioids that have fueled this crisis.''

So I fully agree that the X-waiver reflects a longstanding stigma around substance use treatment, and sends a message to the medical community that they lack the knowledge or ability to effectively treat individuals with substance use disorder. So do you agree that the X-waiver sends a terrible message to practitioners and the public alike, and increases stigma?

*Ms. LaBelle. I think there is a great deal of stigma in every aspect of our addiction system, and this -- you know, the Buprenorphine waiver is just one element.

*Mr. Tonko. Okay. Well, again, I thank you for your devotion to this issue and, again, for your open-mindedness as you approach it.

*Ms. LaBelle. Certainly, thank --

*Mr. Tonko. With that, Madam Chair, I yield back, and thank you again.

*Ms. Eshoo. The chair thanks the gentleman, and the letters will be placed in the record at the end of the hearing.

[The information follows:]

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

*Mr. Tonko. Thank you.

*Ms. Eshoo. So thank you for joining us.

And now we are going to switch back to a member of the subcommittee before we go to Mr. O'Halleran, who is waiving on.

To Mrs. Fletcher from Texas, you are recognized for your five minutes of questions. Great to see you.

*Mrs. Fletcher. Thank you so much, Madam Chairman. It is great to see you, and I am so grateful that you are holding this important hearing today.

It is clear from the data and the testimony today that substance abuse disorders are an epidemic in this country. And my hometown of Houston is not immune. The pandemic has also exacerbated this crisis. Tragically, first responders in Houston reported a 17 percent increase in overdoses in the second quarter of 2020, compared to that same time period in 2019. So I really appreciate that the committee is holding this hearing today.

The alarming drug use overdose statistics are staggering. They are deeply concerning. However, I want to acknowledge that substance use disorder is a diagnosable and treatable disease. We have FDA-approved medications and evidence-based treatment that work. Patients with substance use disorder can and do recover, and they go on to lead meaningful lives in our society.

In fact, the Biden Harris cabinet includes department heads like Secretaries Marty Walsh and Deb Haaland, who are both open about their long-term recovery from substance use disorders. They exemplify the fact that recovery is possible.

My first question for you, Acting Director LaBelle, in your experience talking to communities across the country, what benefits do you hear about when it comes to efforts like recovery housing, college and high school recovery programs, and other peer support services?

*Ms. LaBelle. Thank you, Congresswoman, for asking that question. Recovery is something that is a relatively new area of research. But we know -- I mean, I think all of us know people who have benefitted from recovery facilities. Recovery high schools, I mean, literally, save lives. And so I think recovery supports -- having people, peer support workers, working with folks in early recovery is a really important part. It is in our -- included in our policy priorities, and something that we look forward to working --

*Mrs. Fletcher. Thank you so much. And I just want to follow up with that. Can you talk a little bit about the ways the federal government supports Americans in long-term recovery, and how your office plans to build on or improve upon those efforts?

*Ms. LaBelle. Sure. So in a couple of ways. One is,

as I mentioned, we have hired people who are in long-term recovery in our office. We engage people in recovery in all of our work. We will continue to engage people in recovery, and not just to tell their stories, but to engage them in the policy development process and implementation process. Those are two ways.

Also, we intend to work with the -- with HHS on expanding recovery support services and -- as well as research on what works best with different communities, and making sure we have culturally-competent recovery services across the country.

*Mrs. Fletcher. Well, thank you for that explanation, and thank you for all the recovery-related efforts that you and the Administration are working on, and plan to put forward. I appreciate your testimony here today.

And again, I appreciate you, Madam Chairwoman, holding this hearing. And with that I will yield back the balance of my time.

*Ms. Eshoo. The gentlewoman yields back, and now it is a pleasure to welcome back to our subcommittee the gentleman from Arizona who is waiving on, Mr. O'Halleran.

You have five minutes for your questions, and thank you for --

*Mr. O'Halleran. Thank you, Madam Chair -- I appreciate it -- and Ranking Member, for putting on this meeting in a

group that historically has been very bipartisan in addressing these types of issues. And I am looking forward to that occurring throughout this process and these bills.

You know, I have -- this is a different time, different place, different drugs, but here we are -- all are again, sitting here. I was addressing it as a police officer back in the 1970s, drug overdoses, drug crime. As far as how it was dealt with then, a lot of things have changed, but we still have a problem that is a continuing problem, day in and day out. And our families are being devastated by this, and we need to address it. And I know this group feels that way.

But it is a comprehensive approach. It is not just one piece or another piece. It has to be comprehensive, taking into account the disparities within our society, taking into account the real elements of what causes this, and how do we get the therapists necessary to address this issue.

And that is especially true in areas like rural America. We are short of doctors, anyway. We are short of therapists to a high degree. We have distances for patients to travel that are unreasonable. I know telemedicine is going to be coming around at a higher level later on, but not immediately, and we have to do something now. Two people die in Arizona every day.

In August of this year -- last year, I should say -- 507 people died from overdoses. And anybody that hasn't been

around somebody that has died from an overdose, and watched them die, I can guarantee you -- I am glad the families don't have to see it as much as the rest of society sees it when it happens in the public arena. But everybody should know that this is a tragic example of how America treats people with this type of health problem.

And so, Ms. LaBelle, thank you for being here, obviously, but how is the Administration planning on addressing the opioid -- in rural America?

Now, I want to -- I don't see a health care issue, whether it is the VA or anything else dealing with health care, where there are specialists, where there are therapists, and our patients sometimes have to drive 10 hours round trip to get there. If you are calling from -- for an overdose, you have to have people that -- it might take an hour for people to get -- even get to the house. And that is just something that has to be addressed immediately. So I am interested in how to address that.

And by the way, hospitals are declining in rural America, they are not increasing.

*Ms. LaBelle. Thank you, Congressman. So I think in a couple of ways. One is you mentioned how long it takes for -- it might take a first responder to get to a rural area to resuscitate someone who has experienced an overdose. So the first thing we want to do is make sure that we expand

Naloxone availability across the country, particularly in rural areas, to people who are at risk.

The second piece of what you talk about -- and this is going to take a little longer -- is the workforce issue. As identified before, we have shortages. You just said, you know, you have health care shortages that are already predominant in rural areas. So we need to get -- and specifically in targeted areas, with high rates of overdose, or high rates of substance use disorder generally -- get the addiction workforce, the trained addiction workforce available, and encourage them to stay there through loan repayment programs. So we will be working with our colleagues at HHS on those workforce issues that are important in rural America.

*Mr. O'Halleran. And I know that you have just started on this, so I appreciate the need for some time to get this going. But I think the people of America, and the people of rural America especially, would appreciate the ability to see a plan of action, not a plan that is going to take two years, three years to get it --

*Ms. LaBelle. Right.

*Mr. O'Halleran. -- addressed, and then the workforce issue is imperative. It is just imperative.

And the realization, again, that this is not just one piece, it is not waking up in the morning and saying, "I have

an addiction to opioids.'' It is a process of lifestyle, it is a process of being -- not being able to get jobs, or -- alcoholism is part of it. It is a vast issue for this huge country of ours, and it hasn't been addressed in the appropriate way for decades.

And I thank you, and I yield back.

*Ms. LaBelle. Thank you.

*Ms. Eshoo. All right. Well, the gentleman yields back.

And I want to thank you, Doctor. I don't know when you -- you probably didn't realize, when you signed on and said yes to us, that you were going -- would be willing to come and testify today, that you would be with us for, let's see, 10:30, 1:30 -- three hours and 10 minutes.

What it demonstrates is what a deep and broad interest and concern every single member of the subcommittee has. And you heard firsthand what they see and have experienced in their districts, in their own families and extended families, and their knowledge of the various policies that have been proposed, legislation that we have put on the books, more -- you know, bipartisan bills that are being voted on in the House today.

So we look forward to working with you to put more than a dent in this. We have a lot of work to do. But you have a subcommittee that wants to work hand-in-hand with you.

*Ms. LaBelle. Right.

*Ms. Eshoo. And to the extent that your agency succeeds, then the -- it will be the betterment of our country from this scourge that is taking place in people's lives. So we thank you. We thank you for being with us, and the time that you gave to us. And we will keep working together.

Now it is a pleasure for me to welcome our second panel of witnesses. Let me introduce them to you: Mr. Geoffrey Laredo, a principal at Santa Cruz Strategies LLC; Ms. Patricia Richman, National Sentencing and Resources Counsel for the Federal Public and Community Defenders; Mr. Mark Vargo is the Pennington County State's Attorney, and the legislative committee chairman for the National District Attorneys Association; Dr. Timothy Westlake is the emergency department medical director at the Pro Health Care Oconomowoc -- let me do this again, Oconomowoc Memorial Hospital, I got it done, I did it -- and last, but not least, Dr. Deanna Wilson, who is the assistant professor of medicine and pediatrics at the University of Pittsburgh School of Medicine.

Welcome to each one of you, and thank you for your patience, for waiting in the wings. I am sure that you found it highly instructive, whenever you joined us in the testimony of the new acting director and, very importantly,

the excellent questions of members of the subcommittee.

So I am going to go to you, Mr. Laredo, for your five minutes of testimony.

And thank you again to each one of you, a panel of just superb experts who -- you should each know will be highly instructive to each one of us.

So, Mr. Laredo, you are recognized for your five minutes of testimony. Remember to unmute, please.

*Mr. Laredo. Thank you so much, and I hope that you can see and hear me okay this afternoon.

*Ms. Eshoo. I can, thank you.

STATEMENT OF GEOFFREY M. LAREDO, PRINCIPAL, SANTA CRUZ STRATEGIES, LLC; PATRICIA L. RICHMAN, NATIONAL SENTENCING AND RESOURCES COUNSEL, FEDERAL PUBLIC AND COMMUNITY DEFENDERS; MARK VARGO, PENNINGTON COUNTY STATE'S ATTORNEY, LEGISLATIVE COMMITTEE CHAIRMAN, NATIONAL DISTRICT ATTORNEYS ASSOCIATION; TIMOTHY WESTLAKE, M.C., F.F.S.M.B., F.A.C.E.P., EMERGENCY DEPARTMENT MEDICAL DIRECTOR, PRO HEALTH CARE OCONOMOWOC MEMORIAL HOSPITAL; AND J. DEANNA WILSON, M.D., M.P.H., ASSISTANT PROFESSOR OF MEDICINE AND PEDIATRICS, UNIVERSITY OF PITTSBURGH SCHOOL OF MEDICINE

STATEMENT OF GEOFFREY M. LAREDO

*Mr. Laredo. Chairwoman Eshoo, Ranking Member Guthrie, members of the subcommittee, thank you so much for inviting me here today. My name is Geoffrey Laredo. I am a substance use and addiction policy expert who retired from the federal civil service in 2018, after serving for 30 years in a variety of policy positions, mostly within the U.S. Department of Health and Human Services. Twenty-two of those years were at the National Institutes of Health, where I advocated, as appropriate, for science and scientists, research and researchers. I continue that work now, as a consultant.

*Voice. See, I have never had to do that before.

*Mr. Laredo. Thanks also for continuing your focus on the addiction crisis in the United States.

This committee has, for several years, written in advance legislation aimed at a broad array of addiction research, prevention, treatment, and recovery issues. And it was my honor to work with you and your staffs on those bills.

You are considering a range of legislative proposals addressing the addiction crisis. One of those is the potential class-wide scheduling of fentanyl-like compounds. And because of that issue's timeliness, and my experience working on it as a legislative and policy staff at the National Institute on Drug Abuse, that is where I have focused my testimony.

It is absolutely crucial to define what we care about. As a public policy professional especially focused on public health, what I care about is morbidity and mortality. Every aspect of our nation's drug policy must be laser-focused on decreasing disease and death.

How do we decrease both, and how do we advance evidence-based practices to achieve both?

Class-wide scheduling is not the road to success. Despite alternative claims, to my knowledge there just isn't any credible evidence to show where the class-wide scheduling of any compound actually reduces morbidity and mortality. Conversely, there is ample evidence that properly funded and

scaled research programs and evidence-based services can dramatically reduce morbidity and mortality.

Further, proposals to increase the use of class-wide scheduling minimize or eliminate the role of health agencies in this process. This is just unacceptable. Health agencies should have the primary, if not the sole, responsibility for deciding how or whether to schedule compounds. I don't support including the Drug Enforcement Administration in this decision process, and I would strongly support removing the agency from the process as it currently stands. Let health and medical authorities do the work of health and medicine, and let's provide them appropriate resources to do that work.

I think you are familiar with the arguments around the difficulties of conducting schedule one research; you have talked about that a bit today. Since our time here is limited right now, I won't delve into those details. We tried hard when I was at NIDA to work with the DEA and the FDA to streamline that process. We reached some agreement, but it was unclear to me, frankly, whether any of those steps have actually really been taken. And I have to say this was not a pleasant process, and I will come back to that in a moment.

Researchers have clearly shown that similarities in the chemistry of certain compounds do not necessarily equate to similar abuse liability. This is really important when

discussing requirements for a schedule one designation, and I refer you to Dr. Sandra Comer and colleagues' work, as I mentioned in my written statement.

So we find ourselves in a situation where placing an entire class of compounds into schedule one would clearly delay and deter research on exactly what you have been begging for, additional and improved solutions for opioid addiction, overdose reversal medications, and other medications' development results that we perhaps haven't even thought about. Why would we take a class-wide scheduling action at exactly the time that we need to be increasing and accelerating potentially lifesaving work?

In my written statement, I also describe steps we took in an effort to improve the overall situation. I hope you will read those details. They are pretty unpleasant. Not only did we not succeed, but senior DEA staff actually told me that I personally -- and NIDA, as an agency -- were, "aiding and abetting drug dealers.'' That is pretty outrageous.

That said, I am not naive, and I do understand the difficult position that the subcommittee and the full committee is in. I understand the politics. I understand the optics, and the possible need for compromise. I also understand that you might choose to implement class-wide scheduling. Such implementation without addressing crucial

research issues would be a setback for our field. If you move in that direction, I strongly recommend that you include in your decision provisions that, for research purposes, treat all schedule one compounds as if they were in scheduled two; truly streamline the process for obtaining a schedule one license; don't create separate licensing and process requirements for different classes of compounds; and finally, facilitate the de or rescheduling of compounds when scientists verify that that would be justified.

Members of the subcommittee, you focused a lot of time and effort on these issues over the past several years. So have other committees. If we are all really serious about this health issue, then I think you deserve to take and have the lead on legislation guiding those efforts.

We should listen to science and scientists, and help them do their jobs. We should be thoughtful, especially in the face of significant disease and death. We should make the wise choice, and avoid the knee-jerk reaction of just trying to "ban'' substances that might or might not be helpful.

And they might or might not -- excuse me, they might or might not be harmful, and they might or might not be helpful. By doing so, we will help find answers that will improve conditions in the field.

*Ms. Eshoo. Thank you, Mr. --

*Mr. Laredo. Thank you so much for the honor of sharing my views with you, and I will be glad to discuss these issues further.

[The prepared statement of Mr. Laredo follows:]

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

*Ms. Eshoo. Thank you very much, Mr. Laredo. We appreciate your being with us, your willingness to testify, and the content of your testimony.

Next the chair would like to recognize Ms. Richman for five minutes for your testimony.

And thank you for being a witness, and for your patience, and for your willingness to be instructive to us. We are all ears, so you may proceed.

STATEMENT OF PATRICIA L. RICHMAN

*Ms. Richman. Thank you, Chairwoman Eshoo, Ranking Member Guthrie, members of the subcommittee for inviting me to this hearing today, and the opportunity to share my perspective. I, too, will focus my remarks today on why this committee should reject the permanent or continued class-wide scheduling of fentanyl analogues.

Yesterday Senators Booker, Markey, Hirono, Warren, and Whitehouse wrote President Biden to caution against "adopting a policy explicitly designed to expedite drug prosecutions and increase penalties.'' I urge you to follow their advice.

We are in the midst of a national reckoning over police officers' use of force against communities of color. Last Sunday Dante Wright was killed just 10 miles from where a police officer is on trial for the killing of George Floyd. Incidents like these are, in part, the product of a tough-on-crime culture focused on punishment, instead of preventative community and health solutions.

As a former federal public defender in Baltimore, Maryland, I witnessed the impact of these punitive practices. My clients faced harsh sentences for drug offenses. In recent years, nearly 80 percent -- 80 percent -- of people who received drug mandatory minimums in Maryland's federal courts are Black, even though they make up only 42 percent of

the state's population.

And there is no bright line between user and seller. The vast majority of my clients grappled with substance use disorder, and many had lost friends and family members to the overdose crisis. This crisis is a complicated problem.

Today I ask this committee not to repeat past mistakes. Over the past decade, bipartisan efforts such as the Fair Sentencing Act of 2010 and the First Step Act moved in the right direction. And President Biden has pledged to end mandatory minimums, reduce racial disparities in the criminal legal system, and shift drug policy towards public health solutions.

Today fear and misinformation are being used to support class-wide scheduling of fentanyl analogues, and I ask you to look to the evidence. To be clear, harmful fentanyl analogues are illegal, with or without class-wide scheduling. If the class-wide expires on May 6, no harmful fentanyl analogue will become legal.

During the three years that the ban has been in place, many experts have examined whether the class-wide approach works. They have asked two core questions: first, does class-wide scheduling actually reduce overdose deaths; second, does class-wide scheduling reduce the supply of harmful substances in our country? The answer to both questions is no.

These are the facts, according to the CDC and the GAO. The CDC has reported that, during the three years the ban has been in place, the number of overdose deaths attributed to fentanyl and fentanyl analogues has continued to rise, and fentanyl and fentanyl analogues have continued to enter the country in large quantities. The recent GAO study found that "seizures of fentanyl and its analogues entering the U.S. ports increased substantially from 2017 to 2020.''

And a chorus of voices, public health experts, scientists, and impacted people in the criminal justice community have also identified ways that class-wide scheduling is counterproductive and unnecessary.

Public health experts warn that, even if there is a shift away from novel fentanyl analogues, it will be to something even more potent and harmful.

Scientists warn that blanket bans of substances impede scientific research, and may delay or eliminate the discovery of badly-needed antidotes and treatments. They have identified specific substances that have been improperly scheduled by the ban, and have therapeutic promise.

And the criminal justice community cautions that class-wide scheduling would expand mandatory minimums, exacerbate racial disparities, and eliminate crucial checks against DEA overreach.

Federal sentences for fentanyl analogues increased

nearly 6,000 percent between 2015 and 2019, and people of color made up 68 percent of those cases in 2019. That year, mandatory minimums were imposed in more than half of those cases. Meanwhile, class-wide scheduling has not been used to prosecute kingpins, but to continue the failed practice of prosecuting low-level players. This practice does not disrupt supply, or the real driver here, demand.

Class-wide scheduling is not regulatory. It is punitive. We cannot incarcerate our way out of this problem. It is time to do the work to heal our communities and country by finding and building evidence-based, science-first solutions that are proven to reduce demand and harm associated with these substances.

And in addition to this work, the most important step Congress can take to fix America's broken drug policy is to end mandatory minimums, and to apply those changes retroactively.

Thank you so much for the opportunity to testify today.

[The prepared statement of Ms. Richman follows:]

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

*Ms. Eshoo. Thank you so much for your testimony. We will now go to Mr. Vargo.

The chair recognizes you for your five minutes of testimony, and thank you again for your willingness to be with us, and the work that you do. You are now -- make sure you unmute, please.

STATEMENT OF MARK VARGO

*Mr. Vargo. Thank you, Chairwoman Eshoo, Ranking Member Guthrie, and to the rest of the committee. I am proud to be here to represent the National District Attorneys Association, and very grateful that you invited us to participate in this very important set of hearings on this topic, which we all know is extremely dire at this moment.

I was struck as I prepared to address you today by Director LaBelle's characterization in an article she wrote a few years ago that addiction is the only disease where we expect people to diagnose themselves by hitting rock bottom. But then, you know, it dawned on me that perhaps we don't rely on them, but rather that all of you have been relying on me, because it feels like we define rock bottom as arrest, incarceration, and criminal prosecution. And it is at that moment that we want to mobilize the forces of addiction recovery.

It is my hope that today we can discuss about ending that mentality. And so everything that I tell you I want to put through the lens of moving the point of the intercept. Because the costs of waiting to intercept drug addiction are disastrous, they are disastrous for the addict. And Representative Kelly and Representative Cardenas, along with Dr. Wilson, in her written testimony, have talked about how

early treatment is necessary, and how our communities of color are being deprived that early treatment.

It is also disastrous for our communities and our families. Fentanyl and all other drugs lead to abuse, neglect, and poverty. And methamphetamine, which remains a scourge in western South Dakota, adds to the problem. It is paranoia, hyper-vigilance, and aggression. People on methamphetamine are 10 times more likely to be violent if they use every other day than a -- even a meth addict who is presently in remission. And it is the only drug for which the most recent NIDA figures show an increase in drug overdose deaths, not just in combination with fentanyl or other synthetic opioids, but on its own.

As prosecutors, we do what we can from where we are with what we have, and I am very proud of what we are doing from the point of intercept that has been assigned to us onward. Our diversion programs, which I went into extensively in my written testimony, are just one example of how we are trying to change the way that we engage with people who have addictions to ensure that they have the best chance possible to become productive, functioning members of our community. I am very proud of my staff, who, with very little budget, have put together a tremendous array of programming to give diversion candidates a chance of success.

Because we have very little funding, and because we

never ask our offenders to pay, we rely on a wide variety of community resources, including governments like the Oglala Sioux Tribe, and cultural and community programs like the Wambli Ska Pow-Wow, an indigenous American legacy.

We tried to change behavior without the criminogenic consequences of a conviction. I would like to mention to you that NDAA has specifically supported Representative Tonko's MAT Act, Representative Curtis and Peters' Methamphetamine Response Act, and we support the extension of class-wide fentanyl analogue scheduling, and we support the EQUAL act, which would reform sentencing.

But I want to take the little time that I have left to ask you three things.

I am asking you to move the intercept point. The descriptions of the needs of our communities, our at-risk communities and our communities of color, are very stark. We need from Congress money in both the criminal justice system and before the criminal justice system. In other words, we need you to lead.

Secondly, we need you to use us in state and tribal government as the laboratories of innovation. Representative Tonko, who in the last session talked about Buffalo MATTERS, an outstanding program that has been spearheaded by my friend and colleague, John Flynn, in Erie County. Programs like that within the criminal justice system, and programs like

treatment programs that are being dealt with by programs like Native Healing and Native Women's Health Care, here in South Dakota, are very important. In other words, we need you to follow.

And then finally, I ask you to reduce the federal collateral consequences of state court drug convictions. The origins of our diversion were that we recognized that people with minor drug convictions had major problems, largely based on federal law. In other words, we need you to get out of the way.

And so with apologies to both Mr. Payne and to General Patton, we need you to lead, we need you to follow, and we need you to get out of the way.

[The prepared statement of Mr. Vargo follows:]

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

*Ms. Eshoo. Mr. Vargo, thank you for your excellent testimony, really grabbing the attention of every single member. Thank you, and thank you for the superb work you and your organization do. Now the chair would like to recognize Dr. Westlake.

Welcome to the committee. Thank you for being willing to be a witness and give testimony today, and for your patience in waiting for panel two to begin.

So please unmute, so that everyone can hear you. And welcome, again.

STATEMENT OF TIMOTHY WESTLAKE

*Dr. Westlake. Great, thank you. Thank you, Chair Eshoo, Ranking Member Guthrie, and members of the subcommittee, thank you for the opportunity to talk with you, and for your leadership. My name is Tim Westlake. I am a full-time emergency physician, and the immediate past chair of the Wisconsin Medical Examining Board. I am a licensed provider and prescriber of Buprenorphine, and provide the medical control for the statewide peer-to-peer recovery network that provides free Narcan education and access. I was also the physician architect of the Wisconsin Prescription Opioid Reform Strategy starting in 2014.

I originated the idea of targeted fentanyl class scheduling while serving on the Wisconsin Controlled Substance Board, and got it enacted first in Wisconsin in 2017. The DEA then temporarily put in place the same language federally in 2018. Before that point, scheduling of fentanyls was like a lethal game of Whack-A-Mole, as you have heard before, except for me it was literally waiting for kids to die before we could control and stop the spread.

As an emergency physician, I was beyond weary and heartbroken, having to tell parents, sometimes even friends of mine, that their kids were never coming home again after overdosing.

The inspiration for the fentanyl class scheduling reform arose out of the tragedy of my friend's son, Archie Badura. Archie was an altar server alongside my daughters in church. Archie first got hooked on prescription pills, and then IV opioids. I resuscitated him on his second-to-last overdose. We pulled out a body bag and laid it out for him, warning him that he would end up in it if he didn't reach out for help. He was able to stay clean for six months after that, but then fentanyl caught up with him, and ended his life like it has for hundreds of thousands of other kids in our country. His mom, my good friend Lauri, remembers seeing me showing him the body bag in the emergency department. And the next time she saw that bag, Archie was being zipped up into it and taken away to the morgue.

In 2020 Congress enacted a temporary extension of what I like to refer to as the "Archie Badura Memorial Fentanyl Class Scheduling Language,'' closing a loophole in federal drug law which cartels have been exploiting for years to create and then legally distribute these deadly substances. Now is not the time to eliminate a proven harm reduction and overdose prevention strategy.

When looking for policy and legislative solutions to the fentanyl devastation that is wreaking havoc in our country, it is critical to look at this situation from the proper perspective. Unlike marijuana, hallucinogenic, cocaine, or

even heroin, fentanyls are so toxic and lethal that can be -- that they can be classified and actually can be used as chemical weapons. A lethal dose is two milligrams, meaning that one teaspoon, which is what is in this packet of sugar, can kill 2,000 people; 24 pounds is more than enough to kill all 5.4 million residents of Metropolitan Washington, D.C.

The effects of the three years of fentanyl class scheduling are clear: the creation and distribution of finished fentanyl and fentanyl-related substances from China has ground to a halt. Most importantly, according to the National Forensic Laboratory Information System, overdose deaths related to fentanyl-related substances -- newly created fentanyl-related substances -- have effectively ceased. In Florida, in comparison, between 2016 and 2017 there were 2,500 deaths attributed to fentanyl-related substances themselves. During that same time in New York City, there were 900 deaths in the city alone.

Concerns about potential negative consequences on research and increased incarceration simply really have not materialized. Most research concerns raised in opposition are theoretical, and seem to be focused on schedule one research writ large, and are not specific to fentanyl-class research itself. In clarification, there are an exceedingly small number of researchers who have studied and -- registering to study the fentanyls, approximately 30 in

total, with many of these being DEA and Department of Defense subcontractors focused exclusively on the analysis, detection, and attempt to understand the harm of these substances. The only dampening or restricting of research has been purely theoretical.

Fentanyl and its derivatives have been extensively researched since discovery in 1960, and in that time not one fentanyl-based reversal agent or medication-assisted treatment has ever been found in the 60 years since.

Naloxone and Narcan work exceedingly well at reversing overdoses from all opioids, including fentanyl and fentanyl-related substances. This is something I, unfortunately, see sometimes on a daily basis. If it wears off, then more can easily be administered. Kids die because they ingest a lethal dose of toxic opioids, not because Narcan isn't effective.

Opposition posits that the Analogue Act is sufficient to control any new fentanyl-related substances. But if that were the case, all 50 attorney generals, including then California AG Xavier Becerra, wouldn't have crossed the aisle, coming together two years ago, to ask Congress to enact this language, and we wouldn't be discussing it here in this hearing right now.

It is important to understand using the Analogue Act is a reactive strategy. It often reacts to the deaths of

hundreds or thousands of our kids. Over-incarceration has simply not been seen. In fact, in the three years since the class scheduling has been in place, there have been a total of eight federal prosecutions, half of whom already have known ties to drug cartels. It is because this is not a law enforcement bill, this is a prevention bill.

Regarding the mandatory minimums, the amount that triggered the minimums are 10 and 100 grams, which at first glance seems harsh. But it is critical to remember that that is enough to kill 5,000 and 50,000 people, respectively.

Also setting the record straight, there have been zero prosecutions for non-bioactive fentanyl-related substances. This is due to the fact that all fentanyl-related substances encountered and researched to date have been found to be strong and potent opioids. Benzyl fentanyl is not classifiable as a fentanyl-related substance.

I would suggest that so little incarceration is occurring as a result of the fentanyl class scheduling because it is, first and foremost, an overdose prevention and harm reduction tool and strategy originated by me, an emergency physician, who was beyond weary having to tell more parents that their children would never be coming home.

*Ms. Eshoo. Dr. Westlake, can you just summarize in a sentence or two, because your time has expired?

*Dr. Westlake. I am sorry, yes. The solution is not to

allow the expiration of the fentanyl class scheduling. Congress should enact the Archie Badura Memorial Fentanyl Class Scheduling language seen in the bipartisan FIGHT Fentanyl Act.

We need to deploy every --

*Ms. Eshoo. Thank you very much. Thank you, Doctor, we appreciate you being with us, and for your testimony.

[The prepared statement of Dr. Westlake follows:]

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

*Ms. Eshoo. Last but not least, the chair recognizes Dr. Wilson for five minutes for his testimony, and -- your testimony.

And thank you again for your patience in waiting for panel two to begin, and we are ready to hear from you. So thank you very much. Lovely to see you, and thank you for joining us.

*Dr. Wilson. Chairwoman --

*Ms. Eshoo. And please unmute.

STATEMENT OF J. DEANNA WILSON

*Dr. Wilson. Chairwoman Eshoo and Chairman Pallone, Ranking Members Guthrie and Rodgers, and members of the committee, thank you for the opportunity to speak with you today. My name is Dr. Deanna Wilson. I am a pediatrician and internist with subspecialty training in addiction medicine. I am an assistant professor at the University of Pittsburgh, where I teach students and physician trainees about addiction, and I also conduct research focused on improving health equity and reducing disparities among vulnerable populations with substance use disorders.

The worsening overdose crisis and the setting of the COVID-19 pandemic has both unmasked significant health inequities, but has also created opportunities for us to rethink how we deliver care in ways that, one, prioritize equity; two, increases treatment access; and three, increases our workforce's capacity to treat addiction.

In cities like Philadelphia, while rates of overdose deaths fell by 31 percent among White Americans, there was a concurrent increase by more than 50 percent among Black Americans. The racial and ethnic disparities and overdose rates today reflect our failure to center the needs of Black and Latinx communities, and address the underlying systemic inequities, social inequalities, and structural racism that

drive differential access and disparate treatment outcomes.

For example, we know that medications like buprenorphine and methadone substantially reduce the risk for both all-cause and overdose mortality, making them truly lifesaving. And yet your race determines how likely you are to receive them. Black patients have 77 percent lower odds of receiving a buprenorphine prescription during an office visit, compared to White patients.

We must re-imagine how we deliver addiction treatment, partnering with community organizations like faith-based groups to rebuild trust and reduce stigma, supporting low-threshold models of care that minimize barriers, preventing marginalized groups from being well-served by traditional health systems.

We need greater investment in how to support these programs, to document their efficacy, and to scale up their use.

Secondly, we need improved treatment access. In response to the COVID-19 emergency there has been greater flexibility and funding to support telemedicine for the induction and maintenance of buprenorphine. Our ability to engage patients who are unable to physically make it into clinic allows us to see patients who may never have linked to, or may have fallen out of care. We need legislation that permanently supports our ability to use telehealth, but we

also need initiatives making sure that telehealth is more equitable, such as supporting digital literacy and improving access to broadband coverage.

Similarly, opiate treatment programs were granted flexibility to increase take-home doses of methadone. Preliminary studies show no increase in fatal overdose. This suggests the intense regulation of methadone distribution may be unnecessarily restrictive. We urgently need studies to further examine outcomes from this period, so we can reform methadone regulations to become both more evidence-based and patient-centered.

In light of rising use of stimulants like methamphetamines and cocaine, we need to invest in research on effective medical therapies. We also need to remove current coverage gaps, limiting our ability to offer evidence-based behavioral treatments like contingency management.

Similarly, we need to reform policies that contribute to lags in addiction care for incarcerated individuals, post-release. Incarcerated individuals are 129 times more likely to die from an overdose within the first two weeks after release, compared to the general population. Lengthy lag times in reactivating insurance post-release contributes to potentially fatal return to use.

In addition, we must recognize that abstinence-only

approaches to substance use treatment can further stigmatize and marginalize patients. Harm reduction services are not only effective at reducing harms associated with drug use, but by engaging patients who may be ambivalent over time. They provide critical access points to link patients to addiction treatment when they are ready. We must remove regulatory barriers and thoughtfully implement and study promising harm reduction interventions.

Thirdly, we need to increase the capacity of our health provider workforce to treat and normalize the care of patients with addiction. The regulatory barriers associated with prescribing buprenorphine, the X-waiver, have unnecessarily restricted access to lifesaving therapies. Removing the X-waiver is low-hanging fruit with the potential to drastically increase patient access. But at the same time we need to support training in addiction medicine for all providers.

For example, requiring education in addiction, including logistics on buprenorphine prescribing as part of DEA registration would empower all providers with a DEA license learn how to recognize and treat patients with addiction.

If I may leave you with these three thoughts, one, we need to center equity in our policies and programming; two, we have to use evidence-based strategies to expand access to addiction treatment; and three, we must remove regulatory

barriers and normalize the treatment of addiction by all providers. Thank you, I am happy to take any questions.

[The prepared statement of Dr. Wilson follows:]

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

*Ms. Eshoo. Thank you very much, Doctor. The chair recognizes herself for five minutes of questioning.

I would just note that, amongst you, the five witnesses, there seems to be a really sharp diversion on the issue of the expiration date, and how that should be handled. So I am not going to go into it, but know that it is clearly noted that there are just really sharp differences.

We have two lawyers, two doctors, a researcher. This is really a very fine panel.

In listening to you, I cannot help but think of FEMA coming into New York and other communities, setting up beds, treatment being made available to those that were tested positive for COVID. Now, I don't want to underestimate what treatment for opioid addiction is, but it seems to me that we need to ramp up on the urgency of this.

I mean, to hear the doctor talk about the young person, and showing him a body bag, and saying that if he didn't do such-and-such a thing, that he would end up being zipped into it, and he was. So would each one of you want to comment on this?

Don't we need more beds, more treatment, that we need to ratchet this up so that it matches the urgency that we all know this is?

I just don't think that when we say that it is urgent, that we have to stem the tide of the deaths -- I think that

we need strike teams. I think people in every community and every state around the country have to see that we are taking this seriously, and that we are going to do something about it.

I mean, the number -- over 540,000 deaths due to COVID in this last year; 88,000 just for opioid. I mean, what, are we going to be satisfied with these numbers?

So I invite any one of you to tell me that I am off track, that we need more treatment, we need more beds, we need help for people. I think our system is really fragmented.

So I have used my time to really dump my thinking and my frustration and my emotions on you. But you are the experts, so I want to hear what you think. You can say yes or no to more beds, more treatment, more people trained, more money in the effort, if that is what it takes.

But we need to -- I think that we have the capacity in this great country to go to near elimination of this.

And when the district attorneys describe what they are left with, because we are not doing everything that we need to do -- these people are sick. They don't belong in the criminal justice system. Then we have to find money to pay for the people that are in jail, and in prisons before they leave. I mean, what are we doing?

So who would like to start?

Dr. Wilson, would you like to take it?

*Dr. Westlake. Sure, I think --

*Dr. Wilson. Yes --

*Dr. Westlake. Oh, sorry.

*Ms. Eshoo. Dr. Wilson?

*Dr. Wilson. Yes. Thank you so much, Chairwoman Eshoo. I think that is a critical point. We absolutely need additional treatment. We need more access to evidence-based therapies, and we need to make sure that we have equitable access to evidence-based --

*Ms. Eshoo. Are therapies not the right ones? I mean, have we not settled on what works?

*Dr. Wilson. We have wonderful evidence that medications to treat opioid use disorder, like buprenorphine and methadone, are highly effective at keeping people alive. So I think the evidence and science is clear to show that that is the case.

The problem is we are not getting the medical therapies to the patients and communities that need them. And so that is the huge treatment gap that we need urgent attention and action to address. And that means --

*Ms. Eshoo. So like trying to get the vaccines, enough allotments, into the states and into the arms of people.

Another one of the doctors want to comment? My time is just about gone, because I talk too much.

Yes?

*Dr. Westlake. Yes, Chairwoman, I think you are spot on with that.

In the emergency department I would estimate between 10 and 30 percent of the patients that I see, there is something to do relating to substance use disorder. Usually it is untreated. And so this is -- I think we are going to look back 30 years from now and say, you know, I can't believe that we were doing --

*Ms. Eshoo. You can't -- you don't have the ability to refer them anywhere?

*Dr. Westlake. Well, it depends on where you are at. So I am in a resource-rich community, and so I can. But so much of the state, especially the rural parts -- and that is where the telehealth expansion is really helpful. But there is so much that can be done, I think, moving forward.

*Ms. Eshoo. Well, I thank each one of you. My time has expired, and I think you clearly know where I am.

So now I would like to recognize, really, a wonderful, important member of our subcommittee, the ranking member, Mr. Guthrie, for his five minutes of questions.

*Mr. Guthrie. Thanks, Madam Chair. And I want to say I think when -- somebody said it, they understand the politics and optics, and I certainly don't say there is not politics and optics in Washington, D.C., but I will tell you all of us

are trying to figure this out, to get it right, because it is people's lives that we are dealing with.

And one that really springs to me, I was touring a lot of opioid recovery centers when we were working on the SUPPORT and the CARES Act, and one guy -- Kentucky has a law that you can get -- if you are a minor user or so forth -- expunged, but you can't get expunged if you sell. And that makes sense, when you think about it. But I met an individual who said about everybody who is addicted had some selling in their background, because I would buy 30 pills and sell three so I could afford the 30. But it was -- I was selling to support my habit. And so -- but if you read the book "Dreamland,'' there are completely pure criminal enterprises that prey on people like him.

And so I don't think it is all one or the other. I think we have to figure out how we punish those who are truly criminal, and those who are being -- who are committing crimes -- committing to support their habit, if you -- and I said in my opening statement -- if you can help them with their addiction, then you help them with -- then the crime goes away with that.

And so -- but I am concerned about the truly criminal enterprises that we have to deal with. And Dr. Westlake, in your testimony you did say that the goal of the fentanyl class scheduling is not to -- not locking up low-level drug

users, but to stop the development of deadly fentanyl poisons at their origin, namely in drug labs overseas. That is the quote. And could you explain -- expand on this point, and further describe how the scheduling order is meant to prevent large-scale importation and distribution, and not target individuals with substance use disorder?

Mr. Vargo, after, if you would comment on how you use this, as well, to focus on the -- more the large-scale criminal than the low-level user.

So, Dr. Westlake?

*Dr. Westlake. Sure, thank you. Thank you. The -- I think that the main point of the whole Act was to -- or the whole set of languages -- is to stop the creation of these substances, so that -- these substances have been very well -- there is very well-researched structure activity pathways that go back 60 years. And so it is simply -- it is as simple as plugging in a different chemical in a formula structure, like a cookbook.

And so what that -- and those are very well laid out. And if you look at my testimony, my written testimony, I go through this in detail. I don't think I have the time to do that now.

But the goal was to make those so that those would be illegal, so that the -- and they wouldn't be created because, again, it was this Whack-A-Mole game, where they are going

around what is what is legal, and waiting for the Analogue Act, or waiting for the CSA to catch up with it, which would be a year or so, or maybe a couple thousand deaths.

So this -- what this does, was this stops the -- and it disincentivizes them from doing that. I mean, granted, they may have switched over to producing illicit fentanyl, you know, but what it has done is it shut down the new fentanyl-related substance creation machine, the mine of new fentanyl-related substances, by -- again, by eliminating the incentives for that to happen.

*Mr. Guthrie. Mr. Vargo, instead of answering that, can I just focus on a specific part of that?

So -- and it was said earlier in testimony that, if the de-scheduling goes away, that they still remain illegal. But you have to use the Federal Analogue Act for them if they are not scheduled. And so could you talk about how that could be inconsistent jury findings?

You have to present to a jury for -- that they fall under the Federal Analogue Act, and not -- that they are not illegal by law, they are illegal if you can prove they are illegal to a jury. Could you talk about that process, and why it would hamper your prosecutions of major criminals?

*Mr. Vargo. Certainly, Representative Guthrie, and I will tell you that, obviously, I, as a state prosecutor, don't do a great deal of that now. I was, for 15 years, a

prosecutor in the federal system, so I have some familiarity.

I will tell you that it does appear that the -- both the goal and the effect of the class-wide scheduling have been effective. If we look at the -- what was happening before, we have kind of a before-and-after control group, if you will. And, as Dr. Westlake pointed out in his written testimony, the number of analogues that we are seeing at the border fell significantly after the passage of that legislation. In other words, the legislation worked in changing the game of Whack-A-Mole that we were playing with the Chinese laboratories that were creating new versions of fentanyl analogues.

The -- as far as prosecution goes, I think it is illustrative that the article which -- by the Sentencing Guideline Commission recently identified only two cases since the passage of that legislation that were actually scheduled -- or sentenced under the fentanyl analogue class-wide scheduling. So it has not led to a large-scale incarceration, or even large-scale prosecution, but it has been effective in reducing the number of new analogues that we see.

The difficulty becomes, if we went under the Analogue Act, you have to prove individually that the -- it is an analogue, and then you have to prove the person who was distributing it or possessed it knew that it was a controlled

substance, or had a controlled nature. Both of those would be very difficult, under the Analogue Act, with every new substance.

*Mr. Guthrie. Thank you. I would -- I will yield back my time.

Thank you for those answers, I appreciate it.

*Ms. Eshoo. The gentleman yields back. The chair recognizes the gentlewoman from California, Ms. Matsui, for your five minutes questions.

*Ms. Matsui. Thank you again, Madam Chair, and I do thank the witnesses for their testimony today, and I think you feel and see the frustration in our voices because all of us are troubled by the rise in overdose deaths, especially over the past year. And, despite the enormity of the COVID-19 pandemic, which is, you know -- and the overdose deaths and the substance uses have been exacerbated. So we can't lose focus on addiction crisis in this country.

Now, over the past several years we have worked in a bipartisan way to support targeted efforts that have finally begun to reverse some of the overdose trends. But the pandemic has robbed us of that progress. So in a way we are talking today about what are we going to do, moving forward.

The bills presented today represent an opportunity to take a much-needed, broader and bolder approach to address the crosscutting facets of the addiction epidemic.

You know, the task to combat the crisis continues to evolve. We know that. And as our witnesses have stated, we are now seeing fentanyl increasingly mixed into drugs like cocaine or meth, and that is presenting unique challenges to those on the front lines. And in some parts of states, including California, stimulants are the primary drugs of choice.

Mr. Vargo, you brought attention to the issue of meth. Can you talk more about how Americans who use meth may differ from those who use opioids?

*Mr. Vargo. Thank you, Representative Matsui, I would be glad to.

Methamphetamine is one of our most challenging substances because every drug that is illegal, every substance that is illegal, creates a criminogenic factor because you are dealing with it illegally. In the old words of Glenn Fry, I always carry weapons, because you always carry cash. So we know that we create problems any time something is illegal.

Methamphetamine, though, is, if not unique amongst drugs of abuse, certainly the most prominent -- drugs of abuse. It carries with it biological factors that render those people more dangerous: the hyper-vigilance, the paranoia, hallucinations, the aggression that comes with it. Even if meth were 100 percent legal at every level, it would create

criminality because it creates violence. It is very much like PCP was back in the 1980s. I am that old that I remember that.

So methamphetamine presents a particularly difficult circumstance and, more importantly, presents a very difficult treatment because it is one of the most difficult drugs to treat. Until recently we didn't believe there was medically-assisted treatment available. There is some hope in that regard, but it is a very difficult drug, both in its use and in its treatment.

*Ms. Matsui. Okay. Dr. Wilson, you also discussed in your testimony the growing number of patients that use stimulants, either as a primary drug or mixed in with other opioids. How does this impact how you care for patients?

And how are treatment recovery services for these patients different from those who -- primary for opioid disorders?

*Dr. Wilson. Thank you so much for that question. You know, I think it is really important to recognize that, while we have really effective medications to help patients with opiate use disorder, we do not have effective medical therapies to support patients who have stimulant use disorder like methamphetamines or cocaine. There are some medications that have very modest effects, but the primary treatments that have been shown to be effective for patients with

stimulant use like methamphetamines have been behavioral health treatments.

The sort of greatest evidence base supports things like contingency management, where you reinforce patients who are having negative urines and remaining abstinent, for example. But it is really hard to operationalize those kind of therapies within sort of traditional kind of outpatient treatment programs. And so getting access to sort of efficacious behavioral therapies for patients with stimulant use disorders is more challenging.

Many of the patients that I see who use stimulants are also using other substances. And so I think it becomes really sort of challenging to figure out sort of how can you link and engage patients in care, and get them access to a full complement of results. So --

*Ms. Matsui. It seems to me that we don't have as many effective treatments for patients that use stimulants.

*Dr. Wilson. That is absolutely true.

*Ms. Matsui. Right, and so we need to have more research in order to find some way to deal with this, because meth has been around forever, in essence. And I know, in California, people don't hear about it as much as they hear about opioids, and yet meth is still growing, in essence.

So I see I am running out of town. Thank you for -- time. Thank you very much, and I yield back.

*Ms. Eshoo. The gentlewoman yields back. It is a pleasure to recognize the ranking member of the full committee, Mrs. Cathy McMorris Rodgers.

*Mrs. Rodgers. Thank you, Madam Chair. I want to just thank you again for holding this important hearing today. I know it has been a long one, but it is really important. And a big thank you to all the witnesses for joining us today, sharing your perspective, your stories.

To Dr. Westlake, just thank you for sharing your own heartbreaking story. It is, unfortunately, is repeated too often right now in America. And my heart just breaks for you. I wanted to start with a question to you, Dr. Westlake, as well as Mr. Vargo.

GAO's recent analysis found that a number of reports of unscheduled fentanyl analogues decreased by 90 percent after DEA issued the class-wide scheduling order. So they found that after DEA issued this class-wide scheduling order, the fentanyl analogues decreased, the number of reports of it decreased by 90 percent. So specifically, in 2016 and 2017 there were over 7,000 law enforcement reports, 7,058 law enforcement reports of encounters with these substances. So that was 2016, 2017. You look at 2018, 2019, the encounters were down to 787, so over -- yes, 7,000 to 787.

Why did class-wide scheduling so significantly reduce the encounters?

And I will start with Dr. Westlake, and then Mr. Vargo.

*Dr. Westlake. Sure. Thank you for the question, Congresswoman.

I have a -- there is a phrase that I want to drive home, if there is, like, one point that I want to get brought out of this hearing. It is that you can't die from something that has never been created, and you can't be incarcerated for selling something that doesn't exist.

And so that is what has happened, is, you know, in conjunction with our scheduling language -- the Chinese actually knew about the language coming up. We have been, you know, partnering closely with them, trying to get them to control the fentanyls, and eventually that happened. And so that just stopped. So it is not just that there is no new fentanyl-related substances that are being seen, or very few.

The NFLIS, the National Forensic Lab Information System, shows that there is almost no deaths that are occurring from new fentanyl-related substances. So you are still seeing deaths from the older fentanyl-related substances that are now fentanyl analogues, but you are not seeing deaths from the new ones. And so that was the goal of this. The whole -- this is not a law enforcement bill. The vehicle is a law enforcement vehicle for scheduling, but the bill is ultimately opioid, you know, harm reduction, and opioid reduction of overdoses, overdose prevention.

*Mrs. Rodgers. Thank you.

Mr. Vargo?

*Mr. Vargo. Thank you, Madam Chair. I will tell you that it is hardly surprising that criminal enterprises go where the money is, and where the criminality is least likely to be punished. I think that the response that we have seen from these organizations -- I wish I could tell you that I don't think they are dealing drugs anymore. I doubt that is the case. But it means that they haven't tried to go into the area of new fentanyl analogues, because that is no longer profitable, and it is more likely to be punished.

So I think that that, again, kind of speaks to the question of whether or not the original Analogue Act itself was sufficient. It was not. And it is the reason that I believe that an extension, at least until we get some other format in place, is absolutely essential.

*Mrs. Rodgers. Thank you. Thank you. I appreciate that.

Mr. Vargo, in your testimony you mentioned the work with the Sioux tribe, and the importance of cultural competency. I represent several tribes in eastern Washington. I wanted to ask if you would just speak about what you are doing to meet the needs of the tribal communities who have consistently experienced larger increases in drug overdose mortality. I know that the Colville Confederated Tribe in my

district is building a new treatment facility, and just -- would you speak briefly as to what role Congress can play in aiding these efforts?

*Mr. Vargo. Yes, absolutely. Thank you, Representative.

The Oglala Sioux tribe is the closest tribe to us, but we also have the Cheyenne River Sioux Tribe and the Rosebud Sioux tribe that are very much part of our geographic area. They face extreme poverty, 90 percent unemployment, and they have been hit hardest by methamphetamine probably of any group, certainly in South Dakota, possibly in the nation. And they are fighting, literally, for their lives in a lot of instances.

I think that Congress's role here can be to enhance and support what they are trying to do, both on the reservations and off.

Native Women's Health Care is an organization that provides health care to, primarily, pregnant women. We are partnering with them as diversion partners. So we send pregnant women with criminal offenses to them. If they successfully complete their medical program, we dismiss the criminal cases.

We have also not only partnered with, but invested in an organization that involves a tribe called Native Healing. That is a residential drug treatment facility.

Unfortunately, because of COVID, they are not going to be open until June of this year. They were supposed to be open April of last year. But it is 25 beds. To give you a frame of reference, though, we had over 1,200 arrests last year for methamphetamine, so 25 beds is a great beginning, I believe it gives people hope, but it is hardly enough. And I think Congress needs to take a close look at those communities to whom the United States has a very particular and special relationship.

*Mrs. Rodgers. Thank you. Thank you very much. My time has expired. I yield back, thank you.

*Ms. Eshoo. The gentlewoman yields back. The chair now recognizes the gentleman from California, Mr. Cardenas, for your five minutes of questions, and thank you.

*Mr. Cardenas. Thank you very much, Madam Chairwoman and Ranking Member, for us having this incredibly important hearing that affects every single person in America. And I would hope and pray that we can be an example for the world of how to handle drug addiction, and how to make sure that we curtail this method in the United States that -- we have been trying to incarcerate our way out of this, which never works. It has never worked anywhere on the planet, and it is something that we can do better, here in the United States.

And I do appreciate the testimony of every single person on this panel. And it appears that you all are, in some

fashion, in agreement that we need to look at this as treating addiction, rather than incarcerating our way out of this. So thank you so much for all of that.

And I want to thank all of my colleagues for all the legislation that you have done in the many various positions that we have all been in. For example, when I was in the state legislature, we passed the Schiff-Cardenas Act, which is the Juvenile Justice Crime Prevention Act, which provided $120 million per year to local communities to fund prevention and intervention programs.

Also, today in Congress, my colleague, Representative Griffith, and I led the At-Risk Youth Medicaid Protection Act, which was signed into law in the SUPPORT Act. This bill allowed a young person, who is otherwise eligible for Medicaid, to continue their health care coverage immediately following release from the juvenile justice system.

And also we are considering many great bills today. One bill I am incredibly supportive of is my colleague Representative Tonko's Medicaid Reentry Act. This bill would extend Medicaid eligibility to incarcerated individuals 30 days prior to their release. Passing this bill is critical to improve access to substance use disorder treatment. Ninety-five percent of adults who are incarcerated in America will transition back into our communities, and data shows that individuals released from incarceration are 129 times

more likely -- that is 129 more likely -- to die of a drug overdose during their first two weeks after release.

Dr. Wilson and Ms. Richman, can you each please share your thoughts on this bill, as well as the role Medicaid and access to health care plays in addressing substance use and misuse in America?

*Ms. Richman. Thank you so much for that question. I am happy to answer it, and I am very grateful for the work that is being done and proposed in both of those bills.

As a federal public defender, many of my clients who had grown up in Baltimore did not receive the opportunity for either mental health or substance use, or sometimes even just core health care, until they entered the incarceration system, whether it be when they were a juvenile or when they were an adult. And what I saw in a lot of those clients' lives was a cycling in and out, and a discontinuity in their treatment because of their movements in and out of incarceration, and because of the lack of resources in the community. So I am very glad to see work in this crucial area.

*Mr. Cardenas. Thank you.

*Dr. Wilson. Thank you. I think this is a critical point, and an important piece of legislation.

So we know that access to substance use treatment within the correctional system is a critical public health and

ethical issue. And research shows that, if we start medications like methadone or buprenorphine for the treatment of opiate use disorder while individuals are incarcerated, that improves the likelihood that they will enter treatment, and it reduces their risk for dying post-release. And so reinstating Medicaid coverage before re-entry to the community is an important and essential way to keep people alive, and facilitate their entry into evidence-based treatment.

*Mr. Cardenas. Thank you, yes, evidence-based treatment is something that, unfortunately, in my opinion, is a little too new in the United States. We were stuck on just tough on crime for far, far too long. And unfortunately, this has affected almost every family. We have actually had Members of Congress admit to the fact that some of their family members have been subjected to addictions, et cetera, and everybody wants to see their loved ones treated with respect and dignity, not be treated like criminals because they have fallen prey to being addicted to some kind of substance. So I really appreciate the opportunity for us to bring this to light.

And also, I would like to point out that this issue of addiction has been going on for hundreds and hundreds of years across the planet, and certainly has been going on since the founding of our country. So hopefully, during this

Congress, we can actually make substantive changes and have the kind of programs funded so that we can treat everybody with dignity and respect.

So my time has expired, and I yield back. Thank you.

*Ms. Eshoo. The gentleman's time -- the gentleman yields back. I now would like to recognize the gentleman from Virginia, Mr. Griffith, for your five minutes.

You need to --

*Mr. Griffith. Thank you, Madam Chair. Yes, ma'am. Thank you, Madam Chair. My mask fell down there, so you all can hear me.

Mr. Vargo, as we have discussed, last year Congress extended the order temporarily classifying fentanyl analogues as schedule one substances. If Congress does not further extend that order, what will be the status of fentanyl analogues come May 7, 2021?

[Pause.]

*Mr. Griffith. Mr. Vargo, can you hear me?

*Mr. Vargo. I knew I was going to do it at some point. Sorry to do it on your time.

*Mr. Griffith. That is all right.

*Mr. Vargo. Thank you for the question, Representative. Those analogues are at least arguably legal. And certainly, if Ms. Richman were defending one of those defendants, she would say that those analogues had not been scheduled, and

were not illegal, or that her client did not know that those analogues were illegal, and therefore cannot be prosecuted.

And so it is certainly something that is possible to argue, that under the old Analogue Act we can try to stop that importation, and we can try to bring criminal prosecution, but it would be much less likely to be successful.

And I believe that just the before-and-after has shown us that it emboldens folks when they are not specifically scheduled.

*Mr. Griffith. Well, and I appreciate that. And I can assure you, having been a criminal defense attorney myself for a big part of my career, that is exactly what Ms. Richman would argue, and properly so. She has got a duty to defend her clients. Our job is to make sure the law doesn't create loopholes that folks who are trying to do bad things can drive a Mack truck through, which, by the way, are made in my district, some of them.

Mr. Laredo, some folks have said keeping fentanyl analogues in schedule one inhibits scientific research. Yet DEA has approved nearly 800 applications to research schedule one-controlled substances, and half of those have been approved in just the last five years. Do you believe valuable research could continue if analogues remained in schedule one?

*Mr. Laredo. Thank you so much for the question. I do believe that research can continue. There would be much, much less of it if you folks don't provide some exemptions for researchers on the research field so that they can really do that work.

There, you know --

*Mr. Griffith. So --

*Mr. Laredo. -- for the time that I was at NIDA, it was almost a daily occurrence that I would get a phone call from a researcher in the field, complaining about something about that.

And even now, I would strongly recommend you reach out to the National Institute on Drug Abuse and the College on Problems of Drug Dependence, who have been compiling more information about this. I personally believe they should be compiling even more. But there are some documents that I think that they have now that should be shareable with the committee that would help you as you talk about this.

*Mr. Griffith. Well, and so, from listening to your comments, do you believe that my bill -- and I think you do -- but do you believe my bill, the Streamlining Research on Controlled Substances Act, would improve the landscape for conducting this research?

*Mr. Laredo. I thought you might be going in that direction.

*Mr. Griffith. Yes.

*Mr. Laredo. I do. I would like to study the bill just one more time to look at all the details. But overall, I very much appreciate your approach.

*Mr. Griffith. Well, and as I have said before, I am a big believer in trying to do research. And sometimes we find -- out of odd and strange things you find a cure, or a treatment for something that you weren't even necessarily looking for. So I want to make sure we --

*Mr. Laredo. Exactly.

*Mr. Griffith. -- the American medical science community, because they do amazing things, as we have seen this year with the coronavirus. And I want to make sure they have all the tools available. I want it to be done legally. I want it to be done in a way that -- we are looking for a way to use these substances, if possible, for medicine. And I think that the bill does that.

However, that being said, if you or any of your colleagues has a way that we might improve the bill, I am always happy to take a look at that, as well.

*Mr. Laredo. Thank you. I would be glad to look at that again.

*Mr. Griffith. Thank you. And I invite anybody who wants to sponsor it, it is H.R. 2405. If they have concerns in this area like I do, please jump on the bill and cosponsor

it on both sides of the aisle.

And Director LaBelle said in her testimony, Mr. Vargo, that early data suggests a steep rise in overdose deaths during the pandemic. When do you expect that we will have a full picture on how the pandemic has affected illicit drug use?

*Mr. Vargo. Boy, that depends on when the pandemic ends, doesn't it, Representative?

Part of that is going to be we have to basically get back to some kind of normal. We have to readjust for the fact that we probably spent a year to maybe two years not doing the things that we wanted to do. And then we have to guess what things might have been.

I would say that your effect of the pandemic is going to be at least as long as the pandemic. So after it is over, it is going to take at least as long as that to determine what it meant.

*Mr. Griffith. All right. And then you don't think now is the time that we should be lightening up on the analogues, do you?

*Mr. Vargo. Absolutely not.

*Mr. Griffith. I thank you very much.

And Madam Chair, I yield back.

*Ms. Eshoo. The gentleman yields back.

Before I recognize Ms. Kuster, Ms. Richman, your name

has come up several times. Do you want to just take one minute to -- for any kind of response? I think that it would only be fair to do that, but for a limited amount of time, though. You have, like, a minute, a minute and a half, at the most.

*Ms. Richman. I thank you for the opportunity. A couple points I would like to respond to. I think it is tempting to draw simple causal connections, but the fact is that the GAO report could not analyze a connection between class-wide scheduling and the decrease in novel substances because of multiple confounding factors.

With respect to the Analogue Act, I do understand there have been many complaints about it. But the Department only relied on it five times between 2015 and 2019 to prosecute fentanyl analogues. In all other cases they have been able to make good use of individually-scheduled substances, which still comprised most substances that are charged.

In addition, most of these cases are polydrug cases, the overwhelming majority, meaning that the presence of the fentanyl analogue doesn't make the difference about whether something is interdicted or not. It acts, in essence, as a sentencing enhancement that triggers mandatory minimums for any trace of a fentanyl analogue in a substance weighing 10 paperclips. It is five years. And so that is the source of many of our concerns.

Thank you for the opportunity.

*Ms. Eshoo. Thank you. The chair now recognizes the gentlewoman from New Hampshire, Ms. Kuster.

You need to unmute, Annie. I have got to hear you.

*Voice. I am sorry, it is Dr. Ruiz.

*Ms. Eshoo. Oh, you know what? I made a mistake, Annie. The next one up is a fellow Californian, Dr. Ruiz.

You are recognized for five minutes.

*Mr. Ruiz. Thank you.

*Ms. Eshoo. I am sorry.

*Mr. Ruiz. Thank you. No worries. Thank you to all the witnesses for taking the time to be here today. We have heard in today's testimony about the increasing rates of substance use and overdoses in the United States over the last year.

However, disparities in prevention, treatment, and recovery strategies continue to plague communities of color. A 2020 issue brief by the Substance Abuse and Mental Health Service Administration lists a number of barriers to care for Hispanic individuals, including a lack of culturally-responsive prevention and treatment, less access to medically-assisted therapy such as buprenorphine and Naltrexone than White individuals, and a higher likelihood of relying on detox alone.

A stigma and misperception within the Hispanic

community, with only five percent of Hispanics with a substance use disorder thinking they need treatment, is also an issue. And one of the most commonly-cited issues regarding prevention, treatment, and recovery strategies in the opioid crisis: language barriers for substance use disorders, materials, and treatments, and culturally-relevant treatment from providers who understand the communities. In other words, diversifying the workforce, the provider workforce.

So it is clear that we need to examine the policies that we consider through a health equity lens, and make sure that they address prevention and treatment services in high-risk communities.

Dr. Wilson, can you speak more about barriers to prevention and treatment services that drive inequalities in outcomes for minority communities?

And in your experience, what are the most common barriers?

*Dr. Wilson. Thank you so much. I think we know that stigma related to addiction, to opioid use disorder and other substance use disorders exist, and stigma related to that, as well as racial bias, really intersect to create overlapping and compounding systems of disadvantage. So this contributes to lower quality of care, and worse treatment outcomes for racial and ethnic minorities.

We have another -- a number of physicians who often, due to racial bias or structural racism, have inequitable prescribing practices and treatment. So we see that, for example, when we look at well-known disparities in pain management, for example, with lower rates of over -- opioid prescribing or increased oversight for Black patients, and we see similar things when we look at disparities in the prescription of medications to treat opiate use disorder, with much lower rates being prescribed to patients with opiate use disorder in communities of color.

And so, you know, I think, when we think of barriers, it is essential that we train our workforce, and we train our workforce to provide care to communities of color, and we also increase the number of providers of color treating those communities.

*Mr. Ruiz. So, Dr. Wilson, I practiced medicine, emergency medicine, and I do a lot of public health work in under-served, medically-under-served areas. And would you say that the driving force of the decrease in access to prevention and treatment is more the systemic barriers that exist, the lack of providers, the lack of clinics, the lack of language, the lack of knowledge to empower, the lack of services focused in these under-served areas, versus the stigma portion?

*Dr. Wilson. I mean, I think all of those things come

together, right? I think that patients in these communities, families within these communities, are desperate for help. I think historically, our solutions for those communities have been mass incarceration and failed policies.

And so I think what we really need to do is invest in widespread treatment, and I think that means partnering with community organizations where patients have had positive experiences, increasing culturally-competent care, and increasing a workforce that is able to provide competent and equitable services to those communities.

*Mr. Ruiz. You know, one of the risk factors that have been cited in the social studies literature is the lack of social capital within communities, or the lack of communities that are -- so do you think the promotora community health worker models by individuals in the communities --

*Dr. Wilson. Yes.

*Mr. Ruiz. -- to keep people together should be expounded on in our country?

*Dr. Wilson. Absolutely. I think -- I learned a lot of what I learned from addiction from amazing peer recovery specialists with lived experience in addiction. And I think that there is nothing that you can do to sort of help prescribe hope to patients, other than showing them somebody who has lived through addiction and has come out on the other side. And so I think supporting and investing in those

models is essential to increase that sort of treatment access in communities of color.

*Mr. Ruiz. Great. So with your 15 seconds remaining, what other recommendations do you have that Congress can do to help relieve these disparities?

*Dr. Wilson. I think one essential thing is to support training in addiction medicine, and to support sort of building a more diverse addiction medicine workforce. And so that means sort of supporting physicians of color, and building and supporting the pipeline, and incentivizing physicians of color to go into addiction medicine.

*Mr. Ruiz. Thank you. I agree. I yield back my time.

*Ms. Eshoo. The gentleman yields back, and it is a pleasure to recognize the gentleman, the very patient gentleman, from Ohio. He has been with us, I think, since we began at 10:30 this morning. I kept asking my staff, "What about Mr. Latta? What about Mr. Latta?'' So here he is, and the gentleman has five minutes for his questions.

And it is great to see you, thank you.

*Mr. Latta. Well, let me thank the chair, the gentlelady from California, for allowing me to waive on today, and I really appreciate it. And again, this is such an important subcommittee hearing that you are holding today, so I really appreciate it. And I also want to thank our witnesses for today.

But, you know, over a year ago the lives of every American changed due to the coronavirus. And every day we are getting closer to ending the COVID-19 pandemic and returning to normalcy. However, long before COVID-19 dominated the spotlight, we were dealing with another crisis in this country, and that epidemic is still ongoing, which is the opioid crisis that has been significantly heightened due to lockdowns and immense stress on those already struggling with addiction.

And before COVID-19 we were beginning to see some light at the end of the tunnel, you might say, that -- we saw that the number of deaths were going down for the first time in decades. And however, you know, we already talked about today -- is that we have seen in the last year, from August of 2020, that over 88,000 people died from drug overdoses in this country, which is the largest ever in a 12-month period.

So substance use disorder, SUD, and mental health have been overshadowed through the pandemic. And those suffering from SUD have shown that they are particularly susceptible for contracting COVID-19. So we must go back to work in defeating this deadly, ongoing crisis, and prepare to meet the needs in a post-pandemic world.

And I have introduced several bills that would help curb the opioid pandemic, increase telehealth services, and assist those struggling with mental health. One bill that will

immediately assistance in stopping the illegal distribution of drugs is H.R. 1910, which is the Fight Fentanyl Act that I introduced with my colleague from Ohio, Mr. Chabot.

In addition, my fellow Ohioan, Senator Rob Portman, and Senator Joe Manchin also introduced a Senate companion.

In February of 2018 the DEA issued a temporary scheduling order to schedule fentanyl-related substances to allow our law enforcement to crack down on criminals flooding our neighborhoods and communities with this deadly drug. However, the order is set to expire on May the 6th, 2021. And so the Fight Fentanyl Act will simply codify the DEA's precedent to approve a schedule fentanyl-related -- currently scheduled fentanyl-related substances as a schedule one drug.

So, again, I want to thank our witnesses for being here today and, if I could, ask my first question to Dr. Westlake.

In your written testimony you discussed how the goal of fentanyl class scheduling isn't to lock up low-level drug users, but to stop the development of deadly fentanyl poisons at their origin. Do you believe that the permanent scheduling of fentanyl as a schedule one substance, as my bill, the Fight Fentanyl Act accomplishes, would -- will help lower overdose death rates, and help stop the influx of the illicit fentanyl into our communities?

*Dr. Westlake. Thank you, Congressman Latta. Yes, absolutely. So I think, to be clear, it will definitely

decrease the existence and availability of newly-created fentanyl-related substances. That has already happened. There has been a 90 percent decrease coming over from China that -- the fentanyl-related substances that are new are not being seen in overdose deaths. And so that is definitely a part of it.

So I think it is a huge piece, and I think that, you know, the language is very surgically targeted. If you look at my testimony, the written testimony, you can see that it is only very specific modifications to the molecule that have already been proven to have bioactive structure activity chemical relationships through the 60 years of research into the class. And so the language in your bill exactly, you know, is the perfect language to stop the creation of those likely bioactive substances.

So, yes, I think it is a necessary -- and from an emergency medicine perspective, you know, I am glad that I don't have to resuscitate people that are dead from a fentanyl-related substance. Unfortunately, we are seeing other, you know, illicit fentanyls coming through, and that is a whole different -- there is only so much you can do at a time, and that is one thing we can do.

*Mr. Latta. Great. Well, let me ask -- you know, as I mentioned, we have seen the largest overdose in our history in the last year, with 88,000 deaths. You know, what do you

believe is the best way to address the crisis, as we move forward, you know, while also addressing the needs of those who are suffering out there?

*Dr. Westlake. Yes, I think it is a huge -- the issue for me -- so I looked at this, and I led the Prescription Opioid Reform Strategy in Wisconsin over the past seven years, since we became aware of it.

And so it is a really, really difficult issue. I mean, addiction goes back probably forever in human history. I don't think there is any time that we are ever going to get rid of addiction. I think that is, you know, like, you can't get rid of cancer, you are not -- you know, it is a disease. What we have to do is, you know, we try to de-stigmatize it.

I think the medication-assisted treatment part, and making it so that you can prescribe medication-assisted treatments -- I am running out of -- I think you are out of time -- is really important and critical, because I can prescribe, as a physician, without any restrictions other than a DEA license. I can prescribe as much Oxycontin as I want, but I have to take eight hours to prescribe Buprenorphine. And that makes -- that has put a stigma on the prescribing of Buprenorphine. And so that is something that is concrete that you guys can do that would make a big effect, just like it did in France, as was mentioned previously.

*Mr. Latta. Well, thank you very much. Yes, I appreciate the witnesses today.

And Madam Chair, again, thank you very much for allowing me to waive on today. I appreciate it.

*Ms. Eshoo. Well, you are always, always welcome, Mr. Latta. You enhance our subcommittee any time you are with us.

*Mr. Latta. Thank you.

*Ms. Eshoo. We all feel that way about you.

The chair is pleased to recognize the gentlewoman from New Hampshire. I think I am correct this time.

Ms. Kuster, for your five minutes of questions.

*Ms. Kuster. Thank you so much, Madam Chairwoman. I apologize for my technical difficulties, but thanks to all the witnesses on the panel, and I appreciate your perspectives on the addiction epidemic in this country, and your efforts to find solutions that will save lives and our communities.

This is the reason that, seven years ago, I founded the bipartisan Congressional Opioid Task Force, and why this Congress we have now expanded it to the Addiction and Mental Health Task Force, to include this complex crisis that needs comprehensive solutions.

It also is why I waited six years to join the Energy and Commerce Committee, and I am so delighted to be on the Health

Subcommittee at this point. I want to commend you all for the incredible work that you do on substance use disorder and mental health, most recently working to include $4 billion in support for substance abuse and mental health services administration as part of our incredible American Rescue Plan.

But that is not enough. We must do more to address the new realities of this epidemic defined by illicit synthetic opioids, as well as ensure that our policies don't reinforce the mistakes of our past that disproportionately have impacted communities of color.

So my legislation with Congresswoman Lisa Blunt Rochester, known as the Stop Fentanyl Act, is comprehensive in its public health approach to addressing fentanyl. And I want to take the time with all of you today to discuss some of those provisions.

Ms. Richman, thank you for joining us. You stated the Stop Fentanyl Act takes a comprehensive health and evidence-based response to fentanyl and fentanyl-related substances. Why do you think that this approach is necessary to addressing the addiction crisis in our country?

*Ms. Richman. Thank you so much for that question and the opportunity to comment on your legislation, Representative Kuster.

I appreciate this putting sort of the work into finding

what are the evidence-based science solutions that we can turn to. If you dive into the history of -- the legislative history between -- behind the draconian war on drugs laws that were put on the books in the 1980s and 1990s, you will see that they were passed with the intent to incarcerate manufacturers, kingpins, to keep things from ever being brought into our country.

And yet we are seeing substances that have been subject to harsh penalties for 30 years -- Methamphetamine is a case in point -- proliferate new versions of it that are stronger. We are seeing new types of synthetic opioids, not fentanyl analogues, proliferate. U-4700 is beginning to see -- beginning to be seen in more drugs.

The truth is that most individuals who are incarcerated for drugs in our country are low-level dealers, are individuals who are minimally involved. And in the case of fentanyl analogues, many of them have not made a conscious choice to include that substance in whatever they are consuming or selling. So it is just acting as a way of bringing these harsh penalties onto communities of color that have been disparately impacted for far too long.

*Ms. Kuster. Well, thank you. And one provision of our Stop Fentanyl Act includes Good Samaritan protections to ensure that there are no impediments or fears and judiciary repercussions to assisting during an overdose, or reporting

an overdose. Can you explain why these types of reforms are necessary to save lives?

*Ms. Richman. Gosh, I think that these are so very important, and I think that the stigmatization and punitive approach to drug use in our country really makes people afraid to reach out for help when people are in crisis.

In particular, there is a 20-year mandatory minimum in the federal system for giving or selling drugs to somebody that results in death. And we have heard of circumstances where people are in a sober house together, one user shares with the other one, that person begins to overdose. Their response to that may be inhibited by their fear of exposure to criminal penalty, and that harms public health.

*Ms. Kuster. Great.

And Ms. Wilson, the Stop Fentanyl Act includes funding directed at community-based organizations that provide harm reduction services. Why are these services particularly critical for our fentanyl response policies?

*Dr. Wilson. Thank you so much. You know, I take care of a lot of patients who are at various points of interest in sort of stopping the use of substances, and it is important for us to offer sort of treatment and services to everyone, regardless of where they are. You know, it is -- the harm reduction axiom is, "Meet people where they are, but don't leave them there.'' These services help keep people alive,

keep them engaged and linked to care, so that when they are ready they are able to actually access and get plugged into treatment.

*Ms. Kuster. Great. Well, my time is up. Thank you, Madam Chair, for including our bill, the Stop Fentanyl Act. Thank you. I yield back.

*Ms. Eshoo. The gentlewoman yields back. I want to -- oh, we still have two members, okay.

The chair recognizes the gentleman from Florida, Mr. Bilirakis, for your five minutes of questions.

*Mr. Bilirakis. Thank you, Madam Chair. I appreciate it. This question is for Dr. Westlake.

Higher-dosed pills from improperly-mixed batches known as hot spots that led to overdose and death in a given area were often the way the medical community and law enforcement learned that fentanyl or an analogue had been introduced into a local drug market, which in turn would beget reactive scheduling in states or, as you put it in your testimony, a lethal game of Whack-A-Mole. This led to work to remove the incentive that these international drug traffickers had in modifying the drug molecule by targeting likely bioactive fentanyls as a class.

Can you discuss how fentanyl class scheduling is critical, not only for law enforcement, but for patient and community health, as well?

And should this scheduling ban expire, is it realistic to expect an increase or even sharp increase in overall deaths?

*Dr. Westlake. Yes. Thank you for the question, Congressman.

I think, you know, when you look back at what was happening with fentanyl-related substances before the scheduling language was in place in your state, in Florida alone, in 2016 to 2017 there were 2,500 deaths from two different fentanyl-related substances. We happen to have the similar deaths from similar substances in Wisconsin. So we scheduled them, we were the first state to schedule them. We are not seeing those any more. NFLIS is not reporting those, as I have said before.

So I think it will definitely decrease the deaths and availability of those particular fentanyl-related substances. I think there is a lot of other things that need to fall into place to start to eliminate deaths, you know, writ large.

I think also that, again, the important thing to remember about the scheduling is that it is surgically specific to only target the likely bioactive fentanyl molecules. It is not all potential fentanyl modifications. There is one fentanyl molecule, Benzylfentanyl, a fentanyl analogue, that was found to be non-bioactive, and they did not include that in re-scheduling for fentanyl-related

substances. And so it -- there has never been a non-bioactive fentanyl-related substance found.

*Mr. Bilirakis. Thank you. This question is for Mr. Vargo.

While patients were not criminals, some career criminals do pose as patients or, in some cases, are even providers themselves, as recently observed in my district, unfortunately. As you alluded to throughout your testimony, prevention is worth a pound of cure, and treatment can be more successful than incarceration.

From your conversations with district attorneys across the nation, what law enforcement gaps, if any, exist within the current prescription drug monitoring program to detect and track?

So again, yes, again, to detect and track patterns of abuse. Can you answer that question for me, please?

*Mr. Vargo. Yes, certainly, Representative, thank you for the question.

*Mr. Bilirakis. Of course.

*Mr. Vargo. I would say that we have done a fairly good job over recent years of making sure that our data has improved, but there is very much still room to take another step.

Twenty years ago in South Dakota, if I wanted to prosecute somebody for doctor-shopping, that was almost

impossible. I would have to go to every doctor that they might have talked to, and we didn't have a central clearinghouse. And so our ability to say that you were doctor-shopping and getting multiple prescriptions for the same reason was very, very limited. We took care of that clearinghouse now, and that has been very effective in making sure that people are only getting the prescriptions that they should, and that doctors have all the information that they need in making sure they are not double-prescribing.

But I would guarantee you that there are circumstances where diversion still takes place. And so the monitoring and the tracking that -- I believe could still very much be improved.

*Mr. Bilirakis. Thank you. Given the current opioid crisis in our nation, the fact that all opioids are controlled substances, and our efforts to curb and eliminate doctor-shopping, would you consider it to be a best practice for states to require patients to show ID when retrieving an opioid prescriptions, similar to purchasing alcohol, Sudafed, or even retrieving an MLB ticket from will call?

What do you think about identification?

*Mr. Vargo. I would say that we want to make sure that the person receiving the prescription is the person for whom the prescription was made. And by whatever means that occurs, whether it is because it happens at the doctor's

office, where the doctor would have direct knowledge, or whether it occurs at a linked pharmacy -- again, where they would have direct knowledge, or whether there is an identification factor that guarantees it, that is very important.

*Mr. Bilirakis. Thank you so much.

Madam Chair, my bill, H.R. 2355, the Opioid Prescription Verification Act, would encourage states to adopt systems that require pharmacists to check IDs to dispense opioids, and require CDC to work collaboratively with other federal agencies to provide guidance to pharmacists on ID verification, while deferring to states on acceptable forms of identification, allowable immediate danger exemptions, of course, in addition to other state-specific needs that may need to be addressed. I encourage my colleagues to review this particular bill, and consider joining my efforts by cosponsoring the bill.

So I will yield back, Madam Chair. Thank you so very much.

*Mr. Bilirakis. You are very welcome for the extra 23 seconds.

The chair now recognizes the gentlewoman from Delaware, Ms. Blunt Rochester, for your five minutes of questions.

*Ms. Blunt Rochester. Thank you, Madam Chair, and thank you to the witnesses for joining us for the second panel.

It is clear our nation's ongoing overdose crisis isn't limited to one community, one region, one race, or one socio-economic class. Previous congressional efforts to reduce the number of fatal drug overdoses have helped us make progress. But as our chairwoman has said, it is far from enough. States like Delaware continue to be in the middle of a public health crisis, due to the rise in synthetic opioids like fentanyl.

We are anticipating a total of over 500 overdose deaths for 2020, an all-time high for my state. That is why Congresswoman Kuster and I introduced the Support, Treatment, and Overdose Prevention of Fentanyl Act, STOP, a comprehensive package of public health policies to address the proliferation of synthetic opioids without the mainly punitive measures used in previous approaches to drug control.

Dr. Wilson and Ms. Richman, how will a public health response to substance use disorder address some of the challenges you have seen throughout your careers? And we will start with Dr. Wilson.

*Dr. Wilson. Yes, thank you. I mean, I think it -- as a physician, it is absolutely clear that addiction is a disease, and this is a huge public health crisis.

We cannot schedule our way out of this epidemic, and we cannot incarcerate our way out of this epidemic. We

absolutely need evidence-based and informed public health solutions. So expanding access to treatment, we need to get effective therapies to communities that need them. We need to partner with community organizations that are already embedded within communities to strengthen those communities, and provide greater links from sort of our health care systems to sort of organizations already doing the work on the ground in local community settings.

We need to keep people alive, which means we need to expand access to harm reduction services to prevent morbidity and mortality associated with opiate use, recognizing that not everybody is going to be ready to quit today, but they may be tomorrow, and we have to keep them alive so that they can reach that point.

*Ms. Blunt Rochester. Thank you.

Ms. Richman?

*Ms. Richman. Yes, thank you, Representative Blunt Rochester, I appreciate the opportunity to comment.

I have also been very grateful for Mr. Vargo's response and remarks today about shifting the intervention point. And I think directing resources away from enforcement and towards public health gives the opportunity to bring those interventions earlier, and keep individuals from going down a path that will be very damaging.

When I look at the lives of my clients, I see so many

different intervention points that there could have been: with their mother, before she overdosed; when they were a child, to be placed in a setting where they would be given holistic, educational, medical substance abuse services, all the way into the criminal justice system.

I will never forget working with my social workers, and just spending hours on the phone for clients who came in suffering from substance use disorder to try to find them some sort of residential placement where they could go so that the court wouldn't send them to jail. A lot of my clients did not have a home to go to. They were struggling, and it would be incredibly difficult to find that place. And then you just cross your fingers and hope it worked.

*Ms. Blunt Rochester. Well, I thank you for sharing all of that.

Included in our STOP Fentanyl Act is dedicated funding and support for overdose prevention and treatment programs, including grants for harm reduction providers and improving our understanding of evidence-based overdose interventions.

Dr. Wilson, I think you also may have talked about harm reduction and the benefits of it. Can you tell us what scientific evidence there is that shows that there is a benefit for harm reduction efforts?

*Dr. Wilson. Absolutely, I think the evidence is really care that -- clear that programs, for example, that

distribute Naloxone are -- there is a dose response, which is sort of one of the sort of strongest relationships in the medicine.

So the more you integrate overdose prevention within communities, the greater the Naloxone you distribute within communities, the lower the risk of having fatal overdoses, and your mortality rate will actually decrease. So there is great evidence showing that needle and syringe exchange programs, for example, reduce hepatitis C, reduce HIV, and infections related to injection drug use.

And so, again, you know, I think we have to think broadly about this. Our goal is not just to reduce overdose, it is also to reduce sort of infectious complications, like infective endocarditis, associated with injection drug use. You know, we have to keep people alive so that we can get them access to treatment and harm reduction services. There is really a strong evidence base that these things are effective at doing that.

*Ms. Blunt Rochester. Thank you. The STOP Fentanyl Act is the long-term solution that our nation needs to respond to the overdose epidemic. And I look forward to working with the committee to advance this critical legislation.

Thank you, Madam Chairwoman, and I yield back.

*Ms. Eshoo. The gentlewoman yields back. The chair now recognizes the gentlewoman from Minnesota, Ms. Craig, for

your five minutes of questions.

*Ms. Craig. Well, thank you so much, Madam Chair, and thank you to the panelists here today, the witnesses, for your incredible expert opinion that helps guide our policymaking.

Mr. Vargo, you said something in your testimony that I would like to highlight. You wrote that, "Just as we cannot incarcerate our way out of an epidemic, neither can we ignore it and expect it to go away.'' I completely agree with you, Mr. Vargo. And incarceration is not the answer to our current substance use epidemic. I would argue that we need additional public health support.

I am proud to represent Minnesota's 2nd congressional district, where our county and local law enforcement partners have launched programs that focus on intervention, rather than incarceration for non-violent offenders struggling with addiction.

The Shakopee Police Department offers a scholarship program to cover the cost of drug or alcohol treatment funded by drug and alcohol forfeiture cases. Scott County's drug court provides supervision and treatment, an effective alternative to incarceration that saves taxpayer dollars and directs participants to long-term recovery.

Mr. Vargo, starting with you, thank you again for your testimony here today. As you all know, one of our great

colleagues, Representative Annie Kuster, put forward H.R. 2366, the Support, Treatment, and Overdose Prevention of Fentanyl Act. One provision requires HHS to report on how SAMHSA can provide and support health services to under-served individuals, taking into account drug courts.

Can you talk a little bit more about how drug courts work, and the overall impact they may have in combating drug use and abuse, from your experience?

*Mr. Vargo. Thank you, Representative Craig, I would be happy to. Drug courts are near and dear to my heart.

I am an old prosecutor, and I started in Miami in 1988, when Ms. Reno was the state attorney down there. And in the fall of 1988 into the spring of 1989 she began the nation's first drug court. And so that has always been something that has -- I have paid attention to. You could not find a county in America that doesn't have some access to one of these -- what we call specialty courts.

The weakness of specialty courts, drug courts, DUI courts, even mental health courts, is that they tend to be aimed at those who are in the last steps before a penitentiary sentence. So they are wonderful. They do divert people from the penitentiary. They do not divert people from conviction, and they do not divert people at the beginning of their criminal justice involvement. That is why we believe that diversion, which we unabashedly stole from

Manhattan and the Bronx, are answers that need to be more widely incorporated with prosecutors' offices from here on out.

So I really am thrilled to hear about what is going on in Minnesota. I know some of your wonderful prosecutors -- Mr. Freeman, Mr. Orput -- are good friends of mine, and I am glad to hear what they are doing.

I will tell you that I would love to see in the STOP legislation -- the numbers are sometimes daunting. When you talk about HHS making reports on SAMHSA, we are in the process of looking for a grant or a diversion opportunity to test out the medical-assisted treatment model for methamphetamine. When working with our partners here who already provide opioid MAT treatment, they inform me that for half a million dollars a year I could probably treat 25 people. In a small county that is a daunting number, even on a grant funding.

And so I am thrilled to hear that we are going to be documenting just what happens, because ultimately that 25 people, that is still cheaper than putting them in the penitentiary. So in the end, if we can get that to work, that is great. But I do know that it is daunting, and that the SAMHSA numbers are going to be stretched very thin. And so that is part of the hope that I would send to you, which is that you would treat this as even more important than the

other infrastructure projects that you are presently considering. Human capital has to be our first goal of infrastructure.

*Ms. Craig. Thank you so much for that thoughtful answer.

And with that, Madam Chair, I will yield back.

*Ms. Eshoo. The gentlewoman yields back. The chair now recognizes the gentlewoman from Washington State, Dr. Schrier, for your five minutes of questions.

*Ms. Schrier. Thank you, Madam Chair, and thank you to all of our witnesses today for talking in such frank terms about how to take away stigma, and address the real issues at hand, which are, you know, drug addiction, and treatment, and finding the right time, and mitigating mortality. I very much appreciate that focus on how to care for our families and our communities. I want to turn to Dr. Wilson for my question.

Doctor, I very much appreciate your candor about how physicians in general do not receive sufficient education on how to recognize and treat substance abuse disorders. My state of Washington has been a leader in working to integrate behavioral health into primary care, and utilize care coordination so people with complex conditions, whether that is diabetes and depression, or co-addiction to opioids and methamphetamines, can get the care that they need. And yet,

personally, as a pediatrician, the extent to which I personally treated substance use disorder was screening for it and then, if I found it, ensuring immediate safety, and then referring out to specialists.

And so I was wondering, you know, from a pediatrician's perspective, could you just talk about what it looks like to treat a patient with substance abuse disorder in the primary care setting?

*Dr. Wilson. Absolutely.

*Ms. Schrier. Thanks.

*Dr. Wilson. You know, I often think of addiction as a pediatrics disease that we often fail to recognize and treat during childhood, which leads to worse outcomes later in life. The vast majority of adults who use substances have actually started using those substances during their adolescence. And so this is a huge missed opportunity to really shift the life trajectory of a generation of adolescents and young adults. So I think it is essential that we do a much better job, as a profession, of recognizing substance use in young people.

As a pediatrician and adolescent medicine provider, I think I am the sort of perfect person to recognize substance use in my patients. You know, pediatricians have the ability to build deep relationships with patients and their families over time. We provide lots of anticipatory guidance and

education about what to expect as they grow up about puberty, about all sorts of things that we know are going to impact the lives of our patients. And we know that substance use is a huge potential area that would have serious impact on their future. And so I think it is natural for us to be the ones to sort of have those kind of preventive conversations, and start the conversations with patients.

We also see patients regularly for well child visits, and that is a perfect opportunity to screen patients as we are doing a lot of preventive health care.

And then to sort of offer treatment in the setting, it helps sort of remove some of the stigma that both patients and their families might have about the disease of addiction, right? So I don't say, "You have an addiction, you have to go someplace else.'' I say, "You have a disease, just like you have asthma. And as your doctor, I am going to treat you.'' And there is something that is so powerful about sort of flipping that narrative for parents. There is nothing shameful about dealing with addiction, it is a disease, and we have effective treatments, and our job as physicians and pediatricians are to get those effective therapies to children and their parents.

*Ms. Schrier. So I really appreciate that perspective. And I think it is really nice to de-stigmatize it like that. I guess -- here is my next question.

I am in a generation that did not receive this kind of training in medical school or residency. And I understand that, you know, that the X-waiver may not be ideal. But then again, less than, I think, one percent of pediatricians have ever even applied for the X-waiver, so aren't in a situation to do this testing.

Can you talk about -- if it is not -- you know, what your thoughts are with the X-waiver and, if it is not that, how do you catch the more experienced doctors up to speed on treating substance use disorders?

*Dr. Wilson. I think --

*Ms. Eshoo. Excuse me, if you could, just summarize your answer, because the gentlewoman's time has expired.

*Ms. Schrier. Oh, I missed that.

*Ms. Eshoo. Oh, it hasn't. I am sorry, I am sorry. You have 37 seconds. I am sorry.

*Dr. Wilson. I think we have to both integrate for sort of our learners into health professional education and medical residency programs, better education in addiction.

And I think the X-waiver training is sort of an additional regulatory hurdle. I think we should eliminate the X-waiver training, but integrate basic tenants of addiction medicine as sort of linked to, for example, DEA licensure. So as you sort of obtain your DEA license, you have to complete a certain amount of hours related to --

basics related to addiction and buprenorphine prescribing, so all prescribers who are able to prescribe controlled substances are actually also able to recognize, treat, or refer to treat patients with addiction.

*Ms. Schrier. Great, thank you very much.

*Ms. Eshoo. The gentlewoman's time has expired, and excuse me for interrupting.

The chair now recognizes the gentlewoman from Massachusetts, who has been with us all day, and I think that is the quality of the hearing, right?

*Mrs. Trahan. Absolutely.

*Ms. Eshoo. Yes. Congresswoman Trahan, you are recognized for your five minutes, and thank you. You are a wonderful addition to our subcommittee.

*Mrs. Trahan. Well, I so appreciate that, Madam Chair, and I really do appreciate you convening us on this important issue, and prioritizing it. Your leadership on substance use disorder is unparalleled. And I want to thank all the witnesses today. I know it has been a long day, but your contribution to our policymaking is so important.

So in 2016 Max Baker was 23 years old when he died of an overdose after suffering from heroin addiction. Prior to his passing, Max's father, Dr. James Baker, a hospice care physician who works in my district, he sought help for his son through his own primary care doctor. But the answer Dr.

Baker received was not at all encouraging: "I hope he finds the help he needs.'' And this particular primary care doctor didn't have the working knowledge to treat Max's addiction, or even the tools to refer him to someone who could.

And that isn't a criticism. You know, it is a description of an all-too-common problem, as Dr. Schrier just mentioned. In fact, even over Dr. Baker's 35 years of practicing medicine, he hadn't learned how to treat opioid use disorder, not in his coursework at Johns Hopkins, or Harvard, not in his medical school residency, and not in his public health education.

So, Dr. Wilson, I am going to stay with you. Why should all medical professionals know how to identify and treat SUD?

And what would you say to your medical colleagues across different medical specialties if they questioned why requiring education on treating patients with SUD is important to improving addiction treatment for all Americans?

*Dr. Wilson. Yes, thank you so much. You know, I think the sort of key takeaway point is there should be no wrong door for a patient who is seeking help, right?

And so I think that we, historically, have had separation -- have separated addiction treatment from medical treatment. And so historically, providers, physicians have not learned about addiction medicine as part of routine sort of education or curriculum offered in medical school, or as

part of their residency training.

And so, you know, I would call this out as a failure of our profession. And I think part of the treatment gap that we are seeing right now is because we haven't recognized that, you know, addiction and addiction medicine is part of the care that we need to offer all of our patients, right?

And so you may not provide sort of really in-depth medical sort of addiction medicine when you see patients, but you should be able to screen, to diagnose, to recognize that a patient is struggling with addiction, and to know how to refer them to treatment, and what treatments exist.

You know, I take care of patients in the hospital who often are admitted with -- for many things that have nothing to do with their addiction. And that is an opportunity for us to see them, offer treatment, and sort of really alter the course of their lives.

*Mrs. Trahan. Sure. So let's imagine that the X-waiver requirement were eliminated, and so a barrier to treating patients with buprenorphine, for example, was no longer an issue. That is a powerful drug which many prescribers may not be familiar with. And it strikes me that, under that scenario, it would be even more important for our prescribers to understand how to use Buprenorphine to properly treat SUD.

So would standardized education on treating addiction lead to better treatment for those suffering with SUD,

especially if some treatment barriers are soon eliminated?

*Dr. Wilson. Yes, so I actually think that we often -- and, in part, I think this is related to stigma around addiction -- we prescribe many things which are far more dangerous for patients like morphine, like Oxycodone, like the medications that started this crisis to begin with, that do not have the regulatory hurdles like prescribing buprenorphine. It should not be easier for us to prescribe pain medicine than it is for us to prescribe Buprenorphine to treat someone with an opiate use disorder.

So I think part of that is helping providers recognize it is actually not that challenging. This is something you can do, you are empowered to do it, and with sort of a short sort of kind of educational module, an hour or two focused on the medication of Buprenorphine and how you start it, all providers will, I think, realize that they too can recognize and treat patients with opiate use disorders.

*Mrs. Trahan. And that is a huge part for us, eliminating the stigma.

I mean, look, had standardized education been the protocol a few years ago, perhaps Max Baker would have received the early intervention and the support that he needed. And parents like -- patients like him show up in medical offices across the country, and the medical community, frankly, needs to be ready to spot problems of

this sort, whatever their specialty.

I mean, this is, after all, a national crisis, and it is going to require all of us to do a bit more to keep patients healthy and safe, which is what the MATE Act aims to do.

So I really appreciate your contribution to today's conversation, Dr. Wilson, and I yield back the remainder of my time.

*Ms. Eshoo. The gentlewoman yields back, and I think the final recognition of a wonderful member is going to be our last one, and that is the gentlewoman from Texas, Mrs. Fletcher. Are you there?

*Mrs. Fletcher. Thank you --

*Ms. Eshoo. There you are.

*Mrs. Fletcher. Thank you so much, Chairwoman Eshoo. Yes, and thank you to all of our witnesses for testifying today about this critically important topic, and for being with us throughout the day. It really is important. And I want to touch on one thing that we haven't, to my knowledge, touched on in this panel, and get insights from all of you.

I have the privilege of representing a lot of medical professionals in my district in Houston, just outside the Texas Medical Center. And I have heard from a lot of the doctors and other medical professionals in my district that a lack of insurance coverage can significantly impact an individual's recovery.

You know, for example, a person may be on medication-assisted treatment, and doing very well, but they are laid off, or get dropped from their partner's coverage. There are a lot of scenarios, unfortunately, that we have seen over the last year where people have lost their coverage, and then they can no longer afford their treatment, and they relapse.

So Medicaid is the largest payer of mental health and substance use disorder treatment in the country. Unfortunately, in states like mine that have not expanded Medicaid, you know, many people who are struggling with substance use disorders are unable to get the coverage they need.

So I want to start with Dr. Wilson. In your testimony you discuss the many barriers that can exist to accessing addiction treatment. In your opinion, would Medicaid expansion help reduce barriers and expand access to critical substance abuse disorder treatment?

*Dr. Wilson. Absolutely. It is really a no-brainer. You know, I think it is cost-prohibitive for people to pay out of pocket for addiction treatment. And I see patients all the time who have been doing great, are in sustained recovery, doing well, taking medications, engaged in recovery services, and they lose insurance coverage through no fault of their own, and then have withdrawal from the medications that have been helping them stay sober and abstinent from

illicit opioids, and really lose access to all the recovery support services that have helped them stay in long-term recovery.

And that can be -- we know that any return to use could be a potentially fatal return to use. And so this is really a conversation about how we keep people alive, and keep them getting access to medications and treatment that can help save lives.

*Mrs. Fletcher. Thank you, Dr. Wilson, and I would love to just open that question up to anyone, especially since I am the last -- last couple of minutes of the hearing, just to see if anyone else wants to weigh in on that question about how we can keep getting people access to critical services, or -- really, if somebody else has something to say that we didn't get to, and you want to use this minute, I would be glad to hear your thoughts as we wrap up.

*Mr. Vargo. If I might, Representative?

*Mrs. Fletcher. Go ahead.

*Mr. Vargo. Well, thank you very much for giving me the opportunity. I will tell you that it is not just the existence of or the lapse of insurance. It is whether they have it in the very first place.

As I said, we have got a 90 percent unemployment rate on the Pine Ridge Indian Reservation. So that means that the ACA makes no inroads, as far as insurance goes.

And I will also, though, point out one other difficulty, which is the ability of Medicaid and Medicare to reimburse for off-label uses of proven drugs that would be of assistance. It makes it prohibitively expensive for those people to seek treatment, and for us, as governments, to then pay for that treatment, because we are essentially out of pocket. So even before you get to Medicaid expansion, the capacity -- I would rather that a doctor like Dr. Wilson, who knows what she is doing, and she makes a decision that this drug is necessary for a patient's care, even if it is off label, it strikes me that that should be reimbursed by Medicaid.

*Mrs. Fletcher. Thank you, Mr. Vargo, I appreciate that.

And I think that, Mr. Laredo, you had your hand up.

*Mr. Laredo. Thank you so much. Just following on what Mr. Vargo just said, you have a nationwide, systemwide problem of complete lack of services compared to the need. So, whether there is insurance or not, whether there is Medicaid expansion or not, it is another example of needing an all-of-the-above approach and, unfortunately, a truly dramatic increase in funding across the board to pay for these services.

The public health system, as we have seen throughout the COVID pandemic, is in deep, deep trouble. And that

translates through the substance use and addiction treatment system. It is -- frankly, calling it a "system'' is a little bit of an overstatement. So anything at all -- you don't always want to throw money at a problem. This is a problem that has for decades required significantly more funding than it has ever received.

*Mrs. Fletcher. Well, thank you so much for that, and I am at the end of my time here.

So, Chairwoman Eshoo, thank you again for holding this incredibly informative hearing, and thank you to all of our witnesses for your testimony here today. I yield back.

*Ms. Eshoo. The gentlewoman yields back. I don't see any other hands for members, whether they were part of the subcommittee or waiving on.

I want to thank each one of you. You have really given superb testimony. What always makes it very interesting in a hearing is, you know, the two sides of an issue from two professionals. And, you know, none of these issues are -- well, I think the issue of, you know, the whole -- the schedule one issue, and that we are going to have to sort out, it is an important one, but I can't give you an answer right now of where I am on it, because people have made excellent points about it. And that is the point of a hearing, is that we get the expert testimony. No one can say to any one of you that you don't know what you are talking

about. You bring decades of professional experience to the Congress of the United States.

And we are not only very deeply grateful to you, we are proud of you. When I listen to all the professionals I always think to myself, what a country we have, what a country we have, individuals that are so committed, so committed to the public health system, to research, to the criminal justice system. I could go on and on. So you have the collective gratitude of our entire committee, and you have been highly instructive to us. You have been highly patient for us to take up your panel, and we are lastingly grateful to you.

So thank you, thank you, thank you, and know that we will circle back with you with the questions that members submit. If they didn't have the opportunity, they will submit questions, and I trust that you will answer them in a timely way.

So keep doing your extraordinary work. Our country and this issue really need you. And hopefully, we will shape policies that are going to really put a -- really address what -- as I said earlier, this scourge in our country.

I mean, it just has wiped out -- wrecked lives, wrecked families, taken tolls on communities across the country. And it doesn't matter what zip code people live in. Not a surprise, in poorer areas it is even worse. So thank you

again.

Now, I have a request of my wonderful -- our wonderful ranking member. I have 37 documents to enter into the record. They are all wonderful, and important, and organizations weighing in. And I would like to request a -- make a unanimous consent request to enter into the record the 37 documents that have been submitted to our subcommittee.

[The information follows:]

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

*Mr. Guthrie. Okay, thanks, and before -- I don't object, so I won't object. But I just want to say again, to echo what you said, to have our witnesses here today, to spend an entire day of your time -- I know you got to listen to the morning session, and then spend your entire afternoon with us is -- I know your time is valuable, but it is helpful. It really is helpful, because a lot of us are really trying to sort this out, and not coming with a preconceived views or optics, or anything like that. We really want to come up with the right answer. And we appreciate your time.

And I do not object to your unanimous consent request.

*Ms. Eshoo. Well, thank you. Thank you very much. And I appreciate it. And yes, five hours and 10 minutes, total.

But I think it also -- I think that, as you -- before you turn off your laptops, I am very proud of our subcommittee, and the members on both sides of the aisle. You heard so many thoughtful, probing questions.

So while, you know, Congress has always been kind of the -- at the -- well, let's just put it that way, a lot of fingers pointed at us, we are made fun of, or mocked in different ways. Sometimes it is earned. But I think most of the time, frankly, it isn't. You saw and heard firsthand the deep concern of members, the knowledge that they have about the subject matter, and they are reaching out with deep

respect to each one of you to probe further, and seek your professional advice. So I am very grateful, and I am very proud of our subcommittee. It is a very important one. And I know that Mr. Guthrie shares that view, as well.

So God bless each one of you. I know you are going to keep serving our country well. You have served us so well today.

And with that, I adjourn the Health Subcommittee hearing of today, April 14th, the birthday of my son.

[Whereupon, at 3:43 p.m., the subcommittee was adjourned.]