**Stephen Loyd, MD**
Responses to Member Questions – "Lives Worth Living: Addressing the Fentanyl Crisis, Protecting Critical Lifelines, and Combatting Discrimination Against Those with Disabilities"
House Committee on Energy and Commerce

Questions Submitted by the Honorable Frank Pallone, Jr.

**Why is it important to shift the focus away from criminalization and towards treatment and recovery?**

The reason for this is simple: criminalizing drug use will do nothing to change the underlying addiction. If we are serious about addressing the fentanyl crisis and the broader opioid epidemic in this country, we must treat substance use disorder, and evidence has shown that treatment and recovery is the best path for that.

Outside of the medical community, and even in some parts of it, many people believe that those suffering from addiction are doing so as a matter of choice. They believe that the person using drugs is doing so as a choice, not because of an underlying brain disorder driving behavior. Society needs to recognize that drug addiction is a disease and treat it as such, which does not involve strictly punitive measures, but must also include appropriate and evidence-based treatment.

**According to data from the Department of Justice, half of state and federal prisoners meet criteria for substance use disorder. However, it largely goes untreated in criminal justice settings. What can be done to improve access to treatment for justice-involved individuals?**

In my experience treating justice-involved individuals, the largest barrier to access is knowing who needs treatment. You can't treat substance use disorder without knowing who has it. First, we need to increase screenings for SUD as people enter the system. Next, we need to initiate treatment process at the appropriate level of care for people with SUD, which should be continued throughout the time that someone is incarcerated. Finally, in order to make sure there is no recidivism, the treatment protocol should be incorporated into an individual's release plan, and follow-up should be done consistently during the probation and parole period.

**Dr. Loyd, you have been very involved in the state of Tennessee's work to determine how to use opioid settlement dollars. As a person in recovery as well as a clinician, what do you think the best use of these settlement dollars is? And relatedly, how can states effectively allocate these funds?**

In my opinion, any effort to abate the impacts of the opioid epidemic must be a multi-faceted campaign that gets to all aspects of the epidemic; for me, those key areas are:

1. Programs to treat people with OUD, including infrastructure and delivery, treatment along the full continuum of care, and provider training and support
2. Programs to reduce harms from opioid use, including Naloxone, HIV/HCV screening

and treatment, remedial pain management, and increased investment in child welfare, foster care, and abatement of adverse childhood events

3. Programs to prevent future opioid misuse, including additional investment in Prescription Drug Monitoring Programs, programs for targeted audiences (school-aged children, college-aged adults, and at-risk communities), and additional training for prescribers
4. Coordination and monitoring of efforts, administration and appropriate stewardship of opioid settlement monies

Any effective allocation of settlement dollars should be done with those four pillars in mind, as they are key to abating the impacts of the opioid epidemic in our communities. Many of these will take years to see the full impact on our communities, which is why careful allocation and stewardship of the funds is so essential.

From a treatment angle, guaranteeing quicker and consistent access to care is the easiest way to see quick results. By specifically targeting at-risk populations, the initial impact will be greater; my recommendation would be to be increased focus on justice-involved individuals and overdose survivors that have been treated in emergency departments.

**As a doctor who actively treats people with opioid addiction, how will passage of the MAT Act will affect your practice and your patients?**

The passage of the MAT Act will greatly impact my practice, as well as potential patients as it immediately improves access to essential care for those impacted by substance use disorder. If we can get people into the appropriate treatment, there is an immediate impact on not only the lives of that patient, but their friends, family, and broader community. Additionally, it has great potential to increase retention in treatment as it will be easier to access, which will greatly improve long-term outcomes.

**Now that the X-waiver has been eliminated and doctors can prescribe buprenorphine to an unlimited number of patients under their care, how do you think this will affect the opioid treatment landscape?**

I think this will have a two-part impact on the current opioid treatment landscape. First, it will increase access to care by permitting more prescribers to treat patients, as well as decreases the initial barriers to care for patients seeking treatment. Second, it has the potential to increase awareness among physicians of evidence-based treatment, as more doctors can prescribe this treatment. Additionally, the continued requirement for education on addiction treatment for providers is an important inclusion in the X-waiver as it ensures that prescribers will be providing the best possible care to patients.

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**Can you please dispel any misconceptions about the misuse or diversion of buprenorphine and suboxone?**

There is a common and incorrect belief that all people who misuse or divert buprenorphine and suboxone are doing so for illicit purposes – i.e., to inject or snort. However, studies have shown that those who use non-prescribed buprenorphine or suboxone often do so to bridge the gap in treatment services.[1] The diverted buprenorphine and suboxone are used to stop withdrawal symptoms, commonly referred to as dopesickness, or do self-detox. Those that take this path often have other barriers to care, including limited access to a prescribing physician or a lack of health insurance.[2]

The most impactful way to decrease diversion is to increase access to care; studies like the ones I cited above show that many people using diverted buprenorphine and suboxone are not using it illicitly, but rather to manage withdrawal or to ease symptoms during a self-detox period. By increasing access to MAT, these individuals will be able to manage their SUD through a legitimate prescription, rather than diverted drugs.

**As a doctor of Internal Medicine, can you tell me what education on addiction you received in medical school? Residency?**

Between medical school and residency, I had one hour of training on addiction; it was during my first-year course on Neuroanatomy. From what I understand, this is a bit of an outlier as most physicians that trained around the same time I did received less than that. We were only given this small amount of time because the course was taught by someone who was in recovery.

For additional context, I graduated medical school in 1999, and completed my residency training in 2001.

**Do you agree that more physicians, especially new physicians entering the workforce, should have access to continuing education and training to identify and treat substance use disorders?**

Yes, I do. At this point, it's inconsistent across states, and this is not only a health equity issue,

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[1] Monico, L. B., Mitchell, S. G., Gryczynski, J., Schwartz, R. P., O'Grady, K. E., Olsen, Y. K., & Jaffe, J. H. (2015). Prior experience with non-prescribed buprenorphine: Role in treatment entry and retention. Journal of Substance Abuse Treatment, 57, 57–62 doi:S0740-5472(15)00109-9.

[2] Allen B, & Harocopos A. Non-Prescribed Buprenorphine in New York City: Motivations for Use, Practices of Diversion, and Experiences of Stigma. Journal of Substance Abuse Treatment. 2016;70:81-86. doi:10.1016/j.jsat.2016.08.002

but it also impacts patients' lives directly if they visit a physician with little-to-no training on what is a pervasive issue.

I believe that the best way to increase training on it is fairly basic – the best way to ensure that training happens is to add questions on substance use disorder to the US MLE, which is the national licensing exam that all aspiring physicians have to take in order to practice medicine in the United States. By adding questions on this, medical schools would then add it to their standard curriculum, and it would provide a sound foundation for additional trainings and continuing medical education courses as people progress in their careers.

**The Biden Administration's proposal to address FRS exempts those charged with an FRS offense from quantity-based mandatory minimum penalties, unless the offense results in death or serious bodily injury. Is there any indication that permanent scheduling of FRS, with exemptions for quantity-based mandatory minimums, will lead to an increase in new FRS being created?**

I agree with the Biden administration position that mandatory minimums should be limited for those whose offenses do not result in death or serious bodily injury to another person. In my opinion, I do not believe this will lead to more FRS on the market; the illicit drug market is like any other, and it responds to market forces like supply and demand.

If we want to reduce the FRS market, as well as other illicit drug markets, the best course of action is to provide treatment for those with underlying SUD in order to facilitate lower demand; if there are fewer customers, the market will necessarily shrink. By increasing access to safe, evidence-based care and treatment, we can limit the customer base for the FRS market and also prevent the deaths and overdoses associated with this class of drugs.