

May 13, 2026

Dear Honorable Chairman Griffith,

Thank you for the opportunity to provide responses to additional Questions for the Record following the March 26, 2026 Subcommittee on Health hearing entitled “Policies to Protect Our Communities From Illicit Drug Threats.” I very much appreciated the invitation to testify before you and the esteemed Committee members at the hearing, and hope that this additional information will prove helpful to you.

Please let me know if I may answer other questions or be of further service.

Kind regards,

A handwritten signature in black ink, appearing to read "Yngvild Olsen". The signature is written in a cursive, slightly stylized font. The first name "Yngvild" is written in a more fluid, connected script, while the last name "Olsen" is written in a more blocky, capital-letter style.

Yngvild Olsen, MD, MPH

Cc: Diana DeGette, Ranking Member, Subcommittee on Health

Responses to Questions for the Record Dr. Yngvild Olsen

From The Honorable Frank Pallone, Jr. (D-NJ)

Q: SAMHSA oversaw the implementation of expanded methadone take-home flexibilities beginning with the COVID-19 public health emergency in 2020 and formalized them in the 2024 Final Rule. You have stated publicly that this did not increase the rate of methadone-related mortality. Can you describe for the record what the data showed regarding methadone-related overdose deaths and what that tells us about the relationship between expanded take-home access to methadone and patient safety?

A: The National Center for Health Statistics at the Centers for Disease Control and Prevention (CDC), using standardized forms and model procedures embedded in the National Vital Statistics System¹, systematically tracks overdose related mortality for the nation. This includes deaths from illicit substances as well as those involving approved, pharmaceutically manufactured medications, including methadone. The period of the expanded methadone take-home flexibilities under the COVID-10 public health emergency began in March 2020² and transitioned to the Final Rule in February 2024. According to a National Vital Statistics Report³, the rates for drug overdose deaths involving methadone did not significantly change between 2017 and 2023. In 2017, 4.7% of 70,715 drug overdose deaths involved methadone compared to 3.2% of 106,352 deaths in 2023. This stands in contrast to the 38.9% of drug overdose deaths involving fentanyl in 2017 and 68.9% in 2023. Specifically, for the years spanning 2020 through the end of 2023, the data from this report finds the percentage of drug overdose deaths involving methadone compared to fentanyl as follows:

Year	Total number of drug overdose deaths	Percentage of drug overdose deaths involving methadone (%)	Percentage of drug overdose deaths involving fentanyl (%)
2020	92,491	4.0	60.4
2021	107,557	3.6	65.6
2022	108,790	3.1	68.0
2023	106,352	3.2	68.9

In 2024, with the rate of fentanyl-related overdose deaths at 14.3 per 100,000, the rate of drug overdose deaths involving methadone declined from the 2023 rate of 1.0 per 100,000 population to 0.9 per 100,000 population.⁴ The fact that no change in overdose related mortality occurred during the same period as methadone take-home flexibilities expanded suggests that allowing patients to take more methadone doses home did not compromise patient safety or the public's health.

Q: In your testimony, you described some of the research around the benefits of methadone for the treatment of opioid use disorder (OUD). Can you expand on what research has shown, both in terms of individual patient outcomes as well as broader trends such as crime and employment?

A: Researchers in the U.S. and across the world have published over 3,600 scientific articles since the early 1970's addressing outcomes associated with methadone treatment for opioid use disorder (OUD).⁵ The vast majority of these have been published since 2003, with sixty-seven studies specifically focusing on aspects of methadone treatment for opioid use disorder during the COVID-19 public health emergency. Over 400 articles address the impact of methadone treatment on opioid-related overdose mortality, with some of them also including data on changes in all-cause mortality among people taking methadone for OUD. Over 400 articles reference crime and methadone treatment, while fewer studies focus specifically on the association between methadone treatment and employment.

This body of scientific literature demonstrates the benefits of long-term treatment of OUD with methadone. For example, a study of 260 patients with OUD followed for five years after starting methadone treatment found that unemployment dropped from 51% to 19%.⁶ One of the largest studies of the association between crime and methadone treatment, conducted using data from British Columbia, Canada, included 14,530 people with criminal histories followed from the beginning of their treatment with the medication.⁷ This study found a 33% lower rate of violent crime and a 35% lower rate of non-violent offenses in the first two years of treatment when comparing periods when patients were receiving methadone versus periods when they were not. With a mean time of 3.3 years in treatment with methadone and 4.6 years out of care, the sample had an occurrence of 0.5 violent offenses and 4.2 non-violent crimes per person during the 17-year study period.

Comprehensive reviews of the literature, such as that done for a National Academies of Sciences, Engineering, and Medicine report⁸ from 2019, document that treatment of OUD with opioid agonist medications, including methadone, reduce illicit opioid use and the transmission of infectious diseases, particularly HIV and hepatitis C. A Cochrane systematic review of 1,129 participants found a 44% reduction in objectively measured heroin use compared to individuals receiving opioid withdrawal management only or on a wait list.⁹ A study of 552 injection drug users found a 69% reduction in the rate of new hepatitis C infections among those treated with opioid agonist therapy compared to those individuals receiving treatment that did not include medications or consisted of opioid withdrawal management only.¹⁰

Finally, studies addressing the impact of methadone treatment on mortality, with many also reviewed in the National Academies report, have found reductions that exceed 50%. For example, a study of over 48,000 people in Maryland enrolled in outpatient OUD treatment during 2015-2016 found an 82% reduction in the risk of opioid-related overdose death among those individuals treated with methadone or buprenorphine compared to those receiving treatment without one of these medications.¹¹ A meta-analysis including close to 123,000 people treated with methadone found a pooled mortality rate of 2.6 overdose deaths per 1,000 person years during time in treatment with methadone compared to 12.7 such deaths when individuals were out of care.¹² All-cause mortality rates also differed in this study, with 11.3 deaths per 1000 person years while in methadone treatment and 36.1 deaths per 1000 person years when out of care.

The multiple citations above include references to hundreds of additional studies demonstrating the benefits of methadone.

Q: What data exists on methadone diversion and its impacts?

A: Methadone diversion, by its nature, is not an easily measured or studied phenomenon. About 50 scientific articles, done in the U.S. and internationally, going back to the early 1970's, have attempted to look at different aspects of the issue. A handful have tried to quantify the extent of methadone diversion, with widely varying estimates of patients reporting ever sharing, giving away, or selling their take home methadone doses.^{13,14,15} One recent study conducted during COVID found that, of 87 people receiving take-home doses, four patients reported selling their medication.¹⁶ Most of the studies investigating the frequency of methadone diversion have focused on the use of methadone obtained from others.^{17,18,19,20,21,22}

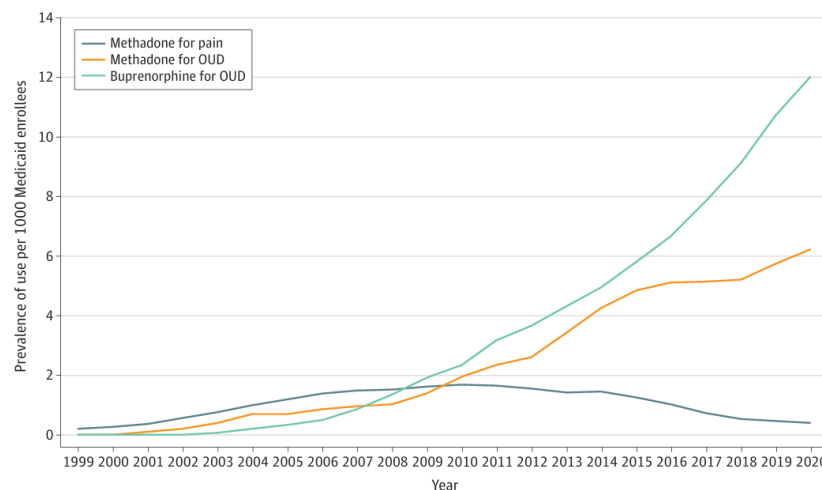
The largest study involving questions about methadone diversion suggested that poor access to treatment may be a significant factor. Conducted in Maryland during the late 1980's through the 1990's of over 2,800 adults with a history of injection drug use, the study found that those who experienced severe opioid withdrawal in the prior 6 months had a 2.5 higher odds of using diverted methadone compared to those without such an experience.²³ Other studies corroborate this finding and demonstrate that use of diverted methadone is often self-treatment of an opioid use disorder.^{13,17,22}

The most definitive data on methadone diversion comes from the DEA's National Forensic Laboratory Information System (NFLIS) program.²⁴ NFLIS publishes an annual report on drug identification results systematically collected from analyses of substance samples, both controlled and noncontrolled, submitted to federal, state, and local forensic laboratories following law enforcement operations across the country. In each annual report, the DEA provides information on the top 25 substances identified through the

NFLIS program. As the DEA website states, NFLIS is “an important resource in monitoring illicit drug use and trafficking, including the diversion of legally manufactured pharmaceuticals into illegal markets.” It has been a decade since methadone showed up on the top 25 NFLIS list.²⁵

There’s one more point that’s important to make. Prior to a decline that began around 2010, methadone was frequently prescribed for pain management, often by prescribers with very little to no training on methadone pharmacology or addiction. Research has clarified that these prescriptions written by non-addiction specialists for pain, and **not** methadone dispensed in the treatment of opioid use disorder, were associated with methadone diversion and related overdose deaths between 2000 and 2010.²⁶ Beginning in 2010, these rates began to drop, with continuous reductions in methadone prescribing for pain while methadone for the treatment of opioid use disorder increased (see figure below)²⁷

Figure. Trends in Methadone and Buprenorphine Use by Indication Among Medicaid Enrollees, 1999-2020



By 2020, the prevalence of buprenorphine use for opioid use disorder (OUD) was 12.0 users per 1000 Medicaid enrollees, methadone use for OUD was 6.2 users per 1000 Medicaid enrollees, and methadone use for pain was 0.4 users per 1000 Medicaid enrollees. Persons may be counted more than once if they were exposed to more than 1 of these medications in the same year.

Source: Hsu YS, Thakrar AP, Leonard CE, Lowenstein M, Brensinger CM, Bilker WB, Bogar KF, Hennessy S. Trends in Methadone Use for Pain and Opioid Use Disorder Among Medicaid Enrollees. JAMA Health Forum. 2025 Nov 7;6(11):e255023.

a. How do SAMHSA’s expanded flexibilities in the 2024 Final Rule address the risk of methadone diversion?

A: The Final Rule requires OTP providers to develop and implement a Diversion Control Plan that needs to include 1) child-proof packaging; 2) clear take-home medication container labels with the name, address, and contact information for the OTP and; 3) a

new requirement for mandatory, documented education of patients on safe transport and storage of take-home medication doses.

The Final Rule also is expected to reduce methadone diversion indirectly. By reducing barriers to medication continuity, the Final Rule should decrease the number of people who turn to diverted methadone to self-treat their OUD. ,

Q: What would the impact of an immediate reversal of the 2024 Final Rule be on states and communities, including people trying to access treatment for substance use disorder?

A: The impact of an immediate reversal of the 2024 Final Rule would be one of significant disruption and chaos for states, OTP providers and their patients, communities, and people trying to access treatment for opioid use disorder. In response to the proposed rule released in December, 2022, SAMHSA received 400 comments, predominantly positive and supportive of the proposed changes. Since that time, state officials have revised or are finalizing revisions to their own state OTP regulations based on the 2024 Final Rule¹; state legislatures have approved updated state regulations; Accreditation Bodies have revised and begun reviewing OTP providers based on the Final Rule; OTP providers have trained staff, rewritten policies and procedures, and adapted operations in accordance with updated state guidance and the Final Rule; and most importantly, patients have been able to receive life-saving treatment for their opioid use disorder, and at the same time, find or keep employment, go to school, and take care of their families. There are now multiple studies establishing the benefits and safety of these regulatory changes. Going back to outdated regulations will likely drive many patients out of care and keep people trying to newly access treatment to forgo it. At a time when the National Drug Control Strategy emphasizes making treatment easier to obtain than continuing drug use, reversing the Final Rule would be a step in the wrong direction.

From the Honorable Troy A. Carter (D-LA)

Q: Dr. Olsen, given your past leadership at SAMHSA and your work with ASAM, how do you navigate the specific clinical needs when treating a behavioral addiction like gambling alongside a chemical addiction?

A: Navigating the clinical needs of individuals with both a substance use disorder (SUD) and a behavioral addiction like gambling starts with awareness and screening. This includes awareness on the part of clinicians treating patients with a gambling disorder of the frequent co-occurrence with SUD, particularly alcohol use disorder, and the awareness on the part of SUD treatment providers of the potential and risk for gambling

¹ Of note, [per SAMHSA's website](#), 45 states concurred with the expanded take-home flexibility under the COVID-19 public health emergency.

disorder. Treatment providers should also be aware of the elevated co-occurrence of mood and generalized anxiety disorders among people with gambling addiction. Given this, the need to integrate evidence-based screening tools for both at-risk, problem gambling, gambling disorders, and high-risk substance use and substance use disorders is critical. Fortunately, valid and tested screening instruments exist both for gambling and substance use. Once a diagnosis has been made of either the presence of a gambling disorder or a substance use disorder, the treating provider should discuss concerns with the individual and engage with them in developing a plan for how to address both. Fortunately, studies have found that cognitive behavioral therapies and motivational interviewing can be effective for gambling disorder. As these are interventions frequently used in treating SUDs, there are opportunities to integrate treatment for both. In terms of pharmacological treatments for gambling disorder, naltrexone, a FDA-approved medication for alcohol use disorder, has shown some promise. However, no FDA-approved medications for gambling disorder are available at this point in time.

- a. Specifically, given that over 50% of individuals with gambling disorder have a co-occurring substance use disorder, what do you view as the 'gold standard' for integrated treatment, and what infrastructure is most critically missing at the state and local levels to support this high-risk population?**

A: Over the past two decades, the interest in and recognition of behavioral addictions, including gambling addiction, has steadily increased among researchers and addiction medicine practitioners. Despite this, the research base for gold standard treatment of gambling addiction is not as robust as it should be, including for both pharmacological and non-pharmacological interventions. That makes identifying a gold standard for integrated treatment challenging. Based on currently available evidence²⁸, providers treating people with gambling addiction should universally screen patients for at-risk substance use and substance use disorders, with a particular focus on alcohol, and talk with their patients about their elevated risks for substance use disorders. On the SUD provider side, screening for problem gambling also would be a best practice. When both are identified, treatment needs to occur simultaneously, preferably with the same practitioner, or at least by the same organization, to avoid having patients fall through the cracks. This means having a workforce trained to recognize, understand, and apply effective interventions for both types of disorders, insurance coverage that reimburses for integrated or simultaneous treatment, and a public health system that educates communities about the risks and opportunities of recovery from both.

¹ About the National Vital Statistics System. https://www.cdc.gov/nchs/nvss/about_nvss.htm. Accessed May 11, 2026

² Methadone Take-Home Flexibility Guidance for Opioid Treatment Programs. <https://www.samhsa.gov/substance-use/treatment/opioid-treatment-program/methadone-guidance>. Accessed May 11, 2026.

³ Garnett MF, Cisewski JA, Ahmad FB. Drugs most frequently involved in drug overdose deaths: United States, 2017–2023. *Natl Vital Stat Rep*. 2026 Mar;75(1):1–13. DOI: <https://dx.doi.org/10.15620/cdc/174640>.

⁴ Garnett MF, Miniño AM. Drug overdose deaths in the United States, 2023–2024. *NCHS Data Brief*. 2026 Jan;(549):1–13. DOI: <https://dx.doi.org/10.15620/cdc/174639>

⁵ Based on analyses of PubMed searches using search terms including methadone; outcomes; crime; employment; overdose mortality; all cause mortality; hepatitis C; HIV; treatment; COVID and excluding articles referencing pain; heroin-assisted treatment; heroin maintenance; neonatal.

⁶ Judson BA, Ortiz S, Crouse L, Carney TM, Goldstein A. A follow-up study of heroin addicts five years after first admission to a methadone treatment program. *Drug Alcohol Depend*. 1980;6(5):295-313.

⁷ Russolillo A, Moniruzzaman A, McCandless LC, Patterson M, Somers JM. Associations between methadone maintenance treatment and crime: a 17-year longitudinal cohort study of Canadian provincial offenders. *Addiction*. 2018 Apr;113(4):656-667.

⁸ National Academies of Sciences, Engineering, and Medicine. 2019. *Medications for Opioid Use Disorder Save Lives*. Washington, DC: The National Academies Press.

⁹ Mattick RP, Breen C, Kimber J, Davoli M. Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence. *Cochrane Database Syst Rev*. 2009 Jul 8;2009(3):CD002209.

¹⁰ Tsui JI, Evans JL, Lum PJ, Hahn JA, Page K. Association of opioid agonist therapy with lower incidence of hepatitis C virus infection in young adult injection drug users. *JAMA Intern Med*. 2014 Dec;174(12):1974-81.

¹¹ Krawczyk N, Mojtabei R, Stuart EA, Fingerhood M, Agus D, Lyons BC, Weiner JP, Saloner B. Opioid agonist treatment and fatal overdose risk in a state-wide US population receiving opioid use disorder services. *Addiction*. 2020 Sep;115(9):1683-1694. Epub 2020 Feb 24.

¹² Sordo L, Barrio G, Bravo MJ, Indave BI, Degenhardt L, Wiessing L, Ferri M, Pastor-Barriuso R. Mortality risk during and after opioid substitution treatment: systematic review and meta-analysis of cohort studies. *BMJ*. 2017 Apr 26;357:j1550.

¹³ Johnson B, Richert T. Diversion of methadone and buprenorphine by patients in opioid substitution treatment in Sweden: prevalence estimates and risk factors. *Int J Drug Policy*. 2015 Feb;26(2):183-90. Epub 2014 Oct 30.

¹⁴ Winstock AR, Lea T. Diversion and injection of methadone and buprenorphine among clients in public opioid treatment clinics in New South Wales, Australia. *Subst Use Misuse*. 2010;45(1-2):240-52.

¹⁵ Duffy P, Baldwin H. The nature of methadone diversion in England: a Merseyside case study. *Harm Reduct J*. 2012 Jan 13;9:3. doi: 10.1186/1477-7517-9-3.

¹⁶ Figgatt MC, Salazar Z, Day E, Vincent L, Dasgupta N. Take-home dosing experiences among persons receiving methadone maintenance treatment during COVID-19. *J Subst Abuse Treat*. 2021 Apr;123:108276. Epub 2021 Jan 8.

¹⁷ Roche A, McCabe S, Smyth BP. Illicit methadone use and abuse in young people accessing treatment for opiate dependence. *Eur Addict Res*. 2008;14(4):219-25. Epub 2008 Aug 4.

¹⁸ Ompad DC, Fuller CM, Chan CA, Frye V, Vlahov D, Galea S. Correlates of illicit methadone use in New York City: a cross-sectional study. *BMC Public Health*. 2008 Oct 28;8:375.

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- ¹⁹ Zhao JK, Kral AH, Wenger LD, Bluthenthal RN. Characteristics Associated with Nonmedical Methadone Use among People Who Inject Drugs in California. *Subst Use Misuse*. 2020;55(3):377-386. Epub 2019 Oct 14.
- ²⁰ Goldman FR, Thistel CI. Diversion of methadone: illicit methadone use among applicants to two metropolitan drug abuse programs. *Int J Addict*. 1978 Aug;13(6):855-62.
- ²¹ Greene MH, Brown BS, DuPont RL. Controlling the abuse of illicit methadone in Washington, DC. *Arch Gen Psychiatry*. 1975 Feb;32(2):221-6.
- ²² Grassi MC, Nencini P, Paroli E. Illicit use of methadone in heroin addicts in Rome. *Ann Ist Super Sanita*. 1991;27(4):671-4.
- ²³ Vlahov D, O'Driscoll P, Mehta SH, Ompad DC, Gern R, Galai N, Kirk GD. Risk factors for methadone outside treatment programs: implications for HIV treatment among injection drug users. *Addiction*. 2007 May;102(5):771-7.
- ²⁴ National Forensic Laboratory Information System (NFLIS) NFLIS Overview
<https://www.nflis.deadiversion.usdoj.gov/overview.xhtml>. Accessed May 11, 2026
- ²⁵ Based on a review of NFLIS annual reports and NFLIS Drug Snapshots from March 2025 through and including 2016 accessed at <https://www.nflis.deadiversion.usdoj.gov/publicationsRedesign.xhtml>
- ²⁶ Jones CM, Baldwin GT, Manocchio T, White JO, Mack KA. Trends in Methadone Distribution for Pain Treatment, Methadone Diversion, and Overdose Deaths - United States, 2002-2014. *MMWR Morb Mortal Wkly Rep*. 2016 Jul 8;65(26):667-71.
- ²⁷ Hsu YS, Thakrar AP, Leonard CE, Lowenstein M, Brensinger CM, Bilker WB, Bogar KF, Hennessy S. Trends in Methadone Use for Pain and Opioid Use Disorder Among Medicaid Enrollees. *JAMA Health Forum*. 2025 Nov 7;6(11):e255023.
- ²⁸ Brand M, Antons S, Böhle B, Demetrovics Z, Fineberg NA, Jimenez-Murcia S, King DL, Mestre-Bach G, Moretta T, Müller A, Wegmann E, Potenza MN. Current Advances in Behavioral Addictions: From Fundamental Research to Clinical Practice. *Am J Psychiatry*. 2025 Feb 1;182(2):155-163. Epub 2024 Dec 11.