

**Opening Statement of the Honorable Tim Murphy**  
**Subcommittee on Oversight and Investigations**  
**Hearing on “What is the Federal Government Doing to Combat the Opioid Abuse**  
**Epidemic?”**  
**May 1, 2015**

*(As Prepared for Delivery)*

Today we convene the third in a series of hearings examining the growing problem of prescription drugs and heroin addiction that is ravaging our country. This is our nation’s single biggest public health concern.

Over the past five weeks this Subcommittee has heard from addiction experts working within local communities and our leading academic and research centers.

Dr. Robert DuPont, the former White House Chief on drug control policy and the first director of the National Institute on Drug Abuse, testified that federal programs lack directions and standards on treating addiction as a chronic condition and noted: What is being done to follow-up with patients to prevent relapses and put them on a path of real recovery? He challenged us to even ask the most fundamental question: what is recovery?

Dr. Anna Lembke of Stanford Medical School provided critical testimony on how we must revise our health care quality measures to reduce over-prescribing, reform medical privacy regulations, and incentivize use of Prescription Drug Monitoring Programs. We know that those with opioid-addiction disorders need a broad range of treatment options, and that many with substance abuse disorders have a co-occurring psychiatric disorder – but we need to tear down federal policy and funding barriers that keep us from treating both simultaneously.

About three weeks ago, one of today’s witnesses -- Mr. Michael Botticelli, the Director of the Office of National Drug Control Policy -- presented the following slide at the National Rx Summit on major causes of death from injury 1999-2013. While the trends of other major causes of death such as auto accidents went down, drug poisoning continued to go up 21 percent from 2008 to 2013. In many states these numbers are soaring at high double digit rates of increase. As Mr. Botticelli has indicated to me privately and at the Rx Summit, we must do better and we have much work to do.

Today, hear from the federal agencies charged with providing guidance, direction, and leadership in our Nation’s public health response to the opioid epidemic.

No federal agency has a more central role in this ongoing epidemic than the Department of Health and Human Services (HHS). HHS and its Substance Abuse and Mental Health Services Administration (SAMHSA) are responsible for leading our nation’s public health response to the opioid, heroin abuse and addiction crisis. SAMHSA regulates our country’s 1,300 opioid treatment programs, and SAMHSA is responsible for certifying the 26,000 physicians who prescribe the most commonly used opioid maintenance medication: buprenorphine. According to testimony provided by SAMHSA before this Subcommittee in April of last year, there were nearly 1.5 million people treated with these opioid maintenance medications in 2012 – which is a 5-fold increase in the last ten years. Has SAMHSA defined the goal of recovery for what these federally subsidized treatment programs are supposed to accomplish? Is SAMHSA collecting and evaluating meaningful data at an individualized level that would hold grant recipients individually accountable for effective results? So far, our preliminary examination indicates the answers are no. And when you don’t define where you are going, every road you take still leaves you lost.

The numbers indicate we are failing as a nation, and we darn well better come to terms with that. The 43,000 lives lost last year, the thousands of babies born addicted to opioids tell us the terrible toll this epidemic has taken.

You have heard my thoughts about the government-sponsored promotion of what I have characterized as “addiction maintenance.”

I have referred to buprenorphine as a “heroin helper” not because the medication is altogether lacking, but rather, because the infrastructure the federal government has created for the use of this highly potent and important medication is not working and worse yet, contributing to the growing problem. It has to be fixed, and that is what we need to discuss – honestly, openly, humbly.

If we do not reverse the current trend, where will it end? How many millions of citizens do we want to have on opioid maintenance? How many more must die? How many more lives and dreams must be shattered before we recognize the depth of this scourge?

I do not agree in “better living through dependency.”

Again, please do not misconstrue this critique as a general indictment of opioid maintenance. It is not. For some people, opioid maintenance is the most appropriate bridge treatment and there should be no shame or stigma associated with it. But opioid maintenance therapy should not be the only treatment offered to opioid dependent individuals, nor the only goal.

What patients on opioid maintenance can be successfully transitioned off of these medications? What protocols are best for effecting this transition?

What are the best practices for the prevention of relapse for those patients who end opioid maintenance treatment? There are non-addictive medications approved for this use, but are these medications widely available?

The diversion of buprenorphine for illicit, non-medical use is a related problem because this is how the opioid epidemic can be spread. According to the DEA, buprenorphine is the third most often seized prescription opioid by law enforcement today.

Where is the call to modernize our existing opioid addiction treatment system to ensure that the right patient gets the right treatment at the right time? Why aren't we hearing about expanding access to non-addictive, non-narcotic treatments that have zero potential for abuse or diversion, such as naltrexone and evidence-based counseling? These are incredibly important tools that are barely mentioned in the HHS plan.

Last week, Dr. Westley Clark, the former Director of SAMHSA's Center for Substance Abuse Treatment, and the man who oversaw the growth of buprenorphine over the past decade, declared before the American Society of Addiction Medicine that many buprenorphine practices had become pill mills where “Doctors and Dealers” were increasingly indistinguishable and “Physician Negligence,” and “Alleged Laboratory Fraud” prevailed. The problem is not with buprenorphine, however. The problem lies with current practice and this is what we need to discuss.

I consider opioid maintenance as a bridge for those with addiction disorders to cross over in the recovery process. It is not a final destination. I seek to lay out a vision for recovery that includes complete withdrawal from opioids as an option. For cancer, diabetes, AIDS, we want people to be free of the disease, not learn to just live with it. We need to commit to research and clinical efforts that boldly declare that we must change.

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