Statement

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to the

United States House of Representatives

Committee on Energy & Commerce

Subcommittee on Health

Re: “Examining Legislative Proposals to Combat our Nation’s Drug Abuse Crisis.”

October 20, 2015

Summary

The following is a summary of my statement:

- An overview of my background and qualifications to testify
- A brief description of Cumberland Heights, the addiction treatment facility where I serve as Chief Medical Officer
- The opioid problem in Nashville, Tennessee
- The challenges and process of abstinence from opioids
- The course of opioid detoxification and treatment
- Support for the H.R. 2872: The Opioid Addiction Treatment Modernization Act
- Support for H.R. 2805, the Heroin and Prescription Opioid Abuse Prevention, Education, and Enforcement Act of 2015

I want to thank the Committee for holding this important hearing on legislative solutions to combat the worsening drug crisis that has swept across our country. Like all of us, I am deeply concerned about what I see happening with regard to the opioid epidemic, in particular, and I am grateful to have this opportunity to share with you my observations and thoughts.

I am Chief Medical Officer of Cumberland Heights, a private not-for-profit addiction treatment center on the banks of the Cumberland River in Nashville, TN. I previously served as Medical Director of Addiction Treatment Services at Pine Grove Behavioral Health in Hattiesburg, MS. I am certified by the American Board of Addiction Medicine, and I am a Fellow of the American Society of Addiction Medicine. I represented Mississippi, Alabama, Florida, Tennessee, and Kentucky on the Board of Directors of the American Society of Addiction Medicine from 2005 until 2009, and served as Secretary of ASAM from 2009 until 2011.

Cumberland Heights will celebrate it's fiftieth anniversary of treating addiction in 2016. We provide addiction treatment to men and women, both adults and adolescents. Though most of our patients are working class and insurance dependent, we also treat a fair number of patients with the resources to pay for treatment out of pocket, and we treat a number of patients dependent upon scholarships to fund their treatment.

A watershed moment in my career as an Addiction Medicine physician came around 2006. On a Saturday morning I was making rounds on our twenty-five bed detox unit. At the end of the day, I realized that every one of the twenty-five patients had a diagnosis of Opioid Dependence. Some of those patients had other substance use disorders as well, but every single patient had a diagnosis of Opioid Dependence. Every one of those patients was dependent upon

prescription opioids. Over the years I have seen our most commonly occurring diagnosis shift from Alcohol Dependence to Opioid Dependence. Of the more than 1,500 admissions to Cumberland Heights in the past year, the most common diagnosis is Opioid Dependence, particularly in young adult patients. Heroin addiction has become more and more prevalent as access to prescription opioids becomes more limited through less abusable formulations, monitoring of controlled substance prescription databases, and education.

My expertise is based in direct patient care. I am an expert in what my patients disclose to me, face to face, in my office.

In 2008, at the ASAM Medical Scientific Conference in Miami, I was asked by a colleague if I used Buprenorphine to treat Opioid Dependence. I replied that we utilized Buprenorphine to detox from Opioids. He remarked that he had never seen a patient recover without Buprenorphine. I told him that I had recovered from Opioid Dependence without Buprenorphine. He said, "Yes, but you weren't using intravenously". He appeared incredulous when I told him that indeed recovered from IV Opioid Addiction without Opioid Agonist Therapy. I am appalled when an addiction treatment provider makes recommendation based on his or her personal experience in treatment; that is not what I am saying. My experience is that there are multiple paths to recovery; there is no one size fits all approach.

Over the years, I have been amazed at the stories of diversion and abuse of Buprenorphine among patients presenting to Cumberland Heights for treatment. Buprenorphine may be used sublingually as designed, used intranasally, or injected. Motivations include "to get high" as well as to treat withdrawal. Of course, some patients with Buprenorphine diversion and abuse take it with the motivation to get off other opioids.

A typical 8 mg dose of Buprenorphine costs $20 in Middle Tennessee, and as much as $40 per 8 mg dose in East Tennessee. The street value supports the level of diversion and abuse. In fact, Buprenorphine has been identified as the third most diverted medication in the United States by the DEA.

My attraction to Cumberland Heights was the ability of the organization to honor tradition while maintaining an innovative approach to treatment. Rarely are patients naïve to Buprenorphine treatment when they present to Cumberland Heights for evaluation. Often, Opioid Dependent patients have failed Buprenorphine or Methadone treatment. During the course of evaluation, the patient identifies a desire to be free of opioids. We have developed a bit of a niche in the local addiction treatment community by using pharmacotherapy to support abstinence from opioids while provided psychosocial treatment to promote ongoing recovery. The most effective technique is residential treatment, detox from opioids, and initiation of long acting naltrexone through injection. We completely understand that addiction is a chronic medical illness, and ongoing recovery requires ongoing treatment. Upon discharge from residential treatment, patients are referred for ongoing psychosocial treatment as well as ongoing administration for extended release naltrexone, Vivitrol.

I am very enthusiastic about two of the bills that are currently under consideration.

The first is the bill that was introduced by Dr. Larry Bucshon and Congressman Womack, titled “H.R. 2872: The Opioid Addiction Treatment Modernization Act.” This bill would require that doctors who obtain certification to prescribe buprenorphine be trained on the use of all FDA-approved treatments for opioid addiction; and they would be required to offer directly, or by referral, all treatment options, based on the individualized needs and preferences of the patient.

Likewise, I like that the bill would require that buprenorphine practices conduct drug screens to ensure patients are actually taking their medication, and not just selling them on the street. Another important provision of this bill is the requirement that these practices maintain diversion control plans. Simply giving opioid dependent individuals a 30-day supply of buprenorphine to take home with them is a prescription for disaster. I am not at all opposed to buprenorphine treatment, but I am opposed to poor and irresponsible treatment. HR 2872 would ensure that individualized, professional treatment is offered based on the needs of the patient, including the option to get off of all opioids.

I understand that HHS is planning on lifting the cap on buprenorphine practices. I do not see how we are ever going to end this opioid epidemic by simply increasing the amount of opioids being prescribed. Quality care and treatment options for patients should be priority number one, not the advancement of the current one-size-fits-all approach that is dominating today's treatment landscape. It is in this context that lifting of the caps should be considered.

There has been a lot of misinformation spread about how liberal access to buprenorphine in Baltimore, or in France, reversed the number of heroin overdoses. However, the data paints a different picture. Heroin overdose rates in Baltimore are at an all-time high, and the numbers of opioid overdoses in France are increasing steadily too.

Lastly, I also want to applaud Congresswoman Brooks and Congressman Kennedy for introducing "H.R. 2805, the Heroin and Prescription Opioid Abuse Prevention, Education, and Enforcement Act of 2015." This bill calls for the formation of a "Pain Management Best Practices Inter-Agency Task Force" to develop recommendations for appropriate training in pain management; and a plan for disseminating the Task Force recommendations. In addition, it

would strengthen prescription drug monitoring programs so that providers can access for the early identification of patients at risk for addiction in order to initiate appropriate interventions.

Our country has to try and eliminate the irresponsible prescribing of opioids, and I support efforts at helping people get off of opioids whenever possible. These two bills do that and for that reason I hope you will give them your thoughtful consideration.