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Congress of the United States
House of Representatives
Committee On The Judiciary
2138 Rayburn House Office Building
Washington, DC 20515-6216

**RE: HOUSE COMMITTEE TESTIMONY**

Honorable Committee Members:

I appreciate the opportunity to submit this written document in advance of my testimony on May 8, 2018 to the House Committee on the Judiciary's hearing, entitled "Challenges and Solutions in the Opioid Crisis."

These remarks are based upon my experience as a physician, caring for patients impacted by opioids, both in the community and behind bars at the Rhode Island Department of Corrections for nearly a quarter of a century. They are also based upon my training in Internal Medicine, Infectious Diseases, HIV/AIDS, Addiction and Public Health, as well as my experience as a clinical researcher.

Opioid addiction, or what we now call opioid use disorder, is generally a poorly understood disease. Both the disease and its treatments have long been highly stigmatized in our society. This combination of a lack of understanding and stigma has resulted in misdirected resources and contributed to a worsening of the problem. (1)

Opioids can alleviate pain and suffering and also induce a state of euphoria. Opioids have two physiologic properties, which distinguish them from most other addictive substances and lead to many of the adverse outcomes: tolerance and the withdrawal phenomenon. When opioids are taken regularly, on a daily basis, tolerance and withdrawal can develop rapidly (days to weeks). Tolerance refers to the need to continually increase the dose in order to achieve the same effect. Said another way, the more one uses, the more one needs to use. Tolerance also can be lost quickly when opioid use is interrupted for as little time as days to weeks.

Withdrawal is an incredibly uncomfortable feeling that occurs when someone who has developed tolerance attempts to or is forced to cease opioid use abruptly. Withdrawal has been described as about the worst feeling that a human can feel. A patient said "imagine the worst flu you have ever had, combine that with the worst stomach bug you ever had and multiply them both by a thousand." Withdrawal symptoms typically worsen in intensity for 2-3 days, and then begin to diminish. People do desperate things to avoid or get out of withdrawal.

When too much opioid is consumed, the person loses consciousness and eventually stops breathing, resulting in an overdose death. With increasing and decreasing tolerance and fluctuating potency, quantity and purity of opioids, it can be very difficult to predict when an overdose can occur.

An overdose occurs when there is a discrepancy between the individual's tolerance and the amount and potency of the opioids that are consumed. Of course, additional sedatives such as alcohol or benzodiazepines also contribute to overdoses. Overdoses can be effectively reversed with the prompt use of naloxone. The illicit opioid supply (including heroin and counterfeit pills and even cocaine) has in the past few years become contaminated with fentanyl and related compounds which are 50 to thousands of times more powerful than heroin. Fentanyl overdoses can also be reversed with naloxone, but it must be given much more rapidly and often in higher doses to be effective. (2)

Some people with exposure to opioids will go on to develop opioid use disorder, which is characterized as ongoing use despite adverse consequences. There is a strong situational component that contributes to the development of opioid use disorder. The situational component could be peer pressure, physical and social isolation, or often prior trauma. For example, several of my patients were molested and abused as children and were told "it didn't happen" and "if it did, it's all your fault" and "we don't talk about that." They carried this psychological burden into adulthood, and once exposed to an opioid, that whole psychological burden gets lifted briefly, and they feel happy. It is no wonder they would want to go back to that place where their psychological pain is relieved.

I think of the brain in two parts: the thinking brain, the cerebral cortex, and the primitive or reptilian brain, which is "hard wired" for survival. Most of our behavior and actions can be controlled by our thinking brains. For example, we can hold our breath for a long time, but there comes a time when the primitive brain kicks in and takes over; it forces us to breathe, even if we are in a smoke-filled burning building.

This is the part of the brain that is damaged in opioid use disorder. The brain interprets symptoms of withdrawal as "we are going to die" and commands the body to do whatever it has to do to obtain and consume an opioid in order to survive and to avoid the feelings of dying.

When someone gets hooked on opioids, as their tolerance increases, they need to consume ever increasing amounts to stay out of withdrawal. They are being squeezed like a boa constrictor. Every time they breathe out they get squeezed tighter and cannot breathe back in. This puts a strain on their resources, which, for many can lead to stealing, and/or involvement in the sex and/or drug trades.

We know what needs to be done to stop this epidemic. A public health approach based on sound science and evidence based practices. (1) First of all, we need to provide effective treatment. Medications for Addiction Treatment (MAT), which include methadone, buprenorphine (Suboxone) and depot-naltrexone (Vivitrol) are the most proven effective therapies to reduce overdose deaths. They work by different mechanisms but, when taken correctly, block the euphoric effects of opioids and keep the patient from developing withdrawal. This allows people to stabilize their lives and return to work, school or family activities. An increase in MAT in Baltimore dropped the overdose rate by 80%. (3) In France, where buprenorphine is widely available, fatal overdose is nearly non-existent. (4)

The availability of access to these medications is extremely limited throughout many parts of our nation (http://opioid.amfar.org/indicator/SMAT_fac). A sustained effort to develop widespread availability of comprehensive, high quality medication treatments for people with opioid use disorder, similar to what the Ryan White Care Act did to address the AIDS epidemic, is what is desperately needed.

However, in the US, much of the discussion of "treatment" is based upon the antiquated notion that complete abstinence is the best treatment. For many this involves going to a detox, a place where you can stay until you are detoxified. A bed.

There is a problem with "detox" as drug treatment: Up to 90% of the time, patients relapse to opioid use. Because they have lost their tolerance during the detox, and now that much of the illicit opioid supply is contaminated with fentanyl and related compounds, there is an even greater risk of fatal overdose. It has never been so dangerous to relapse to illicit opioid use. Thus, MAT approaches have a far superior track record at promptly reducing overdose deaths than does the antiquated approach. For those who are not interested in or aware of MAT, there are many things that can be done to engage them in care, including outreach programs for syringe services, naloxone distribution and other services that reduce overdose risk, mitigate drug-related harm, build trust and reduce stigma.

A crucial problem with the current epidemic, which includes illicit fentanyl, is that both sellers and consumers often have no idea what is in what they are buying, selling and consuming, or how powerful or concentrated it is. Drug checking services are a promising strategy that can be helpful (5). In the US, what has prevailed over a public health approach is a punitive approach, such as increasing penalties for distribution of dangerous substances. The problem is that, although it seems like that approach should work, the fact is that it does not. (6) What it will do is increase incarceration rates and incarcerate a lot of low level dealers who are primarily involved in the drug trade as a way to address their own addiction.

The punitive approach can have the opposite effect and drive people away from needed services. It is based upon the notion that the "abstinence only" model is effective, which, for the vast majority of people, especially in the short run, it is not. Most people with opioid use disorder do not simply stop using opioids and get on with their lives, no matter how much they are coerced, threatened or punished.

There are, however many examples of public health and public safety collaborations that have yielded promising results. For example, the Good Samaritan laws in many states have strongly encouraged people to call 911 for help in the event of an overdose. The heroic work being done by police and firefighters in getting naloxone into overdose victims are excellent examples of changing attitudes to further engage people struggling with opioid use disorder including pretrial and pre-arrest diversion into treatment. For example, The Law Enforcement Assisted Diversion (LEAD), and the Police Treatment and Community Collaborative (PTAC) which includes pre-arrest diversion into treatment. In Rhode Island, the firemen's Safe Stations are examples of public health/public safety collaborations designed to divert people struggling with addiction, who volunteer for help, into treatment. Most of these pre-arrest diversion programs also offer wrap-around services and case management designed to help engage and retain individuals in treatment.

Further increasing penalties will only squander those successes and drive people underground, further away from desperately needed treatment. The war on drugs has not worked. The National Research Council panel, on which I was the only physician member, examined the Causes and Consequences of High Rates of Incarceration and found that "the best empirical evidence suggests that the successive iterations of the war on drugs–through a substantive public policy effort–are unlikely to have markedly or clearly reduced drug crime over the past 3 decades." (7) The Pew Charitable Trusts also recently documented, in a nationwide study, that increased imprisonment does not reduce drug problems. (6) Opioid use disorder is not something that can be treated effectively with punishment or threat of punishment. If it did, we would have already solved the problem.

Increasing penalties for smaller amounts of drugs, including fentanyl, could make the situation a lot worse. It would incentivize high-level traffickers who import most of the fentanyl and opioid analogues to increase the purity of the fentanyl they are manufacturing, importing and introducing into the US illicit market. That would substantially increase the danger associated with fentanyl. On the other hand, having more dilute drugs in circulation would reduce overdose risk.

Increasing the penalties for selling opioids will most likely capture predominantly low level sellers who are unlikely to know what they are selling and do not have the ability to sell any other drugs, and will be easily replaced by other desperate individuals.

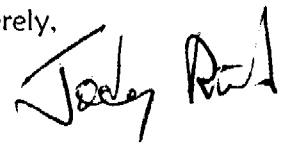
We exercised a very strong punitive approach to the crack cocaine epidemic beginning in the 1980s, based in part on some misinformation about the dangers of crack cocaine. Congress enacted mandatory minimum sentences for small amounts of crack cocaine. The result was a dramatic escalation of incarceration that devastatingly, disproportionally impacted minority, impoverished and inner-city residents. In 2010 Congress took an important step toward rectifying the crack sentencing disparity and passed the Fair Sentencing Act but more work remains to eliminate this disparity. We should not repeat the mistakes of the past with our response to opioids. Although fentanyl and other opioids undoubtedly pose more health risk than crack cocaine, increasing penalties and incarceration would surely worsen the opioid overdose crisis.
In Rhode Island, Governor Raimondo chose to invest in MAT for people with opioid use disorder and started with those passing through the prison and jail. Within a year of implementation, there was a statewide drop in overdose deaths of 12%, and for those recently released from incarceration, a 61% drop in overdose deaths. (8) This highlights the fact that increasing MAT availability will drive down opioid overdose deaths.

In summary, opioid use is poorly understood by most people. The black market is unregulated, leading to opioids with highly variable potency, which challenges efforts to control the damage done by them. What is needed is a strong public health and medical approach with a dramatic up-scaling of high quality MAT programs and strategies to engage people with opioid use as well as give them tools to reduce harmful use as much as possible.

Further punitive measures may make people feel like tough action is being taken. But out in the world where people are dying, such an approach will only make matters worse, and distract attention and resources away from what needs to be done.

Thank you and if you should have any questions, please feel free to contact me in my office at: (401) 793-4770.

Sincerely,



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