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A SUSTAINABLE SOLUTION TO THE EVOLVING OPIOID CRISIS: REVITALIZING THE OFFICE OF NATIONAL DRUG CONTROL POLICY

HEARING

BEFORE THE

COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM HOUSE OF REPRESENTATIVES

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A SUSTAINABLE SOLUTION TO THE EVOLVING OPIOID CRISIS: REVITALIZING THE OFFICE OF NATIONAL DRUG CONTROL POLICY

Thursday, May 17, 2018

HOUSE OF REPRESENTATIVES,
COMMITTEE ON OVERSIGHT AND GOVERNMENT REFORM,
Washington, D.C.

The committee met, pursuant to call, at 11:10 a.m., in Room 2154, Rayburn House Office Building, Hon. Trey Gowdy [chairman of the committee] presiding.

Present: Representatives Gowdy, Sanford, Amash, DesJarlais, Meadows, DeSantis, Ross, Walker, Blum, Hice, Grothman, Hurd, Palmer, Comer, Cummings, Maloney, Norton, Lynch, Connolly, Kelly, Krishnamoorthi, Welch, and DeSaulnier.

Chairman GOWDY. The Committee on Oversight and Government Reform will come to order. Without objection, the presiding member is authorized to declare a recess at any time.

Senator Cornyn, we are thrilled to have you. We realize that there are votes that have been called in the Senate. So my colleague from Maryland has graciously agreed to allow you to make your opening first, and then we will allow you to go vote.

With that, you are recognized.

WITNESS STATEMENTS

PANEL I

STATEMENT OF THE HON. JOHN CORNYN

Senator CORNYN. Thank you Chairman Gowdy and Ranking Member Cummings. I appreciate your courtesy and the opportunity to be here today to address America's drug addiction crisis.

From 1999 to 2016, more than 350,000 Americans have died from an overdose involving opioids, more people than in the current population of the city in St. Louis. This epidemic is hitting every community in every State, with more than 2,800 deaths in my home State of Texas in 2016.

But, of course, this didn't happen overnight. The Centers for Disease Control and Prevention has outlined the rise of the opioid overdose deaths in three distinct waves.

The first began in 1999 with increasing overdose deaths attributed to prescription opioids. Then, in 2010, we saw a rapid increase in overdose deaths involving heroin, which is cheaper than diverted prescription opioids.

The third wave began in 2013 with significant increases in overdose deaths involving synthetic opioids like illicitly manufactured fentanyl. Of the more than 64,000 overdose deaths in 2016, more than half were the result of heroin and synthetic opioids, not prescription drugs.

What is clear is that addressing only prescription opioids will not remedy this crisis. We must also halt the flow of illicit drugs like heroin and fentanyl, including through increased detection and intervention efforts at America's borders and ports of entry.

Transnational criminal organizations and drug cartels will stop at nothing to exploit Americans who are addicted to these narcotics that are tearing apart our families and our communities. And sadly, demand for the illicit drugs being sold by these criminal organizations has only increased as we have stepped up efforts to limit prescription opioid diversion.

Now more than ever, we need to carry out a comprehensive and coordinated strategy across all levels of government to address both the supply and the demand for illegal narcotics in the United States.

That is why I am pleased to have worked with Senator Dianne Feinstein to introduce the Substance Abuse Prevention Act of 2018 of the Senate. I hope you all will take a look at that.

Our bill strengthens and reauthorizes the Office of National Drug Control Policy, which oversees all executive branch efforts on narcotics control, implements a national drug control strategy, and strengthens and complements State and local antidrug activities.

This includes the High Intensity Drug Trafficking Area program, which provides resources for Federal, State, and local law enforcement task forces operating in our most critical drug trafficking regions.

The bill also improves the program by targeting funds for the implementation of a coordinated drug overdose response strategy. It reauthorizes the Drug-Free Communities Program, one of our most important programs for preventing substance abuse and reducing demand for illicit narcotics at the community level.

The Drug-Free Communities Program has been a central bipartisan component of our Nation's demand reduction strategy since its passage in 1998, because it recognizes that the drug issue must be dealt with in every hometown in America.

Solving our drug addiction crisis requires more than just law enforcement solutions. Families and communities must work together to implement evidence-based approaches that prevent drug addiction.

This is exactly the mission being carried out by Drug-Free Communities Coalition partners, and their efforts are critical to solving the drug abuse crisis.

And while we hope to prevent substance abuse from becoming a criminal matter, there is no avoiding the fact that our courts will always have a role to play in addressing drug addiction challenges.

That is why this legislation would also reauthorize the Department of Justice's Drug Court Program, which helps provide judicial and law enforcement officials on the front lines with the tools and the resources they need to help criminal defendants seek treatment

and rehabilitation instead of repeating the tragic cycle of addiction and incarceration without an opportunity to break that cycle.

Finally, the Substance Abuse Prevention Act also builds on the achievements of the Comprehensive Addiction and Recovery Act of 2016, known as CARA, to help families in substance abuse challenges by providing resources for sobriety, treatment, and recovery teams that pair social workers and peer mentors with these families.

This legislation that I have described here is supported by a broad coalition of 102 organizations, including the Community Anti-Drug Coalitions of America, the Addiction Policy Forum, the National Association for Children of Addiction, the National Council for Behavioral Health, and the Fraternal Order of Police.

Mr. Chairman, I know that you will soon introduce legislation that would also reauthorize and strengthen the ONDCP to address many of the issues that I have talked about today. I look forward to working with you and your committee as these bills move forward in our respective bodies so that we can be sure that the Federal Government is doing everything in our power to respond to this grave challenge facing our Nation.

I hope this committee and Members on both sides will continue their efforts to find consensus solutions to our substance abuse crisis. Saving our children, our families, and our communities from drug addiction is a humanitarian issue, not a partisan issue.

Mr. Chairman, thank you for allowing me to provide these comments and for your many courtesies today.

Chairman GOWDY. Senator Cornyn, I know I speak on behalf of all of the members on both sides of the aisle when we thank you for your career in public service, in the justice system, in law enforcement, and most recently, the United States Senate, and for your leadership on this very important issue. And we have benefited from your opening statement, and we thank you.

Senator CORNYN. Thank you, Mr. Chairman. I appreciate the visa that allows me to visit the House side. And I will return it promptly.

Chair GOWDY. You are welcome any time. Yes, sir.

We will briefly stand in recess while the second panel assembles. And then Mr. Cummings and I will make our opening statements.

[Recess.]

Chairman GOWDY. We welcome our second panel of witnesses. Mr. Cummings and I will make our opening statements, then we'll recognize you for your opening statements.

Our country is in an opioid crisis, and it's getting worse. Statistics can be helpful because statistics help us quantify and provide scope and scale. But statistics are what usually happen to other people.

What paints the most vivid image of this crisis are those who have lost children to overdose, those who are now and will forever be in the throes of addiction, and those whose lives have been ended, upended, and are in fear of retreat back toward addiction.

The increasing reality is more and more as our fellow Americans have come face to face with this crisis within their own families, to say nothing of within their own communities and the broader American family.

Each year over 64,000 Americans die from a drug overdose. That's more than the number of Americans killed in the entirety of the Vietnam war, a war which has consumed parts of the American consciousness for over half a century.

And while consensus exists on the depth of this challenge and the need to confront it in an apolitical way, the problem is worsening as more potent drugs emerge and the online market for illicit distribution expands.

Our country is in desperate need of a central coordinated response. The issue knows no geographic boundary, is no respecter of State lines, which means we need a coordinated governmental response at the national level.

So 30 years ago, Congress created the Office of National Drug Control Policy. This office is designed to play a central role in coordinating the Nation's drug control policy and programs. National drug control efforts are spread across 16 departments and agencies implementing programs and operations throughout the U.S.

So a central coordinating body is essential to ensuring effective evidence-based drug control programs. Drug control efforts should be synchronized and targeted at achieving specific strategic goals.

While the ONDCP continues to receive annual appropriations from Congress, it nevertheless operates under an expired authorization. Reauthorizing ONDCP with revamped and enhanced authorities will improve coordination and effectiveness of Federal agencies and their diverse drug control efforts.

ONDCP is also tasked with administering two grant programs, HIDTA and the Drug-Free Communities. ONDCP is uniquely positioned to administer these programs in a way that gives those working at the State and local level a prominent seat at the table.

As Congress appropriates increasing levels of funding, the need for a national coordinating office is more important than ever. And to be sure, our Nation's drug crisis will not be curtailed merely by appropriating money. The money must be spent in an effective way rooted in evidence, experience, and expertise.

Last week our committee shared a discussion draft of reauthorization text for the ONDCP. The committee has held hearings and roundtable discussions to better inform our reauthorization efforts. And through the posting of our draft text online we've received constructive feedback from the general public.

Today, we want to hear from partners about the importance of reauthorizing ONDCP. By ensuring a synchronized national effort we're better positioned to achieve our common goal of ending this devastating crisis.

This week is the week we set aside each year in Congress to honor law enforcement. So I want to end it by honoring someone in law enforcement, an old narcotics officer by the name of Kevin Simmers.

Kevin dedicated his career to the interdiction and detection and apprehension of drug dealers. He wanted to do his part to keep his community free from the scourges of addiction and trafficking. He felt like he was doing the Lord's work.

But Kevin was not just a law enforcement officer. He was also a father to a beautiful daughter named Brooke. Well, we know addiction is no respecter of people, not even of law enforcement offi-

cers who dedicate their lives to keeping drugs away from other people's children. No one is immune.

So when Kevin's daughter Brooke developed an addiction, he did everything a father could do. He tried treatment, he tried unconditional love, he tried tough love. He tried treatment again. Even tried jail.

You can imagine how hard it would be for a father to leave his daughter in jail. But he did so because he wanted her to be clean.

He came home from work and parked his police car behind his daughter's car so he could block off, not just her car, but also her path back to addiction. He wanted to keep his daughter from leaving in the middle of the night. He wanted to separate her, he wanted to protect her, he wanted to trap her. A father's love can be a benevolent trap. But heroin is a trap, too.

So Kevin woke up one morning to the ominous sound of an empty house and the ominous sight of tire tracks through the front yard. His little girl was gone again, 6 o'clock in the morning.

Brooke went to a gas station. She called her sponsor. Her sponsor said, "Call your dad." But she didn't want to disappoint her father again. So she drove to a church where she played basketball as a child, crawled into the backseat of her car, and overdosed on heroin.

It's not the statistics. It's not the money. It's something you can't count. It's the grief of parents burying their child.

The gentleman from Maryland is recognized.

Mr. CUMMINGS. Thank you very much, Mr. Chairman.

The first overdose death that I heard of, I was 6 years old, 6. I'm 67 now. And this young man was a hero in our neighborhood, and I didn't even know what drugs were.

Then I had an opportunity later on in my life, as a 15-year old working in the drugstore, to watch people come in trying to get Robitussin. Do you remember that? Trying to get high. People that were in so much pain, they didn't even know they were in pain, of all colors.

That was 50-some years ago. And I am glad that we are moving to this moment, because I do believe that this is a destiny moment where we say enough is enough.

Fighting the opioid epidemic has been one of my top priorities for several years. I had a family member to die from this. Not only because it's a terrible thing that has destroyed so many Baltimoreans lives, but also because it's devastating a Nation, in red states, in blue states, in purple states.

It is time that we finally recognize this epidemic for truly what it is, a national emergency that is killing 115 Americans every single day, 115, and counting.

In December, the Centers For Disease Control and Prevention warned that life expectancy in the United States dropped for the second year in a row, and drug overdoses are the single biggest reason why. In 2016, nearly 64,000 Americans died from drug overdoses. These numbers are only getting worse with every passing minute.

I understand that today's hearing is supposed to be about proposals to reauthorize the Office of National Drug Control Policy. But it's hard to do that when we have not been able to speak to

the acting director of that office. We asked for him to testify here today, but our request was denied.

It's also hard to do it when we will not be hearing from other stakeholder agencies that are involved in this fight, like the DEA and the Coast Guard.

We're supposed to markup a bill next week, but we have not received any official feedback or technical assistance from the administration. We had a roundtable meeting with ONDCP staffers, and I thank you, Mr. Chairman for that, but I'm concerned that this legislation may not be ready for primetime.

Compounding this problem is the Trump administration's total lack of leadership on this issue, and they are simply missing in action. The National Drug Control Strategy was due in February, but they did not submit one. Remember what I said. We've got 115 people dying a day, but no drug control strategy.

Now, the President has just assumed office. I got that. So maybe it is understandable. But this February also came and went, and he still has not submitted a strategy, 115 people dying a day.

ONDCP staff told us that Kellyanne Conway is calling the shots. I sent a letter to the chairman on February 16, 2018, asking for a briefing from her, or anyone, from the White House who could tell us what's going on. But that never happened.

Ladies and gentlemen, this is the most deadly national health crisis we have seen in three decades, in three decades. Where President Trump has shown no leadership, Congress must step into the void and demonstrate a bipartisan commitment to taking on this fight in an effective and efficient manner.

We could talk all we want about how we might want to reorganize ONDCP, require new reports, and reshuffle the lines of authority. But they are not doing their jobs now. They are already failing to do what Congress required. So I have little hope that these kinds of changes alone will make a difference.

Here is the main point I would like to convey today, and I would like to place it in the DNA of every cell of our brains. Reauthorizing ONDCP is an important step. We want to ensure that we have a coordinated, effective, and efficient and evidence-based strategy.

But rearranging the deck chairs is not enough. Nibbling at the edges is not adequate. If someone has a gaping wound, we cannot just slap a Band-Aid on it. If someone is fatally hemorrhaging, we cannot just hand them a new organizational chart for a government office. They need expert medical care.

As a Nation, we need to dedicate significant and sustained new funding for treatment to combat this epidemic. The Department of Health and Human Services estimates that more than 2 million people in this country have opioid use disorders, which is likely an undercount. Yet, only 10 percent are able to access the specialty treatments they need.

Imagine 10 people with cancer and you tell them that only one of you can get the treatment in the United States of America, with one of the greatest health systems ever found. Something is wrong with that picture. We cannot stop this crisis if 90 percent of those affected cannot be treated.

Last month, I introduced the CARE Act with Senator Elizabeth Warren to start treating the opioid crisis like the public health crisis it is. Our bill is modeled directly on the Ryan White Act, which Congress passed with bipartisan support in 1990 to address the AIDS crisis. This has been endorsed by more than 30 organizations, including health advocacy groups, nursing organizations, local government associations, and public health organizations.

I urge all of my colleagues on both sides of the aisle to join our bill. My staff has already contacted each of your offices, and my door is open to answer any your questions.

To conclude, I want to thank our witnesses for being here today, including Ms. Goodwin from GAO, Mr. Parekh from the Bipartisan Policy Center.

I look forward to hearing from Mr. Carr, an old friend and the executive director of the Washington/Baltimore HIDTA, Intensity Trafficking Area. I appreciate his effective leadership and I thank him for his endorsement of the CARE Act.

Finally, I thank Commissioner Gupta of the West Virginia Bureau for Public Health for joining us today.

And as I close, let me say this. This is our watch. This is our watch. And it is our duty to protect our neighbors. I think the chairman said it quite eloquently. We've got to do things to protect our neighbors.

And it will affect all of us. There was one time that it seemed that the only place that was affected was the areas like the one I live in today and lived in for 35 years, the Black community.

Well, hello, there's a big difference now. It's everywhere. And so we have to address this in a bipartisan way, and I'm looking forward to it.

And, Mr. Chairman, I want to thank you for working with me and for your indulgence.

Chairman GOWDY. The gentleman from Maryland yields back.

We're pleased to introduce our second panel of witnesses. Dr.Anand Parekh, chief medical advisor of the Bipartisan Policy Center. Dr.Rahul Gupta, commissioner and State health officer of the Department of Health and Human Resources' Bureau for Public Health, State of West Virginia. Mr. Thomas Carr, executive director of the Washington/Baltimore High Intensity Drug Trafficking Areas Program. And Ms. Gretta Goodwin, Director of Homeland Security and Justice at the Government Accountability Office.

We welcome all of you. Pursuant to committee rules, I must administer an oath, so I would ask you to please stand and raise your right hand.

Do you solemnly swear that the testimony you are about to give should be the truth, the whole truth, and nothing but the truth, so help you God?

May the record reflect all the witnesses answered in the affirmative.

You may take your seats.

There's a series of lights that should inform and instruct you. Just be aware that all members have your opening statement in full, so if you could summarize the salient points within the 5 minutes, that will allow more time for the members to ask questions.

With that, Dr.Parekh, you are recognized.

PANEL II

STATEMENT OF ANAND PAREKH

Dr. PAREKH. Chairman Gowdy, Ranking Member Cummings, and members of the committee, thank you for the opportunity to appear before you today.

I applaud the committee's efforts over the last year to identify ways to strengthen the White House Office of National Drug Control Policy and enhance the Federal response to the opioid epidemic.

My testimony today is based on my perspective as a physician, a former deputy assistant secretary of health at the Department of Health and Human Services, and now currently as chief medical advisor at the Bipartisan Policy Center, a nonprofit organization that combines the best ideas from both parties to promote health, security, and opportunity for all Americans.

As the chairman and the ranking member noted, in 2016 alone, 2.1 million Americans had an opioid use disorder and over 42,000 Americans died from overdosing on opioids. This crisis, 20 years in the making, will get worse before it gets better.

Fortunately, there are evidence-based interventions and solutions that, if scaled by the combined efforts of the public and private sectors, can bend the curve of the epidemic.

The Bipartisan Policy Center's Governors Council, made of up former governors, has previously recommended four critical approaches to tackling the opioid epidemic.

Number one, curbing overprescribing. In 2016, 91.8 million adults, nearly 4 in 10 adults in this country, used prescription opioids. As a physician, I can tell you there is no reason, neither for acute pain nor chronic pain, that this many Americans should be prescribed or be using these drugs.

Number two, curbing the illicit supply, specifically heroin and synthetic opioids, which are currently driving the evidence.

Number three, facilitating treatment and recovery through increased training of healthcare professionals and medication-assisted treatment, public and private insurance coverage of these services, and increased funding to support the treatment infrastructure. We have made it far too difficult in this country to treat opioid addiction.

And number four, educating America to reduce stigma and expand evidence-based harm-reduction strategies, such as making Naloxone more widely available.

In order to coordinate the Federal response the Bipartisan Policy Center's Governors Council has also recommended that ONDCP be reauthorized, adequately funding and staffed, and empowered to track all Federal drug control initiatives.

On that issue, I would like to make three key points to the committee today in response to the bipartisan discussion draft to codify ONDCP.

First, the opioid epidemic is a multidimensional public policy challenge spanning public health, criminal justice, macroeconomics, international diplomacy, and homeland security.

In order to comprehensively tackle the opioid epidemic, it is critical that States and communities have a Federal partner that has

itself coordinated. The Federal response requires a leadership office, such as ONDCP, to ensure coordination and collaboration of executive branch agencies and departments that have a role in addressing the supply side and demand side of this epidemic.

The committee's envisioned National Opioid Crisis Response Plan, with goals, measures, targets, action steps and designations of responsible offices or officials, is urgently needed. This plan would also more clearly inform Congress about the appropriate Federal funding levels necessary to address the epidemic over the next several years.

Second, the robust performance measurement and data collection activities that the committee envisions for ONDCP will require sufficient funding and staffing support. I encourage the committee to ensure ONDCP tracks both process measures and outcome measures to gauge progress in combating the epidemic.

The critical drug control information and evidence plan the committee is envisioning should include assurances from ONDCP that performance metrics can be tracked using existing data surveillance systems or that systems be developed if not currently in operation.

I also encourage the committee to build in some flexibility with respect to performance measurement. The committee should ensure agency accountability while not being overly prescriptive.

And third, for ONDCP to truly succeed it must be empowered by Congress and supported by the administration. The President should underscore ONDCP's authorities to Federal agencies and departments who must be accountable for their role in implementation of the response plan.

Ultimately, ONDCP needs to be the quarterback of the Federal response to the opioid epidemic and needs the staffing, funding, and authority so it can lead and inspire disparate agencies and departments in tackling the opioid epidemic and other threats that may come down the road.

Thank you for the opportunity to address this committee. And I look forward to your questions.

[Prepared statement of Dr. Parekh follows:]



BIPARTISAN POLICY CENTER

A Sustainable Solution to the Evolving Opioid Crisis: Revitalizing the Office of National Drug Control Policy

Written Testimony by BPC Chief Medical Advisor Anand K. Parekh, MD MPH

U.S. House Committee on Oversight and Government Reform

May 17, 2018

Chairman Gowdy, Ranking Member Cummings and members of the committee, thank you for the opportunity to appear before the committee. I applaud the committee's efforts over the last year to identify ways to strengthen the White House Office of National Drug Control Policy (ONDCP) and enhance the federal response to the opioid epidemic.

My testimony today is based on my perspective both as a physician and a public servant. As a physician starting at Johns Hopkins Hospital 16 years ago, I treated many patients with substance abuse disorders, most commonly acute drug or alcohol intoxication.

I was also part of the medical establishment which in the late 1990s and early 2000s began to prescribe opioids, a new class of pain relieving medications at the time marketed to health care professionals as having no addictive properties. That claim as we now know is not and was never true.

Subsequently, as a public servant in the Office of the Secretary at the Department of Health and Human Services (HHS), I dealt with an array of substance abuse prevention and treatment policy issues. Specifically, as Deputy Assistant Secretary of Health (Science & Medicine), I witnessed firsthand the unique convening ability and leadership role that ONDCP plays in the development, implementation, and tracking of the National Drug Control Strategy.

I also recall the ability of ONDCP to convene timely briefings for executive branch agencies around emerging topics such as neonatal abstinence syndrome, a condition in which a baby experiences withdrawal symptoms after being exposed to substances such as opioids.

The need for an entity such as ONDCP to promote executive branch collaboration and coordination was so apparent that in 2010 HHS created a Behavioral Health Coordinating Council to provide a similar internal forum to address issues such as prescription drug abuse and marijuana.

Opioid Epidemic

Today, the opioid epidemic is one of the most significant public health challenges of our time. In 2016 alone, 2.1 million Americans had an opioid use disorder and 42,249 Americans died from overdosing on opioids, 116 every day. The epidemic touches all segments of the population – white and black; young and old; urban and rural; rich and poor; and, red states and blue states.

The crisis, 20 years in the making, will get worse before it gets better. Fortunately, there are evidence-based interventions and solutions that if scaled by the combined efforts of the public and private sectors can bend the curve of the epidemic.

Tackling a crisis of this scale will require aggressive action by both government and the private sector, active engagement by both public health and law enforcement, sufficient funding and targeted investment to scale what works, and additional research on opioid alternatives.

The Bipartisan Policy Center's Governors Council has previously recommended **four critical approaches: 1) curbing overprescribing; 2) curbing the illicit supply; 3) facilitating treatment and recovery; and, 4) educating America to reduce stigma and expand evidence-based harm reduction strategies.**[1]

With respect to overprescribing, education of all health care professionals on safer prescribing practices as documented in CDC's Guideline for Prescribing Opioids for Chronic Pain is essential to prevent opioid misuse and addiction. Tying renewal of a controlled substances license, obtained through the Drug Enforcement Administration (DEA), to a requirement for a course in proper prescribing and addiction is an idea whose time has come.

In addition, prescription drug monitoring programs need to be integrated with electronic medical records and made interoperable from state to state to maximize their utility.

While prescribing rates have dropped over the last several years, in 2016, 91.8 million (more than one-third of U.S. civilian, noninstitutionalized adults) used prescription opioids. As a physician I can tell you there is no reason, neither for acute pain nor chronic pain, that this many Americans should be prescribed or be using these drugs.

With respect to curbing the illicit supply, stemming the flow of illicit fentanyl from China and Mexico needs to be one of our top international diplomacy and foreign policy priorities. Domestically, more funding, cooperation and coordination is needed by federal agencies to interdict fentanyl and disrupt drug trafficking networks.

[1] Bipartisan Policy Center. "Former Governors Offer Recommendations to President Trump's Opioid Crisis Commission." July 2017. Available at: https://bipartisanpolicy.org/library/letter-to-the-presidents-commission-on-combating-drug-addiction-and-the-opioid-crisis/.

With respect to facilitating treatment and recovery, a significant and sustained investment of resources is needed to ensure that all treatment facilities offer medication-assisted treatment, public and private payers provide barrier-free coverage of these services, and health care professionals are trained in providing this care.

In comparison to prescribing opioids, we have made it far too difficult for health care professionals to prescribe medication-assisted treatment for opioid addiction. Whereas obtaining a DEA license to prescribe opioids requires only filling out a short form, obtaining a waiver to prescribe buprenorphine requires completion of an eight-hour training. In addition, there are arbitrary caps placed on the number of patients a health care professional can treat with buprenorphine. These barriers to treatment must be addressed.

Finally, with respect to educating Americans to reduce stigma, employing harm reduction strategies, including syringe exchange programs and increasing widespread availability of naloxone, would save lives, reduce rates of infectious diseases, and facilitate treatment and recovery.

Role of ONDCP

In order to comprehensively tackle the opioid epidemic, it is critical that states and communities have a federal partner that is itself coordinated. While this epidemic is a public health crisis, the federal response is one that demands not just HHS making it a priority but each and every executive branch department as well.

The federal response must include a comprehensive supply-side and demand-side strategy that is funded appropriately, promotes interdepartmental coordination and collaboration, and includes specific measureable goals and timelines. With this in mind, I am pleased to see this Committee's bipartisan discussion draft to codify provisions relating to ONDCP.

Designating opioids as an emerging threat will require ONDCP to produce a National Opioid Crisis Response Plan within 60 days. While the final report of the President's Commission on Combating Drug Addiction and the Opioid Crisis, in addition to several other evidence-based reports, specifies important strategies to deal with the epidemic, a detailed federal implementation and action plan with goals, measures, targets, and designations of responsible offices or officials has not been produced to date.

A response plan would also more clearly inform Congress about the appropriate federal funding levels necessary to address the epidemic over the next several years. While Congress has appropriated dollars targeting the epidemic through The 21st Century Cures Act and, more recently, the Bipartisan Budget Act of 2018, these amounts have not all been developed through a data-informed process.

I am pleased the Committee's discussion draft emphasizes that ONDCP ensure federal agencies and states adopt evidence-based standards for drug control policies, practices, and procedures. This is especially important to accelerate the adoption and integration of medication-assisted treatment within the health care delivery system.

More broadly, establishing in statute the importance of evidence-based standards is an example of good governance and consistent with the findings of the Commission on Evidence-Based Policymaking, jointly sponsored by Speaker Paul Ryan and Senator Patty Murray.[2]

The discussion draft's requirement of a national evidence-based media campaign within 60 days of the opioid epidemic being given an emerging threat designation is also promising. I recommend that ONDCP carefully consider the recommendations of the President's Commission to ensure that such a campaign is developed and implemented in a way that maximizes impact.

I also recommend that ONDCP consult with the Centers for Disease Control and Prevention which has a track record in implementing successful public health education and outreach campaigns, most recently with respect to the national *Tips From Former Smokers*® campaign.

My caution for the Committee in reauthorizing ONDCP is not to overcomplicate its organizational structure. There are currently multiple plans, strategies, dashboards, centers, and leadership offices envisioned. The structure should be simple enough to ensure results-oriented accountability and clear channels of communication with executive branch agencies.

The committee should also ensure that ONDCP remains a leadership and policy office first and foremost and refrains from taking on too many programmatic activities that might be best suited for implementation at the level of executive branch agencies.

Ultimately, ONDCP's role in combating the opioid epidemic will be judged on whether it can develop and implement an executive branch-wide action plan to support states and communities which leads to a reduction in overdose deaths and opioid addiction over the next several years. The expectations of the office should be high because the urgency of the crisis demands nothing less.

[2] The Bipartisan Policy Center's Evidence-Based Policymaking Initiative supports the implementation of the recommendations of the Commission on Evidence-Based Policymaking.

Chairman GOWDY. Thank you,Dr. Parekh.
Dr.Gupta.

STATEMENT OF RAHUL GUPTA

Dr. GUPTA. Chairman Gowdy, Ranking Member Cummings, and distinguished committee members, thank you for the opportunity to appear in front of you today to discuss an issue of significant importance to the lives the American people, the opioid epidemic.

State and territorial health agencies are on the front lines responding to the current crisis of substance misuse, addiction, and drug overdose.

As a public health official and as a practicing physician for nearly 25 years, I have witnessed the consequence of this crisis in the form of overdose deaths, substance-related interaction with the criminal justice and welfare systems, HIV, hepatitis, prenatal substance exposure effects, and the burden on the healthcare system.

This crisis is unweaving the very fabric of our society.

In West Virginia, we continue to experience the highest rate of overdose fatalities in the Nation. We are also enduring a surge in the rate of neonatal abstinence syndrome among infants, a condition in which babies are born drug-dependent. Currently, 1 in 20 babies are diagnosed with NAS, and 1 in 6 expecting mothers are found to have intrauterine exposure to drugs.

Children are being placed in foster care at a higher rate than ever before, causing a tremendous demand on the social and early childhood resources. In fact, we estimate that there is an additional cost of at least $1 million for each baby born with NAS diagnosis.

Our State is not alone. The number of babies born in the United States with a drug withdrawal symptom has quadrupled over the last 15 years.

Under the leadership of Governor Jim Justice, West Virginia has made significant strides to take major steps in the right direction. Last year, we conducted a social autopsy of deaths and then engaged the public, a broad array of stakeholders and experts, to inform policymaking.

Throughout this initiative, there was significant support for reducing the harms of overprescribing, improving access to evidence-based treatment, and increasing the use of Naloxone and other harm-reduction strategies. I would be happy to share with you the findings today.

Recently, as a practicing internist, I saw a young woman who was brought into the clinic by her teenage daughter, being afraid of going through withdrawals, and having received Naloxone so many times that she was told she would not get it again. She was desperate to enter treatment. And we got her into treatment, but it wasn't easy.

But for three other patients that afternoon, I tried every possible way, but the best I could do was to listen to their story, their struggles, counsel them, offering them help whenever they were ready.

As I left the clinic that afternoon, I sincerely hoped we would be able to help these folks before they became a statistic.

Today, as we keep these real Americans in mind, I would like to stress upon three major points in my testimony.

One, to develop a sustainable solution to this contemporary challenge, we must have authentic national leadership that can envision and coordinate robust and wide-ranging, cross-cutting support from multiple organizations to develop an evidence-based comprehensive response strategy.

ONDCP provides this leadership. As the committee explores the reauthorization, its position should be strengthened, resourced, and allowed the expertise to develop robust leadership potential. ONDCP has done in recent years more to narrow the divide between public health and public safety than any other agency.

Second, Congress and States must work towards further expanding access to evidence-based treatment. We know that there are a number of barriers in accessing treatment, including stigma, homelessness, and poverty.

Individuals often need ancillary services, such as housing, recovery support, employment assistance and training, childcare support, and others.

Therefore, we should consider establishing a program to provide treatment and services to individuals with substance use disorders modeled on the Ryan White program, which provides treatment for AIDS patients.

With that in mind, I urge you to ensure that any changes in statute are building upon the existing system and programs that currently exist without creating an undue burden to State and local communities.

And finally, we must understand that this fight has to be fought on multiple fronts. In order to fully address this epidemic as well as substance use and misuse disorders as a whole, we must move further upstream to address the exposures during the life course that can lead to addiction, such as toxic stress in infants and adverse childhood experiences.

We must bolster efforts to work with schools, school-age children, build resilient communities, and increase investments in programs that work to address the social-psychological determinants of health.

In conclusion, the opioid crisis and substance misuse will not be solved by an individual agency or State. Instead, we need a comprehensive science-driven approach. As my patient rebuilds her life, she is going to need addressing her health, her home, her community, and the relationships with having a purpose in life.

So I applaud your commitment, and I implore the committee to take swift action.

Thank you.

[Prepared statement of Dr. Gupta follows:]

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Bureau for Public Health
Commissioner's Office

Bill J. Crouch
Cabinet Secretary

Rahul Gupta, MD, MPH, MBA, FACP
Commissioner
State Health Officer

United States House Committee on Oversight and Government Reform
"A Sustainable Solution to the Evolving Opioid Crisis:
Revitalizing the Office of National Drug Control Policy"
May 17, 2018

Testimony of

Rahul Gupta, MD, MPH, MBA, FACP
Commissioner and State Health Officer, West Virginia Department of Health and Human Resources
Bureau for Public Health

Chairman Gowdy, Ranking Member Cummings, and distinguished Committee members, thank you for the opportunity to appear before the House Committee on Oversight and Government Reform today to discuss an issue of significant importance to the lives of the American people, the opioid epidemic. State and territorial health agencies are on the front lines responding to the current crisis of substance misuse, addiction, and drug overdose. As a public health official and as a practicing physician for nearly 25 years, I have witnessed the consequences of this crisis in the form of overdose deaths, substance-related interaction with the criminal justice and welfare systems, HIV and hepatitis, prenatal substance exposure effects, and the burden on the healthcare system.

The nation is in fact suffering from the twin challenges of the overprescribing of prescription opioids for pain and a growing use of heroin, often adulterated with fentanyl. Every day, more than 115 people in the United States die from opioid overdose. That's one American almost every 12 minutes, mostly comprising of the working age population. In fact, the misuse of and addiction to opioids such as prescription medications, heroin, and synthetic opioids like fentanyl, not only constitutes a public health emergency but is also unweaving the very fabric of our society. Unlike any epidemic before it, this crisis is impacting the entire life cycle of our society.

In West Virginia, we continue to experience the highest rate of overdose fatalities in the nation at 52 per 100,000 in 2016, 33 percent higher than the rate of the second highest state, Ohio. Moreover, preliminary data from 2017 indicate an additional 20 percent rise in overdose deaths. West Virginia is also enduring a surge in the rate of Neonatal Abstinence Syndrome (NAS) among infants, a condition in which babies are born drug-dependent and begin to suffer the terrible consequences of withdrawal. Currently, one in 20 babies are diagnosed with NAS and one in six expecting mothers are found to have intrauterine exposure to drugs. Children are being placed into foster care at a higher rate than ever before, causing a tremendous demand on social and early childhood services.

In fact, we estimate that there is an additional cost of at least $1 million for each baby born with a NAS diagnosis. Our state is not alone; the number of babies born in the United States with a drug withdrawal symptom has quadrupled over the past 15 years.

The price of this epidemic is staggering. In November 2017, the White House Council of Economic Advisers estimated that in 2015, the economic cost of the opioid crisis was $504 billion, or 2.8 percent of gross domestic product (GDP) that year. This is over six times larger than the most recently estimated economic cost of the epidemic. This means that the cost of the opioid crisis to West Virginia's economy may have been as much as $8.8 billion or 12 percent of the state's GDP in 2015. Princeton University economist Alan Krueger recently estimated that the increase in opioid prescriptions could have caused 20 percent of the observed declines in labor force participation (LFP) among men and 25 percent among women in the United States. Over the last 15 years, LFP fell more in counties with higher opioid prescription rates.

Collectively, states and territories recognize the opioid crisis as a public health emergency. As with any emergency, we must respond with the resources necessary to sustain a full continuum of care and ensure that proven prevention, treatment, and recovery services are used consistently. To do that, we need to work with other government agencies, healthcare providers, law enforcement, as well as local, state, and national organizations to counteract stigma and view addiction as a chronic health condition that affects the brain. Just like asthma or diabetes, if we apply appropriate, evidence-based strategies, addiction is both preventable and treatable. My public health colleagues and I firmly believe that preventing the misuse and addiction of opioids and other substances in the first place is the best way to end our nation's epidemic. We need to look "upstream" and intervene in areas that will support our efforts.

In November 2017, the West Virginia Bureau for Public Health sought public input and engaged a panel of national and regional experts to develop a strategic plan to address the opioid epidemic. This process involved more than 500 public comments, a public meeting, and engagement of a broad array of stakeholders. Throughout this initiative, there was significant support for reducing the harms of overprescribing, improving access to evidence-based treatment, and increasing use of naloxone and other harm reduction strategies. This strategic plan, delivered to the Governor and the State Legislature on January 30, 2018, included twelve high priority, short-term recommendations. (Appendix A)

Soon after the release of the plan, Governor Jim Justice sponsored legislation to advance several of the recommendations. The Governor's proposal aimed to limit initial opioid prescriptions in emergency rooms and outpatient settings for all prescribers including physicians, dentists, optometrists, and veterinarians. It also backed the expansion of medication-assisted treatment by removing unnecessary state-level regulatory barriers and creating an exemption from state-level registration for practitioners treating no more than 30 patients. In advance of the recent advisory issued by Surgeon General Jerome Adams Advisory on Naloxone and Opioid Overdose, the proposal included a mandate for first responders to carry the opioid antagonist rescue kits and authorize the State Health

Officer to prescribe opioid antagonist on a statewide basis by one or more standing orders. With broad bipartisan support, on March 27, 2018, Governor Justice signed the Opioid Reduction Act with all of these provisions into law.

The new legislation represents a major step in the right direction for West Virginia. Yet, our public comment process also revealed that substantial stigma on opioid use disorder and its treatment remains. For every comment that stated something like, "When someone decides to go [into treatment] we need them in right now not two weeks from now," there was one that stated something like, "Anyone requiring an antidote should be sent to a psychiatric hospital for a minimum of 30 days. The hospital is not a resort; let them see what it is like to be locked up." Clearly, more than treatment is needed to address this crisis.

To develop sustainable solutions to this contemporary challenge, we must have authentic national leadership that can envision and coordinate a robust and wide-ranging cross-cutting support from multiple federal agencies, national organizations, and state and local governments to develop an evidence-based comprehensive response strategy. The White House Office of National Drug Control Policy (ONDCP) provides this leadership. As the Committee explores the reauthorization of ONDCP, its position should be strengthened, resourced, and allowed the expertise to develop robust leadership potential. ONDCP has done more in recent years to narrow the divide between public health and public safety than any other agency. Two programs supported by ONDCP include the Drug Free communities and the High Intensity Drug Trafficking Areas (HIDTA). Drug-Free Communities in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA) provides grants to community coalitions to reduce local youth substance use. The HIDTA program provides assistance to state, local, and tribal law enforcements agencies operating in areas determined to be critical drug-trafficking regions of the United States.

The opioid crisis is evolving—illicit fentanyl and other synthetic opioids are the major driver of overdose deaths in many parts of the country now. While the opioid crisis is not just a criminal justice issue, we must support and strengthen the role of law enforcement to address the supply of illicit fentanyl, as well as other emerging illicit drugs. Overdose deaths are increasingly being associated with methamphetamine, indicating that a comprehensive approach to all illicit substances, that includes law enforcement and health agencies, is needed. ONDCP can provide the leadership for that coordination, and through funding of the HIDTAs, can facilitate coordinated responses at the state and local levels.

This collaboration among ONDCP, local jurisdictions and state level responses are saving lives. As an example, in West Virginia we received notification at our medical examiner's office of several overdose deaths in a southern part of the state. We immediately issued an advisory to hospital emergency rooms and other healthcare partners to monitor for a fentanyl laced heroin batch. However, it was HIDTA that through its law enforcement relationships contacted confidential informants, arrests were made, and the deaths stopped. We also have a public health expert embedded in Appalachian HIDTA. Thus,

states like ours cannot afford to lose this resource and critical law enforcement partnerships.

ONDCP was created to provide broad-based policy direction on drug policy, and to serve as the single agency Congress could identify as responsible for understanding the many facets of drug policy, from the public health aspect to international and supply reduction efforts. What the House Oversight and Government Reform Committee should consider is whether ONDCP has been equipped adequately to fulfill that mission. Is ONDCP empowered to provide overarching policy direction to the federal government and guidance to the states? Does ONDCP have the authority to hold federal government agencies accountable?

State and territorial public health departments must have sustained and predictable sources of federal funding to improve monitoring and surveillance; expand and strengthen evidence-based prevention and education strategies; manage access to opioids and improve access to and use of effective treatment recovery and support. Additionally, in order to fully address this epidemic, as well as substance abuse and misuse disorders as a whole, we must move further upstream to address the exposures during the life course that can lead to addiction such as toxic stress in infants and adverse childhood experiences. We must bolster efforts to work with schools and school-age children, build resilient communities, and increase investments in programs that work to address the social determinants of health. Prevention programs like ONDCP's Drug-free Communities help ensure that this work is done – but such programs including those at CDC and SAMHSA must also be expanded and strengthened. I'm also very excited to see that under the leadership of Commissioner Dr. Scott Gottlieb, the Food and Drug Administration (FDA) is already leading the way by fostering the development of novel pain treatment therapies and appropriate prescribing by providers. However, opioid addiction affects a wide array of individuals, from high school athletes to blue-collar rural workers, yet stereotypes about those afflicted with addiction still exist. Stigma can lead to a lag in seeking addiction assistance and support from friends and family. As people get help, they often need to rebuild their lives which includes four components: personal health, home and family, community re-integration and relationships, and finally, finding and following a purpose in life.

Congress and states must work towards further expanding access to evidence–based treatment. We know there are a number of barriers in accessing treatment including stigma, homelessness, and poverty. However, we know also that we cannot exclusively treat our way out of this problem, just like we cannot exclusively jail our way out of this crisis. Individuals often need ancillary services such as housing, recovery support, employment assistance/training, childcare support, and others. Therefore, we should consider establishing a program to provide treatment and services to individuals with substance use disorders, modeled on the Ryan White program, which provides treatment for AIDS patients. With that in mind, I urge you to ensure that any changes in statute are building upon the existing system and programs that currently exist without creating undue burden to state and local communities.

Public health must ally with law enforcement agencies to improve health outcomes. This includes developing partnerships with quick response teams that help connect non-fatal overdosed individuals to treatment and prioritizing treatment of inmates. Similar to Rhode Island, which showed more than 60 percent reduction in opioid overdose deaths among those who were recently incarcerated after medication-assisted treatments were offered, West Virginia is aiming at helping prison and jail inmates who are struggling with addiction. One pilot program, being expanded statewide this summer, gives assisted treatment to inmates with an opioid medication upon their release and then helps connect them to longer term care in the community.

As the Committee considers evidence-based approaches to the opioid crisis specifically, I strongly urge you to refrain from a narrow focus on "opioids." While the opioid epidemic is a crisis of the moment, in many states other drugs such as methamphetamine, cocaine, and benzodiazepines, often in combination with opioids, are the emerging predominate causes of substance abuse and misuse among some populations. This is in addition to the long-standing challenge of alcohol misuse and addiction.

The opioid crisis and substance misuse will not be solved by an individual agency or a single state. Instead, we need a comprehensive science-driven approach that combines the efforts of local, state and federal agencies, organizations, and industry. I implore the Committee to take swift action to expeditiously coordinate the implementation of these solutions. I applaud your commitment and I look forward to working with you and your committee to help address this public health emergency.

Appendix A
Opioid Response Plan for the State of West Virginia
High Priority Short-Term Recommendations

Prevention	1. West Virginia should expand the authority of medical professional boards and public health officials to address inappropriate prescribing of pain medications. 2. West Virginia should limit the duration of initial opioid prescriptions.
Early Intervention	3.West Virginia should expand awareness of substance use disorder as a treatable disease by developing a public education campaign to address misinformation and associated stigma. This campaign should also support access to treatment through 1-844-HELP4WV. 4. West Virginia should expand promising law-enforcement diversion programs, such as the Law Enforcement Assisted Diversion (LEAD) model, to help people experiencing a substance use disorder access treatment and achieve sustained recovery. 5. West Virginia should strengthen support for lifesaving comprehensive harm reduction policies, by removing legal barriers to programs that are based on scientific evidence and by adding resources.
Treatment	6. Reflecting the need for all patients to have access to multiple options for treatment, West Virginia should require a statewide quality strategy for opioid use disorder treatment and remove unnecessary regulatory barriers to the expansion of effective treatment. 7. West Virginia should expand access to effective substance use disorder treatment in hospital emergency

	departments, other healthcare settings, and the criminal justice system to reach people at key moments of opportunity to enter care.
Overdose Reversal	8. West Virginia should require all first responders to carry naloxone and be trained in its use, support community-based naloxone programs for initial responders, and authorize a standing order for naloxone prescriptions to improve insurance coverage. 9. West Virginia should require hospital emergency departments and Emergency Medical Services to notify the Bureau for Public Health of nonfatal overdoses for the purpose of arranging for outreach and services.
Supporting Families with Substance Use Disorder	10. West Virginia should expand effective programs that serve families, including Drug Free Moms and Babies, home visitation programs, and comprehensive services for the families of children born with Neonatal Abstinence Syndrome, such as Lily's Place. 11. West Virginia should expand access to voluntary, long-acting, reversible contraception and other contraceptive services for men and women with substance use disorder in multiple settings.
Recovery	12. West Virginia should continue pursuing a broad expansion of recovery supports, including peer-based support services, families, and allies.

Source: Opioid Response Plan for the State of West Virginia https://dhhr.wv.gov/bph/Documents/ODCP%20Response%20Plan%20Recs/Opioid%20Response%20Plan%20for%20the%20State%20of%20West%20Virginia%20January%202018.pdf

Chairman GOWDY. Thank you, Doctor.
Mr. Carr.

STATEMENT OF THOMAS CARR

Mr. CARR. Chairman Gowdy, Ranking Member Cummings—and, Congressman, it's nice to see you back in the office again.

Mr. CUMMINGS. It's good to be back.

Mr. CARR. And distinguished members of the committee, it's an honor to appear before you today to discuss the proposed transfer of the HIDTA Program and the revitalization of the Office of National Drug Control Policy.

I come to you today as a representative of the National HIDTA Directors Association, but also with a sense of deja vu, since 13 years ago to this month I testified against a similar proposal that was before this committee. That proposal would have transferred HIDTA to the Department of Justice, and I'm glad to say it was rejected by Congress, and I urge you to do the same with this iteration.

The administration's rationale for the proposed transfer is to improve coordination among drug enforcement efforts. I submit the coordination that the proposal claims to seek already exists in the HIDTA program.

The most significant feature of the HIDTA program is a longstanding policy that each HIDTA is managed by an executive board. Moreover, the voting power on that executive board must be equally divided between Federal and State and local and tribal agencies.

The executive board is vital to the success of the HIDTA program, and it has unlimited discretion over activities and ensures that each HIDTA can tailor its strategy to the situation in that neighborhood.

In 2017, HIDTA has funded 825 initiatives. More than 22,000 personnel participated in these initiatives. As a result of the discretion afforded the executive boards, the makeup of the executive boards, and the top-to-bottom commitment to interagency cooperation, HIDTAs have established a track record of quickly devising and implementing creative responses to the drug challenges.

I said earlier I had a sense of deja vu. And I think you should know that since 2005, HIDTAs have disrupted on average 2,882 drug trafficking organizations each year. They've dismantled 17,000 methamphetamine labs, taken more than 7,700 tons of drugs off the street, including 44 tons of fentanyl, heroin, and prescription drugs, seized $8.5 billion in cash, and provided training for 556,000 personnel.

Now, as impressive as these statistics are, they don't tell the whole story, so let me tell you a little bit more about it.

One of the things we did was we developed something called the Heroin Response Strategy. This is the first multidisciplinary approach that I'm aware of that was focused on combating heroin and opium. The initiative brings public health and public safety partners together to reduce overdose fatalities. Common sense, if you ask me.

The HRS includes 10 HIDTAs in 22 States. And I think it's important to note that in their recent review of the HIDTA program

the GAO states, and I quote: "As demonstrated through its management of programs like HIDTA's HRS, an agency like ONDCP is uniquely positioned to collaborate with its law enforcement and public health counterparts."

GAO also recognized that a major obstacle to dealing with the opioid crisis has been the lack of shared methodology to track overdoses in real time across jurisdictions.

In 2017, the Washington/Baltimore HIDTA developed what we call ODMAP to address this need. ODMAP tracks overdoses as one would track a disease and issues alerts to public safety and health agencies about overdose spikes. More than 650 agencies across the country are now using ODMAP to share information.

So what makes this all possible? Well, we believe the discretion, balance, and independence of the executive boards is a direct result of the HIDTA program being administered by the Office of the National Drug Control Policy.

As you're well aware, ONDCP is charged with preparing a National Drug Control Strategy. Key to ONDCP's strength is its ability to coordinate the formulation of the President's drug control budget. It needs that hammer.

ONDCP's responsibilities cross the entire spectrum of drug activities, including enforcement, treatment, and prevention, and we believe those responsibilities give ONDCP the unique perspective to accept a wide variety of approaches to the opioid epidemic.

It is more urgent today than ever before for ONDCP to be reauthorized to continue its mission. Our members and our executive boards believe that the HIDTA program has been extremely efficient and effective under ONDCP and there's no evidence that demonstrates any benefits from moving the HIDTA program out of ONDCP.

We think the neutrality of the HIDTA program is a key ingredient for its success, and we also know that it would be difficult for DOJ to remain neutral and objective should they become our parent agency. Further, our non-DOJ representatives, and there are many, believe DOJ cannot operate as a neutral broker as well as ONDCP.

The success of the DOJ is determined by how well each of its agencies fulfills the mission of the Attorney General. The success of the HIDTA is determined by how well it carries out the assignments given to it by the executive board.

So as was cited before, we have 115 people dying every day from this crisis. We cannot afford now to abandon the ONDCP, abandon our mission, and we have to move forward.

And I thank you very much.

[Prepared statement of Mr. Carr follows:]

NATIONAL HIDTA DIRECTORS' ASSOCIATION

A Sustainable Solution to the Evolving Opioid Crisis: Revitalizing the Office of National Drug Control Policy

Statement by Thomas H. Carr
Treasurer, National HIDTA Directors' Association and
Executive Director, Washington/Baltimore HIDTA

Committee on Government Reform

May 17, 2018

Chairman Gowdy, Ranking Member Cummings, and distinguished members of the Committee:

It is an honor to appear before you today to discuss the Administration's FY 2019 proposal that would transfer the High Intensity Drug Trafficking Areas (HIDTA) Program from the Office of National Drug Control Policy to the Drug Enforcement Administration and about revitalizing the Office of National Drug Control Policy.

I come to you today as a representative of the National HIDTA Directors Association, which is comprised of the Executive Directors and Deputy Directors of the now 29 HIDTAs.

I have more than 47 years of law enforcement experience, including 23 years in drug law enforcement, ranging from investigating drug crimes to leading the Maryland State Police Bureau of Drug Enforcement and 24 years as the Executive Director of the Washington/Baltimore (W/B) HIDTA. My colleagues in the NHDA and I collectively represent more than 1,500 years of law enforcement experience.

I also come with a sense of *déjà vu* since I testified in front of this Committee on a similar proposal 13 years ago this month. That proposal was rejected by the Congress, and I urge you to do the same with this iteration.

The Administration's stated rationale for the proposed transfer is to improve coordination of drug enforcement efforts among Federal, State, and local law enforcement agencies in the United States. I submit the coordination the proposal claims to seek already exists in the HIDTA Program and in each designated HIDTA.

How the HIDTAs Operate

Over the years, the HIDTA Program has developed distinctive features that separate it from other Federal grant programs and State and local assistance programs administered by Federal law enforcement agencies.

The most significant feature of the HIDTA Program is the long-standing policy, codified into law in 2006, that each HIDTA is managed by an Executive Board comprised of senior federal law enforcement agents and State/local/tribal law enforcement executives from the HIDTA's designated area. Moreover, voting power on the Board must be equally divided between the two types of representatives –Federal and State/local/tribal. Other programs may combine Federal, State, and local law enforcement agencies into a single task force, but the work of those task forces is directed by a single agency, not a balanced group as with the HIDTA Executive Boards. As a result, those task forces are usually extensions of a single agency. In 2017, the composition of the HIDTA Executive Boards included 102 State, 239 local, and 301 Federal law enforcement administrators.

Second, the Executive Board in each HIDTA has virtually unlimited discretion over the HIDTA's activities. Every year, HIDTA Executive Boards assess the drug trafficking threats in their defined areas, develop strategies to address those threats, design initiatives to implement the strategies, and allocate the funding needed to carry out the initiatives. This level of local control and discretion ensures that each HIDTA Executive Board can tailor its strategy and initiatives to local conditions and can respond quickly to changes in those conditions. It also leads to wide-ranging and creative approaches to counter the drug traffickers operating in the United States.

In 2017, HIDTAs funded 825 initiatives. These initiatives included:

- 641 Enforcement Initiatives that investigate, disrupt and dismantle, and prosecute drug trafficking and money laundering organizations;
- 57 Intelligence and Information Sharing Initiatives that furnish intelligence, perform deconfliction services, collect and disseminate information, and provide other analytical support for HIDTA initiatives;
- 27 Prevention Initiatives that work to reduce drug use and deter new users through a variety of evidence-based programs;
- 12 Treatment Initiatives that support drug treatment services to help individuals, particularly those with criminal histories, to stop using drugs and lead more productive lives;
- 32 Training Initiatives that provide investigative, analytical, administrative, and demand reduction classes for HIDTA participants; and
- 21 Support Initiatives that provide funding for forensic laboratories, information technology, and technical support.

At the operational level, collocated task forces that include Federal law enforcement agents and State/local officers carry out HIDTA-funded initiatives. These task forces are led by a local, State, or Federal agency or often jointly led by more than one agency. The

interaction among the task force members is heightened by the Program's policy of requiring the task force members to be housed and commingled at the same location to facilitate a close, barrier-free work arrangement. In 2017, more than 22,000 federal, state, local, and Tribal agents, officers, analysts, and other staff participated in 825 HIDTA initiatives. This number included 10,695 from local agencies, 5,197 from state agencies, 6,230 from federal agencies, 69 from Tribal enforcement agencies, and three representatives of foreign law enforcement agencies.

As a result of the discretion afforded the Executive Boards, the make-up of the Executive Boards, and the top-to-bottom commitment to interagency cooperation, the individual HIDTAs have established a track record of quickly devising and implementing creative and effective responses to changing drug threats.

HIDTA Accomplishments

I said earlier that I had a sense of *déjà vu* today since I testified in 2005 about a similar proposal from the George W. Bush Administration. I would like now to provide a brief overview of what the HIDTAs have accomplished since that proposal was rejected.

Since 2005, HIDTAs have:

- Disrupted or dismantled an average of 2,882 drug trafficking and money laundering organizations each year, more than 60% of which were part of an international or multi-state operation;
- Dismantled almost 17,000 methamphetamine labs;
- Taken more than 7,700 tons of drugs off the street, including 959 tons of cocaine, 185 tons of methamphetamine, 39 tons of heroin and fentanyl, and more than 5 tons of prescription opioids;
- Seized $8.5 billion in cash and $3.7 billion in real property from traffickers; and
- Provided training for 556,000 agents, officers, analysts, and other staff.

As impressive as these statistics are, they do not tell the whole story of HIDTA accomplishments. The following examples illustrate the ability of the HIDTAs to implement creative and effective responses to drug threats as they emerge.

Heroin Response. HIDTAs developed the Heroin Response Strategy (HRS), the first multidisciplinary approach to combatting the heroin and opioid epidemic. The HRS initiative brings public health and public safety partners together at the Federal, state, and local levels to reduce drug overdose fatalities and disrupt trafficking in illicit opioids.

The foundation of HRS is the Public Health and Public Safety Network (PHPSN). The PHPSN comprises cross-disciplinary teams of drug intelligence officers (DIOs) and public health analysts (PHAs) within each state. These teams are designated as "points of light" within their state, tasked with communicating information and collaborating across agencies and with other states in the HRS.

The HRS began in 2015 with five HIDTAs and now has 10 HIDTAs along the Atlantic seaboard and in the Midwest that encompass 22 states.

I think it is important to note that in a recent review of the HIDTA Program, the GAO wrote: As demonstrated through its management of programs like HIDTA's HRS, an agency like ONDCP is uniquely positioned to collaborate with its law enforcement and public health counterparts to lead a specific review on ways to improve the timeliness, accuracy, and accessibility of fatal and non-fatal overdose data that provide critical information to understand and respond to the opioid epidemic. Such a review should expand on and leverage the findings from previous federal studies. It should also assess the benefits and scalability of ongoing efforts to leverage data systems, such as the Washington-Baltimore HIDTA's ODMAP program, and examine ways in which laws that restrict access to public health data to protect patient privacy have exemptions for law enforcement entities that could be more widely leveraged while appropriately protecting patient privacy.

Overdose Detection Mapping Application Program (ODMAP) Tool. A major obstacle to dealing with the opioid crisis has been the lack of a shared methodology to track overdoses, both fatal and non-fatal, in real time and across jurisdictions. This tracking capability is necessary to mobilize a capable public health response to these issues.

In 2017, the Washington/Baltimore HIDTA developed ODMAP, implemented a software application that first responders can use to enter overdose-related information and generate real-time overdose surveillance data across jurisdictions.

ODMAP sends first responders' input data to a mapping tool that tracks overdoses and issues alerts to enrolled public safety and health agencies about detected spikes in overdoses across an area. The real-time data input and immediate notification of ODMAP facilitates strategic analysis of overdose patterns. More than 30,000 overdose incidents have been reported using ODMAP and over 100 spike alerts issued. More than 650 teaming agreements have been signed with federal, state, and local public safety, health, and policy groups, including the Substance Abuse and Mental Health Services Administration (SAMHSA), ONDCP, the Center for Disease Control, and other HIDTAs.

Domestic Highway Enforcement (DHE). The DHE is a strategy to reduce criminal activity and enhance public safety on the country's major transportation corridors. DHE works to improve information sharing among the HIDTAs and between HIDTAs and their respective state and local law enforcement agencies. The initiative's efforts help identify interior corridors of drug movement and deny drug traffickers the use of the U.S. highway system.

The DHE strategy incorporates both regional and transportation corridor models to encourage the gathering, reporting, analysis, and sharing of intelligence regarding criminal activity and threats to public safety. The network developed through the DHE activities enables the information to be shared quickly and efficiently.

In 2017, HIDTA-funded DHE operations removed approximately 22.3 tons of marijuana, 1.5 tons of cocaine, 2.2 tons of methamphetamine, and almost a half a ton of heroin from the market and seized more than $1.7 million in cash.

What Makes This Possible?

I believe the discretion, balance, and independence of the Executive Boards is a direct result of the HIDTA Program being administered by the Office of National Drug Control Policy. As I know you are well aware, ONDCP is charged by law with preparing a National Drug Control Strategy that establishes the nation's plan to reduce drug use and its consequences. This Strategy is required to address the nation's needs with evidence-based programs, policies, and practices so that it can achieve its measurable short- and long-term goals and objectives. Key to ONDCP's strength is its ability to coordinate the formulation of the President's drug control budget, which is critical to the successful implementation of the National Drug Control Strategy. ONDCP's responsibilities cross the entire spectrum of drug activities – enforcement, treatment, and prevention, and we believe those responsibilities give ONDCP the perspective to recognize, encourage, and accept a variety of approaches to our Nation's drug problems. Given the severity of the opioid epidemic and conclusive evidence that cocaine and methamphetamine use are becoming significant contributors to overdose deaths, it is more urgent today than ever before that ONDCP be authorized to continue its mission.

HIDTA Executive Directors and the members of their respective Executive Boards unanimously agree that the HIDTA Program should remain part of ONDCP. Some of the reasons for that view are:

- The HIDTA Program has been extremely efficient and effective under ONDCP. There is no evidence that demonstrates any benefits from moving HIDTA out of ONDCP.

- The neutrality of the HIDTA Program is a key ingredient for its success in the partnerships developed over the years. This neutrality is attributed to the fact that the program is in ONDCP, which does not have a competing operational program or anyone sitting on any of the HIDTA executive boards.

- The U.S. Department of Justice administers five agencies (DEA, FBI, ATF, BOP, and U.S. Marshal's Service) that participate in HIDTAs and compete with each other, other federal agencies, and our State and local partners for limited resources and funds. It would be difficult for DOJ to remain neutral and objective should they become the parent agency over HIDTA.

- Non-DOJ representatives have expressed concerns about moving the HIDTA Program to DOJ. They believe a DOJ department cannot

operate as a neutral broker as well as ONDCP. They believe that the priorities and management practices of the Justice Department would, in time, overtake the HIDTA Program.

- The success of DOJ is determined by how well each of its agencies fulfills the mission assigned it by the Attorney General. The success of the HIDTAs is determined by how well the local initiatives carry out the assignments of the multi-agency executive Board.

- The HIDTA Program gives ONDCP real-time and direct access to some of this Nation's top criminal justice experts for input on threats, strategies, and policy. This is a critical asset to the ONDCP director and leadership who are responsible for this nation's drug policy.

Conclusion

I know the Congress recognizes how effectively the HIDTAs work; the funding appropriated for the program in times of resource constraints clearly demonstrates Congressional support. Given the demonstrated success of the HIDTAs, what would be gained by the dramatic restructuring envisioned in the 2019 Budget?

Moreover, with an opioid epidemic claiming an average of 115 lives per day and Congress likely to authorize and appropriate billions of dollars in response, what would be gained by diminishing the capacity of the Office of National Drug Control Policy? The National HIDTA Directors Association believes HIDTA and the Drug Free Communities Support Program should remain in ONDCP. We also believe that now is the time to reauthorize and strengthen ONDCP and empower it to develop and coordinate an aggressive opioid strategy.

I thank you for this opportunity to express the views of the National HIDTA Directors Association and look forward to working with the Committee on these issues.

Chairman GOWDY. Thank you.
Ms. Goodwin.

STATEMENT OF GRETTA GOODWIN

Ms. GOODWIN. Chairman Gowdy, Ranking Member Cummings, and members of the committee, I am pleased to be here today to discuss GAO's recent work on combating the opioid problem, including the role of the Office of National Drug Control Policy, ONDCP.

Today, I will talk with you about two topics.

First, Federal agencies' opioid-related strategies and the extent to which each agency is measuring its performance.

Second, Federal agencies' efforts to enhance collaboration and information-sharing to limit the availability of illicit opioids, the ongoing challenges to doing so, and ONDCP's role in that process.

In particular, there are five strategies that ONDCP and the Department of Justice have implemented to specifically combat illicit opioids. These include ONDCP's Heroin Availability Reduction Plan, HARP, and DOJ's 360 Strategy, which the Drug Enforcement Administration implements.

We found that of the five strategies, only one, HARP, included outcome measures or measures that are results-oriented. The others either did not include performance measures at all our measured outputs instead of outcomes.

For example, one of the goals in the HARP is to significantly reduce the number of heroin-involved deaths. ONDCP measures its progress towards this goal in part by using cause-of-death data. This is an example of a strategy with a clearly defined goal and a quantifiable measure that helps officials understand outcomes.

Most importantly, an outcome measure of this kind helps the agency understand if what it is trying to achieve is actually happening.

In contrast, the 360 Strategy captures the number of participants attending its activities, which is an output. Measuring outputs has some utility, but it does not allow the agency to assess the impact of its efforts or whether or not the resources it is investing are yielding the intended result.

We recommended that ONDCP and DOJ develop outcome-oriented performance measures for their respective strategies. ONDCP raised concerns about the recommendation, and DOJ disagreed, stating that it would be difficult to do so.

We continue to believe that our recommendations are valid and that finding meaningful ways to measure the effectiveness of these approaches is essential, despite being difficult.

With respect to coordination, I will touch on some of the challenges agencies are experiencing and the role we recommended for ONDCP.

Federal law enforcement agencies are increasingly coordinating with the public health sector to share overdose information. However, both sectors reported ongoing data-sharing obstacles and related challenges with the timeliness, accuracy, and accessibility of overdose data.

For example, toxicology results can take months to obtain, and this affects the timeliness of data on overdose deaths. These data are needed to anticipate and respond to threats.

Additionally, some of the data can be incomplete because medical examiners or coroners may not always test for opioids, especially synthetic opioids, thereby leading to inaccurate or incomplete data.

Further, legal restrictions to protect patient privacy on how data can be shared and analyzed affect how much information law enforcement and public health officials can access and share, respectively.

ONDCP is uniquely positioned to collaborate with its law enforcement and public health counterparts to identify solutions to these challenges. We recommended that ONDCP lead a specific review on ways to improve the timeliness, accuracy, and accessibility of overdose data. ONDCP neither agreed nor disagreed with our recommendation, but did say it would consider it.

I will note that during our review the lack of timely, accurate, and accessible information was one of the most pervasive concerns we heard from the public health and law enforcement officials we interviewed.

Given ONDCP's role in framing a national strategy, GAO believes the agency should bring together law enforcement and public health officials to improve national-level data and support data-improvement efforts at the State and local levels.

Chairman Gowdy, Ranking Member Cummings, and members of the committee, this concludes my remarks. I am happy to answer any questions you have.

[Prepared statement of Ms. Goodwin follows:]

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ILLICIT OPIOIDS

Office of National Drug Control Policy and Other Agencies Need to Better Assess Strategic Efforts

Gretta L. Goodwin, Director,
Homeland Security and Justice

Chairman Gowdy, Ranking Member Cummings, and Members of the Committee:

I am pleased to be here today to discuss GAO's recent work related to combating the opioid problem and the role of the Office of National Drug Control Policy (ONDCP). Though drug abuse in our nation is not a new phenomenon, the scale and impact of illicit drug use in this country has reached new levels. Deaths from drug overdoses have risen steadily over the past two decades and are the leading cause of death due to injuries in the United States. In fact, according to the Centers for Disease Control and Prevention (CDC), drug overdose deaths surpass the annual number of traffic crash fatalities, as well as deaths due to firearms, suicide, and homicide, respectively. In 2016, the most recent year for which national data are available, nearly 64,000 Americans died from drug overdoses, or approximately 175 people every day.

Recently, there has been a rise in opioid use in the United States involving the abuse of prescription drugs and more traditional illicit opioids, such as heroin. Coinciding with this increase, there also has been a significant increase in the use of man-made (synthetic) opioids, such as fentanyl and fentanyl analogues, which is a main contributor to the spikes in overdose deaths. For example, according to CDC, of the nearly 64,000 drug overdose deaths in 2016, nearly two thirds of the deaths involved opioids. Of those opioid-related overdose deaths, more than 15,000 involved heroin and more than 19,000 involved synthetic opioids such as fentanyl. Public health and law enforcement experts expect this number to continue to increase.

The Administration has taken certain actions to address the crisis. In March 2017, the President issued Executive Order 13784 establishing a commission to study the scope and effectiveness of the federal response to drug addiction and the opioid crisis.[1] The President's Commission on Combating Addiction and the Opioid Crisis issued a final report in November 2017, making a number of recommendations to the President to enhance the federal government's response to the opioid problem. Further on October 26, 2017, the President directed the Acting Secretary of Health and Human Services (HHS) to declare the drug demand and opioid crisis to be a public health emergency.[2] That same day, the Acting

[1]Exec. Order No. 13,784, 82 Fed. Reg. 16,283 (Mar. 29, 2017).

[2]See 42 U.S.C. § 247d. HHS has since renewed the October 26, 2017 determination twice — on January 19, 2018, and April 20, 2018 —for additional 90-day periods.

HHS Secretary declared the public health emergency under section 319 of the Public Health Service Act.[3]

While multiple agencies have a role in drug prevention, treatment, and supply reduction, ONDCP is responsible for, among other things, overseeing and coordinating the implementation of national drug control policy across the federal government to address illicit drug use (see appendix I).[4] In this role, the Director of ONDCP is required annually to develop a National Drug Control Strategy to reduce illicit drug use through programs intended to prevent or treat drug use or reduce the availability of illegal drugs.[5] ONDCP is also responsible for developing a National Drug Control Program Budget proposal for implementing the Strategy.[6] When we last testified to this committee on this issue in July 2017, ONDCP officials had told us that work was underway to develop a new Strategy.[7] As of today ONDCP has not issued a new strategy, and based on publicly available health data, our analysis shows that the majority of the former strategy's goals have yet to be fully achieved.

My testimony today is based on our March 2018 report examining illicit opioids and federal agencies' efforts to combat them.[8] In particular, I will highlight our findings pertaining to (1) federal agencies' specific opioid-related strategies and the extent to which each agency is measuring its performance; and (2) federal agencies' efforts to enhance collaboration and information sharing to limit the availability of illicit opioids, ongoing challenges to doing this, and ONDCP's role in enhancing such collaboration.

[3]GAO has recently begun work focused on the public health emergency declaration for opioids, including the actions that the declaration enables the government to take, and the actions that it has taken to date.

[4]21 U.S.C. § 1702(a)(2).

[5]21 U.S.C. §§ 1703(b), 1705(a).

[6]21 U.S.C. § 1703(c).

[7]GAO, *Drug Control Policy: Information on Status of Federal Efforts and Key Issues for Preventing Illicit Drug Use*, GAO-17-766T (Washington, D.C.: July 26, 2017).

[8]GAO, *Illicit Opioids: While Greater Attention Given to Combating Synthetic Opioids, Agencies Need to Better Assess their Efforts*, GAO-18-205 (Washington, D.C.: March 29, 2018).

Information on our scope and methodology can be found in the original March 2018 report. To assess more recent progress on attaining the goals contained in the National Drug Control Strategy, we used the same data sources that ONDCP uses to assess progress when it developed its original 2010 Strategy and did not independently assess the reliability of these data. We conducted the work on which this statement is based in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In summary, we found that federal agencies have documented specific strategies to combat illicit opioids; however, many lack outcome measures, or those that are results-oriented. The five strategies we reviewed were:

(1) ONDCP's Heroin Availability Reduction Plan (HARP), which was implemented in 2016. HARP aims to guide and synchronize interagency activities performed through ONDCP's National Heroin Coordination Group to reduce the supply of heroin, fentanyl, and fentanyl analogues in the U.S. market.

(2) ONDCP's High Intensity Drug Trafficking Areas (HIDTA) program's Heroin Response Strategy (HRS) which began in August 2015. HRS establishes a cross-disciplinary initiative that brings public health and public safety partners together at the federal, state, and local level to reduce drug overdose fatalities and disrupt trafficking in illicit opioids.

(3) The Organized Crime Drug Enforcement Task Forces' (OCDETF) National Heroin Initiative. OCDETF is a component of the Department of Justice (DOJ) and it began this initiative in December 2014 to support local and regional initiatives in disrupting the flow of heroin into communities in every OCDETF region across the country. The initiative aims to bring together otherwise disparate agencies, investigations, and information to develop a coordinated law enforcement action plan involving federal, state, tribal, and local authorities.

(4) The Attorney General's Strategy to Combat the Opioid Epidemic, which began in September 2016 and rests on three pillars: prevention, enforcement, and treatment.

(5) The Drug Enforcement Administration's (DEA) 360 Strategy, which began in November 2015. DEA is also a DOJ component and the goal of the 360 Strategy is to bring together three key DEA activities—enforcement operations, diversion control initiatives, and demand reduction efforts—under one strategy targeted toward opioids.

We have long reported on the importance of measuring program performance.[9] Our prior reports and guidance have stated that performance measurement should evaluate both processes (outputs) and outcomes related to program activities. Specifically, we have noted that output measures address the type or level of program activities conducted and the direct products or services delivered by a program, such as the number of presentations given, while outcome measures address the results of products and services, such as reductions in overdose deaths. Outcome measures can help in assessing the status of program operations, identifying areas that need improvement, and ensuring accountability for end results. However, of the five strategies we assessed, we found that only one—ONDCP's HARP—included outcome-oriented performance measures. Two—HIDTA's HRS; and DEA's 360 Strategy—included some type of performance measurement but these measurements were output instead of outcome-focused. Finally, two—the Attorney General's Strategy to Combat the Opioid Epidemic and OCDETF's National Heroin Initiative—did not include measures at all. For example, one of the stated goals in the HARP is to have "a significant reduction in the number of heroin-involved deaths in the United States due to a disruption in the heroin and fentanyl supply chains." ONDCP measures their progress towards this goal, in part, using CDC's cause of death data on heroin-involved overdose deaths. In contrast, DEA's 360 Strategy measures the number of participants in its activities (an output), for example, but it does not have goals or outcome-oriented measures in

[9]GAO, *Electronic Health Record Programs: Participation Has Increased, but Action Needed to Achieve Goals, Including Improved Quality of Care,* GAO-14-207 (Washington, D.C.: March 6, 2014); GAO, *Designing Evaluations: 2012 Revision,* GAO-12-208G (Washington, D.C.: January 2012); GAO, *Performance Measurement and Evaluation: Definitions and Relationships,* GAO-11-646SP, (Washington, D.C.: May 2011); and GAO, *Executive Guide: Effectively Implementing the Government Performance and Results Act,* GAO/GGD-96-118 (Washington, D.C.: June 1, 1996).

place to help officials understand what they are trying to achieve and whether the activities they have included in their strategy are yielding the desired results. Likewise, absent any measures at all, the Attorney General's and OCDETF's strategies make it difficult to set a course for its efforts and understand whether related efforts are having the intended impact.

During our review, federal agencies told us that it was difficult to set outcome-oriented performance measures for their respective strategies for a number of reasons, such as:

- the programs are being implemented in different locations that have unique needs and challenges;
- the federal government still does not have a complete understanding of the opioid problem; and
- the programs are time limited and outcomes are difficult to measure and achieve over a short time period.

However, as we stated in our report, without specific goals and outcome-oriented performance measures, federal agencies will not be able to truly assess whether their respective investments and efforts are helping them achieve the goals set out in their strategies. Further, while we acknowledged in our report that it may be difficult to single out individual agencies' contributions to these activities, the stated goals of these strategies revolve around the collaboration among multiple agencies. Therefore, establishing outcome-oriented performance measures would enhance these agencies' ability to assess whether these collaborative efforts are producing intended results. We recommended that DOJ, OCDETF, ONDCP, and DEA develop outcome-oriented performance measures for their respective strategies. ONDCP raised concerns about the recommendation, and DOJ did not concur with the recommendations for some of the reasons stated above. However, we continue to believe that our recommendations are valid and that finding meaningful ways to measure the effectiveness of these approaches will help ensure that the invested resources are yielding intended results.

We also found that federal law enforcement agencies have expanded their collaboration with one another, as well as with state and local law enforcement officials and with public health officials. However, ongoing data related challenges have hampered their efforts. For example, each HIDTA that participates in HRS has a drug intelligence officer located in each state where the HIDTA operates to help share information across

jurisdictions. Some HIDTAs have leveraged this increased coordination to better understand and respond to the opioid problem in their area. For example, our report discusses the RxStat Initiative in in the New York/New Jersey region, which consists of regular monthly meetings among 44 federal, state, and local government agencies to bridge the gap between public health agencies' population-level view of the opioid problem and public safety agencies' case-level view. HIDTA officials in the region reported that the initiative has been beneficial because it helped them understand the scope of the opioid abuse problem and target approaches in order to address it more effectively.

Despite these initiatives, officials from each of the six HIDTAs with whom we spoke during our review indicated that accessing and analyzing data on fatal and nonfatal overdoses continue to pose challenges to coordination, a view also shared by nearly all of the law enforcement and public health officials we interviewed. In particular, officials cited timeliness, accuracy, and the accessibility of overdose-related data as their primary concerns.

- With respect to *timeliness*, overdose data traditionally comes from the official cause of death listed on the death certificate that is prepared by medical examiners or coroners. However, toxicology test results can take months to obtain. Therefore, it is very difficult for law enforcement and public health officials to have timely data on overdose deaths so they can anticipate and respond to emerging trends.
- With respect to *accuracy*, law enforcement and public health officials we spoke with reported that some of the data on overdose deaths may be incomplete because medical examiners and coroners may not always test for synthetic opioids like fentanyl in their toxicology tests. This may be due to factors such as the lack of resources to conduct the test, the level of training of the person performing the autopsy, or there was no indication at the time of an autopsy that a fentanyl test was needed. An undercount of the number of overdose deaths may affect the scope of law enforcement and public health officials' response.
- With respect to *accessibility*, much of the relevant data for law enforcement and public health officials has legal restrictions to protect patient privacy on how the data can be shared and analyzed. For example, access to data from state Prescription Drug Monitoring Programs, which monitor controlled substance prescriptions dispensed by pharmacies and doctors, may be restricted based on

state law. Separately, law enforcement and public health officials we spoke with indicated a need for data on non-fatal overdoses to help them identify and investigate the sources of these drugs in their communities and to be able to direct people to available drug treatment programs. They particularly noted that data of this kind would provide an early warning system for law enforcement and public health officials to anticipate and respond to emerging drug overdose trends.

As we noted in our report, ONDCP is uniquely positioned to collaborate with its law enforcement and public health counterparts to identify solutions to these data challenges. As such, we recommended that ONDCP lead a specific review on ways to improve the timeliness, accuracy, and accessibility of fatal and non-fatal overdose data that provide critical information to understand and respond to the opioid epidemic. In response, ONDCP neither agreed nor disagreed with our recommendation but did say it would consider it. During our review, the lack of timely, accurate, and accessible information was one of the most pervasive concerns we heard from the public health and law enforcement officials with whom we spoke. Given ONDCP's role in framing a national strategy and supporting the HIDTAs, we continue to believe the agency should bring together law enforcement and public health officials to improve national-level data and support the data improvement efforts occurring at the state and local levels.

Chairman Gowdy, Ranking Member Cummings, and Members of the Committee, this completes my prepared statement. I would be pleased to respond to any questions that you may have at this time.

GAO Contact and Staff Acknowledgements

If you or your staff have any questions about this testimony, please contact Gretta L. Goodwin at (202) 512-8777 or goodwing@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Individuals making key contributions to this testimony include Joy Booth (Assistant Director), Julia Vieweg (Analyst-in-Charge), Eric Warren, Kisha Clark, Kevin Reeves, Amanda Miller, Billy Commons, and Jan Montgomery. Key contributors to the prior work on which this testimony is based are listed in the product.

Appendix I: Examples of Federal Agencies Involved in Combating Drug Trafficking and Drug Use

Table 1: Examples of Federal Agencies Involved in Combating Drug Trafficking and Drug Use

Agency	Tasks
Department of Defense (DOD)	
Joint Interagency Task Force West & Joint Interagency Task Force South	• Detects and monitors illicit drug trafficking, and facilitates international and interagency interdiction
National Guard	• Supports the detection, interdiction, disruption, and curtailment of drug trafficking activities and use at all levels of government, through use of military skills and resources
Department of Health & Human Services (HHS)	
Centers for Disease Control and Prevention (CDC)	• Detects and responds to new and emerging health threats causing death and disability for Americans • Uses science and technology to prevent disease • Promotes healthy and safe behaviors, communities, and environment
Food and Drug Administration (FDA)	• Protects public health by ensuring the safety, efficacy, and security of human and veterinary drugs, biological products, and medical devices • Coordinates with DEA on scheduling drugs under the Controlled Substances Act[a] • Collaborates with CBP to prevent the importation of unapproved drugs and investigates their distribution • Inspects registered facilities that manufacture drugs approved for marketing in the United States
National Institutes of Health	• Supports research to protect and improve public health, prevent disease, and expand medical knowledge • Includes the National Institute on Drug Abuse (NIDA), which supports research on the causes and consequences of drug misuse
Substance Abuse and Mental Health Services Administration (SAMHSA)	• Develops best practices and expertise in preventing and treating mental and substance use disorders. • Evaluates and disseminates evidence-based behavioral health practices • Supports behavioral health programs and services with grant funding • Supports behavioral health with data from national surveys and surveillance
Department of Homeland Security (DHS)	
Customs and Border Protection (CBP)	• Manages and controls border, including the enforcement of customs, immigration, border security, and agricultural laws. This includes screening inbound cargo at ports of entry, including international mail and express consignment carrier items • Collaborates with FDA to prevent the importation of unapproved drugs and investigates their distribution
U.S. Coast Guard	• Conducts maritime drug interdiction • Contributes vessels and aircraft deployed to disrupt illicit drug smuggling

Agency	Tasks
Department of Homeland Security (DHS)	
U.S. Immigration and Customs Enforcement (ICE)	• Enforces federal laws governing border control, customs, trade, and immigration • ICE's Homeland Security Investigations (HSI) investigates the illegal movement of goods within and out of the U.S., including narcotics
Department of Justice (DOJ)	
Criminal Division	• Develops, enforces, and supervises application of federal criminal laws except those assigned to other divisions • Advises the Attorney General, Congress, the Office of Management and Budget, and the White House on matters of criminal law and assists federal prosecutors
Drug Enforcement Administration (DEA)	• Enforces laws and regulations related to the growing, manufacture, or distribution of controlled substances • Conducts investigations in coordination with international, state, local and tribal law enforcement agencies • Coordinates with FDA on scheduling drugs under the Controlled Substances Act[a]
Federal Bureau of Investigation (FBI)	• National security organization with intelligence and law enforcement responsibilities, including terrorism, cyber-attacks, and other major criminal threats
Office of Justice Programs	• Disseminates information on strategies for crime control and prevention to federal, state, local, and tribal justice systems • Administers grant programs to develop and implement these strategies
Organized Crime Drug Enforcement Task Forces (OCDETF)	• Identifies, targets, disrupts, and dismantles major drug trafficking organizations, money laundering organizations, and related criminal enterprises • Coordinates prosecutor-led, intelligence-driven multi-agency and multijurisdictional task forces, including DOJ, DHS, and USPS component agencies
U.S. Attorney's Office (USAO)	• Enforces federal laws throughout the country, including drug trafficking and production offenses
Department of State	
Bureau of International Narcotics and Law Enforcement Affairs	• Helps foreign governments implement programs to reduce the demand for and supply of illicit drugs
Office of National Drug Control Policy (ONDCP)	• Advises the President on drug-control issues • Coordinates drug-control activities and funding across the federal government • Develops the annual National Drug Control Strategy • Administers the High Intensity Drug Trafficking Areas (HIDTA) Program and the Drug-Free Communities grant program[b] • Leads the interagency National Heroin Coordination Group, which developed the Heroin Availability Reduction Plan

Appendix I: Examples of Federal Agencies Involved in Combating Drug Trafficking and Drug Use

Agency	Tasks
United States Postal Service (USPS)	
U.S. Postal Inspection Service (USPIS)	• Protects against and prevents criminal attacks to postal employees, customers, infrastructure, and the U.S. Mail • Enforces laws that defend the nation's mail system from illegal or dangerous use • As the federal law enforcement arm of the USPS, investigates cases and prepares them for court along with U.S. Attorneys, other law enforcement, and local prosecutors

Source: GAO Analysis of Agency Documents | GAO-18-205

[a]Enacted in 1970, the Controlled Substances Act and its implementing regulations establish a framework for the federal government to regulate the use of these substances for legitimate medical, scientific, research, and industrial purposes, while preventing them from being diverted for illegal purposes. This Act assigns controlled substances—including narcotics, stimulants, depressants, hallucinogens, and anabolic steroids—to one of five schedules based on the substance's medical use, potential for abuse, and risk of dependence. FDA compiles and transmits to DEA a medical and scientific evaluation regarding a drug or other substance, recommending whether the drug should be controlled, and in what schedule it should be placed.

[b]The Drug-Free Communities Support program provides grants to community coalitions to create and sustain reduction in local youth substance use. For more information, see GAO, Drug-Free Communities Support Program: Agencies Have Strengthened Collaboration but Could Enhance Grantee Compliance and Performance Monitoring, GAO-17-120 (Washington, D.C.: Feb. 7, 2017).

Chairman GOWDY. Thank you.

The gentleman from Alabama is recognized for his questions.

Mr. PALMER. Thank you, Mr. Chairman. We've talked about the overdose deaths, the crisis that we have there. And first of all, I think we're talking about 64,000 people possibly that died last year. I think that is understated.

Dr.Parekh, in your experience, are you seeing where the death certificate does not show death by overdose but perhaps natural causes?

Dr. PAREKH. I think you're right. I think that's probably an underestimate. Certainly, the 42,000 for opioids is likely an underestimate as well. A lot of times the death certificates don't get into the specific cause of drug overdose deaths. Toxicology reports take a long time.

So, unfortunately, these are likely underestimates, and these numbers will get worse, Congressman.

Mr. PALMER. That's what concerns me. I think Ranking Member Cummings made this point, that the CDC has lowered the life expectancy for Americans is not just because of drug overdoses, it's also because of suicide. For people 10 to 24 years old, the second-leading cause of death is suicide.

And to follow up with you, are we seeing suicides that are linked to drug abuse?

Dr. PAREKH. We are. And these are overall called the deaths of despair. So you see drugs, alcohol, suicides taking a toll across the country, leading to the reductions in life expectancy, as you suggested.

There are lot of factors here, economic factors as well, that lead to this, but they all, unfortunately, interrelated and driving the lowering of life expectancy, as you cited.

Mr. PALMER. Well, it ought to be shocking to people that the suicide issue for 10-year-olds to 24-year-olds is the second-leading cause of death.

And I'm going to get into some area I probably shouldn't get into right here, but it has to do with the number of children, the percentage of children that are on psychotropic drugs that have adverse effects that might lead them to other issues like opioid abuse.

I mean, in my own district it's no longer shocking to hear that a young high school student has committed suicide. We had a 1-week period where a high school that's 4 miles from my house had two in 1 week, and another one just a few miles from there.

Mr. PALMER. And I think when we're looking at this crisis, we've got to look at the totality. It's just not the people who are dying from overdose, it's also the suicide aspect and link it all together. I think if we did, we would all just be shocked at the total numbers.

I mean, we've got veterans, 22 a day committing suicide. I wonder if any of you have any information about that, any of those related to adverse reactions to drugs that cause them to have these suicidal tendancies. Do you know anything about that?

Dr. PAREKH. I think they're all—I'll start—I think they're all—they can all be related, they're interrelated. I think, Congressman, what you're getting at is the overall importance of looking at the determinants of health and taking a prevention approach.

Mr. PALMER. Exactly.

Dr. PAREKH. I think the Drug-Free Communities Program, for example, is trying exactly to do that with community coalitions. But that's what we need to do, prevention, prevention, prevention, look at the underlying causes, the determinants of health. That's the best way to reduce all these deaths of despair, whether it's drugs, alcohol, or suicide.

Mr. PALMER. Well, there is profiling can be done through looking at DNA before anyone is prescribed a drug that would lay down some markers about the effectiveness of the drugs and the propensity to lead them to other things. I think that might be part of the solution.

Mr. Carr, we're talking about fentanyl, and one of the things that I talked about with some of the folks in law enforcement is that they're now deploying dogs that can sniff this out, particularly what's coming in the mail. A lot of this is coming from China. A lot it is produced by North Koreans.

I made this comment to former Governor Chris Christie, that we've gone from a war on drugs to a war with drugs, it seems like, and thousands of Americans are falling victim.

One of my concerns is, and I don't know if you can answer this, is that if we're going to try to interdict this through the mail, what are we doing to interdict it through the mail that goes from Mexico and to Central America and Canada that comes across our border?

Mr. CARR. Congressman, that's a big problem. One of the biggest facilitators of drug trafficking by virtue of the fact that they are such good shippers is the U.S. Postal Service.

I know there are efforts underway that the U.S. Postal Inspection Service has that are using computers and computer programs to profile packages. We're working with them right now with our ODMAP project, because when we detect spikes in overdoses in geographic areas, then we hope to work backwards and target the packages that did come and are coming into that particular area so we can be more effective in the interdiction.

But one of the problems with the way that they are shipping now is the fact that they are shotgunning. They are not sending big loads, they are sending multiple, multiple smaller loads. So it takes a lot of manpower and time to pick off those loads. And so if we got to 10 percent—I'll pick a number out of the air—we got 10 percent of them, 90 percent of them are still getting through, which is still a problem.

Can I go back to one comment you made, and it touched on prevention. We're using the ACEs model, Adverse Childhood Experiences, to help us profile young children.

We are working with the schools in Jefferson County, West Virginia, particularly the city of Martinsburg, the police, the schools, the board of education, the counselors in the schools, public health officials, all working together to identify those kids most at risk and to do something not only with them, but with their parents.

And that's the future of this, we have to look at long-term prevention if we're going to be successful in it.

Mr. PALMER. I agree 100 percent.

Mr. Chairman, if I may, I just want to comment on your opening comments. One of the things that indicates how widespread and se-

rious this crisis is, I don't think I know anyone who does not have a personal story of a friend or a colleague or a family member similar to what you delivered. And I thank you for that and for your indulgence.

And I yield back.

Chairman GOWDY. The gentleman from Alabama yields back.

The gentleman from Massachusetts is recognized.

Mr. LYNCH. Thank you, Mr. Chairman.

And I want to thank the witnesses for coming here and trying to help us grapple with this problem.

Just referring back to the gentleman from Alabama's comments regarding suicide, in my district a few years ago we had a suicide cluster. And I lost 14 young boys, the oldest probably 17, the youngest probably 14, in a very short period.

And there is definitely a correlation between this opioid epidemic, not one-to-one correlation, but there is definitely a connection there with the desperation that comes with addiction, and then these young people have no way out.

The problem is bigger than that, but I think the gentleman from Alabama is spot on in trying to identify, drill down on that, and deal with that.

In our community I didn't know what to do. I reached out to CDC and a lot of other folks. I reached out to my construction unions. We actually built a residential facility for young people. Because up to that point we were actually collocating kids with adults, which is a bad situation.

But we established a Cushing House for boys, and now we've established a Cushing House for girls. It is an adolescent residential facility dealing with this problem. And got the support of the Tufts Medical Center and also my local community health center and set it up. But the line is out the door. We've got 40 beds and I've got a list probably several hundred long trying to get in.

I was touched by the chairman's initial remarks. There's 42,000 stories out there last year alone of similar situations with families losing their kids.

I do want to say that step one, though, is to have the director of the Office of National Drug Control Policy at this hearing, at that table right there. And we did not ask him to come here, and that just blows my mind. Because this is all about accountability.

And I'm proud of Congress because the last bill that we put out has $3.5 billion to deal with this problem and we don't have a director here who is willing to testify. We don't have a President that has a drug policy that we can articulate to families out there that are in the situations that we just described. We are dragging our feet on this and this is inexcusable.

And each witness here has talked about having leadership on this issue and a direction and a strategy on this issue, and we have a big fat zero because President Trump has somebody there for 8 months and that didn't work out. And now we've got a new person and we won't even ask him to come here and describe what the President's policy is because we don't have one. So we've got $3.5 billion to support a policy that does not exist at this point, and that is inexcusable.

I've got 2 minutes left.

Let me ask you, Dr. Parekh and Dr. Gupta, so there's a strategy for the Suboxone. It is a replacement therapy when our kids are hooked on opioids. And they are handing this stuff out like candy. And we're replacing opioid addiction with Suboxone addiction, which is also an opiate.

And I don't see any improvement there. We're just substituting drugs, one drug for another drug, and we're spending a lot of money on it. And I end up with an addict in each case.

Can I get your sense of this?

Dr. PAREKH. Thank you, Congressman.

So I think the short answer is, in fact, they are different drugs. One is a full opioid, the other is a partial opioid. That makes a big difference. And it allows this Buprenorphine or Suboxone to actually treat opioid addiction. And the best evidence we have, the gold standard evidence for treatment of opioid——

Mr. LYNCH. I'm down to 45 seconds.

My follow up, Dr. Gupta, Vivitrol, it's another version, it's a non-opiate, it doesn't seem to have the abuse potential that some others do. I that you didn't come prepared for this, but that's my question, is it better?

Dr. GUPTA. Congressman, what I would say, just like diabetes or any other chronic disease, this is a chronic brain relapsing disease. We wouldn't tell somebody with diabetes don't take insulin, because otherwise you are artificially giving insulin, what your body's missing. Just like this.

These drugs go, they have been studied, they do four things. They prevent relapse into the system, they prevent overdoses and deaths, they reduce infectious disease risk, and lastly, they reduce the risk of somebody having criminal activity.

So there are documented, evidence-based measures behind the use of MAT in the population. The best science we have today, it seems to work.

Mr. LYNCH. Okay.

Mr. Chairman, thank you for your indulgence, and I yield back.

Chairman GOWDY. The gentleman from Massachusetts yields back. I will tell the gentleman, my friend from Massachusetts, that the nominee was invited to the roundtable. And I am disappointed that he did not come. The membership participation was good and——

Mr. LYNCH. Well, I apologize then.

Chairman GOWDY. No, no, no.

Mr. LYNCH. I did not know that he was invited.

Chairman GOWDY. He was invited.

Mr. LYNCH. You ought to subpoena him if he didn't come.

Chairman GOWDY. I think it would have benefited him and us to have him present, but he decided not to do so.

The gentleman from North Carolina, Mr. Meadows.

Mr. MEADOWS. Thank you, Mr. Chairman.

And I thank both sides of the aisle for their heart and passion on this particular issue, because it does affect every community.

And yet, at the same time, it is critically important that we recognize that as important as it may be to have a new director of this agency/subset of the executive branch, it is far more critical that we actually start doing something about it. Because this did not

start with this administration. We've had this issue for a long time. And I know the gentleman from Massachusetts would agree with that.

I do agree that it should be all hands on deck. And I think the problem that you're hearing is a frustration of the fact that we have a drug that is being used and there are so many deaths each and every day, as, Ms. Goodwin, as you pointed out that, that we've got to deal with it.

Now the other thing is—and I would encourage—the ranking member of this committee has been very vocal in this area and I appreciate his leadership. It also goes into other areas, like FDA. We've got to find other alternatives for pain management that are, quite frankly, in the hopper waiting to be approved.

And so we need to work in a bipartisan way on areas that perhaps have a less addictive nature. This was supposed to be the wonder drug and it has really taken over in a critical area.

Ms. Goodwin, I want to come to you, because you talked about the coordination and where we are and that it's critical that we have coordination. And yet I think what I understand is, is so whether it's the DEA coordinating with the Coast Guard, coordinating with other areas on domestic illegal synthetic opioids, GAO found that only one of five strategies it reviewed actually included a results-oriented matrix or measurement. Is that correct?

Ms. GOODWIN. That's correct. So we looked at the five strategies that are out there and the only one that had a performance-related metric was the HARP program.

Mr. MEADOWS. Okay. So if we have five programs and only one of them has a measurement, how do we know when we're succeeding or making progress? Is it all just——

Ms. GOODWIN. Well, that's something we recommended. In our recommendation we submitted to ONDCP we talked about the need for them to come together and kind of pull all of those strategies together, have a conversation, and help each of those strategies develop metrics. Because you can't really get to the heart of the problem or begin to address the problem if you don't have evidence-based information.

Mr. MEADOWS. So if it is evidence-based, I think we will find Democrats and Republicans alike that will want to look and say: Are we making progress here?

And what you're saying is, is that the only progress that we see currently is really whether deaths go down from overdose? I mean, how do we measure whether we're making progress with any policy, no matter how great it is? What would be your recommendation?

Ms. GOODWIN. We didn't talk through or we don't put out there as GAO like what each of the entities are supposed to do. We ask that ONDCP start a review to develop a strategy that crosses all of the different stakeholders.

And working very closely with the public health officials, law enforcement, and the other stakeholders, we think that's a way to come to a strategy and begin to think about——

Mr. MEADOWS. Yeah, let me interrupt because I've only got 1 minute left. And I appreciate your answer.

But I guess my question is, if you've identified it as a concern, you obviously have areas that you believe need to be measured, do you not?

Ms. GOODWIN. Yes.

Mr. MEADOWS. So have you made those recommendations in the areas that need to be measured? Because you just said you didn't make a recommendation. But when you're doing the analysis, you have to run across what your areas of concern are.

Ms. GOODWIN. Yeah, one of things we are look for when we are doing our analysis, when we looked at HARP we noticed that they were actually collecting data, paying attention to the information, and reporting out. The other four strategies we looked at were just measuring whether someone showed up to a meeting or participated in an activity. We didn't feel like that that went a long enough way——

Mr. MEADOWS. Far enough.

Ms. GOODWIN. —went far enough to actually getting at a conversation about what's the extent of the problem, what's the nature of the problem, and how can you best develop strategies around that.

So when GAO goes in to look at something the first thing we want to know is, where are the data? And we weren't finding the type of data we thought would be useful for this conversation.

Mr. MEADOWS. So, Mr. Chairman, may I offer this. In a bipartisan fashion, I know you have made this a priority for the reauthorization and really moving forward.

Mr. Chairman, I know where your heart is, I know where the heart of the ranking member is on this particular issue. And if we only reauthorize, to not actually have a plan that implements with a measurable tool like Ms. Goodwin did, we will have failed.

And so I'm committed to work in a bipartisan fashion with both of you on the leadership on this particular issue. I thank you.

Chairman GOWDY. I thank the gentleman from North Carolina.

The gentlelady from Illinois is recognized.

Ms. KELLY. Thank you, Mr. Chair.

And I just wanted to let the ranking member know that I can really relate to what you were saying. When I was much, much, much younger than I am now, a little girl, I lost an aunt to heroin. She had three children and her oldest daughter died of a heroin overdose, a dirty needle. So this is something near and dear to me.

One of the most critical tools in addressing the opioid epidemic is the overdose reversal drug Naloxone. Naloxone is a generic drug. It was first approved in 1971. Yet the prices of these products have increased so dramatically in recent years that State and local communities are now having trouble stocking the drug. They are being forced to ration. One of these products, an auto injector like the EpiPen, now costs $4,500 for a pack of two.

Dr. Gupta, as part of West Virginia's opioid response plan, all first responders are now required to carry Naloxone. Is that correct?

Dr. GUPTA. Yes, Congresswoman.

Ms. KELLY. And some of the first responders are from volunteer organizations. Isn't that correct?

Dr. GUPTA. That is very true.

Ms. KELLY. So how does the price of Naloxone affect the ability of first responders to adequately equip themselves?

Dr. GUPTA. I think that's the important part. So one of the things that Governor Justice did, he actually put money behind, State money. So he's put about $10 million into the plan, with specifically $1 million, and repurchased over 37 doses of Naloxone with State money. And we got about $26 a piece. But smaller agencies do not have that capacity and ability to have the purchasing power to do that.

And we are very worried that the price increases and the price policies that are created are going to be a stumbling block no matter how many discounts are given, how many free Naloxone is distributed.

We're afraid that the average person who needs it isn't going to be able to get it because they feel it's something that's, while life saving, is also extremely expensive in their perspective.

Ms. KELLY. One of my hospitals I know has a program and they give it to our law enforcement in my rural area of my district.

We've heard similar testimony from county officials who testified at a hearing on the opioid epidemic last month in our Health Subcommittee. One witness said because of price increases local communities have to, and I quote, "fly by the seat of our pants all the time in terms of coming up with the medication."

Dr. Gupta, from a public health perspective, how do these pricing issues affect your ability to truly combat this epidemic?

Dr. GUPTA. Congresswoman, I can tell you from data, when we conducted a social autopsy we found that of the people EMS went to who have died from overdose, only a third of them actually got the Naloxone. And when we talk about elderly and African American, it was even worse.

So what we're seeing is that people are having—we have evidence to show that people—first responders are having to decide who to give, who not to give. And then there is always the issue of stigma because folks think that maybe the elderly aren't dying because of overdose. So that adds to the problem.

Ms. KELLY. The CARE Act, which I am cosponsoring, would invest $500 million per year in a Naloxone distribution program. Under this program the Federal Government would negotiate discounted prices for the product and then distribute it to the States, to first responders, local health officials, and the public.

Would this kind of Federal role in negotiating, purchasing, and distribution of the product help West Virginia equip your first responders in your community?

Dr. GUPTA. Yes, Congresswoman, that would be critical in ability to help that person. Because, again, if they have to have breath in their lungs in order to meaningfully have a chance to enter treatment, then we have to build the rest of the system as well to make sure that those folks, we save them first and then provide them the help. But this would be very helpful.

Ms. KELLY. And I think we would all agree that it is unacceptable that communities all across the country are health hostage by these arbitrary price increases, especially for a life-saving drug. And it is also unacceptable that drug companies would use the

opioid crisis as a way to profiteer at the expense of all of our constituents.

And I'm interested in working in a bipartisan way to see how we can combat this issue. And also I hope my colleagues will help by cosponsoring the CARE Act so we can bring these prices down and provide States and local communities with the tools they need to address the problem.

I yield back.

Chairman GOWDY. The gentlelady yields back.

Dr. DesJarlais.

Mr. DESJARLAIS. I thank the chairman and thank the panel for being here today.

Ms. Goodwin, I'll start with you. I've met with many groups over the years that stress the importance of instituting a nationwide prescription database. As you know, or may know, Tennessee borders eight different States and the congressional district I represent borders two.

This poses a unique problem because in the absence of a nationwide prescription database, drug abusers in my district will frequently get a prescription for an opioid in Tennessee and then simply cross the border into Alabama or Georgia and attempt to fill another.

What steps are you taking to address this problem?

Ms. GOODWIN. So GAO has not looked into that specifically. When we did some of our review, we did talk to a number of representatives from the HIDTA program. So I think actually Mr. Carr can speak more eloquently to that than GAO could.

Mr. CARR. Thank you, Congressman. I'll try.

Several years ago we were detecting people that were getting prescriptions written for them in Kentucky and they were driving to Miami to fill them. I don't know how many pharmacies they passed on the way. So I think you can know what they are up to.

With the PDMP that's been implemented, prescription drug monitoring program, I think that's a good first step. There are some issues with PDMP in that they are all activated at the State level. So in some cases doctors are required in that State to look at the PDMP to find out if their patient before them has in fact been given a prescription for an opioid or the like by another doctor.

In other States however, it is only recommended and they don't have to look. So I think we need to do some more work on that.

I think, personally speaking, I think a national database makes sense, especially as fluid as our population is today.

Mr. DESJARLAIS. And I would agree with you. Thank you.

This is for any of the panelists, regarding hospice care. Under the current law, to my understanding, hospice care staff are not allowed to dispose of the patient's prescriptions when the patient passes away. This often leaves the family sometimes taking narcotics or opioids home with them, or they may end up in their medicine cabinet and be forgot about, or somehow taken out of the home. And it leads to an increase of the drugs being distributed back into the community.

What safeguards can we enact to ensure that this problem is dealt with?

Dr. GUPTA. Thank you, Congressman.

I think it's important for us to be able to have either, again, the take back days, as well as enhanced efforts to destroy the medications going back to.

I think we're get to go a place where opioids as they are in the market are going to have to have companion mechanisms dispensed to patients to be able to destroy the medications.

Also a blister pack. We've just enacted laws to limit the initial prescribing in ERs and outpatient. So what happens? We would like to see blister packs for 3 days' or 7 days' use and then a parallel system where they can put it in a package and then destroy it. So I think that technology is needed.

Nationalizing, I just want to be real careful about that, because we need systems that will connect State PDMPs with other State PDMPs, rather than federalizing or nationalizing, because we are able to use our data in ways, creative ways in advance as a laboratory in States that would be a little bit difficult from federalizing the PDMP.

Dr. PAREKH. Congressman, I'll just add that FDA, I think Dr. Gupta is absolutely correct, FDA is looking into this blister pack idea and I think that's very, very promising.

To your point, there are 15 billion pills of opioids dispensed every year. Only 6 billion, 40 percent, are consumed. So 9 billion pills are, as you suggest, going different places and oftentimes end up in families' medicine cabinets.

Mr. DESJARLAIS. If you can answer this for me, I've heard that of the prescription opioid related deaths, over 90 percent of those are not the person that the drug was originally prescribed to. Is that your understanding?

Dr. PAREKH. I think it's a large number. There are 11 million Americans who are misusing opioids. Either they didn't have a prescription or they are not following the prescription.

Mr. DESJARLAIS. So I mean think that's a really important point to drive home, is that the physicians that are prescribing the opioids were doing that at a lower rate, but the opioids are getting in the wrong hands. And there needs to be a focus on punishment for distributing controlled substances, and the patients need to be educated before they leave the office and probably at the pharmacy as well.

And if the chairman would indulge just one last question, I recently met with a group of pharmacists that explained to me how e-prescribing can prevent overprescribing opioids by allowing healthcare providers to see a patient's medication history at the point of care, thereby helping them determine if the patients are doctor shopping.

Have any of you all been paying attention to this movement in States toward electronic prescribing for controlled substances? And if so, have the results been positive?

Dr. GUPTA. Congressman, I would say that we have attempted to do that in West Virginia. One of the challenges, I go back to this rural America divide, is that we have places we don't even have broadband in West Virginia. We have places where physicians rely on fax to transmit data.

So I think this links to another issue that we really have, which is e-prescribing is only good as the ability to get to our practices

in sometimes the rural parts of the State, and that's a limiting factor. But we do have some type, but it is very hard to be more robust in that.

Mr. DESJARLAIS. I thank the panel for their expertise.

I yield back, Chairman.

Chairman GOWDY. The gentleman yields back.

Mr. DeSaulnier.

Mr. DESAULNIER. Thank you, Mr. Chairman. I want to thank you for this hearing.

And I want to thank the ranking member for his passion and his urgency.

And I want to thank the panel members. This has been really interesting.

I guess my question is in two parts. One part is the urgency of getting this right and the suffering that the ranking member talked about.

And all of us, I think, anecdotally have had experiences, personally perhaps, but definitely professionally in this regard. I have constituents who have come to me over the years who have lost sons and daughters, and many of them are from very diverse economic aspects of my district in the bay area.

So my question is, Dr. Gupta, you are really in a very unique position, I think, given the challenges of West Virginia, so the urgency of getting out now. But you said at some point we have to go upstream to look at the real cause and effect.

So there are stories in the book of "Dreamland," which is a compelling book that you've had a chance to read about, the evolution and the causes of this, some of it ascribed to Purdue Pharma and aspects of their marketing. So in that case, there's pretty good evidence that they targeted the marketing specifically to West Virginia and other areas where they knew there was a lot of manual labor. Surely it seems intuitively that they targeted the worker's compensation system, permanent disability.

So how does that make you feel? And if you have evidence. I know my county just joined a whole group of counties in California in suing Purdue Pharma and others, because they have caused us to spend money, as you said, $1 million per child.

And the context of my question is, I'm a survivor of an incurable cancer. I have remarkable medicine that will keep me alive, keep my quality of life high. I just had a meeting with constituents who work at the University of California were involved in the CRISPR system there. Looked like, very promisingly, we can use genetics to identify bacteria in our system.

So I look at the system and the sustainability question of the urgency of now. But then how can we learn from this to really transform, given the context of what medical research is giving us right now?

If we could take the money that we're spending on that child, multiplied towards whatever number, and put it into these programs that can avoid this thing happening in the first place, including private sector companies or organized crime, using the system to divert our limited resources to stop this.

So you were at the front lines of this. Could you respond to that?

Dr. GUPTA. Thank you, Congressman, very much for that question.

You know, we as physicians began prescribing for pain, and we ended up over the years treating suffering instead of pain. And that's what we have today.

When we conducted our social autopsy of all the deaths in 2016 from overdoses in West Virginia what we found was four out of five people actually came in contact with the health system. We were having a lot of lost opportunities that we could have helped these people.

But as a result, what we found was if you're 35 to 54 years old, single, male, less than high school educated or high school, and work in a blue collar industry, you have a very high risk of dying because of an opioid overdose.

How we work is we are also seeing, again, a tremendous and such a demand on child welfare. We worry about the next generation as we sit here. We're losing 10, 15 years from now those babies being born now that are going into schools. These are the kids who are going to have lifelong traumatic experiences.

So as we work to address social determinants of health, as my colleagues have mentioned, we have got to look at those things. We've got to look at childhood experiences, we have got to look at traumatic communities, and we have to then work.

NAS, for example, we have programs now looking at long-acting reversible contraceptives as part of the corrections system. Our corrections officers know the way they are making the math right now, doing the math, they are saying 33.5 correction officers equals $1 million a year investment, 37 inmates equals $1 million dollars a year.

So they are saying we have thousands and thousands of people that need MAT. We don't we start doing MAT instead of putting people in prison?

So there's this relationship that is developing in trying to get folks to actually go through science- and evidenced-based treatment on one hand, save lives on the other hand, and are connecting those for treatment, and then really working upstream.

It's really not a partisan issue for us to look at how do we help a woman actually get into treatment before she starts to plan a family? I mean, this is just a social responsibility because we are seeing the other side of this in society so much.

We recently had a person, 82-year old great-grandmother, taking custody of a child. Those are the examples we are seeing on the ground every single day.

Mr. DESAULNIER. I really appreciate that.

And to the chair and the ranking member, I really think this is an amazing opportunity for us in Congress to change the dynamics on these reoccurring public health crises, to really look at the cause and effect. And not to ascribe blame to the private sector or anybody, but to look at evidence-based and say, not only can we sell the opioid program, but all of us can remember being told 20 years ago that crack babies were going to cost us money. We fall in this pattern of these reoccurring public health crises that maybe we can approach in a different way and avoid these unnecessary costs in human suffering dollars.

Thank you, Mr. Chairman.

Chairman GOWDY. The gentleman yields back.

The gentleman from Maryland is recognized.

Mr. CUMMINGS. First of all, I want to thank all of you for this excellent testimony.

You know, one thing you didn't mention, Dr. Gupta, and I was looking at a CNN piece on West Virginia, was foster care, the cost of foster care, because the parents are dead or they are on drugs. Can you comment on that very, very briefly?

Dr. GUPTA. Yes. Thank you, Mr. Ranking Member.

We are not even able to now find parents to foster the children, it has become so bad. West Virginians are great, giving people, but we at the point that we have the highest levels we've ever seen in the history of the State in kids entering into foster care. It is the biggest, unquestionable, challenging burden of the future for our State and we are very worried about that.

Dr. GUPTA. Dr. Gupta, you are from West Virginia. Your State has been hit extremely hard by this epidemic. This issue does not discriminate based on politics. It affects red States, blue States, and purple States.

Last November we held a hearing with Governor Chris Christie of New Jersey who chaired the President's opioid commission. The commission stated only about 10 percent of those who need treatment receive it and they warned that people are, and I quote, "losing their lives as a result of it."

Dr. Gupta, is that right? Are people dying today because they simply can't access treatment? Is that true?

Dr. GUPTA. That's absolutely correct and very true. And part of the reason is the stigma. It's not just they can't receive treatment. Some people worry they are going to lose their job. Some people think that they don't have enough coverage, they can't travel to get treatment. They have to in West Virginia average wait 30 to 60 days before they can enter outpatient treatment.

So we have so many barriers, including stigma, why people can't get treatment and as a result end up dying.

Mr. CUMMINGS. You know, I mean, there's a big elephant in the room, Doctor, okay? Anybody who has ever been around drug addicts knows that quite often they end up being another person. In other words, they begin to lie, steal.

One of my earliest cases as a lawyer was a fellow who literally killed his—hatcheted his grandmother to death trying to get money for drugs.

So they turn into another person. They look like the same person, but to somebody else.

So I guess for an employer that's a kind of difficult situation. I was just with the railroad people yesterday and they were telling me how hard it is for them to get people to hire, because people simply cannot pass the drug tests. And they worry about accidents big time, and they should.

In January your State of West Virginia instituted an opioid response plan that also called for expanded access to treatment. It states, and I quote, "One of the most important actions that any State can take to address the opioid crisis is expanding access to effective treatment." Is that right?

Dr. GUPTA. Yes, sir, that's absolutely correct. One of the things we did was we had State regulations for MAT clinics. We've created exemptions for physicians so they don't have to pay the registration, they don't have to go through the whole process if they want to treat their own patients up to 30. We have also cut down on onerous regulations within our State.

We are making every effort possible to make MAT treatment—and MAT is just not drugs, it's a whole host of behavioral, social, cognitive therapies that go along with it—as the primary focus of our effort to make sure that every West Virginian who has an opportunity, wants to get into treatment, has no delay, treatment on demand type of——

Mr. CUMMINGS. And I gave you the 10 percent figure nationally that are able to get treatment. What's it like in West Virginia? Do you have any idea?

Dr. GUPTA. We have wait times, as I mentioned. There is a great COAT Program at West Virginia University and their average wait times are between 30 and 60 days.

So you can imagine what happens in those 30 days, because people don't wait 30 days when they have this monster on their head that they have to worry about every time, getting a dose in 3, 6 hours, sometimes even more frequent.

Mr. CUMMINGS. So here is the big question. We here on the committee can talk about organizing ONDCP. We can discuss moving things around on an organizational basis. We can even ask ONDCP to send us more reports. But if that's all we do, if we fail to ensure sustained funding to expand access to treatment, will we be able to turn this crisis around as a Nation?

And I know I've run out of time, but I want you also to just speak very briefly. We spend a lot of time talking about deaths, but we've got a pipeline. I'm talking about the living and the dead. Because a pipeline car is far bigger than the folks, the 1 in 15 I am talking about, that are dying daily.

So would you comment on that, Dr. Gupta?

Dr. GUPTA. Certainly, sir. One of the things I would say is that every person who has an opioid overdose, nonfatal, that comes in, it's a cry for help basically. What they are saying is that is suicide attempt, because they know every time it's Russian roulette when they inject that drug.

The question is, are we able to then connect that cry for help and get those people immediate treatment? We are working on that in West Virginia, trying to make sure that every emergency room visit, first of all, that it doesn't happen, but if it happens, how do we connect that cry for help back to treatment, they get that treatment. There's a lot more people, it's the tip of the iceberg beneath that.

So the first thing is to avoid deaths. This is a preventable problem. This is something we can prevent and get people into treatment. Everyone that dies we see, they had, four out of five people, came into context with the health system and we failed them, to be really honest.

Mr. CUMMINGS. How do you see us getting past the stigma? And that's a tough one. The stigma on the part of the patient—I mean, the drug addict.

But there's another stigma, too, that we haven't talked about here: the doctor. A lot of doctors don't know how to treat this stuff. You know, they see a drug addict come in and they say: Aw, no, no, no, no, no, no. They don't want to touch it.

So talk about that and how you deal with that end of it in West Virginia.

Thank you, Mr. Chairman.

Dr. GUPTA. Yes, sir. The most important part of this disease, how we differentiate this from perhaps the HIV, even, the epidemic, is that the stigma of this is across the communities, it's across the healthcare system, law enforcement.

And there's a lot of good-intentioned, good-faith folks trying to help, but that stigma continues. And it is that reason that we need to have programs like harm-reduction strategies, that people will come in, be treated in a very nonjudgemental manner.

We have to redo the way we look at folks, we have to redo the way we treat folks, address this problem. People don't choose not to get treated. Folks have told me, every five times before, we were telling them they need help, they listened, they weren't dead and not listening. It's just that it didn't filter in until the time they were ready.

We have to build a supportive system of that stigma, whether it's police officers, whether the treatment, physicians, hospitals, criminal justice system, as well as the court system, the entire society.

I think we're far away from being able to entirely remove stigma. We have stigma websites. We're doing everything in West Virginia and a lot of organizations are working together. But it's going to take every fabric of that society to undue the stigma aspect of this problem. It's a big problem.

Mr. CUMMINGS. I yield back.

Chairman GOWDY. The gentleman yields back.

The gentleman from Wisconsin is recognized.

Mr. GROTHMAN. Sure. A couple of questions.

I agree with you, Dr. Gupta, that I think whenever anybody takes heroin—and as I understand it, everybody who takes it knows people who've died from it—there is an element, suicide is too strong a word you, but at least you're saying that it's not the end of the world if I die. And that's a problem.

I think it was Dr. Parekh who told—one of the two of you in your original testimony, and I didn't see it in your written testimony—said the number of people in this country every year who are prescribed some sort of painkillers that could be described as opiates, could you repeat that statistic again?

Dr. PAREKH. Sure. So this is the National Survey on Drug Use and Health in 2016. So 91.8 million American adults, nearly 4 in 10, say they've used opioids in the preceding 12 months. Now, that could be that they were prescribed or they are misusing.

And the misusing number is 11.5, so 11.5 million Americans are misusing opioids. So either they didn't have a prescription in the first place, they got it from family, friends, or they had a prescription.

Mr. GROTHMAN. Could you tell us the equivalent number from other countries?

Dr. PAREKH. I think, unfortunately, Congressman, this is a uniquely American problem. We have 5 percent of the world's population, we consume 80 percent of the world's opioids.

Mr. GROTHMAN. Wow. So that would show it's an American problem and it shows that other countries don't seem to have this problem. So you wonder what they're doing differently.

Have we looked into at all the background of the average heroin user? Do we ever study family background, religious background, what have you?

Dr. PAREKH. Other panelists may want to jump in, but I think one statistic that is important to note is if you look at first time heroin users, 80 percent of them first started abusing prescription opioids. And I think that is a critical piece.

Mr. GROTHMAN. Okay. I mean, do we have anything else, though, as far as demographic examples, family background, educational background, age? Do we have those statistics, Dr. Gupta?

Dr. GUPTA. Yes, Congressman. We conducted a social autopsy of everyone who died in 2016 in West Virginia from overdose. What we found was typically individuals are 35 to 54 years old, male, high school educated or less, single, and working in blue collar industry. So this is the social autopsy.

Mr. GROTHMAN. Single people. What about their parents? What did we find out about their parents?

Dr. GUPTA. Well, I think what we find is basically it's one of those situations of hope.

Mr. GROTHMAN. Not hope. But what was their background, what type of family background did the people grow up in?

Dr. GUPTA. I couldn't—yeah, I'm sorry.

Mr. GROTHMAN. Put enough money into it. Next time you do a study, you should check into that.

At least I felt heroin's been around this country a long time. There was a time the stigma against taking heroin, I mean, there was a bright line, I think, between alcohol and marijuana or even cocaine and heroin. I know there's been a lot of emphasis on removing the stigma.

Are you sure we want to remove that stigma? There used to be a stigma. And I think at the time there was a stigma and less people took heroin. But are you sure we want to remove that stigma?

Dr. GUPTA. Congressman, I'll give you an example. So 71-year-old woman living with her children—her children living with her—every time she started to use heroin for postherpetic neuralgia, that's pain after you get shingles, because her doctor took her off the Percocet, and she uses three syringes.

The first time she injects a small dose, back in a bigger dose to make sure there's not enough fentanyl to kill her, and then she gives herself the main dose. And that's all because she actually trusts her dealer.

So, yeah, there's a lot of that because she wouldn't go and get help because she thinks her family will find out and it would be a bad thing for people to know a 71-year-old is using heroin. So there's a tremendous amount of stigma.

Mr. GROTHMAN. I'll give you another question. I recently had something in my district in which a member of law enforcement was very concerned. Somebody was pulled over with a substantial

amount of heroin, clearly a dealer, and they were given time served or something. It really bothered the law enforcement person because these people are probably as dangerous as can be.

I know we're stuck on kind of a trend of saying too many people are in prison, and there may be too many people in prison. But to me heroin and related drugs are a new thing.

I am very concerned on hearing stories, and particularly in more liberalish areas, of people who are dealers not really going to a prison for a long period of time. And I know in other countries that don't have these problems who are not as, oh, so afraid to put somebody away, they don't have these heroin problems either.

Usually the police aren't the problem, the police want to put them away. But do you think our judges or the rest of the judicial system is getting too involved in this treatment stuff and are not sending a strong enough message to the dealers by putting them away for long periods of time since they are killing so many people?

Chairman GOWDY. The gentleman is out of time, but you may answer his question.

Dr. GUPTA. Congressman, I think the distinction to be made between dealers, which obviously are bad guys, and every year that they could be in prison for, versus the folks who have actually gotten into this and don't understand it and have something called substance use disorder or opioid use disorder that actually need help, and they can be productive. It's because the people, the majority of people we are dealing with, they are actually workers. They are work-engaged populations. We are losing work productivity in this country at a rate like never before.

Chairman GOWDY. The gentleman yields back.

Mr. GROTHMAN. I'll just point out he didn't answer my question. But okay.

Chairman GOWDY. The gentleman yields back.

My friend from Vermont is recognized.

Mr. WELCH. Thank you, Mr. Chairman. Thanks for having this hearing. And I appreciated your opening statement.

And our ranking member, Mr. Cummings, I also want to thank you for your incredible leadership on this, and I want to thank the panel.

I'm from Vermont. I'm going to take advantage of the opportunity to talk a little bit about Vermont, and I'll ask a few questions. But I am going to take advantage of that opportunity.

Our Governor was the first, Governor Shumlin, to dedicate his entire State of the State, in 2011, to the problem we saw emerging in Vermont of opioid dependence and addiction.

And I remember coming back here after the Governor did that and my colleague saying, "Peter, why did the Governor do that? That's bad press for Vermont." And the answer from our Governor was: We acknowledge our problem and try to face it. That's what we did.

And then a few weeks later one colleague after another would come up to me and say, "You know what, we've got a problem that's as bad or worse in my State, my district."

And I think the fact that there was a focus on acknowledging the issue has helped us in Vermont establish a pretty good treatment

program, the Hub and Spoke program, that is having some significant success.

But in the past year I've been having roundtables in one community after another, Brattleboro, Bennington, Newport, St. Albans, and just this question of who are the victims. It's everybody is the victim.

I mean, there are some folks who work, some folks who got on it because they had a proclivity to use excess drugs, some who started out with a work-related injury and got opioid prescriptions and it led to bad things and they couldn't get off it, others who are having a crisis of hope.

And Dr. Gupta you're ground zero in West Virginia, which I've traveled to. And there is the real crisis here of good people.

I don't meet people who are addicted that want to be addicted. You know, the dealers are a separate question and throw the book at them as far as I'm concerned, but it's a lot of good everyday citizens who would prefer to be in the workforce and aren't.

And this is affecting all of our communities, especially, in my view, rural America, where there is a collapse in the local economy. And a lot of the local institutions that have been so important to help people have a sense of purpose and live those rural values of helping one another, helping their community, that's all being frayed. And we have got to have as part of our response a revitalization of rural America. That's my view.

But while we're trying to get there, I do believe that we must have a Marshall Plan for attacking this, much like we did with the HIV epidemic with the Ryan White bill. This has got no partisan preference. Every one of us who represents our districts have people in it who are really suffering.

And the Cummings bill, which does have a Marshall Plan agenda, significant resources that are applied to dealing with this issue, that is absolutely what we need. This crisis is not going to help itself.

And by the way, on the stigma question, one of the biggest preventions of people making that step to go into treatment is the apprehension of how they will be labeled. And in our roundtables, the people that were most compelling to me were two groups.

One was the people in recovery. And every single one of them said it was their ability to cross that line, from being private and secret to being open and public, which is what empowered them to take the difficult next step. And it's what opened up the opportunity for other people in similar situations to provide mutual support, ultimately something really essential, as I see it.

The other group that I was really impressed with, I mean all of them really, was law enforcement. They do not like the dealers. Their job is to arrest people. But their message to us: We're not going to arrest our way out of this problem. It's not going to happen. So they saw treatment is absolutely essential. And the biggest, biggest challenge was that people who had gotten to that point, where they're ready for treatment, there was no treatment available.

And that's why I believe the Cummings bill is absolutely essential. That's the Marshall Plan that we need in order to give folks

who were ready to make that step and rid themselves of this addiction can take it successfully.

Mr. Chairman, I'm at the end of my time.

And I thank the panel for listening to me. I really thank you all for your work. And I'm just speaking out on behalf of Vermonters. Thank you.

Chairman GOWDY. The gentleman from Vermont yields back.

The gentlelady from New York is recognized.

Mrs. MALONEY. I thank you, Mr. Chairman. I want to thank you and all the panelists and Mr. Cummings for focusing on what has really become a national crisis. And I am pleased that we are jointly looking at this.

In recent years pain has come to be called the, quote, "fifth vital sign," end quote. And in many clinical settings, including hospitals, patient pain levels have been measured obsessively, including with the use of sad and smiley faces, and many have warned that this focus on eliminating all pain and getting all patients to select smiley faces spurred the extensive use of opioids in clinical settings. And well-intentioned policies that incorporate patient pain into quality ratings and other measurements may have aggravated the problem.

So I want to ask Dr. Gupta, who probably has more experience on the level with the people with the illnesses, we want to ensure that individuals who are experiencing serious pain, including those that are at the end of their life, get the pain relief that they need. But on the other hand, we don't want to move to the point that people are being inappropriately prescribed more pain pills that they really need.

I mean, I've read some stories where patients were getting pain treatment and got addicted, which is a tragedy. And apparently it's a very hard deal to get off this addiction.

So one of the recommendations of the opioid response plan you just issued in West Virginia was, and I quote from your report, "West Virginia should expand the authority of medical professional boards and public health officials to address inappropriate prescribing of pain addiction and medications."

So, Dr. Gupta, what additional authorities do professional boards and public health officials need in your State to address inappropriate prescribing? And do you think that there has been any inappropriate prescribing, in your overview?

Dr. GUPTA. Thank you, Congresswoman.

There certainly has been. There were over 780 million pills that were shipped into small towns of West Virginia. We know that West Virginia had one of the highest prescribing rates for opioids.

But there's good news. We've seen from 2017 data that we've made the most progress of any State in the Nation in curbing those prescriptions.

Specifically——

Mrs. MALONEY. May I ask, of these pills that went into West Virginia, were they illegal drugs or were they prescribed through doctors?

Dr. GUPTA. These were distributed prescription drugs that were distributed through distributors that came in without necessarily a check.

Governor Justice sponsored and passed with wide bipartisan support earlier this year a bill that limits the prescription of opioids in ER settings to 4 days, in outpatient settings for dentists, primary, optometrists, and veterinarians to 3 days, and for other physicians to 7 days.

So one of the things we have to do is we have to turn the tap off for initial prescribing. Initial prescribing is sort of your tap to getting people hooked later on, and we know from science that beyond 3 to 5 days of prescribing really in vulnerable population leads to this disease of addiction.

Mrs. MALONEY. Whoa, 3 to 5 days? That's astronomical.

Now, is there anything that the Federal Government can do to help you in your efforts in West Virginia in this overprescribing?

Dr. GUPTA. I think one of the things, Congresswoman, that can do done as we move forward, we have to be cognizant about the people when have legitimate pain. So as we go and we see the crackdown that happens with our State and Federal partners on pain clinics, illegitimate pain clinics, we have got to find folks who have genuine pain to be connected back into appropriate physicians who do prescribe.

So we want to make this where it's okay to have legitimate pain and have prescriptions, a very important piece for a treatment armamentarium until we develop those nonopioid treatments.

Mrs. MALONEY. Let me ask you, are the majority of people that are overdosing in West Virginia taking opioids that have been prescribed, either to them or someone else, or are they taking street drugs such as the fentanyl?

Dr. GUPTA. We found 9 out of 10 had prescription history; 49 percent of women filled the prescription within 30 days of their death. Yet the death we're seeing is because of street fentanyl and heroin. So what's happening is there is a crossover happening, but prescription drugs still remain a critical component of that.

Mrs. MALONEY. Okay. Do harm-reduction efforts create important opportunities to get individuals with substance use disorders into treatment?

Dr. GUPTA. Very important opportunities. We need to look at harm reductions, such as syringe exchange programs, Naloxone distribution, and a host of social services that go along with that, including screening for diseases, and that as a gateway to treatment.

Mrs. MALONEY. Well, I want to thank you.

My time has expired. And I believe this is a bipartisan issue we can work together on for treatment. Thank you.

Chairman GOWDY. The gentlelady yields back.

The gentleman from Virginia is recognized.

Mr. CONNOLLY. Thank you, Mr. Chairman.

And welcome to our panel.

Dr.Gupta, the Senator from your State, Joe Manchin, did his own report using the methodology used by the Council of Economic Advisers and came up with the cost of the opioid crisis in your State alone of $8.7 billion. Does that sound right to you?

Dr. GUPTA. Yes, sir. That's about 12 percent of the State's GDP.

Mr. CONNOLLY. Yeah.

Dr. GUPTA. And that's extreme. But there's many other States similarly placed, if not exact same position.

Mr. CONNOLLY. So that would suggest whatever we're investing or need to invest in treatment will have a huge return on it, given that cost.

Dr. GUPTA. Yes, sir.

Mr. CONNOLLY. And obviously we're underfunding treatment right now?

Dr. GUPTA. Yes, sir.

Mr. CONNOLLY. I don't know where to begin.

So I had a constituent whose son died. He was an athlete at a major university in the Northeast. He had an injury. He was prescribed opioids and he developed an addiction. He was a motivated young man and did everything in his power to try to kick it. He went into rehab, he went into treatment facilities. The treatment was wrong and ultimately led him to need the high, he moved to heroin, and he died of an overdose. Tragic, tragic story.

I'll ask either one of you, Dr.Parekh or Dr.Gupta, are treatment facilities regulated for this crisis, for this problem?

Dr. PAREKH. I think treatment facilities are regulated at the State level. I think that the issue, Congressman, is that not enough treatment facilities are offering the gold standard, which is medication-assisted treatment.

Mr. CONNOLLY. Well, let me go back to certification, though. Can I put out a shingle and say, "We've got the expertise here to deal with your opioid crisis, give us a call"?

Dr. PAREKH. Unfortunately, that is being done right now.

Mr. CONNOLLY. That's right. That is my point. It's not regulated, not uniformly.

And so treatment, the idea of going for treatment, well, what treatment? For example, the example I gave of my constituent's son. As I understand it, correct me if I'm wrong medically, but one of the treatment centers he went to embraced the AA model: Go cold turkey and follow the 10 steps or 12 steps.

Well, it turns out, according to my constituent, that is exactly the wrong thing to do. You cannot simply go cold turkey with this addiction. It's different than alcohol. And if you don't have some intervening treatment, you put yourself at enormous risk. And the craving for that high will absolutely move you to something else, heroin or fentanyl, for example, leading to worst outcomes.

I see you shaking your head, Dr.Gupta. Is that accurate?

Dr. GUPTA. Yes, Congressman. Only half of the private treatment facilities across this country actually offered MAT. And in that, only a third actually get MAT. MAT is the best science-based treatment available, yet we struggle across States.

There is going to be a small silver of the population that maybe the 12-step works for them. But there often seems to be a prohibition for using any mind-altering drug.

Mr. CONNOLLY. I'm running out of time, forgive my interruption. But my constituent argued it is actually life-threatening. It was life-threatening for his son to go that route, even with the best of intentions.

Dr. GUPTA. Congressman, I'll add one more quick thing. People who have opioid use disorder, having other mental conditions is the

rule, not the exception. So you have to be treating other underlying medical conditions. And if organization does not accept that treatment for bipolar or depression, then you're in trouble.

Mr. CONNOLLY. So, Ms. Goodwin, in the time I have left, the President's own Council of Economic Advisers estimates the cost of this crisis to the U.S. economy—we talked about West Virginia—is a half a trillion a year. Correct?

Ms. GOODWIN. Correct.

Mr. CONNOLLY. So certainly, the President has proposed a national strategy to deal with this, has he not?

Ms. GOODWIN. Yes.

Mr. CONNOLLY. He has? And what is that strategy?

Ms. GOODWIN. So that strategy is kind of in the making.

Mr. CONNOLLY. Oh, in the making?

Ms. GOODWIN. Yes.

Mr. CONNOLLY. Has the President declared this a national emergency, as was recommended to him?

Ms. GOODWIN. Yes, it has been declared a national emergency.

Mr. CONNOLLY. And what flows from that?

Ms. GOODWIN. So the declaration of an emergency will mean that the different Federal agencies will start to think through and think about how they will address the crisis.

You may already know that GAO has ongoing work looking at public health declarations around this crisis. That's in the beginning stages. So we are in the process of designing the scope and methodology for that.

Mr. CONNOLLY. My time is up.

I want to thank the chair for having this hearing.

There is no way we can move forward without this being on a bipartisan basis. This is a crisis that affects every community, every socioeconomic strata. This is not something limited to one group or another. And it's reached crisis proportions, obviously, in the United States. So we've got to work together to find solutions.

Thank you, Mr. Chairman.

Chairman GOWDY. The gentleman from Virginia yields back.

I'm going to go last. So I want to start by thanking the panelists for your expertise, your commitment to helping us combat this issue.

Dr.Gupta, what progress, if any, is being made in the ability to objectively diagnose pain? As opposed to allowing the patient to pick which frowny face, or on a scale of 1 to 10, which is inherently subjective, is there any progress being made in being able to objectively diagnose pain?

Dr. GUPTA. Mr. Chairman, I think there is some work in the research and development sort of phase of this. It's been a difficult thing from a clinical aspect to be able to diagnose something that's very subjective. I do think efforts need to happen there from an R&D standpoint in order to get more objective signage. But clearly, there's a need for that.

Chairman GOWDY. Okay. So if I were to present myself at either of the doctors—I assume you all are medical doctors or are you Ph.D.'s? Medical doctors.

I present myself, I tell you I have pain. You are not totally reliant upon me to quantify that, but it helps. There's no test you could administer.

What are the alternatives to habituating prescriptions? What are your pharmacological alternatives to something that is habituating right now.

Dr. GUPTA. First of all, we would want to make sure to do the proper testing to find out if there's a legitimate physical reason for it. But then again, opioids is just one part of it. They are not very good a pain treatment to begin with. There's other options, including nonpharmaceutical options, as well as pharmaceutical options.

So we're talking about—back pain, for example, very common. Most of back pain treats itself in about a couple of weeks, so oftentimes you need supportive treatment, not really opioids. That's something that opioids were traditionally used.

Combination of medications like acetaminophen and ibuprofen, that really means Tylenol and Motrin put together, tends to have, in some studies, better outcomes or better impact on pain than does opioids.

Chairman GOWDY. Okay. You put your finger on something. I present to one of your physician practices. I tell you I'm in pain. I want something that I consider to be strong. You're recommending something I could get at CVS or Walgreens.

So I've got a couple options. I can either go see another doctor and hope for a better result. So you've got—in July we were told—and look, I like doctors. I grew up in a house with one. I don't get excited talking about prosecuting physicians. But the reality is there are illicit drugs that are handled in an improper way. And there's money to be made doing that.

So is this a misinformation issue? I mean, you just said there are better alternatives to opiates. I assume doctors know that. So if there are better alternatives, is it a lack of information that allows them to prescribe it or is it the money aspect?

Dr. GUPTA. Mr. Chairman, there's a whole host of issues. In my practice, since 2000 or so, I've been told by the industry that these are medications that are very highly effective, there is no potential for addiction, and all kinds of things. If short term doesn't work, we have long-acting medications. They are really sold and marketed as the ultimate solution, and now we know that that's not the case.

Chairman GOWDY. All right. But you don't get to be a medical doctor by not being bright. So the fact that some pharmaceutical rep comes in, gives you a calendar and a key chain, and says, "Hey, look, you really need to prescribe this medicine, even though I made straight C's in college, take my word for it," is a doctor really going to be persuaded by a pharmaceutical rep?

Dr. GUPTA. If you look at direct-to-consumer advertising campaigns and the pharmaceutical budgets, companies' budgets that go into this type of work, at least the evidence demonstrates that that strategy tends to have some impact on the prescribing habits.

Chairman GOWDY. This will probably be over my head, but we'll try it anyway.

What is the pharmacology of opiates that makes it so difficult to—you know, last week they told us nicotine was the toughest

drug to beat. In a previous life, I dealt with heroin addicts. I would list that as the toughest drug to get off of.

What is it about the pharmacology that makes it so difficult?

Dr. GUPTA. Mr. Chairman, it's the same pharmacology would be for heroin, which is it goes and crosses your blood-brain barrier and attaches to the receptors, the particular receptors that gives you a pleasure to begin with, as well as a number of other activities.

And that's the reason when people have a craving, the need for increasing the dose continues. People go to the cheaper, readily available street alternative. That is the same action of receptors that we work with MAT, whether they block them, they are partial agonists to them, or they are pure agonists.

But ultimately, the idea here is to work on the same receptors that opioids have sort of stayed on in terms of heroin or prescriptions and almost cause a person to become addicted to that and have the disease of addiction.

Now, we prescriptively do that with drugs like Buprenorphine and others to block those or actually partially work with those receptors. So it's the same mechanism, it's just the drugs that we talk about, MAT, are not something that people are going to be able to get high on or overdose from in the doses that they are prescribed. But they can, if they also use some of the other drugs along with it, the street drugs.

Chairman GOWDY. All right. I'm out of time, and I want to hold myself to same standard I hold my colleagues to. So I'm going to give myself one more question after running out of time like I do them.

I was just in your beautiful State 2 weeks ago. It's a beautiful, beautiful place to be.

Are you satisfied with DEA's diversion, not DEA agents that wear guns and badges, I mean the diversion, the folks who actually monitor pharmacists and physician practices, are you satisfied with the presence of DEA diversion in West Virginia?

Dr. GUPTA. Thank you, Mr. Chairman.

West Virginia is a great State. We are very thankful for DEA folks helping us with diversion.

One of the things that can definitely happen, we in West Virginia have a requirement for licensees, like myself, to have a mandatory training for opioid prescribing. That is perhaps something—I also hold a DEA license—that is something that perhaps needs to be nationalized where it's important for every physician, every person going to medical school, nursing school, anywhere they are going to be close to opioids, be able to have a particular curriculum-based training as a part of their practice.

That's something of an outstanding piece, but we're very appreciative of DEA's partnership with us.

Chairman GOWDY. All right. I want to thank the members for their participation. I especially want to thank our witnesses for your expertise, for your comity, with a "t," with each other, and with the members, and look forward to visiting with you again.

The hearing record will remain open for 2 weeks for any member to submit written opening statements or questions for the record.

If there's no further business, the committee stands adjourned.

[Whereupon, at 1:13 p.m., the committee was adjourned.]

APPENDIX

MATERIAL SUBMITTED FOR THE HEARING RECORD

A Sustainable Solution to the Evolving Opioid Crisis: Revitalizing the Office of National Drug Control Policy
House Committee on Oversight and Government Reform
10:30 AM, Thursday, May 17, 2018
2154 Rayburn House Office Building
Rep. Gerald E. Connolly (D-VA)

Thank you, Chairman Gowdy and Ranking Member Cummings for holding this hearing on the role of the Office of National Drug Control Policy (ONDCP) in combatting the opioid epidemic. Every day, 91 Americans die from an opioid overdose. Since 2000, the opioid and heroin epidemic has claimed more than 200,000 lives across America, more than three times the number of Americans killed in the Vietnam War. There are no signs that this epidemic is slowing down or will end soon.

Congress created ONDCP in 1988 at the height of the crack cocaine epidemic to oversee federal drug control efforts and advise the President and the Administration on drug control policies and strategies. ONDCP's responsibilities are to produce a National Drug Control Strategy, develop and oversee the National Drug Control Budget to carry out the goals and policies of the Strategy, evaluate the effectiveness of programs across the federal government in implementing the Strategy, and oversee the High Intensity Drug Trafficking Areas (HIDTA) and Drug Free Communities programs. Congress last authorized ONDCP in 2006. This authorization expired at the end of Fiscal Year 2010. Since that time, ONDCP has continued to receive annual appropriations.

The last ONDCP authorization required the President to submit a National Drug Control Strategy to Congress by February 1 of each year. However, in the midst of the opioid epidemic President Trump has not submitted a strategy during his term as President. At a hearing in the Oversight and Government Reform Committee last July on the topic of ONDCP Reauthorization, I asked then-Acting Director Baum about the Trump Administration's failure to produce the Strategy required by statute. In response to my questions on when Congress will receive a strategy from this Administration Mr. Baum replied, that "early next year, you'll have a comprehensive drug strategy from the Administration [c]overing the entire scope of the issues." More than nine months have passed since that testimony and ONDCP has still not delivered the Strategy to Congress.

I am concerned that the absence of a National Drug Control Strategy is another example of this Administration's lack of urgency to address the opioid epidemic. Sixteen months into this Administration, ONDCP is still without a permanent Director, known as the nation's "Drug Czar." Only last month, did President Trump nominate James Carroll to be the Director of ONDCP after the previous nominee withdrew from consideration amid controversy last October. The Drug Enforcement Agency (DEA) is also without a permanent Administrator after the previous Administrator resigned in September. Most strikingly, despite President Trump's pledge to declare the opioid crisis a national emergency, the President waited three months before directing the Department of Health and Human Services to declare a public health emergency, which unlocked no new federal funding.

Additionally, instead of strengthening ONDCP so it has the ability and resources to work across the federal government to produce a comprehensive approach to tackling the opioid

epidemic, this Administration has proposed to remove the HIDTA and Drug Free Communities programs from ONDCP, and transfer them to the Department of Justice and the Department of Health and Human Services, respectively. This move would reduce ONDCP's budget by over 90 percent. It would also reduce the prominence of the grants and put them into agencies whose missions are not primarily combatting the opioid epidemic.

Fortunately, Congress has rejected this proposal on a bipartisan basis. Instead, the recently passed omnibus package provides nearly $4 billion to fight the opioid epidemic this fiscal year. The bill includes $500 million for a new National Institutes of Health (NIH) effort to research opioid addiction, a $350 million increase to the Centers for Disease Control and Prevention for prevention, surveillance, and monitoring, $415 million for the Health Resources and Services Administration to improve access to addiction treatment in rural and underserved areas, and $300 million in law enforcement grant funding.

Still, more must be done to combat the evolving opioid crisis. This Committee must work together to empower ONDCP by passing an authorization bill that strengthens the agency and provides it with adequate resources. We also must not overlook the need for significant funding for prevention and treatment. In 2016, nearly 64,000 Americans died from drug overdoses. Of those overdoses, more than 42,000 are attributable to opioids. Yet, only 10 percent of those in need of specialty treatment are able to access it. That is why I am supporting legislation introduced by Ranking Member Cummings, which would direct federal resources to the front lines of the opioid epidemic. The Comprehensive Addiction Resources Emergency Act of 2018 (H.R. 5545) would provide $100 billion over 10 years, including nearly $7 billion a year for prevention, treatment, and recovery services at the state and local level, $500 million annually to expand access to the overdose reversal drug naloxone, $1.8 billion per year for public health surveillance and improved training for health professionals, and $1 billion per year to support expanded service delivery.

We must never forget the human cost of these epidemics. This Administration and Congress need to address this problem with a sense of urgency and focus and contribute adequate resources to assist state and local governments as well as hospitals and nonprofits who are the front lines of this epidemic.

BIPARTISAN POLICY CENTER

June 29, 2018

The Honorable Trey Gowdy
Chairman, Committee on Oversight and Government Reform
2157 Rayburn House Office Building
Washington, DC 20515-6143

Submitted via U.S. mail and electronically

A Sustainable Solution to the Evolving Opioid Crisis: Revitalizing the Office of National Drug Control Policy
Response to Question for the Record by Bipartisan Policy Center Chief Medical Advisor Anand K. Parekh, MD MPH

Question from Representative Gary J. Palmer

1. Would genetic profiling prior to prescribing a pain medication help prevent prescribing something that would lead to addiction?

Response

Thank you for your question and the opportunity to provide further feedback to the committee. I support your focus on identifying ways to limit the oversupply of opioids in the health care system.

With respect to using genetic profiling to identifying patients that could be at higher risk of opioid use disorder, it is critical that these tests are scientifically validated. The Food and Drug Administration recently launched a program to incentivize the development of new devices, including diagnostics, that could provide novel solutions to detecting, treating and preventing addiction. [1] The committee should encourage these regulatory efforts to support the development of new tools to combat and prevent opioid use disorder.

In addition, more work needs to be done on the basic research side to identify the genetic markers that could predict addiction risk. The National Institute on Drug Abuse (NIDA) is leading work on improving the understanding of the underlying genetics of addiction, and as they point out, addiction is a complex disease and variations in many different genes

[1] Food and Drug Administration. "As part of efforts to combat opioid crisis, FDA launches innovation challenge to spur development of medical devices – including digital health and diagnostics – that target pain, addiction and diversion." May 30, 2018. Available at: https://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm609188.htm.

contribute to a person's overall level of risk or protection.[2] Congress should continue to provide robust support to NIDA and the National Institute of Neurological Disorders and Stroke for targeted research related to opioid alternatives, pain management, and addiction treatment. This research holds great promise to identify the specific genes and epigenetic factors that contribute to addiction and will help lead to new treatments and assist the medical community to prevent addiction. At the same time, even if one has a genetic predisposition to developing a substance use disorder, prevention, in the form of decreasing risk factors and increasing protective factors are key aspects to a comprehensive response to the opioid crisis.

BPC appreciates the committee's ongoing leadership in responding to the opioid epidemic.

Sincerely,



Anand Parekh, M.D., M.P.H.
Chief Medical Advisor
Bipartisan Policy Center

[2] National Institute on Drug Abuse; National Institutes of Health; U.S. Department of Health and Human Services. "Genetics and Epigenetics of Addiction." February 2016. Available at: https://www.drugabuse.gov/publications/drugfacts/genetics-epigenetics-addiction.

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES
Bureau for Public Health
Commissioner's Office

Bill J. Crouch
Cabinet Secretary

Rahul Gupta, MD, MPH, MBA, FACP
Commissioner
State Health Officer

July 2, 2018

The Honorable Trey Gowdy
United States House of Representatives
Committee on Oversight and Government Reform
2157 Rayburn House Office Building
Washington, DC 20515-6143

Dear Congressman Gowdy:

Below is my response to the post-hearing question that was directed to me by Representative Gary J. Palmer via correspondence dated June 20, 2018 as it pertains to the hearing that was held on May 17, 2018 entitled "*A Sustainable Solution to the Evolving Opioid Crisis: Revitalizing the Office of National Drug Control Policy*".

QUESTION

Would genetic profiling prior to prescribing a pain medication help prevent prescribing something that would lead to addiction?

RESPONSE

There are genes identified which are more prevalent in patients with opioid use disorder than "normal" controls. However, there is no clinical evidence to support testing for these genes to determine who is and is not at-risk of developing a disorder when given an opioid.

People without these genes still develop opioid use disorder and people with the genes don't. The best practice is to assume everyone is at-risk and prescribe (or not) with universal precautions.

There may be some benefit to obtaining the testing for the purpose of educating a patient regarding the genetic risk and thus the need to be extra vigilant. This would be an expensive measure with unknown clinical utility.

Thank you for the opportunity to testify at the May 17, 2018 hearing. If you have any additional questions or need further clarification, please do not hesitate to contact me at (304) 558-2971 or via email at rahul.gupta@wv.gov.

Sincerely,

Rahul Gupta, MD, MPH, MBA, FACP
Commissioner and State Health Officer

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