Testimony from Linda Hurley to the Senate Committee on the Judiciary hearing on: "Attacking America's Epidemic of Heroin and Prescription Drug Abuse."

The opioid overdose death epidemic that resulted in the deaths of an average of 125 people daily in this country in 2014, continues to grow. Since 2002, rates of heroin addiction have doubled and heroin related overdose deaths have nearly quadrupled in the United States. The rate of opiate pain medication prescriptions have increased dramatically in the last 5 years.

New vulnerable populations are emerging. Parts of our country are faced with limited or no resources to assist those needing care. Infectious disease such as HIV/AIDS is again on the rise, and HepC numbers have increased at alarming rates. The disease of addiction, this chronic relapsing, often permanent, disease of the brain (AMA) is costing taxpayer dollars, is costing lives and we as a society are losing the creativity, the individual contributions that each lost life represents-and replacing those contributions with fear and grief. The pain, distress and stress that are the result of lost lives have permeated our communities and have become part of the problem. My understanding of this tragedy is why I am honored to have been invited to participate in the conversation today.

I have been asked to speak to prevalence supporting the need for prevention and treatment, what populations are being most affected by this disease, what are the treatment needs of those individuals and families and what challenges do we face in meeting those needs.

The growing numbers of those with opioid use disorder (also called opioid dependence or addiction) reflect new trends in those who are becoming addicted to opioids. The traditional bell curve of opioid dependent individuals coming to treatment reflected an average age of 39 to 42, 30% female and 70% male, much more urban than rural and of lower incomes, education and health supports. There has been a considerable shift in these demographics between 2004 and 2014. CDC mortality figures indicate that white middle age populations are demonstrating an increase in death rate with opioid related deaths growing, as diabetes and heart disease related deaths are decreasing. There is also a rise in mortality rates for young white adults.[i] these figures correspond to the increases in emergency room visits, recorded treatment episodes and police data reflective of opioid use. What we are seeing is an increase in opioid dependence in younger and older white populations, rural populations and more female populations. The emerging or growing vulnerable populations are: women, young adults, adolescents, middle age adults, returning veterans, those receiving multiple prescriptions, patients receiving care for chronic pain, including the elderly, and at very high risk, those in the criminal justice system.

This disease no longer knows gender, race, age or socio-economic boundaries.

The challenge of treating multiple populations is in providing care that is individualized, effective and evidenced based for that population. What is effective for an 18 year old male may not be effective for a 40 year old female. Cognitive and emotional development, stages of reproductive lives, cultural norms, multiple forms of trauma, the individual's readiness for change, strengths, resiliencies and recovery supports are just some of the clinical variables that need to be addressed in providing successful treatment. Over 50% of those who come to treatment come with at least one other mental health/psychiatric condition, most commonly forms of depression,

anxiety and other manifestations of trauma.[ii] This is a highly complex, bio-psycho-social-spiritual disease, accompanied by physical states of tolerance and withdrawal and relapse. Treatment providers, physicians, licensed independent practitioners and counselors, need to be prepared to address this complexity with competence, knowledge of treatment options, compassion and a clear understanding of the neuroscience of addiction.

Medication Assisted Treatment (MAT) for opioid dependence has been the most effective, researched, and regulated evidenced based treatment for this disease. The pharmacological intervention utilizing methadone is an established practice that has assisted individuals in regaining their lives from opioid dependence for over 50 years. It works by replacing the heroin or prescribed opiates on the receptor sites in the areas of the brain affected by those opiates. Science has shown us over and over that replacement therapy with competent, concurrent behavioral therapy (counseling) works. The correct dosage of medication allows an individual to not feel the extreme pain of withdrawal, but also does not provide the euphoria or "high" associated of misuse and dependence. This in turn provides the individual the opportunity to heal; physically, emotionally and spiritually. Studies have shown that a minimum of 3 years may be needed for someone to work through their shame (internalized stigma) and other psycho-social challenges, to develop social and coping skills to support their recovery and to develop a full recovery support system. "Medication-assisted therapy can preserve life and allow an individual to work on their recovery. Sustained long term recovery ideally includes health, home, community and a purpose. A medication addresses none of these, but allows an individual to work on all of these." [iii]

Buprenorphine is a partial replacement therapy developed to address opioid dependence. This medication is extremely effective, particularly in populations more physiologically naive; in those who have not used opiates as long or as much, so that the brain change may not have been as severe or permanent. The assessment process to determine which medication is indicated requires a fairly deep understanding of the disease. Buprenorphine is not heavily regulated, though well researched and now-evidence based, and is therefore attainable like any other medication through a primary care physician's office. This can increase accessibility dramatically, at the same time however, that it is not requiring the same level of expertise, accountability or patient support that is required of methadone intervention. It is here that another challenge to addressing this epidemic arises. We need more accessible, effective treatment, but, there is no magic wand. Providing only medication will not be successful for the majority of patients receiving MAT. We need more prescribing physicians knowledgeable in the specialty of addiction.

Another medication more recently utilized in this population is depot-naltrexone. Patients receive naltrexone by injection once every 30 days. Naltrexone helps patients overcome urges to abuse opiates by blocking the drugs' euphoric effects. The slow released formula naltrexone allows patients a 30 day "protection" in the face of cravings, and is shown to increase retention in counseling.[iv]

There continues to be a social "veil" of moral judgement stigmatizing this disease, those who come for care and even those who provide care. The stigma can be seen in the regulation of methadone (as compared to other prescribed opioids) and those environments in which it is provided. The regulation appears to reflect the stigma attached to the population for whom it was created. The harsh laws incarcerating individuals for the symptoms of their disease versus assisting in them in rehabilitation fill our prisons and destroy lives. This has resulted in the

highest incarceration rate in the world and is widely known to be ineffective at reducing drug use, with high rate of relapse to drug use, crime and re-incarceration.[v] "Additionally, the criminal justice approach has fostered a fear of arrest that often impedes bystanders from calling to seek life-saving medical help in the case of an opioid overdose emergency. Taking a purely punitive approach in the face of the current crisis" appears to be "misguided and risks further harm to individuals and communities already struggling with addiction." In 2013, Rhode Island had the highest rates of illicit drug use in the nation, as well as the highest rate of drug overdose in New England. Up from 9% in 2009, 21% of those who died in RI from opioid overdose last year were recently released from prison.[vi]

Stigma is also reflected in the ongoing struggle with the implementation of parity in reimbursement rates. Unattainable or difficulty attaining authorization to provide care creates a significant barrier to treatment. Often families and individuals do not have the resources to advocate for themselves and their loved ones. Treatment providers do not have the staff hours to assist in this. Low rates paralyze providers in many ways and complexity of benefit utilization paralyzes consumers.

Social stigma is observed in the language used to describe treatment. People are "on" buprenorphine or methadone, as opposed to "being prescribed" a beta blocker" or taking" a cholesterol lowering medication: all of which are chronic relapsing diseases for which medication may be clinically indicated for a lifetime. A frequently asked question by family members and/or their recovery community is "when will you be off that stuff?" implying that their recovery is somehow invalidated by taking a medication. Would that question be asked of a person utilizing insulin for their diabetes?

So in addition to these examples of stigma, we see challenges to meeting the growing needs of a growing population in inaccessibility geographically and financially, in inadequate capacity and in inadequate competency. These are not small obstacles but they are not insurmountable. If we can build on what we know works, hold our systems accountable to best practice standards, reimburse at a realistic rate and continue to build an easily accessible continuity of care, we can reverse this societal crisis.

Lastly, once treated, or precluding treatment, how do we prevent the continuing tide of opioid dependence and related loss of resources and ultimately lives? A trend that emerged nationwide is partially due to a clear guidance for physicians and other healthcare providers to manage pain in their patients. At the same time new opiate pain medications were coming to the marketplace. This convergence led to all-time highs in the number of these medications being prescribed. Concurrently there has been a rise in the prescribing of benzodiazepines (for example, Xanax, Valium). This is a deadly combination and has been a significant variable in the increase in opioid overdose deaths. Prescriber education and the Prescription Drug Monitoring Programs being implemented, state by state, nationwide are strong steps toward managing this trend and preventing over prescribing. Other prevention strategies for initiation include but are not limited to; patient education in the use and storage of these medications, family education in modeling and teaching safe use of medications, continued public health education venues and the use of community peer recovery resources and law enforcement interventions decreasing supply of heroin, fentanyl and illicit prescription opiates. Treatment within a recovery oriented system of care, individualized for the patient, can prevent the progression of the disease and overdose.

Teaching broadly defined first responders how to use naloxone, providing naloxone and MAT to inmates prior to or at release and strengthening Good Samara tin laws decrease opioid overdose death as has been clearly demonstrated in Massachusetts in the past 2 years. Opioid overdose death is preventable.

I am quoting directly here from the *Rhode Island Governor's Overdose Prevention and Intervention Task Force, 2015* Report. It is succinct and clear. "This is a dynamic epidemic, exposing the need for collaborations between public health, public safety and behavioral health, reaching into the medical, pharmacy, harm-reduction and recovery communities, and in partnership with civil society, representing a communal call for action."

Thank you for this opportunity. I welcome the opportunity to provide further resources for your offices. Please let me know if you would like a more thoroughly developed resource list. Unfortunately the time frame for the preparation of this testimony did not allow for any further elaboration. Again, though, I am happy to add to this.

References and Resources

[i,iii] Centers for Disease Control and Prevention, National Center for Health Statistics. Underlying Cause of Death 1999 2013 on CDC WONDER Online Database, released 2015. Accessed at http://wonder.cdc.gov/ucdicd10.html on Oct 14, 2015

[ii]Challenges and Outcomes of Parallel Care for Patients with Co-Occurring Psychiatric Disorder in Methadone MaintenanceTreatment
Van L. King, M.D.*, Robert K. Brooner, Ph.D., Jessica Peirce, Ph.D., Ken Kolodner, Ph.D., and Michael Kidorf, Ph.D.
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[iv]SAMHSA; National Survey on Drug Use and Health (NSDUH), 2012-2013.

Multiple Cause of Death Files from the National Vital Statistics System, 2002-2013

[v]NIH/NIDA; Nida Notes 2007 **Depot Naltrexone Appears Safe and Effective for Heroin Addiction**

[v]*Rhode Island Governor's Overdose Prevention and Intervention Task Force, 2015* Report.

Sarah E. Wakeman MD & Josiah D. Rich MD, MPH (2015) Addiction Treatment Within U.S. Correctional Facilities: Bridging the Gap Between Current Practice and Evidence-Based Care, Journal of Addictive Diseases, 34:2-3, 220-225, DOI: 10.1080/10550887.2015.1059217
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