Written Testimony of Michael Botticelli
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Chairman Portman, Ranking Member Carper and members of the committee. Thank you very much for the invitation to be here today and for your leadership on this incredibly important issue. My name is Michael Botticelli and I currently the Executive Director of the Grayken Center for Addiction Medicine at Boston Medical Center and a Distinguished Policy Scholar at the Johns Hopkins Bloomberg School of Public Health. Prior to this, I was the Director of the Office of National Drug Control Policy in the Executive Office of the President.

By all accounts, the opioid epidemic is the most pressing public health issue of our time. The 2016 National Survey and Drug Use and Health estimates that approximately 2.1 million people in the US have an opioid use disorder requiring treatment.

In 2015, the last year that we had complete national statistics, 91 people a day died from an overdose of opioids including prescription pain medication, heroin and/or fentanyl resulting in over 33,000 deaths in 2015 alone. In MA, 1900 died of an overdose, up from 742 in 2012.

Since 1999, the amount of prescription pain medication sold in the US has nearly quadrupled and deaths from prescription opioids have quadrupled as well in a near perfect correlation. There is also a significant variation in the number of prescriptions by state with the highest state prescribing nearly 3x the lowest. As with national trends, states with the highest number of prescriptions had higher number of overdose deaths tied to these medications.

Diversion of legitimately prescribed opioids is a also major cause of misuse and addiction. Approximately 55% of people who misused prescription pain medication got them free from a family or friend.

Early on in this epidemic, lax state laws and regulations also contributed to “pill mills” where rogue physicians distributed millions of prescriptions for pain medication to people with no medical conditions. Prior to enforcement actions

and changes to state laws, Florida was a startling example of the proliferation of pills mills. At one point, Broward County accounted for almost 50% of the dispensed pain medication in the US.

While less of a source of diversion but nonetheless important, is the role that doctor shopping – seeking medications from multiple prescribers and/or multiple pharmacies has played as a contributor to misuse and overdose risk.

We also know that the misuse of pain medication is a significant driver in the increase in heroin use. The same national survey showed that approximately 80% of new heroin users started opioid use with a prescribed medication. It should be noted, that only a small portion of actually transition to heroin and that factors such as the low cost and widespread availability as well as the progression of the disease seem to account for this transition rather than a decrease in the availability of medications.

Injection drug use associated with the epidemic has been linked to dramatic increases in viral hepatitis across the country along with local outbreaks of HIV. A recent analysis done by the CDC showed that there are at least 220 counties, mostly in Appalachia, that are at significant risk for another outbreak similar to the one we saw in Scott County, Indiana two years ago.

Over the past two to three years, we have seen the emergence of synthetic opioids like fentanyl. Fentanyl is 50x more potent than heroin and 100x more potent than morphine. The CDC estimates that overdose deaths attributed to synthetic opioids other than methadone increased by over 72% from 2014 to 2015. Reports from the DEA as well as state law enforcement indicate that these deaths have been associated with law enforcement seizures testing positive for fentanyl. This increase is not a result of fentanyl prescribing indicating this is largely illicitly manufactured. Domestic law enforcement seizures have increased by 426% from 2013-2014. Analysis limited to those states with excellent of very good reporting which means that overdoses deaths are reporting with the specific drug involved in the death. 26 states reported statistically significant increase from 2014 to 2015 with states in the northeast and mid-west experiencing the highest increases.

A recent analysis of overdose deaths in Massachusetts showed that deaths involving fentanyl rose from 32% during the 2013-2014 period to 72% in the first half of 2016.

Fentanyl is often mixed with heroin and cocaine with or without the user's knowledge, usually without. As we have seen in some high-profile deaths, it also can be disguised as prescription pain medication and again taken without the user knowing that it contains fentanyl. The fentanyl in the supply appears to be largely illicitly manufactured in China, either directly shipped to the US, via both open and dark web sources, or shipped to Mexico where it gets mixed in with heroin before transport to the US.

The Obama Administration's response to this epidemic started at the very beginning with the release of the Prescription Drug Abuse Prevention Plan in 2010. This was a government wide response that called for action along four main pillars.

Education – ensure that every prescriber had at least some minimum training on safe and effective opioid prescribing. This area also focused on educating the public on the health risk and addiction potential from prescription pain medication

Monitoring – Reduce doctor shopping by establishing state-based Prescription Drug Monitoring Programs (PDMP) that allow prescribers and pharmacies to access a patient's prescribing histories.

Disposal – reduce the diversion of unwanted and/or unused medication by providing safe, efficient disposal opportunities.

Law Enforcement – reduce the volume of prescription pain medication through federal and state enforcement actions; close "pill mills"

Underpinning all those efforts is ensuring people who need treatment have timely access to high quality addiction treatment, particularly medication assisted treatment. It also ensured people received care for other behavioral and medical conditions. The ACA contributed to perhaps greatest expansion of treatment access by ensuring that substance use disorder treatment was one of the ten essential benefits that Medicaid expansion plans and marketplace plans had to cover. It also ensured that these benefits were offered on par with other health

services to comply with the Federal Mental Health and Addiction Equity Act. A recent HHS analysis has showed that the ACA and particularly Medicaid expansion has played a critical role in expanding access to treatment and particularly in some of the hardest hit parts of the country.

We also worked to expand access to treatment in rurally underserved areas or what I call "treatment deserts" by providing funding for community health centers to integrate addiction treatment and to expand the number of physicians who are able to prescribe. HHS raised the cap on the number of patients these doctors serve and Congress also passed legislation to expand prescribers to Physician Assistant and Burse Practitioners.

We also promoted and supported efforts to expand the use of naloxone, a safe and effective way to reverse an overdose, by law enforcement and other first responders and others who might be on a position to witness an overdose. The response to this call to action on the part of our law enforcement community has been overwhelming to say the least. We have thousands of local and state police forces administering naloxone and have saved countless lives because of their efforts.

We also supported the expansion of Sterile Syringe programs to reduce the incidence of hepatitis and HIV and to serve as a glide path into treatment. Congress saw fit to eliminate the ban on the use of federal funds for the programmatic parts of these programs. For that, I am very thankful. Following Congress' lead many states have expanded existing programs or passed laws to authorize programs.

Congress also supported these efforts over the past four years by, among other things passing the 21st Century Cures Act which allocated $1 billion over two years to enhance states' response to the epidemic and passing the Comprehensive Addiction Recovery Act and supporting some of its grant provisions. I want to thank the members of the committee and Congress for their support on these and other issues

While we still have a very long way, we are seeing some promising trends that may indicate these strategies. Over the past two years, we have seen a reduction in in the number of opioid prescriptions. In 2015, there were 17 million fewer prescriptions written.

We have also seen a reduction in prescription drug misuse among youth and young adults and a dramatic slowdown in prescription drug overdose deaths.

However, we have seen that this epidemic has evolved and so too must our approaches. This is also no time to backslide on the progress we have made. This is the time to redouble our efforts and our commitment to ending this epidemic.

As we move forward, there are some recommendations for action that I see as crucial to our efforts, particularly on fentanyl.

1. Continue to enhance our intelligence on the manufacturing and distribution of fentanyl. While I was very appreciative of the Intelligence Communities calls for better information, there are still many unanswered question on how fentanyl enters the US, particularly through US Mail and other carriers.
2. Since fentanyl is much harder to detect and can present a hazard to state, federal and local law enforcement, we need to promote ways to expand current drug testing technology and continue to develop detection capabilities
3. Continue to provide fact-based handling instructions to law enforcement, border patrol and others who may come in contact with fentanyl.
4. Continue our engagement with China and press them for additional action to schedule fentanyl analogues and take down illicit manufactures and shippers. In October 2015 China scheduled more than 100 synthetic substances including tow fentanyl analogues and in February of this year made the manufacture of many fentanyl analogues illegal
5. Since there is a significant amount of variability of standard testing of fentanyl, law enforcement, criminal justice systems, coroners and medical examiners and treatment programs need to incorporate fentanyl into their drug testing panels
6. With public health experts, develop and distribute informational material to users on how to minimize overdose risk in areas where fentanyl might be present
7. Expand the use of naloxone by anyone who is in a position to witness or reverse an overdose. Because of the potentcy of fentanyl and what appears to be a pattern of users injecting alone, the period of time we have to reverse an overdose has shortened.

8. Expand sterile syringe programs and other programs that engage active drug users to promote safer injecting, distribute naloxone, and minimize overdose risk
9. Preserve the coverage gains made through the Affordable Care Act, particularly Medicaid expansion and other federal grant programs. Even with these provisions timely access to quality care remains an issue for many, particularly in rural communities.

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