

## Senate Testimony Statement

Thank you Chairman Blunt, Ranking Member Murray and members of the committee for the opportunity to come before you today to talk about the devastating opioid epidemic. I am a Clinical Psychologist and Professor in the Department of Psychiatry at the University of Alabama at Birmingham. I am both a clinician and researcher focused on addiction treatment. I provide direct care for patients with addiction, many of whom have psychiatric problems such as depression, posttraumatic stress disorder, and anxiety disorders. During my 20 year career conducting NIH-funded research, I have studied addiction, including opioid use disorders, particularly among disadvantaged populations such as individuals in the criminal justice system and persons living with HIV/AIDS. I have conducted several trials of buprenorphine treatment. I have also conducted a trial training the public to recognize and treat opioid overdose using naloxone. More recently, I led a group of about 60 physicians, researchers, policy makers, and business partners to develop a comprehensive response to the opioid epidemic in our state that could serve as a model across the nation as part of an internal University of Alabama at Birmingham Grand Challenge grant competition.

As you all know, opioid overdose is now the number one cause of accidental death in the United States, killing approximately 72,000 Americans each year. That's more than car accidents, gun violence or HIV/AIDS, even at the height of the epidemic. Overdose deaths, in conjunction with suicide, are responsible for a decline in life expectancy in the United States over the past three years. This pattern has not been seen since 1915 and differs from other developed countries where life expectancy continues to increase. And deaths from opioids are only predicted to rise in the next few years, particularly with the continued influx of illicit fentanyl and fentanyl-derived drugs mixed into deadly cocktails with other pain medications and heroin.

Alabama has the dubious distinction as the state with the most opioid prescriptions written per capita in the nation; in 2017, there were 107 prescriptions written for every 100 residents. This problem is particularly severe in some rural areas of the state. For example, Walker County, AL which is a primarily rural county located next to Birmingham, has one of the highest prescribing rates in the country, with 216 prescriptions for every 100 residents. The CDC recently identified Walker County as #37 out of 220 counties at highest risk of an HIV and/or hepatitis C outbreak due to the scope of the opioid epidemic in that region. In addition to high rates of opioid prescriptions, we have the second highest rate of benzodiazepine prescriptions in the nation; these two medications, when taken together, are particularly deadly.

*Today, I would like to talk about three areas for intervention and additional research that may impact these numbers both in Alabama and the U.S.*

Number one: expanded access to quality addiction treatment is needed. Alabama is 48<sup>th</sup> in the nation in wealth, with over 19% of our citizens living in poverty. Gaps in healthcare access across the State have left many of our most vulnerable citizens without access to healthcare. Alabama, like much of the country, has a provider shortage. There are not enough providers who have completed the prerequisites required by law to prescribe buprenorphine, one of the medications used to treat opioid addiction.

The regulations surrounding buprenorphine prescribing are a barrier to treatment. Providers need to attend a full day of training or online course to learn to prescribe buprenorphine, a safer medication to use than opioid pain medications. Such specific training is not required for providers to prescribe these other medications, such as fentanyl or oxycodone.

In addition, patients with addiction are complicated and often have other psychiatric conditions such as depression, posttraumatic stress disorder, or other psychiatric illnesses. They often have chronic pain and other health conditions that have gone untreated. Increasing parity in reimbursement to providers who treat these complicated patients is imperative for expanding the workforce.

*Thus, one recommendation is to increase reimbursement parity for providers treating addiction. In addition, reducing the regulations for prescribing buprenorphine is one way to expand access to treatment.*

Also, the medications available to treat opioid use disorder are expensive and often unaffordable for uninsured patients. For example, injectable, long-acting naltrexone, the life-saving anti-opioid drug, is about \$1,300 per month. Buprenorphine is several hundred dollars per month.

*Reducing the costs of these prescription medications would further expand access and save lives.*

At UAB, some of our patients are not interested in treatment with medication-assisted therapy for opioid use disorder, even if they are able to access it. This is likely due to stigma of taking a medication or not wanting to take a medication to treat addiction. Finding effective and patient-acceptable forms of treatment is important. While we know that cognitive-behavioral treatments are effective for addiction, ensuring that patients can access these evidenced-based treatments is another gap in care. Further, other psychosocial interventions, including peer-support programs such as 12-step, have not been rigorously evaluated and a better understanding of these treatments is needed. Most treatment programs do not provide their success rates, which makes it difficult for consumers, policy makers and others to know if what these programs are doing is effective or to compare across different programs. Research that focuses on treatment outcomes for inpatient and outpatient substance abuse treatment programs could provide this important information. Finally, development of novel medications to treat opioid use disorder and other addictions is critical. While deaths due to opioids have been devastating, we are also seeing a rise and transition to methamphetamine and other stimulant use and we currently have no FDA-approved medications to treat stimulant use disorders.

*Thus, increased research dollars are needed to expand pharmacotherapy treatment options as well as provide access to effective behavioral treatments for addiction.*

Number two: to reduce deaths associated with opioid use disorders, we must target infectious diseases that result from injection drug use. In addition to injection drug use putting a person at heightened risk for overdose, sharing needles and injection equipment puts these people at risk for infectious diseases such as HIV, hepatitis C, and bacterial infections, such as infections of the heart, bone, skin and soft tissues. Across the United States, hospitals have experienced a surge in admissions related to these bacterial infections. These hospitalizations are expensive. Treating one case of endocarditis (infection of the heart valves) costs over \$50,000. Total hospital costs associated with just this one infection has increased 18-fold from 2010 to 2015. Attention needs to be given to the development of limited, harm reduction programs to stem the threat of infectious diseases. In addition, research should be expanded to evaluate the efficacy of these types of programs.

Number three: We must focus on developing alternatives to opioids for chronic pain management. There is not a SINGLE STUDY that shows any clear benefit of long-term opioid use for chronic pain over other non-pharmacological treatments or non-opioid treatments. Not one. We need to employ non-opioid techniques for chronic pain that have been proven to be efficacious and that do not have the serious consequences associated with their use. These treatments include cognitive behavioral therapy, meditation, yoga, physical therapy, and exercise. Diet and nutrition can also be important for reducing pain. However, in order to utilize these non-opioid treatments, insurance companies need to be willing to pay for these services and our workforce needs to be developed and trained to be able to meet the demand.

*If we live long enough, each of us will experience pain that lasts longer than we would like. Having strategies to manage this pain is important.*

In summary, we can improve the health of patients with opioid use disorder by

- 1) Increasing access to treatment through reimbursement parity, reducing regulations, reducing costs of medications, and increasing research dollars for behavioral and novel medication development.
- 2) Reducing life threatening complications of injection through harm reduction strategies and evaluation of these strategies through research.
- 3) Developing effective opioid-free treatments of pain.

Thank you for the opportunity to speak with you today on this critical issue.