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TO: Committee on Education and the Workforce: Joint Subcommittee on Early Childhood, Elementary, and Secondary Education and Higher Education and Workforce Development

FROM: Dr. Leana Wen, Baltimore City Health Commissioner

RE: Testimony: "Close to Home: How Opioids are Impacting Communities"

Subcommittee Chairmen Rokita and Guthrie, Subcommittee Ranking Members Polis and Davis, Chairwoman Foxx, Ranking Member Scott, and Distinguished Members of the Committee and Subcommittees:

Thank you for inviting me to testify on the epidemic of opioid abuse that is sweeping across our country. Opioid abuse is a public health emergency that is claiming the lives and livelihoods of our citizens. It affects the entire life course, and touches upon every aspect of our communities, from public safety to the workforce to children and families.

As an emergency physician, I have witnessed firsthand the effects of substance addiction, including treating hundreds of patients who have overdosed on opioids. I remember well my patient, a 24-year old mother of two who came to the emergency room (ER) nearly every week requesting addiction treatment. She would be told there was nowhere for her to go that day or the next, and would be offered an appointment in three weeks' time. Because she lacked housing and other supportive services, she would relapse. One day, her family found her unresponsive and not breathing. By the time she arrived in the ER, it was too late for us to save her, and she died.

I always think back to my patient now: she had come to us requesting help, not once, not twice, but over and over again, dozens of times. Because we do not have the treatment capacity, people looking to us for help fall through the cracks, overdose, and die. Why has our system failed her, just as it is failing so many others who wish to get help for their addictions? How does our system continue to fail her family? Nationwide, 2.5 million children are raised by grandparents and other relatives, with parents missing—and that number is rising, in part because of the epidemic of opioid addiction. After a long period of decline, the number of children in foster care is rising for the same reason.

My colleagues and I frequently felt frustrated by the limitations of clinical practice; by the time patients made their way to us, society had missed significant opportunities to intervene further upstream in that individual's life. We treat addiction differently than we treat any other illness. Would we ever tell someone who has had a heart attack to wait three weeks to get treatment? Despite scientific studies showing that addiction is a disease and that recovery is possible, many

still question why people "choose" a lifestyle of using drugs. Would we impose such stigma on any other disease? How can we intervene early—not just when someone is dying from an overdose, but much earlier, to prevent addiction in the first place and to provide treatment for people the moment they need it? These are the experiences that drove me to public health: a desire to tackle the epidemic of addiction at a community-level, and in doing so, save lives while also redefining our societal approach to the treatment of addiction.

As the Health Commissioner of Baltimore City, I work every day with my dedicated staff at the Health Department and partners across our city to prevent overdose and stem the tide of addiction. These partners include our local behavioral health authority, Behavioral Health System Baltimore, whose board I serve on as the Chair. I am encouraged that the approach to the opioid epidemic is shifting away from the rhetoric of the "war on drugs" and instead focusing on treating addiction as a disease. But while our rhetoric is changing, funding for treatment lags behind. Of the more than 25 million people who abuse some form of drug, only about 1 in 10 is able to receive treatment. Ensuring those struggling with addiction can access treatment on-demand requires urgent funding and support from the federal government.

The Opioid Problem in Baltimore

With over 21,000 active heroin users in Baltimore and far more who misuse and abuse prescription opioid medications, opioid addiction and overdose is a critical health priority in our city. In 2016, 694 people died from drug and alcohol overdose, which is more than twice the number of people who died from homicide. Drug addiction impacts our entire community and ties into nearly every issue facing our city including crime, unemployment, poverty, and poor health. It claims lives every day and affects those closest to us—our neighbors, our friends, and our family.

Baltimore's Response to Addiction and Overdose

Our work in Baltimore is built on three pillars:

- First, we have to prevent deaths from overdose and save the lives of people suffering from addiction.
- Second, we must increase access to quality and effective on-demand treatment and provide long-term recovery support.
- Third, we need to increase education and awareness in order to reduce stigma and encourage prevention and treatment.

1. Preventing deaths from overdose

In 2015, I declared opioid overdose a public health emergency and led the charge in one of the most aggressive opioid overdose prevention campaigns across the country.

a. The most critical part of the opioid overdose prevention campaign is expanding access to naloxone – the lifesaving drug that reverses the effect of an opioid drug overdose. Naloxone is safe, easily administered, not addictive, and nearly 100% effective at reversing an overdose. In my clinical practice as an emergency physician, I have

administered naloxone to hundreds of patients and have seen how someone who is unresponsive and about to die will be walking and talking within seconds.

Since 2003, Baltimore City has been training drug users on using naloxone through our Staying Alive Program. In 2015, we successfully advocated for a change in State law so that we can train not only individuals who use drugs, but also their family and friends, and anyone who wishes to learn how to save a life. This is critical because someone who is overdosing will be unresponsive and friends and family members are most likely to help.

In 2017, we further amended the state law to eliminate the training requirement for obtaining naloxone. Today, naloxone is now essentially available over the counter in Baltimore. Anyone can walk into any pharmacy and obtain naloxone under my blanket prescription.

Our naloxone education efforts are extensive. Since 2015, we trained nearly 30,000 people to use naloxone: in jails, public housing, bus shelters, street corners, and markets. We work with businesses, libraries, restaurants, and other entities to conduct outreach and education, and go to where people are.

We were one of the first jurisdictions to require naloxone training as part of court-mandated time in Drug Treatment Court. We have trained federal, state and city legislators so that they can not only save lives, but also serve as ambassadors and champions to their constituents.

b. We use up-to-date epidemiological data to target our training to "hotspots," taking naloxone directly into the most at-risk communities and putting it in the hands of those most in need. This was put into effect in 2015, when 39 people died from overdose of the opioid Fentanyl between January and March of 2015. In 2016 we lost 419 people to a Fentanyl overdose; the numbers continue to escalate, and there are now 50 times the number of people dying from Fentanyl than there were in 2013. Fentanyl is many times stronger than heroin, and individuals using heroin were not aware that the heroin had been laced with Fentanyl. These data led us to target our messaging so that we could save the lives of those who were at immediate risk. Through our citywide Fentanyl Taskforce, we coordinate our data with agencies across the city, including the police department, fire department, and hospitals, to ensure our information is complete and our efforts are unified.

c. In order to train even more people in the use of naloxone, we have launched an online platform that now allows residents to get trained online and immediately receive a prescription for naloxone. This online platform, which is the first-of-its-kind around the country and the world, is the next step to reduce barriers to the use of naloxone.

d. Already, our naloxone outreach and trainings are changing the way our frontline officials approach addiction treatment, with a focus on assessment and action. In addition to training paramedics, we have also started to train police officers who have since saved

182 lives. The initial trainings were met with resistance from the officers who were hesitant to apply medical interventions that some did not see as part of their job description. However, in the first month of carrying naloxone, four police officers used it to save the lives of four citizens. After those involved acclimated to the change, I attended a training where I asked the officers what they would look for if they were called to the scene for an overdose. In the past, I would have received answers about looking for drug paraphernalia and other evidence. This time, officers answered that their job was to find out what drugs the person might have taken, call an ambulance, and administer naloxone, because their duty is to save a life. By no means is naloxone training the panacea for repairing police and community relations. However, it is one step in the right direction as we make clear that addiction is a disease and overdose can be deadly. We are changing the conversation so that all of our partners can join in encouraging prevention, education, and treatment.

e. We successfully advocated for Good Samaritan legislation, which expanded protections for those who assist in the event of an overdose, and malpractice protection for doctors who prescribe naloxone.

f. Our state Medicaid program has agreed to set the co-pay for naloxone at $1. While we still struggle with the pricing for naloxone (see below), this has allowed us to provide prescriptions to patients and others at a greatly reduced cost. We have to get naloxone into the hands of everyone who can save a life—which we believe is each and every one of us.

Some people have the misconception that providing naloxone will only encourage a drug user by providing a safety net. This dangerous myth is not rooted in science but in stigma. Would we ever say to someone whose throat is closing from an allergic reaction, that they shouldn't get epinephrine because it might encourage them to eat peanuts or shellfish? An Epi-Pen saves lives; so does naloxone, and it should be just as readily available. Our mantra is that we must save a life today in order for there to be a better tomorrow.

2. Increasing access to on-demand treatment and long-term recovery support

Stopping overdose is only the first step in addressing addiction. To treat people with substance addiction, we must ensure there is adequate access to on-demand treatment. Nationwide, only 10% of patients with addiction get the treatment they need. There is no physical ailment for which this would be acceptable—imagine if only 10% of cancer patients or 10% of patients with diabetes were being treated. If we do not increase access to quality treatment options we are merely treading water, waiting for the person who has overdosed to use drugs and overdose again.

The evidence is clear: addiction treatment requires a combination of medication-assisted treatment, psychosocial support, and wrap-around services including supportive housing. All of these must be in place for individuals suffering from addiction to recover, and they must be available at the time the individual is seeking these services—the same as for any medical

condition. There are three FDA-approved medications (methadone, buprenorphine, and naltrexone). All three should be available and covered by insurance equally in all places where people are seeking treatment.

a. In Baltimore, we have started a 24/7 "crisis, information, and referral" phone hotline that connects people in need to a variety of services including: immediate consultation with a social worker or addiction counselor; connection with outreach workers who provide emergency services and will visit people in crisis at homes; information about any question relating to mental health and substance addiction; and scheduling of treatment services and information. This hotline is not just for addiction but for mental health issues; behavioral health issues are so closely related, and there is a high degree of co-occurrence. Those who are seeking treatment for behavioral health should be able to easily access the services they need, at any time of day. This 24/7 line receives approximately 1,000 phone calls every week. It is being used not only by individuals seeking assistance, but by schoolteachers and family members seeking resources, and police and providers looking to connect their patients to treatment.

b. We have implemented the Screening, Brief Intervention, and Referral to Treatment (SBIRT) approach, which provides universal screening of patients presenting to ERs and primary care offices. SBIRT is now being implemented in nine of our eleven hospitals and in our city clinics to ensure delivery of early intervention and treatment services for those with or at-risk for substance use disorders.

c. We have piloted a real-time treatment dashboard to obtain data on the number of people with substance use disorders, near-fatal and fatal overdoses, and capacity for treatment. This enables us to map the availability of our inpatient and outpatient treatment slots and ensure that treatment availability meets the demand. The dashboard is being connected to our 24/7 hotline that will immediately connect people to the level of treatment that they require—on demand, at the time that they need it.

d. We have secured $3.6 million in capital funds and $2 million in operating funds for a "stabilization center"—also known as a sobering center—for those in need of temporary service related to intoxication. This is the first step in our efforts to start a 24/7 "Urgent Care" for addiction and mental health disorders—a comprehensive, community-based "ER" dedicated to patients presenting with substance abuse and mental health complaints. Just as a patient with a physical complaint can go into an ER any time of the day for treatment, a person suffering from addiction must also be able to seek treatment on-demand. This center will enable patients to self-refer or be brought by families, police, or EMS—a "no wrong door" policy ensures that nobody would be turned away. The center would provide full capacity treatment in both intensive inpatient and low-intensity outpatient settings, and connect patients to case management and other necessary services such as housing and job training.

e. We are expanding and promoting medication-assisted treatment, which is an evidence-based and highly effective method to help people recover from opioid addiction. This combines behavioral therapy with FDA-approved medications. Taking medication for

opioid addiction is like taking medication to control heart disease or diabetes. When prescribed properly, medication does not create a new addiction. Rather, it manages a patient's addiction so that they can successfully achieve recovery. Baltimore has been at the cutting edge of innovation for incorporating medication-assisted treatment, including providing medications in structured clinical settings. Last year, we expanded access to buprenorphine treatment by offering services in low-barrier settings, such as recovery centers, emergency shelters, and mental health facilities. This year, we are looking to double the number of physicians who are able to prescribe buprenorphine, and to begin buprenorphine induction in other settings including our city clinics and ERs. Providing access to buprenorphine services allows us to engage more people into much needed treatment.

f. We are expanding our capacity to treat overdose in the community by hiring community-based peer recovery specialists. To build trust, these individuals have been recruited from the same neighborhoods as individuals with addiction, and are trained as overdose interrupters who can administer overdose treatment and connect patients to treatment and other necessary services. To date, eight of eleven hospitals participate in our Overdose Survivors Outreach Program, in which overdose survivors in the emergency room are linked with peer recovery coaches in the community. These peers work with patients after they are discharged to provide a "warm hand-off" into treatment and other support services.

g. We are working to expand case management and diversion programs across the city so that those who need help get the medical treatment they need. In our city of 620,000, more than 75,000 people are arrested each year. The majority of these arrests are due to drug offenses. Of the individuals in our jails and prisons, 8 out of 10 use illegal substances and 4 out of 10 have a diagnosed mental illness. Addiction and mental illness are diseases, and we should be providing medical treatment rather than incarcerating those who have an addiction.

   Baltimore already has highly-effective diversion efforts such as Drug Treatment Courts and Mental Health Treatment Courts. At the start of 2017, we began implementing a Law Enforcement Assisted Diversion Program (LEAD), a pilot model that has been adopted by a select group of cities. LEAD establishes criteria for police officers to identify eligible users and take them to an intake facility that connects them to necessary services such as drug treatment, peer supports, and housing – rather than to central booking for arrest. Cross agency partnerships will be key in making these programs successful. LEAD implementation in Baltimore involves not only the Health Department and our behavioral health providers but the Police Department, State's Attorney's Office, Public Defender's Office, and many more entities that together recognize the importance of addiction treatment.

h. We are increasing our capability for case management services for every individual leaving jails and prisons. These individuals are in a highly vulnerable state, and must be linked to appropriate physical and behavioral health care, social and supportive services, employment, mentoring and housing. Our outreach workers already target a subset of this

population; we need to expand capacity to every one of these individuals. Additionally, we are deploying community health workers who are individuals in recovery themselves. Based in the communities in which they work, they are "credible messengers" who reach people where they are. In deploying this tactic, we are also excited to bring jobs and opportunities to vulnerable individuals and neighborhoods that otherwise have limited employment opportunities.

3. Providing education to reduce stigma and prevent addiction

In addition to treating patients, we must also change the dialogue around the nature of substance use disorders while we work towards preventing addiction. This effort has multiple components, including educating doctors and the public, and providing prevention and early intervention services throughout the life course.

a. We have been at the forefront of changing public perception of addiction so those in need are not ashamed to seek treatment. We have launched a public education campaign, "DontDie.org," to educate citizens that addiction is a chronic disease and to encourage individuals to seek treatment. This was launched with bus ads, billboard ads, a new website, and a targeted door-to-door outreach campaign in churches, all coordinated with neighborhood leaders. We work with restaurants and bar owners to post "Don't Die" posters in their establishments. "DontDie.org" has also become our portal for online trainings and for the dispensing of naloxone through the Standing Order mentioned above. Any resident can watch a short (10 minute) video, take a four-question quiz, and have completed the training.

b. We have established permanent prescription drug drop boxes at all nine of the city's police stations and have conducted educational awareness campaigns around not using prescriptions that were given to anyone else. Anyone can drop-off their unused, unwanted, or unnecessary prescription drugs—no questions asked. Drugs left in the home can end up in the wrong hands—spouses, elderly family members, or even our children. More than half of 12 to 17 year-olds who misuse prescription opioids say they got them from a friend or family member. Despite this, half of all patients prescribed opioids report receiving no instructions about safe storage and disposal.

c. We are targeting our educational efforts to physicians and other prescribers of opioid medications. Nationwide, over-prescribing and inconsistent monitoring of opioid pain medications is a major contributing factor to the overdose epidemic. According to the Centers for Disease Control and Prevention (CDC), there were 259 million prescriptions written for opioids in 2014. That is enough for one opioid bottle for every adult American. Every day, people overdose or become addicted to their prescription opioids.

   To address this, I have sent "best practice" letters to every doctor in the city. These letters addressed the importance of the Prescription Drug Monitoring Program and judicious prescribing of opioids, including not using narcotics as the first-line medication for acute pain, and emphasizing the risk of addiction and overdose with opioids. We emphasize adherence to CDC guidelines. Importantly, this best practice requires co-prescribing of

naloxone for any individual taking opioids or at-risk for opioid overdose. Hospitals keep naloxone on hand if patients receive too much intravenous morphine or fentanyl. Patients must also receive a prescription for naloxone if they are to be discharged with opioid medications that can result in overdose.

These best practices were developed through convening ER doctors, hospital CEOs, and other medical professionals in the city. To reach practicing doctors, we have been presenting at Grand Rounds, medical society conferences, and have also launched physician "detailing," where we deploy teams of public health outreach workers and people in recovery to visit doctors to talk about best practices for opioid prescribing. We are working on a convening for pharmacists to set pharmacy best practices, and have supported statewide legislation to require the use of Prescription Drug Monitoring Programs by physicians and pharmacists. All of us—as providers, patients, and family members—must play our part to prevent addiction and overdose.

d. We recognize that education must begin as early as possible, and that our schools are a critical part of our efforts. We launched a concerted effort to target prevention among our teens and youth through a campaign called "BMore in Control." We are also incorporating prevention into the public school curriculum. As of 2017, Maryland state law requires schools to teach on addiction. We are working with our school district to implement evidence-based educational curricula.

e. We have trained all of our nurses in our 180 public schools to save lives with naloxone. We now have addiction and mental health services in 120 of our schools. These efforts are a good start, but are limited for two reasons. First is the issue of billing: certain critical services such as case management and care coordination are not reimbursable, yet these are key to identifying children in need. Second is that there must be a focus on a true prevention intervention model. Substance use is often not the problem but a response to trauma, and there must be a more comprehensive approach to social and emotional learning and to addressing intersecting issues such as poverty, violence, racism, and trauma.

f. A guiding principle in public health is to intervene as early—and as "upstream"—as possible. This is particularly salient given the statistics that show that the number of babies born addicted to drugs has tripled between 1999 and 2013. In some places, up to 40% of NICU costs are from babies with neonatal abstinence syndrome. In Baltimore, more than half of children who die have a parent or caregiver with addiction and mental health concerns.

Home visiting for pregnant women helps to identify families in need of treatment and support. Becoming a parent is one of life's most rewarding experiences—and also one of its most difficult. I am a new mother to an 11-week old baby. My son and I are healthy, and I am privileged to have many resources available to me, including excellent health insurance and many social supports. Even so, learning to care for a newborn has been very hard. Many new mothers face significant obstacles, including stress, poverty, trauma, and social isolation, and physical and mental health issues. Home visiting has been shown to be an evidence-based, effective method of supporting families.

In our experience, home visitation identifies issues ranging from lack of resources to purchase cribs (in which case, we help to supply them); to homes with peeling paint and allergy- and asthma-inducing molds (in which case, we work with other city agencies to remediate homes to prevent lead poisoning and asthma exacerbations); to other social issues that could have otherwise resulted in serious harm such as domestic violence and substance use disorders.

Home visitation is a key component of our citywide strategy, B'More for Healthy Babies, which has successfully reduced infant mortality citywide by nearly 40% and sleep-related infant deaths by 70% in 7 years. B'More for Healthy Babies has more than 150 partners around the city who work to provide support and resources for women, children, and families. These supports include identification and connections to behavioral health treatment and housing assistance.

Despite the success of strategies like B'More for Healthy Babies, this and other programs that focus on upstream, early interventions are chronically underfunded. Such programs are evidence-based and cost-effective. They are necessary to break the cycle of intergenerational poverty and addiction. Studies have shown that children who grow up with family members who have substance use disorder are themselves much more likely to develop substance use disorder.

Critical to programs like these are care coordination services to identify and conduct outreach to women and families and need. Home visitation is most effective when it is combined with a continuum of care services such as child development and other family services in the community. These programs and the connections to care must also be significantly expanded.

g. In August 2017, the Baltimore City Health Department was informed that our grant from the Department of Health and Human Services' Office of Adolescent Health was to end early. This grant funds sexual health education and outreach programming, promoted through our "U Choose, Know What U Want" campaign. With a total cut of $3.5 million, this will affect 20,000 youth in our city.

   This program is much more than about sex education in schools. It is an integrated effort to reduce the city's teen pregnancy rate and to empower girls and women. It provides needed education, connection and services, including to behavioral health providers. It helps to break intergenerational poverty and trauma. Programs like these must be recognized as a key component to reducing and preventing addiction, and should be funded and expanded.

Working with the Federal Government:

The Baltimore City Health Department, together with our partners across the city and state, has made significant progress in tackling the opioid epidemic. However, there are some areas where

we face continued challenges. Though there is much that can be done on the city- and state-levels, the federal government also plays a critical role.

Congress has shown clear concern for this pressing tragedy, including through the passage last year of the Comprehensive Addiction and Recovery Act. There is also increased recent attention to the crisis by President Trump's declaration of a limited public health emergency.

There are three specific areas that we urge for this Committee to consider:

1. <u>Congress must protect and expand insurance coverage for on-demand addiction treatment.</u>

One in three patients with substance use disorders depend on Medicaid. If Medicaid were gutted and they were to lose coverage, there is no margin of error: the only option for millions might be to use drugs, and potentially overdose and die. Other patients on private insurance could find themselves without access to treatment too if addiction is no longer required to be part of their health plan.

The federal government needs to protect and expand Medicaid and require that all insurance plans cover evidence-based addiction treatment. Essential health benefits are called essential for a reason, and all insurance plans should cover preventive care and addiction and mental health services. There should also be coverage for wraparound services that are critical for treating addiction, such as connections to treatment, coverage for supportive housing, and reimbursement for peer recovery specialists.

Block grants should not replace insurance coverage, because no disease can be treated through grants alone.

2. <u>Congress should urgently allocate new funding directly to local jurisdictions hardest hit by the opioid epidemic.</u>

While states have traditionally received block grants from the federal government, local jurisdictions are the closest to the ground in service delivery, and understand the needs of residents the best. We urge Congress to consider direct support for local jurisdictions, particularly those in areas of greatest need, by providing cities and counties with the autonomy to innovate and provide real-time care for our residents.

Baltimore is in dire need for more funding to purchase the opioid antidote, naloxone. Naloxone is part of the World Health Organization's (WHO) list of essential medications. It is available as a generic, yet both the generic version as well as brand-name versions are too expensive for local jurisdictions to afford with their limited budgets.

In Baltimore, not only have we equipped paramedics, EMTs, and the police with naloxone, my blanket prescription equips every resident in our city to carry naloxone. Since 2015, we have trained 30,000 people, and everyday people have saved the lives of nearly 1,500 of their fellow residents.

But we have a problem: our city is out of funds to purchase naloxone, forcing us to ration and make decisions every day about who can receive this antidote. This issue is particularly acute because of Fentanyl. The number of people dying from Fentanyl has increased 50-times since 2013, and because of how strong Fentanyl is, we need more naloxone to revive individuals who are overdosing.

Last month, Representative Elijah Cummings led a coalition of 51 members to call for the President to negotiate directly with manufacturers of naloxone. We urge for these negotiations to occur—imagine how many more lives we can save if we had the resources to do so. In the short-term, we need many more resources to purchase this life-saving medication. If our city receives funding today, we can immediately translate it into saving lives through purchasing naloxone and through expanding treatment access.

For years, we on the frontlines have been able to do a lot with very little. We need resources from the federal government to help us—new resources, not repurposed funding that will divert from other critical health priorities. These funds should be directly given to communities of greatest need. Cities and counties know what works, and local officials should not have to jump through additional hoops to obtain the resources we need. Issuing grants and having local jurisdictions compete for them will cause months if not years of delay, as would funding that passes through the states before getting to cities and counties.

3. <u>Congress should support and fund early interventions for women, children, and families.</u>

Upstream, early interventions such as home visitation and school-based supports are evidence-based and cost-effective. A recognition of substance use as not the cause but as a response to trauma, poverty, and violence calls for early investments in our women, children, and families.

To mitigate the impact of addiction on families and to prevent future addictions from occurring, educational campaigns are not enough. They must be combined with social support interventions, including home visitation and care coordination programs.

Congress should immediately reauthorize funding for the Children's Health Insurance Program, as well as fully fund and expand evidence-based home visitation funding for programs such as Healthy Start, Healthy Families America, and Nurse Family Partnerships. Additional support should be given to expand whole-family, multi-generational approaches such as Early Head Start. Congress should also urge the Department of Health and Human Services to restore funding for teen pregnancy prevention and expand similar holistic approaches that empower girls, women, and families.

<u>Conclusion</u>

While some of the challenges facing Baltimore are unique, we join our counterparts around the country in addressing the epidemic of opioid abuse and addiction. According to the CDC, the number of people dying from overdose has quadrupled from 15 years ago. In many states, there are more people dying from overdose than from car accidents or suicide. This crisis extends far

beyond the individual suffering from addiction; it ties into the very fabric of society and has impacts across the life course and for generations to come.

There are some who say the opioid problem is too big and too complicated—that it cannot be solved. It is true that treating the opioid epidemic requires many approaches. However, this is a problem with a solution—if only we have the will and commit the resources. Treating addiction is not only the humane thing to do, it is also cost-effective. According to the NIH, treating opioid addiction saves society $12 for every $1 spent on treatment. Treatment also impacts communities by reducing excess healthcare utilization, increasing productivity and employment rates, and decreasing poverty and unnecessary cost to the criminal justice system. Furthermore, treating addiction is a moral imperative and a matter of life and death.

I'd like to end with one final plea: imagine if a natural disaster like a hurricane were claiming 142 lives a day. No one would question the resources required to repair houses and rebuild infrastructure, and billions of dollars would immediately be appropriated. The opioid epidemic can be solved if we commit a similar level of resources with urgency, compassion, and action. I urge Congress to put the full weight of the federal government to stem the tide of this epidemic, and to join those of us on the frontlines to commit the necessary resources to save lives and reclaim our communities.

I want to thank you for calling this important hearing. I look forward to working with you to stop the epidemic of heroin and opioid addiction in the United States.