Mitchell S. Rosenthal, M.D Remarks

As deputy chairman of the National Council on Alcoholism and Drug Dependence, it is a privilege for me to share with the commission the experience of our organization's affiliates... that serve more than 90 cities and towns throughout the country.

As a psychiatrist... and founder of Phoenix House... I have been treating addiction for more than half a century. At the Rosenthal Center for Addiction Studies, which I now head, we have been tracking the opioid addiction epidemic and assessing efforts to contain it.

What our affiliates report and the frightening statistics of CDC confirm is that the addiction crisis of today is likely to be the most deadly drug epidemic in this nation's history. We are engulfed by "a perfect storm" of disabling forces: the drug trade on the dark web, the availability of hyper-potent synthetic opioids and the ennui and despair that prevail in small towns and cities where the factories are closed, the stores on Main Street are empty, and the mall that replaced them is closing too.

The crisis is not only a threat to life -- killing close to 60 thousand a year -- and sharply raising the death rate for Americans in the prime of life; it is tearing at the social fabric of the nation and spreading a dark cloud of fear, frustration and anger over cities, suburbs, and rural areas that had been relatively untouched by drug abuse before. And let me be blunt: today there is not nearly enough drug treatment capacity in America to help most of the victims of this epidemic. I am particularly concerned about the lack of long-term treatment, the treatment necessary to repair lives shattered by addiction.

Faced with the ferocious escalation of opioid addiction, NCADD affiliates have mounted programs of awareness, prevention, counseling and referral for populations far more heterogeneous than any they had seen before. For today, everyone is at risk and every family prey to loss.

Most terrifying is the reality that nothing we are doing today has been able to halt the spread of opioid addiction.

Controlling the prescription of opioid medication has not done so. Prescription monitoring programs, strict limits on the number of pills physicians can prescribe and the CDC pain management guidelines have capped usage of prescribed opioid medications. But overdose deaths from heroin and highly potent synthetics like fentanyl have gone through the roof.

Equipping first responders with naloxone, the overdose reversal medication, is a key feature in just about every community's response to the crisis. But while the medication can avert an overdose fatality, there is no guarantee that the life that's been saved from one overdose will survive the next one.

Most troubling to the NCADD affiliates is the difficulty they often find making referrals to treatment. Adequate treatment resources are scarce. And there is enormous disparity between one state and another in what treatment and prevention services are available.

In large measure, it is the states that determine what and where treatment and prevention services are delivered. But they look to the federal government for much of the funding that supports them.

I would like to point out three areas that I hope you will thoughtfully consider.

The most obvious of these is the future of Medicaid. Under the American Health Care Act, as passed by the House of Representatives, 14 million of today's Medicaid patients will be uninsured by the start of 2020 and some 30 percent of Medicaid patients today are being treated for substance misuse or mental health issues.

A second concern is the rapid proliferation of Medically Assisted Treatment programs without the use of counseling and behavioral therapies. Bear in mind that the key word in medically assisted treatment is "assisted," for the practice is designed to employ medications, "in combination with counseling and behavioral therapies." The goal is not just to change the drugs you're taking but to change you and your way of life. Often lost in the rush to get buprenorphine medications to as many patients as possible are the behavioral components of treatment they need to achieve recovery and sustain it.

My third concern is for the needs of the most vulnerable and needful substance abusers. These are the men and women with few social or economic resources whose addiction has proven most disabling.

Essential to their recovery is long-term residential treatment of a kind that makes possible a new level of self-awareness and the acquisition of social and vocational skills along with the sense of self-worth and responsibility that are the bedrock of sustained recovery.

Few states today have any long-term treatment capacity.

What we see all too frequently for those most vulnerable addicts fortunate enough to find treatment services is a pattern of serial admissions to short-term programs. The pattern may start with overdose and rescue followed by detoxification, then a short period of residential treatment and return to the community, a pause and then the same sequence is repeated again and again. In so many tragic cases the end comes with a final overdose. ...

If the commission does nothing else, I would hope your report recommends the expansion of true long-term treatment, treatment that lasts as long as needed. It will actually save money by reducing the number of multiple admissions and it will truly save lives; rather than today's practice that so often amounts to postponing death.

Thank you.
Mitchell S. Rosenthal, M.D