House Policy Committees

Rep. Kerry Benninghoff, Majority Chairman
Rep. Mike Sturla, Minority Chairman

JOINT POLICY HEARING AGENDA

Pennsylvania's Drug Epidemic
Lycoming College
Aug. 30, 2016

2:00 p.m.	**Welcome by Chairman Kerry Benninghoff**
2:05 p.m.	**Opening Comments by Rep. Jeff Wheeland**
2:10 p.m.	**Welcome by Dr. Kent Trachte, *Lycoming College***
2:15 p.m.	**Congressman Tom Marino**
2:45 p.m.	**Panel 1** Tony Mussare, *Lycoming County Commissioner* Charles Kiessling RN, BSN, SEN, *Lycoming County Coroner* Tom Dann, *Retired State College Police Sergeant*
3:40 p.m.	**Panel 2** Cheryl Andrews, *Pennsylvania Association of County Drug and Alcohol Administrators* Chris Byers, *Pinnacle Treatment Centers* Jim Laughman, *AmeriHealth Caritas*
4:30 p.m.	**Adjournment**

MORE INFORMATION
House Majority Policy Committee: www.pagoppolicy.com
House Minority Policy Committee: www.pahouse.com/PolicyCommitee

TESTIMONY ON IMPACTS OF

PENNSYLVANIA'S DRUG EPIDEMIC

PRESENTED TO THE

Members of the House and Senate policy committees

By

Tony R. Mussare, Vice Chairman

Lycoming County Commissioners

County of Lycoming

August 30, 2016

Good afternoon, my name is Tony Mussare and I am a Lycoming County Commissioner, Chairman of the Prison Board, and President of the Lycoming/Clinton County Joinder Board which oversees Lycoming Children & Youth and MH/ID. Thank you for holding this hearing in Lycoming County and taking time to listen to our needs and help us find solutions to our heroin and opioid epidemic.

In November of 2012 I received my first of many phone calls from a parent who pleaded with me-- and I'll quote, "please leave my child in prison; it is the only way he will stay alive." At first, I thought to myself, what type of parent wants their child to stay in prison? Only after becoming aware of how heroin and opioids affect those who take these drugs and the toll it extracts on their families, could I begin to understand WHY such a plea was made.

Her child, as well as four other children whose parents personally called me, overdosed, died and were laid to rest. In each case these parents asked me why our county government failed to save their sons and daughters while they were under the supervision of the County's courts and Adult Probation Office. Their nightmares will never disappear and that brutal reality of losing their next generation will haunt them for the rest of their lives.

This mother's plea demands that we to ask ourselves what did she know that the policy makers and legislators in Harrisburg and Washington D.C. did not?

She knew that her family's-- and specifically her child's -- only HOPE was incarceration. She painfully understood that the standard 14 to 28 day drug rehabilitation program ordered by the courts fails families time and time again. Given this rate of failure, I think we must ask ourselves why we continue to waste limited precious dollars on short term programs that have very little effect on the addict.

Rather, I recommend the state and federal governments identify resources to fund long term programs and construct what I will call "confined addiction facilities" Please note I did not say build more prisons. I agree with the growing consensus of experts that heroin and opioid addiction is a disease and therefore incarceration is not the answer --- long term intensive care is! Let me be clear about what I mean by "long term"--- not a 30-45 day program but a 6-9 month period at an intensive treatment facility.

The success of treating addiction is not measured by the addict never using drugs again. Instead, it is measured by how long the addict stays clean. In terms of the financial impact of this drug epidemic has to the County, consider three salient facts: every day the addict or recovering addict is not using or using our criminal justice systems we 1) save our taxpayers $70 a day in our prison overcrowding expenses, 2) save our sheriff's department between $80 to $300 a day in transportation cost, and 3) save our community hundreds (even thousands) of dollars a day by the addicts not committing crimes that are associated with heroin and opioid addiction. Counties can redirect those dollars for intense long term monitoring.

In fact, if we deal with the drug addiction epidemic proactively and comprehensively, we can reduce the real-world strain on our police departments, sheriff's office, our court system, probation offices, and especially our prison & parole system. We could realign our focus away from criminal justice approaches and toward long-term/sustained rehabilitation & recovery programs that work!

In 2012, Lycoming County experienced a consistent overcrowding prison population for the first time in decades. Through a collaborative effort between the District Attorney's office and the president judge, and with the advice of Congressman Tom Marino, the county commissioners monitored and evaluated our options to combat both the overcrowding and our increase in heroin and opioid trafficking. At a cost of $880,000 per year, the County contracted with GEO, a re-entry service company, that uses evidence based practices and cognitive behavior skills to reduce the rate of recidivism and prison overcrowding.

Our District Attorney, Eric Linhardt, with the concurrence of the commissioners, implemented the county Narcotics Enforcement Unit (or NEU). County taxpayers cover 75% of this annual $400,000 cost with state picking up the balance. Let me assure you that we are seeing positive results with both the GEO Reentry and NEU programs.

Lycoming is a fifth class county with a median household income of $45,877—far below the state and national median incomes of approximately $53,200 The median earnings for individual workers residing in Lycoming county is only $26,567. This means that half of our working population makes less than this $26 thousand dollar figure. Our county seat is located in the city of Williamsport which struggles with its economic base since 27% of the city's population lives under the poverty level. Given these daunting income figures, the commissioners had to make a tough decision when we agreed to raise taxes to implement those programs and strategies that would make our communities safer and deal with the power of addiction.

I firmly believe we need state and federal dollars to combat this drug epidemic by realigning the funding priorities in Harrisburg and Washington DC. I believe we can accomplish our goals without raising state or federal taxes.

I also suggest state legislators examine our current state laws on marijuana and paraphernalia. Although their impact pales in comparison to heroin and opioids, they consume just as many County resources because of their illegality.

As a further cost control measure I strongly recommend reducing the number of school districts in our state. Consolidating some of our 501 districts into larger more efficient units would save enough state funds to help cover the expense of additional Adult Probation Officers. This in turn would enable these officers to reduce their case load and allow them to focus on the addicts and their recovery/rehabilitation.

From a federal government perspective, we need to stop sending billions of taxpayers' dollars to Iran and other countries that despise us and our way of life. I recommend we redirect those funds to build confined addiction facilities across America. We need DC leadership to help us bring HOPE to our families and our community.

In closing, I no longer want to have to hug those parents and cry with them at their child's funeral. I want to smile and rejoice with those families by helping them deal with this lifelong addiction. I want to be able to say to them that our legislative leaders made the right choices by supporting and funding programs that work for opioid and heroin addicts.

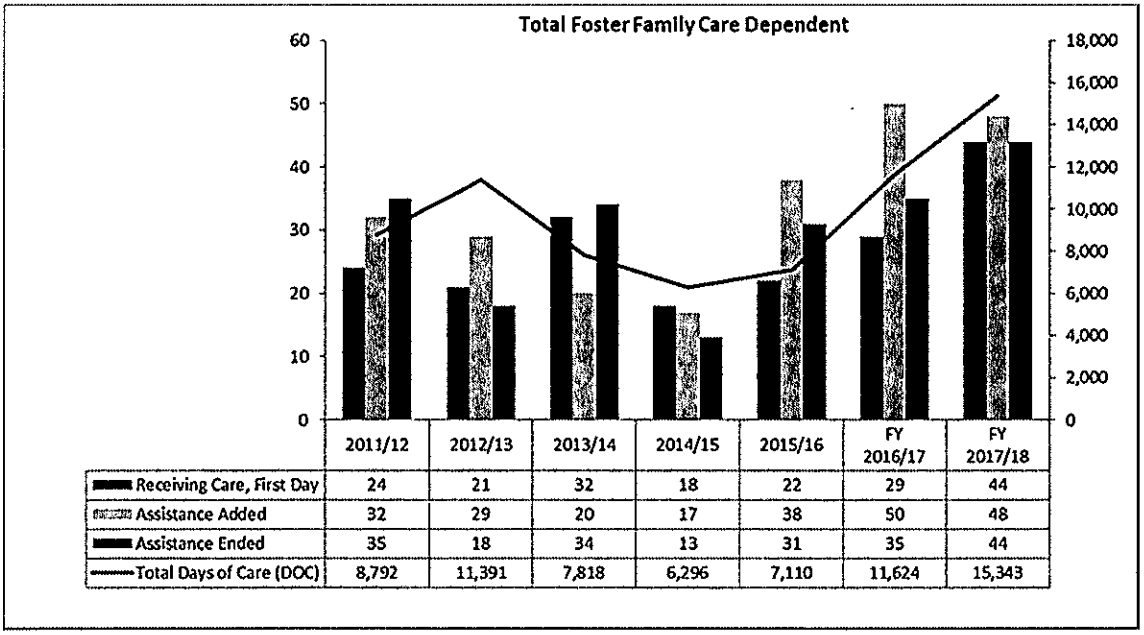
I thank you in advance for making those tough decisions.

Lycoming Children and Youth Services

Lycoming County has been hit hard by the heroin epidemic spreading across the state and nation. It is the leading underlying factor responsible for the Agency's recent placement increases. A review of current caseloads show's that of the 47 open accepted for service in-home cases (excluding SCR and IL cases) 31 cases have at least one parent identified as having D&A issues. Fifteen of the 31 cases involved heroin/opioid related issues. Further, out of the 37 children currently in placement, 21 children have at least one parent struggling with D&A issues, 11 of the 21 are heroin/opioid related.

Dependent foster care days-of-care reached an all-time low of 6,296 days in 2014-15 with only 17 children entering placement that year. This number doubled in 2015-16 with 38 children entering care, most within the last three months of the fiscal year. This trend continues; between 7/1 and 8/10/2016, fifteen children entered care, of which six were able to be returned home or are living with other relatives. The Agency expects to see more placements as families struggle to keep their children safe while battling their heroin addiction which frequently impacts their ability to provide stable housing, appropriate supervision, and/or appropriate medical care for their children.

The chart below shows the Agency's 5 year placement history and projections for the current and next fiscal year. (We certainly hope we don't experience the projected increases but need to have the resources available within our budget if recent trends continue.)



	2011/12	2012/13	2013/14	2014/15	2015/16	FY 2016/17	FY 2017/18
Receiving Care, First Day	24	21	32	18	22	29	44
Assistance Added	32	29	20	17	38	50	48
Assistance Ended	35	18	34	13	31	35	44
Total Days of Care (DOC)	8,792	11,391	7,818	6,296	7,110	11,624	15,343

Lycoming County Prison

Lycoming County is a fifth class county. For perspective purposes, the inmate population of the Lycoming County Prison is one of the largest fifth class county facilities in terms of commitments/population. The chart referencing the average daily population for the past three years will be referred to. In addition the total population charts for the years 2012, 2013, 2014 will be reviewed with particular attention to the overcrowding numbers for each timeframe. The age profile chart for the past three years clearly indicates the largest age group increase as the 25-34 year olds. The chart referencing prescription drug costs will be discussed to show increased costs over the past three years. It also provides a current perspective on what a small county prison spends on pharmaceuticals. The impacts of heroin use on prescription medication costs will involve future monitoring. There is a potential concern these costs will continue to grow due to the increase of IV drug use.

The various charts involving detox observations and commitments per month will be highlighted. Please note the detox observations are self-report data obtained by medical staff upon commitment. It is perhaps the clearest indicator the prison system records show that speaks to an increase in opiate use amongst this offender population. Pregnancies of opiate addicted offenders present special challenges and often times additional costs. The potential future impact of the prevalence of Hepatitis C and other infectious diseases due to the increase of IV use is extremely concerning. It is reported an 8-16 week treatment regimen for Hepatitis C could cost in excess of $100,000. We defer to Warden Stewart of Bradford County for additional comments.

The Lycoming County Single County Authority (SCA) West Branch Drug and Alcohol was consulted to obtain some data as it relates to the Criminal Justice System. Their records indicate over the past two years 67% of the referrals for treatment originated from the Criminal Justice System. Additionally, Lycoming County is part of an initiative involving the Department of Drug and Alcohol and the Department of Public Assistance known as the Medical Assistance Pilot Project. This project allows for referrals directly from the prison system to an inpatient drug/alcohol treatment program. From the timeframe of 07/01/13 – 03/31/14 the prison system referred twenty-one (21) individuals to the MA Pilot Project. The Bail/Release Program was recently expanded to assist with the high inmate population. The County Prison Bail/Release Program utilizes a treatment component as part of the supervision. It is reported by the Bail/Release Program Supervisor an effective tool in monitoring and supervising the drug/alcohol problem clientele is the sweat patch. These patches are costly to maintain and administer. The Bail/Release Program staff continue to initiate multiple referrals to inpatient/outpatient treatment programming. It is imperative, from the prison system perspective, that there is a continued focus on funding allocations by the legislature as well as associated decision makers and stakeholders in order to address this crisis. Enhanced funding allocations would provide greater access to prevention and treatment programs (inpatient/outpatient) for the applicable incarcerated individuals.

An outline.....

- Commitment/Population Numbers

□ Age Profile

□ Prescription Medication Costs

- Future Monitoring for Impacts of Heroin Use

□ Medical

- Detox Cases
- Opiate Detox #s Twelve Months
- Pregnancies
- Hepatitis C
  - Extremely Costly
  - Future Impacts
  - Comments – Defer to Warden Stewart for additional comments.

□ Treatment (Prison)

- Pilot Study (Inpatient) #s – MA Program
- Counseling Programs
- Costs – Supervision (Sweat Patches – Effective)
- Outpatient Services
- Bail/Release Program

□ West Branch Drug & Alcohol Data

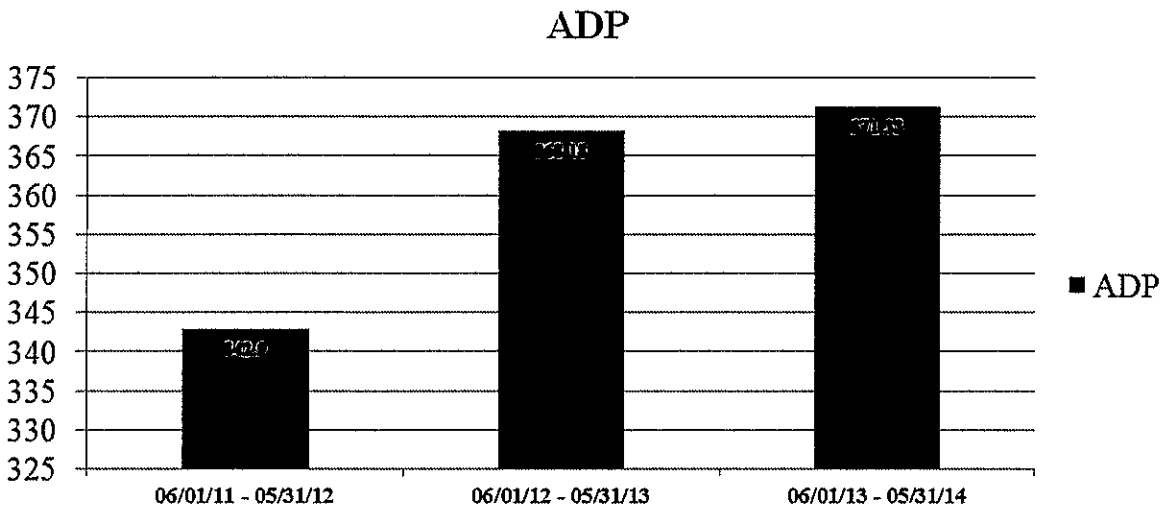
- 2009-2014 – Clients tripled
- 67% involved in criminal justice system

□ Suggestions

- Focus on allocation of funding and funding utilization.
- Expand access to prevention and effective treatment programs (outpatient/inpatient).

Total Population

06/01/11 – 05/31/12	06/01/12 – 05/31/13	06/01/13 – 05/31/14
342.90	368.18	371.33



Total Population

2012

		Overcrowding Transfers			
	In-House Population	Male	Female	Male/ Female	Total
January	335.68	0.00	0.00	0.00	335.68
February	343.31	0.00	1.03	1.03	344.34
March	332.97	0.00	0.00	0.00	332.97
April	330.77	0.00	0.00	0.00	330.77
May	364.50	1.94	0.00	1.94	366.44
June	373.80	17.40	1.93	19.33	393.13
July	370.35	20.10	1.84	21.94	392.29
August	370.03	23.53	3.68	27.21	397.24
September	370.77	37.86	3.73	41.59	412.36
October	376.68	21.12	3.61	24.73	401.41
November	375.43	19.90	11.10	31.00	406.43
December	362.77	5.68	6.07	11.75	374.52
Yearly Average	358.92	12.29	2.75	15.04	373.97 *

* Total includes overcrowding transfers.

Total Population

2013

	In-House Population	Overcrowding Transfers			Total
		Male	Female	Male/ Female	
January	362.23	0.00	0.00	0.00	362.23
February	360.89	5.57	0.00	5.57	366.46
March	350.55	1.13	0.00	1.13	351.68
April	368.47	0.00	0.00	0.00	368.47
May	376.16	7.90	0.23	8.13	384.29
June	378.80	15.80	0.73	16.53	395.33
July	377.35	30.23	0.00	30.23	407.58
August	377.58	16.65	0.00	16.65	394.23
September	375.80	0.80	0.00	0.80	376.60
October	363.55	0.00	0.77	0.77	364.32
November	373.57	0.00	2.27	2.27	375.84
December	370.74	0.00	0.19	0.19	370.93
Yearly Average	369.64	6.51	0.35	6.86	376.50 *

* Total includes overcrowding transfers.

Total Population

2014

		Overcrowding Transfers			
	In-House Population	Male	Female	Male/ Female	Total
January	369.71	3.48	1.65	5.13	374.84
February	369.64	16.86	0.00	16.86	386.50
March	364.32	15.26	0.00	15.26	379.58
April	367.07	9.70	0.20	9.90	376.97
May	367.77	7.77	2.13	9.90	377.67
June					
July					
August					
September					
October					
November					
December					
Yearly Average	367.70	10.61	0.80	11.41	379.11 *

* Total includes overcrowding transfers.

West Branch Drug & Alcohol

Here are some local statistics. Our Single County Authority (SCA) covers both Lycoming and Clinton Counties. SCAs serve as local administrative entities for a catchment area that includes one or more counties. Currently, there are 47 SCAs serving the 67 counties in the commonwealth. It is the SCAs' responsibility to determine the needs of their catchment area and engage providers to deliver the appropriate services. The statewide system of SCAs have the responsibility of assisting the Department of Drug & Alcohol Programs in planning for community-based drug and alcohol services, to include: assessing needs; managing and allocating resources; and evaluating the effectiveness of prevention, intervention, treatment and treatment-related programming, including case management services.

I compared 2015 to 2010 so you can see the changes. If you are interested in other years please let me know. As you can see race and gender remained stable. Alcohol remains the primary drug of choice. Opiate use (heroin and prescription narcotics) has more than doubled going from 16% in 2010 to 36% in 2015. The number of substance abuse screenings increased almost 19%.

Purposes of screening include:

1. To obtain information to ascertain if emergent care is needed in the following areas:
    a. Detoxification
    b. Prenatal Care
    c. Perinatal Care
    d. Psychiatric Care
2. To motivate and refer, if necessary, for a Level of Care assessment or other services.
3. To identify individuals being referred by an emergency room or urgent care facility following an overdose.

- In 2015 the SCA conducted **2590** screenings.

    Screenings by race
    86% Caucasian
    10% African-American
    4% other

    Screenings by gender
    67% male
    33% female

    Screenings by drug of choice
    42% alcohol

24% heroin
12% opiates
3% cocaine
15% marijuana
4% other

Screens by age
7% 0 to 18
44% 19 to 29
25% 30-39
13% 40-49
8% 50-59
3% over 60

- In 2010 the SCA conducted **2119** screenings.

Screenings by race
88% Caucasian
9% African-American
3% other

Screenings by gender
71% male
29% female

Screenings by drug of choice
58% alcohol
10% heroin
6% opiates
7% cocaine
12% marijuana
7% other

Screenings by age
10% 0-18
39% 19-29
22% 30-39
19% 40-49
9% 50-59
1% over 60

- I was cutting and pasting this chart so if it doesn't make sense let me know.

Estimates of the Prevalence of Substance Abuse Disorders (Dependence or Abuse) of Illicit Drugs or Alcohol
Pennsylvania, Single County Authorities and State
Based on 2012-2013 National Survey on Drug Use and Health (NSDUH)

Total 2013 Population	Age 12+		Age 12-17		Age 18-25	
	Population	Prevalence (Rate= 8.28%)	Population	Prevalence (Rate= 5.74%)	Population	Prevaler 19.
LYCOMING/CLINTON	156,708	135,534	11,222	10,819	621	31,497

- This report contains statewide data on the prevalence of substance abuse:

http://store.samhsa.gov/shin/content//SMA15-4895/BHBarometer-PA.pdf

Juvenile Probation Office (JPO) info on D&A issues – 2016

- During the weeks of 6/7 – 21/2016, all active JPO youth were given urine screens for illegal/banned substances. Of the 110 samples taken, 10 were positive. Of those 10 positive tests, 7 were THC, 2 were acid and 1 was cough syrup.

- To date, JPO has received 189 referral from law enforcement or District Justices. Of these 189, 39 were related to drugs and alcohol. Of those 40, 34 were charged with possession of drugs or paraphernalia, 4 were charged with DUI and 2 were charged with Possession with Intent to Deliver (PWID).

- Juvenile Probation facilitates a Juvenile Drug Treatment Court. Criteria for entry on our Drug Court is an elevated Youth Level of Service (YLS) assessment in the D&A section, recommendation for Drug Court placement from a West Branch D&A evaluation and D&A impacting youth's daily, normal functioning. There are currently 3 youth involved in our Drug Court

Adult Probation Office

As of this date, Opiate use is still the second most popular drug of choice among defendants on probation and parole, Marijuana being first. Due to the heroin/opiate epidemic, caseloads have increased dramatically. We have seen an increase in the out of county offenders which come to Lycoming Co. specifically Williamsport to buy heroin. With that said, the Lycoming Co. Adult Probation Office now has 452 out of county individuals in which we are responsible for. These individuals primarily are opiate addicted individuals and if they violate (new arrest, or test positive) their supervision is returned to Lycoming Co. thus taking up valuable prison space. As of August 2016, the Lycoming Co. Adult Probation Office has seen 7 defendent over doses resulting in death.

Lycoming County Adult Probation

Urine Analysis (2015)

***Frequency of Tests** (and Result of Urine Test Charts)*

There were 3,223 UA administered and recorded by Lycoming County APO in 2015. For purposes of this analysis, 3,216 tests are valid—and there are 7 invalid UA tests because there was not enough information associated with that specific test (i.e. docket# was missing because the test was given by PBPP, or the result of the test was missing). The fact that these few cases are not included in the analysis is miniscule because 99.8% of the cases are valid.

A frequency test determined that 2,278 UA tests were negative, 696 UA tests were positive for *one* drug, and 242 UA tests were positive for *multiple* drugs. In total, there were 938 positive UA tests. To put it into perspective, 70.8% of the tests were negative, 21.6% of tests contained a single positive, and 7.5% contained multiple positives. It is important to recognize the fact that the overwhelming majority of tests were negative.

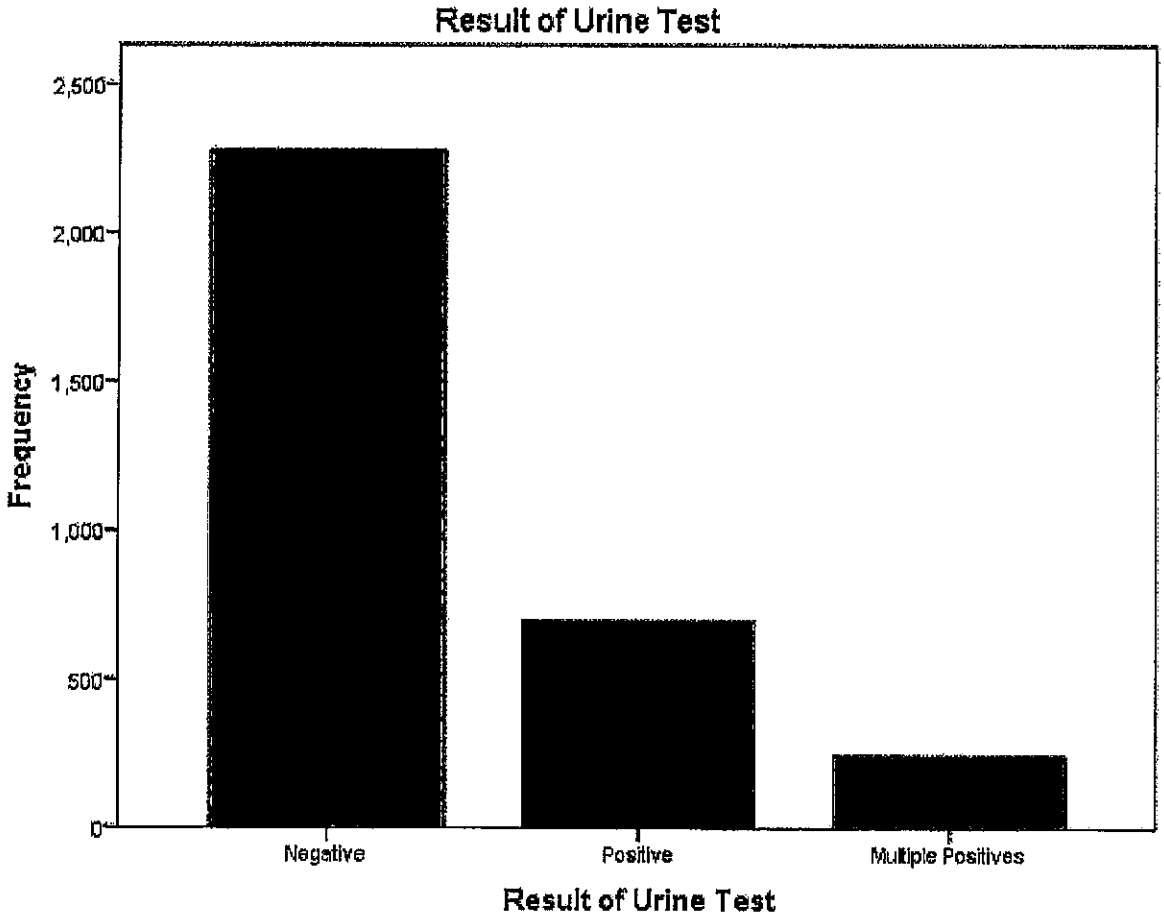
Statistics

Result of Urine Test

N	Valid	3216
	Missing	7

Result of Urine Test

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	Negative	2278	70.7	70.8	70.8
	Positive	696	21.6	21.6	92.5
	Multiple Positives	242	7.5	7.5	100.0
	Total	3216	99.8	100.0	
Missing	System	7	.2		
Total		3223	100.0		


Result of Urine Test
2,500
2,000
1,500
1,000
500
0
Frequency
Negative
Positive
Multiple Positives
Result of Urine Test

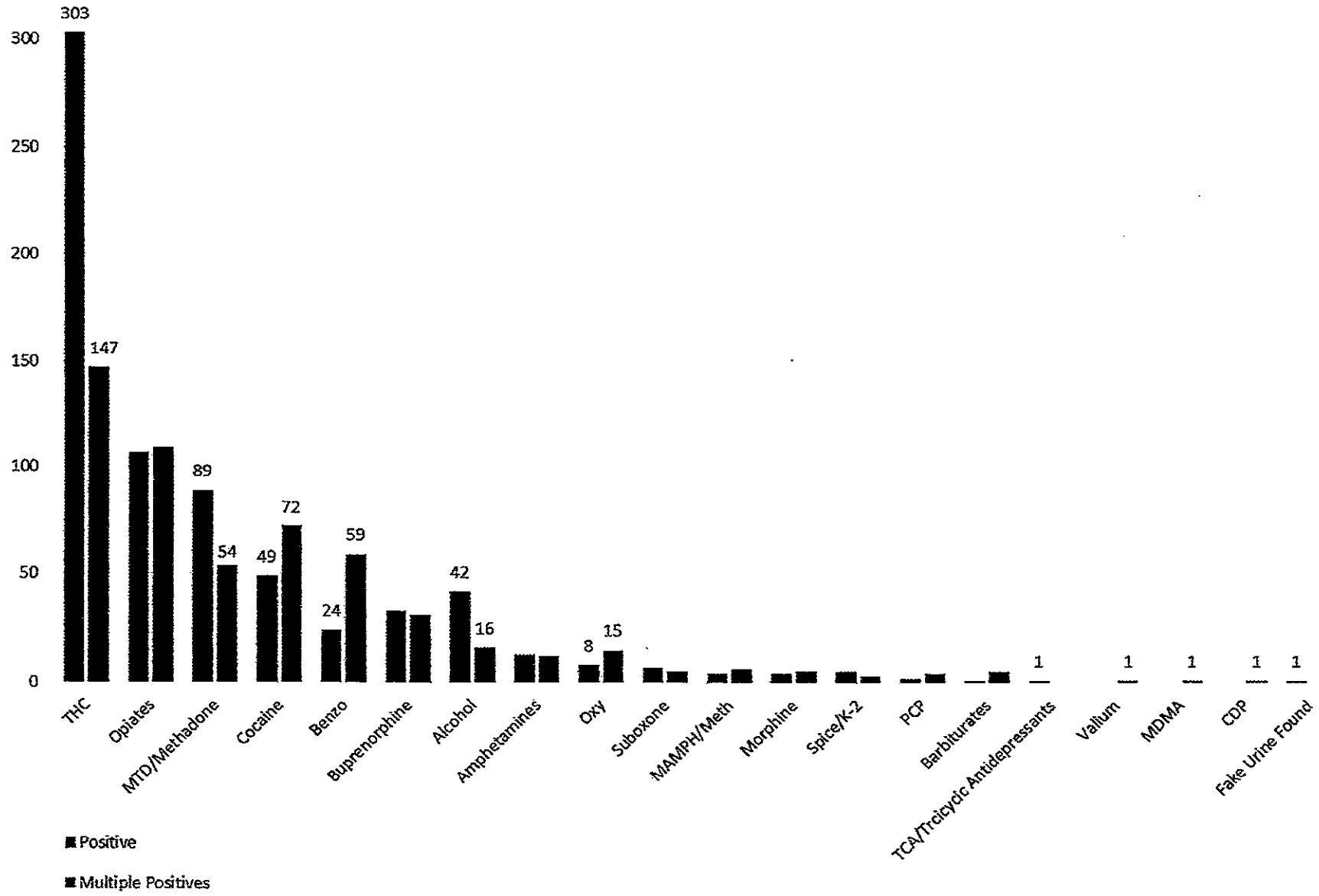
Frequencies of Different Substances *(with Frequency chart and graph)*

The following tables and graphs were tabulated using Microsoft Excel and the SPSS data. THC, Opiates, Methadone, and Cocaine were the most frequent substances that showed up in the urine analysis. THC was the substance that occurred most frequently in positive tests; it was present in 303 single positive tests and in 147 of multiple positive tests. This means that 450 of 938 positive tests included THC (this is 47.97%) and that THC was more than twice as likely to be present in a single positive test compared to multiple positive tests. Opiates was the next most frequent drug, being present in 107 single positive tests and 109 multiple positive tests; or 216 of 938 positives (23.02%). Interestingly, it seems as if opiate users are just as likely to produce a single positive as they are to have multiple positives—this means they are equally as likely to use other substances besides opiates as they are to only use opiates. Next, Methadone was the third most frequent substance, being present in 89 single positive tests and 54 multiple positive tests. It also looks as if Methadone is more likely to be present in a single positive test as opposed to a multiple positive test. In total Methadone is present in 143 of the 938 positive tests (15.35%), but again, it should be noted that it is not known whether these users are in Methadone clinics or if they are obtaining the drug illegally. Cocaine was the fourth most frequent substance and was found in 49 single positive tests and 72 multiple positive tests—or in 121 of 938 positive tests (12.90%). This finding is interesting because it looks as if Cocaine users are significantly more likely to also have other substances in their system.

Benzo (the fifth), Buprenorphine (the sixth), Alcohol (then seventh), Amphetamines (the eighth), and Oxy (the ninth) were much less frequent than the four substances listed above. There is evidence that Benzo is more than twice as likely to be present in a multiple positive test than it is in a single positive test—and is present in 59 multiple positives versus 24 single positive tests. This leads one to believe that the Lycoming County Benzo users who are on probation most likely consume this with other substances. Buprenorphine was just as likely to show up in a single positive test as it was in a multiple positive test. Alcohol was distinctly more present in single positive tests versus multiple positive tests (42 single positives versus 16 multiple positives)—which suggests that frequent Alcohol users primarily only consume alcohol as opposed to a combination of substances. Lastly, Oxycodone was almost twice as likely to be present in a multiple positive test (15) versus a single positive test (8)—suggesting that users are more likely to consume this substance with others.

Respectively, THC, Opiates, Methadone, Cocaine, Benzo, Buprenorphine, and Alcohol were the most prevalent substances in the 2015 Lycoming County Urine Analysis.

Frequencies of Different Substances



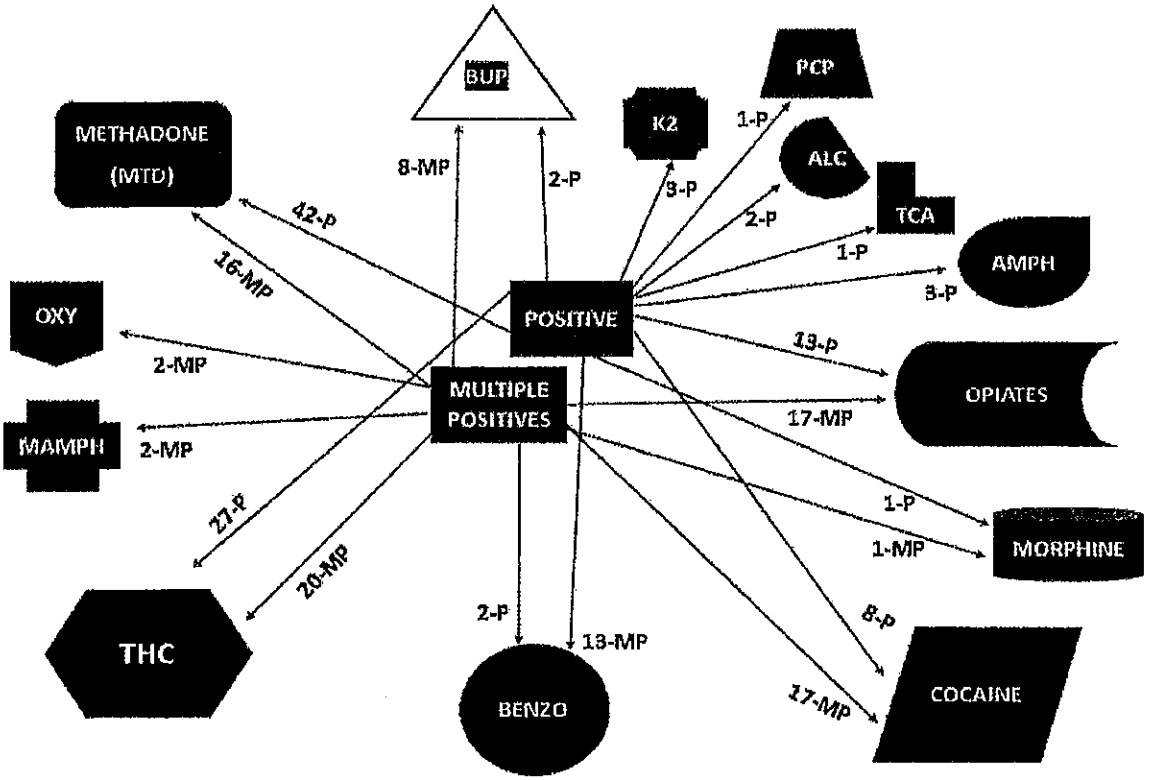
Frequency of Different Substances			
Substance Type	**Positive**	**Multiple Positives**	**Total Frequency**
THC	303	147	450
Opiates	107	109	216
MTD/Methadone	89	54	143
[redacted]	49	72	121
[redacted]	24	59	83
Buprenorphine	33	31	64
Alcohol	42	16	58
Amphetamines	13	12	25
[redacted]	8	15	23
Suboxone	7	5	12
MAMPH/Meth	4	6	10
Morphine	4	5	9
Spice/K-2	5	3	8
PCP	2	4	6
Barbiturates	1	5	6
TCA/Trcicycic Antidepressants	1	0	1
Valium	0	1	1
MDMA	0	1	1
CDP	0	1	1
Fake Urine Found	1	0	1

**yellow = more likely to show up as a single positive results
**blue = more likely to show up as a multiple positive results

"Most Susceptible Offenders" (Spreadsheet and Flowchart)

These individuals have been identified as "potential problem offenders" because they failed four or more urine analysis tests during 2015. Of the 938 positive UA results, 28 individuals account for 144 (15.4%) of the positive results (102 single positive tests and 42 multiple positive tests). The offender who had the most positive urines was Docket# 1578-2015 and this individual gave 5 single positive tests and 6 multiple positive tests; cocaine showed up in 6 out of these 11 tests, but MTD showed up in 10 out of 11 of these tests. Of these 28 offenders, 7 of them gave the same number or more "multiple positive" tests than they did single positive tests. Also, these 28 offenders were tested 220 times in 2015 and 144 of those tests were positive, which is a significant portion of those tests (65.5%).

Amongst these 28 offenders, Methadone (MTD) was most commonly associated with giving repeated positive tests; it is unknown whether or not these offenders were on the Methadone clinic or if they illegally obtained the drug; regardless, 58 of the 144 positive tests (40.3%) contained Methadone. Also, looking at the same cohort of offenders, Opiates were also associated with repeated positive tests (they were present in 30 of the 144 tests or 20.8% of the time). It is worth noting that 19 out of the 28 people had *not* tested positive for opiates during 2015. Additionally, 47 of the 144 cases (32.6%) contained THC and 20 of those 47 cases involved a multiple positive—meaning another drug. The next most frequent drug was Cocaine which was present in 25 of the positive results (17.4%). These percentages explain the drugs individually, not in the aggregate, so it is important to understand that 42 of the 144 positive tests contained multiple drugs. All of the Brown shapes below are insignificant.



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2015 APO Urine Analysis: 28 Most Frequent Offenders

Docket #	Postitive Frequency	Multiple Positive Frequency	Total Number of Tests Taken	TEST 1	TEST 2	TEST 3	TEST 4	TEST 5	TEST 6	TEST 7	TEST 8	TEST 9	TEST 10	TEST 11
31-2014	4	0	8	THC	THC	OPIATES	THC							
91-2015	6	1	15	THC	THC	THC	THC/COCAINE	THC	THC	THC				
125-2015	4	0	4	MTD	MTD	MTD	MTD							
149-2015	3	2	14	MTD	ALCOHOL	MTD	BENZO/MTD	THC/BENZO/ MTD/PCP						
228-2013	4	1	5	MTD	MTD	MTD	MTD	MTD/MAMPH						
287-2013	2	6	12	THC	THC/BENZO	THC/BENZO	BENZO	THC/BENZO	THC/BENZO	THC/BENZO	THC/BENZO			
306-2015	3	1	4	THC	THC	THC/OPIATES	OPIATES							
373-2012	2	2	4	THC	THC/BENZO/OXY	COCAINE/OPIATES	THC							
390-2015	4	0	6	THC	ALCOHOL	BUP	BUP							
636-2015	0	4	4	THC/MTD	THC/MTD	THC/MTD	THC/MTD							
741-2014	4	0	5	THC	THC	THC	THC							
820-2015	1	3	4	MAMPH/MTD	MTD	BENZO/MTD	BENZO/MTD							
1007-2013	8	0	8	MTD	MTD	MTD	MTD	MTD	MTD	MTD	MTD			
1036-2013	6	0	7	MTD	MTD	MTD	MTD	MTD	MTD	MTD				
1068-2015	3	3	6	THC	THC	THC/BUP	THC	THC/BUP/OXY	THC/BUP					
1140-2015	4	0	7	COCAINE	COCAINE	COCAINE	COCAINE							
1264-2014	4	1	7	OPIATES	OPIATES	OPIATES	MORPH	COCAINE/OPIATES /MORPH						
1323-2012	4	0	6	COCAINE	COCAINE	COCAINE	COCAINE							
1578-2015	5	6	11	COCAINE/ OPIATES/MTD	THC/COCAINE/ OPIATES/MTD	THC/COCAINE/ OPIATES/MTD	MTD	COCAINE/MTD	MTD	TCA	COCAINE/ OPIATES/MTD	MTD	COCAINE/ MTD	MTD
1640-2014	6	0	6	MTD	MTD	BENZO	MTD	MTD	MTD					
1785-2014	5	2	11	OPIATES	OPIATES	OPIATES	OPIATES	OPIATES	BENZO/OPIATES	COC/OPIATES				
1911-2013	4	0	11	K2	K2	THC	K2							
1938-2014	3	1	16	AMPH	AMPH/BENZO	AMPH	AMPH							
1972-2014	7	0	7	MTD	MTD	MTD	MTD	MTD	MTD	MTD				
2162-2012	0	7	7	OPIATES/BUP	COCAINE/OPIATES	COCAINE/OPIATES	COCAINE/ OPIATES/BUP	COCAINE/ OPIATES/BUP	COCAINE/ OPIATES/BUP	COCAINE/ OPIATES/BUP				
2165-2013	3	1	17	THC/OPIATES	OPIATES	OPIATES	OPIATES							
14465-2009	3	1	8	THC	THC	THC	THC/COCAINE							
Total	102	42	220											

Month * All Positives Crosstabulation

			All Positives		
			Negative	Positive	Total
Month	January	Count	180	75	255
		% within Month	70.6%	29.4%	100.0%
	February	Count	230	76	306
		% within Month	75.2%	24.8%	100.0%
	March	Count	255	95	350
		% within Month	72.9%	27.1%	100.0%
	April	Count	207	79	286
		% within Month	72.4%	27.6%	100.0%
	May	Count	216	72	288
		% within Month	75.0%	25.0%	100.0%
	June	Count	167	59	226
		% within Month	73.9%	26.1%	100.0%
	July	Count	212	98	310
		% within Month	68.4%	31.6%	100.0%
	August	Count	134	65	199
		% within Month	67.3%	32.7%	100.0%
	September	Count	177	70	247
		% within Month	71.7%	28.3%	100.0%
	October	Count	198	77	275
		% within Month	72.0%	28.0%	100.0%
	November	Count	151	80	231
		% within Month	65.4%	34.6%	100.0%
	December	Count	148	88	236
		% within Month	62.7%	37.3%	100.0%
Total		Count	2275	934	3209
		% within Month	70.9%	29.1%	100.0%

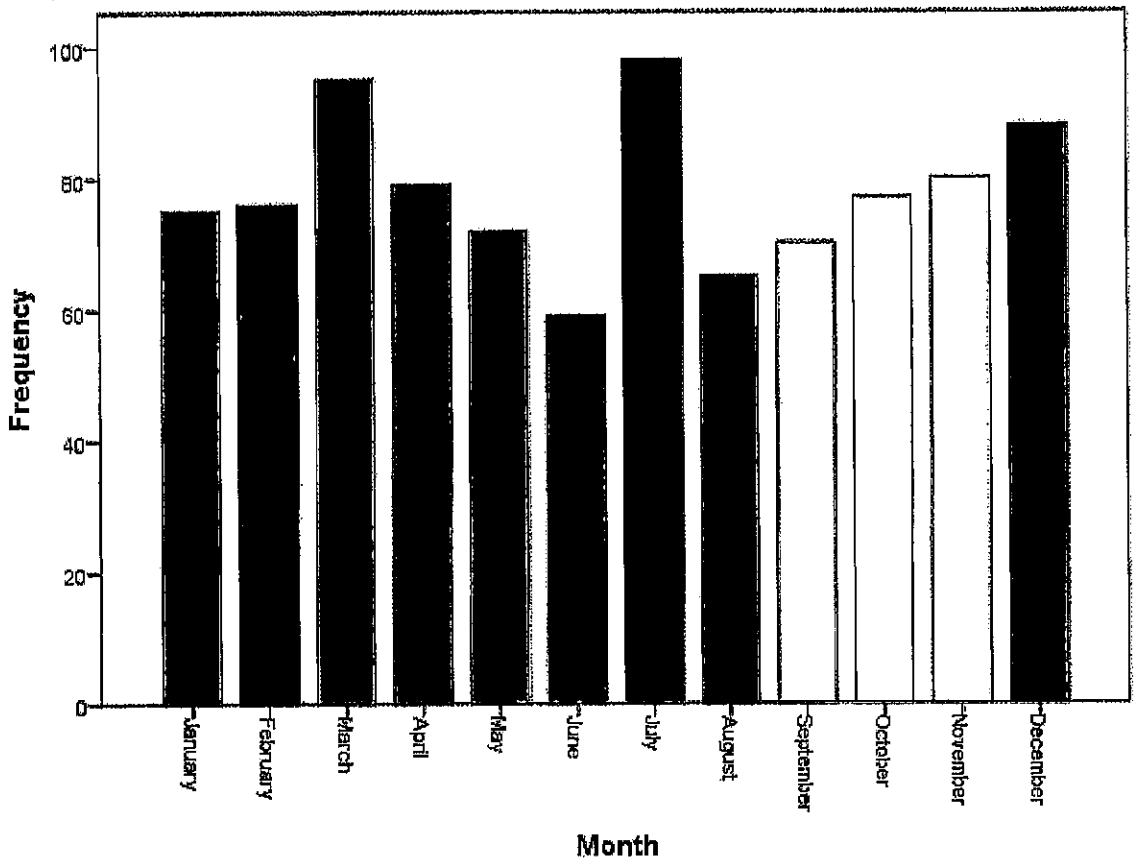
Frequency of Positive Test by Month (and Chart and Graph)

There were no discernible differences between months and the number of total positive urines (meaning both single and multiple positives). Although July contained the greatest number of positives (98), it was also the month where the most number of UA tests were administered (310).

December contained the greatest number of positive results in relation to total number of tests given that month—and this was statistically significant at the .05 level. Moreover, 37.3% of the tests in December were positive and 62.7% were negative. November produced the second greatest number of positive results in relation to the total number of tests administered that month; while this was not statistically significant, it was close to the .05 level. There were 34.6% positive tests and 65.4% negative tests in November.

The bar chart below is color coordinated by season to show the total number of positive UA tests by month. Red=Winter, Green=Spring, Blue=Summer, and Yellow=Fall. An ANOVA test (of statistical difference) was used to determine if there were any differences in the number of positives between seasons; but there were no significant differences.

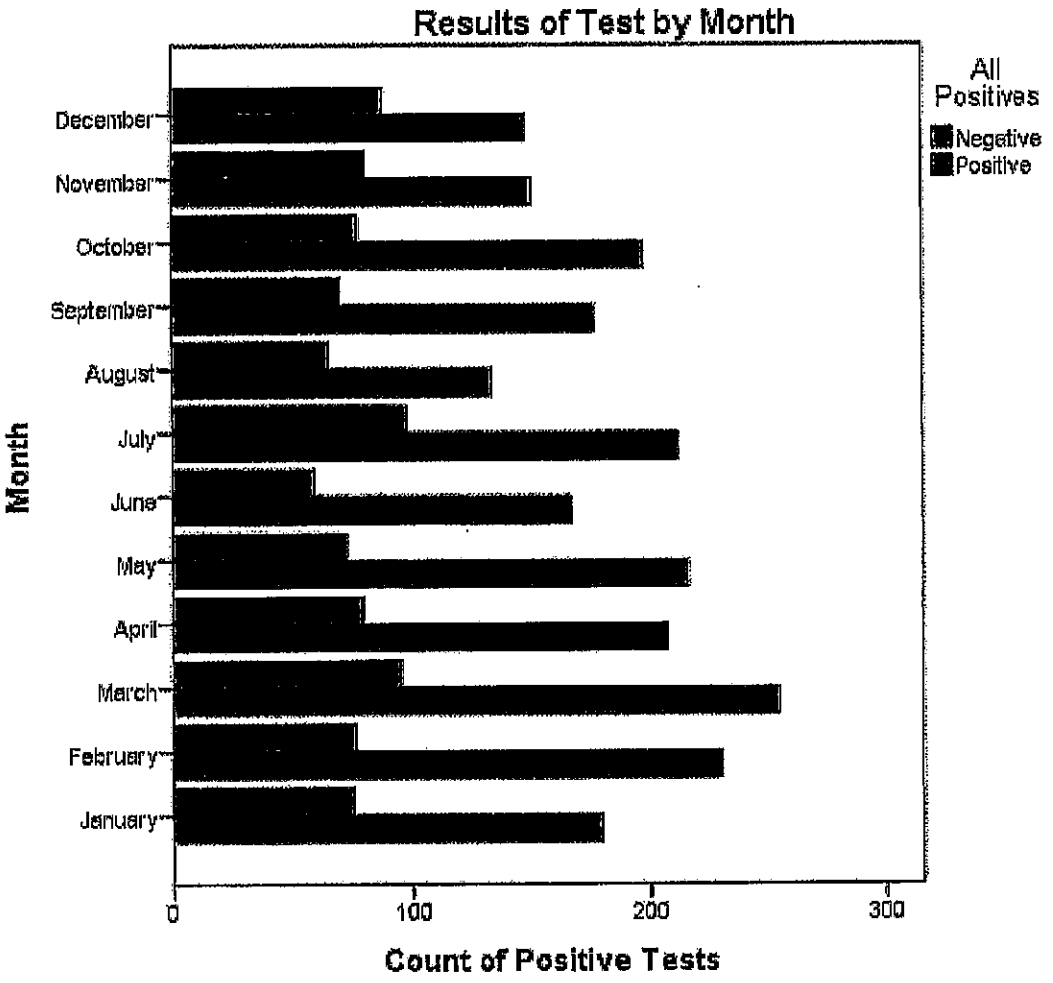
Frequency of Positive Tests by Month *(not in proportion to total number of monthly tests)*



This data was unable to tell us what time of the year offenders are most vulnerable to produce a positive UA test, but as mentioned there is *some* evidence that this would occur in December and maybe November.

The graph below displays the number of positive results in relation to the number of negative tests by each month. December and November produced the closest negative and positive numbers, suggesting that proportionately these months are likely to produce the greatest number of positive urine tests.

Frequency of Positive Tests by Month *(with reference to the number of negative tests given each month)*



Limitations to the Research

Unfortunately, with the way the variables are structured the researcher was unable to produce many statistical measures. In order to have better statistical measures Lycoming County APO would have to include more variables on the urine analysis sheets (i.e. offender's gender, race, socioeconomic or employment status, and criminal charge(s)). It may be impractical for APOs to enter this information on every urine analysis sheet, but this would be the only way for future research to predict any causal relationships (meaning x causes y; or x is highly correlated with y because of z). As mentioned previously, the researcher was also unable to determine which users who tested positive for Methadone were in Methadone clinics; knowing this detail would also allow APO to better gauge whether or not Methadone is being abused by offenders on probation.

With that being said, all of the findings above were still methodologically and theoretically significant.

BEFORE THE HOUSE REPUBLICAN POLICY COMMITTEE AND THE HOUSE DEMOCRATIC POLICY COMMITTEE JOINT HEARING ON PENNSYLVANIA'S DRUG ABUSE EPIDEMIC

AUGUST 30, 2016

WILLIAMSPORT, PENNSYLVANIA

TESTIMONY OF CHARLES E. KIESSLING, JR., RN, BSN, PHRN, CEN

LYCOMING COUNTY CORONER AND PRESIDENT

PENNSYLVANIA CORONERS ASSOCIATION

Good afternoon Chairmen Benninghoff and Sturla and Members of the Committees. My name is Charles E. Kiessling, Jr., RN, BSN, PHRN, CEN. I have served as the Lycoming County Coroner since 2000 and for the last eleven years have served as a flight nurse on the Geisinger Life Flight service. I have also been an EMT since 1978. (A complete bio is attached.) I am currently the President of the Pennsylvania Coroners Association with membership of the 64 county Coroners and the 3 county Medical Examiners. I am pleased to be here today to give you the PSCA perspective on the present drug epidemic in our Commonwealth.

Thank you for allowing me to appear here today to discuss this very important issue which not only affects the drug user, but also impacts friends, families, co-workers and society.

Along with my testimony I have included a copy of the 2015 PSCA Report on Drug Deaths, which had previously been emailed to all Legislators.

The CDC has stated that our country is in the midst of an overdose epidemic.

The New York Times quoted Dr. Hamilton Wright of Ohio stating "Of all the nations of the world, America consumes the most opium in one form or another. The habit has this Nation in its grip to an astonishing extent. ... The drug habit has spread throughout America until it threatens us with a very serious disaster." What is astonishing about these comments is not that they were said, but when they were said. These remarks were made in 1911 by the first appointed US Drug Czar (appointed by President Theodore Roosevelt).

Drug related deaths have continued to increase. In 2014 that number reached at least 2,489 individuals. The year 2014 showed an average increase of about 20% over the prior year for many counties. In 2015 the number of drug related deaths increased to 3,505 or a 30% increase over the prior year. If, initial data for 2016 is any indication, the number of deaths will continue to increase.

Ten (10) people die every day in Pennsylvania from drug related causes. Not known are the number of persons who overdose but survive. In addition, this number may be somewhat conservative since many hospitals will throw away admission blood after three days, leaving nothing to be forensically analyzed in case of death.

The age of the deceased ranges from under 2 months to 94 years of age. The majority of deaths are found in the age group 30 – 39 years old, but with the vast majority occurring between the ages of 30 – 49 years old. Men represent 2/3rds of the deaths. Deaths are split along racial lines in accordance with the percentages represented in the Commonwealth. The typical decedent is male, single, either never been married, divorced or widowed.

Most deaths are the result of multiple prescription drugs either alone or with the addition of heroin or cocaine, to a lesser degree. In addition, there has been a significant increase in the number of heroin deaths which were accompanied by the addition of fentanyl or acetyl fentanyl. Also, the use of cocaine to which levamisole has been added continue to increase. Lastly, there is an increase in the presence of THC found in marijuana and synthetic cannabinoids. The latter drug is also seen increasingly in statistics reported by the PSP on impaired driving. And it is now reported that the elephant tranquilizer, carfentenil, has been found in Ohio cutting the heroin. This drug is 1000 times more potent than heroin and presents a risk to Coroners, first responders, forensic pathologists, law enforcement and any who may come in contact with as much as a grain of salt size

of the drug which can be absorbed into the skin or accidentally inhaled. The immediate result is an overdose which will take several applications of Narcan to potentially overcome the effects.

Found in 14% of the toxicology reports of the drug related deaths are the opioids generally prescribed to treat addiction or overdose events, methadone, buprenorphine (found either as suboxone or subutex), naloxone, naltrexone. Methadone is prescribed in clinics under the regulation of the Substance Abuse and Mental Health Services Administration (SAMSHA) and the Pennsylvania Drug and Alcohol Programs. To prescribe buprenorphine, the prescriber only needs to secure a DEA authorization.

As stated by US Senator Tim Murphy at the beginning of hearings he is chairing into the issue of Examining The Growing Problem Of Prescription Drug And Heroin Abuse: State And Local Perspectives, March 26, 2015:

> "Buprenorphine can more safely maintain a person's dependence by reducing the need for illegal opioid use, such as heroin, and thereby the risk for overdose. But make no mistake, buprenorphine is a highly potent opioid, which according to SAMSHA, is 20 to 50 times more potent than morphine. So it is worth considering that our national strategy to combat substance abuse is to maintain addiction by either prescribing or administering a heroin-replacement opioid. ... And unlike clinics that administer methadone, there are no requirements for buprenorphine clinics to offer or even discuss non-addictive treatment alternatives, no requirement to develop treatment plans, no requirements to protect the public against it being diverted for illicit use."

Statewide drug related deaths occur throughout the year with a slight increase in October. (In 2014 the slight increase was in May.) Deaths generally increase on the weekends and 2/3rds of the deaths occur between the hours of 4 PM and 8 AM.

There are several ways in which these drug related deaths may be characterized and each requires a solution which considers the unique variables. There is the group of children either born with NAS or toddlers exposed to drugs and those drugs used for treatment who in error access them with fatal results. There is the group of teens and younger adults who are experimenting with drugs, perhaps as a matter of peer pressure. There is the vast majority of adults who perhaps believe that the American Dream has passed them by, have become addicted and see no clear path to recovery or have been unable to readily access the means of recovery. There are the elder citizens who are generally not experimenting with illegal drugs but are overdosing on prescribed medications. And, lastly, there are the veterans who have volunteered to serve our country and who come home with medical issues and mental health issues for which they have been receiving inadequate treatment in the form of a cocktail of drugs – a sleeping pill, anti-anxiety medication, an anti-depressant, and an anti-psychotic and sometimes, even a stimulant.[1]

While the Federal Mental Health Parity Law requires parity for addiction treatment, that parity remains elusive. There are insurance companies who don't do admitting paperwork on a weekend, there are a scarcity of pain management practices or clinics, and there is an apparent lack of facilities with beds to provide long term treatment or to accept mothers with their small children, so as to not needlessly further tear apart families during the healing process.

Perhaps an example will clarify the lack of parity further. In the first example,

[1] *The Military's Prescription Drug Addiction,* The American Conservative, Kelley Beaucar, October 3, 2013

--- you suffer shortness of breath and collapse. A family member gets you to the hospital. While in the ER you are told you suffered a heart attack. Now imagine that the next response is to hand you a brochure giving you a list of cardiologists, their phone numbers and their addresses. You are told you should make an appointment to see one of them and discharged. Sounds ludicrous and it doesn't happen.

In the second example,

-- you suffer a drug overdose and are taken to the ER. You are successfully revived. The next response is that you are handed a brochure giving you a list of addiction treatment programs, their phone numbers and addresses and told you should give one of them a call. Sounds ludicrous. Unfortunately it happens all the time. Does anyone honestly believe the brochure makes it much further than the exit door? And, if someone is actually motivated enough to make a call, they may be told they can be seen in 2 days or 2 weeks or more.

The Legislature should look at the establishment of having addiction counselors immediately available to talk with the addict to encourage treatment and provide an immediate bridge to treatment.

There needs to be a stronger tying of an overdose incident with the treatment process. It needs to be remembered Narcan must be administered on a timely manner, it may not work with synthetic opioids, or if heroin is cut with other drugs, such as, W18. Heroin can outlast the Narcan and require re-dosing or manually taking over respiratory support for the person. Even if you give Narcan, you should still call 911. Otherwise, this safety net may be made out of tissue paper.

Since we don't have any data on the number of times Narcan is given to a person, I can only say anecdotally that Coroners hear reports from first responders, law enforcement and others of too many cases like the following:

An individual was brought into the ER for an overdose, was revived and left the ER. The person got high again, overdosed and was brought back to the same ER only 7 hours later.

This leads to the realization that Narcan, on the one hand can save a life and the person may decide they have hit rock bottom and seek help. On the other hand, Narcan merely becomes an enabler allowing the person to seek the next high. It becomes Russian roulette. Will the addict be saved and seek treatment or not? Narcan can be only a change in the date of death.

The Legislature should review the possibilities of involuntary civil commitment for an addict. Studies have shown no difference in treatment outcome rates for voluntary or involuntary commitments to a treatment facility. There are Constitutional rights which will need to be addressed. Involuntary commitments have been found to meet Constitutional requirements when the person who is suffering addiction is fully involved in the process. An example might be:

> (1) A family member, friend, doctor, clergy, or member of law enforcement may petition the court for the civil commitment of a substance dependent individual.
> (2) A hearing shall occur during which:
> (a) the respondent is present; and
> (b) the respondent may be represented by counsel of his choice; if the respondent is indigent, counsel shall be appointed to represent him; and
> (c) the respondent's counsel represents the interests of the

respondent in an adversarial fashion, including but not limited to cross-examination of state witnesses and production of expert and non-expert witnesses on behalf of the respondent.
(3) If the court finds by clear, cogent, and convincing evidence that the respondent is a substance dependent individual and as a result of the substance dependence is dangerous to himself or others, it shall order for a period not in excess of ninety days commitment to and treatment by an inpatient facility.
(a) "Dangerous to oneself" is defined as actions in the relevant past which indicate a substantial risk of physical harm to oneself, including threats or attempts of suicide or serious bodily harm or other conduct demonstrating that the person is a danger to himself.
(b) "Dangerous to others" is defined as actions in the relevant past which indicate a substantial risk of physical harm to other persons, including homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.

And while we are fortunate to have Congressman Marino here today, I would like to mention the need that we have discussed to not treat prisons as a substitute for treatment. Our prisons are ill-equipped to provide necessary addiction treatment. When a person leaves prison he or she will likely try to get high again based on the same amount of drugs as when they entered prison. The likely result is death.

Also, the Congressman is encouraged to do all he can to stop the CMS Final Rule, CMS-2390-P. This rule takes away flexibility from the Medicaid managed care patients by arbitrarily providing a 15 day monthly limit on patients in residential addiction treatment facilities. Staying longer will result in the loss of Medicaid coverage for addiction treatment **and the loss of coverage for any more general medical needs, like treatment for diabetes, hypertension or cancer.** Congress needs to act.

There needs to be a scalpel brought to the discussion of broad based policies to stem the tide of this drug pandemic. Take for example, an elderly women who has been diagnosed with pain generating medical issues. She has been given a prescription to relieve the pain while waiting 4 months to get another appointment with a specialist. This prescription is only valid for two weeks. After two weeks she has to get a relative to take her to the doctor to get another two week supply. She has no diagnosed tendencies to abuse or divert the drugs for another use, she has been caught in a system to try to stop abuse.

Another example is a mother with a child who has been diagnosed with ADHD. She can get a thirty day supply of the needed drugs, but to get a refill she must travel at least half an hour and on the precise day the prescription runs out to get a refill. Again, there are no indications of drug abuse or diversion of the use of the drugs for another purpose, she has been caught up in a one-size-fits-all system to stop drug abuse.

Can we not trust any of our physicians to exercise judgment in filling prescriptions? Shouldn't the ABC-MAP Act of 2014 provide the information necessary to catch those who would abuse their ability to prescribe?

Another obvious conclusion from reviewing the data relates to the number of drugs found in an individual's toxicology. While the average number of drugs in a toxicology assessment, both prescription and illegal, is about 3 per person, there are too many instances where an individual may be found with multiples of a classification of drugs. An example is the toxicology of one individual who had five antidepressants in their toxicology. Why would anyone take such multiples of one type of drug? Perhaps part of the answer may be found in the current use of drugs for off-label purposes. For example, antidepressants are prescribed by various physicians for treatment of

Charles Kiessling is a registered nurse who graduated from the Williamsport Hospital School of Nursing (1984) and completed his Bachelor of Science in Nursing from Lycoming College (1997) in Williamsport. He worked as an emergency room nurse at Williamsport Hospital for 21 years and for the past 11 years as a flight nurse with the Geisinger Life Flight Program. Charles served as Deputy Coroner in Lycoming County from 1986 and was elected Lycoming County Coroner since 2000. Charles has been and EMT since 1978 and active in volunteer fire and EMS serving as Assistant Chief with the Old Lycoming Twp. Vol. Fire Company. Charles is President of the PA Coroner's Association and Liaison to the PA Coroner's Education Board. He is a member of the International Association of Forensic Nurses, the National Emergency Nurses Association, the International Association of Coroners and Medical Examiners. He established the first Child Fatality Review Team in Lycoming County in 2001 and has been an active member of Safe Kids Lycoming County appointed to as serve as Chair in 2011. Charles established the Lycoming County Cribs for Kids Program in 2008 providing cribs to needy parents throughout Lycoming County. Charles has actively promoted Safe Sleep Practices for infants through various public education programs. He has supported the efforts of PA Representative Garth Everett prompting the PA House of Representatives to recognize November as "Infant Safe Sleep Month" for years 2010, 2011, 2012, 2013, 2014 & 2015 which has provided media coverage to promote safe sleep awareness.

Certifications held:

Board Certification in Emergency Nursing (CEN)

Prehospital Registered Nurse (PHRN)

Advanced Cardiac Life Support (ACLS)

Pediatric Advanced Life Support (PALS)

Neonatal Resuscitation (NRP)

PA Firefighter I

Pennsylvania Association of County Drug and Alcohol Administrators

An Affiliate of the County Commissioners Association of Pennsylvania

Testimony presented to the Democratic and Republican Policy Committees

August 30, 2016

Lycoming College, Williamsport, PA

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The following remarks are submitted on behalf of PACDAA, the Pennsylvania Association of County Drug and Alcohol Administrators. PACDAA members are the Single County Authorities (SCA's). The SCA receives state and federal dollars through contracts with the Department of Drug and Alcohol Programs (DDAP) to plan, coordinate, programmatically and fiscally manage and implement the delivery of drug and alcohol prevention, intervention, treatment and recovery support services at the local level. SCA's also receive funding from the Pennsylvania Department of Human Services, (DHS), through the Office of Mental Health and Substance Abuse Services (OMHSAS). The Services funded by DHS are primarily targeted to individuals in non-hospital residential care who are eligible for Medical Assistance or to a continuum of treatment services for those individuals who are no longer eligible for Medical Assistance as a result of welfare reform.

The current opioid epidemic presents one of the greatest challenges ever faced by our communities. Medicaid expansion presents an opportunity to respond to individuals and families who face addiction and to improve outcomes for long term recovery. In light of the current crisis and opportunities of Medicaid Expansion, the role of the SCA is evolving and in some ways, we are redefining the way we do business. The SCA is uniquely positioned to assess the needs, support the community partnerships, build capacity, assist with the planning and implementation of resources and provide monitoring to ensure quality of service. I would ask that each legislator take the opportunity to introduce yourself to your SCA administrator and begin to have an open dialogue regarding the specific needs within each of your respective legislative districts.

I am Cheryl Andrews. I am the SCA Administrator for Washington County. On behalf of the PACDAA membership, I appreciate the opportunity to comment on several items that the organization strongly encourages the legislature to consider as we begin to change the conversation from problem to solution.

Training for Physicians

Mandated training, not recommended, but mandated training for physicians, including dentists which would cover safe prescribing, substance-use disorder identification and intervention strategies. Physicians in a laboratory setting

should be considered exempt from mandated prescribing training since they do not have patients nor do they prescribe medications.

Training for First Responders

Mandated training on addiction for first responders—to include EMS, law enforcement, and fire departments should also be considered in order to increase understanding of the addiction process and the brain chemistry. Currently, many first responders do not understand why an overdose victim appears ungrateful upon revival and often times refuse transport to the hospital as well treatment options that are offered. This coordinated rapid response training protocol could be part of a comprehensive solution that would improve the "warm handoff" and increase the number of overdose survivors who engage in treatment.

Overdose Reporting

Consistent reporting of overdose death data is the key to informing public health and public safety prevention and intervention efforts, more importantly, there is a need for overdose survivor data. SCA's would like to see strong policy, protocol, and process to acquire real-time overdose survivor data. Data on overdose episodes, which do not result in a death, should also be collected by all Emergency Medical Services (EMS) and hospital emergency departments and possibly integrated into a database. This information will allow the SCA to better target and determine intervention strategies

Evidence Based Prevention Programs

A comprehensive response to the epidemic includes evidence-based prevention programs. We need to address the need for quality K-12 prevention curriculum. Many schools are apprehensive to include such programs. A program called, "Life Skills" was offered for free to every school district and only an estimated 10 percent of school districts adopted the program. Another valuable tool with school-age children is the Student Assistance Program (SAP). We should refocus and prioritize the function and core principles of SAP teams.

Centers of Excellence (COE) and Expansion of Medication Assisted Treatment (MAT)

The SCA needs to learn more about their role in the implementation of the Centers of Excellence. The concept of the COE is commendable; however, as details unveil, it appears that some of the responsibilities of the COE have historically been carried out by the local SCA. COE's have the potential to be an effective community partner, but in reality, we still continue to face shortages of beds for detox and rehabilitation.

Involuntary Commitment

The options for involuntary commitment or mandatory assessment for overdose survivors is very complex and much consideration should be given before pursuing these options. Criminalizing addiction could be an unintended consequence of building this type of system. Pennsylvania does not currently have secure or lock down treatment facilities that would inevitably be required for such a mandate. Perhaps an alternative to this concept would be a detox crisis diversion unit, much like we see within the mental health system. These units could be stand-alone detox centers or units embedded within a hospital that would provide a detox protocol. This crisis diversion center would allow for a longer window of time for the SCA to deploy the intervention, conduct an assessment, determine treatment needs and make the appropriate referral. Many OD survivors are in active and aggressive withdrawal and really need medical attention and monitoring until the SCA can make the appropriate referral.

Drug Courts/Specialty Courts

For over two decades, Drug Courts have led the charge towards a more humane, cost effective justice system. Research demonstrates that Drug Courts provide a highly effective alternative to incarceration for individuals whose involvement in the criminal justice system is rooted in serious addiction to drugs and alcohol. By keeping drug-addicted offenders out of jail and in treatment, Drug Courts have been proven to reduce drug abuse and crime while saving money. Drug Court Programs work with clients on an average of eighteen months. In Pennsylvania, we actually have funding constraints that limit our impact. Again, the SCA provides valuable service to this multi-disciplinary approach through case management and recovery supports, yet receives little to no funding to do so.

Loan Forgiveness/Continuing Education Incentives

Burnout and turnover rate among drug and alcohol professionals is staggering. It's easy to see why those of us who work in Human Services field burn out. We have excessively large caseloads with an ever-shrinking resource budget available to assist our clients. This tight budget also forces us to work under the constant fear of downsizing and the potential threat of job loss. Some of us are subjected to forced overtime, on-call after hours, and other schedule imbalances which blur the distinction between time at work and time off. We face overwhelming caseload numbers. Despite working at a frantic pace, our efforts are frequently not appreciated by management or clients. We need to find ways to attract quality workers and keep them. We need to pay competitive salaries and provide other means such as loan forgiveness or continuing education options.

Funding Silos

For the better part of the last 2 decades the SCA and other drug and alcohol professionals have struggled to break down silos in the systems of healthcare, mental health, public funding, criminal justice, and the court system. Every system seems to be offering a remedy to this epidemic, often times, at the exclusion of the very department that was created to be the single driver for all substance use related policy—Department of Drug and Alcohol Programs. In order to bring about effective change, the role of DDAP should be expanded and the SCA should be the conduit for the efforts and funding at the local level. The money to "treat" this epidemic already exists within our state government, it is simply a matter of which direction in which we will channel it.

Thank you for the opportunity to provide testimony today.

PINNACLE TREATMENT CENTERS

TESTIMONY

of

Chris Byers

Regional Director

Pinnacle Treatment Centers

Joint House

Republican Policy Committee

Democratic Policy Committee

on

Pennsylvania's Drug Epidemic

August 30, 2016

Lycoming College

Williamsport, PA

Good afternoon, Chairman Benninghoff, Chairman Sturla and distinguished members of the joint Policy Committee. My name is Chris Byers and I'm the Regional Director for Pinnacle Treatment Centers(PTC). PTC has expanded to provide facilities throughout Pennsylvania, as well as in New Jersey, Indiana, Kentucky, Virginia, Ohio, Minnesota and Michigan. PTC provides residential, outpatient and transitional living programs and is CARF accredited. All of our locations include physicians, nurses, clinicians, administrative and support staff. Our facilities provide drug addiction treatment and services at over 20 facilities to more than 8,000 adults daily. In Pennsylvania, our facilities operate in 18 locations across the Commonwealth, including one in this region, as Representative Wheeland is well aware, at Williamsport Family Medical.

The first step in recovery regardless of modality is acknowledging that there is a problem. Pennsylvania has taken that first step in acknowledging that there is a plague named opiate addiction destroying thousands of lives and costing the commonwealth millions of dollars. The leadership of Pennsylvania has not stopped at acknowledging the problem it has also begun to take action. This hearing and those like it going on around the state, are actions being taken by legislators to gain insight to the depth of the issue and knowledge of how they can help their constituents who are suffering every day. Medicaid expansion has improved access over the past year and a half. The development and implementation of Prescription Monitoring system is a big step forward for the State. Pennsylvania was a leader in getting access to the overdose reversal drug kits available to the public. The awarding of the Centers of Excellence funding to fund programs to educate the community, link treatment modalities and act as a referral hub to assist those in need with finding the right level of care for their problem is another action step taken by leaders like you. Pinnacle Treatment Centers, looks forward to working with the other agencies in the area of our facilities across the state to fill their part of the continuum of care. Thanks to the legislature's support in the last budget cycle Pinnacle was recently awarded 2 Centers of Excellence and is working at this time to develop the network of community supports to assist patients with accessing the resources of their community to meet their needs. All of these steps have challenges but I am thankful that the legislature has the foresight and courage to take action as well as the commitment to continue to address this issue on an ongoing basis.

In operating 18 Medication Assisted Treatment programs across the state, over the past 9 years the leadership of Pinnacle Treatment Centers has been on the frontlines fighting the spread of this epidemic. One thing has been evidently clear throughout time, recovery is a beautiful thing and those lives that are saved and reclaimed are why we take on these challenges every day.

I would now like to outline some of those challenges and ideas to eliminate barriers to care in which state and federal officials can work with us toward resolving this epidemic.

ACCESS -

There are a number of policies that impact access to care that occur at some of the most vulnerable times when patients are seeking treatment and recovery.

Lab Tests: The requirement of methadone facilities to have Lab confirmed UDS results back prior to beginning treatment is delaying patient access to care for 24 to 72 hours and keeping patients at high risk for relapse and overdose. If an onsite Urine dip test or instant test were permitted for screening and admission would increase access for patients in the critical time frame that they are ready to take action. This action is not required of those seeking other medication assisted treatment options, despite the patient receiving prescriptions for a 7 to 30 day supply at the first visit of these other medications.

Counselor Ratios: We have a required patient-counselor ratio of 35 to 1. It is one of the lowest in the nation. This ratio also creates caps on facilities that are lower which limits access to new patients.

Public Transportation: Public transportation and ride services are limited in the rural areas creating issues getting to and from facilities and meeting requirements.

This is further compounded by Pennsylvania's more restrictive take home policies which require more frequent visits and can limit patients ability to move toward gainful employment.

Drug Classification: Vivitrol being classified under medical rather than behavioral health creates barriers to outpatient facilities being able to serve as follow up injection sites.

SILOS -

Pennsylvania has more restrictive confidentiality guidelines than the current Federal Standards. This extra restriction adds to the silo effect of treatment rather than a comprehensive multidisciplinary approach to treating the client. They are looking at reducing restrictions at the Federal level if Pennsylvania doesn't follow suit the gap will widen making it more difficult for those needing care from more than one entity. As our Centers of Excellence develop they can make huge strides to allowing for full coordination of care and access to all needed services.

PREGNANCY AND INCARCERATION -

We cannot "jail away" the problem of addiction. Studies have shown savings for each dollar spent in treatment produce a societal savings of up to $14.

The jail systems are not capitalizing on the opportunity to treat inmates and reduce recidivism. Having those opiate addicted individuals in a controlled environment would allow for initial Vivitrol injections to be administered prior to release reducing relapse and recidivism. Inmates

who are addicted to opiates are typically not treated in the jail setting unless they are pregnant and then only until giving birth then are cut off cold turkey and made to suffer needlessly.

Additionally, we wanted to let you know that Pinnacle has partnered with the Childrens Institute in Pittsburgh to educate pregnant and mothering patients. The program can reduce NICU stays, allow for higher engagement and attachment with the mother and child. Partnerships like this will increase patient and provider awareness of what to expect and create improved care for all those involved. Again, this is an area where The Centers of Excellence projects will foster partnerships and linkages for this kind of collaboration to be successful.

Thank you again for your attention to this issue and for hearing the perspective of the providers who deliver the treatment. The leadership team at Pinnacle looks forward to working with you on the policy changes proposed in my testimony. We welcome a continued dialogue with actionable steps toward resolving this health crisis in the Commonwealth.

Geisinger

Testimony on Drug & Alcohol Addiction with a Focus on Opioid/Heroin Abuse
By Dr. Margaret Jarvis, Marworth Alcohol & Chemical Dependency Treatment Center,
Geisinger Health System
August 29, 2016

Thank you for the opportunity to provide written comments on drug and alcohol addiction, with a focus on opioid abuse. My name is Margaret Jarvis. For the last 16 years I have been the Medical Director for Marworth, an alcohol and chemical dependency treatment center which is part of the Geisinger Health System and located just north of Scranton in Waverly. I am also a psychiatrist who has taken care of addicted patients for my entire career. I completed all of my training, including a fellowship in Substance Abuse Medicine, at the Medical College of Virginia in Richmond. I would like to thank the General Assembly for the opportunity to share my experience and professional input on drug and alcohol addictions.

We are all reminded, on a daily basis, of the extent of the opiate epidemic, both in the numbers of people affected and the tolls taken in those lives. As you have heard in other testimony, there have been contributions to this epidemic from the prescription of medications used for pain. These practices started with well-intentioned campaigns to alleviate pain. Sadly, at the time that this started and to the present day, we do not know enough to be able to predict vulnerability to substance use disorders to continue these prescribing practices without consequence. Many physicians, and most especially primary care doctors, have been put into the position of being expected to alleviate pain, avoid contributing to addiction and to do this in less-than-15-minute office visits without having expertise in either pain or addiction. It truly is no wonder that we have arrived at this moment.

I am often asked by primary care physicians how they can get their patients off of opiates and other addicting medications. They don't have the tools or the infrastructure to do so, in most cases, and they are frustrated and disheartened by this. They know that their patients have an illness that they are unprepared to treat. Changes like the Prescription Drug Monitoring Program can help identify patients who are having behavioral problems around medication, and can help contain those behaviors. This will be useful to many primary care physicians.

Addiction specialty care is often not readily available, and the channels through which referrals are made to addiction specialty care are different than when the referral is to "medical" specialty care such as cardiology. This makes it that much more difficult for the primary care physician to get an addicted patient into treatment. Even if those referrals are consistently made, we know that the specialty physician workforce is nowhere near the capacity it needs to be in order to address this problem.

I hope that you will consider supporting physician education about the disease that is ravaging our country, especially at the level of specialty training. There has been much talk of continuing education training that could be associated with state or DEA licensing, and concern has been raise that this would be consciousness raising, at best, without much true transfer of knowledge. There has been debate about training associated with expansion of the number of buprenorphine patients an individual doctor

might have, and while that may go some way to address the current epidemic, it will not be so useful if the next epidemic is one of sedative-hypnotic drugs or stimulants.

Currently, there are 39 addiction medicine fellowships and 43 addiction psychiatry fellowships across the country. The American Board of Addiction Medicine has been working hard over the last 10 years to expand the number of fellowships, and to gain recognition by the American Board of Medical Specialties, and has been quite successful with this. Now, we need to encourage physicians to take advantage of these training opportunities, perhaps through loan forgiveness programs or other ways. We need these doctors to be able to lead teams of nurses, counselors and other healthcare professionals. We also need these specialist physicians to work side by side with other physicians in emergency departments, hospital wards and clinics. By seeing that addicted patients can be treated, that treatment can be successful, other doctors not only start to pick up the technical points of treatment, they can develop compassion for the addicted patient. By having a cadre of well-trained addiction specialist physicians, we can be address the current opiate epidemic and be prepared for the next chemical that gains popularity.

Emphasizing the need for specialty training, with attendant professionalism, quality improvement and maintenance of certification can also address the growth of untoward, often unethical, so-call addiction services where buprenorphine is prescribed in ways that are not therapeutic and can be quite harmful. Given the choice of sending patients to physicians whose only addiction training has been the 8 hours needed to get an x-waiver or to specialists who have had at least a year of training, most primary care doctors, health system administrators and insurers would prefer to see patients receiving true specialty care. Many geographic areas don't afford that kind of choice.

Marworth/Geisinger has had an addiction medicine fellowship since 2007, and the first person to complete the fellowship has returned to be the fellowship director. All of the doctors who have completed the training have gone on to gain certification from the American Board of Addiction Medicine. We are very proud of our graduates, and we see them doing great things to take care of addicted patients across the country. We would believe that they are the doctors who will ultimately make addiction a disease that is treated in the same way that diabetes, coronary artery disease and schizophrenia are treated

We look forward to continuing to work with the state legislature, state agencies, and the Administration on developing smart healthcare policy that supports improving the experience of healthcare, improving the health of populations, and reducing per capita costs of healthcare.

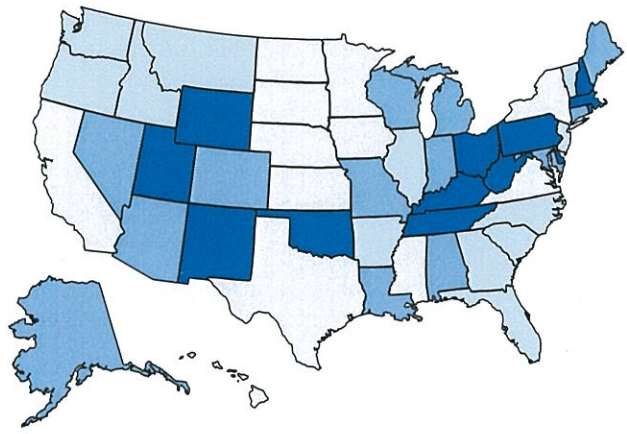
Thank you.

The Opioid Epidemic: By the Numbers

Our nation is in the midst of an unprecedented opioid epidemic. More people died from drug overdoses in 2014 than in any year on record, and the majority of drug overdose deaths (more than six out of ten) involved an opioid.[1] Since 1999, the rate of overdose deaths involving opioids—including prescription opioid pain relievers and heroin—nearly quadrupled, and over 165,000 people have died from prescription opioid overdoses.[2] Prescription pain medication deaths remain far too high, and in 2014, the most recent year on record, there was a sharp increase in heroin-involved deaths and an increase in deaths involving synthetic opioids such as fentanyl.

Prevention, treatment, research, and effective responses to rapidly reverse opioid overdoses are critical to fighting the epidemic—a top priority for the U.S. Department of Health and Human Services (HHS). In March 2015, HHS Secretary Sylvia M. Burwell announced an initiative targeting three priority areas to tackle the opioid epidemic and help save lives. These include: improving prescribing practices, expanding access to and the use of medication-assisted treatment, and expanding the use of naloxone.

Drug overdose death rates, United States, 2014*



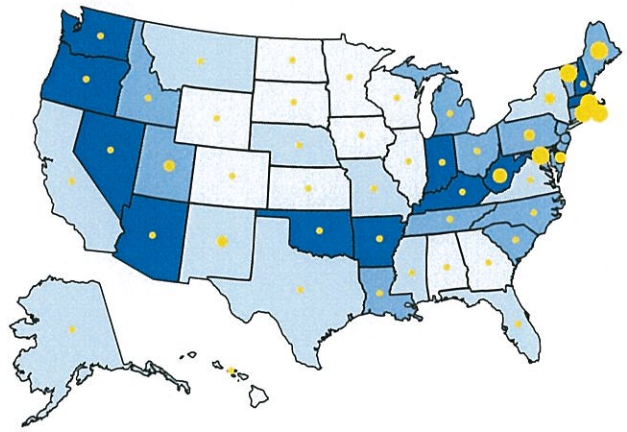
Drug overdose deaths per 100,000 population

- 6.3 - 11.7
- 11.9 - 14.4
- 15.1 - 18.4
- 19 - 35.5

*Age-adjusted death rate per 100,000 population

Source: CDC National Vital Statistics System

Rate of Past Year Opioid Abuse or Dependence* and Rate of Medication-Assisted Treatment Capacity with Methadone or Buprenorphine



Rate per 1,000 persons aged 12 years and older

Rate of dependence

- 3.4 - 6.4
- 6.5 - 9.2
- 9.4 - 10.3
- 10.8 - 12.9

Treatment capacity

- 0.7 - 3.0
- 3.2 - 4.3
- 4.4 - 7.2
- 7.3 - 16.5

*Opioid abuse or dependence includes prescription opioids and/or heroin

Source: AJPH 2015;105(8):e55-63.

Economic Impact of the Opioid Epidemic:

- **$55 billion** in health and social costs related to prescription opioid abuse each year[1]
- **$20 billion** in emergency department and inpatient care for opioid poisonings[2]

Source: Pain Med. 2011;12(4):657-67.[1]
2013;14(10):1534-47.[2]

On an average day in the U.S.:

- More than **650,000 opioid prescriptions** dispensed[1]
- **3,900 people** initiate nonmedical use of prescription opioids[2]
- **580 people** initiate heroin use[2]
- **78 people** die from an opioid-related overdose*[3]

*Opioid-related overdoses include those involving prescription opioids and illicit opioids such as heroin

Source: IMS Health National Prescription Audit[1] / SAMHSA National Survey on Drug Use and Health[2] / CDC National Vital Statistics System[3]

1. CDC, MMWR, 2015; 64;1-5.
2. CDC Vital Signs, 60(43);1487-1492