**CENTER FOR RURAL PA PUBLIC HEARING**
**OPIATE ABUSE TREATMENT AND RECOVERY SERVICES**

York, PA

August 18, 2015

Hello. My name is Jack Carroll, and I'm the Executive Director of the Cumberland-Perry Drug and Alcohol Commission. Our agency is responsible for managing public-funded substance prevention, intervention, and treatment services for the residents of our two-county area. I appreciate the chance to offer comments today on behalf of Cumberland and Perry Counties, and also on behalf of other county drug and alcohol administrative units.

I'd like to start by thanking the Center for Rural PA for the previous series of public hearings about the heroin problem that you conducted last year. Those hearings and the report that was produced were instrumental in raising public awareness and in educating members of the General Assembly about the extent of the opiate abuse problem in our state. The hearings helped to generate overwhelming bipartisan support for three pieces of legislation enacted last fall that are important new components of Pennsylvania's public policy response to the opiate epidemic:

- Act 139 of 2014, the Good Samaritan overdose legislation that greatly expanded access to naloxone throughout the state;
- Act 191 of 2014, the new law which expands and strengthens Pennsylvania's prescription drug monitoring program; and finally
- Act 184 of 2014, which revised the rules for dispensing medication through our state's Workman's Compensation Program, and imposed stricter limits on the quantities of prescription painkillers that could be prescribed and dispensed by physicians.

Although these new laws are important first steps, most of the hard work is still ahead of us. Our country's current opiate epidemic is the result of a four-fold increase in sales of opioid painkillers, combined with a street supply of heroin that has never been more potent, and has never been cheaper. These patterns developed over a period of 10 to 15 years. We're simply not going to solve it overnight, and no single county or statewide agency will be able to solve it alone. We need a comprehensive, coordinated, and sustained response in order for us to reverse current trends.

In Cumberland and Perry Counties we've identified the following as key elements to a comprehensive response:

- **Reduce the oversupply of opioid pain medication flooding our communities;**
- **Make naloxone, the anti-opiate overdose antidote, more widely available to first responders and other community partners;**
- **Identify, screen, and divert non-violent addicted offenders into treatment; and**

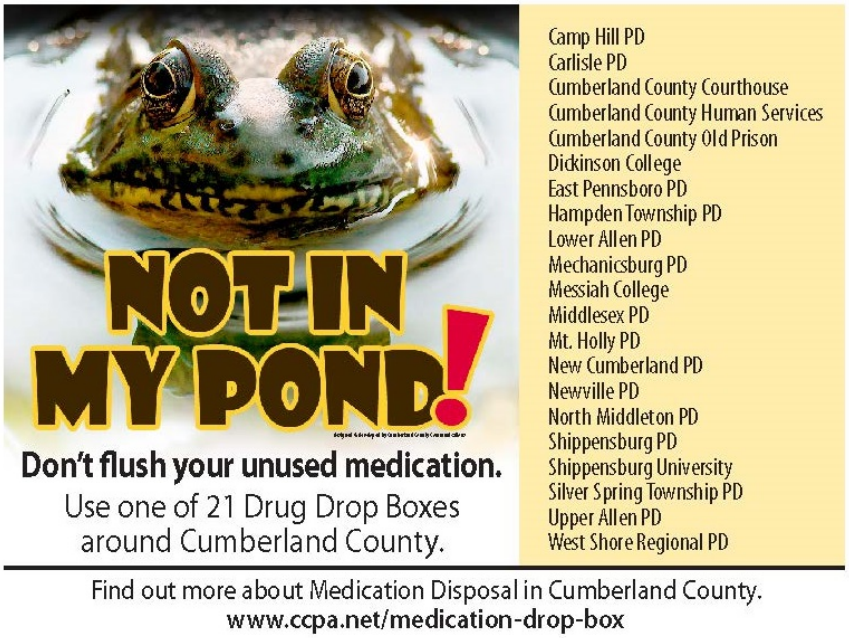
- **Increase access to a full continuum of substance abuse treatment and recovery support services.**

Here's a brief description of some of our local efforts in each of these areas:

**REDUCING THE OVERSUPPLY OF OPIOID PAIN MEDICATION**

1) Promotion of Medication Take-Back Boxes – In Cumberland County, through the leadership of our District Attorney Dave Freed, and the cooperation of local police departments we have 21 different Medication Take-Back Boxes placed throughout the county. Through community presentations, town hall meetings, and the dissemination of promotional materials we are strongly encouraging residents of both of our Counties to use these boxes to safely dispose of their excess medication.

   In Cumberland County we have a Community Opiate Overdose Prevention Coalition that has teamed up with our County's Recycling and Waste Authority to promote use of the Take-Back Boxes. We've found considerable support from environmental organizations concerned about the negative effect that flushing medications is having on our waterways. Here's an example of one of our promotional messages:




2) Training for Physicians – Thus far we have conducted two training workshops for physicians to encourage them to use the best practice guidelines for prescribing prescription opioid painkillers that have been produced by the state's Safe and Effective Prescribing Practices and Pain Management Taskforce. The PA Medical Society deserves recognition for the central role it has played in developing and promoting these guidelines. Much additional

training is needed for medical practitioners: to help change current prescribing practices; to provide tools for identifying patients with opiate abuse disorders, and then providing these patients with brief intervention and referral services; and to help patients with chronic pain implement pain management strategies that minimize the chances of developing an addiction.

3) Implementation of Act 191 of 2014 – Although this new law strengthening Pennsylvania's Prescription Drug Monitoring Program was enacted in October 2014, funds were never allocated for its implementation. We are behind many other states in creating this new tool that physicians and pharmacists can use to identify potential opiate abusers in need of help. It is also a tool that law enforcement agencies can use to identify "dirty doctors" who are abusing their prescribing privileges.

**INCREASING ACCESS TO NALOXONE**

1) Equipping Local Police Officers with Naloxone – We are grateful to Delaware and York Counties for leading the way in encouraging and facilitating local police departments to carry naloxone. The early outcomes of this venture as measured by successful overdose reversals (or more plainly stated – lives saved) are truly impressive. It's made it much easier for other local police departments to proceed with this change in practice.

   I'm pleased to report that in Cumberland County several municipal police departments are just about ready to begin carrying naloxone. Credit for this good news goes to a number of people: to our District Attorney, Dave Freed, for promoting the idea and assuring that funds will be available to cover the cost of the medication and related supplies; to Duane Nieves, Chief of Holy Spirit EMS, for hammering out the necessary EMS agreement for local police departments to carry naloxone, and for providing the necessary training; and to the individual police chiefs who recognize the crucial role police officers can play in administering naloxone if they are the first on the scene to encounter an overdose.

2) Equipping State Police with Naloxone – In early April it was announced that PA State Police would begin carrying naloxone. This is a huge win for rural communities. In our area almost all of Perry County relies upon state police coverage, as does large segments of central and western Cumberland County. Given the inherent challenges in providing timely emergency medical services in large, sparsely populated areas, it is a great advantage that the state police are now available to complement EMS in responding to heroin and other opiate overdoses.

3) Making Naloxone Available to Others – Public health reports from states that are a few years ahead of Pennsylvania in responding to the opiate crisis indicate that it is useful to also make naloxone available to people who are not first responders, such as family members, friends, or other people in a position to assist someone at risk for an opiate-related overdose. In May, Allegheny County Health Department Director Dr. Karen Hacker issued a Standing Order

that allows any licensed pharmacy in that County, which chooses to participate, to dispense naloxone to individuals at risk of a heroin or opioid-related overdose, or those who may witness one.

Training and equipping police with naloxone should be our priority in the short run; but in the long run we should also be looking at other ways of making naloxone more available in our communities.

**DIVERTING NON-VIOLENT OFFENDERS TO TREATMENT**

Research from the corrections field indicates that about 70% of prisoners have a substance abuse problem that is directly linked to the criminal behavior that led to their arrest. It is also clear that incarceration will not break the cycle of addiction and criminal behavior. Over the past decade, faced with growing jail populations, the state corrections system and Counties have developed a variety of Community Corrections programs using work release, house arrest, electronic monitoring, day reporting, intensive probation/parole supervision, and drug testing in combination with substance abuse treatment as cost effective alternatives to incarceration.

These types of programs make sense, and they need to be expanded; however, they can only be successful if adequate resources are dedicated to ensure that treatment is provided at the medically necessary level of care and with the appropriate length of stay. In addition, sufficient resources must be allocated for consistent and sustained probation supervision. "Justice Reinvestment" can only be effective if the funds saved from reduced prison bed days are, in fact, reinvested into substance abuse treatment and strong probation/parole supervision.

**INCREASING ACCESS TO SUBSTANCE ABUSE TREATMENT**

While Naloxone is highly effective at reversing an opiate-related overdose and saving a person's life, it does nothing to address the underlying addiction that led to the overdose. Addiction and substance abuse disorders are medical conditions that require formal treatment.

Dr. Alan Leshner, former director of the National Institute on Drug Abuse, cites scientific advances over the past decade with leading us to a new understanding of addiction as a brain disease. Although the use of drugs or alcohol is initially voluntary behavior, repeated use over time changes brain structure, chemistry, and function in fundamental and long-lasting ways that can persist long after the individual stops using. As Dr. Leshner notes, the consequence can be "virtually uncontrollable compulsive drug craving, seeking, and use that interferes with, if not destroys, an individual's functioning in the family and in society."

Not surprisingly, research indicates that the best predictor of success in substance abuse treatment is keeping someone engaged in the treatment and recovery process for a significant length of time – at least three months, but ideally nine months. With our more recent

understanding of addiction as a product of altered brain chemistry, it makes sense that time engaged in treatment and recovery activities is a critical factor in healing a "highjacked" brain.

Here are some key points regarding treatment:

1) Appropriate Level of Care and Adequate Length of Stay – For treatment to be effective, it must begin with a comprehensive clinical assessment to determine what level of care is appropriate at the start. Decisions about level of care should be based on medical necessity criteria, not on arbitrary treatment precertification and funding authorization protocol. A full range or continuum of treatment services should be available. This includes hospital and non-hospital detoxification, hospital and non-hospital rehabilitation, halfway house and partial hospitalization services, and intensive outpatient and regular outpatient counseling.

   Individuals should move between levels of care based on their progress, or lack of progress in treatment. Again, decisions about length of stay (or duration of treatment) should be based on medical necessity criteria, not on arbitrary treatment funding protocol.

2) Medication-Assisted Treatment – With opiate addiction we have the advantage of different types of medication that can be used to reduce cravings and allow a person to focus more effectively on the content of treatment counseling. Methadone treatment has been available for several decades, and research indicates that it does produce positive outcomes in terms of reduced drug use, reduced criminal charges, and increased employability. Within the past ten years we've seen the emergence of buprenorphine (also known as Suboxone) another alternative that can produce similar outcomes.

   More recently, some exciting work is being done with an injectable form of naltrexone named Vivitrol. Research indicates that this medication is effective in blocking cravings with some opiate-dependent individuals. Unlike methadone and buprenorphine, naltrexone is not an opiate; this greatly reduces the likelihood of it being diverted on the street. In fact, since Vivitrol is administered as a monthly shot, the problem of diversion is effectively eliminated. However, there are some disadvantages with Vivitrol. The cost runs about $1,000 per monthly injection. Most communities currently lack the infrastructure of physicians who are familiar with Vivitrol, and willing to prescribe and administer the monthly shots. And not every client will succeed with Vivitrol – a high level of motivation seems to be a key factor in using it successfully and safely. I'm glad to see, though, that the state is seeking to fund some Vivitrol pilot programs so we can all learn more about this new option.

   One final word about Medication-Assisted Treatment that must be emphasized is that the medication alone does not constitute treatment. Whether it's methadone, Suboxone, or Vivitrol, the medication is intended to complement, not become a substitute for, individual and group counseling.

3) Funding for Treatment – Increased access to treatment means increased funding for treatment. Here we have some good news and some bad news.

The good news is that with the state's recent move to Medical Assistance Expansion a greater number of low-income Pennsylvanians will be eligible for Medical Assistance, and therefore will have access to a full range of substance abuse treatment services through the state's HealthChoices program.

One piece of bad news is that there will still be many people in need of substance abuse treatment who do not qualify for Medical Assistance, and who will continue to turn to Counties for help in paying for their treatment. Unfortunately, most Counties struggle to fund the full continuum of treatment services throughout the full fiscal year. Over the past 10 years the state has cut DHS funding to Counties for substance abuse treatment services by $15.8 million (or 28.8%). (See attached chart.) During this same 10-year period, due in large part to the opiate epidemic, the demand for County-funded drug and alcohol treatment services has never been higher.

A second piece of bad news is related to private insurance. A growing number of Pennsylvania families are finding it difficult to afford substance abuse treatment services through their medical insurance due to the proliferation of high deductible insurance plans.

I don't have a solution to these funding dilemmas. But it is clear that untreated substance abuse does not just disappear. Instead, it shows itself as a major cost driver in state and local budgets through increased demands on police, courts, prisons, probation and parole, hospital emergency rooms, child protective services, domestic violence services, mental health crisis programs, and other social services. It is equally clear that without adequate access to professional substance abuse treatment, our ability to adequately address the public health crisis of heroin and other opiate addiction will be severely limited.

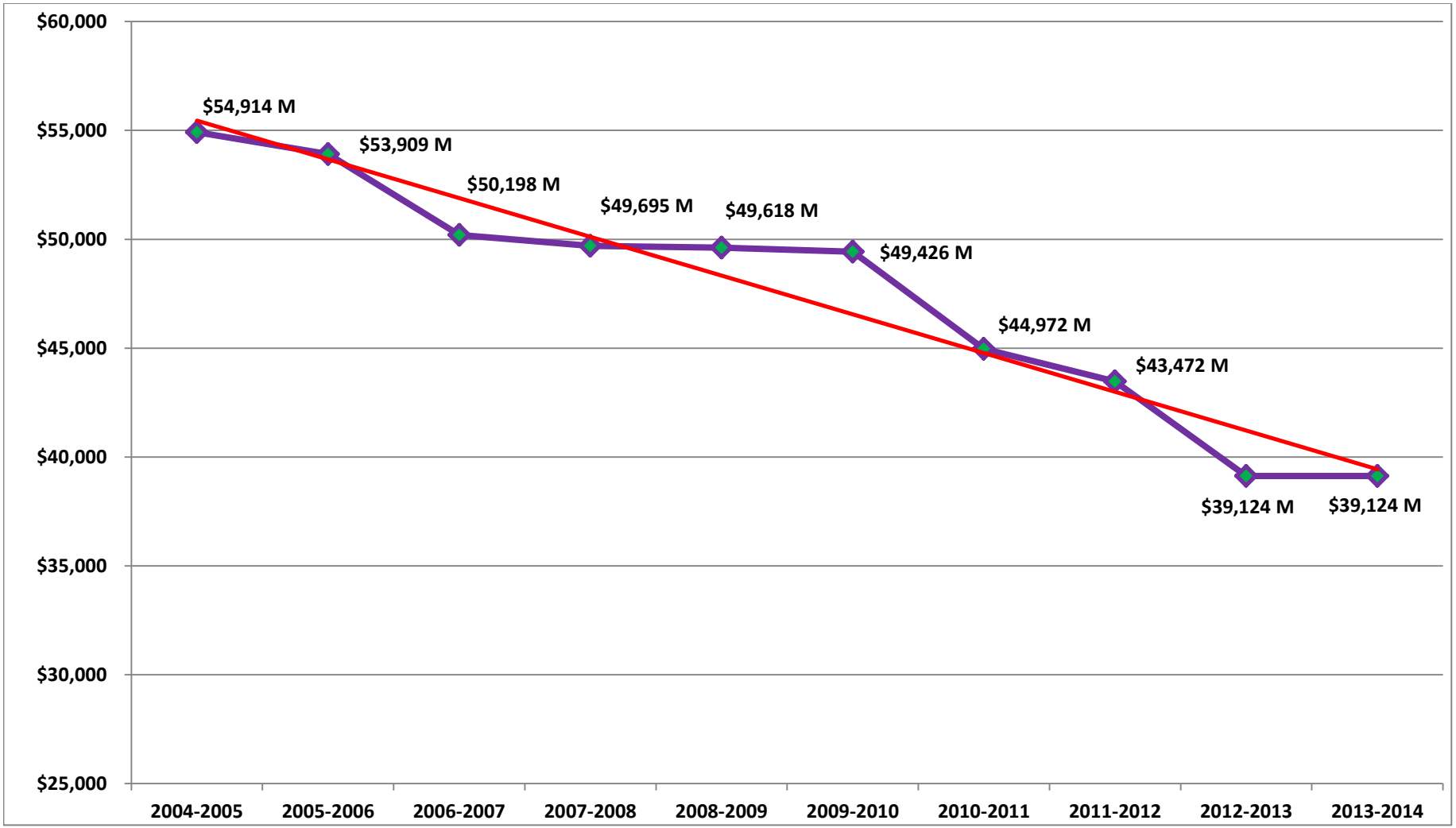
**RECOVERY SUPPORT SERVICES**

In order to maximize the chances that a person will be able to sustain a drug and alcohol free lifestyle over the long haul, it's important to supplement professional substance abuse treatment services with recovery support services in their home community. It should be noted that for a person with an opiate dependency, the transition from a structured inpatient facility (or from a jail) back to their home can be a particularly high-risk time for a relapse, and due to lowered tolerance, a very high risk time for an overdose. This is just one example of where recovery support services play a critical role in a comprehensive approach to our opiate epidemic. I will leave this topic of recovery support to someone who knows a lot more about it than I do – my colleague, Shawn McNichol, who will be addressing you shortly.

## OMHSAS Substance Abuse Treatment Funding to Counties

### 2004-05 thru 2013-14

**(Numbers in Thousands)**




**The total reduction in OMHSAS substance abuse treatment funding to Counties across this ten-year period is $15.79 million, representing a 28.8% cut.**