U.S. Attorney's Working Group on Drug Overdose and Addiction:

Prevention, Intervention, Treatment and Recovery

Final Report and Recommendations

Pittsburgh, Pennsylvania

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Introduction

Opioid-related overdoses have become a national epidemic and a major public health crisis. According to the Centers for Disease Control and Prevention, approximately 110 Americans die every day from a drug overdose. The National Center for Health Statistics studied drug overdose deaths and reported Pennsylvania's overdose death toll as 2,342, or the 7th highest rate of drug overdose deaths per capita for 2011, the most recent year for which national data is available. In Western Pennsylvania, this crisis touches every city, suburb and small town, stealing lives and devastating families.

The reasons for the increase in the numbers of people abusing opioids are varied. Among them is the explosion in prescriptions which contain highly addictive synthetic opioids. Some estimates indicate that in 2012, health care providers wrote 259 million prescriptions for opioid painkillers, enough for every American adult to have a bottle of pills. Further, it is often the case that when a person becomes addicted to prescription drugs, they will eventually transition to street heroin, a cheaper and stronger alternative.

This problem demands a 360 degree solution. We have increased the number of community impact prosecutions targeting trafficking organizations and we have collaborated with other law enforcement components locally, nationally and internationally to stem the supply. However, we cannot prosecute or incarcerate our way out of this problem. To reduce overdose deaths, we need to recognize that addiction is an illness that can be treated, and to do so we must eliminate the stigma surrounding substance abuse and seeking treatment.

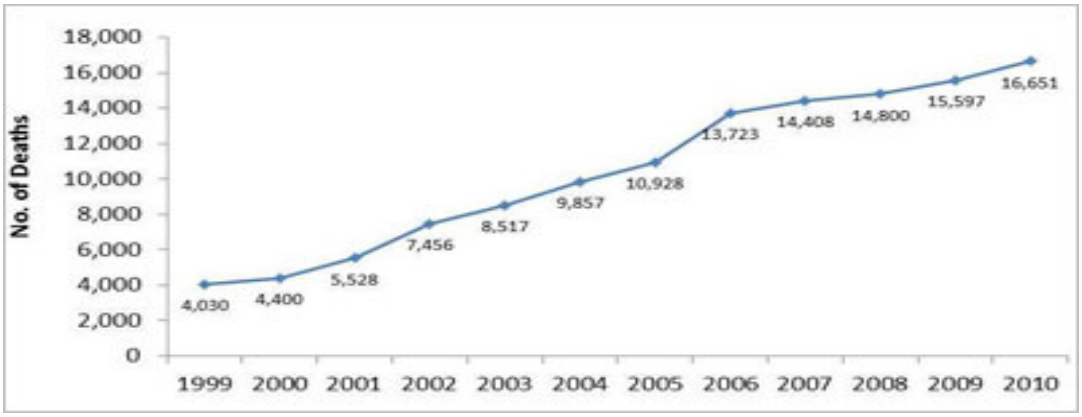
To meet our challenge we convened a representative Working Group to study what we could do better in the areas of prevention, treatment and recovery. With the guidance of Dr. Mike Flaherty and Dr. Neil Capretto, this group has worked quickly and tirelessly to develop the recommendations set forth in this report. Words are inadequate to express my gratitude for this selfless contribution to the well-being of the citizens of Western Pennsylvania. We will begin to implement these recommendations immediately in hope that we can build a better community through expanded public awareness and provider/prescriber education, the elimination of shame and secrecy surrounding drug addiction, the provision of better treatment for those suffering with addictions, and better measurement, assessment and accountability to inform decision making.

On this 29th day of National Recovery Month, 2014, I present Western Pennsylvania's Action Plan for reducing opioid overdose deaths.

David J. Hickton
United States Attorney

Purpose of the U.S. Attorney's Working group

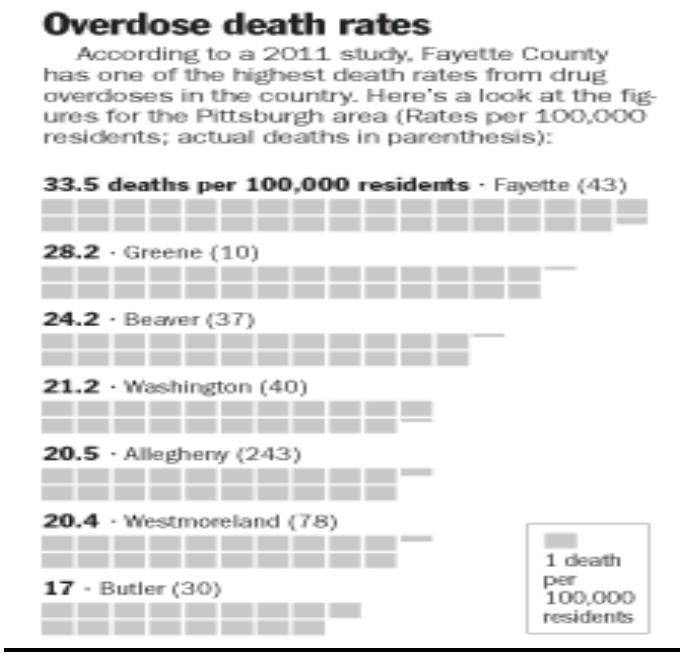
Over the past 10 years, prescription drug abuse has increased exponentially in Western Pennsylvania. [1] Public health officials, legislators, law enforcement and policy-makers here scrambled to address the rapidly growing problem. Pennsylvania is not unique, as the nation itself has experienced this same epidemic. The rate of death from overdoses of prescription opioids in the United States more than quadrupled between 1999 and 2010 (see graph 1), far exceeding the combined death toll from cocaine and heroin.



In 2010 alone, prescription opioids were involved in 16,651 overdose deaths, whereas heroin was implicated in 3,036. Beyond this tragedy, in 2007, prescription opioid abuse cost insurers an estimated $72.5 billion[2] making these health and economic costs similar to those associated with other chronic diseases, such as asthma and HIV infection. Eighty percent of drug overdoses are reported to be "unintentional".

In 2011, Fayette County had one of the highest death rates from drug overdoses in the country, more than half of West Virginia, the state with the highest rate in the nation. In Westmoreland County, for the first time, overdose deaths were surpassing all other types of unnatural deaths combined, including car accidents, homicides and fires.

Allegheny County, Western Pennsylvania's most populous county, had 243 overdose deaths in 2011 (most recent data on file at time) or a rate of 20.5 deaths per 100,000. Allegheny County has also had increases in such deaths (288 in 2012; 278 in 2013) each year since the data has been gathered and is projecting even higher numbers of such deaths in 2014. Westmoreland County also projects increases in overdose deaths in 2014. All counties in southwestern Pennsylvania are outpacing the State in the number of deaths per 100,000. Statewide, the rate is 15.3 per 100,000, the 14th highest rate in the nation. In Western Pennsylvania, the following overdose death rates have been reported by county (Graph 2):



Graph 2 – Source *Pittsburgh Post-Gazette*, January 23, 2014

In early 2014, the Pittsburgh area achieved national notoriety when a sharp uptick in overdose deaths occurred and was attributed to heroin laced with fentanyl. The 2014 fentanyl epidemic mirrored a similar situation in 1988 when fentanyl overdoses resulted in the loss of 17 lives. The fentanyl induced overdose deaths were widely publicized in Pittsburgh, but despite the warnings, people addicted to opioids actually sought out the fentanyl-laced heroin in search of a more intense high. The deaths from the recent fentanyl-laced heroin alarmed both the medical community and law enforcement and were largely responsible for the formation of this Working Group. Ongoing use despite warnings about the potential for overdose underscores the importance of not only education about the recognition and treatment of addiction and overdose, but also for the availability of naloxone for people who choose to use such potentially lethal drugs.

Confronted with this alarming trend, on March 31, David J. Hickton, U.S. Attorney for Western Pennsylvania, sought advice from two local and national experts on addiction and recovery, Neil Capretto, D.O., Medical Director of Gateway Rehabilitation Center, and Michael Flaherty, Ph.D., past head of the St. Francis Institute for Psychiatry and Addiction Services and Founder of the Institute for Research, Education and Training in the Addictions in Pittsburgh. After attending town meetings and hearing from many communities, their concern and despair over drugs, addiction and overdoses, U.S. Attorney Hickton was seeking to find a coordinated way to address the problem in Western Pennsylvania. While his concerns were primarily to reduce overdose deaths, he, along with Dr. Capretto and Dr. Flaherty, saw a related and equal need to locally address addiction itself with strong community involvement and prevention, intervention, treatment and interdiction that would address overdoses and offer recovery for all. He asked Dr. Capretto and Dr. Flaherty to Co-Chair a Working Group of citizens, parents, individuals in

recovery, physicians, providers and regional leaders to seek solutions for Western Pennsylvania that could offer to each community the best science and practice in overdose prevention. He specifically sought an energized, time limited Working Group, given the severity of the issue, (exponentially increased overdose deaths) and the urgent need for long-term solutions. The Working Group was convened with one **overarching purpose**: identify ways to halt and reduce overdose deaths in Western Pennsylvania.

Process employed by the Working Group

Dr. Capretto and Dr. Flaherty marshaled representatives from a diverse pool of community members, including, those in recovery, families who have lost someone to overdose, community leaders, county and state government officials, prevention and treatment providers, medical experts in addiction and opioid treatment, county coroners, research and university leadership, members of churches and faith based organizations, members of philanthropic organizations, and virtually anyone who expressed an interest in contributing. The individuals involved are listed in the Appendix. The Working Group's membership was fluid and was regularly joined by new individuals with interest or suggestions as it proceeded. Recovering individuals and/or parents served on all Committees, as did practicing physicians and providers. Dr. Capretto and Dr. Flaherty, Co-Chairs of the Working Group, also served on each Committee.

The Working Group divided itself into three component Committees explained below.

The **Prevention and Education Committee** has addressed ways to educate the community about the dangers of drug abuse and to offer real time access to information, help, and solutions to those who might be overdosing or to a friend or family member of someone at risk for overdosing. It also was tasked to review what was helping elsewhere to reduce overdose and to coordinate any recommendations with practices that have proven successful. The Prevention and Education Committee was Co-Chaired by Debra Kehoe, Executive Director of the Alliance for Safe and Drug Free Children in Western Pennsylvania, and Cheryl Andrews, County Drug and Alcohol Administrator for Washington County and a Prevention Specialist

The **Treatment Committee** worked to survey existing access to and the adequacy of treatment for opioid dependence in Western Pennsylvania and to recommend how treatment could be improved in the Western Pennsylvania area. Some of the most accomplished medical practitioners in Western Pennsylvania made contributions to this Committee, which was Co-Chaired by Scott Golden, M.D. and Chief of Addiction Services at the VA Pittsburgh Healthcare System and James Schuster, M.D. and Medical Director of the UPMC Community Care Behavioral Health Organization (CCBHO).

The Treatment Committee, while mostly comprised of practicing physicians, was joined by individuals in recovery, parents of recovering individuals, and representatives of various organizations providing care in other counties. The Committee identified and assessed treatment guidelines for opiate treatment, such as those promulgated by CCBHO and David

McAdoo, Director of the Southwest Behavioral Health Management and Co-Chair of the Quality Committee.

The **Quality Improvement, Adverse Events and Interdiction Committee (Q/A/I)** worked to provide a list of evidence-based strategies to reduce overdoses and overdose deaths. In addition, the Q/A/I Committee identified the methodology for all agencies and communities to conduct epidemiological or root cause analyses of each death in order to identify trends and insights for system improvement, reduced diversion and overall community safety. The availability of treatment, the quality of the agencies and the competencies of providers are paramount concerns. Following the publication of this report, this Committee will work closely with law enforcement to advance public safety and improve interdiction. The Q/A/I Committee of the Working Group is Co-Chaired by David McAdoo, Director of Southwest Behavioral Health Management, Inc., and Janice L. Pringle, Ph.D., Director of the University of Pittsburgh, School of Pharmacy, Program Evaluation and Research Unit (PERU).

Each Committee developed recommendations with input from its members and from the community at large and submitted those recommendations to the **Executive Committee** (Mr. Hickton, Dr. Capretto, Dr. Flaherty and Mitchell West, D.O., an emergency physician who volunteered to assist the Executive Committee). Those recommendations are highlighted in the next section. The recommendations also incorporate input from the general public and others, who were also addressing the problem in their communities.

The full Working Group itself met four times over a five month period: April 7, May 6, June 9, and August 14. Each Committee met individually in person and/or via numerous web and phone conferences over this time. The Pennsylvania Department of Drug and Alcohol Programs (DDAP) and Secretary Gary Tennis were consulted, as they also were addressing this problem from a statewide perspective. Secretary Tennis or his representative attended all Working Group Meetings[3].

The first insight of the Western Pennsylvania Working Group was that much was already being done nationally, across the Commonwealth of Pennsylvania, and in Western Pennsylvania to address overdose and overdose deaths. The priority of the Working Group was to become educated about such efforts and to assist in coordinating those efforts and information for the benefit of all. The first conclusion of the Working Group was that real solutions are best developed and implemented locally with strong community participation and regional support. A regional coordinating body or lead agency to facilitate shared knowledge, information and technical assistance often expedites and assists everyone involved.

The Executive Committee began by studying examples of other communities' efforts to address overdose and opioid addiction with an eye toward local relevance and use. At the national level, the Executive Committee reviewed the guiding "Pillars" from the Office of National Drug Control Policy and its 2014 National Drug Control Strategy[2] and its 2011 "Epidemic: Responding to America's Prescription Drug Abuse Crisis" (www.ondcp.gov). The U.S. Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA)

also has produced (viewable draft) "Guidelines for Opioid Treatment",[4] and "The Opioid Overdose Toolkit" [5] (see Appendix), and numerous resources and informative pamphlets for those in opioid treatment and their families. These resources are available at www.SAMHSA.gov. The National Institute on Drug Abuse (NIDA) also has many resources on treatment at its web site (www.drugabuse.gov) on the array of effective and proven treatments for heroin and opioid use, particularly on medication assisted treatment. [6]

Other states are also experiencing and addressing opioid and heroin overdoses. Promising strategies in other states that were studied, and seen as relevant to our efforts, included the Vermont "Hub/Spoke" Initiative, which is available online at, www.healthvermont.gov/adap/documents /HUBSPOKEBriefingDocV122112.pdf, the Massachusetts Opioid Overdose Response Strategy (www.mass.gov/dph/bsas); and the US Attorney's Office in Northern Ohio's Community Action Plan for the Heroin Epidemic (www.justice.gov/usao/ohn/programs/HeroinActionPlan.html). In Ohio, Hancock County has addressed overdoses through a community-based Shared Philosophy for Opioid Treatment. In this county, the community and providers agreed to a unified approach of increased access to treatment for opioids and heroin, but with a careful eye on individual and community safety, diversion, and the need for individuals to be matched by each provider to all of the ways that opioid dependent persons can be treated. As a result of their unified approach, overdose rates there have stabilized over the course of one year.

Two other projects warranted particular study for their reported significant success in reducing drug overdose and their relevance to Western Pennsylvania: Project Lazarus in Wilkes County, North Carolina (www.projectlazarus.org) and the Florida Office of the Attorney General Statewide Task Force on Prescription Drug Abuse and Newborns, and a subsequent CDC Report on their results (www.cdc.gov/mmwr). Among all projects, Project Lazarus stood out as the model most adaptable for Western Pennsylvania. Facing parallel numbers of overdose deaths, Wilkes County unified its citizens via community/provider "oversight boards" and the plan reports a two year 42% reversal in overdose deaths in their community. Project Lazarus highlights the importance of community leadership, joined with health and policy leaders in oversight and action.

Similar declines in overdose deaths were found in Florida following a process to address record-high numbers of prescriptions (Operation Pill Nation). This effort required each medical examiner to submit a report to the Florida Medical Examiners Commission (FMEC) on every death in which a drug is detected in a decedent. Additionally, as in Project Lazarus, prescription drug monitoring was identified as a key component to overdose reduction. The key to Florida's success were various laws and enforcement actions in combination with the Federal Drug Enforcement Agency that aided the community and providers to reach more people needing help with addiction, while monitoring and prosecuting physicians and owners of "rogue pain clinics" in South Florida.

In Pennsylvania, the Pennsylvania Medical Society's (2011) campaign "Pills for Ills, Not Thrills", which was developed in collaboration with the Pennsylvania College of Emergency Physicians,

recently released guidelines regarding the appropriate use of opioid medication and the management of pain (http://www.pamedsoc.org/ERopioidguidelines). These guidelines were adopted for all of Pennsylvania in August, 2014 and are a resource for all Western Pennsylvania emergency departments. Additionally, the Opioid Treatment Guidelines, developed by UPMC Community Care Behavioral Health and the Southwest Behavioral Management, Inc., are highly relevant for community/practitioner use. As with Project Lazarus, an active, helpful, engaging, and timely website for all communities' access was seen as a valuable asset, especially if relevant to individuals and families seeking help. In Western Pennsylvania, two such sites have been developed. One from the Allegheny County Overdose Prevention Coalition (http://www.acopc.pitt.edu/) and the other from the University of Pittsburgh, School of Pharmacy, Program Evaluation and Research Unit (www.OverdoseFreePA.pitt.edu).

Additionally, the Pennsylvania General Assembly's Center for Rural Pennsylvania, recently conducted statewide hearings on the "Heroin Crisis Facing Rural Pennsylvania". This office sought and received input from several members of the U.S. Attorney's Working Group. They have recently produced a plan to address "Heroin: A Growing Epidemic in Pennsylvania" available at www.rural.palegislature.us.

Locally, the Working Group Executive Committee benefited from direct interaction with leaders from regional counties addressing overdose, specifically, Allegheny, Beaver, Westmoreland, Washington, Fayette, Indiana, Clarion and Armstrong Counties, as well as several groups with historical involvement addressing this issue, such as Prevention Point Pittsburgh and the Allegheny County Overdose Prevention Coalition (ACOPC), Allegheny County Medical Examiner, the University of Pittsburgh, School of Pharmacy Evaluation and Research Unit (PERU), the Alliance for Safe and Drug Free Children, Message Carriers of Western Pennsylvania and Sage's Army in Westmoreland County.

U.S. Attorney Working Group Recommendations

Introduction

Each of the following recommendations was generated as a result of a series of meetings held by members of each of the Committees or as submitted to the Working Group by individuals during this process. The scope of the issues related to drug addiction and overdose prevention is extremely broad and it is impossible to redefine all of the aspects of treatment, education, and prevention. Instead, these recommendations are framed from the perspective of the U.S. Attorney on behalf of the Department of Justice. In addition, these recommendations intentionally avoid direct legislative advocacy or fundraising, given certain restrictions on the activities of the U.S. Attorney. The recommendations are organized under three categories that correspond to the three Committees, namely, Education, Prevention and Family Intervention, Treatment, and Quality Improvement/Adverse Events/Interdiction.

Education, Prevention and Family Intervention Committee Recommendations

1. Develop a comprehensive public awareness and education plan to reduce overdose deaths.

- The Committee recommends the development of a series of educational "Town Hall Meetings" that are focused on the particular local communities in which they are held. Such meetings should feature credible, local speakers with high visibility in their community and those speakers would address issues specific to each community, thereby addressing the problem locally. Potential speakers might include physicians, treatment providers, people in recovery, law enforcement officers, and elected public officials. Partnering with community organizations, such as hospitals, business and civic groups, and treatment facilities would lend credibility to the meetings and raise visibility. These meetings can catalyze Community Oversight and Action Boards to coordinate the needed activities in each community.

- The Working Group felt that it was important to involve members of the local media as partners in communicating the seriousness of the current drug abuse epidemic to the public. The media has been very effective in reporting the deliberations of the Working Group and making the public aware of our recommendations.

- Every effort should be made to utilize the Internet and social media to increase public awareness regarding overdose prevention, treatment access and recovery systems in general.

2. Coordinate websites containing information on overdose prevention and links to recovery-based resources

A centralized website containing easily accessible information on overdose prevention is necessary. Two websites in Western Pennsylvania, the Pennsylvania Alliance for Safe and Drug Free Children and OverdoseFreePA, fulfill those requirements. Websites need to collaborate with and be linked to other related sites such as Prevention Point Pittsburgh and other national resources.

- **The Pennsylvania Alliance for Safe and Drug Free Children**, also referred to as "The Alliance", is a website that promotes overdose prevention resources to a multi-county area in Western Pennsylvania by developing an overdose "landing page" with specific links to state, county, and local resources. The Alliance website will eventually link to numerous regional resources, including but not limited to: the Pennsylvania Department of Drug and Alcohol Programs, Prevention Point Pittsburgh, Message Carriers of Pennsylvania, and OverdoseFreePA.

http://www.drug-alliance.org

- **The Program Evaluation and Research Unit (PERU),** from the University Of Pittsburgh School Of Pharmacy, has a website, **OverdoseFreePA,** containing information and links to prevent overdose deaths. It has a highly visible tab on its home page that links to information regarding the signs of an opioid overdose, as well as instructions to call 911. The site contains detailed instructions about how to perform rescue breathing, and how to administer nasal spray naloxone. The website also contains a Speakers Bureau and educational resources for healthcare professionals, people in the criminal justice system, school and community leaders, as well as the general public.

  http://www.overdosefreepa.pitt.edu/

- Every effort should be made to utilize the Internet and social media to promote regional overdose prevention, treatment and recovery in general. Websites can be a valuable source of information about harmful trends, upcoming community meetings and educational programs. They should connect people in need to treatment providers that can provide assistance to peer supports that can aid individuals and families and to social service agencies (e.g. housing, transportation, food and medical services) available in each community.

3. Assure access to and promote a regional hotline dedicated to overdose prevention and enhance 911 response

The Committee identified two regional hotlines that serve the purpose of a local hotline that people in crisis could easily and quickly access.

- **UPMC re:solve Crisis Network** provides round-the-clock crisis intervention and stabilization services for residents of Allegheny County.
  - **1-888-7-YOU CAN**
    (1-888-796-8226)
  - **re:solve Crisis Network**
    333 North Braddock Ave.
    Pittsburgh, PA 15208

- **PA 2-1-1 Southwest** is a free resource and information hub that is funded by the United Way and connects people with community, health, and disaster services in 11 area counties.

- **911** is the number most citizens think of and call when an emergency arises. The 911 operators who answer these calls need to be trained on overdose prevention and be able to give directions regarding the administration of naloxone.

4. Develop and Implement an Overdose Prevention Program for Incarcerated Populations

- The Committee recommends that overdose prevention programs should be developed that specifically focus on individuals that are incarcerated. This is one of several recommendations that affect individuals that are incarcerated and reflects growing awareness that this group of people is especially at risk for overdose. People recently released from incarceration with past history of opioid abuse/addiction, are at increased risk, in large part, because of the reduced opioid tolerance they experience as a result of being incarcerated. In addition, a period of incarceration often intensifies drug cravings and, too often, one of the first things a person does upon release is to use drugs.

- Prevention Point Pittsburgh (http://www.pppgh.org/) is a valuable community resource that promotes harm reduction related to injection drug use and has presented successful training programs at the Allegheny County Jail. To date, more than 5,000 inmates at the county jail have participated in overdose prevention training. In addition, Prevention Point Pittsburgh offers overdose prevention education within the community that includes naloxone prescribing, HIV testing and counseling, a needle exchange program and crisis management. Anyone from local communities or correctional facilities can schedule a training or workshop for staff or clients through Project Coordinator Alice Bell at 412-247-3404 or abell@pppgh.org.

- An overdose prevention program should be implemented during the period of incarceration and should include education on the signs of overdose, as well as training on the appropriate use of naloxone. All persons needing treatment for substance use and, in particular, for heroin or opioid dependence, should be afforded access to peer recovery support services that can assist in accessing treatment and finding pathways to sustained individual recovery. Peer supports should also be available to the families of those in treatment or suffering from alcoholism or drug dependence and assist in outreach and treatment upon release from incarceration.

- Potential barriers for this type of intervention include resistance from jail administrators and a shortage of trainers who are willing to provide the necessary education. However, as more people with substance use disorders are released from incarceration, this becomes an issue that cannot be ignored. Implementation of this recommendation will involve meeting with regional jail administrators in order to explain the nature of the proposed programs and gain their buy-in.

5. Promote Physician Education and Intervention Programs

- From a historical prospective, physicians have played a significant role in the recent epidemic of overdose deaths. In the mid-1990's, patient advocacy groups and pain management specialists asserted that pain was not being adequately treated. At the same time, pharmaceutical companies developed powerful time released opioid analgesics and aggressively marketed these drugs to physicians. Pain experts promoted their use for "chronic, non-malignant pain" and ensured physicians that when used appropriately, these drugs posed very little risk of causing addiction. These drugs were actually highly addictive and prone to misuse and the prescription drug epidemic exploded. Most physicians now realize that these drugs were over prescribed and largely responsible for the current addiction epidemic. There have been many programs aimed at reducing prescribing rates and the supply of these drugs is less than it was a few years ago. However, many physicians continue to prescribe excessive quantities of opioids. The reasons given for the high rate of opioid prescribing include unfamiliarity with prescribing guidelines, lack of training on the management of complex, chronic pain syndromes and concern on the part of physicians that if they refuse to prescribe opioids to patients that demand them, that it will be reflected in poor patient satisfaction scores that will affect physician income and possibly their employment.

- Despite the fact that the majority of opioid prescriptions are written by primary care physicians, there are relatively few programs that focus on providers and their prescribing patterns, rather than on patients. This underscores the need for interventions targeting prescribing behaviors, in addition to those targeting medication sharing, selling, and diversion.

- The Committee recommends that the U.S. Attorney engage and strongly encourage the physician leadership at the major hospital systems in Pittsburgh (UPMC and the Allegheny Health Network), as well as physician leaders in community hospitals and managed care entities such as Community Care Behavioral Health, to develop an educational program directed at physicians, physician assistants and nurse practitioners. This educational program should address the appropriate use of opioids, the management of chronic, non-malignant pain, issues of addiction in patients who require opioids, patient Screening, Brief Intervention and Referral to Treatment (SBIRT), and linkage to recovery supports. An important component of such a program would be the introduction of an element of accountability. By utilizing the electronic health record, physician leaders can identify physicians who prescribe opioids outside of acceptable standards and limits and may benefit from remediation and continuing education.

- According to the HHS report, "Addressing Prescription Drug Abuse in the United States", education and training in both pain management and substance abuse, especially how to identify patients who may be at risk for abuse and ensure patients treated with opioids receive the appropriate dose and quantity of medication for their condition, are important

to address the significant percentage of providers, who may be contributing to abuse and overdose.[2]

- The University of Pittsburgh, UPMC and the Allegheny Health Network have the resources and expertise to assist in the planning and implementation of such a curriculum and the training noted above. Physical and behavioral managed care entities should be involved in this training, as well as the relevant Western Pennsylvania medical societies, physicians, pharmacists, treatment providers and outreach agencies within the community. This training should lead to a clear, shared philosophy for outreach and treatment to all ages and at-risk populations that educates the community and offers focused prevention and alternatives to continued drug use

6. <u>Educate buprenorphine providers on the best practice guidelines and enforce adherence to the guidelines by federal and state law enforcement agencies</u>

- Buprenorphine is increasingly prescribed for patients who are addicted to opioids and has been a very useful component of a medication assisted treatment program. [5] However, buprenorphine providers often do not follow appropriate prescribing guidelines. In some cases, patients are maintained on buprenorphine despite continuing to have positive urine drug screens for opioids, benzodiazepines, and other drugs of abuse, which dramatically raises their risk profile.

- Often, patients receiving buprenorphine continue to be deeply enmeshed in the drug culture and frequently are in relationships with individuals, who continue to abuse drugs. Some sell their buprenorphine in order to obtain money for other types of opioids, while others use buprenorphine as a means of decreasing the severity of withdrawal symptoms when they run out of heroin or potent opioid medications. This pattern of misuse of buprenorphine places this group of individuals at increased risk for overdose.

- The Working Group recommends that the **"Community Care Best Practice Guidelines for Buprenorphine"** become part of an educational program for buprenorphine and methadone providers. [7,8] The educational aspect of this recommendation might be coordinated by one or more of the local drug and alcohol treatment centers or buprenorphine programs, such as

  Gateway Rehabilitation Center (www.gatewayrehab.org)
  Pyramid Healthcare (http://pyramidhealthcarepa.com)
  Greenbriar Treatment Center (http://www.greenbriar.net)
  Jade Wellness Center (http://www.myjadewellness.com)

- Buprenorphine providers should be encouraged to provide overdose prevention education to their patients and they should provide all patients with a prescription for naloxone, along with instruction on its proper use given their experience with the target patients. Prevention Point Pittsburgh can be very helpful in this process.

- Federal law enforcement agencies, such as DEA, should expand their oversight to ensure that providers are held accountable for adhering to practice guidelines and for prioritizing safe practice measures, such as daily dosing regimens that serve to reduce diversion. The role of agencies, such as DEA, in educational programs directed at providers should be enhanced and supported.

7. <u>Develop and educate probation officers and federal and state law enforcement about addiction and medication assisted treatment (MAT)</u>

- The Committee recommends that an educational program that focuses on addiction, psychiatric disorders and medication assisted treatment (MAT) should be developed and presented to probation/parole officers, members of law enforcement and correctional officers. Being on MAT should not be a stigma, or perceived as not being in treatment, when people are compliant with that particular form of treatment. To the contrary, properly medically managed MAT today for many may be life saving. The MAT offered should include all medications clinically warranted including naltrexone (oral or injectable), buprenorphine or methadone, with access to naloxone being provided in order to reduce the likelihood of overdose death. Linkage to peers or those in recovery is also recommended as an adjunct to such treatment both for individuals and families.

- A large number of people involved with the criminal justice system have substance use disorders and many have co-existing psychiatric disorders. Comprehensive assessment and treatment of these disorders will minimize recidivism, decrease overdose deaths, and enable people to live productive lives.

- Among members of the Working Group, there is a wealth of knowledge and expertise about addiction and MAT. Group members have expressed a willingness to participate in the development of a curriculum regarding addiction that can be presented to members of the law enforcement community. SBIRT training can also be part of the educational program as it is particularly helpful and effective with young adults and problematic drug use in all populations. (see: www.ireta.org/sbirt)

- Once probation and parole officers and providers are adequately informed about the benefits of MAT and naloxone, they can be instrumental in encouraging adherence to these types of programs. People who are incarcerated or about to be released can be incentivized to participate in MAT programs as part of early release or as a requirement of ongoing probation or parole.

Treatment Committee Recommendations

1. Increase the number of drug and alcohol assessments and referrals to medication assisted treatment (MAT) for people who are incarcerated or on probation

- This recommendation specifically targets individuals who are incarcerated or on probation or parole. An analysis of overdose deaths in Western Pennsylvania by Dr. Flaherty reveals that the majority of people who overdose and die have had previous involvement with either the criminal justice system or prior treatment for substance abuse. The group involved with the criminal justice system, while relatively small in terms of numbers, is responsible for consuming a significant amount of opioids and represents a cohort at great risk for overdose.

- The Committee recommends that all incarcerated people within the criminal justice system undergo a drug and alcohol assessment prior to release and, when indicated by virtue of their history of substance use, they should be referred to treatment that includes a comprehensive evaluation for medication assisted treatment. Such programs include those that provide for the administration of methadone, buprenorphine, naltrexone, and naloxone. Only half of all federal and state prison systems offer MAT with methadone or buprenorphine and only 23 states provide referrals for some inmates upon release from prison. These policies are counter to guidelines issued by both the World Health Organization and the Centers for Disease Control and Prevention, which say prisoners should be offered MAT for treatment of opiate dependence. Each contact with the criminal justice system that involves opioid use, whether pre or post incarceration, should include an assessment for treatment with MAT upon disposition.

- According to the 2010 National Survey on Drug Use and Health, although effective drug abuse treatment exists, the majority of people who need treatment do not receive it. [9] Primary reasons for not receiving treatment include: inadequate accessibility or availability of treatment; a belief on the part of patients that they can handle the problem without treatment; not being ready to stop using; and lack of health insurance coverage; privacy concerns; and inability to afford treatment. Across Pennsylvania, incarcerated persons lose Medical Assistance (MA) eligibility. The Committee recommends statewide implementation of the MA County Jail Model, piloted by four Pennsylvania Single County Authority entities in conjunction with the Department of Drug and Alcohol Programs. In this model, Single County Authorities partner with County Assistance offices, jails, and probation departments to coordinate drug and alcohol assessments, expedited enrollment in MA, and case coordination to ensure the inmates do not encounter a delay in treatment or insurance coverage upon release from jail or court.

2. Promote efforts to increase the availability of naloxone in the community as a safe antidote for opioid overdose

- The recommendation to make naloxone (Narcan) more available in the community and to educate community members on its use and administration is the one recommendation that members of the Working Group feel would be very effective in reducing overdose deaths. Naloxone has been shown to be an effective measure to decrease the frequency of overdose deaths, and it has been used effectively without significant adverse events in many communities. Naloxone is an opioid antagonist that reverses the respiratory depression associated with an opioid overdose. It is not a drug of abuse, nor does it lead to increased rates of opioid abuse.[10]

- In October 2010, the Harm Reduction Coalition, a national advocacy and capacity-building organization, surveyed 50 programs known to distribute naloxone in the United States, to collect data on local program locations, naloxone distribution, and overdose reversals. Staff members at 48 (96%) of the 50 programs completed the online survey. Since the first program began distributing naloxone in 1996 through June 2010, the 48 responding programs reported providing training and distributing naloxone to an estimated 53,032 persons. From the first naloxone distribution in 1996 through June 2010, the programs received reports of 10,171 overdose reversals using naloxone. A useful resource, "Guide to Developing and Managing Overdose Prevention and Take Home Naloxone Programs", is available through the Harm reduction Coalition at http://harmreduction.org/wp-content/uploads/2012/11/od-manual-final-links.pdf. As of May 2008, Prevention Point Pittsburgh received first-hand reports of 220 successful overdose reversals using naloxone obtained through their program. [11]

- There are many high risk groups of people that would benefit from ready access to naloxone. These include patients released from drug treatment programs, people involved with MAT programs that provide methadone or buprenorphine, prisoners released from jail, and patients who have been prescribed potent opioid medication for various pain syndromes. Every person in one of these high risk groups should receive a prescription for naloxone and education regarding its proper use in the event of an opioid overdose. Family members of patients receiving potent opioid medication or those addicted to opioids should also receive naloxone, along with instructions on what to do if they encounter an overdose in a family member or friend.

- Another group of patients at risk are those admitted to medical and surgical units of general hospitals, psychiatric facilities, or facilities such as skilled nursing facilities. Commonly, upon admission, their opioid drugs are either discontinued or the dosage is reduced, which results in a decrease in their drug tolerance. On discharge, the opioids are frequently restarted at the original dose, which places the patient at an increased risk of overdose. Discharge instructions regarding the potential for overdose are necessary and, perhaps, this group of patients would also benefit from the provision of naloxone.

- The Committee strongly recommends that local EMS providers and other first responders, such as police officers and firemen, be given naloxone and instructed on its use and administration. Recently, federal law enforcement agents, as well as some local police departments, such as the Pitcairn Police Department, have received approval to carry and administer naloxone as needed. [12] The Committee believes that these initiatives ought to be expanded to include all state, county, and local police and fire departments.

- Some people have expressed reservations about the risk of naloxone. A commonly mentioned concern is that readily available naloxone may increase opioid use or delay entry into an addiction program. The argument is that people who have access to naloxone might be more likely to consume even larger amount of opioids based upon a false sense of security that if they do overdose, then naloxone will be available to reverse the overdose. This is an intuitive concern; no data from existing OEND (Overdose Education and Naloxone Distribution) programs have yet demonstrated increased drug use by the participants.[13, 14] Issues have also been raised regarding the amount of training that is necessary for safe use of naloxone and concern over the use of naloxone by people who received no formal training has been raised. Several studies demonstrated that formal training does improve knowledge regarding overdose and naloxone administration.[15] However, other investigators found no substantive differences in overdose rescue management by those trained by the OEND program directly compared to those trained via social networks. Emergency medicine physicians have long recognized that it is possible to precipitate acute opioid withdrawal symptoms by administering naloxone to someone with physical dependence on opioids. While uncomfortable, opioid withdrawal is generally not life threatening and is certainly preferable to a potentially fatal overdose. In many communities (e.g. Boston) emergency rooms themselves are willing to provide naloxone to those seeking it. This is something Western Pennsylvania emergency rooms might also consider.

3. <u>Support Good Samaritan Laws and Prescription Drug Monitoring Programs (PDMP)</u>

- Many states have enacted Good Samaritan Laws and Prescription Drug Monitoring Programs. At this time, Pennsylvania has a very limited prescription monitoring program that is only able to be accessed by the state Attorney General for schedule II medications and is not available for medical professionals. Pending legislation will make the PDMP available for physicians and pharmacists to check for schedule II, III, and IV controlled substances. A section in the Appendix lists all of the pending legislation in the Pennsylvania House and Senate. It is strongly recommended that members of the Working Group and the public support Good Samaritan legislation and PDMP's.

- Good Samaritan Laws provide immunity from prosecution for people who call 911 to report a drug overdose while in possession of drugs themselves. The intent of these laws is to encourage people to call for help without fear of legal consequences for themselves or the person who is experiencing a drug overdose. Studies show that

people witnessing an overdose may not call emergency services, because of a fear of arrest for drug use or sale. Prevention Point Pittsburgh reports that in 72% of the cases where 911 was not called during a witnessed overdose, the reason given was fear of police involvement; anecdotally, people also reported concern about stigma associated with drug use. The second provision of Good Samaritan Laws provides varying levels of criminal or civil immunity for those involved with the prescription, possession or emergency administration of the opioid antidote naloxone to reverse the effects of the overdose.

- The Legislative Committee of the Pennsylvania Association of County Drug and Alcohol Administrators (PACDAA) tracks and updates legislative actions on the PACDAA website. Single County Authorities can serve as liaisons to the Working Group on the status of Pennsylvania House and Senate bills relative to Good Samaritan Laws and Prescription Drug Monitoring Programs.

- The Prescription Drug Monitoring Program (PDMP) is a statewide electronic database which collects designated data on substances dispensed in the state. Before prescribing controlled substances to a patient, providers are encouraged to query the database. The database can identify patients who might be receiving inappropriate amounts of controlled substances from several providers, a process referred as doctor shopping. The ACLU, as well as several state medical societies, has expressed reservations about PDMP's related to privacy concerns, to unauthorized access to information by law enforcement agencies, and to doubts about the long term efficacy of such programs. With these concerns in mind, the Committee supports the passage of PDMP legislation.

4. Support measures to increase capacity for treatment of addiction

- The Committee recommends a strong and sustained commitment to increasing local drug and alcohol treatment capacity and outreach. Whenever the opportunity arises, we should proactively engage insurance companies and support policies that increase coverage for drug and alcohol treatment. Immediate access to medical screening and treatment should be available.

5. SBIRT – Screening, Brief Intervention and Referral to Treatment should be used in settings where substance abuse is seen as an earlier identification of clinical need that may in the end reduce overdose

- It is critical for medical professionals to be able to identify the signs of substance abuse in their patients and to intervene early. These early interventions can result in savings to the healthcare system and, more importantly, save lives. The SAMHSA SBIRT (Screening, Brief Intervention and Referral to Treatment) model is a comprehensive, integrated public health model designed to provide universal screening, secondary prevention, early intervention, and timely referral and treatment for people who have

substance abuse disorders. One of the strengths of SBIRT is the relative ease with which it can be used to screen patients for an identified problem. This allows healthcare professionals to screen for problematic use amidst a spectrum of other health and behavioral problems, even when the patient is not actively seeking an intervention or treatment. www.ireta.org/sbirt or www.samhsa.org/sbirt .

Quality Improvement, Adverse Events and Interdiction Committee (Q/A/I) Recommendations

1. Establish an Overdose Database that is available to local communities and community leaders working to address overdose deaths

- The Committee believes that ongoing analysis of drug overdose trends at the local level is an important component of overdose prevention.

- The Q/A/I Committee recommends that all overdose deaths be reviewed and that the medical examiners for Western Pennsylvania counties work together to establish a database containing overdose death data. The database would include information about the decedent's demographics, drugs present at the time of death, circumstances surrounding the death, prior system engagement (e.g., treatment, criminal justice), and any other pertinent information. An analysis would be completed on the trends in the deaths and the results of the analysis maintained in the database. This information should be available in a timely manner to affect outreach and system improvement in all counties.

- The University of Pittsburgh's Program Evaluation and Research Unit (PERU), which is led by Dr. Janice Pringle, already has an overdose database with extensive data and analysis from Allegheny County Data. A Pennsylvania Commission on Crime and Delinquency (PCCD) grant supports the work and offers the opportunity for other Pennsylvania Counties to add their data to this website.

- The Committee also recommends that data on overdose episodes, which do not result in a death, should also be collected from Emergency Medical Services (EMS) and hospital emergency departments (ED) and possibly integrated into the same database. The EMS and ED data can provide near real-time monitoring of trends in overdoses. It would also be useful documentation of what enabled the survived overdose.

- Toxicology results are critical in developing targeted interventions. While Allegheny and Westmoreland Counties obtain toxicology screens on all overdose deaths, it is recommended that they engage in an outreach program to involve other Western Pennsylvania counties in uniform toxicology screenings.

2. **Utilize Overdose data, on an ongoing basis, to identify and target interventions to reduce overdoses and overall drug abuse**

- The Committee recommends the use of data to identify the populations at risk for overdose in each community. Analysis of such data can be used to identify new patterns of drug abuse or previously unrecognized drugs of abuse. In addition, analysis of the data may identify key opportunities for investigation and interventions. The surveillance data can be used as a guide for the implementation and subsequent evaluation of overdose prevention programs.

- The Committee recommends the development and dissemination of educational materials which identify and describe evidence-based practices that can be utilized by community leaders working to address overdose deaths. Trends in overdose as related to treatment provision and the competencies of providers should be noted.

- The Office of Mental Health and Substance Services (OMHSAS) of the Commonwealth of Pennsylvania, Department of Public Welfare, issued a bulletin in July of 2006 to establish guidelines and procedures for a consistent statewide process for reporting, categorizing, and investigating incidents involving individuals in the public mental health system. This bulletin communicates and standardizes clear and specific processes at the provider and county levels for reporting and follow-up of incidents.

- The Committee recommends the implementation of a statewide incident management and report system and a process for a root cause analysis (RCA) of sentinel events among persons with substance use disorders similar to the OMHSAS process. The investigation and reporting of incidents does not indicate a failure in the treatment system, but serves as a mechanism to provide protective action for persons utilizing services in the substance use disorder system of care.

3. **Stress the important role that law enforcement agencies play in efforts to reduce overdose deaths**

- Law enforcement at all levels should continue to share intelligence, personnel and other assets to target and prosecute heroin and prescription pill trafficking organizations operating in Western Pennsylvania. Because law enforcement personnel are often the first responders on the scene of a potential overdose, they should be trained on opioid overdoses and equipped with naloxone, a prescription medicine that, if given in time, restores breathing to a victim in the throes of an opioid overdose. Law enforcement supports new DEA regulations allowing additional drop-off sites - including pharmacies, hospitals, clinics and other authorized collectors - for the safe disposal of unused or expired prescription medications. Additionally, law enforcement endorses public education and prevention efforts for youth, families, service providers, faith-based representatives and the health care community.

- Local communities need to work closely with the Courts and law enforcement/interdiction agencies to intervene in illegal activities that threaten the well being of the community. To this end, each region or community should ensure that strong family, community and recovery representation is part of their individual community initiative to reduce overdose deaths.

4. The community should support and promote the National Take-Back Initiative

- . The use of medication turn back boxes, where individuals may safely drop off unused, unwanted, or outdated medications, is highly recommended. Each community is encouraged to establish a safe area such as a courthouse, or a government building with adequate security, where medications can be dropped off. The Federal government has recently approved pharmacies for such a purpose. The type and amount of the medications dropped off may also be an indicator of community drug prevalence. Such drop offs should be as anonymous as possible and there should be no legal consequences for individuals who drop off unwanted drugs

Closing Summary

The opioid overdose epidemic that is gripping American communities and causing the tragic deaths of our citizens may appear to be an intractable problem. The U.S. Attorney's Working Group has developed a number of recommendations, that when applied in a consistent, thoughtful manner, have the real potential to reduce overdose deaths. Many of the recommendations are straightforward and simple, but they will not necessarily be easy to implement. Persistence on the part of those responsible for reversing this epidemic is essential.

From the onset, it was apparent that the public would need to be aware of and engaged in efforts to reduce overdose deaths. Overdose deaths among people addicted to drugs is, unfortunately, not a major concern to many individuals in our communities. Quite often, those suffering from addiction are disenfranchised, often stigmatized and evoke little in the way of sympathy. The message that "addiction can and does happen to anybody and that everyone who consumes opioids, whether they obtain them illicitly or from their physicians, is at risk" must be conveyed. Our partners in the media have helped to publicize our activities and increase public awareness. The availability of treatment remains a concern with the prevalence or demand for treatment far exceeding treatment capacity nationally and locally (treatment committee view).

It is obvious that physicians who prescribe opioids and pharmaceutical companies who promote them have played a large role in the current epidemic. Physicians are beginning to realize that in many cases they have been too liberal in their prescribing of opioids and are making efforts to follow guidelines that would limit the amount of opioids prescribed. There are many educational programs aimed at reducing excessive prescribing and, if the rising street price for "prescription" opioids is any indication, these programs are having a positive impact. However, there are still providers whose prescribing rates fall outside of acceptable standards and these providers need

to be held accountable. Physician leaders, medical societies, hospital administrators, and law enforcement agencies, such as the DEA, need to remain vigilant and ensure that practice guidelines are adhered to.

Targeted interventions designed to impact those individuals at highest risk for overdose death are extremely important. In truth, any person who consumes potent opioids is at risk; however, there are specific groups of people who are at highest risk. These include people with a history of opioid abuse who have been recently released from incarceration or a drug treatment program; people who have received emergency department care for an opioid overdose or toxicity; people who require opioids for a legitimate pain problem that also have a history of drug abuse; and patients who consume benzodiazepines in addition to opioids. The U.S. Attorney's Working Group has suggested several measures directed at these vulnerable groups. Educational programs that address the risk of overdose should be available to incarcerated individuals prior to release and should be part of the educational curriculum at drug treatment centers. Physicians who prescribe opioids and pharmacists who fill the prescriptions need to play a more active role in disseminating information regarding drug interactions and the risk of overdose. Funding for drug and alcohol treatment programs is essential and should be a priority.

Total abstinence from all mood altering drugs is a worthwhile goal of treatment providers and individuals involved with persons suffering from substance use disorders. Unfortunately, for a significant percentage of people, this is a goal that they struggle to attain. The advent of medication assisted treatment (MAT) has afforded these people a much better chance of success. Medication assisted treatment for opioid dependence involves the use of naltrexone, buprenorphine, and methadone. When appropriately administered as part of a comprehensive drug treatment program, these medications can greatly increase a person's adherence to a recovery program, decrease the likelihood of overdose and decrease recidivism rates within the criminal justice system. Unfortunately, some providers of MAT fail to follow appropriate guidelines and like physicians who prescribe excessive amounts of pain pills, these providers need to be held accountable and prosecuted if they refuse to comply.

The Committee is optimistic that implementation of the recommendations will have a measureable impact on overdose deaths. We believe that the provision of naloxone to people at risk will produce a significant result. Naloxone is a safe medication that has been used thousands of times by emergency medical personnel to rapidly reverse an overdose. Any initiatives that increase the availability of naloxone in the community should be vigorously embraced.

Finally, there is adage that states, "You can't manage what you don't measure." The importance of data and measureable outcomes cannot be stressed enough. The establishment of an overdose database is an essential part of the Working Group's recommendations.

Next Steps

The Working Group will collaborate with the U.S. Attorney's Office to broadly promulgate and implement this plan of action throughout Western Pennsylvania. Following the public dissemination of this plan, the Working Group requests that the U.S. Attorney reconvene a follow-up meeting within 120 days. The meeting should include members of the Working Group who are involved in the implementation process, as well as community leaders and representatives of all stakeholder groups. The purpose of the meeting would be to collaboratively assess implementation, make an initial assessment of progress and share constructive feedback. Ideally, this group should include individuals from the Q/A/I Committee who can assist in an assessment of the progress of the implementation process and recommend further action to refine its efforts and attain its goals. While the Working Group recognizes the value of a single oversight entity to address overdose deaths, the vast geography and diverse governmental systems in Western Pennsylvania precludes the existence of such a single entity. In that light, the Working Group recommends the need for its existing leaders, with the assistance of each community and all current agencies and recovery supports, to work together and self-design ongoing coordination of a prioritized effort to reduce overdose deaths by implementing these recommendations. Lives depend upon it.

Appendix

OD Working Group and Committee Participants

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Related Articles

The information below should be openly available and disseminated to all suffering with opiate dependence.

SIGNS OF AN OPIOID OVERDOSE (from OverdoseFree PA)

Breathing:
- Slow or shallow
- Gasping for air when asleep
- Deep or gurgling snoring

Appearance:
- Skin pale
- Fingertips blue or gray

Responsiveness:
- Can't talk
- No response to stimulus

Heartbeat:
- Slow heartbeat
- Low blood pressure

CALL 9-1-1

Do not wait

Say "Someone is unresponsive and not breathing"

Provide clear information on your location

PERFORM RESCUE BREATHING

Tilt head back with hand on chin

Check and clear airways of any blockage

Pinch nose and make a seal around mouth

Give 2 regular breaths - forceful enough to make the chest rise

Repeat breathing every 5 seconds

IF OPIOID OVERDOSE IS SUSPECTED, USE NALOXONE (NARCAN)

Remove yellow caps from both ends of needless syringe.

Take red cap off of naloxone vial.

Twist Mucosal Atomizer Devise (MAD) “wings” onto the point of the syringe.

Screw capsule of naloxone into barrel of syringe.

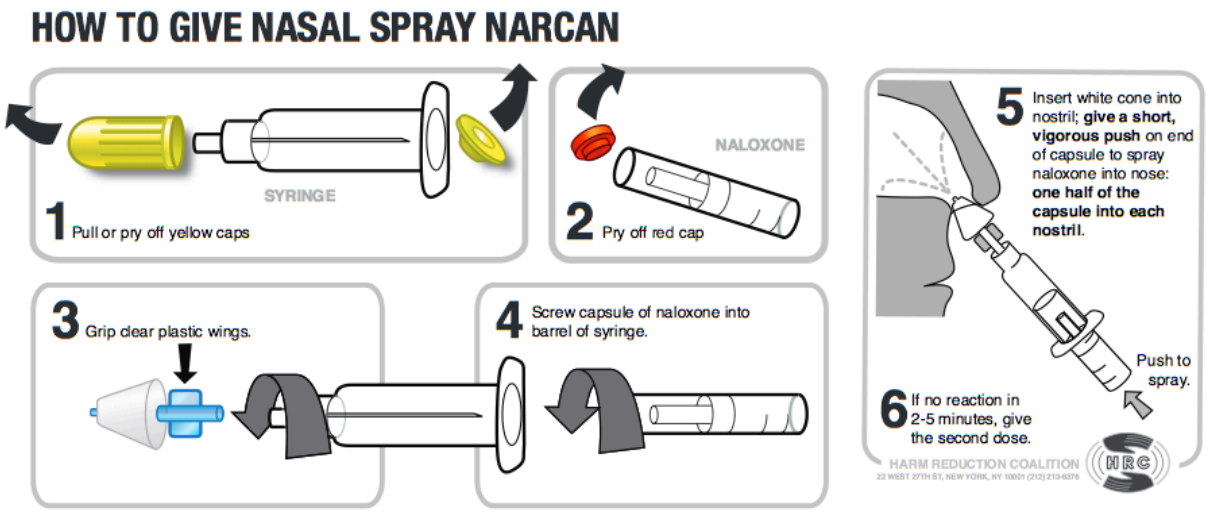
Spray approximately one-half of vial into each nostril with a short, vigorous push.

Continue to breathe for the individual.

If not responding within 2-5 minutes, dose again.

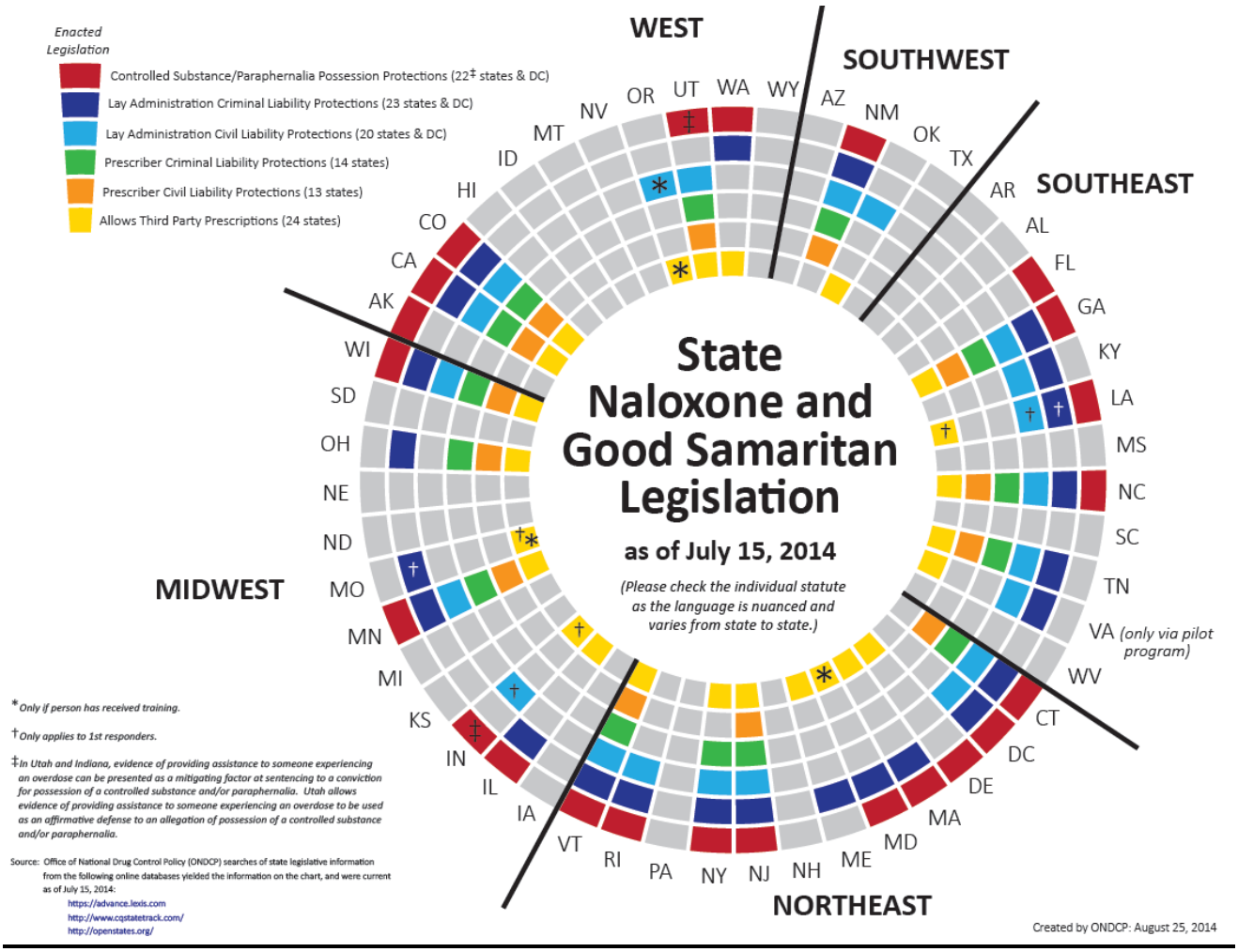
See “What to Expect after Administering Naloxone".

Even if someone revives - seek medical attention!



State Naloxone and Good Samaritan Legislation

An increasing number of states are passing legislation to increase access to naloxone and remove barriers that may keep a bystander (or "Good Samaritans") from seeking emergency assistance for the overdose. The color wheel below reflects the status of legislative initiatives across the U.S.



Below is a summary of salient points in the infographic, with the corresponding colors.

Red: Twenty states (AK, CA, CO, CT, DE, FL, GA, IL, LA, MD, MA, MN, NJ, NM, NY, NC, RI, VT, WA, & WI) and the District of Columbia have statutes which prevent charge or prosecution for possession of a controlled substance and/or paraphernalia for persons who seek medical/emergency assistance for someone experiencing an opioid-induced overdose. Additionally, in UT and IN, evidence of providing assistance to someone experiencing an opioid overdose can be presented as a mitigating factor at sentencing to a conviction for possession of a controlled substance and/or paraphernalia. Utah allows evidence

of providing assistance to someone experiencing an overdose to be used as an affirmative defense to an allegation of possession of a controlled substance and/or paraphernalia.
Purple: Twenty-one states (CA, CO, CT, GA, IL, KY, ME, MD, MA, MN, NJ, NM, NY, NC, OH, RI, TN, VT, VA, WA, & WI) and the District of Columbia have statutes which protect lay persons from criminal liability for administering naloxone to someone believed to be experiencing an opioid induced overdose. In Virginia, this protection applies to persons who are participating in the provisional pilot program. Two additional states (LA & MO) provide criminal liability protections to first responders.
Blue: Eighteen states (CA, CO, CT, GA, KY, MN, NJ, NM, NY, NC, OK, OR, RI, TN, UT, VT, VA, & WI) and the District of Columbia have statutes which protect lay persons from civil liability for administering naloxone to someone believed to be experiencing an opioid induced overdose. In Virginia, this protection applies only to persons participating in the provisional pilot program. Two additional states (IN & LA) provide civil liability protections to first responders.
Green: Fourteen states (CA, CO, CT, GA, MN, NJ, NM, NY, NC, OH, TN, UT, VT, & WI) have statutes which protect prescribers from criminal liability actions.
Orange: Thirteen states (CA, CO, CT, GA, MN, NJ, NM, NC, OH, TN, UT, VT, & WI) have statutes which protect prescribers from civil liability actions.
Yellow: Twenty-one states (CA, CO, DE, GA, IL, ME, MD, MA, MN, NJ, NY, NC, OH, OK, OR, TN, UT, VT, VA, WA, & WI) have statutes which allow for "third-party" prescriptions of naloxone (i.e., the prescription can be written to a friend, relative, or person in a position to assist a person at risk of experiencing an opioid overdose). Virginia allows third-party prescriptions only through a provisional pilot program. Three more states (IN, LA, & MO) allow prescriptions of naloxone to qualified first responders (e.g., law enforcement, EMTs, and firefighters).

Current Overdose Related Proposed Legislation in Pennsylvania:

- **Good Samaritan and Naloxone (Pennsylvania House of Representatives)**

  HB 1149
  Amends the Controlled Substance, Drug, Device and Cosmetic Act providing for immunity from prosecution.
  HB 1149 is awaiting a vote in the House before it goes to the Senate.

  HB 1627
  Amends the Controlled Substance, Drug, Device and Cosmetic Act providing for criminal immunity.
  HB 1627 has been referred to the House Judiciary Committee before it is approved by the House and referred to the Senate.

HB 2090
An Act amending the Pennsylvania Drug and Alcohol Abuse Control Act, further providing for definitions; providing for opioid-related drug overdose death prevention programs; imposing duties on the Department of Drug and Alcohol Programs and the Department of Health; and making editorial changes.
HB 2090 is awaiting a vote in the House before it goes to the Senate.

❖ **Prescription Drug Monitoring**

HB 317
Amends Title 44 (Law & Justice) establishing the Pharmaceutical Accountability Monitoring System; and imposing penalties.
HB 317 is awaiting a vote in the House before it goes to the Senate.

HB 1694
Amends Title 44 (Law & Justice) establishing the Pharmaceutical Accountability Monitoring System; abrogating a regulation; and imposing penalties.
HB 1694 has been approved by the House and has been referred to the Senate Public Health and Welfare Committee.

❖ **Additional Consideration**

HB 1846
Act amending the Workers' Compensation Act, further providing for a scheduling of compensation.
HB 1846 has been approved by the House and is awaiting a vote in the Senate.

HR 659
A Resolution establishing the task force on opioid prescription drug proliferation and its impact on heroin use in this Commonwealth; and creating an advisory Committee.
HR 659 has been approved by the House and has been referred to the Senate.

❖ **Good Samaritan and Naloxone (Pennsylvania Senate)**

SB 1164
Amends the Controlled Substance, Drug, Device and Cosmetic Act providing for drug overdose response immunity.
SB 1164 has been approved by the Senate and is awaiting a vote in the House.

SB 1376
An act providing for opioid-related drug overdose death prevention programs; imposing duties on the Department of Drug and Alcohol Programs and the Department of Health; and making editorial changes.
SB 1376 has been referred to the Senate Public Health and Welfare Committee before it is approved by the Senate and referred to the House.

❖ **Prescription Drug Monitoring**

SB 423
Amends Title 44 (Law & Justice) establishing the Prescription Drug Monitoring Program; providing for powers and duties of the Department of Drug and Alcohol Programs; and imposing penalties.
SB 423 has been referred to the Senate Public Health and Welfare Committee before it is approved by the Senate and referred to the House.

SB 1180
Act providing for prescription drug monitoring; creating the ABC-MAP Board; establishing the Achieving Better Care by Monitoring All Prescriptions Program; and providing for unlawful acts and penalties.
SB 1180 has been approved by the Senate and has been referred to the House Health Committee.

SAMHSA Opioid Overdose Tool Kit

This kit should be available to all communities and agencies and is free at:
http://www.store.samhsa.gov .

This kit contains essential information for all communities, first responder, family members, patients, prescribers and overdose survivors.

http://www.store.samhsa.gov

A New Blend of Heroin is Killing Pittsburgh Addicts

By Nick Keppler
February 6, 2014

There is a time each week when one can walk into a government building in Allegheny County, Pennsylvania, and hear something other than the typical line on illicit drug use. **Prevention Point Pittsburgh** holds hours every Sunday in an otherwise dark and empty health department building next to an Arby's. Here, intravenous drug users can get clean needles, be prescribed the overdose-reversal drug Narcan, and learn what to do if they're around someone who OD's (everything from CPR to how to administer one of those syringes of Narcan). The nonprofit gets funding from the state and county but has to seek private donations to buy the needles. The idea is not to prevent drug use per se (though they do have case workers who will help with that) but to prevent deaths from drug use.

Alice Bell, the group's project coordinator, says Prevention Point's clientele has been shaken by the recent spate of overdoses from a batch of fentanyl-laced heroin. "Some people are scared," she says. "Some people say they know someone who has died from it. Others are looking for it. If you can get a batch that is a lot stronger, you can stay high for a lot cheaper."

The heroin that has hit Allegheny County—a rusted-out patch of former mill towns with Pittsburgh at its epicenter—in the last two weeks is, if anything, stronger than average. On the last Friday of January, the county medical examiner's office saw three overdose deaths in 24 hours. Four more came the following Saturday. Investigators linked them to a particularly potent batch of horse mixed with fentanyl, a painkiller 100 times more potent than morphine that's used in operating rooms and war zones. Right now, the state attorney general's officer thinks it's bootleg fentanyl cooked up somewhere out of state. It has been sold out of bags marked "Theraflu" and has also gone under the street names "Bud Ice" and (inexplicably) "Income Tax." As the fatalities have continued and overdoses in neighboring counties have been linked to the stuff, the death toll from the Theraflu mix stands at 22.

Dr. Neil Capretto, medical director of Gateway Rehab, a regional chain of recovery centers, says he has encountered patients who have survived the combo. "I talked to one who was a real heavy heroin user. He typically did 25 [stamp-sized] bags a day, seven to ten at a time. His dealer told him, 'This stuff is potent. Do less than usual.' He cooked up two bags and went unconscious before he could take the needle out of his arm." Luckily, the guy's mother found him and called 911. Capretto says a few others have checked into Gateway after "near-death experiences."

Bell recounts a story from one of Prevention Point's regulars, who claims that he and his friends scored some Theraflu. Three friends all shot it into their arms and were unconscious instantly. "He said he could hear the sound of one of them hitting the floor, like a knock on a door," says Bell. None OD'ed.

There has been the expected clampdown on dealers across the area, some of whom were selling Theraflu and some of whom were not. In **one of the colorful busts**, police collared an employee of a city

McDonald's who was allegedly selling heroin through the drive-through. “I’d like to order a toy” was apparently code to get a Happy Meal box containing a stamp. Yet the 26-year-old employee, who was still wearing her Mickey D’s uniform in her mug shot, wasn’t selling Theraflu but a less potent batch. A source said it went under the street name “Night, Night, Nigger.”

Drug overdoses are on the rise all over the US but are particularly skyrocketing in Allegheny County. Nationwide, they tripled from 1990 to 2008, according to the CDC, but nearly quintupled in this bit of urban Appalachia. According to figures from the county health department, drug overdoses in Allegheny County averaged 58 per year across the 80s, broke past the 100 mark in 1998, and then hit the 200 mark in 2002. They hurdled to 288 in 2012.

Just as is the case all over, there is a trend of users going from prescription painkillers to heroin. “It’s pretty rare that someone starts by injecting,” says Point Prevention executive director Renee Cox. “Most of our clients start with something like a car accident and then get a prescription for a painkiller, and then they become addicted to opioids.” When the doctor stops croaking up prescriptions, they start seeking H.

Or they could go that route because it’s cheaper. “You stay high every day for about a fifth of the cost [of prescription painkillers] if you do the new heroin,” says Capretto, Gateway’s medical director. And as the drug became a lo-fi replacement for white-market drugs like Percocet and Oxycontin, it made the predictable and cliché inroads into Pittsburgh’s suburbs. “My patients are increasingly people from nice homes whose moms went to all their baseball games,” says Capretto.

And it’s not a coincidence that the Pittsburgh region is slurping down narcotics at a rate higher than our pill-head nation at large, says Capretto, who has treated addition in the region for 30 years. “We were a major marketing area for the first round of prescription painkillers in the 1990s,” he says. “Believe me; I got all the advertising—Big Pharma is smart. They know their demographics and knew we had a higher population of people who would need these products.” At the time, western Pennsylvania had an older populace, many of whom destroyed their bodies in steel mills and lumber yards. “They didn’t market this stuff to San Diego as aggressively,” says Capretto.

Every decade or so in Pittsburgh, someone tries to up their game, and a particularly dangerous street opioid like Theraflu leads to a body count and and a few days of headlines. **In 1988**—in a case that anticipated *Breaking Bad*—an industrial chemist cooked up a batch of “China White” heroin and partnered with a junky to distribute it. Eighteen people OD'ed on it. In 2006, another batch of fentanyl-laced smack, sold under the street name “Get High or Die Trying” was linked to nine deaths.

Even when there is not a particularly dangerous product out there, overdoses are a frequent crisis for emergency rooms, one that Pennsylvania has not yet responded to by implementing a Good Samaritan law to shield anyone who calls 911 about an OD from a possession charge or by making drugs like Narcan more available. (It currently can only be prescribed to users, not friends or parents, apparently leaving them with the task of injecting it themselves as they overdose.)

“It causes a lot of talk when there are 22 deaths in a week,” says Point Prevention Pittsburgh’s Bell, “but [Allegheny County] deals with four or five in a typical week. That is status quo. That should be enough for us to talk about how we are treating users.”

PITTSBURGH TRIBUNE-REVIEW
TRIB TOTAL MEDIA

Westmoreland drug deaths outpace 2013's record rate

By Richard Gazarik
July 1, 2014

Drug overdose deaths could set a record this year in Westmoreland County, where heroin has again surpassed prescription painkillers as the leading cause, Coroner Ken Bacha said. The county recorded 86 drug-related deaths in 2013 and is on target to hit about 100 in 2014 and the sixth consecutive record, Bacha said.

Of the 49 overdose deaths this year, 19 were caused by heroin. The coroner believes four of eight pending cases involve heroin. He determined that 21 died of prescription drugs and one death involved cocaine. “It's almost 50-50 now,” Bacha said of heroin versus prescription drugs. “We were about two-thirds prescription drugs and one-third heroin. Heroin use is up now.”

Bacha believes a law enforcement crackdown has tightened the prescription medication market, so addicts are turning to heroin, a cheaper and equally potent alternative. “Pills are just tougher to get,” he said. “People are going to heroin sooner.”

Attorney Tom Plaitano, a Westmoreland County Drug Task Force member, operates methadone clinics in Greensburg and Blairsville. He noted the local efforts to reduce prescription drug diversion have simply accelerated the transition to heroin. “Being the opportunists that they are, heroin dealers have been ramping up production waiting for this to occur,” Plaitano said.

The state and U.S. Attorney's Office in Pittsburgh have set up task forces to study the problem and draft recommendations for reducing the death rate, which experts call a national public health issue.

While a Westmoreland task force has been studying the problem for nearly a year, officials said it isn't yet effective. Task force member, Dirk Matson, county director of human services, said the group has a public awareness campaign and a website, getinWestmoreland.org, to hammer home the dangers of drug abuse, as well as a curriculum for physicians about proper prescribing practices. “It may take a while to sink in,” Matson said.

Meanwhile, Westmoreland County Drug and Alcohol Commission Inc. has hired a mobile case manager to offer immediate treatment services to overdose patients in hospital emergency rooms. A drug detoxification unit set to open next year at Excela Health Frick Hospital in Mt. Pleasant will be run by Gateway Rehabilitation of Beaver County.

Gary Tennis, state secretary of Drug and Alcohol Programs, said he is working to get addicts into treatment programs instead of jail because it is less expensive and a more effective deterrent. “The problem will continue for some time,” Tennis said. “It's going to take us years.”

Attorney General Kathleen Kane said her office created a database containing 1,100 names used to brand individual doses of heroin, called stamp bags. Agents are using the brand name to track where heroin is being sold and who is selling it. “This is a war,” Kane said.

Pennsylvania allocates millions of dollars for treatment every year. A proposed 2014-15 state budget appropriates $41.7 million for drug treatment through the secretary of Drug and Alcohol Programs and $35.5 million for drug law enforcement and local drug task forces through Kane's office. An additional $439 million is slated for inpatient and outpatient treatment under Medicaid, including methadone clinics and other addiction treatment services.

Other states are spending more to stem the tide of addiction. In January, Vermont Gov. Peter Shumlin devoted his State of the State speech to the “full-blown heroin crisis” there. Dr. Henry Chen, Vermont's health commissioner, said Shumlin appropriated $8 million on top of the $30 million a year it spends on addiction to provide “treatment on demand.” He said the extra money will halve waiting lists for treatment programs and double the capacity of methadone and suboxone clinics. With only 626,000 residents, Vermont now budgets nearly $61 per person on treatment annually, while Pennsylvania spends less than $8.

Chen said it's too early to judge Vermont's approach. “There are times I feel we're swimming against the tide,” he said. “It's going to take some time.”

PITTSBURGH TRIBUNE-REVIEW
TRIB TOTAL MEDIA

Babies born addicted growing problem across Western Pennsylvania

By Mary Pickels
Feb. 9, 2014

Nicole Ehredt of East Liberty was in methadone treatment when she delivered three of her four children, struggling to break a drug habit that started when she was 12. The youngest suffered tremors from addiction when he was born underweight two years ago at a Cambria County hospital. Ehredt, 30, took her son home and breastfed, providing the methadone and easing his symptoms. When he was 6 weeks old, she weaned him by switching to formula. “(The tremors) went away after he (nursed),” Ehredt said. “He's still a small baby.”

The state doesn't mandate substance testing for newborns, track the number of babies born addicted or require hospitals to report women who are in drug rehabilitation when they deliver. Reporting is mandatory only when babies born to mothers not in rehab have withdrawal symptoms. At least 648 babies were born addicted or treated for addiction last year at Uniontown, Magee-Womens Hospital and West Penn and Forbes hospitals. Although hospitals aren't required to track them, officials agree the number has multiplied in a decade in tandem with a statewide surge in heroin and prescription drug abuse.

At Excela Health Westmoreland Hospital, which delivers about 1,800 babies a year, addicted infants typically fill two of the six beds in the special care nursery, nurse practitioner Kathy Eisensmith said. “We have had times when every baby in that unit has been in drug withdrawal,” she said.

Nearly 30 percent of the babies delivered at Uniontown Hospital in one year were addicted, said nurse Lea Walls, director of Family Beginnings Birthing Center. Their mothers used opiate street drugs — heroin, morphine, oxycodone — or prescription pain medication while pregnant, she said.
Nationally, the number nearly tripled between 2000 and 2009, to 3.4 per 1,000 hospital births, according to the Journal of the American Medical Association. Sixty to 80 percent develop Neonatal Abstinence Syndrome, a withdrawal condition.

Because newborns in withdrawal need more intensive care and hospital stays of four weeks to several months, medical costs, too, more than tripled, data show. Hospital billings to private insurers or Medicaid rose from $190 million in 2000 to $720 million in 2009, when the average was $53,400 per baby. Medicaid paid for 77 percent of those deliveries, including Ehredt's son.

In Pennsylvania, the number of addicted births covered by Medicaid rose from 883 in 2010 to 1,122 in 2012, according to the Department of Public Welfare. In 2012, Medicaid paid $17.3 million — an average of $15,449 per birth — compared to $15.1 million in 2010. The actual hospital billings were higher, according to welfare department spokeswoman Kait Gillis.

PRENATAL SAFEGUARDS

The long-term effects of prenatal exposure to drugs aren't certain. Both drug and alcohol exposure raise the risk of infant death, developmental delay, poor school performance and learning disabilities, West Penn tells parents. Although fetal addiction has little impact on motor skills, the risk is higher for behavioral disorders such as aggression and attention deficit hyperactivity disorder, said Dr. Harolyn Belcher, family center director of research at Kennedy Krieger Institute in Baltimore, a children's research hospital. Addicted newborns require close monitoring as they are weaned from drugs, often through morphine. While the ratio of nursery care for healthy babies is six per nurse, the highest ratio in the special care unit is three per nurse, Eisensmith said. Many pregnant women enroll in drug rehab programs, typically taking methadone or subutex. But those drugs, too, can cause fetal addiction.
“The majority of women we see here are already on methadone. We have a very large clinic for women on methadone or who want to convert,” said Dr. Barbara Cohlan, director of the neonatal follow-up clinic at Magee-Womens Hospital, where the number of addicted babies treated rose from 67 in 2005 to about 250 in 2012. Some of the mothers are Westmoreland County jail inmates. In 2013, 32 inmates tested positive for pregnancy; 13 were sent to Magee to start drug withdrawal treatment, said Warden John Walton. “Most of it is heroin (use),” he said.

Westmoreland County Common Pleas Judge Rita Hathaway has jailed pregnant defendants who continue to use drugs, even while they are on parole or probation. “At least I know I can keep them clean until delivery if they are incarcerated,” she said. Allegheny County Jail records, available only from August through December of 2013, show 22 inmates tested positive for pregnancy. Women in withdrawal are sent to Magee for methadone treatment; those already in rehab receive follow-up care at an Oakland treatment center. Officials estimate a 50-50 mix of heroin and prescription drug use.

Attorney Tom Plaitano operates methadone clinics in Greensburg and Blairsville, Indiana County.
“Five years ago, if we had three to five patients who were pregnant, that was a lot. Today, 15 to 30 is the norm,” he said. “They are your neighbors, family members, coworkers and college students.”

BABIES CAN THRIVE

Dr. Neil Capretto, medical director at Gateway Rehabilitation Center in Beaver County, said taking methadone under a doctor's supervision is better for pregnant women and their babies than turning to prostitution or crime to buy street drugs. They also can learn about social service resources.
“For some of these women, pregnancy is a blessing in disguise,” Capretto said.
Walls has crafted a $10,000 grant proposal for a pre-admission program to counsel and support pregnant women enrolled in drug rehab programs. “We (hospital staff) are only a ‘blink' in their life, but anything we can do for best outcomes is our goal,” she said. Ehredt, a single mother, moved to Allegheny County

to enter a life skills residential program through Sojourner House and said she has been drug-free for a year.
While she is critical of methadone, “it helped me deliver healthy babies,” she said. “Fortunately, my kids didn't go into horrible withdrawal or have to be in the (neonatal intensive care unit). Doctors told Ehredt her pregnancy prevented a cold turkey withdrawal from drugs. “Any guilt I feel is more in the fact that I abused it (methadone). I didn't get clean. I just wasn't ready,” she said.

West Penn pediatrician and neonatologist Dr. Robert Cicco said a baby born drug-addicted can thrive in an environment with caring parents. “A woman who is untreated (not in rehab) with a dependency on opiates has a difficult time fulfilling that (caring) role,” Cicco said. “The message is to never become dependent, period

PITTSBURGH TRIBUNE-REVIEW
TRIB TOTAL MEDIA

Pitcairn police department to carry Narcan for heroin overdoses

By Matthew Santoni
Aug. 21, 2014

Pitcairn police will become the first department in Western Pennsylvania to be equipped to administer a potentially life-saving medication to heroin overdose victims, officials said. In partnership with Allegheny Health Network and Forbes Hospital in Monroeville, Pitcairn will equip its officers with naloxone — known by its brand name, Narcan — a drug that counteracts the effects of heroin or opiates through a nasal spray or injection into a muscle with an Epipen-type autoinjector. It will not reverse damage from overdoses or the effects of cocaine, methamphetamine and other narcotics.

The few minutes between a police officer's arrival and the arrival of medics can be critical, said Dr. Daniel Schwartz, EMS medical director at Forbes Hospital. Most ambulances and medics carry the medication, but aren't always on scene first, he said. “That five to 10 minutes can make the difference between the person surviving with no problems and being brain-dead because of oxygen deprivation,” Schwartz said. “You can't get to rehab if you don't survive the overdose.”

On Thursday afternoon, Schwartz trained most of Pitcairn's 16 officers on when and how to use the drug and disposable nasal sprayers, for which the hospital is picking up the $22-per-dose cost.

“People might think it's just for junkies, for heroin overdoses, but it's for opiate-based (drugs),” said Pitcairn police Chief Scott Farally. “It could help a child who accidentally takes medication; it could help an elderly person who has accidentally overdosed.” Locally and nationally, an uptick in the potency of heroin, along with some dealers adding fentanyl to their heroin or repackaging it to look like oxycodone, is contributing to an increase in overdoses, Schwartz said.

Hospital staff and medics noticed an increase in overdoses during the last few years in Pitcairn and the region, though exact numbers were not immediately available because some patients refused medical treatment upon returning to consciousness. Others died at the scene and their cases were handled by the medical examiner's office, Schwartz said.

“For the number of people in town, it's frightening,” he said. “If we had any other kind of health crisis like it, people would be clamoring for an answer.”

When Schwartz found that the police, emergency medical services and borough government in Pitcairn all were willing to be the first to try deploying naloxone, the partnership with the hospital began.

Mark Hall, chief of the Clarion police department and president of the Western Pennsylvania Chiefs of Police Association, said other local departments will closely watch Pitcairn's success with

Narcan. But he said they may hesitate to use it because they fear exposing their municipalities to potential additional liability.

“It's similar to the situation years and years ago when police departments were hesitant to put (automated external defibrillators) in their cars. And now look — almost everybody has them,” Hall said.

TIMES
BEAVER COUNTY

It's time to stop calling them alcoholics and addicts

By Neil Capretto, DO
Timesonline.com, Beaver, PA
Published: July 21, 2014

Society's view was they were to blame for their lot in life because they lacked discipline or willpower. But over time, research determined addiction is much more complicated and, in fact, that addiction is a primary chronic disease of the brain influenced by genetics and environment. Just as understanding the disease of addiction has evolved, it is time for society to evolve in terms of how it refers to those diagnosed with addiction. It is no longer acceptable to refer to a person with a physical disability as "crippled" nor is the term "retarded" accepted in referring to the developmentally disabled.

Society has moved away from these words because they are pejorative, harmful and inflict pain. The same applies to words such as "alcoholic," "drunk," "addict" and "junky." Such words stigmatize those who are diagnosed with a disease, creating a barrier to treatment. Thousands of people in this country die every year from the disease of addiction, yet only about 20 percent of the people who are afflicted seek help. Many times people are ashamed, afraid and intimidated because of the stigma placed on them. A person who has problems related to eating is referred to as having an eating disorder, not as a food abuser. Likewise, substance-use disorder is the general term for alcohol and other drug problems.

The general public also often fails to recognize the distinction between such terms as addiction and physical dependence. An example of physical dependence is a baby born to a mother with a substance-use problem. It is incorrect to a say the baby is born addicted to drugs. The baby may be born with a physical dependence due to the mother's drug use, but the baby does not have the disease of addiction. As a result, the baby can be weaned off the drug and be fine. Meanwhile, the mother may be suffering from not only physical dependence but also from addiction.

But isn't this all just political correctness? Words used to describe people who have a substance-use disorder really don't matter, do they? Well, at least one study says words do matter. Massachusetts General Hospital researchers found changing words used to describe someone with alcoholism or drug addiction may alter attitudes of health-care professionals. The study, released in 2010, asked 500 mental-health professionals — about one-third of whom specialized in addiction — to review a case file of a hypothetical patient who had failed to comply with a court order to refrain from using alcohol and drugs. Some of the health care professionals received a file referring to the patient as a "substance abuser" while

the rest received a file describing the patient as having a “substance-use disorder”. Most agreed treatment was warranted, but those with a file that called the patient a substance abuser were significantly more inclined to recommend punishing the patient for failing to comply with the court order and felt more strongly that the patient was to blame for failing to abstain from alcohol and drugs.

Even those in recovery from substance-use disorder should be mindful of their words. Dr. Abraham Twerski, founder of Gateway Rehabilitation Center, suggested people simply proclaim their recovery by stating their name followed by saying ‘I am a beautiful and wonderful person in recovery’. People are not their disease. By using “people-first” language we identify a person with an illness rather than a person whose identity is dictated by an illness and we promote respect for the worth and dignity of all people.

All this does not mean that people with addiction bear no responsibility for seeking treatment and following through. But the barriers stigma creates must be broken down. With that change may come a greater understanding of addiction and a greater likelihood that those suffering will reach out for help. Remember, the next person who may need substance-use disorder treatment could be your husband or wife, son or daughter, sister, brother or friend. It could even be you.

The Indiana Gazette

A Sobering Story: Addicts must confront their demons, experts say

By Sam Kusic and Julie Martin
April 13, 2014

To understand what alcoholism and drug addiction are, it's necessary to first understand what they aren't — a character flaw, a moral weakness, or a personal decision on the part of an inherently bad person.

Addiction is, for all intents and purposes, a brain disease, one whose causes are multifaceted and whose effects are observable. "There's a lot of people who don't understand it, and so what they say is, 'How can it be a disease because you just don't catch it, you do it to yourself.' So people tend to still see it as a moral weakness," said Vince Mercuri, executive director of The Open Door Alcohol & Other Drug Treatment Center in Indiana.

However, addiction is not a moral failing, and brain-imaging techniques have helped to show that, according to Ruben Baler, a health science administrator with the National Institute on Drug Abuse, part of the National Institutes of Health.

"From the scientific point of view, there is no doubt that addiction is the reflection of measurable dysfunctions of the brain," he said. He said its sometimes difficult to accept addiction as a disease because of the inclination to separate mind from body. "If we put that aside for a minute, then we are left with an organ that is, for all practical purposes, really no different than the pancreas, the lung or the heart," Baler said. "And when it goes out of order, when it has imperfections, impairments or disruptions in its inner workings, then we have overt symptoms and diseases, like addiction. So once we move away from the notion of this nonmaterial entity inside our brains that dictates everything we do, then it's much easier to understand that these dysfunctions in this particular organ can lead — and do lead very often — to all sorts of mental illnesses, drug abuse and addiction included," he said.

That having been said, it still may seem counterintuitive to call addiction a disease, but the concept is supported by the American Psychiatric Association, which in latest edition of the Diagnostic & Statistical Manual of Mental Disorders places addiction within the spectrum of substance use disorder. And the American Medical Association has long recognized alcoholism as a medical problem — it labeled it as an illness in 1956. More recently, the American Society of Addiction Medicine redefined addiction as a chronic brain disorder, and not a behavioral problem.

"Simply put, addiction is not a choice. Addictive behaviors are a manifestation of the disease, not a cause," said Dr. Raju Hajela, a past president of the Canadian Society of Addiction Medicine and the chairman of the committee that rewrote the definition, said in statement announcing the change.

Mercuri said the classification provides a framework for understanding the problem. He said that for something to be considered a disease, it has to be primary, meaning that it is has symptoms all of its

own; progressive, meaning that symptoms will get worse over time if left untreated; chronic, meaning that the underlying problem continues to exist even with treatment; and has the potential to be fatal. Drug addiction fits that bill, he said. It is a problem one its own, and it progresses as people move along the continuum from recreational use to a full-blown dependency. Addiction also is chronic — it doesn't resolve by itself and relapses can occur if the afflicted are not diligent in keeping up with their treatment. And if addicts don't receive treatment, they could eventually die from their use.

But Mercuri and others said that the label does not absolve addicts of responsibility for their actions. "It doesn't mean people aren't responsible for their behavior," Mercuri said. "It doesn't mean that people aren't responsible for their recovery, either. They do have a disease, but they're responsible for their recovery just like somebody that has high blood pressure is responsible to eat less salt. If you're a diabetic you're supposed to take your insulin. The insulin here is recovery, abstinence and going to meetings."

Carlton Erickson, a pharmacology professor at The University of Texas at Austin and director of its Addiction Science Research and Education Center, agreed. "We don't have to blame people for having the disease, but we can blame them for not going into treatment. We really ought to blame them for not seeking treatment," he said. However, he said people who suffer from addiction can't simply bootstrap themselves into sobriety by "just stopping" anymore than a than a schizophrenic can stop hearing voices. That, he said, results from the changes that extended use of a drug causes in the brain. "Neuroscientists have been showing that for over 20 years now, that when you use a drug over and over again, your brain adapts to the drugs and that adaptation causes disregulation of the reward pathway in the brain. That's where chemical dependence occurs," said Erickson. That disregulation, he said, ultimately impairs decision-making, judgment and impulse control.

Dr. Antoine Douaihy, a University of Pittsburgh psychiatry professor and medical director for addiction medicine services at Western Psychiatric Institute and Clinic in Pittsburgh, said that repeated drug use affects the frontal cortex of the brain, where the high-level decision-making functions occur. In the brains of addicts, that circuitry is impaired, effectively shutting down the brain's inhibitory abilities. "In a sense the brain operates with no inhibitory effect. It's like the brain hijacked. There is no decision-making," he said. And that, he said, helps set up a downward spiral in which people become preoccupied with a particular drug, get high and then crash, the only relief for which is to use again. "It's a vicious cycle that they cannot get themselves out of," he said. "The key way to get themselves out of it is to stop using and start really working on change."

And change can be achieved, especially through some form of extended treatment, according to experts. "The longer they're engaged in some kind of treatment, the better the outcome," said Marty Ferrero, clinical director of adult services at the Caron Treatment Center in Wernersville, Berks County. Caron is a nationally recognized, nonprofit organization that provides treatment for alcoholism and drug addiction. In addition to Berks County, it has treatment centers in Florida and Texas. Ferrero knows a few things about treatment — he recently celebrated the 21st anniversary of his recovery. In his younger years, when he was studying to be a teacher, Ferrero wrestled with a serious addiction. He credits an intervention staged by family and friends with helping him get on the path to treatment. He was initially resistant to the 12 steps used by many recovery programs and not knowledgeable about treatment options, he said. Ferrero soon learned, however, that with treatment, it was possible to turn his life around. "For many people, it's lifesaving, and it's certainly been for me," he said. "I was dying. And thank goodness,

my friends intervened when they did." He said the 12 steps became an important part of his treatment and recovery, and he continues to value them today. More than three years into his recovery at a treatment center in Minnesota, Ferrero decided to become a counselor. He received training at that location. Since then, he has worked in the field for about 17 years. Primary treatment — offered for at least 31 days at Caron — is really just the beginning of recovery, he said.

And recovery doesn't always occur in a straight-line trajectory. Relapses do occur, but Baler said that does not mean treatment is ineffective or has failed. "If we understand addiction as a chronic and relapsing disease, then we understand the limitations of any treatment. This is no different than asthma and diabetes, which are also chronic and relapsing conditions. So if sugar goes up again in the diabetic patient, it doesn't mean the treatment has failed, it means that we need to keep up with the treatment," said Baler. "The situation is exactly the same in addiction," he said. "Having said that, this is a very difficult disease to treat, and it's different for the different drugs (a person uses)."

And, according to Douaihy, treatment is not as available as it should be. "The majority of people who have addictions are not in treatment. Access to treatment is huge. We're not doing enough to improve it. It's an embarrassment," he said. There are many barriers to treatment, according to a 2012 report by the National Center on Addiction and Substance Abuse at Columbia University. Among them: a misunderstanding of the disease, insufficient insurance coverage of the costs of treatment, lack of information on how to get help, limited availability of services including a lack of addiction physician specialists, and insufficient social support. The report found that addicts often have to break through several at once before entering treatment. "Rarely is there only one obstacle to a person receiving needed treatment," it stated.

For many treatment includes working a 12-step program, which originated with Alcoholics Anonymous. Abstinence is a key component of those programs, but it should not be confused with recovery. An addict can't do in alone. While abstinence refers to putting down the addictive substance, recovery is about addressing many factors the chemically dependent person may face. These include psychological and spiritual areas as well as family dynamics and social stressors. Those seeking treatment benefit from a "jump-start" of an in-patient treatment program that includes a multidisciplinary approach, Ferrero said.

The initial treatment, he said, is really just the beginning of a person's recovery process. And there are programs that provide a number of ways to support an individual in recovery over a 12-month period, and beyond. Alumni events keep graduates of programs connected, which helps when one is on the path of long term recovery. While treatment approaches continue to evolve and advance, one important factor stays the same when it comes to a program's success. "It's up to the individual," Ferrero said. "We do our best to heal them and point them in the right direction. It's up to them."

The method of treatment aside, the U.S. isn't spending as much on treatment in general as it is on other diseases. And that's in spite of addiction being a larger problem than diabetes, cancer, and heart disease, according to the CASA report. According to the report, although addiction affects 40.3 million Americans, it spent $28 billion on treating it. Meanwhile, diabetes affects 25.8 million people, and the country spent $43.8 billion on treatment. Cancer, the report said, affects 19.4 million people, but the U.S. spent $86.6 billion on treatment. And there are 27 million people suffering from heart conditions, on which the U.S. spent $107 billion.

And of the money the government does spend on addiction, researchers found that most of it, 95.6 cents on the dollar, is put toward paying for the consequences, such as prosecution and incarceration. "Only 1.9 cents was spent on any type of prevention or treatment," the report said.

The country's criminal justice system would probably save a lot of money, too, if steered inmates into community treatment programs instead of prison, according to a 2012 study by Temple University and RTI International, a nonprofit research group. According to the study, the criminal justice system could save $4.8 billion if it put 10 percent of eligible offenders into a community-based treatment program instead of prison. Findings such as that are not lost on local law enforcement officials, who have been rethinking the wisdom of simply locking up the addicts.

U.S. Attorney David Hickton, for one, said he believes the right approach is steer the people suffering from addiction toward treatment, while continuing to aggressively prosecute dealers, who essentially are profiting from the illness of others. That aside, even if spending were significantly increased on addiction treatment, it alone wouldn't be enough, according to Douaihy. Along with more treatment, society also needs to address its other ills, he said. "What we really need to understand is addiction does not happen in a vacuum," he said.

"If we don't address poverty, homelessness, if we don't provide opportunities for people to be able to work and to get educated … and we send them back to an environment that isn't supportive, all that you've done would be nullified."

Endnotes:

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2. National Drug Control Strategy – A 21st Century Drug Strategy: Relying on Science, Research and Evidence to Improve Public Health and Safety in America. Office of National Drug Control Policy. (2014) Downloaded 09.03.14 from www.whitehouse.gov.

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