COUNCIL OF THE CITY OF PHILADELPHIA

COMMITTEE ON PUBLIC HEALTH AND

HUMAN SERVICES

Room 400, City Hall
Philadelphia, Pennsylvania
Friday, May 20, 2016
10:25 a.m.

PRESENT:
COUNCILWOMAN CINDY BASS, CHAIR
COUNCILMAN DEREK S. GREEN
COUNCILWOMAN HELEN GYM
COUNCILMAN DAVID OH
COUNCILWOMAN MARIA D. QUINONES-SANCHEZ
COUNCILMAN AL TAUBENBERGER

RESOLUTION 160052 - Resolution authorizing the holding of public hearings pursuant to City Council's declaration of 2016 as "The Year to Combat The Heroin Abuse Epidemic in Philadelphia" to explore the serious Effects that heroin abuse is having on our communities and to develop a strategy with the Department of Behavioral Health and Intellectual disAbility Services to effectively address the heroin Epidemic as an urgent local health priority.

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COUNCILWOMAN BASS: Good morning. This hearing is called to order. This is a public hearing of the City Council Committee on Public Health and Human Services, and the purpose of this public hearing is to hear testimony on Resolution No. 160052.

I want to recognize the presence of a quorum of Committee members. Members in attendance are Councilwoman Gym, Councilman Green, Councilman Oh, and also Councilman Taubenberger and our unofficial Councilman but always a Councilman, Councilman Denny O'Brien I see in the back there. And I want to particularly recognize that Councilman Oh is the prime sponsor of this resolution.

Would the Clerk please read the title of Resolution No. 160052.

THE CLERK: Resolution authorizing the holding of public hearings pursuant to City Council's declaration of 2016 as "The Year to

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Combat The Heroin Abuse Epidemic in Philadelphia" to explore the serious Effects that heroin abuse is having on our communities and to develop a strategy with the Department of Behavioral Health and Intellectual disAbility Services to effectively address the heroin Epidemic as an urgent local health priority.

COUNCILWOMAN BASS: Thank you very much.

And before we actually begin accepting testimony, we're actually going to play the video and we'll hear from you directly afterwards. Thank you.

(Video played.)

COUNCILWOMAN BASS: Powerful video. Thank you so much, NBC10, for the work that you did in putting that video together and really putting a spotlight on such an important issue that's affecting all of us. I can't think of any of us who don't know someone, who haven't somehow been touched or affected by this epidemic. And, again, so many,

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many thanks to you for the work that you've done.

Councilman Oh.

COUNCILMAN OH: Thank you very much.

I feel the pressure of the many expert witnesses and their graciousness in coming here, so I will forego an opening statement and simply ask that you give us three to five minutes of the most important thing you have to tell us. Councilmembers may have questions, and with 28 witnesses, the time will be moving quickly.

So please, because you are being recorded, would you please identify yourself for the record and begin your testimony. And I am sorry. I should let the Clerk call the first panel.

COUNCILWOMAN BASS: Before we have the Clerk to do that, we're going to have comments from Councilwoman Gym.

COUNCILWOMAN GYM: Thank you, Madam Chair. I just wanted to thank the

Committee and especially my colleague Councilman Oh for having the wherewithal to take on an issue of such magnitude. He had seven hearings across the City, several that many of us on Council attended, and we acknowledge you, your staff, and all the work that you put in to bring this hearing to what it will be today. So thank you very much.

COUNCILWOMAN BASS: Thank you, Councilwoman.

Okay. Can we have the Clerk call the first panel.

THE CLERK: Denise Nakano, Vince Lattanzio, and Morgan Zalot.

MR. LATTANZIO: Good morning, members of Council. My name is Vince Lattanzio. I'm a journalist at NBC10. I've been here for eight years at this station doing special projects and original reporting. I grew up in South Philadelphia and I'm a current resident of Graduate Hospital, proud Philadelphian through and through.

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My colleagues sitting beside me here, Morgan Zalot and Denise Nakano, were part of the team who produced Generation Addicted, as you saw. It was a six-month-long investigation into the heroin and opioid crisis gripping not only our city but the nation. A lot of the people who were part of that program are actually in this room today. So we have to say our thanks to them for being part of our reporting and helping to get this out to the public.

Thank you so much for inviting us here today for this important hearing. Each of us will be sharing our experiences while reporting this heart-breaking topic. It is our hope that the effective policies will be the result of increased attention to this topic.

I would like to share with you all today why we chose to take on this investigation into the heroin and opioid epidemic. For me, as you saw in the

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video, I lost my cousin Jesse and my family lost that. It's a very personal story for us. Just like you said, Councilwoman Bass, everybody knows someone. Prescription painkillers and later heroin took him. These powerful drugs slowly destroyed this brilliant, caring, and talented man, turning him into a hallow shell and ultimately leading him to his death.

Jesse's story is all too common, something that Morgan and I first learned while reporting on another special project about youth homelessness. As we searched for those young people, we met others who were in the throes of their drug addiction. Our team would regularly receive Facebook messages and e-mails from desperate parents, siblings, and friends asking for help in either finding a loved one who is suffering from addiction or those who are desperate to get them help.

Now, research has showed that

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the number of drug overdose deaths has continued to soar as doctors continue to prescribe painkillers freely. On average, 130 people were killed a day in 2014 from drug overdoses, and about half of them are from opioids. That's OxyContin, Percocet, Vicodin.

We sat down with officials from the Drug Enforcement Administration who reminded us that not only does Philadelphia have a heroin problem, it is the heroin capital of the East Coast. The strongest, cheapest heroin can be found right here on our streets.

The epidemic has gotten so bad that the DEA has started making changes to the way that it's fighting the war on drugs. They've realized that they can't just arrest drug traffickers, but there must be help from the medical community in revising prescribing practices and better educating the public - parents and young people especially - about the dangers of the most notably prescription

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painkillers. Although it was our goal when we set out to do this report to, one, open people's eyes to the realities of a complicated issue that people were uncomfortable to discuss, quickly judged as a character failure, and is continuing to grow if major changes aren't made by policymakers, law enforcement, the medical community, and the public as a whole.

Thank you.

COUNCILWOMAN BASS: Thank you.

Please state your name for the record and begin your testimony.

MS. ZALOT: Good morning, members of Council. My name is Morgan Zalot and I am a journalist at NBC10 doing original reporting and special projects. Prior to coming to NBC10 about a year ago, I was a staff reporter at the Daily News and I focused on crime. I grew up in Northeast Philadelphia.

Not long after we began our research for Generation Addicted, we

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started to see clearly just how widespread heroin addiction is and how dire the situation is right here in our own city.

To find people right here battling the disease of addiction, we spent countless hours on the streets in Kensington. At first we thought it might be challenging to find people who were willing to open up and talk with us about their addiction, but we were so wrong.

Everywhere you look in Kensington, people are suffering from this. Virtually every single person we approached on the street had been touched by addiction in one way or another, whether they were fighting it themselves or knew someone.

From bright college students sucked into the underworld of heroin, to people battling lifelong addictions, to sobbing mothers desperately searching for their kids on some of the City's most dangerous streets, hoping to save them

from the grips of heroin, we found it all in Kensington. These stories were disturbingly easy to find.

Our reporting started in Gloucester, Massachusetts, where a forward-thinking police chief decided to take the opioid epidemic into his own hands and offer people the option of turning to police for help getting rehab and other services that they need.

Other stops included Pittsburgh to talk with the DEA there about the new 360 strategy, to Baltimore to interview Bankole Johnson, a leading specialist in the field of addiction, and to Washington, DC to meet with Michael Botticelli himself at the Office of National Drug Control Policy.

Exploring what other municipalities and the federal government are doing did two things. It showed us innovative solutions that we may not have found had we focused here in Philadelphia exclusively and it gave us an up-close

look at just how extensive and widespread this problem is.

People, especially those who are addicted and their families, were more often than not quite open to talking with us about it, a phenomenon that's pretty surprising considering we're trying to get people to go on TV to talk about their deepest, darkest struggles.

That willingness should demonstrate just how serious this problem is.

Thank you.

COUNCILWOMAN BASS: Thank you.

Please state your name for the record.

MS. NAKANO: Members of Council, good morning. My name is Denise Nakano. I'm an anchor and reporter at NBC10 and I've been with the station for 13 years.

I first reported in depth about the heroin epidemic back in 2014 in a two-part investigative series which

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garnered an Emmy Award. As Councilman Oh had mentioned, Council also honored my efforts to give a voice to people who are struggling with addiction with a Council resolution last year.

We have each come out of this reporting experience with a better understanding of the opioid and heroin epidemic. It has changed us personally and professionally. We talk about the epidemic in different terms now. I will never again call a person who is suffering from substance use disorder a junkie. It just -- we've just changed the stigma on this. And we've learned that the war on drugs has been failing.

From the White House Office of National Drug Control Policy down to the officers on the front lines, this war on drugs has moved away from arrests and incarceration to a more compassionate approach, which is prevention and support.

We learned that the struggle

really defies all rationality. We met people on the streets who watched their friends die, who compromise their bodies for drugs, who know that in the end what they're doing will lead to death. Yet in many cases, they go back to abusing the painkillers and going back to heroin.

Research shows that these substances chemically change the brain. This is no social or moral failing. This is a disease.

More than two years ago when I first started reporting about the heroin epidemic, I met a young woman in Camden who came from a good family, like many of these folks come from families that love them. She got hooked on heroin and turned up to 20 tricks a day to feed her dependence.

We've spoken to families who have tried to help their loved ones beat addiction, but when it came time for them to help, to move in, they ran up against insurance limits and lack of space.

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One Philadelphia police officer shared with me the struggles of his 22-year-old daughter. She had been battling heroin addiction for four years. She tried to get off the drug, relapsed four times. He found insurance only covered inpatient care for 30 days in the City. She went to the facility, came back out much too quickly. He had to actually put her on a plane to Florida, set her up with about three Percocets so she could make it through the trip to get help that she needed in a 90-day inpatient program in Florida.

She is now on the road to recovery and she is one of the lucky ones. Not everyone has the type of resources to put your child on a plane out of state.

Council, we really appreciate your efforts having this dialogue about a disease that is tearing families and our communities apart.

Thank you so much for asking

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ours team here at NBC10 to share with you what we found in our investigation.

COUNCILWOMAN BASS: Well, thank you all for your testimony and, again, I really thank you for the work that you've done on having so much awareness through NBC10 around this very important issue.

I do want to take a moment and recognize that we've been joined by Councilwoman Maria Quinones-Sanchez, a member of this Committee.

And one of the things that really stuck in my mind is that it seems that we have as a society really been just infatuated with a couple of things, and the first is that we've been infatuated with dealing with this issue and only in terms of thinking of the supply side of it, which is who is selling the drugs, get them, lock them up, that will fix the problem, which we now know was just such an off way of thinking in terms of how to handle such a problem, because even once someone is

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addicted, even if you get rid of that drug dealer, that addiction carries on.

And so I'd like to hear your thoughts on that in terms of how did we let this get away from us to the point where we weren't -- the demand was continuing. It's been continuing, and we haven't effectively dealt with the demand in any sort of way in the past. We've only dealt with the supply side of this issue. And so had we dealt with the demand or the addiction, maybe we wouldn't be here right now.

So if you want to comment on that.

MR. LATTANZIO: That's an excellent point, Councilwoman. I think that everybody that we have talked to on the expert side and the medical community who deal with these -- with treating people who have this disease, the disease of addiction, all have said that it's been wrong since the '70s, you know. The war on drugs is just a spectacular

failure, is what they say.

You can't attack the problem from just the supply side. They've been doing that for all of this time. I think that there's a realization amongst law enforcement finally that that's just not going to work. The DEA has been -- and I'm sure you're going to hear from Gary Tuggle in a little bit about what they're doing to kind of change their strategy and instituting a strategy where there's education, and the medical community is coming together. But if you're just going to try to arrest drug dealers, the Philadelphia Police will tell you they'll have another dealer out there in two hours. You know, you're members of the community. You know what it's like.

The biggest problem is that there's just not enough treatment and not enough quality treatment for people. So we heard from a number of people that would say they went in and out of rehab because they have a 30 or 90 day, and

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Bankole Johnson, who you saw in the video, is a big proponent of strong outpatient facilities for people. So not just pulling them out of the community, putting them -- sequestering them somewhere so that they can get a little treatment to get themselves off the drug, and then you're going to put them right back into the environment where they are faced with all of these challenges again, and there's not a strong family net or community net to kind of help them.

So a lot of people who are moving towards treating the demand side as well are looking towards having some more outpatient facilities.

This also all goes back to mental health. There is not enough mental health, quality mental health, services in any city across the nation. You need treatment from a mental health standpoint, so seeing a psychologist. You also need drug dependency treatment, wean yourself off of the drugs and not

just try to do it cold turkey. Everybody is different, experts will say. So that really does help in that respect.

But to your point, just arresting people and putting them in jails is all we're doing and it's just making a bigger burden on society instead of taking that money and putting good money towards treatment for them.

COUNCILWOMAN BASS: Absolutely. It's been a complete waste of resources and time. And just if you think about again on the supply side of things and on the demand side, when folks are trying to get their lives in order, they've been to rehab, they've received treatment and then they come back to the exact same environment, it doesn't lend itself to being able to make a recovery in a substantial way. And it's the same thing when you think about someone who may have been on that supply side who may have gone to jail, been incarcerated, been released back into the community. I know

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young men who have said, I don't want to do this anymore, but I can't get a job. So it's a vicious, vicious cycle all the way around.

MR. LATTANZIO: It's all interconnected, we found.

COUNCILWOMAN BASS: Absolutely.

Councilwoman Sanchez.

COUNCILWOMAN SANCHEZ: Thank you.

I also want to thank the sponsor of this, Councilman Oh, and all of you for this reporting. I represent a large component of what I call ground zero where this is happening, and as someone who worked in the community for many years before getting elected, had no idea the scope of what was going on and very quickly learned through our partners on the ground that we were targeting the wrong folks as it relates to this.

I'm interested because one of the things is the Police Department, particularly the Philadelphia Police

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Department, has become more sensitive to this issue. The one thing that has been the hardest for me to grasp of this whole piece has been the medical profession, and I know we're going to hear from some medical professionals, who are the first one to introduce this that triggers all of the situation.

Have you found that in the medical profession that they're more sensitized to the type of opioid prescription that they do, from your perspective?

MS. ZALOT: We did. The majority of the doctors who we interviewed for this special said, look, the medical community is partially responsible to putting us here. We were prescribing opioids too freely. One doctor went as far as to basically say, It's our fault, I take responsibility for this, but we have to scale it back now. And it seems that there's a real movement underway among doctors to be more

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careful, ask more questions, make sure that someone they're describing an opioid or considering prescribing an opioid to hasn't struggled with addiction in the past. I'm sure you've heard about a lot of efforts to create a database so that pharmacists can look and make sure that someone isn't drug-seeking at several different pharmacies and just kind of doctor shopping and going around and getting prescriptions. And it seems like there's really a lot of awareness and a lot of initiative to do something to change that at this point among doctors.

MS. NAKANO: There's a startling statistic that through reporting that we've learned that 80 percent of people who become addicted to heroin started on painkillers. So oftentimes you hear that you're just one injury away from becoming addicted. And that's really scary, because there's injuries all the time and you hear stories of people on the street, I've

interviewed people on the street, who broke their leg, got on the painkillers, became addicted, and now they're on the street because the heroin is so much cheaper for them to purchase.

And so I think there has to be this changing tide, just as the tide is changing with the way it's approached away from the arrest and incarceration to more support, the prevention, going into the schools and talking to students and getting them in focus about not abusing drugs. Painkillers can lead to heroin.

The same thing is happening in the medical community. That slow shift is taking place, but it needs a wide community acknowledgment, awareness, and support to continue that shift.

COUNCILWOMAN SANCHEZ: Yeah. Thank you. And I'll end with this. One of the startling statistics that the DEA director gave me was, I have 1,200 doctors in my district prescribing. And so for me, we've spent so much energy and

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time with that drug dealer in the corner, and it's the drug dealer in the office that -- and these are well-informed folks, and that has been the part of this puzzle that has troubled me the most.

So thank you.

COUNCILWOMAN BASS: Thank you, Councilwoman.

The Chair recognizes Councilman Derek Green.

COUNCILMAN GREEN: Thank you, Madam Chair.

Unfortunately, I'm going to actually have to leave to go chair a Gas Commission meeting today, but I want to thank Councilwoman Bass for having this hearing. I want to thank Councilman Oh for your work in putting this together and raising additional attention. I want to thank NBC10 for your reporting. I had a chance to see the report when it first aired, and it gave me an opportunity to reflect on some thoughts I've had over the past couple years, especially in

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reference to the fact that for years we're not able to advertise various drugs on television, and I think that started to create a culture of people wanting a certain type of drug, and that when you tie that with the various pharmaceutical companies being much more marketing focused in trying to get people to think of these drugs and then you add that to the Internet and people going to their doctor, saying I want a specific type of drug because I'm dealing with a specific type of pain. My sister is a physician. She's practicing in California. That's how I started hearing these same things. So when you couple that perspective in our society where people are much more inclined to -- we have a very instant society. I have a lot of pain, so let me instantly get rid of it. So when you have that type of perspective and then you couple that with the Internet and people going online and researching certain things about how it can resolve

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these issues and then when you also see -- some years ago in Philadelphia, pharmacies were closing. For then the past number of years I'm seeing all these new pharmacies pop up out of nowhere in areas of the City you find somewhat unusual.

So when you put all those things together, it starts to give you a perspective, and I think you did a good job of making that connection from where we were before to now, how people go from the pain management issues to heroin. But hopefully you have an opportunity to also do some investigations regarding the larger level in reference to both the impact of insurance companies not providing some of the treatment that you talked about and also the stigma issue.

Having a child who is on the autism spectrum, I see the issues of stigma in that community as well, and I see the similar kind of perspective in reference to mental health, and it's

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really the insurance companies that are not really providing some of the services that people need and thinking that, well, you're addicted, so you have a stigma, as opposed to providing the treatment that is really needed that would benefit not just that individual but our entire society.

So hopefully you'll continue to do some of that investigative reporting, especially in reference to the additional need for mental health services as well as the connection between insurance companies and pharmacies and how we've gotten to this situation.

So thank you.

MR. LATTANZIO: You're welcome.

COUNCILWOMAN BASS: Thank you very much. Thank you, Councilman.

Councilman Taubenberger.

COUNCILMAN TAUBENBERGER: Thank you, Madam Chair.

I would like also to thank Councilman Oh for helping with this

problem, bringing it to light.

Councilwoman Bass, thank you for hosting this hearing, for chairing it.

I am looking -- and thank you, of course, for what you've done, but what I'm looking at right now are three experts in this field, without question. You know it better. And it's not an easy topic. It's not sexy. It's not something people are going to run to the movies to see this film. And to be very blunt, it's uncomfortable to watch in certain instances. Absolutely right.

If tomorrow you found yourself in a position to really end this problem or to be the lead charge in the United States, for example, President Obama, which would call you and say, End it, you'll have the complete resources of the United States, you have that magic wand to end this, what are the top three things you would recommend?

MR. LATTANZIO: I think that

you echoed a question that we asked every single expert in the field that we had interviewed.

COUNCILMAN TAUBENBERGER: Well, you heard the collective wisdom in that.

MR. LATTANZIO: Totally. I say that there is no straight answer, and I hate to give you a non-straight answer to that. It is a true multi-pronged effort that people would take. Mental health issues underlie the biggest problem, which is -- that could go for gun control and gun issues. It goes for incarceration. It goes for drug abuse, suicide, all of those things, homelessness. All of those are mental health issues. So having better mental health.

Having more community-based treatment that are outpatient is a big problem. There's not enough. You'll hear a lot of experts say that there's not enough treatment for people, whether they be inpatient or out of patient.

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They'll say beds. Whether they're beds or whether they're reputable doctors who are providing services like Suboxone treatment and IOP, intensive outpatient treatment, that is important.

And the third thing I would say is, you know, the pharmaceutical companies, they play a major role in this, and we heard from doctors who said that you have to treat pain, and no one negates that. No one wants to be in pain, but these drugs are highly addictive. There are troubles with the way of not having certain fail-safes in the actual pills from the prescription painkiller side that make them hard to, let's say, crush up. There are formulas that weren't used.

There's a great piece that just went out from the Los Angeles Times that I recommend that you read about OxyContin and just over time with the Purdue Company. But there would be more control of those, I personally feel, of the

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pharmaceutical companies.

MS. ZALOT: One thing that I would add is, I wish that we could universally just change hearts and minds and get rid of this stigma around this, because I think that that's such a huge, huge factor in people not seeking help and people not wanting anyone to know that they're battling an addiction. As part of our research on this, I watched the documentary that HBO did up in New England on heroin and this one quote from a mom stuck with me. She was in a support group. She had lost a child to an overdose, and she said, If my child died of cancer, people would be bringing me casseroles, but because my child died of an overdose, people just don't want to talk about it.

So if we could really get at that stigma and get rid of that, I think that that would help with a lot of change.

COUNCILMAN TAUBENBERGER: You

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raise a very good point, and I think it is something that no one wants to talk about because it shows the frailties of all humans. I mean, I can almost say in watching this that almost anybody could fall into this trap.

MS. ZALOT: Absolutely.

COUNCILMAN TAUBENBERGER: Let me ask you this: Bringing on the pharmaceuticals, do you believe many people or most people, or tell me what you think the percentage is, that actually start their addiction with prescription painkillers. How many do you think that really is?

MR. LATTANZIO: It's 80 percent of heroin users.

MR. NAKANO: Eighty percent of heroin users --

COUNCILMAN TAUBENBERGER: Eighty percent of heroin users actually start --

MS. NAKANO: On painkillers.

COUNCILMAN TAUBENBERGER: On

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painkillers.

MS. NAKANO: And then move to heroin. So that's a huge number.

COUNCILMAN TAUBENBERGER: One last question. Is there any place on earth that is combatting this the best, whether it be in the United States or in Europe or somewhere, Asia?

MR. LATTANZIO: I would say the Commonwealth of Massachusetts has been very progressive. They've been one of the hardest hit on this problem. They've instituted some somewhat controversial efforts and also some of the most progressive efforts. I'll give you just a couple examples.

They are -- well, they were considering -- I have to check what the latest is with it, but considering a 72-hour script for prescription painkillers. So you go to the hospital, you have an injury, and you only get a script for 72 hours instead of you walking out with a 30-day supply of an

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extremely dangerous pill that you really don't need that much, requiring you then to go back to a doctor to get more as they evaluate your care.

They have considered sequestering people against their will for, I think it was, 72 hours as well. So that's more of the controversial efforts, but they have the -- that's where the Angel Program, which we kind of talked about that Bensalem has started, comes out of Gloucester, Massachusetts. Leonard Campanello just got an award from the White House for his work, and we spent time up there with him, a week, and he basically offers a free haven for people to come into amnesty, to come into the police station and say, Hey, I need help. And he partners with some of the treatment facilities to get people into facilities. The caveat to that is, he's a 40,000 person town. We're a 1.5 million person city, with people coming from all 12 counties all around us. So

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it's a much different situation.

Boston, last thing is considering instituting safe injection sites. This is something that is like super controversial, but it cuts -- you have a place where you can go. They do them in Vancouver right now. And inject your drugs under the supervision of managed care, so a nurse who can take care of you right immediately if you overdose. Some people see it as compelling you or saying that it's okay to use, but when you're in the throes of it, from people that we talked to, that's not the case. They have the opportunity there to talk to them about getting into treatment and also they provide safe needles, like the folks at Prevention Point Philadelphia do, to help reduce the HIV and hepatitis C rate among injectable heroin users.

So these are all great programs that I think should be considered for the City of Philadelphia and cities all

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around our region.

COUNCILMAN TAUBENBERGER: Thank you very much.

Madam Chair, thank you.

COUNCILWOMAN BASS: Thank you.

Well, thank you so much for your testimony and for being here. And, again, the information you provided today has been very powerful. We're going to make sure that the word continues to spread and that also people understand that they can -- if they missed seeing this live now on public access cable, then they can catch this later and maybe NBC10 will air parts of it again so that we can keep the information out there. We want people to know. We want people to know what's going on and if there's an opportunity to get help as well.

So thank you so much for being here.

MR. LATTANZIO: Thank you. And it's all available on NBC10.com and people can watch it and they can read

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additional stories and get resources.

COUNCILWOMAN BASS: Wonderful. So we can just go to NBC10.com and see the video and get more information. Thank you.

MR. LATTANZIO: Thank you, Councilwoman.

COUNCILWOMAN BASS: You're very welcome.

MS. NAKANO: Thank you.

COUNCILWOMAN BASS: We're going to have the next panel come forward. Can we have the Clerk call the next panel.

THE CLERK: Gary Tennis, Dr. Thomas Farley, Roland Lamb, and Dr. Arthur Evans. And I understand Dr. Rose Julius is joining the panel for questions, if necessary.

DR. EVANS: For Q and A.

(Witnesses approached witness table.)

SECRETARY TENNIS: Thank you, Councilwoman Bass, and thank you, Councilman Oh. You came up to my office

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to invite me down here to speak, and I so appreciate it. I very much appreciate you putting your attention on this.

COUNCILWOMAN BASS: I'm sorry. Before you begin your testimony, just state your name for the record.

SECRETARY TENNIS: Oh, yes. Gary Tennis. I'm the Secretary of the Department of Drug and Alcohol Programs for Pennsylvania.

COUNCILWOMAN BASS: Thank you.

SECRETARY TENNIS: You are right to be putting the attention on this problem. We are in -- this is nationally the worst drug overdose epidemic in the history of all humanity. It is about 1,000 Americans a week that are dying of overdoses. We would not tolerate this for a minute if we had ISIS terrorists roaming the streets, killing 1,000 Americans a week. We wouldn't tolerate this for a minute if it was Ebola or some exotic disease, but because of the stigma around this disease, we continue with

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policies, federally, state, and local, that are really fundamentally inhumane, fiscally irrational, and really just make no sense at all. And when I talk about those irrational and inhumane policies, according to the federal government, we fund -- we provide enough funding for treatment nationally to treat one person for every ten people with a disease of addiction. What other disease would we do that with? I always say why don't we pick cancer for ten years and let's take care of addiction for a while and watch the good things that happen in our communities.

We need to be very dramatically ramping up the efforts that are going into prevention, treatment, and law enforcement. It's not one versus the other. It's a three-legged stool. They go together, and they actually can help each other in important ways.

While we have descended into this worst overdose epidemic ever,

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Congress over the past ten years has cut funding to Substance Abuse Prevention and Treatment Block Grant -- that's the money we pass over to Roland Lamb, Dr. Evans -- by 25 percent. So when they go -- if someone goes around saying they're doing so much to help for our federal folks, just take a look and see how they voted, for example, on a recent amendment by Senator Shaheen to restore that 25 percent cut. That's been the response. So I'm sorry if I speak with a little bit of anger in my voice, but --

COUNCILWOMAN BASS: That's all right.

SECRETARY TENNIS: -- I am so, so tired of meeting with families who have been shattered forever by the unnecessary loss of their loved ones.

There are solutions. And I'm going to say just a couple of things that we're doing at the state level. We're doing a whole lot. It's kind of comprehensive. It was raised to a

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department level, because it really crosses every agency in state government. Governor Wolf, by putting in Medicaid expansion, added a half million Pennsylvanians onto the Medicaid rolls. Medicaid in Pennsylvania pays for whatever level of treatment you need. It covers residential rehab. And, by the way, residential rehab never works by itself. It always has to be followed by intensive outpatient, outpatient recovery supports. We need all levels of care.

I urge you to avoid the battle between MAT versus drug free. This is a clinical decision. We bureaucrats in government need to let the clinical people do their jobs and respect them, just like we would a cancer doctor who is looking at whether someone needs radiation, chemotherapy or whatever. It's a disease. Let the clinical people handle it.

I want to -- I know I only have a couple of minutes, so I've got about

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six suggestions. This is not in my written testimony, but I want to kind of give you some six concrete things.

One, over the past two and a half years, we've developed six sets of prescribing guidelines. We know -- by the way, the question was asked why so bad now. Well, obviously we're vulnerable to one epidemic after another if we don't fund treatment. We would be with any disease. But this time it was the pharmaceutical industry. They hoodwinked the healthcare providers, and over 15 years the opioid prescribing quadrupled. We're only a few percent of the world's population. We consume 80 percent of the world's opioids. We are a wash in opioids.

So over the past two years, we did prescribing guidelines in six different areas. I urge you to do what you can, and we'll get those to you to make sure that all of the hospitals, your medical -- work with the Philadelphia

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Medical Society, your medical schools are working to get those guidelines implemented kind of where the rubber meets the road. They very much urge physicians and other prescribers to look at other things. There are other things other than opioids to treat pain. Sometimes you have to have them. Sometimes they're necessary, but we didn't need to quadruple it. And you don't have to eliminate all pain. You can restore functionality, and that's what it's about. That's number one.

Warm handoff to treatment. So we have been pushing hard, and Philadelphia has been stepping up more and more to have police carrying Naloxone, because often police, no matter what anybody tells you, because they're out driving around, they're often the first ones on the scene, and a minute or two is life or death in an overdose situation. And police across the state have gotten -- we're coming up on 1,000

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lives saved by police across the state. So I urge you to make sure that every police officer in Philadelphia has it. I think they do, but I'm not sure.

But, more importantly, once we save the life, it's critical that we get them to treatment. So we've worked -- and I know Roland Lamb is working on this and Dr. Evans. We've sent out requirements to all of our county Drug and Alcohol Directors to work with your emergency physicians and treat these people like you would treat someone with a massive coronary. When they come in and you save their lives, you don't hand them a card and say, You know, maybe you ought to go get treatment for your heart disease, you're going to die. You say, Okay, we saved your life, now meet this addiction counselor, meet this recovery specialist, we're going to run tests on you and we're going to start you in treatment now. And we're having success with that. I was just talking to the SCA

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and a director for the Reading Medical Center emergency department. They're getting two out of three overdose survivors directly into treatment, and that's a dramatic improvement from anything that I've seen going on in other places. Other counties are doing some things. So that's number two.

Number three, my Training Division Director, my department -- I love to hire recovering people in my department, because I need -- we got a lot to do and we're understaffed and we got to be deeply committed to the issue. My Training Division Director was saved by -- first of all, he was reversed by Naloxone 14 years ago in the Kensington neighborhood of Philadelphia, and then two weeks later he was considering suicide. He approached a police officer, a Philadelphia police officer and said, I need you to arrest me. I need to go to jail or I'm going to die, and the officer said, I can't arrest you, you don't have

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a crime here, but come sit with me. And that officer somehow knew and he hooked my guy up with treatment. He now has 14 years recovery from his heroin addiction. He is my Training Division Director. He's passionate about the issue. He trains on this very issue.

He and his wife are about to have their first baby next month or two, and this world is a better place because he is in this world.

So what I would urge -- we have three counties now, Potter County, Beaver County, and Franklin, where all of the municipal police are getting formal training in how to intervene with our people. Our people are full of shame and stigma and hopelessness. The suicide rates, set aside the overdose, are enormously high for those with drug and alcohol addiction. So they need to know to treat our people with respect, to give them the value that they don't feel inside themselves because of the shame

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and stigma that we put around the disease. If we could move forward in Philadelphia and have all of our police trained -- and I know it will stress and strain our system to do that, but we still have to do it. That's number three.

Number four, we talked about the pharmaceutical industry. The City of Chicago took them to court and said, You have cost this city millions and millions and millions of dollars. You've got to pay to help clean it up. They have made -- and Gary Tuggle will talk to you about the amount of tens of hundreds of billions of dollars that they've made off of OxyContin and these other drugs. And it's documented, the kind of the fraudulent marketing campaign that they did to get this overprescribing going on. If the City of Chicago can do something like that, why can't the City of Philadelphia? That would be number four or five.

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Take-back programs. We've started doing take-back here. I would urge you to put them all over. We have collected -- and, by the way, Becky Berkebile is here, one of my heroes, because she got the Attorney General's Office working with the National Guard in 2015. I think they collected 47,000 pounds of prescription drugs across the state, lest there be any question about the overprescribing.

Our kids get these drugs out of the medicine cabinets. We've got to have a public relation campaign and we need to have these take-back boxes convenient throughout the City. The National Guard and the Attorney General's Office will come and actually do the removal. They've lined up incinerators. Covanta is the one up in Conshohocken that will do it. They take them to the incinerators. They incinerate them properly and destroy them. I would do that.

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Finally, the General Assembly realized after about ten years of looking at this that the drug and alcohol issue cuts across all departments, and so they made it a cabinet-level department. I would urge you at the City of Philadelphia -- you have extremely talented individuals. I mean, Dr. Evans is nationally known and recognized, and Roland Lamb is passionate about this issue and with enlightened approaches toward the issue. The more juice you can give them across departments, because whether it's housing to be able to pull some of those federal housing dollars in to help support our recovery housing, whether it's vocational rehab, there are so many areas that if they had the juice and I don't know -- I haven't talked to them about this. I don't know how they feel about what I'm saying, but the more juice you can give them to work across all of the agencies with the authority and the backing of the Mayor and the City

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Council, I think the more that's going to get done. They know what needs to be done.

I'm going to close there. I want to close on a positive note. With all of this heartache and tragedy, we know that treatment works. With all of this heartache and tragedy, with all of these deficiencies, we have 23 million Americans in recovery. They are our best citizens. These are people that are often as part of their 12-step work out getting other people, helping other people with the disease. It's something they feel great gratitude to be in recovery. Twenty-three million Americans. We probably have many more than that that we still need to get into recovery, but we know what needs to be done. It's a question of whether we have the political will to do it.

Thank you.

COUNCILMAN OH: Thank you very much, Chairwoman.

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So I just wanted to alert everyone, if you see me looking at my watch, it's because I know some of you have appointments and trains to catch. I'm just trying to manage everyone getting up here. And so with that, I'd just like to ask that our Councilmembers as well as all of you just keep your eye on the clock, 28 expert witnesses. Each one of you is fascinating. I have had the pleasure of speaking with you. I've spent hours with some of you, but we have a short time to get everybody through today. And I'm not trying to tell people not to ask those important questions, but just I have to kind of push everyone so we could get everyone through.

Thank you.

SECRETARY TENNIS: Councilman, I would be happy to make myself available in an informal basis at any time in the future, so we wouldn't necessarily have to go into anything now.

COUNCILWOMAN BASS: Do you have

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time for questions today?

SECRETARY TENNIS: Do I have what?

COUNCILWOMAN BASS: Time for questions.

SECRETARY TENNIS: I have about maybe ten minutes, and then I actually have a meeting with the Governor up in Bucks County.

COUNCILWOMAN BASS: Okay. Well, I just had one real quick. I'm going to not break the Councilman's rules, but my question is about treatment. And so one of the problems that I find is that in my communities, I have a lot of houses that are built as recovery houses. And so we know that keeping people in the same environment once you have faced an addiction, you've gone through treatment, you're back in the community, and you're in a recovery house, the idea is that this is supposed to be a good place, a safe place, a place where you can get what it is you need to

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build yourself up before you are back out on your own with the daily pressures and all the things that you face that might be problematic for you. But one of the problems that I have is that all recovery houses are not created equally. And so you may have in certain parts of my district in probably in a four-block radius, I think we counted about 20-some houses, over 20 houses. And so the neighbors then, Oh, we don't want another recovery house in our neighborhood. And part of the problem is that you have some who are bad actors and then you have some who exist who work with the folks from the neighborhood and also provide the appropriate treatment and provide also privacy so that people can recover and there's no effect on the neighborhood.

So how would you suggest dealing with the situation like that? Because all recovery houses are not created equally. There are some that are very reputable. I know that I'm a big

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fan of Gaudenzia and the work that they do. I don't know if anybody from Gaudenzia is here, but I'll give them a big shout-out. They do great work. And there are others as well, but I don't -- there are some other players who are a little bit operating on the margins, if you know what I mean.

SECRETARY TENNIS: Sure. And we've been looking at this issue about a year and a half ago, and Roland Lamb has been part of this and Fred Way with the Philadelphia Association of Recovery Houses. I got the name wrong, but they've been part of this effort, because this is actually an issue that's statewide. And they are on the verge, I think in the next week or two -- and we'll get you a copy of their recommendations -- I think they're going to basically differentiate between those that get funding. For those that are just purely private, those issues are usually often housing issues. You might

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be violating zoning codes or there are other issues. You cannot discriminate under the American Disabilities Act, and you wouldn't want to, because it's really an expression of stigma. You can't discriminate against the recovery house, but you can enforce whatever -- they're subject to the same -- everybody is subject to the same rules and regulations, so you also don't get a pass to break the law, and if that's going on, then the law, the zoning laws or housing laws, need to be enforced.

But for those that are getting funding, we're setting up a number of recommendations in terms of that the person has got an appropriate treatment before they go into the recovery house, because somebody who goes straight to a recovery house could really mess it up for those that are there, because they're not ready for that yet, that level yet.

COUNCILWOMAN BASS: Exactly.

SECRETARY TENNIS: You want to

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make sure that there are no ethical issues in terms of programs referring to -- if somebody is an employee of a program, referring to the houses that they own personally. You want to make sure things are ethically right. You want to make sure the rules and regulations are there.

Fred Way is a tremendous resource here in Philadelphia and becoming so in Pennsylvania. Roland works with him, and probably Roland would have more to say about this than I would. But you've done some really great recovery house work here in Philadelphia, and I do know you have some problems.

COUNCILWOMAN BASS: Thank you. We want to make sure that people are getting help, because it seems that some locations, in my opinion, might be a little bit more financially driven, and then it becomes a model that's predatory.

SECRETARY TENNIS: That's exactly right.

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COUNCILWOMAN BASS: And taking advantage of folks who are need. So we want to make sure that they're getting the quality of care that they deserve.

Oh, I'm sorry. Councilwoman Sanchez.

COUNCILWOMAN SANCHEZ: Very quickly while I have the Secretary here. We want to thank you, and clearly our office works with Fred and the other folks around the good actors versus the bad.

Let me just strongly encourage the state to be as proactive of a partner on this. No one wants to discriminate around recovery houses and all the other pieces, but when we talk about state licensures and all of those things, many times at the local level our hands are tied at the state level. So I'm glad that you're looking at Fred and some of the things we've learned. I have about 300 recovery houses in my district that I inherited.

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SECRETARY TENNIS: Thank you.

COUNCILWOMAN SANCHEZ: And one of my challenges -- and we've used zoning as a vehicle, which is not necessarily always the best, because one of the things I've learned from my Council colleague here Jannie Blackwell who feels very strongly about folks being out in the streets, sometimes you prefer someone to just have a place to be as opposed to in the street. But we need the state to provide further guidance around adopting best practices and giving us tools, so that if we find ourselves in situations where we got to close unsafe places, we're not faced with those challenges of the licensure or more oversight on some of these programs. Whatever it is that -- because we don't license them. You do.

SECRETARY TENNIS: That's correct.

COUNCILWOMAN SANCHEZ: You license the mental health providers. You

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license --

SECRETARY TENNIS: We just do the drug and alcohol providers and then there are ones that do co-occurring drug and alcohol. We do their drug and alcohol license. The Department of Human Services does their mental health.

COUNCILWOMAN SANCHEZ: So what I'm saying is that in this struggle that I've gone through in the last eight years -- and obviously that's changed with this new Administration -- I've not always looked at the data as the state as the most proactive partner. So I'm glad that you're embracing that. I just want to put a sense of urgency around that.

SECRETARY TENNIS: And we have switched our orientation. I'm going to call my Bureau Director, Winona White, who has been just a phenomenon to -- we are here to help support programs get up and running. We're here to make sure we're taking good care of our patient population and get -- we've been doing a

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lot of streamlining to get rid of kind of outdated, irrational regs, and we're also trying to turn new licensure applications around, because we have to grow our infrastructure as fast as we can while maintaining quality. So we are committed to that.

And while I have you, we have also identified that for our Latino Americans in Pennsylvania, that access to treatment is about one-quarter of what it is for the general population. So that's another priority of ours, and we would love to work with you on that, because I know that's an area of interest to you. That's kind of a priority issue. I mean, it's already bad enough for everybody, right? We know there's a shortage throughout, but that's just not right and that's something --

COUNCILWOMAN SANCHEZ: And we appreciate it. I just want to support the local efforts and say we need help.

SECRETARY TENNIS: I

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understand.

COUNCILWOMAN SANCHEZ: So when our City experts go to the state asking for help, that we get it in a more proactive way. And for me it's very troubling because you have people trapped in these neighborhoods, and my job is to assure people that we're looking out for the best interest of everyone, but it's quite complicated on the ground, because many of these young folks are coming from the suburbs, they're coming from other places.

SECRETARY TENNIS: That's true.

COUNCILWOMAN SANCHEZ: And we forget about the people trapped in there, who -- this kind of evolved over time.

SECRETARY TENNIS: I know.

COUNCILWOMAN SANCHEZ: So when we need the tools to help folks with their quality of life on a block or all those other things, it's quite complicated to explain. So I'm glad that we're moving in this more global

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perspective and that we're de-stigmatizing all of this stuff, but that person in ground zero, that person that lives on East Indiana Street, the conversations that I have with them are very, very difficult and complex, because we want people to be empathetic, but we don't want people to forget that there are people trapped in there.

SECRETARY TENNIS: There are. And, Councilwoman, if you ever find that any of the programs in your district are having a difficulty, I hope you'll reach out to me personally.

COUNCILWOMAN SANCHEZ: Oh, I'm the only part of the City, we've closed folks down. Dr. Evans knows that we have closed the bad actors, as many as I can. I have no problem.

SECRETARY TENNIS: Go get them.

COUNCILWOMAN SANCHEZ: I feel like a super hero sometimes trying to go out there. But we have really good partners on the ground, and I think all

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of this attention is really going to help us gain the kind of public support we need around moving this. What we know is going to take years and years of really changing the paradigm about how we think about this.

SECRETARY TENNIS: Well, funding for this has been cut ten years in a row. This is -- under Governor Wolf's first year, this is the first time we're expanding funding. He's doing these hearings all over the state. You have got the Wolf Administration's attention on this issue. I'm honored to get to be part of this, and we want to work with you. So as you identify issues, I hope you will reach out to me personally about if issues or problems with my agency or anywhere, we would like to partner with you on that.

COUNCILMAN OH: Secretary Tennis, I just wanted to thank you for being here. I'm looking at the watch. I know you got to go.

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SECRETARY TENNIS: I do.

COUNCILMAN OH: On your way out, let me tell you we've introduced a resolution urging the state to consider expanding medical marijuana so it is not secondary to opioid prescriptions, but it could be considered by the medical profession on an equal basis.

SECRETARY TENNIS: Okay. Thank you.

COUNCILMAN OH: And just for the public record, let me say that while we do not have a physical witness here representing communities and civic organizations, we have reached out to them. We have written testimony from civic organizations about their frustrations in dealing with medical methadone treatments and drug treatment centers, and that will, of course, be a part of how we look at overall improving dealing with drug addiction and, in particular, heroin and opioid treatment.

Thank you very much.

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SECRETARY TENNIS: Thank you, Councilman Oh. Thank you.

COUNCILWOMAN BASS: Thank you so much for being here.

Commissioner, you want to state your name for the record. We got two Commissioners. Either Commissioner.

DR. EVANS: I think he wants me to go first, and I'm fine with that.

Good morning, Councilwoman Bass --

COUNCILWOMAN BASS: Good morning.

DR. EVANS: -- Councilman Oh and members of Council. I'm Dr. Arthur Evans. I'm Commissioner for the Philadelphia Department of Behavioral Health and Intellectual disAbility Services. Joining me this morning are Deputy Commissioner Roland Lamb; Ms. Joan Erney, who is the CEO of CBH; Dr. Geoff Neimark, who is the Chief Medical Officer of CBH; and Dr. Rose Julius, who is the Associate Medical Director for Addiction

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Services for the Department and CBH.

Thank you for allowing me to testify on this important issue of the growing opiate epidemic in the nation and in Philadelphia. I want to start by saying people can and do recover. It's important to keep this important fact in mind as we discuss the issues related to the growing challenge of opiate addiction. While these issues may seem sometimes complex and seemingly insurmountable, today we have many evidence-based treatments, a strong network of service providers, and I believe for the first time in a very long time the needed public attention to make progress on this issue.

The Department of Behavioral Health and Intellectual disAbility Services, or DBHIDS, coordinates the provision of prevention, early intervention and treatment, and ultimately long-term recovery services for those who are challenged by mental

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health and substance use disorders. As such, through our Office of Addiction Services, DBHIDS has been working with many stakeholders in the community, the field, and across systems to address the consequences of chronic drug use in general and heroin in particular.

Philadelphia is the fifth largest city in the United States and the largest city in Pennsylvania. Our department's Office of Addiction Service estimates that there are between 122,000 and 155,000 persons in Philadelphia in need of treatment. The Department provided care for more than 27,000 people for addictions treatment in Calendar Year 2014.

Philadelphia traditionally boasts one of the richest systems of care with more than 57 providers offering services through more than 117 facilities across multiple service types, from outpatient to hospital-based services. While the current crisis has focused

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needed attention on the overdose crisis, Philadelphia has been addressing drug-related overdose for some time. The DEA Philadelphia field office reported drug-related overdose deaths in Philadelphia have risen 43 percent since 2009, with a corresponding 45 percent increase in heroin-positive toxicology results.

In 2014, 655 persons died of a drug overdose, representing a 33 percent increase within a single year. This represents a rate greater than that of most major cities with similar demographics. Though Philadelphia has seen a growing heroin overdose epidemic in 2013 and '14, we saw a unique increase in the epidemic. Since 2009, there was a 45 percent increase in heroin-positive toxicology results of decedents. In addition with the growing heroin threat, Philadelphia saw an additional unique challenge in the epidemic in 2013, with the first fentanyl epidemic since 2006.

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Deaths attributed to fentanyl increased from 24 in 2013 to 99 in 2014, an increase of 313 percent.

Let me finish by just telling you a few of the things that we're doing here, some of the major things that we're doing here to address the current opiate crisis.

We've initiated a campaign to educate the community about the crisis, and we have identified key communities with which to partner to create creative solutions. We supported the work of Prevention Point, a multi-service public health organization serving the most vulnerable and hard-to-reach populations of Philadelphia. Prevention Point operates a syringe exchange program, which has demonstrated effectiveness in reducing infectious disease transmission rates among IV drug users. They also distribute and train community residents in the use of naloxone to prevent overdose fatalities, educate the

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community on overdose prevention, and provide primary care as well as engage and motivate drug users to access treatment services.

We have supported the expansion of medication-assisted treatment with methadone through the siting of an outpatient methadone program on State Road in 2015. We are also expanding increasing -- we're also increasing capacity in other parts of the City.

We're working with providers to expand the availability of medication-assisted treatment with not only methadone but buprenorphine and naloxone. We've responded to the state's funding initiative announcement for overdose prevention services. And Secretary Tennis isn't here, but the state has been a great partner in trying to make services and resources available.

We've conducted two town hall meetings in conjunction with the Mayor's Drug and Alcohol Commission regarding

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drug use and overdose in those respective areas, and we have town halls scheduled in 2016. We're encouraging families, communities, and service providers to get certified in overdose rescue and obtain overdose kits.

We're deploying peer specialists in psychiatric crisis centers and hospital emergency departments to address the needs of people who may come in in need of substance use treatment.

We're collaborating with Drexel University on a federal grant to educate doctors in terms of their prescribing practices, as well as those who are receiving those prescriptions in terms of opiates, opiate dependence, and addiction.

Philadelphia is a Sentinel Community Site, one of 12 reporting sites participating in the National Drug Early Warning System providing data on substance use, consequences, and availability.

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The City is also a key collaborator in the City's Pill Mill initiative in terms of initiating reports and addressing pill mills.

And, finally, but this again not comprehensive, the list includes that we have improved treatment outreach identification of at-risk groups - youth, women, and those reentering community and as well as older adults.

Thank you for your time and attention to this important issue, and I and my staff would be happy to answer any questions that you may have.

COUNCILMAN OH: Identify yourself for the record, please.

DR. FARLEY: Good afternoon -- or good morning. I'm Tom Farley, Health Commissioner. Thank you for drawing attention to this very severe problem of abuse, addiction, and overdose from opioids. This is a national problem, but it is also very much a local problem. In 2015, there were nearly 700 deaths from

drug overdose in Philadelphia, which is more than twice the number of deaths from homicide.

This surge in overdose deaths has been fueled by two things. First, since the 1990s, physicians have increasingly prescribed opioids to treat both acute and chronic pain. They have done that because they were encouraged to do so by drug companies, some pain experts, and some regulatory bodies, but it is very clear now that this increase in opioid prescribing has been a mistake. Too many people have become addicted to prescription opioids and too many are dying of overdoses.

Second, the widespread availability of heroin with the high purity has made it less expensive for people who are addicted to prescription painkillers to switch to heroin, which when injected has an even greater overdose potential. While only a small fraction of people who use prescription

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painkillers later switch to heroin, enough do use heroin to cause many overdoses.

There are several things we need to do to address this problem. First, we need to encourage physicians to prescribe opioid painkillers less often, in lower doses, and for shorter durations.

Second, we need to help people who are dependent on opioids receive treatment for their drug dependence. While some of this treatment can be done by existing drug treatment providers, primary care physicians can offer treatment with buprenorphine, a medication that prevents withdrawal symptoms and has a very low overdose potential.

And, third, we need to make widely available the antidote to opioids, a drug called naloxone or Narcan. The Health Department will be working with the Department of Behavioral Health and

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Intellectual disAbility Services and other organizations in these three areas.

Thank you.

COUNCILWOMAN BASS: Thank you for your testimony.

Any questions?

COUNCILWOMAN SANCHEZ: Real quick, and I know we're having a broader discussion and so I don't -- our local folks, our experts are here all time. But I just wanted to -- there's 57 providers and 117 facilities. Is there any quality rating that is established by the state or locally, and where can people see this?

DR. EVANS: Sure. So the Department monitors and evaluates providers through a variety of means. We credential every provider that is in our network. The state licensure is a floor for being a part of the network, and there are then criteria over and above that. So each provider is rated and we credential them based on their ranking.

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We also have a very extensive pay-for-performance system. It's probably one of the most sophisticated pay-for-performance systems in the country. We've had it evaluated by University of Pennsylvania, but that system allows us to measure each provider in our service system. We rank them each year.

COUNCILWOMAN SANCHEZ: Is that public? Is there any place people could go and see that?

DR. EVANS: Yes. So this year we will be publishing those results. And so providers -- we started with hospitals about six years ago. So each of the hospitals in our system. But at this point, all of our levels of care, including most of the addictions providers, are ranked. And so that information will be presented and made public through our website starting this year.

COUNCILWOMAN SANCHEZ: Okay.

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Thank you.

COUNCILWOMAN BASS: Thank you.

Very good information to know.

Councilman Oh.

COUNCILMAN OH: Yes. I would have an overall kind of a question. As we have discussed, Philadelphia does not have an overall kind of a panel or leader to set the policy and protocols. And not just for our City departments but for all entities in our city.

For example, as I look at Chief Nestel from the Transit Police, he's been to every one of our seven community meetings. I truly appreciate that. And in his police force, which is such an important part of dealing with this addiction problem because they're at the train stations and they do run into people that are overdosing or on heroin or opioids, but only a portion of his police force has Narcan, that portion that received a grant from the Delaware County DA's Office. I know our DA

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provides the funding in part or in whole for Narcan for our police officers, but then he's got his police force in Philadelphia that doesn't have Narcan. And then I think about the Housing Police, the Drexel Police, the federal police, and there just doesn't seem to be an overall body. Once we get into Bucks County, Delaware County, overall kind of how do we group our resources and then even issues as was raised about insurance? Chester County insurance only covers Chester County providers. A Chester County daughter ends up in Philadelphia. They can't get treatment because their public assistance insurance doesn't cover Philadelphia.

Is there a process of trying to bring everyone together on this issue?

DR. EVANS: I think the point you're raising is a good one. What the federal government did was, they created the Office of National Drug Control Policy during one of the last major drug

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epidemics in the country. It was clear that it's a very complex issue, it touches many parts of government, and that there's no one part of government that can really manage that issue. And so what the federal government did is, they created Director Michael Botticelli's position, the drug czar position, because there was a recognition that policy needed to be coordinated across housing and health and human services and law enforcement. That model hasn't really been replicated as much at the state and local levels, but I think there is some merit in doing that.

Most of the issues that we deal with, as you're pointing out, have to be coordinated. And so far, I think what we've done is more of a more siloed approach to addressing the issue.

COUNCILMAN OH: Finally, I'd just like to make the comment that I truly appreciate the elected officials from our surrounding counties - Bucks

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County, Delaware County, Chester County, Montgomery County - for taking the time out to come here today and testify and share with us. And so in part, that is one of the reasons I tried to keep us on time as we look to all our expert witnesses who are here.

Thank you very much.

DR. EVANS: Thank you.

COUNCILWOMAN BASS: Thank you very much.

Sir, did you have testimony that you wanted to provide?

DEPUTY COMMISSIONER LAMB: No. I was identified as being here. It was a part of the Department of Intellectual Disability.

COUNCILWOMAN BASS: And your name for the record, sir?

DEPUTY COMMISSIONER LAMB: My name is Roland Lamb. I'm the Deputy Commissioner for the Department of Behavioral Health.

COUNCILWOMAN BASS: Thank you

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so much for being here.

DEPUTY COMMISSIONER LAMB: Thank you very much.

COUNCILWOMAN BASS: Thank you.

And can we have the Clerk call the next panel forward.

THE CLERK: Daniel MacDonald, Jeremiah Daley, Seth Williams, Gary Tuggle, Becky Berkebile, and Thomas Nestel.

(Witnesses approached witness table.)

COUNCILMAN OH: I apologize. There are not enough seats for that little three-seated table. If the other witnesses will just sit to the side, and when someone is testifying, if you could allow the next witness to sit at the table. Thank you.

COUNCILWOMAN BASS: Thank you, gentlemen, for being here. You can decide who will start first. State your name for the record and please begin your testimony.

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INSPECTOR MacDONALD: Good morning. I'm Chief Inspector Daniel MacDonald. I am the Commanding Officer of the Philadelphia Police Department's Narcotics Bureau, and I'm here on behalf of Police Commissioner Ross. I'd like to thank you for this opportunity to provide testimony from the Police Department's perspective.

COUNCILWOMAN BASS: Thank you for being here.

INSPECTOR MacDONALD: My goal here today is to give you a brief overview of the volume and extent of the heroin trade in Philadelphia. As sad as these statistics may show, I'm also here to identify proactive measures that the Philadelphia Police Department has undertaken to help break this cycle of addiction and to save lives.

First, let me address the scope of the problem here in Philadelphia. In 2014, over 650 people died of overdoses. That continues to be a problem through

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2015, and this year, there was over 77 that we can directly relate in the first quarter of deaths related to morphine or opioid overdoses that caused deaths.

So far this calendar year, the Philadelphia Police Department has arrested over 2,000 people for selling drugs. Just sales. And my Bureau alone has arrested over 1,100 of these individuals for selling drugs out there, and we've confiscated over $40 million worth of narcotics.

Of the total drug seizures this year, heroin had a street value of $14.6 million of these drugs that were seized, about 37 percent of all the drug seizures in Philadelphia. For the same period in 2015 -- that's January to now -- we arrested about the same amount of dealers, 1,142, but only seized about $6.2 million in heroin last year.

During the same period, our OxyContin/oxycodone has increased from 7,800 worth of street value to about

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11,500 in seizures in the same period last year. Guns and money, we've got about the same amount, 175 guns each year to date off of drug dealers, related to drug-related endeavors, and another $2.5 million each year to date in actual cash seizures from drug dealers.

Now, while my role in the Narcotics Bureau is to target drug dealers and remove illegal drugs and guns from the streets, I, along with Police Commissioner Ross and police leaders from around the country, have long recognized law enforcement's role in the drug prevention and training. As such, the Police Department's Community Relations Office has been committed to the DARE program where we reach out to kids out there, which focuses on improving their decision-making skills and keeps them away from illegal drugs. We also have heavily invested in the HEADS-UP program. It's a local program, Heroin Education and Dangerous Substance Understanding

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Program. Locally created with members of the Department, along with volunteers from the recovering community and members who have lost loved ones to drugs conduct presentations to the children to educate them in order to prevent their involvement in the drug use and to give them role models and tools that they can build good character with. This program is chilling. It is like a scared straight kind of thing. It is not pleasant to see, but it does put them on the right path.

In addition to training and education, the Philadelphia Police Department has begun to directly intervene to prevent illegal medicines from falling into the wrong hands and to save the lives of those who are already addicted to opioids. First, as the experts here have talked about, opioids are extremely addictive, and prescription medication is a gateway to heroin addiction. The issue of overprescribing

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this type of medication is not just local. It's national. I've been all over the country and talked to the narcotics investigators. Everywhere is dealing with it. In medicine cabinets across the City and across the country, we're going to have illegal -- or legal opioid painkillers that are sitting in there just waiting, and this is where our children, our family members, and friends can begin the cycle of addiction in addition to what we're being overprescribed.

Other experts have testified it's incredibly addictive. But when these pills, these legal opioid pills, run dry, that's when the people turn to a cheaper, more readily available substitute, which is heroin.

Now, knowing this fact, the Police Department has partnered with the District Attorney's Office as well as the Pennsylvania District Attorney's Association to address the excess opioid

medications and installed drop boxes in, I think, 13 now -- we're going to have 21 -- drop boxes in police districts throughout the entire City where anybody 24/7 can come in and drop off their excess medicine. And I'm sure the District Attorney will discuss that as well. And this has been -- the DA's Office has really helped us with this program a lot.

And, finally, in November of 2013, Pennsylvania Senate Bill 1164, which authorized naloxone to be used by police officers out on the street, was passed, and in anticipation of this, the Philadelphia Police Department worked with the Fire Department and Deputy Commissioner Laster to get everything hashed out so our guys and girls out there on the street can start carrying this. We began carrying it in January 27, 2015, and to date, there are 813 naloxone overdose kits in the hands of Philadelphia police officers. These

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officers are assigned to East Division and Northeast Division, where we predominantly see our heroin problems. There have been 129 lives saved based on this - 112 in East Division and another 17 in Northeast Division.

Now, in closing, I've described the overall scope of the heroin problem -- it's big -- and efforts the Department has taken. I want to add like many other people have that opioid addiction is clearly not one way we're -- it's not a solution we're going to arrest our way out of. It's just not. We need to focus on prevention, intervention, and drug enforcement together, working together out there.

The Philadelphia Police Department is committed to saving lives, everybody's, and we stand committed to stemming the flow of heroin into Philadelphia, but also to help those that have fallen victim to this epidemic of addiction.

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This concludes my testimony. I'd be happy to answer any questions you have at this time.

COUNCILWOMAN BASS: Well, thank you very much for your testimony. We're going to wait to ask questions, but the one thing I just really want to point out from your statement that I think is very telling is that the cycle of addiction -- I think most of us think that it's going to begin on a street corner, that our child is going to encounter someone who is going to encourage them to take something or do something and that that's where it's going to begin. But actually, as you stated, it can begin in our own medicine cabinets at home. So just really something very telling that I wanted to emphasize.

Mr. District Attorney, welcome.

DISTRICT ATTORNEY WILLIAMS: Good morning, Councilwoman and members of Council. I'd like to thank you for this opportunity. I'd ask that my complete --

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I've submitted my testimony. I'd ask it be accepted for your record and I'll try to condense my oral testimony --

COUNCILWOMAN BASS: We appreciate it.

DISTRICT ATTORNEY WILLIAMS: -- in abundance of caution and for your time.

COUNCILWOMAN BASS: Thank you.

DISTRICT ATTORNEY WILLIAMS: I want to really thank all of you and I want to thank Councilman Oh for having your hearings and town hall meetings across our city, because it's so important for us to address this. As I sat here waiting to give my testimony, I was just thankful to have the opportunity again to hear Gary Tennis so passionately describe the need for us to address it. And while I was sitting here, I watched members of the audience that were crying. Clearly, this is more than just statistics. This hits families and addresses homes. Almost all of us have

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family members that have been addicted to something one way or the other. So I was very thankful to have the opportunity to be here just to be a part of this.

Philadelphia, like much of the country, is in the midst of a heroin crisis. The statistics unfortunately paint a grim picture of tragedy and despair.

Consider that since 2009, Philadelphia has seen a 43 percent increase in drug overdose-related deaths. Philadelphia has also seen a 45 percent increase in overdose deaths where heroin was present in an individual's system. Nearly 350 fatal drug overdoses in Philadelphia involved heroin in 2014. Indeed, more than half of the 655 drug-related overdoses in Philadelphia involved heroin. Heroin overdoses represent a citywide problem.

Naloxone, an overdose antidote, was administered by emergency medical services in every zip code, except for

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two, from January to June in 2015. I think it's important to recognize that while we're here, this panel, the second panel, as law enforcement, we'll be the first ones to tell you that we're not going to arrest our way out of this problem, that we have to address it as a public health problem, and that we have to have a holistic approach. And all of us I think -- you'll hear from the federal authorities and now from SEPTA. All of us are trying to, as progressively as possible, work together to address it on the front end.

But there's a direct link, as you've just identified, between prescription drug abuse and heroin abuse. During the last legislative session in Harrisburg, my office successfully lobbied in Harrisburg to pass legislation creating a prescription drug database, which will allow practitioners to better monitor patient prescription drug use and provide law enforcement with information

about people abusing the system.

Governor Wolf and his staff have been actively engaged in implementing this database, and we expect it to be operational in the very near future. Such databases are considered best practices in the fight against opioid abuse.

At the same time, we also -- that's the Pennsylvania District Attorney's Association -- successfully lobbied in Harrisburg for the passage of a Good Samaritan law, which ensures that those who call 911 to save someone from overdosing and overdose victims themselves cannot be prosecuted for simple drug possession. We've also worked closely with Commissioner Ross, as you've heard, in our implementation of our prescription drug box program, which allows people to drop their prescription drugs in a secure drop box at various police precincts. As you've just stated, the majority of people who are now

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addicted to heroin were originally addicted to prescribed painkillers, and we have to address the pharmaceutical companies who are profiting off of this death. But at present, drop boxes are at 13 different police districts across our city - the 1st, 3rd, 5th, 6th, 7th, 12th, 14th, 15th, 19th, 22nd, 25th, and 26th and the 35th. Soon all the remaining police districts will be equipped with drop boxes. To date -- and we've implemented -- we put the first ones in January. To date, we have collected over 200 pounds of prescription drugs.

In addition, with our colleagues in the District Attorney's Association, we secured $50,000 in funding from Blue Cross for the police here in Philadelphia to purchase more naloxone kits, which will literally save lives. Working with the courts, we have robust treatment and intermediate punishment programs to help those arrested for crimes like drug possession

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get into drug treatment. They work, but we need more treatment beds. We have more addicts, unfortunately, and the demand for beds far outpaces the supply. But fortunately as a result of Governor Wolf's expansion of Medicaid, more people are able to receive drug treatment. In the Governor's proposed Fiscal Year '16-'17 budget would provide treatment for more than 11,000 addicted Pennsylvanians.

State and local officials are working with the medical community to help ensure that doctors and hospitals will abide by these new guidelines. This is a very important step. You heard a person earlier state that Massachusetts recently enacted such a law limiting initial prescriptions for opioid drugs to that seven-day supply for adults and providing a seven-day limit for all opioid prescriptions for minors.

Finally, we need to ensure that drug addicts who are saved through

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naloxone and our Good Samaritan law or by any other means get drug treatment. The state is developing, as you heard earlier, a warm handoff program to place these individuals into treatment immediately after an overdose, something which is definitely needed. We may need to take an even more aggressive step to put people into treatment if those people are serious and pose a serious and possibly deadly and danger to themselves.

But, again, thank you for this opportunity to testify today, and as always, my office is ready to meet with you to fight this scourge to saves lives in our city.

COUNCILWOMAN BASS: Very good. Thank you very much for your testimony.

Any questions? Not yet? Okay.

All right. Sir, you want to state your name for the record and begin your testimony.

MR. TUGGLE: Gary Tuggle. I'm the Special Agent in charge of the Drug

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Enforcement Administration's Philadelphia Field Division. Madam Chair, thank you. Members, thank you.

If I may, forgive me. I'm going to digress from my prepared testimony. You already have that as a part of the record. What I'd like to do is really put this problem into historical perspective for you, if I may.

The Vietnam War lasted from 1955 to 1975, and in that entire war, we lost just over 52,000 arrest holders, right? Today we're losing just over 46,000 people per year as a result of overdoses.

To put it in another perspective, I've lived through the three worst drug epidemics in the history of this country. There was a post-Vietnam heroin epidemic that was largely confined to the inner city, minority neighborhoods. During the crack cocaine epidemic, I was a police officer and a DEA agent at that time, very destructive,

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highly addictive, caused mass confusion, mass destruction to neighborhoods. And now we're going through this particular heroin epidemic. I'm not going to address the opioid piece yet, and just let me give you an idea of how it compares. This particular heroin epidemic dwarfs the two former epidemics. I want you to understand that. Because it's got a feeder system to it that the other two epidemics didn't have, and that's the misuse and abuse of prescription opioids. We're losing over 125 people a day to that. So I really, really want to put it into perspective for you.

Any suggestion that law enforcement can't play a role in this I'm going to tell you is a fallacy at best, because oftentimes -- and I grew up in Baltimore City. I was a kid there. I was a law enforcement officer there, in areas very, very similar to Philadelphia. As a matter of fact, I call Baltimore

"Little Philadelphia," right? But the role that law enforcement plays is so critical, particularly at the street level, because oftentimes it takes an event, it takes an event to convince somebody to go to treatment. I've seen it happen as a kid. I saw it happen as an adult, as a police officer, and as an agent.

But it has to be a multi-pronged approach. We have to get out of our silos. We've been stuck there. Law enforcement, God knows, was stuck there for years, right? We have to get out of that, and I think we're moving toward it.

I've heard the testimony of my colleagues here, and a lot of the things that are in my prepared testimony, they've already said. So I don't want to beat a dead horse. But what I do want to talk about is DEA's approach at the federal level.

We initiated in November a

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strategy called the 360 Initiative, and for DEA, that's a three-pronged approach that still has enforcement there. We're a law enforcement agency, right? We're always going to be a law enforcement agency, so that's at the forefront. We got the law enforcement piece. We have the regulatory piece. As you know, DEA regulates about 1.6 million registrants throughout the country, about 71,000 in Pennsylvania, right? Then we have the community piece, which we're really trying to get good at, and that community piece calls for us to have those non-traditional partnerships. So we're not just partnering with the gun carriers and the badge carriers anymore. We're partnering with communities to build coalitions to go after this problem at a totally different level. We're partnering with treatment providers, educators, members of this -- as a matter of fact, in this room, folks in this room we've partnered with to attack the issue.

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As we look at the problem from the community perspective, we see opportunity. When law enforcement goes in to particular areas to do operations -- so major investigations are what I'm talking about -- and we dismantle the major drug trafficking that works, we create a time and space for providers, wrap-around service providers, to get in to provide services to those that are adversely affected. I'm not talking about the drug dealers. I'm talking about those who have the illness of addiction.

We recognize that there's a need, a severe need, for increased treatment capacity, and we see that time and space is an opportunity for community leaders, for the clergy, for treatment providers and educators to get in to do what they do best, and that's what we're offering through 360.

In addition to that, in November, we initiated an operation

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called Operation Trojan Horse where we're training state and local law enforcement to investigate fatal overdose scenes, not just as mere medical emergencies but also as crime scenes. So eventually we can go back after the people, the purveyors of death, that sell this stuff that's killing these people, right? But in addition to that, it provides funding, limited funding, in intelligence resources to local law enforcement throughout the state to help them conduct their own investigations.

We've also partnered with the Partnership for Drug-Free Kids to better train not just law enforcement but social services and educators on how best to talk to our young folks, which is where we believe we're going to have the biggest impact in terms of being able to prevent through educating, because the horse is out the door in a very, very big way. Again, we recognize the need for increased treatment capacity, but if we

don't prevent by educating and making folks aware, it's only going to continue.

Let me address one more thing, the regulatory piece. There were three doctors indicted a couple of weeks ago, last week as a matter of fact, on federal drug charges as well as healthcare fraud charges. These three doctors are accused of selling Suboxone and Klonopin. Both are used to treat addiction, but these folks, we allege, were selling this stuff out the back door, and they made about $5 million doing that, right? So another part of 360 is for my office on a regulatory side to get super aggressive in going after what I call the white coat drug dealers, right? It makes them no better than the guy and the girl standing on the corner selling heroin.

That's going to conclude my testimony, and I just wanted to thank you again.

COUNCILWOMAN BASS: I want to thank you for your testimony. I'm making

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comments in between because unfortunately I have to step out of the hearing for a moment. But actually I just wanted to follow up on your last comment in terms of the drug dealer in the white coat, and I think actually because they have that white coat, that actually makes them a worse drug dealer, because they've taken an oath and because they have made a commitment to help preserving lives and saving lives and helping people, and they're doing just the opposite.

So I think that the prosecution on this, we're looking forward to seeing them prosecuted and seeing people being held accountable for their actions and for the impact that they've had on these lives and in our communities. So I wanted to thank you for that.

Chief Nestel.

CHIEF NESTEL: Good morning, ma'am.

COUNCILWOMAN BASS: Very good to see you, as always.

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CHIEF NESTEL: Likewise.

COUNCILWOMAN BASS: If you want to begin your testimony, I'm going to ask the Committee Vice Chair, Maria Quinones-Sanchez, to come and to step in in my absence, and hopefully I'll be able to be back before the hearing is completed.

CHIEF NESTEL: Yes, ma'am. Thank you.

COUNCILWOMAN BASS: Thank you.

CHIEF NESTEL: Good morning. I'm Thomas J. Nestel, III. I'm the Chief of the SEPTA Transit Police. I wasn't on the original list of speakers. I was drafted by Councilman Oh. I've told Councilman Oh that I come to listen and learn.

I am not a drug addiction expert. I'm a cop, and when you listen to the remarks of these great experts, some things jump out and smack you in the face. One of them, $40 million worth of narcotics seized in Philadelphia this

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year. It's May. 40 million. And the rate of people dying of overdoses is higher than ever.

We talk about how many people we arrest. I mean, we're great at arresting people. Wouldn't it be interesting if the next time we meet, we're talking about the number of people that the police and that law enforcement have channeled into drug rehabilitation, drug treatment, and that are still in treatment?

We talk about naloxone, a wonderful thing that saves lives, and you know what we're finding? It's saving the same lives over and over. We're not getting treatment for those people. We're saving their life and not channeling them to the opportunity to save it forever.

We have officers that are out patrolling every day coming in contact, and you heard one of the stories about a Philadelphia police officer that

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channeled somebody into treatment. That happens all of the time, and I can tell you that when we take somebody to treatment, they have hit their lowest rock bottom, because they've approached a police officer and said, I'm a drug addict and I need help. If you're coming to the police to say that you have a drug problem, you are at your lowest point. And we transport them to a treatment center where they can only get counseling because there aren't enough beds.

It's a cycle that we've seen for decades. You know, you can go to the same corner -- I've been a police officer in this city for 33 years. You can go to the same corner that I went to 33 years ago to arrest somebody and they're still selling drugs on those corners.

The answer -- again, I'm not the expert. The answer is not with law enforcement. We are the final line. We will arrest those persons that are selling the drugs, but we need to get

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treatment and intervention for the people that have the addiction problem. And, you know, I hear over and over again that addiction is stigmatized. It is. Yesterday I talked to a lieutenant. We had a contact with his daughter, and the daughter is clearly a heroin addict, and he doesn't want to admit it, you know. It's in every family, in every profession. Addiction treatment is the answer, and we need to be a part of helping people get to that treatment.

I have no other remarks.

MS. BERKEBILE: Good morning -- good afternoon, I guess. My name --

COUNCILWOMAN SANCHEZ: Speak into the mic.

MS. BERKEBILE: My name is Becky Berkebile. I'm from the Pennsylvania Office of Attorney General and I'm the Director of Drug Control Programs there. I would like to thank the City Council and Councilman Oh for inviting me here today.

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The current opioid and heroin epidemic is crushing all of Pennsylvania, not just Philadelphia. Philadelphia as a source city is being hit especially hard. As a law enforcement agency, we know Philadelphia has some of the purest heroin on the street today and the cheapest. We know that people are coming from outside areas to get their heroin here.

As a state agency with health and oversight responsibility, the Office of Attorney General is always looking for new ways to combat the drug problems. In 2015, we created the Drug Control Programs Unit to combat drug problems by using a holistic approach. You'll hear a lot of things that I say are repeated today, because a lot of law enforcement is on the same page. Treatment, education, and enforcement are equally important, and we are adding to our investigative resources by bringing more education and working with treatment

partners.

We have heard it said a million times that we cannot arrest our way out of the problem, but what does that really mean? We can't tell law enforcement to stop arresting people, but we can give law enforcement more tools to do their jobs. Public safety and public health are interconnected.

At the Office of Attorney General, all of our narcotic agents and several other units will be carrying the opioid and heroin overdose reversal drug naloxone, or Narcan. All agents are receiving training to recognize and assist victims of overdose. We are also providing our agents with resources and contacts so that in an event of a Narcan administration, they can call treatment resources or give treatment information to survivors. We are currently designing safe cards for agents to have on hand with resources listed on them at all times.

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The Office of Attorney General is working with the Department of Education, the Department of Environmental Protection, the Department of Drug and Alcohol Programs, the National Guard, and the Pennsylvania District Attorney's Association and other state agencies to build a sustainable drug take-back program to get excess prescription drugs off the street. I believe as of February 2015 up until now, we're about 67,000 pounds of prescription drugs we've destroyed for the State of Pennsylvania.

We've seen firsthand through debriefings that 80 to 90 percent of new heroin users began their addiction with prescription drugs. With the new Prescription Drug Monitoring Program expected to be up and running this fall, heroin addiction and fatal overdoses will increase. We have seen that repeatedly in other states. When the Prescription Monitoring Program takes effect, it's

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harder to get prescription drugs, and heroin, cheap and available heroin, is on the streets.

The Office of Attorney General has also expanded the Education and Outreach section of the office. Drug control programs is working to improve education and outreach presentations and educate friends and family members of addicts about Narcan and treatment resources. The Office is creating new drug brochures that include treatment resources. It is not enough to educate people on the dangers of drugs and not give them information about treatment and recovery. Our office has worked hard to build relationships with the Department of Drug and Alcohol Programs and treatment professionals statewide. We have to stop the siloed approach in government and we need to start working together.

Our office has created working groups regionally that are comprised of

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treatment professionals, law enforcement, and hospital emergency departments. Non-fatal overdoses is the number one thing that we can't seem to get a grip on or get a number on, because no one is tracking that. We don't know if people aren't checking into hospitals, and we can't get those numbers. We know the people who have died. We don't know the people still alive fighting the addiction. It is vital to combatting the current drug threats for different agencies to come together and share resources. We cannot do it alone.

We are seeing the successes of cities like San Francisco who have pulled resources in their Tenderloin district to combat this public health crisis. Philadelphia is on the right path. Council's resolution is great. We are getting drug take-back boxes across the state. There's been a lot of effort made amongst the fire departments, the police departments, the district attorney's

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office. You're on the right path. I would encourage you to look at the Tenderloin health improvement plan and some of the programs that they are using in San Francisco and how they have pulled resources together from non-profits and government and different areas.

We're in the middle of a public health epidemic and we have not seen the worst of it yet. It is essential for communities to change the stigma of addiction and for law enforcement, treatment, and health to work together, not as competing entities.

Thank you.

COUNCILWOMAN SANCHEZ: You may proceed.

MR. DALEY: Good morning, members of Council, and I too thank Councilman Oh for the invitation to be here. My name is Jeremiah Daley and I am the Director of the Philadelphia-Camden High Intensive Drug Trafficking Area. For the last 12 years, I've been in that

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role, and prior to that, I spent 25 years as a Philadelphia police officer, rising to the rank of Inspector and for a period of time running the Narcotics Division in Philadelphia.

Everything that has been said by the previous speakers on this panel I will just incorporate in the essence of time, but I do want to point out a couple of other things that I think need to go on the record again and again and again and a couple of new things as well.

First of all, we are a -- Philadelphia has a long and destructive love affair with heroin. This is not a new problem in Philadelphia in some respects, but it's a far more widespread problem and far more intense problem than we've ever had before.

If you go back to the '60s and '70s, there are parts of the City, primarily inner city neighborhoods, that were impacted by heroin then. It waned for a while. It came back with a

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vengeance in the '90s when new sources of supply from South America came forward. Cheaper, more pure heroin was available on the streets, and we saw this uptick again. In this period from 2005 to 2007, we saw over 100 Philadelphians die from a drug that hasn't been mentioned yet today, fentanyl, which is a mimicker of heroin and other opioids. So during that period, we began the effort of outreach with the public health communities to see if we could get enough information on it, and for a while, we were able to sustain a little bit of effort on that. But now that we're into the second decade of the 21st century, we're seeing this problem all over again, with even new threats, even more recent threats. On top of the prescription drug problem, on top of the historic South American heroin influx into our region, on top of all that, we also have Mexican-sourced heroin coming into this part of the country as well, increasing the supply levels and,

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therefore, lowering the price, keeping the purity levels high, and making this that much more intransigent. And beyond those, synthetic opiates, things like fentanyl and all the analogs of fentanyl and some novel cycle active substances are coming on that are being introduced into the opioid marketplace illicitly. These problems are just magnifying the extreme urgency that we need to address this issue now forthrightly.

We are a regional source of drugs to the Delaware Valley region and beyond, as far south as Maryland, as far west as Pittsburgh and West Virginia, as far north as lower New York state and so forth. We've had investigations that show that the drugs coming from Philadelphia travel there as well.

All that said, our most critical issues are right here in the heart of Philadelphia. In particular, in Eastern North Philadelphia, lower Northeast Philadelphia, we see the

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highest number of trafficking instances, overdose instances, and other indications of severe heroin problems.

We will continue to see this problem until we change a few fundamental things. First, as was mentioned earlier on, we have to look at this as being something beyond a law enforcement problem, well beyond it. In fact, we have a role in it, but we do not have all of the tools that we need. Secretary Tennis mentioned a three-legged stool. I prefer to look at it as a four-legged table - prevention, treatment, enforcement, but also long-term recovery support and sustainment of the folks who are addicted for life, and we have to make sure that that's part of this equation as well.

The second part is within that prevention piece, we really need education to be on board on this. The schools, our medical schools, our pharmacy schools, of which we have

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several great ones here in the City, all need to be prompted to be part of the solution to this problem as well.

Thirdly, we also need to have every agency of government - federal, state, local, public health, safety, criminal justice - all working together and comprehensively. There are models for this. In New York City, they've created what they call the Rx Stat Project that's been very successful in helping identify across disciplines and sectors where problems are. We don't have the capacity right now to share information between these different disciplines and these different sectors effectively. Almost all of our information are in little stovepipes or silos, and we're not exchanging information well.

When we do get the opportunity to exchange information, oftentimes it's historical information, a year or two old. Well, we can't afford to be

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students of history any longer. We have to be agents of change, proactive in our approach to this problem, and we need to take this into consideration in building out any strategy on that.

The last two decades of growth of heroin abuse in the City, we own some responsibility for that, because we didn't see all the different aspects of this coming together at once. With that said, we do own a piece of the puzzle for curbing it.

When we see the volume of heroin that runs through the City, it's shocking. Last year our task forces seized in excess of 100 kilograms, over 220 pounds, of heroin in just their investigations, and that's a fraction of the law enforcement work overall. So we need to be forthright and diligent in addressing the supply side of it, but at the same time, we also need to be supportive and involved and engaged with those that are attempting to address this

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from the demand reduction side as well.

Our partners in the Department of Behavioral Health and Intellectual disAbility Services, Office of Addiction Services are fantastic. The Health Department, the Office of the Medical Examiner has been great in sharing mortality and morbidity data with respect to overdose deaths. We're working more and more in task force operations with non-governmental organizations, like Prevention Point Philadelphia, being supportive of the community coalitions that are coming together to address demand in particular neighborhoods. But unless we all start working collaboratively, we're never going to be able to get our arms around this.

I want to thank City Council for bringing this issue to the forefront, to addressing this head on, and hopefully we can be of assistance to you as we go forward.

COUNCILWOMAN SANCHEZ: We

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really appreciate it.

Is there one more person on this panel? We got everybody.

I really appreciate it. I want to just kind of note the value of having all of our law enforcement folks acknowledge that this really -- we do need to break down these silos. Unfortunately, I know all of the panelists all too well. Mr. Tuggle, who taught me a lot about how bad it is, and the numbers, when we talk about 125 people a day, so while we're having this debate, there are people dying. And so this sense of urgency is hugely important. Nestel, who is on the front ground all the time doing this stuff.

So we really thank you. And for us moving forward, I guess one of the challenges for us is really figuring out how the silos get broken and how we leverage the resources. And going back to Councilman Oh's initial point about ultimately it takes this higher level of

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coordination to look at what everyone is doing and making sure that it's more than collaboration, but how do we all hold ourselves all accountable for the resources that we have and how we utilize them.

So we thank you. Thank you, everyone, here in the panel for coming forward, and I look forward to the Councilman's action steps when we conclude these hearings. So thank you all. Thank you to our DA for coming and joining us.

Will the Clerk read the list -- or I can read the list. So we're going to Panel 4 with -- I know we have elected officials that we want to get through. We appreciate them. We have Dr. David Metzger, Fred Wells Brason, Dr. Gerald Stahler, Brian Work. And then we're going to, after we finish this panel, go to our elected officials panel. I know Dr. Valerie Arkoosh is here and the rest of the elected officials.

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(Witnesses approached witness table.)

COUNCILWOMAN SANCHEZ: We can proceed. Identify yourself for the record. If you have written testimony, because I imagine this is going to be quite a technical panel, it will be submitted for the record. So you could feel free to summarize and highlight the important points that you want us to capture, particularly Mr. Stahler, who has given us a thesis on this.

DR. STAHLER: It's an exhibit.

COUNCILWOMAN SANCHEZ: Thank you. You may proceed.

COUNCILMAN OH: Please identify yourself for the record and give us your testimony.

DR. METZGER: My name is David Metzger. I'm a Professor at the University of Pennsylvania and I'm a Research Advisor to the Treatment Research Institute. I've been working in studying methadone treatment and other

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treatments for addiction since the last opiate epidemic in 1978 in Philadelphia, and I want to thank the Council for convening this very important and very timely hearing. I especially want to thank Councilman Oh for the invitation to speak.

As you all know and has been said many times this morning, opioid addiction has tragic impact on individuals and families in every neighborhood in the City and cuts across all socioeconomic groups. We are in the midst of an opioid epidemic, and in my limited time today, I want to highlight a few key points focused on the treatment of opioid dependence.

The first point I'd like to emphasize is the critical importance of viewing this addiction as a chronic medical condition. It's a condition with both biological and behavioral components, and both must be addressed in effective treatments. As with other

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chronic diseases like hypertension and diabetes, the most effective management requires both the right medication and behavior change.

As a chronic condition, it's also important to recognize that there is no cure. While many people stop use, relapse is common. In fact, it should be expected. Consequently, the management of this disease requires long-term strategies that address mental health and co-occurring medical problems and provide social support for relapse prevention during recovery. Short-term fixes simply will not work.

It's important to state that the City's Community Behavioral Health and its Addiction Services recognize these priorities and have supported an evidence-based progressive agenda designed to build a treatment infrastructure around these priorities.

Importantly, the combination of medications and counseling, which we

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refer to as medication-assisted treatments, have proven to be the most effective strategies for managing opioid dependence. They're not perfect. The two most commonly used medications currently are methadone and Suboxone, which is a combination of buprenorphine and naloxone. Both medications, when properly administered, significantly reduce opioid use.

In the most recent and largest study looking at patients that were randomized to methadone and Suboxone, retention rates were found to be higher at six months for the methadone patients, at about 75 percent versus 50 percent. However, for those who stayed in treatment, the Suboxone group had fewer instances of opiate use. So more people were treated effectively with Suboxone, but fewer people stayed in treatment. So it's not a simple fix and there's still a lot of research that's needed in order to understand the factors that influence

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treatment.

However, for those who remain in treatment -- this was a study that followed people for five years -- both treatments produced about the same effects at the end of five years, which was about 50 percent of the people were opiate free. So I think that gives you some framework for thinking about the power of treatment. Now, without treatment, we know that recovery is rare.

We now have the first long-acting medication for addiction treatment, extended release naltrexone, which is called Vivitrol. It's an antagonist, different from methadone and Suboxone, and safely and effectively blocks the effects of opiates for a full month with a single injection. During the time of coverage, opiate use is essentially eliminated. The problem has always been with these antagonists that people don't want to take their medication, but the fact that it's a

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long-acting medication, the first one for a full month, has some advantages, and I think we're just now starting to realize how best to implement these in programs and settings. In fact, a study that was led by investigator Dr. O'Brien at the University of Pennsylvania was recently reported in the New England Journal of Medicine where 300 opiate-dependent people were given injections upon release from jail, and the group that got the injections had a 60 percent recovery rate after six months, 60 percent versus 40 percent for the people who went into treatment as usual.

So data on Vivitrol is rapidly accumulating, and consequently its use and availability is becoming more widespread.

For each of these medication-assisted treatment approaches, it's important to note that when patients leave treatment, there is a rapid return to opioid use. So the challenge is to

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get people into treatment and to keep them in treatment.

Coverage for the cost of these medications is limited, and there simply aren't enough treatment providers. In addition, many individuals and a fair number of treatment providers themselves lack knowledge of effective treatment strategies and hold beliefs that limit access.

It's clear that access to quality treatment for opioid addiction needs to be greatly expanded, and in order to maximize the public health impact of treatment, a range of options is required. No single approach can address the needs of all the opiate-dependent people.

Importantly, there is considerable consensus that this expansion can only happen through the integration and coordination with the primary medical care system. In fact, it's an expectation of the Affordable

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Care Act. Opioid addiction is a medical problem and it needs to be treated within the infrastructure of our healthcare system.

Thank you.

COUNCILWOMAN SANCHEZ: Thank you.

You may proceed.

MR. BRASON: I'm Fred Brason from North Carolina. I guess one of the few, if not the only, from outside the state, but Pennsylvania is my home state, having been raised in Harrisburg. So I have a great admiration and pleasure to have been from Pennsylvania.

I'm here to talk about Project Lazarus, which we began back in 2004. I was the Chaplain and the Hospice Director in our county in rural North Carolina and came across the issue among our patients and their families with medication diversion, medication stealing, medication selling, to the extent that I never seen it before having been

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long-term home, health, and hospice career.

So as we began to in the community address the problem, we realized the magnitude of it. In 2007, our own Wilkes County was the third worst county in the United States for prescription medication overdoses. We were in a healthcare crisis and have been for a number of years. But because we are -- I'm a person first. Whether it is a person in pain or whether it is a person in addiction, we need to have the care and the treatment for each one without obstacle, without stigma, without problem, and locally. And that was the premise of how we approached our problem of the overdoses. So we took that public health approach and we designed a model around that, to raise awareness, to build coalitions so that we break down the silos and we use local realtime data to help drive that going forward. But surrounding that, we did prescriber

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education. We did emergency department policy changes. We did diversion control in working with local law enforcement and making sure that the drugs that are there are getting disposed of, and also then those that are diverting are being stopped. And at the same time, we wanted to make sure that the people with pain also had the proper care and support so that they were taking responsibly and safely. We want to make sure that there was harm reduction involved, so we were one of the first in the country to initiate the co-prescribing of naloxone. Our North Carolina Medical Board in 2008 was the first medical board in the country to come out with a position statement saying that naloxone should be readily available to individuals who are at risk. Who did we find who were at risk? Well, in investigating the overdoses in our community, we had patients who simply misused.

We're a rural community. We

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share a lot. We horde a lot. We had families and friends dying from overdose because they simply shared medications to self-medicate for their pain. We've had incidences of accidental ingestion because of the number of medications that are in the homes now. We had recreational users who were in our neck of the woods, so to speak, who were pretty much moonshining alcohol. We have the marvelous M's, as I call them now, the moonshine, the marijuana, the methamphetamine, and the medicine causing problems.

But as we designed the approach because of the looking at people with pain dying to substance use problems and everywhere in between dying, we realized that a public health approach had to reach all population groups, all ages, and that was our determination. And we realized that one of the spokes had to be not only the naloxone, but we also have to build addiction treatment, something

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that we did not have in our community, something that our community didn't want. They did not want medication-assisted treatment. First time I mentioned methadone, I thought I was going to have to move back to Pennsylvania. I mean, it was nasty. It was horrible. But now we have over 450 people getting daily treatment within our methadone and buprenorphine clinic, because we educated and we brought awareness. And the science of addiction, which is so important to erase the stigma, that it isn't a moral and behavioral failure on everybody's part. Nobody chooses addiction, but every day addiction chooses somebody, and we've got to find a way locally on how we can appropriate the care, get them systematically into the right treatment, and it may be naloxone, it may be methadone, it may be buprenorphine, it may be 12-step. There's all sorts of different avenues that we need to bring about.

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And, Councilman Oh, I know your office asked me, Well, Project Lazarus being rural and how you did that, is that something that can be done in Philadelphia? And my answer was yes. Philadelphia is a city of neighborhoods, and we take this neighborhood by neighborhood by neighborhood, and then we look at what's missing, what's not being done, how we're doing it.

And one of the aspects that I've been listening for this morning is the social determinants that drive substance use, people that are looking to -- how do I cope better, how can I break my depression, all of those factors, because we're a community where the social determinants are at a very high level. We are a depressed economy in our community. We are -- from 2000 to 2014, they now did a study on income loss among our counties in the United States. We're number two.

So all of those are factors.

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And then how do you study hopelessness? How do you deal with hopelessness when most people find substances as a way out, either long term or short term? But we wanted to make sure that we do prevent the overdoses, but we wanted to make sure that there's responsible pain management, and we promote the substance use treatment, because I want the patient to get the right care. We did develop policies. We do have our prescribers using the Prescription Drug Monitoring Program and proper biopsychosocial assessments, but tying them and networking them in the community so that they have that warm handoff if they find a patient with a problem. And I know Pennsylvania, you're about to launch your PDMP. We did ours in 2007. We did not make it mandatory because we wanted to build it locally first so that our prescribing community -- if all of your doctors in one month check all of their patients within your PDMP in

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Pennsylvania, they're going to find problematic patients. If they do not have a warm handoff and they simply stop prescribing and fire that patient and discharge them from their practice, you are walking into a bigger heroin dose emergency department issue problem. So there's got to be the local connection to all of those. That's a lesson learned on our behalf.

But we want prescribing to be effective, responsible, and safe. We want people to take it correctly, store it securely, dispose of it properly, and never share. That means we do need the take-backs, we do need the permanent drop boxes. And I know there was a question earlier, what's the one thing we can do to do this. There isn't any one thing, but there is everything that can be done. But it has to be -- we can get Harrisburg to legislate and provide the bills and the statutes, but guess what? It all gets implemented at the local community.

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I've been helping Westmoreland and Lycoming and Wayne and Dauphin and Luzerne. I've been all over the State of Pennsylvania, and I guess today is thanks to Secretary Tennis for dropping my name, but he's always finding a way for me to get here, and I love being here.

But we made a difference. In 2011, we had dropped our overdoses 69 percent. Over a five-year period, we have equalled out at 50 percent drop in overdoses. Our school incidences were about 7.4 for substance use per 1,000 drops. That's dropped to 3.4, and we're getting -- as I said, we already have 450 people in treatment that we didn't have in 2010. So all of those factors are working. We work with the travel groups, the military groups. And I just want to read one statistic from our Fort Bragg, the largest military base. They've been doing Project Lazarus as Operation Opioid Safe for six and a half years, and they have out of 140,000 people that they can

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take care of, they have a 25 percent decline of overall opioid prescribing across the entire health system and a 33 percent decrease in high-dose, long-acting formulations. They have instituted pretty much what the CDC is recommending, pain management, risk stratification, risk medication, provider education, and other methods of treatment. All of those have played a role, and we've realized that they dropped their overdoses from 15 per 400 soldiers to 1 to 400. All of that makes a difference.

And I just appreciate your time today. It's a multifaceted approach that needs to be done. Your neighborhoods in Philadelphia can do it.

Thank you.

COUNCILWOMAN SANCHEZ: Thank you.

We're going to hear from our last panelist.

DR. STAHLER: Thank you,

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Councilman Oh and other Councilmembers for inviting me to testify at this hearing. My name is Gerry Stahler and I come here not only as a Professor at Temple University, whose one of his star students is sitting there, Morgan Zalot, and I've really focused my research and teaching on substance abuse throughout my whole career, and I'm here not only as a member of the boards of Prevention Point and Gaudenzia as well as a member of the Overdose Prevention Task Force, but also as a concerned citizen who has had to deal with heroin addiction within my own family.

I'm sure that many of you are very familiar with the statistics, the really dire statistics, about 44,000 people dying nationally, twice the number of deaths in Pennsylvania due to drug overdose as traffic accidents, or how nearly 700 Philadelphians have died from drug overdose this past year.

These are horrendous

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statistics, but what really brought home to me this crisis were two personal events. I teach a class about drug addiction at Temple, and I asked my class last semester how many had had a personal friend or family member killed in combat, in one of America's wars, and one student raised his hand. I then asked how many had a personal friend or family member who had died of a drug overdose, and I was shocked to see about three-quarters of the class raised their hand. In fact, I was so shocked I didn't even count them.

A second incident was last summer when somebody I knew, a young woman who was a friend of my daughter's, had died of a drug overdose and I was going to be attending her funeral. I had a dentist appointment first in the morning, and when I mentioned to the young lady behind the counter saying I have to be out by a certain time, she said, Oh, are you going to that person's

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funeral?

I said, Yes.

And she said, Well, she's the fifth person from my high school class who has died from a drug overdose.

So it's these kinds of personal experiences that really bring home the urgency of this epidemic.

So it's a real privilege for me and an honor to offer some thoughts to City Council concerning what I believe are some actions that would be useful to take.

My recommendations fall into three categories. One is mobilizing increased public recognition and awareness about the epidemic. The second is immediate actions needed to save lives. And the third is information needs for better planning and response for the City.

In terms of increasing public recognition, I really do believe that the City needs to declare the drug overdose

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epidemic as a public health emergency. It really does. I think that would also underscore to the public that the City recognizes the importance of this health problem. And, by the way, I'm very glad to see the picture up there. As you can see, there were drug overdose reversals in every zip code in Philadelphia there, except for one where there's nobody who lives there.

Secondly, I think that the City ought to provide official recognition and funding for the Overdose Prevention Task Force that's been working on a plan for the past several months to address this problem. This is a community-based effort. It was spearheaded by Prevention Point, and it's brought together representatives from such City agencies as Behavioral Health, the Health Department, law enforcement, as well as hospitals, pharmacies, universities, and non-profit organizations. And perhaps this task force should work with an

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interagency group from City government to kind of get over -- deal with the silo effect to facilitate this work.

I've submitted, as Councilwoman has mentioned, as an appendix or an exhibit a draft planning document from this task force as an appendix to my written testimony.

Thirdly, I think one of the dangers that has not really been discussed and really goes under the radar is the problem around benzodiazapines. Benzos, Xanax, Klonopin, Valium, et cetera, as a group, if you look at the data as a group, they are the most common substance found in Philadelphia overdose deaths last year, more so than heroin. Yet there's very little recognition and awareness of this problem compared to opioids and heroin.

Immediate actions to save lives, just real briefly, I think -- and this sort of echoes what most everybody has been saying -- is increased funding

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for targeted naloxone distribution needs to be distributed not only to first responders but to others who are at highest risk of overdose. So this could include homeless, people being released from jails or prisons, those who have already had an overdose, anyone with a history of opioid use. And also not only does the distribution need to be given to individuals, but also to those organizations that serve them and to those who are friends, family, significant others for these individuals. And as somebody who does get reversed, there really does need to be a soft handoff to treatment that everybody has already mentioned. I also believe that community drop-in centers should be established. Anything that makes it easier to access treatment needs to be done.

Thirdly, a third category is information needs. We have a great deal of -- we know a great deal about how many

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people die from drug overdose and what's in their bodies at the time of death, but what we don't know much about is who these individuals are, the trajectory that's led them to this unfortunate place. Are many still under the care of a physician? Are they recently discharged clients from residential treatment? Are they released from prison? Are they long-term heroin users or are they accidental deaths? By conducting death reviews and trying to find out more about the individuals who have died from an overdose and the paths that have led them to this end point, it will better inform interventions and strategies to reduce the rates of overdose deaths.

I think any strategy that is done by the City, there really needs to be an evaluation built in this or any other -- the one that's -- the strategy that's already been developed or any other strategy to examine how well and to

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what degree the interventions are implemented, what barriers still exist, what changes need to be done, and how best to improve the strategic interventions that are initiated.

I think that there should be periodic reports to City Council, given the importance of this problem. There should be regular periodic reports to continue to inform the Council about the progress and barriers to addressing the problem.

And then my final comment is really something that was touched on by several other speakers. I think that the state will be very successful in reducing the supply of opioid medications. I think that's going to happen. The PDMP that's coming on I think will help towards that effort, but as my colleague here had mentioned, it makes total sense that you're going to then have an increase in heroin addiction. This will be -- reducing the supply of opioids will

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be great for reducing the number of new -- of people who are addicted to opioids, but for those who are already addicted, if they can't get opioids, they're going to get the plentiful heroin that's out on the street. So planning really does have to be made, and you have to do this wisely to kind of be prepared for this increase in incidence of heroin addiction.

Thank you for the opportunity to provide testimony to City Council on this important issue. I'm glad that you're really doing this.

COUNCILWOMAN SANCHEZ: Thank you, Dr. Gerald, and thank you for the work of the task force. And I just kind of really want to emphasize what you just said. One of the things that I've learned in working with the officials is that there is going to be a spike and that we haven't hit the spike yet, and in fact, as we try to address this, that that's going to increase. And it's a

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scary thought and one as -- again, I see this every single day as I drive down my district, one that is very painful for me, because on the one hand, internally we have a workgroup that Prevention Point and others are part of and the discussion is always that. It's like once we combat this one area, what are we going to do, and we still haven't answered that. It's quite frustrating.

Councilman Oh is going to make a housekeeping statement.

COUNCILMAN OH: Yes. So we are doing pretty good on time. I'm not trying to rush you at all. We have one more speaker on this panel. What we're going to do is, we're not going to take questions. It is okay, if you can, we'll take questions later. The reason is, we have some elected officials. It is very rare that we have this kind of cooperation. I truly appreciate them being here, being patient. They also have to run entire counties and all that.

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So some of them have to leave. So what we're going to do is set you back once you're completed your testimony. And because someone has to leave at 1:15, we want to start pretty much at 1 o'clock. It gives you your five minutes to testify. We'll set you back. We'll bring our elected officials up, have them testify, ask questions, and if you're able to remain, we'll bring you back up for questions. That's what the Councilmembers were asking me. They have questions. So that's what we're going to do.

Thank you very much.

COUNCILWOMAN SANCHEZ: So we will take Dr. Work.

DR. WORK: Greetings. I'd like to thank Councilman Oh and the entire City Council for having me testify today on the opiate and overdose epidemic in Philadelphia. My name -- and I just want to say that as a teacher of public health, I really appreciate and it

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thrills me when governmental officials take this kind of an interest and hold town meetings and hold hearings, because make no mistake, that is public health in and of itself, and that's very important, and I thank you for doing that.

My name is Brian Work and I'm an Assistant Professor of Clinical Medicine at the University of Pennsylvania School of Medicine, faculty at the Penn Public Health Program, and Senior Fellow at the Penn Center for Public Health Initiatives. I'm also the Chair of Prevention Point Philadelphia and serve on the Overdose Prevention Task Force.

I also feel very strongly about these issues for personal reasons. One, I'm a physician who takes care of people ravaged by drug overdose and drugs in general, and I'm also in recovery from alcohol myself, and I have had multiple friends die as a consequence of drugs.

As you know, the number of

overdose deaths in the City is on target to break 700 this year. I submit to you as a public health professional that if the tuberculosis rate in Philadelphia, which has been in the 70's to 80's per year over the past several years, doubled every year for several years, a public health emergency would immediately be declared, and those resulting TB cases would not even equal the current number of opiate overdose deaths.

I also remember well when the homicide rate in this city broke 400 in 2006, and there was anger and uproar. And I cannot imagine the outcry if the homicide rate, which has only been in the 200's for the past several years, shot up into the 600's.

I'm sure that law enforcement efforts in this city would have been redoubled several times over, and yet we have those numbers already for opiate overdoses in the City and yet the response to date has been anemic at best.

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The yearly rate expected to be, as I said, over 700, is around two deaths per day from opiate overdose, and that does not even represent the full scope of the problem. No one is even talking about the patients with severe brain injury from lack of oxygen during opiate overdose. My job at Presbyterian Medical Center is that of hospitalist. I take care of very sick patients on the ward and in the intensive care unit. I have seen a precipitous rise in the number of patients with severe brain injury from opiate overdose on my service in the hospital, and I am sick of it as a physician and as a public health professional who knows that these are preventable. No one talks about these patients, their family members at bedside hoping against hope that their loved ones will walk or talk again.

So what can we do about this problem? Well, there are two immediate actions that can be taken by and that are

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essential for the City government to address the opiate and overdose epidemic in the City. The first is to have the Mayor and the Commissioner of Public Health declare a public health emergency regarding the opiate and overdose epidemic. You probably recall this was done in the past by Mayor Ed Rendell when he issued Executive Order 4-92 declaring a public health emergency and allowing legal syringe exchange to combat the HIV epidemic going on in the City's IVDU population. That allowed Prevention Point to bring down the HIV rate among the City's IV drug users from approximately 50 percent, 5-0 percent, to 5 percent for the past several years. That order was needed because syringe exchange at the time was illegal in the State of Pennsylvania.

In this epidemic, we need a declaration of a public health emergency not to overcome a legal hurdle but for another reason. An emergency declaration

would help us to focus and unify the current fragmented and siloed effects of the many individual organizations, public and private, that are currently attempting to address this epidemic without an overarching strategy or plan. A declaration of emergency would serve to raise the awareness in the City that we need to address the problem now before its effects grow even larger. We need governmental leadership commensurate with the magnitude of this problem, and a public health emergency declaration would be a solid first step in that direction and very easy to do.

The second action is that the City needs to officially sanction and fund the Overdose Prevention Task Force already in existence in this city. We have been meeting for many months and we've already formulated a plan to address the overdose epidemic with specific strategic recommendations upon which we can act if we have further

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organizational support and funding from the City.

And one last word. Prevention Point operates on a harm reduction model. That means we meet people where they're at, or rather we don't make them stop using drugs before we render them assistance. However, being in recovery myself, I firmly believe that the ultimate goal of our clients is recovery or should be recovery. But you cannot go into recovery, you can't make it to sobriety and you cannot live a happy and sober life if you're dead. If you die from HIV, if you die from hep C or if you die from a drug overdose, you can't recover, and that is why we need to stem the tide of these overdose deaths now.

Thank you very much for your time.

COUNCILWOMAN SANCHEZ: Thank you. I can assure you we're going to have plenty of questions for you and hopefully you'll be able to stay.

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We're going to ask our distinguished elected officials to come forward. So Dr. Valerie Arkoosh, Diane Ellis-Marseglia, Michelle --

COMMISSIONER KICHLINE: Kichline. It's not easy.

COUNCILWOMAN SANCHEZ: I just got lasik and I'm on my monovision adjustment period. Those of who you are doctors could appreciate.

COUNCILMAN OH: And Councilman John McBlain.

COUNCILWOMAN SANCHEZ: Councilman Oh.

COUNCILMAN OH: Thank you, Chairwoman.

I just said I wanted to frame this a little bit, because we did invite you here and we didn't have the chance to speak to you as a group and you're going to testify. So let me say that through this process, we have met people in Philadelphia, and if you had seen the video earlier, 80 percent, I think it

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said, of the young people on the streets were actually from the suburbs. And I'm not sure, but it appears to me -- and I was Assistant DA back in the '80s -- that there was kind of an issue of attacking the problem, arresting the problem, having a war overseas, locking up the dealers, sending a message, but also there was also this thing about Philadelphia as the armpit of drug abuse and problems. Let's build a wall around our counties. Let's somehow separate ourselves. And however it has worked out, it seems to be somewhat there. And so I give the example or gave the example of the mother who had private insurance in one of the counties, was told you can't get this program unless you have public insurance. She got the county public insurance. Then her daughter ends up in Philadelphia. They try to put her into a program and they said, Oh, your insurance doesn't work in Philadelphia, you got to get a block county provider.

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And so I just think whatever was going on in the past, here we are, each one of us elected officials, in a region of America somewhat known for not regional cooperation, I'm sorry to say, whether it's transportation or whatever. And so as a Philadelphia Councilman and as a member of this City Council, I fault ourselves, a big city, a city that has caused problems as well as benefits to our neighbors, but this mutual issue of our families, our loved ones, our resources, our professors, our doctors, our experts, our medical care and as counties, how can we together perhaps get a better handle on dealing with our insurance companies, our resources, our law enforcement and things like that. And that's why I invited this panel, to, one, ask you to be here, and you kindly and generously have appeared here, which is a wonderful sign that we may be able to work together in the future on an equal basis on how to deal with this

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problem. So thank you for being here.

That's what I wanted to say, Chairwoman.

COUNCILWOMAN SANCHEZ: Thank you. So I'll let the elected officials begin.

Thank you. Thank you for your time.

DR. ARKOOSH: Thank you, and good afternoon. My name is Dr. Valerie Arkoosh. I currently serve as the Vice Chair of the Montgomery County Board of Commissioners as well as the Interim Medical Director of the Montgomery County Department of Health. I want to thank Councilwoman Bass, Councilman Oh, and the entire Public Health and Human Services Committee for holding this public hearing today and inviting me to share what we have accomplished in Montgomery County as we work together to combat the opioid overdose epidemic that is plaguing our communities. And I couldn't agree more that we absolutely need to work together.

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I want to commend City Council for boldly declaring 2016 as the Year to Combat the Heroin Abuse Epidemic in Philadelphia, and we stand with you as your neighbors to help in any way that we can.

By way of background, I'm a physician anesthesiologist who practiced medicine in Philadelphia for over 20 years. Frustrated by seeing too many of my patients fall through the cracks in our system, I returned to school to obtain my Master's in Public Health from the Johns Hopkins Bloomberg School of Public Health. I'm honored to serve the 820,000 residents in Montgomery County as their County Commissioner and hope through dialogues like the one that we're having today, we can find ways to work together across county lines to combat this terrible epidemic.

Opioid overdose deaths continue to be a major public health problem in the United States, contributing

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significantly to accidental deaths among those who misuse heroin and prescription opioid drugs. According to a 2015 report, Pennsylvania ranked ninth in the United States in drug overdose deaths. Between 2009 and 2014, deaths due to opioids in Montgomery County increased by 72 percent. Just over half were attributed to heroin. And I would point out that I just got some information that's not in here yet, but we are also seeing a big increase in fentanyl just in the last few months in Montgomery County. Just some news from our Coroner's Office this week.

According to other data provided by our Coroner's Office, we are seeing an annual increase in opioid overdose deaths, which includes a 12 percent increase from 2014 to 2015. We have yet to bend the curve, and we are hoping to do so this year.

It is these staggering rates that precipitated the need for action in

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Montgomery County, and in late 2014, Commission Chair Josh Shapiro established the Montgomery County Overdose Task Force, bringing together various disciplines to develop a multifaceted approach to reducing opioid overdose deaths that includes prevention, intervention, treatment, and problem evaluation. Shortly thereafter, in early 2015, the Task Force developed an implementation plan that encompassed a positive community-based focus on short-term and long-term recommendations.

Our multidisciplinary team brings a spectrum of both field expertise and direct experience that includes law enforcement, public safety, public health, drug treatment service providers, as well as the medical community. It also includes representation from county departments that have been able to leverage resources to maximize community outreach efforts while addressing population-specific needs using best

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practices and evidence-based models.

The Task Force has been vigilant in intervention and prevention activities, and I want to share just a couple quick highlights with you.

We have reduced access to prescription medication. The District Attorney's Office, in partnership with local law enforcement, has implemented 32 medication drop boxes for the safe and secure disposal of unused or unwanted prescription medication. At a recent Drug Take-Back Day held in April, we had over 5,600 pounds of medication collected just on that one day. And to put that into context, in all of 2015, we collected 7,800 pounds of medication. So I'm very encouraged that a lot of our public outreach and community outreach is sinking in and people are cleaning out their medicine cabinets.

We do a lot of preventive education. In conjunction with the DA's Office, over 5,000 students have been

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educated on the dangers of medication misuse and heroin. We involved our school district in the community awareness exercise. Fifteen out of our 22 school districts participated in an overdose billboard contest, creating advertising displays that are currently up on Montgomery County billboards about the dangers of substance misuse. We've had a promotional and social media campaign, including development of an online platform of educational materials related to opioid misuse, naloxone access, prescribing guidelines, and current up-to-date resources, and that is at montcopa.org/overdoseprevention.

We have made sure that as many of our first responders that want it have naloxone. In the spring of 2015, using drug forfeiture funds, the Montgomery County District Attorney made naloxone available at no cost to any police department in the county. These first responders carry and administer naloxone

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under the standing order signed by Physician General Levine in April of 2015.

In October of 2015, serving in my dual role as Interim Medical Director for Montgomery County's Health Department, I issued a standing order covering Montgomery County pharmacies, making naloxone available to the public without a prescription at any participating pharmacy. Individuals can simply walk up to the pharmacy desk and ask for naloxone. This was a critical step towards empowering individuals throughout the county to have access to this life-saving medication.

In order to maximize the impact and reach of this standing order, our Health Department staff has contacted every pharmacy in Montgomery County and worked closely with those that are participating in this program to provide them with free educational materials to be given to anyone requesting naloxone.

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These materials include information on how to directly connect those in need to the treatment services available in Montgomery County. Through our county standing order, we are fostering relationships among our pharmacies, county departments, and service providers to work synergistically toward a common cause, which is saving lives.

As you've, I'm sure, heard today, naloxone is safe, effective, and has no abuse potential. Yet there remains barriers and opposition to preventing the widespread dissemination of naloxone to the public. Opponents often argue that naloxone distribution provides people with a license to use opioids. However, there is no evidence to support this claim, and research indicates that participants in opioid overdose prevention programs report decreased heroin use. Some argue that reversing an overdose with naloxone buys healthcare providers another opportunity

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to provide treatment. However, we know that this is actually very important and that with adequate time, treatment works.

It is important to remember that many cases of opioid dependence begin with the pharmacological treatment of pain via prescription medication. Over time, opioid use changes the functions of the brain, leading to physical dependence and tolerance. Under certain circumstances, opioid dependence will progress to opioid addiction.

Addiction is a disease of the brain that is progressive, chronic, and often fatal. Naloxone is the best means of preventing opioid-related overdose deaths. And as you heard earlier, in order to receive treatment, you have to be alive. We will continue to save a life until any individual is ready to accept treatment.

A couple of progress updates. Currently, 26 of our 49 county police departments carry naloxone while on duty,

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and we are working to get the remainder on board. We do have the unique situation in our county of lots of school districts and police departments, unlike the situation that you face.

Of special note, naloxone is made available to municipal police departments and first responder units, as I mentioned, through forfeiture funds through our District Attorney. We think that's a great use of money that was taken during drug raids to turn around and use that money to pay for naloxone.

Since the program started in mid 2015, there have been 41 documented saves across the county. And as a result of our extensive pharmacy outreach, we have 23 independently owned pharmacies all across Montgomery County participating in our program. They have currently dispensed 261 naloxone kits to the general public under the standing order that I wrote back in October. And then we also have five chain pharmacies

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that are dispensing naloxone under a standing order by Physician General Levine.

In early May of this year, I invited the leaders from our 22 colleges and universities in Montgomery County to participate in an open dialogue with members of our Opioid Overdose Task Force to educate them on the importance of access to naloxone on campus. In addition to the pharmacies participating in the standing order, naloxone is now available in our Health Department clinics for income-qualifying individuals using grant funds from the Montgomery County Office of Drug and Alcohol Programs.

So this is another example how we are trying to break down those silos and leverage dollars across our county departments to make sure that treatment is available.

We continue to utilize community outreach to educate everyone in

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Montgomery County on the steps that each individual can take to prevent opioid overdose deaths. This includes education about addiction, questioning the need for an opioid prescription or the amount of pills in a prescription, how to properly dispose of unused medication, the role of naloxone and its importance in saving lives. We must work collectively across our communities to get this done. We know that nationwide only 11 percent of patients with addiction get the treatment that they need. Our Montgomery County Office of Drug and Alcohol is working towards implementing a countywide protocol referred to as a "warm handoff" that enlists case managers and certified recovery specialists to assist immediately in moving identified overdose survivors in a treatment facility from the hospital emergency department to an actual treatment facility rather than letting them go back into the community, and we're having some success with that.

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Two other quick points that are not in my testimony but I was reminded of as I listened to some of the others. We have a very active Drug Treatment Court in Montgomery County. We just celebrated its tenth anniversary. We've seen 475 graduates of that Drug Treatment Court. And I don't have the numbers in front of me, but the recidivism rate from the graduates of that court is relatively low. I think this is a critically important investment that we should be making to support our drug treatment courts and to make sure that they can serve as many individuals as possible.

Secondly, I want to commend our Montgomery County Medical Society. Together with the Pennsylvania Medical Society, they have shown some real leadership in encouraging physicians to follow prescribing guidelines and empower patients to actually push back a little to their physicians and question whether or not they really need an opioid

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prescription to manage their pain.

We still have a number of barriers. One that I'm currently working on is that some private insurers' pre-authorization policies impede an individual's access to naloxone, making the process confusing and often frustrating for them. So we're hoping to find a solution to that.

I think the other major barrier is stigma associated with drug addiction. Drug addiction crosses every socioeconomic group today, every ethnicity, every background, and we need to continue to educate the public to reduce the stigma that is associated with all sorts of treatments.

So I'm going to conclude there simply to thank you again for the opportunity to testify before you and to share some of the efforts that we've taken in Montgomery County to battle opioid overdose deaths and again to reiterate that we welcome the opportunity

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to work with you to end this epidemic once and for all.

Thank you.

COUNCILMAN OH: Thank you very much. Let me interrupt for one second, because Councilman Green has got to leave.

COUNCILMAN GREEN: I want to thank all of you for being here. I know, Dr. Arkoosh, you have an appointment, so I just want to make some brief comments.

I'm active in the National League of Cities. I know the NLC, this whole issue has been something that we've been discussing. At our March 3rd conference in DC, this is one of the top issues. And I would assume that the National Association of Counties also will probably be focusing on this issue as well. So I think this provides a great opportunity for a collective way of addressing this issue, both working with -- because really when I look at the five-county region - Bucks, Chester,

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Delaware, Montgomery County, and Philadelphia - we really are the keystone to the Commonwealth of Pennsylvania. So hopefully using some of the activities that are happening at NACO as well as NLC provides some additional opportunities to work collectively together to try to work on these issues and partner in a way that can be very conducive to all of our citizens.

Thank you.

DR. ARKOOSH: Thank you.

COUNCILMAN OH: Thank you very much, Councilman.

I will continue with the testimony. I may not have mentioned, if anyone has arrived here a little later from the earlier announcement, you are actually live. Those microphones are live. You are being recorded and televised, and your microphones do reach our police stations, our firehouses, our City workers and people in this building and wherever they may be.

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Thank you. And please identify yourself for the record and provide us with your testimony. Thank you very much.

COMMISSIONER KICHLINE: I just wanted to address Councilman Green. I know you're leaving. I am a Board member of the Pennsylvania County Association of Elected Officials, and this is one of our top priorities. So we definitely look forward to working with the City group as well.

COUNCILMAN GREEN: Thank you.

COMMISSIONER KICHLINE: I will try to condense some of this, because I know you've got a full agenda. I'm going to -- my testimony obviously stands as written. I will skip over a lot of the national state statistics, because I think we've heard them a number of times today.

But what I wanted to start out with, because I think this is to your point, Councilman Oh -- and I guess I

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should introduce myself. I'm Michelle Kichline. I am a County Commissioner from Chester County. I'm here, I represent our Board Chairman Terence Farrell, as well as our Vice Chairman, Kathi Cozzone, because we are united on our efforts to work not only in Chester County but regionally to stop this crisis.

But I want to read into the record a report, and the statistics are a little bit dated because it was written in the Philadelphia Inquirer in early 2015, and obviously there's been a proliferation even since that time, and that's been a year and a half. But this sort of frames the issue I think from a regional perspective as to why this isn't a Philadelphia issue, and to reference your point, that there's been a perception that the drug problem is in Philadelphia. Well, it's not, and I think this frames it.

Though the death rate from drug

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overdoses in Philadelphia has held relatively steady since the late 1990s -- and we've heard some testimony that it's increased -- the Pennsylvania suburban counties and all of South Jersey have had such sharp increases in body counts. Their rates have as much as tripled, putting many on par with the City's rate and in some cases surpassing it.

The scourge of primarily heroin addiction, which seems to suddenly gain momentum outside the urban line in the mid 2000s, has only grown in lethality in suburban and rural communities region-wide and indeed across the two states, despite law enforcement's efforts to curb it.

In 1999, in just the seven counties rimming Philadelphia, 310 drug deaths were reported. In 2013, the toll, apparently driven largely by heroin, was 781. That year in the City, with less than half the population, 402 died.

More than raw numbers of

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victims, however, the alarming story lies in the overdose mortality rates. Recently released federal data for 2013 show that when compared with the City's rate, Bucks County had pulled almost even. Delaware County, after two consecutive years of decreases, was still only slightly lower. Gloucester and Camden Counties soared past Philadelphia for the first time, although their rates were far from highest in the Garden State. That distinction went to Cape May County, with also three times the national average.

Chester County alone came in below the national average, a bit of good news dampened by the fact that the county's overdose death rate nonetheless had doubled since 1999.

To give you a Chester County statistic, the prevalence rate of substance abuse disorders overall is estimated to be 8 percent for ages 12 and up, but 29 percent for ages 18 to 26,

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with opioid use disorders increasing in all ages.

If one looks specifically at overdose deaths in Chester County, in 2015 there were 72 accidental overdose deaths, up from 62 in 2014, with 66 involving of those 72 involving heroin and/or opioid pain medications. The demographics of those who died from opioid heroin overdose was primarily single white males, ages 45 to 54. These deaths occurred in 36 of our 73 municipalities, not just the large urban centers. This is an example of the geographic widespread use and availability of opioids in the county.

It is known that the actual number of deaths would have been significantly higher had it not been for the use of Narcan. Currently, 46 of 47 police departments in Chester County carry Narcan, and 46 saves have been performed. Anecdotally, we know that there are untold, unrecorded saves that

occurred through other first responders, hospitals, and others.

We also know that those overdoses occurring frequently don't result in a death or resuscitation and aren't currently captured in any data reports. This is data that needs to be understood for the full scope of the problem.

As Commissioners, this is a significant issue that we work hard to address. In addition to leadership from the Commissioner's Office, our District Attorney, Tom Hogan, has again taken a leadership role in addressing the deadly issue, as has the Health Department, the Drug and Alcohol Services, as well as domestic violence. There is a definite statistical connection between drug use and domestic violence.

Numerous initiatives are occurring in Chester County to mitigate the problem and the impact on our residents and communities.

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We did initiate the first Overdose Prevention Task Force over 20 years ago. It includes senior management from our Department of Drug and Alcohol Services, the Health Department, the District Attorney's Office, as well as community stakeholders. In addition to each of these agencies' individual efforts, the Task Force has developed and implemented numerous collaborative initiatives.

Our District Attorney, Tom Hogan, has taken a strong stance in the arrest and prosecution of individuals who deal drugs. He reports that they will, quote, "arrest and incarcerate heroin dealers with a vengeance," end quote, and notes, quote, "they now charge a premium to come to Chester County." His office has been involved on the prevention side. For example, their leadership -- through their leadership, we have 19 medication collection boxes covering every corner of the county. Also, Chester County was the

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initiator on the legislative side to the Good Samaritan/Narcan law.

Our Health Department has focused on the epidemic from the public health perspective. Through grant funds, it's organized and facilitated an overdose death review team to track data, identify trends, make recommendations for policy creation, and focused on the education of doctors and other healthcare providers on opioid practices and related topics.

Our Department of Drug and Alcohol goes to great lengths to ensure that the critical component, access to appropriate treatment, including the type, level of care, and duration, is available. The Department of Drug and Alcohol Services funds treatment and is part of the senior management for our Medicaid managed care program.

What I would like to also note is, there is increasing community awareness of the existence of the problem

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and that available resources is also a critical aspect to preventing and intervening in this epidemic. This includes information about prevention and access to treatment, as well as overdose prevention and response.

In Chester County, efforts through the Task Force members collaboratively and individually include a variety of individual and population-specific efforts. That includes addressing public awareness and providing education to schools, families, communities, and various service systems through public service announcements, information distribution, community meetings, and professional training. A few examples of what the Drug Task Force has done has been an outreach to 30,000 students. Again, to address the comment that this is a city issue, we have a couple of the top school districts in the state located in Chester County, one of which is Downingtown High School. A

small anecdote from that is of the 2008 lacrosse team, five members have died of opioid overdose, and including Conestoga High School, which is the number one rated high school in Pennsylvania, there have been at least in the past five years four drug-related deaths. So this is not an issue that is related to income, to demographics. It does affect even the best and the brightest.

We did hold an Overdose Prevention Symposium in October. It's a multidisciplinary educational opportunity that increased participants' awareness of the problem of opioid overdose, and that, again, reached out to students and professionals, including physicians.

We just had on May 12th, we had the Pennsylvania Physician General come to speak to a panel of physicians, and I would like to cite a statistic that I think probably goes to address the root of much of this problem. Oxycodone worldwide production in 1998 was 11.5

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tons. In 2013, it's 138 tons. And over 90 percent of the consumption of opioid-based drugs are in the United States. This is simply not used internationally the way it's used in this country. And much of this was initiated by the Veterans Health Administration Joint Committees on Healthcare in 1998. They called it "Pain is a Fifth Vital Sign," and as a result of that study, there's now a requirement, which we all see in many physicians' offices, of the standard use of the familiar 0 to 10 pain scale. And we've had a robust conversation with our medical community about really revising what is absolutely needed and focusing less on this pain as a fifth vital sign statistic.

We do have a planned event of note. It's the Community Care Summer Institute. It's going to be held in August, and it's going to be attended by providers, county, and other staff as well as the public. We will be focusing

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on opioids and overdose prevention, and of course we do have an issue of standing invitation to our partners to other counties and in the City.

So in conclusion, this is something we cannot do alone. It is affecting us regionally. And we do thank you for the opportunity. I wish I could stay longer, but thanks.

COUNCILMAN OH: Thank you very much for joining us and your testimony.

And the next Commissioner, would you please identify yourself for the record and provide your testimony.

COMMISSIONER ELLIS-MARSEGLIA: Good afternoon. My name is Diane Ellis-Marseglia. I am Commissioner in Bucks County, and I appreciate, Councilman Oh, your inviting me here today, as well as all of City Council for passing that Resolution 160052 and for also inviting Bucks County through me to have a voice here.

I'm here to speak to this, not

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only as a Commissioner of Bucks County but also as a social worker and maybe, more importantly, by someone who has lost too many friends' children and has watched too many leaders in Bucks County lose their children over the past few years.

My concern with the problem actually began in 2009 when my daughter's best friend died of an overdose in a car in Philadelphia. I watched the collateral damage to her parents, to her siblings, and to her own toddler and realized that -- realizing now that this has happened a thousand times over since.

My more active involvement in Bucks County with the heroin overdose and opioid problem began when a man came up to me in the food store and said, What do you intend to do about the heroin problem in Bucks County? And I was aghast that he would ask me what I was to do about it, but moments later, sitting in my car, I realized he was correct. And I started

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off by giving my stated county address about the opioid problem in Bucks County that year.

The problem obviously, as you have said, is not just a Philadelphia problem. It's a problem throughout the county. It's a problem -- I mean throughout the country, the state, and in your neighboring Bucks County where people might not expect it to be such a problem.

We know that a significant number of our residents are coming to Philadelphia to purchase and use heroin. That means we know that it is our residents that are contributing to the traffic on your streets, contributing to impaired driving on your roads, contributing to crime in your neighborhoods and, unfortunately, in difficult situations, they are contributing to the strain on your emergency services, your emergency room, and your Coroner's Office. As Bucks

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County, we do not want to contribute to your burden. We have worked hard to share our tourism with you, and we consider sharing this tragedy an absolute nightmare.

I'm hoping today that I can share a few things we have been doing in Bucks County that may be hopefully a little different, maybe something that you've heard.

Shortly after I did my address on the opioid epidemic, we purchased a very dramatic public service announcement, and then we went to every movie theatre within Bucks County and we purchased time, and for several months, that very dramatic public service announcement was played over and over again, and it tied together an awareness that there's a problem for parents but also the importance of our needing to get opioids out of the medicine cabinets.

Since then, we have held hearings and have held hearings several

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times throughout the county so that parents and families can become aware that there is a problem and become aware of how to recognize the problem. We hold the regular drug take-back events, and we have 33 permanent drug take-back boxes in Bucks County. Unfortunately we are the highest number of poundage of drugs in the State of Pennsylvania. I would like to say that's a good thing because we're getting rid of them, but it has not slowed down, so they seem to be still prescribing the opioids and still people are dropping them off.

Our District Attorney, who, by the way, Assistant District Attorney Matt Weintraub, wanted me to tell you hello.

COUNCILMAN OH: Friend of mine.

COMMISSIONER ELLIS-MARSEGLIA: Yes. That's what he said.

He has set up a tip line, and it is anonymous. You can text any information you have about drug use. You can go online and do that, or you can

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make a phone call, and that has given us some information.

As with the other counties, we are using Narcan. We have saved over 100 lives in the past year. Most importantly, most of those lives saved were in Bensalem and Bristol Township, the two townships that are closest to Philadelphia. We now have Narcan in the police cars. We have it in our schools. We make it available free to any family who asks.

For the past two years, we have taken money from the Human Services Block Grant that we get and we have moved it directly into treatment. So we have been able to eliminate the waiting list we have of people who don't have insurance who need drug and alcohol treatment.

We have also partnered our Drug and Alcohol Commission with our Children and Youth, so that any time we find a parent that has been found to be using drugs or alcohol, we are now sending

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someone out there, a peer, in essence, to work with them and try to convince them to go into treatment.

As a result of the high level of Narcan, we have a lot of people ending up in our emergency rooms who have died and been brought back from an overdose. And so what we have been doing is going around and educating those hospitals on what they can do, giving them our number for our Commission so we can help them find treatment beds for those people, and we are beginning to partner them with a certified peer specialist who will help those people who are in the emergency realize that they do need to have treatment.

In July, we will begin a pilot program in our prison of actually having a treatment milieu. We know it will mostly deal with opioids, and we have not had that before.

In Bucks County, we are hoping that we can all collaborate together.

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During Mayor Nutter's tenure here, we had a Metropolitan Caucus where the Commissioners got together regularly with the Mayor, and what we did find came out of that was that our lobbying efforts were better when we did that as a group, writing letters, calling our legislators, getting them all on board. There are a lot of people in the five counties, including Philadelphia, and we really do need to work together.

One of the things that we would like to work together on is getting to advocate the federal government and the state government to do a little more on interdiction. We can't really deal with that on a county level or even on a city level.

We know that 80 percent, as we've been hearing, of addictions begin with pain pills prescribed or taken unsupervised. We need to make sure that the support for Pennsylvania's Prescription Drug Monitoring Database

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really connects doctors and pharmacists and really works to stop the pharmacist prescription shopping. We also need -- and this is something that has to begin to be emphasized -- an alternative to pain control other than medication and, very importantly, lowering the amount of pills that are prescribed when someone is given a painkiller.

As with everyone in the five-county area, we also need to increase capacity. We don't have enough beds in Bucks County for the people who need treatment. More importantly, we need treatment to be longer. We know the longer the treatment is, the better the outcome.

And, finally, we are also struggling with -- we are struggling mightily with this -- with the recovery houses that are in our county. We have one township that has 93 recovery houses in it, but we only believe ten of them are worthy, and there are many

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Philadelphia residents in those recovery houses. Many of those recovery houses are operating without adequate room, with no supervision, with no real program of recovery. People are dying in those recovery houses of heroin overdoses. We in Bucks County are 100 percent behind working with our state legislators to set up standards for recovery houses, and we believe those standards can be developed and enforced while we still protect housing rights.

So in conclusion, I would like to thank you once again for listening and for being patient with all of us, and I'm hoping that we get to work together as we have in the past.

COUNCILMAN OH: Thank you very much.

And in Delaware County, they're called Delaware County Councilmembers. So just for us in Philadelphia, we don't really -- we have a Mayor and a City Council because we're a county and a

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city, and so it confuses us sometimes, but the leaders of the county are usually County Commissioners who are elected in their townships within them, but in Delaware County, the County Commissioners are called Councilmembers.

COUNCILMAN McBLAIN:

Councilmembers, that's right. Like most things, we tend to do things a little bit differently. Whether that's good or not, we're still trying to figure out. But, yes, like Philadelphia, we are governed by our Home Rule Charter that was adopted in the mid 1970s and, as a result, we have five elected Councilmembers rather than three Commissioners. But we work well together in the suburbs with our fellow counties and with the City of Philadelphia. Like I said, I really do want to congratulate Mayor Nutter, former Mayor Nutter, on very much supporting the Metropolitan Caucus, which I thought was a very effective tool for our region, and we encourage Mayor Kenney to do the same

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and support the Metropolitan Caucus.

So with that, yes. My name is John McBlain. I'm a member of the Delaware County Council, in my second term there and, Councilman Oh, I want to thank you and the Philadelphia City Council for conducting these hearings to this most -- on this most important topic. On behalf of the other members of the County Council and our District Attorney, Jack Whelan, we appreciate the chance to cooperate in any effort or initiatives that will end the devastating heroin epidemic that is robbing us of so many lives.

In 2015, Delaware County lost 104 residents to heroin. We had over 200 total drug overdose deaths, which include other opioids, fentanyl, as you've heard about, and other types of drugs. So far in 2016, we've lost 32 individuals to heroin.

To put those numbers in perspective, there are typically 25 to 35

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total homicides in Delaware County each and every year. So when people talk about criminal problems and gun control issues, which are all very important, I look at it and say I lost over 200 mothers, sons, daughters, uncles, nephews to drugs last year. And without a doubt, we view this as our most important public health problem and criminal problem in Delaware County.

In 2015, the youngest heroin victim was a teenager, a 19-year-old boy from Upper Darby. The oldest was 79, a man from Chester. The average age of the overdose victims in Delaware County is 41. We are losing young people, mothers with babies, athletes, veterans, people of all backgrounds and economic means. And as you pointed out, Councilman Oh, this drug doesn't know any borders, whether they be geographic, municipal, economic, color, race, no matter what.

The encouraging news is that our police have saved 251 lives with the

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use of naloxone or Narcan since 2014 when police were authorized to administer this overdose reversal drug. That's 251 people who have a second chance at life, at treatment and recovery.

In Delaware County, we've been aggressively fighting the heroin and opioid epidemic since 2012 when our Medical Examiner came to us and reported that he was alarmed by the increase in heroin deaths that he was seeing.

Our Council and District Attorney formed a Heroin Task Force. We secured a federal grant to fund the task force activities for a period of five years. Since then, we've accomplished much, and we are pleased that other counties, other states, and the federal government have looked to Delaware County as a model for prevention efforts.

The Task Force members represent many areas of expertise, from law enforcement and emergency medical personnel to behavioral health and

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educators. There are three areas of focus - prevention and education, treatment, and recovery.

We've had many people who have decided to be on the Heroin Task Force. So many that we actually have now created a broader coalition which we call the Prevention Partners.

While we are still fighting this public health crisis, I'd like to highlight some of our initiatives that we have put into place.

Outreach and education: The Task Force started meeting in September of 2012 and immediately began doing educational outreach programs for schools and community groups. District Attorney Jack Whelan and his Drug Crime Unit have organized educational programs that have put on programs for parents and for students at every school -- in every school district in every high school in Delaware County.

One of the members of our Task

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Force, a mother who lost her daughter to an overdose, organized a chapter of NOPE, which stands for Narcotics Overdose Prevention and Education. NOPE volunteers speak very candidly to students, parents, educators, and others in the community about the dangers of prescription drug abuse and heroin. They've held programs at almost every school district in the county and have spoken to over 30,000 students. And I point out as much as we wish to make that outreach to students and we must do that in order to prevent them from beginning down this path, one of the things I've talked about also is the need to reach out to parents. I imagine myself as somebody that grew up in Delaware County to be the average type of kid that grew up in Delaware County. I wasn't an angel, I wasn't a devil, but I can tell you that people in my generation, wrapping their heads around the fact that their child may have a heroin addiction

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is almost incomprehensible.

As you pointed out, in the 1970s, heroin was thought to be an inner city problem, a problem that affected other communities, not in the suburbs. But that's exactly what's happening now, and I think it's a real problem to convince a lot of parents that their child could be suffering from an opioid addiction and a heroin problem.

Next is medicine drop boxes. Once the Task Force was formed, we quickly realized the connection between heroin use and the abuse of prescription painkillers, like OxyContin, Vicodin, and Percocet. We also learned that kids were getting these pills from the family medicine cabinet. So we created the Secure Medicine Drop Box Program and that are placed in every police department in our county. The goal of the drop box is to get unused or expired prescription drugs off the streets and out of the wrong hands.

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Since 2013, we have installed 40 drop boxes throughout the County, including one at our government center, and we have collected over 7,000 pounds of prescription drugs. We also take a mobile drop box to community events such as drug take-back days, giving other people a chance to safely and anonymously dispose of the drugs.

Our Realtor Program, and let me explain to you how this came about. We had our local association of realtors come to our Heroin Task Force and said, There's a problem that we see in the realtor community or in the home sales community, and, that is, an alarming instance of during open houses users and dealers would come on a systematic basis, go to open houses, and go through people's medicine cabinets, stealing medication. It was enough of a problem that realtors spoke about it amongst themselves and brought it to the attention of the realtors.

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So we've appointed a realtor to our Task Force, and he launched a program to educate homeowners to lock up their medications during open house events when someone is trying to sell a house. People know to lock their jewelry and other valuables, but never realized that people were stealing meds out of their bathroom medicine chest when no one was looking.

Police administering Narcan: In perhaps our largest initiative, Delaware County was the first county in the Commonwealth to implement a nasal naloxone program for law enforcement after David's Law was passed in 2014. That law was named after David Massi, a 27-year-old man from Upper Chichester who overdosed in 2013. Until then, only emergency medical personnel could use Narcan, but it was often the police who were the first to arrive on the scene.

In late 2014, we supplied every police car in Delaware County with two

doses of Narcan. To date, 251 people have been revived from a heroin overdose.

Treatment options: The next question became how do we reach those overdose survivors and get them into treatment. Earlier this year, we launched another strategy to connect overdose survivors with treatment programs, as an overdose is often a life-changing event and it's critical to reach these survivors or their family members right away, once they are stabilized and preferably when they are leaving the emergency room. Funded by a grant from the Pennsylvania Commission on Crime and Delinquency, our Office of Behavioral Health hired two trained and certified recovery specialists who can respond to reports of a drug overdose at emergency rooms and try to connect those survivors with a treatment program.

We are working closely with our emergency rooms and with our health partners who have emergency rooms in

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Delaware County at Crozer Keystone, Main Line Health, and Mercy Health Systems.

This is a new program, but we already have individuals who have agreed to enter treatment after surviving an overdose.

Ongoing drug and alcohol treatment: I'll preface this by telling you the story that really brought this home to me, was last summer I received a phone call in my office from a woman who I knew, I went to grade school and high school with. She was a year behind me, actually in class with my sister, but one of her sisters was a good friend of mine my entire life. She said to me, John, my son is in your prison. He's in Delaware County Prison for drugs. John, you can't let him out. If you let him out, he will be dead within a week after getting out of prison.

So I took the information. We looked into it. He indeed was there for drugs. He had a release date in

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September. He had a county sentence. He would max out in September. He was in the programs, the available programs at the prison. He received every piece of information, every piece of treatment that we could offer in a prison. And I'll say it, a prison is not a drug recovery center and we shouldn't look at them those ways. We offered him everything that we could, and I told her, Amy, that we will give your son everything that we can do, but once he's released, he needs to get into treatment. He was given all those options.

Well, she was right. Five days after he was released, I got the call that he had died. He had returned to using heroin at the same level that he did before he went into the prison. And she has become a very effective advocate since her son's death last fall.

So ongoing drug and alcohol treatment, it has been Delaware County's goal to connect individuals with

treatment. In 2015, more than 4,000 individuals accessed drug and alcohol treatment programs that are publicly funded. This does not include the people who undergo rehab through their own insurance or private pay. We've also secured funding to increase the number of detox beds from 140 to 240 for the county.

In closing, I just want to stress two things. As you have well pointed out, Councilman Oh, this is everyone's problem. Addiction can happen to anyone, any family, in any neighborhood. Every overdose victim is someone's son or daughter, husband or wife, mother or father. We all have to work together to fight this battle.

On behalf of Delaware County -- or, secondly, on behalf of Delaware County, we welcome any efforts to strengthen and coordinate efforts to stop the use of heroin and abuse of prescription drugs amongst our counties.

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We look forward to gaining more insight from any strategies developed through the efforts -- through your office of City Council and through the Administration.

So thank you very much for the opportunity to be here today.

COUNCILMAN OH: All right. Thank you very much. And, again, I truly appreciate you coming into Philadelphia to testify and setting that great example of coming into our house to work with us together. Anything we can do to help with any of our institutions, we would love to do. And I see that you're already on top of this with your task forces and whatnot, and we've heard from our task force that we need to fund the task force. And I will look forward to the dialogue that we're going to have in the future, and perhaps maybe the answer is already there through our task forces getting together in some type of coalition or council to advise us on how to put in a five-county or five-county

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and Southern New Jersey strategy that we can work on.

So thank you very much, and I look forward to working with our counties.

COUNCILMAN McBLAIN: Thank you, Councilman.

COUNCILMAN OH: Fantastic.

We did take a break for our medical panel. The stenographer is not super human and neither are all of us. So we will take a break, because she's been going at it straight from this morning. So we're going to take a five-minute break and we will resume our medical panel and then we'll move on with the rest of our panels.

Thank you very much.

(Short recess.)

COUNCILMAN OH: Good afternoon. At this time, we're going to resume our hearing. I'd like to apologize to everybody. These things tend to run over, but I appreciate everyone who is

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here, who is testifying, waiting to testify, and for anyone who wants to make public comment.

We have a great panel of experts, and many of them we have come across in the course of speaking to the public. And so I didn't just come up with the list all by myself. I'd certainly like to thank Matt Pershe and my staff for doing the research and doing the reaching out.

Just a reminder for everyone that the mics are live. They reach a lot more people than you may think. It's a big city. We have 20,000 employees, and they can listen, and they do. It is recorded. I was just explaining to the reporters that we will be getting the video. We'll be reviewing it, getting the transcript, breaking it down. Some things appear to be obvious steps we can take, like pushing for funding and support for the task force, connecting them to the other task forces, those type

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of things. Other things will be much more kind of challenging and some will be, of course, in a democracy an effort of trying to get different ideas together on one sheet of music.

So at this time, I am resuming with Panel No. 4, which is our medical panel. My colleagues unfortunately had to leave. They have other types of important events going on and they, less than I can, can gauge the length of these hearings. So sometimes these things here take a lot longer than they may think.

So with that, I know that Councilman Taubenberger's question was answered. I'm not sure about Councilman Derek Green. I know that our Acting Chair, the Vice Chair, Councilwoman Maria Quinones-Sanchez, will be returning. She had some event to go to. I believe Councilman Taubenberger will return as well.

So let me just pose a question on behalf of all of us to all of you.

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It always strikes me whenever we look for the -- I asked my staff what are they doing in Europe, what are they doing around the world, what are the best medications, and who has been successful historically, what's been going on. And then in this process, we find that we have some of the world's best experts in Philadelphia, and that's always, number one, it's a glow of pride, of course, and, second of all, how do we get these people engaged in our city, because for so many issues, Philadelphia does have this tremendous amount of expertise. And so as you sit here -- and I know that we have two physicians and two experts, one of whom is already quite involved, but what would you expect or what could you say to City government that, Hey, you have not knocked on my door, you haven't done this, or here's how you engage us into the process of forming, advising or being part of a better system of treatment? Anyone can answer that

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question.

DR. STAHLER: Just ask.

DR. WORK: First, let me say that I'll give the same advice to you that I give to medical students, residents, public health students. And I say that I would love -- the way to find out what's going on is to go out in the community, just show up and see what people are doing. I would love to have you and some of the other Councilmembers come to Prevention Point and see what we do. And what that often does is spark -- you'll meet people, and that person will be involved in some other aspect of this problem, and it might be something you didn't know about. And merely that act of showing up to the places that deal with these issues often educates you, engages you, and finds different routes for engagement. And my students and my residents tell me, I'm so glad you had me go do this or come to Prevention Point, because I didn't know all of this stuff

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existed.

And so that would be my biggest recommendation to yourself and the Councilpeople. And I know you're doing a great job at this. You're engaging in the community, but I would love to get more of you to Prevention Point to see the kinds of things that we do. And not just Prevention Point, but go visit Dr. Metzger at Penn and see what some of those folks are doing as well, that sort of thing. Very simple.

COUNCILMAN OH: Well, thank you very much for that. I will say that I will be happy to visit. I have said to some of the other groups -- I saw Angels in Motion earlier today. If you want me to come out at 3 o'clock in the afternoon or 3 o'clock in the morning, I'll be happy to come out. I've been out as an Assistant DA. I've been out in other roles, but I'll be out as a Councilman, thinking a little differently. And if it will be better, I will try to take some

time with my colleagues, try to give them some advanced notice, work out some schedules so we can go visit together. So thank you for that.

DR. METZGER: Well, I would just add that a lot of us feel like we are engaged in the community, although the channels of communication aren't really linked to City government and somehow thinking about better ways to communicate back and forth. It's a two-way street, but almost all the research that I'm involved in and my colleagues are involved in has taken place in Philadelphia. And some of the findings that are in my written testimony have actually informed governments around the world about how to respond to the HIV epidemic and has promoted the expansion of methadone treatment. And how to, you know, make the City of Philadelphia aware of that is I think what you're asking about in one way and also how we can get more engaged in City government. But I

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think there's a receptive audience there.

This is the first time I've been asked to give testimony before City Council, and I'm sure my colleagues would all jump at the chance to be involved. So I think there's a willingness. It's just a matter of setting up the communication channels.

COUNCILMAN OH: Yes. And I was being critical about our government, speaking for myself, in the sense that we have these experts and we need to reach out better. And I have never had a problem with experts, whether it's, quite frankly, been in Washington, DC, New York City or anywhere or even around the world. As a lowly City Councilman giving a call, I've been just so impressed with what leading experts, academics or business people or federal officials say, Sure, I'll make time for you, come down and visit. And I think it is incumbent upon us to reach out to you. But thank you, and it's good to hear that you're

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eager to receive that communication, something we need to do better.

MR. BRASON: I want to emphasize much of what was just said, because my involvement engaged in this came from hospice, chaplaincy, and home health. I did not have an addiction background, a prevention background. I didn't know what harm reduction was. You know, I had my own prejudices regarding needle exchange and my own thoughts about medication-assisted treatment. One of the first things I did is, I began to investigate was Prevention Point in Pittsburgh, hitting the syringe naloxone vans at 6:00 a.m. in Boston to see exactly what they're doing, how they're doing it, and then really getting engaged with those who were involved. And in that, I've been able to learn in my own community what gaps there are.

Getting people into therapy is difficult enough because of lack of therapy, but it's those support services

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surrounding it. Some call it the wrap-around services. I call it field support. It's life. In my county, I can get somebody into detox. Where are they going after detox? Same home, same family, same friends. There's no change and we're expecting them to succeed.

So I was glad to hear from the counties that just testified about the recovery coaches, peer specialists and that kind of support that helps a great deal. That's why we have to look at all of your populations and the whole person as to what those needs are. And I'd like to emphasize getting people out to the street really tells the story and really helps you understand. And I tell the FDA that. I've told the CDC that. Your global decisions affect the person at my level, and you've got to know that person and the needs and how that impacts a community before you make those broad global decisions, because you can have unintended consequences that we don't

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want, like I mentioned about the PDMP and so forth and pushing people out the door who have no place to go.

COUNCILMAN OH: Thank you very much.

DR. STAHLER: A couple things I'd like to add. I think we all operate within silos. So even people in the research community, we sort of operate in our own silos, and those are sometimes very difficult to bridge. You just sort of go through your daily life and your profession. But I think anybody and everybody on this panel who basically lives, breathes, has spent their careers and lives involved with this area of addiction, I think all of us would be extremely eager to have increased communication and do whatever we can to work with City Council on this issue.

It's sort of -- from just speaking personally, I've done research in this area. I teach about it, but I'm a consumer. I've had two family members

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who have been afflicted with addiction. I've learned more from going through that whole ordeal as a parent than I have reading the research on it. And I'll say a couple things that I think are really important to me and, that is, insurance and being able to pay for adequate treatment, the whole parity issue, and this is probably -- I don't know how much this is relevant at the City level versus the federal level, but there isn't parity, and people go through enormous sums of money to support their kids getting the treatment that they need, and that is different than if they had other chronic illnesses like diabetes or if they had to be hospitalized for cancer. You don't say, Well, we're going to give you a certain limited amount of chemotherapy. It doesn't work like that. But with drug treatment, it's sort of like when somebody -- with antibiotics, you're prescribed a ten-day course, but you're only paying for two days of that,

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and then people wonder, well, how come this person didn't -- how come they relapsed in terms of the infection. It's the same thing with drug treatment. So when somebody doesn't get the adequate dose, the length of time in treatment and nor is there sort of very good after care, long-term after care, to support that individual's recovery, then it's sort of no wonder that you have so many problems.

So I just wanted to underscore that. I don't know how relevant it is for local City Council, but to me --

COUNCILMAN OH: I think it's very relevant, very relevant.

DR. STAHLER: To me, the length of stay is critical and removing whatever barriers there are to getting into treatment. Not everybody is ready for treatment who has an addiction. If you just -- if you had beds that were completely open, it still wouldn't solve the problem, but it would certainly help

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the problem.

COUNCILMAN OH: Yes.

DR. WORK: I just want to piggyback on that with the issue of parity. I'm a diabetic. I can't recall ever having had to pay much over 5 or 10 bucks for any of my diabetic supplies, any of my diabetic appointments, and yet I am seven years in recovery and I'm still paying off the debt for that recovery, which I had to pay just flat out above and beyond my health insurance. It shouldn't be that way. I'm lucky enough that I have a job and I can actually pay for that. That needs to change.

Additionally, something that I didn't hear anyone mention, I think the idea of getting a PDMP in the State of Pennsylvania is a fabulous idea, a Prescription Drug Monitoring Program, where we know who is prescribing what, how much, who has been where. That's absolutely essential. But we live in a

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multi-state region, and often a problem that we -- that I see at Penn Presbyterian Medical Center, somebody will show up on my service who is from Delaware. Why didn't you go to your hospital in Wilmington?

Well, I wanted to try out up here.

People easily can cross waters to acquire prescription medications. So this does also need to be a regional effort and not just a city or statewide effort.

COUNCILMAN OH: Thank you very much.

COUNCILWOMAN SANCHEZ: So this funding stuff around this 30-day, we were actually at the meeting that Councilman Oh was sponsoring and someone came to me and asked me about someone who is getting ready to get kicked out because their time period was over and stuff, and fortunately I called Mark Levine and he took care of the person, but how many of

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those people do we have an opportunity.

Is this a private insurance issue, if you know, and how has our establishment of a city HMO, our CBH helped or can help, better help facilitate this kind of treatment methodology?

DR. STAHLER: You know, I couldn't comment on CBH. I know with private insurance, it is a very big issue, and sometimes it's kind of insidious. I'll just give you a quick example.

So the key is whether something is medically necessary, right? So who judges that? Well, the private insurers often have subcontractors who decide whether something is medically necessary or not. Of course, there's a built-in financial incentive to find it not medically necessary.

So, for example, one of my family members was receiving residential treatment ongoing, had been approved, and

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then developed a stomach problem, had to go to the general hospital, was admitted for the weekend and then returned back to the residential treatment. Insurance was denied. Why was it denied? Because it had on her record that she had been discharged from residential treatment; therefore, it was not medically necessary anymore. Well, she was only discharged because she had to go into the general hospital. But it's things like that. And so then you're faced with having to pay $8,000 a week for residential, $10,000 a week, you know, sometimes, depends on the program. You can appeal, but you may or may not be successful, and it will take months. So then what happens is then somebody, not -- because you're worried about the financial aspects. Somebody leaves treatment before they're ready. They come back to the community. They relapse and start the cycle again.

So it's things like that that

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are very difficult to deal with.

Now, I really -- someone else might have a better handle on CBH or the publicly funded, but...

DR. METZGER: I would say CBH is more of a model than the private insurers in most cases. I think they're trying their best not to limit the duration of treatment. And I think the Mental Health Parity Act, it's a law, and when people do these things, they're breaking the law. And just like with the Americans with Disabilities Act, it wasn't until that -- that didn't automatically produce kneeling buses. People had to sue and take people to court and say, You're violating the law. And I think that's the stage that we're at now with the Parity Act, and that's what will, I think, produce the most change the most quickly.

DR. STAHLER: If I could just also add one thing on that very issue. The White House is going to be

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establishing, I guess, a high level interdepartmental review of the Parity Act. They are going to look at how its implementation is being -- how well it's being implemented and to review that. So maybe there will be some good news later on, but let's not hold our breath.

MR. BRASON: Just one quick comment on that too. At least in our state and I'm not sure in Pennsylvania, with Medicaid-assisted treatment and methadone clinics, buprenorphine clinics and so forth, some of them don't even take any kind of coverage. The person has to come up with cash in order to do that, and for us, I know that's been a problem. We have 50 opiate treatment programs. Eighteen take Medicaid. All the rest are pretty much cash only. And then you're talking three, four hundred dollars a month that we're asking people to come up with and be there at 5:30 in the morning and then try and keep a job.

COUNCILWOMAN SANCHEZ: Right.

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Well, thank you. I mean, clearly we're more hopeful with the Wolf Administration. I know for the Corbett Administration, eliminating some of the cash assistance for people on treatment and some other things have made the problem worse, and that's why we have some of the increase in homelessness, folks on addiction.

I have my Tent City around Gurney Street that we're really trying to deal with, that Prevention Point and others have tried to help us understand and get our hands around what is a response. Right now what the City has is kind of a containment strategy. Like we know there's a bunch of people on the tracks. We know that the drug dealers give out drugs for free there. Like everybody knows, and as we sit around the table, we still don't have a plan. We don't have a mapped-out plan about how we're going to address it. So for me that containment strategy has been very,

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very frustrating, because I feel like in government, we should be able to do something. And when I'm faced with regulations that we wrote, it's sort of like, Who wrote this, and if they're at the table, let's get them. But it is quite frustrating, because this is people's lives, and it's been really hard to figure out what's the low-hanging fruit. People need ID. Okay. Let's get people IDs, trying to get people in the silos to say, an ID is an important component to identify someone so that we can get them into treatment and sign them up for Medicaid and all those different things. So the one thing that this national attention does do is kind of highlight all these things.

I'm just very concerned that -- as you mentioned earlier, this is a lifetime challenge for people, and I'm just concerned that the system is a financial system that is not incentivized to get people better. I'm trying to be

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diplomatic, because folks who know me in this room know that I'm usually not. And so that's part of for me this interest in going out with Councilman Oh and having him look at it in a more objective way, because obviously being in ground zero, I have my personal views, but really trying to figure out how do we create those -- how do we measure quality, how do we incentivize so that people are giving people the treatment that they need, how do we ensure that the housing is not an obstacle and that our housing pieces are helping folks. Because the one thing we want is people to be somewhere safe. We need folks to be able to have those safe havens.

So when I hear controversial things as in -- we talked about at one point the needle exchange was controversial. I hope that's no longer controversial. It's mainstream now. But just the safer injection site, the managed care stuff, I never thought that

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as progressive as I am, that all of those things now are things that I look at as almost necessities, because people are going to shoot up anyway. You know, you go to 2nd and Indiana right now, it's there.

So we really thank you, and I particularly like the outline that was provided, Dr. Gerald and others and Dr. Work, around some next steps, and I definitely want to look at how do we resource the Task Force and how do we get folks around the table to really challenge what we've been doing and how the system has grown, but how the system can't be measured because it's sort of like fragmented. And I know that's a challenge. It's a conversation that with Dr. Evans we've been having for eight years. And so the Councilman bringing and making a laser focus around we're going to challenge ourselves to do the right thing.

DR. STAHLER: Well, if there's

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anything any of us can do, don't hesitate to call. You can call all of us at 3:00 in the morning. We don't mind. I'll give you Dave's cell phone number.

COUNCILMAN OH: Thank you so much for being here and waiting, and thank you, everyone, for being so patient. We'll call the next panels. They're combined panels.

THE CLERK: Terrell Bagby, Jeremiah Laster, Matt Tice, Deneene Brockington, Karyn Lynch, and Buddy Osborn.

COUNCILWOMAN SANCHEZ: Karyn Lynch, we called you.

She was outside making a phone call.

(Witnesses approached witness table.)

DEPUTY COMMISSIONER LASTER: Good afternoon, Councilman Oh and Councilwoman Sanchez. My name is Jeremiah Laster, Deputy Commissioner, Fire Department. I oversee the

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Department's management and delivery of emergency medical services. I'm here on behalf of Fire Commissioner Thiel.

In 2015, the Philadelphia Fire Department medic units made nearly 270,000 responses for medical care. We average 700 medical calls daily. The Fire Department Emergency Medical Services consists of 50 medic units. This includes 40 advanced life support medic units, staffed with at least one paramedic, and 10 basic life support medic units, staffed with two emergency medical technicians. All of our engines and ladders function as first responder units and always are staffed with a state-certified emergency medical technician.

I've sat here for quite a while, and I'm going to condense this down, because most of the information that was already shared is important.

Our responses to overdoses: Emergency Medical Services addresses the

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immediate crisis of heroin overdoses, which at times renders a person unable to breathe. The Fire Department responds to calls for persons exhibiting signs and symptoms of overdose resulting from opiates, among other toxic substances. Naloxone, as it is known by its trade name, Narcan, is an opiate antagonist. It blocks or reverses the effects of opiates. The Philadelphia Fire Department equips all of its ambulances and first responder vehicles with naloxone to administer to patients exhibiting signs and symptoms of an opiate overdose. Our annual responses to overdoses in 2015 were 14,888, which represents a 5.5 percent of the annual response in total and a 26.7 increase over the responses to overdoses in 2014, which totaled 11,746 responses. Our providers administered 3,035 doses of naloxone in 2015, a 35 percent increase over the year before and a 74.4 percent increase when compared to 2013 when we

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did 1,740 administrations. In 2014, our providers administered naloxone 2,214 times.

I'll talk about the cost of naloxone now for the Fire Department. The Fire Department's expenditures for naloxone have increased substantially over the past three years, which can be attributed to the increase in demand and increase in price.

In 2015, the Philadelphia Fire Department had $177,842 in expenditures to supply our units with the naloxone. This is a 349.5 percent increase when compared to the 2013 expenditure.

The price per 2 milligram unit increased from $13.74 in 2013 to $37.52 in 2015. Our current price for a box of ten is $378.68, and the retail cost for the box of ten is $518.99. So because we buy a lot of it, we have like a $140 break on it.

Our provider experiences: I'll just say this, all the medical care

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provided by paramedics and EMTs are guided by Pennsylvania statewide medical protocols. Our paramedics are often confronted by individuals experiencing a near death, as a heroin or opioid overdose can significantly diminish breathing. Manually assisting the individual's breathing effort is the first priority, utilizing a bag valve mask device. This is followed up by the administration of Narcan. We refer to Narcan as one of our miracle drugs because it rapidly begins to reverse the effect of the heroin. The medication is titrated to increase respirations. A small number of patients are not transported to the hospital after treatment. These are typical patients who after regaining consciousness from a near-death experience will decline transportation. Sometimes they become angry, combative, upset, and walk away from the scene of care.

Our paramedics and EMTs become

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quite familiar with the occurrences of heroin overdoses in certain geographical areas. And I noticed earlier -- you still have it -- a map of Narcan administrations in the City of Philadelphia, and that's usually data that's taken off of the charts, medical charts, and given to the Delaware Valley Intelligence Center, and they provide that to us so we can exactly see where these incidents occur.

However, these incidents can occur anywhere in Philadelphia. Just the other day as I was riding home, I heard an engine ask for an ETA on a medic unit because they had a serious patient. It comes to turn out that patient was a drug overdose. They responded, We got about a ten-minute ETA, and the first responder company stated, We gave him Narcan, he's coming around. So the medication does work.

Patients are allowed to -- well, let me start here. It is not

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uncommon for our crews to have multiple encounters with the same individual. We administer Narcan and it's the same person day after day or week after week. It is not uncommon for our crews to have multiple encounters with the same individual. Patients are allowed to refuse further care and transport to a hospital after medical command has been contacted and only if they have not departed the scene. Anecdotally, patients also may leave the hospital against medical advice from the emergency department.

What should occur? The hope is that all persons whom Narcan is administered to is transported to a hospital for further evaluation and treatment. This should include a screening, a brief intervention, referral to treatment assessment, as referred to as an acronym SBIRT assessment. We generally are reactive to the heroin opioid crisis. We respond after the

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overdose has occurred. Prevention is key to addressing this debilitating disease. Targeting adolescents through social media, early intervention, prescription drug monitoring programs, prescription drug disposal programs, which numerous law enforcement agencies have already said they are doing, and adequate treatment. This has to become a multidisciplinary effort. Heroin use must be unattractive for everyone.

The Department actions: In 2015, the Fire Department distributed Narcan to all its basic life medic units. In 2016, this year, we distributed Narcan to all engines and ladder companies. This is a total of 183 Fire Department vehicles equipped with Narcan. That means all 50 medic units, 56 engines, and 27 ladder companies all have Narcan on them.

We will continue to address the immediate life crisis of this heroin/opioid overdoses by responding to

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and administering Narcan for persons with symptomatic opioid overdoses. This seems to be the easy part of the problem. Responding and actually reviving them is the easy part, it appears to be. The tougher issue is getting individuals the help that's required to move towards recovery and stability. We will work towards transporting every patient who receives Narcan to a medical facility for further treatment.

When you think about it, you respond on the scene. You find somebody near death. They're barely breathing. You give them Narcan, enough to get them up and moving, and they walk away from a scene. Just think about that. Near death and off they go.

It's our job to do a better job to get them to a hospital, so hopefully at the hospital, they can make the connection with the overdose and try to give them help. But, again, they still have the right to refuse even at the

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hospital.

Also, we will lobby for the expansion of receiving facilities for emergency medical providers to include treatment centers equipped to handle the overdose and to provide long-term care, such as a dry medical facility. If you know, that Saint Joe's Hospital closed. That created a gap. We work together with Hahnemann, Saint Joe's, and Girard Medical Center to make sure that all of those people who would normally go for treatment will now be showing up at Hahnemann or some other facility. Now they have a process where they can get those individuals down to Girard Medical Center.

One problem about overdoses and just dropping people off at a treatment facility, a lot of treatment facilities say they need to be medically cleared. So I have a person in my car. I drive. I see somebody overdose. I take them to get help, but unfortunately they don't

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want to deal with it right away because they want to make sure what's in their system. So they don't have the capacity to say what is your drug screen, what do you have in your system.

We will continue to participate in improved data-sharing with the Delaware Valley Intelligence Center and expand data-sharing to include public health officials, addiction services, police, hospital, and substance abuse treatment facilities.

Lastly, we will continue to work with our Philadelphia Police Department partners and hospital partners to address this epidemic.

This concludes my testimony.

COUNCILMAN OH: Thank you very much.

MR. OSBORN: I want to thank the City Council for exploring the ways to combat the explosive epidemic of the drug with many names on the streets of Philadelphia.

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By the way, my name is Buddy Osborn. I'm the Pastor of Calvary Chapel Kensington of The Rock.

There's many names on the street for Philadelphia with this drug, such as smack, junk, black tar, brown sugar, and Victoria's Secret, just to name a few. Users believe that this deadly drug will fill the void that they feel inside, but it doesn't. As we can all agree, it will ultimately kill the user as well as rip their families apart in the process.

Twelve years ago, I was led to start this ministry in one of the poorest congressional districts in the United States of America known as Rock Ministries of Philadelphia, with the sole purpose of reaching the youth in Kensington before the streets do. The Rock is situated about 50 feet from what has been labeled the number one drug corner in the State of Pennsylvania and the top ten in America. Heroin moves

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through the streets of here faster -- in Kensington faster than the El train can get you to City Hall.

I would venture to say that there's more heroin sold and purchased in Kensington than a good nutritional meal. The devastating effects of the heroin epidemic in Kensington causes many sleepless nights for those in the neighborhood, and The Rock and other ministries in our area, however, are uniquely positioned on the front lines of this battle. We see thousands of young people come through our doors, searching for a safe refuge, and so many of our kids go on to finish school. They go to college and become firemen and police officers and national boxing champions, husbands and fathers.

One of our kids, a Latino boy, came to us as a teenager and he was a kid slinging drugs on the block and was ran out of the City by a rival gang, and now he's married with three beautiful

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children and a wonderful wife and who is actually employed by the City of Philadelphia. This young man is now a heavy equipment instructor with the Operating Engineers Union.

Now, we have seen so many amazing young men and women come through the doors of Rock Ministries as opposed to the doors of a crack house. In my work in the neighborhood, I've had countless conversations with men and women who have been caught up as drug users, and one of the questions I always ask them is, How old were you when you started? And the average age of starting to shoot heroin is the age 12 years old.

This convinces me that combatting this drug epidemic has to start with prevention, and prevention has to start with kids. That's why The Rock and other like-minded ministries in Kensington are working so hard to do that.

Now, I strongly suggest that

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our inner city communities where the heroin is sold and purchased on a daily basis and others that provide a safe refuge that will help our youth with options and resources to choose a life filled with hope as opposed to filled with dope. I stand here before you today without a clear vision on how to win this war, but I want to leave you with this. I pastor a church called The Rock of Calvary Chapel Kensington, right in the epicenter of the heroin market, and every Sunday morning at 11:00 a.m., we have more ex-junkies, ex-prostitutes, and convicted felons make a choice to say no to drugs and yes to Jesus. They have all realized that relying on heroin or any other type of illicit drug is only an attempt to fill the void in their lives that can only be filled by the power of almighty God.

Prison is a temporary solution for a user to stay clean. The most renowned treatment center cannot

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guarantee a person a drug-free life. A methadone clinic can relieve the craving, but it will never cure the person's habit. Hypnotic treatment and other means of psychotherapy can help, but they will never provide the fulfillment that the addict is searching for.

I love this, what God's word says. He says, Of my people who are called by my name will humble themselves and pray and seek my face and turn from their wicked ways, then I will hear from heaven and I will forgive their sins and heal their land.

Now, look, I recognize that there's going to be many different options or approaches to combat this debilitating and heart-wrenching heroin epidemic. I understand that. But in all of my years of hands-on experience on the front lines and dealing with the drug addictions, I have learned there's no program, there's no organization able to help a user until the user is ready to

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help themselves.

And with that, let me tell you something. We will never -- it will never happen until a person admits that they're trying to fill a void that only God can fill.

Thank you for your time.

COUNCILWOMAN SANCHEZ: Thank you.

MR. BAGBY: Good afternoon. Good afternoon, members of City Council. My name is Terrell Bagby, Interim Director of RISE and the Reintegration Services, Philadelphia Department of Prisons. I am accompanied today by Dr. John Lepley of Corizon. Dr. Lepley is Board certified in addiction medicine and will give some closing remarks at the conclusion of our testimony. Dr. Lepley is from Corizon, which is our medical provider.

Thank you for inviting the Department of Prisons to the public hearings for Resolution No. 160052, which

5/20/16 - PUBLIC HEALTH - RES. 160052 was introduced by Councilman David Oh to declare 2016 as the Year to Combat the Heroin Abuse Epidemic in Philadelphia.

I was here for the youth gun violence hearings, and I know that was kind of like a hot topic, but I think this topic is also a problem as well. So I thank you for your leadership and wanting to address this.

On behalf of Acting Commissioner Michael Resnick and incoming Commissioner Blanche Carney, I would like to introduce into testimony a summary of the Department's data regarding substance abuse treatment protocol and OPTIONS, which is our therapeutic substance abuse education program within the facilities.

Nationally, it is estimated that upwards of 80 percent of all individuals incarcerated suffer from drug abuse and alcohol abuse. This condition is referred to clinically as substance use disorder, or SUD.

To enhance the Department of

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Prisons clinicians' diagnostic accuracy at the time a citizen is incarcerated at State Road, the Department of Prisons conducted a City Institutional Review Board-approved study in 2013 to produce a profile of drug use by the Department of Prisons' population shortly before incarceration.

Principal study results were as follows: 41 percent of all those incarcerated in the Department of Prisons reported drug abuse; 74 percent of all those incarcerated in the PPS tested positive for use at admissions for the following: 59 percent for marijuana, 21 for benzodiazapines, 22 percent for cocaine, 14 percent for opiates, 8 percent for PCP, 4 percent for amphetamines, 3 percent for methadone, and 3 percent for barbiturates.

The Department of Prisons uses nationally recognized withdrawal discomfort scales to guide treatment of withdrawal. While some SUD patients do

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not require pharmacologic intervention to mitigate withdrawal discomfort, over 7,000 newly admitted individuals received prescription medications and close monitoring, which we call the withdrawal protocol, to assure that withdrawal is accomplished without avoidable adverse effects.

There is a good deal of encouragement in medical care to initiate medication-assisted treatment, MAT, of individuals suffering from SUD, which comes from the National Institute on Drug Abuse, NIDA, and the U.S. Health and Human Services Department's Substance Abuse and Public Health Services Administration, SAMHSA. The Department of Prisons' use of medication-assisted treatment remains quite restricted. In the course of a year, approximately 20 opiate-addicted pregnant women are induced onto the methadone, at the Thomas Jefferson University Hospital, to protect the unborn child and mother. These women

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are assisted at the Department of Prison in withdrawal from methadone after birth of the child.

In the course of a year, approximately 300 Philadelphia citizens who have been receiving methadone maintenance in the community by a physician order prior to incarceration are maintained on methadone at the Department of Prisons via a Department of Behavioral Health and disAbilities contract with Northeast Treatment Centers. These patients are referred back to their community methadone programs upon release.

So in addition to that protocol, we also have our OPTIONS program, which is our substance abuse program. In addition to medical substance abuse treatment, the Department of Prisons also provides substance abuse education programming through the OPTIONS program. OPTIONS stands for Opportunity for Prevention and Treatment

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Interventions for Offenders Needing Support, and is a pre-release-based drug and alcohol educational program. The OPTIONS/New Directions program is a 90-day program that utilizes the Hazelton Substance Abuse Educational Curriculum and is delivered using a group modality. Hazleton is based on cognitive behavioral therapy and is evidence-based. The program goals are designed to educate and support abstinence and recovery, as well as to teach and reinforce the coping skills that allow for positive community reintegration.

In addition to CBT, individuals are afforded the opportunity to participate in anger management groups, education, literacy classes, vocational training, and work assignments, domestic violence education classes, self-inventory and journaling assignments, peer support groups, individual treatment and discharge planning, committees and are encouraged

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to adhere to rules and standards of behavior of the OPTIONS program contract.

The primary treatment modality is group therapy. However, participants meet individually with social work service managers throughout the duration of the program. Individuals can participate in the OPTIONS program via the therapeutic living environment, TLE, where they are housed together on a designated housing unit, which our TLC units or RCF, which is the women's facility, Riverside Correctional Facility, and we have a TOE at ASD, CCC, which is Cambria Community Center. All the other facilities have outpatient where the individuals have to report to a central location for programming.

The TLE is structured around traditions and substance abuse models that utilize community and morning meetings, therapy groups, and 12-step fellowship meetings such as Alcohol Anonymous, AA. We had about 24 visits a

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year; Narcotics Anonymous, NA, 27 visits a year; Cocaine Anonymous, CA, six visits this year; and Al-Anon, a total of 17 visits this year.

For Calendar Year 2015 to Calendar Year of April 2016, OPTIONS provided educational treatment services to 3,132 court-stipulated individuals and 1,452 pretrial individuals who voluntarily sought treatment. The individuals are inclusive of duplicated admissions to PPS, or Department of Prisons, custody and the program. It is understood that relapse may be -- may occur as part of the recovery process, and individuals and returning citizens are supported in this process.

Court-stipulated individuals are evaluated by the Forensic Intensive Recovery Unit to determine their level of treatment for inpatient or outpatient treatment. At the discretion of the court, stipulated individuals are released to the respective treatment

provider. OPTIONS staff assists pretrial individuals and pretrial engagement with treatment providers in preparation for treatment upon release, at which time returning citizens are enrolled for benefits by the treatment provider.

On behalf of Acting Commissioner Resnick and incoming Commissioner Blanche Carney, we'd like to thank you for this opportunity to testify. Before we close, I would like to have some remarks from Dr. Lepley.

DR. LEPLEY: Good afternoon. My name is John Lepley. I'm a physician with Corizon Health, and we provide contracted medical services for the prison.

I just wanted to add one comment based on everything I heard today. Most of my comments would echo everything that was said today.

My role in the prison is to help our inmates when they're hospitalized transition back into the

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prison setting safely, and I just wanted to point out that in that role, I have the opportunity to review a lot of medical records and really review the care that our inmates receive in all of the hospitals in the area, and we have some of the best hospitals in the country, as you know, here in Philadelphia. And an observation from that would be that our inmates with heart disease, for instance, will always see a cardiologist regardless of the problem being treated at the hospital. And with asthma, they will see a pulmonologist. I do find that our patients with heroin addiction and substance use disorders in general do not receive that attention for that disorder as a routine. It's not really incorporated into their discharge planning.

It is a benefit to this Council that we had these thought leaders here testifying before me, and there is a will in these institutions to provide that

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care, but I think it needs to be disseminated across all physicians on the ground level, people providing care day to day.

When we are trying to treat addiction in the prison setting, it's like we're trying to treat cancer after it's spread to the whole body and ravaged the person.

Many of my patients with addiction disorders needed treatment five years ago. And you can see signs and symptoms of addiction very early. That third prescription for Oxycodone. I imagine our pharmacists are probably aware of the problem before the provider is in some cases.

So I would just like to close with echoing the need for screening and early intervention so that we're making addiction treatment a norm very early in the process of addiction.

And with that, I just appreciate the chance to be here and to

make some remarks.

COUNCILMAN OH: Thank you very much.

MR. TICE: Good afternoon, Councilmembers. My name is Matt Tice. I'm the Clinical Director at Pathways to Housing, a non-profit organization here in Philadelphia. I'm here as a social worker and administrator who has been in the field for many years. My staff and I have worked with hundreds of men and women who have fought to land on their feet reintegrating into communities following homelessness despite addiction, including opioid use, severe mental health diagnoses, stigma, and a lack of resources.

At Pathways to Housing PA, we exclusively serve homeless individuals according to the federally recognized HUD definition of chronic homelessness. So they need to have been on the street or in and out of shelters for at least a year to qualify for our program.

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We focus on those who have been out the longest with the most significant personal and systematic barriers in the way and simply offer them an apartment. Our apartments are scattered across the City and, therefore, integrated into communities. Everything else builds from the housing. Housing First means giving someone an apartment with no pre-conditions, but then immediately upon acceptance into the program, a multidisciplinary team with social workers, a nurse, a psychiatrist, a medical doctor, certified peer specialists and other case managers spring into action to help keep the person stable in their home. They work with as many internal and external resources as possible to increase the best possible -- or the best outcomes for the person by developing highly individualized plans that factor in multiple facets, like recovery, medication, therapeutic interventions

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that deal with past and present trauma, social supports, and much more.

True fidelity to Housing First comes from a harm reduction perspective, which we heard about earlier today, and takes a person right where they are. Research shows that the struggle to kick opioid use is long term and can take years to transition from usage to sobriety. We don't make this a barrier to support and, as a result, find that we can save lives in the end. Participants may be motivated to move into an apartment and work with staff, but not quite ready to cease their usage. It is through their relationship with compassionate service providers and even the slightest grain of interest of change that we will find ways to reduce risky behaviors and achieve better health outcomes.

We connect individuals to medically assisted treatment, like methadone or Suboxone; treatment plans

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that work for them; and adapt when they aren't working optimally and do whatever it takes to try and keep that person in their place on a road towards recovery. We've also started training both staff and participants on naloxone.

This model works. Housing First is a best practice, evidence-based approach recognized by HUD and SAMHSA. Pathways to Housing PA were able to boast of an unheard of 85 percent housing retention rate, which is truly remarkable for this population. You're going to hear a little bit more about that from Deneene.

When we break into individuals who use opioids, we are actually at an 89 percent rate of individuals staying in their housing. With this kind of success, we very much recommend more high fidelity Housing First services for those living with both homelessness and addiction. We found that the best outcomes for those individuals also are

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coupled with robust treatment options that take many different forms. Opioid use, unfortunately, seems to walk hand in hand with homelessness. It's especially true of the Kensington neighborhood where people seem to get stuck in their addiction. Obviously it's in other areas too.

I applaud local service providers and the City's recent efforts of compassionate response to opioid use and its often lethal implications. I want to encourage you as policymakers to support this even further.

Less than a handful of providers are operating in the area, according to true Housing First Fidelity. We can offer technical support if anybody is interested in implementing their own programming. We also need more beds for organizations like Journey of Hope through the Office of Addiction Services, who are moving people towards sobriety.

I'm going to echo many of my

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other colleagues who have said that they highly recommend that we get naloxone in the hands of many service providers, law enforcement officers, and individuals living with addiction as possible. I'm hopeful with the partners represented today here, along with the Philadelphia City Council's support, we can proceed towards a time when we look back at the opioid epidemic as something we banded together to address in a comprehensive and creative way and helped stave off.

Thank you.

COUNCILMAN OH: Thank you.

MS. BROCKINGTON: Good afternoon. I'm Deneene Brockington, Government and Community Relations Director for Resources for Human Development, also known as RHD. Thank you, Councilman Oh, for inviting us to testify today. Thank you, Councilmembers, that introduced and sponsored Resolution 160052 authorizing the holding of this hearing and members

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of the Public Health and Human Services Committee for hosting.

Forty-six years ago, RHD, one of this region's leading human services organizations, was founded to be an agent of change for our communities. Headquartered here in Philadelphia, RHD has grown into a national human service organization serving tens of thousands of people of all abilities in 14 states across our country. Our broad service mission uniquely positions us to respond to a wide variety of individuals and community challenges, including the City of Philadelphia's heroin/opioid abuse epidemic.

Today, I am here in support of Resolution 160052 and to put into record our successes in providing intensive supportive housing case management to people with a history of injection drug use, primarily opiates, who are homeless and/or at risk of homelessness, and these successes are happening in our Camden

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Supportive Housing Program. In 2008, RHD was one of two providers selected by New Jersey's Division of Mental Health and Addiction Services to implement the supportive housing component of Camden County's Medication Assistance Treatment Initiative. The individuals receiving services are also connected to either medical maintenance programs, methadone or Suboxone, or the syringe exchange program.

As Matt pointed out, our Camden talked about the Housing First approach, and the Camden Supportive Housing Program uses the Housing First approach. As he said earlier, the Housing First model aims to house people as quickly as possible and then provide services needed. And this is opposite of the services approach, services first approach, which often disqualifies and dissuades people with substance use disorders from accessing housing. So when we talk about Tent City, right, we

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talk about -- we got to get them housed.

Housing First has emerged as a more effective way to end homelessness for people with serious mental illness and chronic substance use challenges.

Included as a part of my testimony is a policy brief recently published by the Corporation for Supportive Housing, which highlights that Housing First approach is playing a vital role in addressing the opioid epidemic in New York State, touting 85 percent of people who are homeless with addiction challenges who get into supportive housing programs are successful, because they're remaining in their homes.

Also, the National Center on Addiction and Research evaluated a program in New York State and City that offered supportive housing to individuals not willing to commit to abstinence at the time they entered the program, and the center reports that the program was successful in reducing use of shelters,

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jail, and medical services. The reductions in crisis service use were associated with considerable savings, which offset the cost of the housing program. Again, both the copy of the policy and the evaluation of the program are submitted as a part of the testimony.

Now, our program, the Camden Supportive Housing Program, reports similar successes and provides a tested model that can contribute to Philadelphia's multi-pronged approach to this crisis. Using a wellness and recovery-oriented model of support that goes beyond establishing basic linkages to providers, each individual is encouraged to recognize their strengths and create goals they'd like to achieve. Stage-wise interventions and harm reduction approaches are used to guide services for participants as they work on achieving their goals. The most common goals for program participants include achieving success in addiction treatment

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and maintenance, job development and placement, education and training, income and health benefits attainment, resolution of any criminal barriers that may interfere with achieving the goals I just mentioned. The services we provide include housing attainment and stabilization; intensive case management 24 hours a day, seven days a week; recovery services, including mentors, groups, and individual support; co-occurring trauma-specific therapy and illness self-management support and services; independent life skills training; parent and family support and stabilization, including Child Protective Services case support, community involvement, and transportation.

And, again, although participation in these services are not required for getting and maintaining housing, all of our participants choose to access these services. Eighty-two percent have remained in their homes, and

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of the ones that left the program, 82 percent of them are graduated or achieved the ability to move on from the program. There have been zero overdose-related deaths. Ninety-eight percent have reunified with their children that were in Child Protective Services. Of the Child Protective Service cases that did not result in the removal of the children, 86 percent were successfully closed. Forty-seven percent are employed either in supportive or regular jobs. Of those not working, we have assisted them with obtaining Social Security and Social Security disability benefits to ensure that they receive long-term medical care and mental health.

In closing, as the City of Philadelphia develops strategies with the Department of Behavioral Health and Intellectual disAbility Services to effectively address our heroin epidemic, we strongly urge you to direct resources and increase the availability of

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supportive housing programs using the Housing First model. RHD, along with Pathways to Housing, we stand ready to provide services and to help shape the way these services are delivered.

And I just want to say one other thing. Earlier, Councilwoman Quinones-Sanchez, you were talking about the recovery houses, right? And this is also an alternative to the recovery house model, right? We're getting people in homes. They're being integrated in the community, which is big in our system. Community integration is big. And then they're getting the services that they need. And so it's a different -- it's another model to consider. It's one that is evidence-based. It's proven to have a successful track record.

And, Councilman Oh, you know you've seen me at the community meetings, and it's clear that more treatment is necessary. It's clear that funds are coming down the pike to increase the

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amount of services and treatments to address the epidemic, and as we talk about where are we going to go, there are RFPs coming. You know, we have communities that are saying, no, we don't want this in our community. We might have District Councilpeople saying, no, we're not going to support the opening of this service in our community. And so I strongly also urge that Councilmembers, along with the agencies and providers, that we work together to figure out a way to include education, education communities, about why these programs are important, but also work together that we are more evenly distributing these programs across our city. Because I get it. I live in District 8. So I understand what Councilwoman Bass is talking about. And so it's not fair to have so many programs concentrated in the poorest sections of the City. And so we need to work together to figure out how these services are more readily available

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across the City as well.

I also would like to add that Kristin Colangelo, who is the Director of Camden Supportive Housing, is with me today and is available to answer any questions that you may have.

COUNCILWOMAN SANCHEZ: Thank you. I just want to say that the location and the siting of these programs are obviously very controversial. One of the questions we continuously ask CBH and others is, it's the model. I moved into Norris Square, Kensington Hospital. We've had a methadone clinic there forever, licensed for 300 folks. Sixty percent of the clients walk to the center. And literally I was moving them from the front of the park to a commercial property along the corridor that was -- the physical plant was prettier. We were going to have better security and privacy issues for folks, and literally got opposition from everybody, including my neighbors, who

moved there knowing that the clinic was there. And I literally moved it 100 feet. If you go on social media, they will call me the Methadone Queen, because I recognize that there's a need, and what I was trying to do -- all of this to say that the way we fund these programs, in order for them not to become disruptive in the neighborhood, they have to be smaller, and we need more people being able to walk to them. And I think the problem we had and the debate we've had in this Council is, there were three Council folks who wanted to ban methadone clinics from their districts. Their districts happen to represent 60 percent of the clients who use methadone. And so the education has to start here.

MS. BROCKINGTON: Yes.

COUNCILWOMAN SANCHEZ: But then we have to fund them in a way that they don't become disruptive to residents and that there's more education, and that's part of the challenge, and that's why

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it's important that these conversations happen, so that as additional resources come, we're leveraging them better and we're understanding that in order to get community buy-in, we need to make sure that they're funded better and less disruptive for the quality of life for folks. We're not going to take that away. Again, managing 300 recovery houses in my 34/24 zip code is very controversial because people just want me to say I'm against recovery. It's like, you can't be against recovery. And you look in the room and you know everybody knows someone who is in recovery.

MS. BROCKINGTON: Absolutely.

COUNCILWOMAN SANCHEZ: And they'll tell you that privately, but in the meeting I get slammed.

But we thank you. On the housing piece and even accessory housing, which was one of the topics in the Zoning Commission that we actually eliminated from, so you need a special kind of

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exemption, I'm actually looking at creating that kind of zoning designation that would make it more flexible for us to have the smaller 300 square foot kind of housing to allow folks to be able to afford their place, because I really believe in Housing First, and I know as a city, we have not embraced the total concept of Housing First because the model is different. So the business model of how we take care and transition people from homelessness is changing.

So we thank you, and we look forward to working with you and kind of challenging us. You got to continue to challenge the bureaucracy, the titanic.

MS. BROCKINGTON: I actually met with Ketsy on Wednesday and so --

COUNCILWOMAN SANCHEZ: Yeah. We were talking earlier today and she said you were testifying. So we look forward to it. I actually visited one of the sites in Camden. I'm not sure. It was a women's site that I was very

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impressed. I think it was a Vista one -- or Vista is the group?

MS. BROCKINGTON: I don't know if that was --

COUNCILWOMAN SANCHEZ: It was another group. But thank you so much for coming.

MS. BROCKINGTON: Great. Thank you.

MR. TICE: Thank you.

COUNCILMAN OH: We'd ask Karyn Lynch to step forward, Chief of Student Supportive Services, the School District of Philadelphia.

(Witness approached witness table.)

COUNCILMAN OH: And please state your name and identify yourself for the record and provide your testimony.

MS. LYNCH: Good afternoon. My name is Karyn Lynch. I'm Chief of Student Support Services with the School District --

COUNCILWOMAN SANCHEZ: And

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thank you for being so patient. I really appreciate it.

MS. LYNCH: Thank you. I'm very glad to be here this afternoon on behalf of Dr. Hite. He asked me to extend well wishes and to thank you for raising this very important topic in Philadelphia. So I do extend that.

The School District of Philadelphia, I would share, for the most part partners with a good number of City agencies within Philadelphia to help serve our students, particularly those students who have identified or that we suspect might be using drugs or alcohol. We partner most closely with the Department of Behavioral Health and the contractors that they employ in order to provide services.

There is an assistance program, as you probably know from Dr. Evans' testimony, that provides services. We refer students to this program when we suspect or when we believe that they have

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used drugs, might be using drugs. And we look at indicators like their attendance, their grades, change in mood, change in behavior.

We also partner with the Health Department that comes into our high schools annually, and they engage in collecting samples from our students. It's all part of the STD and the drug and alcohol screening that takes place.

Something else that we do in the school system that I think is fairly important is that many of our schools, particularly at the younger years, which we know are sometimes those years where students become introduced to behaviors, we have a life skills program. There is an evidence-based program that comes out of Colorado that many of our schools are participating in. Last year, there was a major push by the City to encourage schools to become involved with the life skills program. And so many of our schools signed up and are participating.

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The beauty of the program is that it brings to the classroom a model that is implemented by teachers and healthcare -- not healthcare, but health educators. So for our health teachers and our gym teachers, an opportunity to really introduce students to ways to avoid those behaviors that we want our young people to avoid.

Before closing, I'd like to mention that one of the ways that we gather information about what our students are doing, what risky behaviors they're engaging in, is we have the Youth Risk Behavioral Survey. That's the study that comes out of the CDC, and the federal Disease Control Agency has very much been involved. We've been involved with them for probably the better part of the last ten years. The information that comes from the survey that's conducted in our high schools every other year tells us a good deal about the drugs that our children are using, our students are

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using, the introduction to risky behavior, including STDs and, most importantly, it provides an opportunity for agencies across the City, for non-profits across the City to observe that data. The 15 data in fact from the 2015 survey is now available, and it's posted on the web, and it gives all the opportunity from the Health Department to Behavioral Health to non-profits that are seeking funding to address the needs of young people throughout the City. It gives them an indication of all types of data related to our young people in risky behavior. So we can see when students are reporting that their use of opiates or their introduction to opiates is -- at what age it occurs, what it is, and so on and so on.

Having listened to several of the speakers today, I can tell you that from 2011 to 2013, we saw a slight decrease in the use of first-time opiates reported by our students, and

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unfortunately in the last survey, we looked at the -- in fact, I just a couple minutes ago looked at that one data point for opiates for 2015, and there's a slight increase. And so it went from maybe 1.8 to 3.3 percent of our students reporting that they had had an introductory experience with heroin. So this is something --

COUNCILWOMAN SANCHEZ: Is that self-reporting?

MS. LYNCH: That's self-reporting. Yeah, that's self-reporting.

The survey results, I urge everyone listening and people in the City to be mindful and aware that they're readily available online. Just go to the CDC website and it navigates to that.

And at that, I'll close.

COUNCILWOMAN SANCHEZ: Thank you. And I want to thank -- since coming on board, I know you've been really focused on all these support services for

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our young people.

I wanted to ask you real quickly. So you talked about the opiate utilization, and that's self-reporting. For kids who are medicated daily, do we keep track of that, for younger folks who may be receiving medication for behavioral issues?

MS. LYNCH: For behavioral issues? If it's reported to us by their doctors. So if they are required to take dosage during the school day, then that's something that we're going to know about as a result of their doctor letting us know and, therefore, can be monitored within the school.

COUNCILWOMAN SANCHEZ: One of the things that's come up in this discussion has been the type of prevention services, particularly of the high school level, because one of the issues is that there's some prevention models in the K to 8 system, but there isn't really from Behavioral Health

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something focused at the high school level.

In light of some of the things that we heard here today, particularly around the addiction and the fact that we haven't spiked and all of the other things, one of the things that we're going to be looking for and I know the Councilman -- and he has some questions that he wants to ask -- is what other educational pieces we need to be doing at the school level so that even that initial introduction doesn't happen at that level.

So Behavioral Health doesn't report to principals directly when there's medication? Unless a doctor provides it, there's no required accountability around you knowing or principals knowing how many kids in their building are being medicated in some form?

MS. LYNCH: So if a student is taking medication that's taken during the

school day, then there is the requirement that --

COUNCILWOMAN SANCHEZ: It is a requirement; it is not self-reporting.

MS. LYNCH: That it's known. So the nurse would have to know, because we want to know what it is that a student might be taking during the day. Say, for example --

COUNCILWOMAN SANCHEZ: We're concerned about -- one of the things that comes up when we are thinking about this is kids carrying medication. And so while at the K to 8 system we might be getting it, there might be high school kids who have it that we're unaware of.

MS. LYNCH: Right. So K through 8, it's more normal than not that medication is going to be stored by the nurse or someone in the principal's office and, therefore, that they would know.

COUNCILWOMAN SANCHEZ: Okay.

I'm sorry. Councilman Oh.

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COUNCILMAN OH: Yes.

Thank you very much, and thank you for your patience. I'll say that so many of us -- and I'm talking about myself -- we assume things and we don't actually know. And what I mean is, I went to junior high school. I was shocked. I think I learned that there's no more junior high school in Philadelphia. I didn't know. I didn't know that there wasn't a 7th and an 8th grade anymore. I thought elementary school was 6th. And I was surprised because when I think about junior high school, I had shop, art, history, Spanish, you know, that type -- music. It was all just -- so I just assume it's part of every school. I also had health ed, and I just assumed there's health ed in every school and we learned about STDs and we learned about drugs and drug prevention, all that. I just don't know with all the funding issues and the personnel issues and so much of what

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everyone has talked about is, you know, really addressing young people before they get wrapped up into things. The school system is there, the funding that should be there. How do we deal with charter schools? Is there a program in public schools? And, for example -- and I don't know that there is, but if there were a program where a 12-year-old, a 13-year-old, an 11-year-old who was coming to a counselor, a nurse, a teacher, someone, and they'd say, I have a drug addiction issue, that what help is available? As part of the community meetings and speaking to experts and even today, we've learned that a person who early said, I had an opioid addiction that became a heroin addiction, I'm two years heroin addicted, I need help, the answer is, You don't qualify for help yet, you know. You are not severe enough yet to receive help. You might want to commit a crime or make -- in other words, even if this student were to say, I have

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been smoking cigarettes, smoking pot, now I'm using some drugs, what is the answer where help is available?

So to reframe, because I know I threw a lot at you, what is in our public schools uniformly, if anything? Is it the kind of thing I think most parents would imagine is in there? And what about our charter schools? Do we have any ability to put a consistent program in for health ed, drug prevention, and does that program include actual gateway to services?

MS. LYNCH: Okay. So I will try and take those questions as I heard them, and if I miss anything, please let me know.

First of all, health is a required course for graduation in Pennsylvania. And so each of our schools offers health. Frequently health is offered in the senior year, which means that a student has to make their way to their senior year in order to receive

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that service. And so one might say that because it's not offered until the senior year, then for younger children, especially freshmen in high school, the things that they are going to learn in the course of their day as they go about their business and then they attend school and they live in their communities, they're going to know far more than they need to know before they get to their senior year.

So the effort to try and increase the access to just health class at a much younger age for entry into high school or even pushing it into middle school is something that we're about trying to do. That's number one.

Number two, the survey results that we are able to receive -- and this is a major agreement that we have with the CDC. It not only allows us to compare the risky behavior of Philadelphia's children with behavior of children in other large jurisdictions

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across the country, but it allows us to see what indicators, what use students are engaging.

For example, the drug of choice in Philadelphia among our young people is marijuana, much more so than it is opiates, and many will say that marijuana use over time could be the entry drug to the use of opiates. And so when we talk with, when we work with, when we engage with the Health Department, Behavioral Health or any of the assistance programs that Behavioral Health has contracted, we look at that data and we see the types of programs and services that need to be geared toward the students that are attending our schools so that we are able to arrest their risky behavior. If marijuana use is high and opiate use is low but marijuana use leads to opiate use, then we are designing programs and services within our schools that are saying to our young people, Young people, marijuana use leads to; Young people,

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avoid marijuana. And the messages that we are sending are related to what the data is telling us. As a result, you can see that in Philadelphia, we've had over time some improvements, because we've looked at the data and geared the programs toward it.

I would say that obesity among young people is one such example. So from the study, we saw that obesity was increasing. We put measures into place as a community called Philadelphia to address that problem of obesity, and now obesity is lower. Same with smoking cessation.

Regarding charters, you know that charter schools are their own intermediate unit, and so our ability to engage them in services really -- they, for the most part, design and develop what those services are going to be, and when it comes to this area of health service or monitoring drug behavior or even the requirement to participate in

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the survey, it is not there. The Risk Youth Survey is done just with School District of Philadelphia schools.

So I'm not really positioned to be able to share what the details are about how our charter schools are addressing the needs of children that are here in Philadelphia. And the needs are all the same across. I am in no way saying that School District of Philadelphia students have a very different experience from those in charter schools. I'm just not that familiar to be able to testify about it.

COUNCILMAN OH: Thank you.

COUNCILWOMAN SANCHEZ: Thank you, Ms. Lynch.

We wanted to ask the prison officials to come up. I also had a question for them.

MS. LYNCH: Thank you so much.

COUNCILWOMAN SANCHEZ: Have a good weekend.

MS. LYNCH: You too.

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(Witnesses approached witness table.)

COUNCILMAN OH: I visited the women's prison. I had visited the men's prison, and I've been to the prison a few times in different capacities, but as a Councilman, I visited the prisons. And, first, I am generally concerned with the lack of attention on girls and women in our city in almost every aspect, including drug addiction and all that stuff. So I wanted to go to the women's prison, and it was like different when I went to the women's prison than when I went to the men's prison.

The women's prison, when I went with an official and I went to a living area, they were sharing showers, rooms, and they seemed quite well adjusted to me and they seemed pleasant and more optimistic than I thought they would. And I asked about it and I spoke with some of them, and I've told people at community meetings, I don't know if it

was a set-up or whatever. I just go there. They bring me to a location. I meet people.

But my perception was that they were doing well and they were optimistic and got along well and they were in kind of a good spot kind of in their life, which ties into my question, which was, how many of them will be back? And the answer I got was, A lot of them will be back, because they're drug addicted. And so they've been treated. They're off of drugs. They got a place to live and a place to socialize and a place to talk to each other about seeing their kids again, and now that they're clean, rebuilding their lives and that type of thing. But when they are done their term, they are just out, without necessarily a driver's license, a job, a place to go, a home to stay in, and everything else that you were kind of alluding to and the other people about the housing. And so likely back to the same community, the same

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problems, the same situation and everything else. And I just wondered if we know -- and that's the other thing. It's not a state prison, for those who don't know. They might be out in a week. They might be out in two months. They might be out in six months. We really don't know unless they're serving county time. Then we know they're doing like six months, for example.

But if we know that they're going to leave in 30 days, is it possible or is it already there that there would be a transitional service to make sure they have perhaps a place to stay, the electricity has been paid, they got a driver's license, all of those types of things and that they've been in touch with a non-profit or a government-sponsored entity where they go to housing, you know, all of those type of things? Naltrexone obviously is pretty expensive, but keeps you from using drugs again once you're out. A

thousand dollars, works for 30 days. I mean, what are the strategies around if they're in a good spot; for example, they're mentally good, they're looking forward, they're reconnecting, to getting them into a better situation as part of their being released from prison?

DR. LEPLEY: Sure.

MR. BAGBY: I'm sorry, Dr. Lepley. I'm just going to give you the social service aspect. Dr. Lepley will give you the clinical.

Under incoming Commissioner Carney, we are looking to expand our Discharge Planning Unit. As you stated, we are a county facility, so our timing of when someone is going to be discharged is not always accurate. But we are going to expand in our Discharge Planning.

But as far as IDs, we do have an ID restoration program. So if anybody in the county does need ID, because we know that reentry, one of the biggest barriers that people have is not having

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any ID. So we do provide IDs at the county level. We also have what's called our SMI Pilot Program where we looked at a number of targeted SMI clients, seriously mentally ill, who didn't have medical assistance benefits. Through an agreement with the state Department of Human Services, we have an MOU where we can have their benefits activated before they're released. So before they're released, everything is in COMPASS application platform. Then they come down to our RISE branch, because as you know, due to the change in Charter, RISE comes under the Department of Prisons now. So once they're released, they report to RISE at 990 Spring Garden. They get their medical assistance activated and they also get the wrap-around services.

I think, in some of the conversations that happened earlier, is that we do a great job of assessing those individuals, what their needs were and

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things like that, but I think sometimes we need to assess the community, because we take them out of a contaminated environment. We have them on county State Road. We provide the services. We stabilize them, but then we release them or they get discharged back into the community that doesn't support that type of recovery.

We have a situation actually at RISE, we have a component where we do offer housing. So we did have an individual in housing, but the environment that he was -- the housing apartment he was at was so bad that he chose to go back into a rehabilitation center instead of staying in housing.

So I think that from a social service aspect, we do a great job of assessing the individuals, but we probably need to do a better job of assessing the communities that they're returning into.

DR. LEPLEY: From a clinical

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standpoint, I think that sense of well-being that you're observing is misleading or it's an illusion, in a sense. It's a function of the revolving door. Certainly the environment is not unfamiliar to most, because many of the women and the men who are addicted to heroin and other drugs are in and out and in and out.

I think one challenge that I encounter when treating the women, I was the Medical Director at RCF for two years and now I work in the prison Health Services wing, but I found that I would see a lot of women and patients who would acknowledge that they use drugs recklessly and endlessly and over and over again, but many truly had difficulty internalizing and accepting that they had an addiction disorder. The ones who really accept that did seem to have a chance at doing well. But a lot of people with addiction disorders, from a clinical standpoint, truly view

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themselves as victims of circumstance. And they do have very difficult backgrounds. Many are victims of trauma. But to go back to my earlier point, I think a lack of continuously reenforcing that this is a medical problem sort of makes it difficult for a person to truly internalize and accept that I have this disorder, that I have this problem. They would rather view it as a victim of circumstance or a scenario in life, because if that changes, then maybe they have a chance. And there's a stigma with addiction that was well talked about here that I think is a barrier to a person accepting that I have this disorder. And we do have a long history. I mean, it's heartening that we are discussing this in a public health forum today, but we do have a long history of viewing this as a criminal justice issue. And certainly if having this disorder means I'm going to be incarcerated over and over again, people do not want to truly accept that,

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that that's my problem. That might be the other person's problem, but I have this bad back and if I could just get on the right combination of medicines.

I think that mindset is really there for a lot of people who suffer from this disorder, and I do think that a potential solution is a broader approach from primary care and all doctors that come together and say, You have this disorder, you have this disorder. Right now we rely on people to make the diagnosis themselves, to sort of hit bottom, and then they seek treatment. I think if we were making the diagnosis earlier in the course of the illness, we would prevent this revolving door that you -- I think that's what you were seeing. I think a lot of people it's just become incorporated into their illness.

I do think inpatient rehabilitation treatment centers also have a similar problem, where people

bounce in and out, in and out. They say what they're supposed to say, but it truly just has become part of their illness. And in those cases, just my opinion from a clinical standpoint, I think those individuals haven't really internalized and accepted that I have this disorder and this is what I need to do.

COUNCILWOMAN SANCHEZ: I got to visit Red Hook's Community Court and a lot of the cases were drug-related cases, folks who were addicted, and the judge let me sit through the courtroom process. And they have their Community Court's counselors upstairs, assessments and stuff, and I watched people come in. The judge sent them upstairs. There was an assessment done. And even people who had like 19 different charges, you saw them willing to do some sort of restitution and get a small victory. And there was one gentleman who came in who kind of had relapsed, and he came in front of the

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judge and he said, I need a shot at restitution. He came -- he self-reported. He came in and was like, I fell off the wagon, I need to come in here, and asked the judge to give him 20 community hours. You know, he wanted to come in and make right, even though he had made all these mistakes. And it was just so powerful to watch, because instead of criminalizing it and Judge Calabrese at Red Hook, incredible nurturing type of person, you know, he wanted to have a victory, and his victory was, one, being able to come in and say -- because he wasn't being a criminal. He was coming into a court that wasn't going to judge him. And his willingness to say, Judge, I need something to provide that restitution so I can feel better about myself. And I'm glad that we're decriminalizing some of this stuff and really looking at it this way, but my question because in the county system, because you don't know how

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long people are going to stay, what are the incentives that we're creating? Because I know part of our challenge was the reimbursements for people that were in the system. So it becomes kind of a financial situation. I think we've gotten better at that at the prisons, although I'm almost scared to ask the question for fear of the answer.

What are the things that you would say as the clinical person at the prisons we should be providing in-house to help? And I absolutely think that -- I don't care if it costs $1,000. We should be providing that. But what are other things do you think we can provide there to better help people transition back?

DR. LEPLEY: I think that's what we need to do, is partner with providers in the community, treatment centers in the community and allow for that transition. And the model described in the OPTIONS program is the standard of

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care. There's been a lot of talk of medication and medication-assisted treatment, and those are important components to assist in treatment, but the treatment really is psychologic counseling, psychology therapy. That is what's going to develop the rational brain to overcome this diseased instinctive brain that was discussed very early in today's proceedings. That video really described it well. You really do need to develop the rational brain and the higher brain to override that instinctive drive that the person with addiction has.

And so I would say that we should be, from a clinical standpoint, doing more to recognize addiction before the patients themselves are aware of the problem. Because I can see the behaviors before the patient is willing to acknowledge it or before he or she sees it themselves. So just like in the community, I would say earlier

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intervention would lead to inflated statistics, but would be a positive thing. And I think increasing the counseling that people get would be beneficial, because that is really the standard of care.

Councilman Oh asked earlier about what's the best treatment. The best treatment is what doctors receive when they have substance problems, and it involves a very intense counseling process.

And so I'm of the opinion that the solution lies in counseling, 12-step programs. People need to get well in the communities that they live in. When they are in jail -- and that will happen because -- and that can be healthy, because people do need to be accountable for their behavior, but as a clinician, if we can have a better handle on where they're coming from and, more importantly, where they are going, we can certainly reach out to providers in the

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community and provide for a better transition.

I think as a clinician, I could do more to interact with the OPTIONS program to maybe make them aware of behaviors that we're seeing in medical that indicate symptoms of addiction. Maybe they're not using drugs in the jail, but they are looking for a pill to help them relieve anxiety, and those patients are going to struggle when they leave. And there is a place for medication as well, and I think it's been explored, things like the Vivitrol. An injection of Vivitrol before a person leaves certainly could be life-saving in some circumstances, but medication alone is not the solution.

COUNCILWOMAN SANCHEZ: Thank you. Thank you both for coming.

(Thank you.)

COUNCILWOMAN SANCHEZ: And adding your voice to this.

We have our last panel of

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folks, Melissa Green-Cannon and Deborah Young. We're not sure if Ronald Pope is still in the room.

Thank you so much for being patient and waiting.

(Witnesses approached witness table.)

COUNCILWOMAN SANCHEZ: I greatly appreciate it.

You can proceed with your testimony. Identify yourself for the record, and thank you.

MS. CANNON: My name is Melissa Cannon. I'm here as a parent of an addict. Thank you for giving me this opportunity to put a face, a real face, to this problem.

I live in the suburbs, but my daughter lives here in the City. And I don't even know if you can call it living. She slept on the streets last night.

My daughter has been an addict for over seven years, and she's only 22.

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I've come to terms with I will probably get that dreaded phone call one day that my daughter is dead.

Some of the obstacles that we've faced over the last few years have been that she had private insurance. When she finally reached out for the very first time and wanted to get help, I tried to get her into rehabs. They wanted me to walk in with $1,500, which I didn't have, which meant at that point after spending hours in the emergency room to get evaluated, she's like, I'm done, and she would go back into that world and I wouldn't hear from her again for a while. That happened numerous times.

We were then told, Well, if she had medical assistance, then she'd be able to get in easier. So I called her dad and I said, Take her off your insurance. The next time she wants to get help, they'll put her on medical assistance and she'll get into rehab. So

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that's what he did.

The next time she reached out we took her to the emergency room like we were told we needed to do, sat there all night. She started to go into withdrawal. The emergency room doctor did nothing to help. At 8 o'clock in the morning when the case manager came in, did the assessment, said she needed rehab, there were no beds available, because rehabs are limited to the number of medical assistance beds they have. But they started the process and at least she became covered through medical assistance. Then I find out that it's done by county and she's only eligible to go to rehab that our county has contracted with. Well, those beds are all taken, but yet in four counties over, there may be seven beds open for medical assistance, but because I don't live in those counties, she can't go there.

The stigma I've heard talked about earlier as well is huge. I've kind

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of kept this a secret for a long time, and I've realized that I can't do that anymore, not only because it doesn't help her but it doesn't help me either. The things that people say on social media are horrible. I read a statement the other day. Someone said, Oh, they're all just junkies, they should just die anyway. They have no idea the struggle that we go through trying to get them help. There's that brief window when they have that moment of clarity where they know they need to get help, and it just disappears so fast.

We have a system that makes addicts criminals. I heard a few things about how in Bensalem you can go in and you can tell them that you want to get help, they'll help you. My daughter is not going to walk into a police station because she has warrants. If she walked into a police station, they run her name, she's going to jail. She's not getting help.

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The other thing that we found when I was able to get her in rehab, because of the numerous traumas and things like that that she has witnessed and experienced, the minute the drugs are gone and that reality hits her, it's just too much. I know a few of the things that she's been through, and they devastate me. I can't even imagine having lived through them, and that just being a few of them.

But when she gets to that point and it's so overwhelming, she just leaves. She wants the drug again because it's easier and it's what she knows at this point.

People are like, Well, they make the choice. My daughter consciously makes a choice at certain times to stay in this life, in this addiction, because I tell her if you -- she calls and wants to come home and I say, If you go to rehab, you can come home. I can't have her in my home using. But she doesn't

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really have a choice. Her brain doesn't let her make choices like we would. She doesn't think like we do anymore. Because what normal person after overdosing and then taking two doses of Narcan and 15 minutes of CPR to bring her back would want to continue that? She died. She was -- a week and a half ago, she was admitted into the hospital because she had an infection in her arm. She now has an incision about seven inches long, about the size of a grapefruit wide and about three inches deep in her arm. It's an open wound that they had to clean out the infection. That's how much of it they had to take. I brought her home to my house after they released her, because if she goes back to where she was, she'll die. The places that she stays in are not clean and safe for her to recover from something like that.

Two days later she lied to me and met up with a friend, and I told her

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if she wasn't home by a certain time, she couldn't come back to my home. She's not back. She's now back living in Philadelphia.

That picture you see isn't my daughter anymore. And I know there's no simple answer on how to fix all of this, and I know she has to want it more than I do for her, but there are just so many obstacles.

I think some of the things that need to be addressed are to get rid of those lines with insurance companies. That's a huge thing. I've seen a petition that I've signed where you can have someone involuntarily placed somewhere for drug addiction. That's not -- right now to 302 someone, drug addiction isn't a legitimate reason for that to happen, and it makes no sense, because if she said, I'm going to kill myself, I can do it, but her slowly killing herself daily with this disease, it's just -- I don't understand that

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concept.

We need to stop prescribing opiates to kids. I went to a task force meeting at a school and found out that you can become addicted to opiates after only three doses, which isn't even a full day. If you get it every six hours, that's four doses. Before you're done your first day, if you're going to be one of those people who becomes addicted to opiates, it's that easy.

When my daughter was 14, she was in the hospital for pancreatitis and they gave her morphine, and I think that turned that little trigger on for her. She had already been experimenting with other drugs, and I know that she was using -- from her telling me things, I know that she used Percocets and things like that before she got to heroin.

No one sets out to be a heroin addict. It's not a choice that people make.

The other thing, my daughter is

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now a criminal with a criminal background due to her addiction, and the charges that she has now, she's never been arrested or convicted of robbing anyone, breaking into anyone's house. Her charges are all, I guess, what someone could say a victimless crime, but she's the victim because the things that she does hurt her and nobody else.

I actually had her arrested originally to try and get her into rehab. The police officer said, We can do this and hopefully you can get her into rehab. Now she had a felony drug charge because she had drug paraphernalia in her purse that she openly admitted to and openly gave to the police officer. And I thought, Okay, this is our way, we're going to get her help. She spent three months in jail. They released her to drug rehab. They picked her up from the jail, took her to rehab. Two days later -- she went there on a Friday. On Saturday, she walked out of the rehab,

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and that's the night she overdosed.

I guess I'm lucky that she's still here, because as long as she's still alive, there is hope. But all the things in place right now work against her. She's lost so many friends, and that's not enough for her to change either. I don't know what the answer is, but we have to figure it out before we lose more kids. They're just -- they're dying faster than they should be.

Thanks for letting me come and speak today.

COUNCILWOMAN SANCHEZ: Thank you. We're going to keep praying for you.

You can proceed. Identify yourself for the record.

MS. YOUNG: My name is Deborah Young, Justice for Families and Children. I'm also -- I volunteer at PRO-ACT Recovery Center and also with Project Home, a number of other organizations to help people that are homeless and are in

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recovery.

I hear the stories too much, too much. Nationwide there's 2,000 kids every single day trying prescription drugs, 2,000. Seventy percent of our children are getting them at home or, like she said, from the hospital. They start them at the hospital. Why are our children getting drugs when they leave the hospital? There's other things out there you can do for our children. And it's a trigger.

My daughter also was given Percocets. I mean, I took them from her. I stopped her from -- but she didn't get addicted to them.

I'm 11 years in long-term recovery. I started off with pot, then I went to crank back then, and then I went to alcohol was my drug of choice. But it is a drug. These children need help. They start at a very young age. Our 8, 9, 10, 11, 12-year-olds doing drugs, from marijuana to prescription drugs to

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alcohol to hard-core heroin, you know. And it is very hard to get people in to get recovery, to get detox. It's extremely hard. I get calls all the time to get people help. If I have to spend eight, ten, 12 hours sitting with somebody or a whole day to try to get them in somewhere, to get them help, I will do that, because if I lose that person, they might be dead the next day, because they can't get the help. They can't get into that detox.

There's certain counties, like she said, you got to live in there. But there's beds all the way in another county, but you can't get them in there. And what are you going to do when that person comes to you and asks you for the help and you can't get them the help because they don't have insurance or there's no beds? And I can't tell you how many times I've heard there's no beds, how many friends I've lost. In the last two years I've lost 13 friends in

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two years. That's a lot of people.

Our kids are doing drugs, prescription drugs. I went out to my neighborhood, because I live near a park, and I did my own little survey with these teenagers and I asked them. You know, they know me from the neighborhood. They see me all the time with other people in the neighborhood. Sixty kids, 60 kids told me they would have no problem getting drugs within 15, 20 minutes. They could get them from home or they could get them from their friend. Prescription drugs, that's where it's starting.

Our kids are dying. They're overdosing.

I'm trained for the Narcan. That's a good thing, but then they're just going back out there and doing it again. There's got to be some kind of policy where you give them Narcan and they got to go into somewhere afterwards to get the help. I mean, people got to

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make the decision that they want to do it, but nobody is in their right mind when they do drugs. I was not in my mind when I was drinking back when I tried crank. My first drink I was 12 years old, 12 years old. And then that's all it took.

Our children need help and they need it now. They need people out there on the streets letting these kids know they have somewhere to go. Me and my sponsor went out and put flyers in all the pizza places where it said where they can go get help.

There needs to be more funding to get people a bed. A bed. That's all it takes is one bed when that person needs help. There is not enough beds in Philadelphia. There's not enough recovery houses. When they come out of there, where are they going to go? They don't have no jobs. They don't have -- there's not enough recovery houses to take people in. I would love to own a

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string of recovery houses to help people. I don't have the money for that to open these recovery houses. When they come out of there and they have nowhere to go, the despair, the depression, the helplessness takes them right back out there.

It's just -- I lost my cousin. She was found hanging. She was on methadone for a lot of years. Why are people on this methadone for a lot of years? She could not get off of it. She hung herself.

My friend Johnny, my best friend, kept fighting to come back in and out, in and out. He got one last bag and it killed him. He couldn't pay for to go in treatment anymore. He already spent thousands of dollars. Because he had a company. He wasn't making a lot of money, but he couldn't keep affording going back in there. He's not here.

How many children -- and I have friends that lost their children. A

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parent should never, ever outlive their child. The worst pain in the world is going to your child's funeral, and I've seen that pain.

This is where -- we need more beds. We need more people out there. You know, PRO-ACT is an awesome recovery center that goes everywhere to help people. There needs to be more funding. I appreciate what you are both doing here. I appreciate -- David Oh, I was at your 17th and Lehigh meeting. I spoke there.

There needs to be more funding to help people, to help her daughter, to help hopefully not your grandchild, anybody's grandchild down the road. You worry about this constantly. I worry about this constantly, my kids, my friends' kids, everybody's kids. There's too many kids dying. There's too many kids on these pills, and they're going to go to heroin, and then they're going to get that one bag of dope bad and they're

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going to be dead. That's where we need the funding. We need to have people out in the street. We need to get beds. We need to open recovery houses. We need this. Not one more child dead. Not one more child.

COUNCILWOMAN SANCHEZ: Thank you.

Thank you both.

Councilman, I didn't know if you for the record wanted to put anything on the record before we close out what has been a very passionate day of testimony.

And we thank you both. Thank you for sharing your stories. There's nothing to be embarrassed about. All of us have been impacted. I had an uncle who was addicted who hung himself. I had a younger cousin who died of an overdose. This touches everyone. It doesn't matter the race. It doesn't matter the economic ladder.

And so I want to thank

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Councilman Oh for doing this. And I represent the epicenter of this, and Chief Nestel for hanging in there with us, because he sees it every single day. And we will make sure that we do -- we have some next steps and that we try to do some of the things that have been highlighted here today. Some are more simpler than others, but clearly the titanic has to be challenged about how we do and how we treat folks.

So thank you very much.

Councilman, I didn't know if you wanted to --

COUNCILMAN OH: No. I just wanted to thank you both for coming out and sharing your story. I know that it is deeply personal, but your efforts are going to help other people and they're certainly helping us here in how we're going to approach this problem, as with all the people who came today, from our doctors and our professors and our police officers and our providers and everyone

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who is trying to do this good work, our reporters. It is clearly a challenge for us, but I think that we can do a better job than we have been doing. And I truly appreciate our elected officials from our surrounding counties to basically venture out here. I mean, if we can address the problem that you just talked about, that would be one less barrier to helping someone to have a better life.

I would like to say that I did invite Buddy Osborn here and there were other people as well, who unfortunately just time-wise just couldn't stay, Bernie Strain, who lost his son because his son was given Percocets for burning a hand and then his girlfriend's mother gave him a methadone pill. An 18-year-old, never got a chance to be an addict. He just overdosed there.

The folks that have come out to support this, I do truly appreciate. You know, what we're going to do from here, so you know, is we're going to recess

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this hearing. We will then wait to get the notes of testimony. We'll get a video of everyone's testimony, and then we'll begin to break it down, look at what was said, try to group things together, reach out to some other folks and begin to see if we can put a process, a better process together. Some of the things are pretty easy, although it's not up to me, but certainly if our Mayor would do that proclamation, I think that things people said could be done, could be very impactful.

So I do appreciate that. And one of the things I was very struck by is so many of the people that we met, and I'm just saying, who have really put a lot of heart into this issue, really working with their children or their niece or someone, many of them came from backgrounds where they didn't have a professional license or they weren't -- didn't have a great job. They didn't graduate with a Ph.D., and I was just

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struck by how many of them said something like, And I'm nobody. And I think that's just very sad when you run into a mother or someone who is really trying to help their child and they're just saying, I'm doing the best I can, but I really don't know what to do and why would she listen to me, I'm nobody. And I think that is one of the kind of things that we have to think about as to how we address those situations, because, I mean, certainly I'm nobody more important or better than any of the people that I've met who said that, and we do have to try to address why they feel that way and how we can ensure that they have confidence to take action. They don't know the solution. We don't know the solution. A lot of folks here don't know the solution, but we're putting our heads together to see if we can do something better.

So thank you very much.

MS. YOUNG: And I thank you. I appreciate everything you're doing,

because there's a lot of people out there that need help, and this is the right step at getting everybody together. There's so many people here today. I heard so many great ideas about helping others, you know, and I just really appreciate what you're doing. I really do. Thank you.

COUNCILWOMAN SANCHEZ: Thank you.

The Committee on Health and Human Services will be recessed. This resolution will be recessed to the call of the bill sponsor.

Thank you. Thank you all. Have a very good weekend.

MS. YOUNG: Thank you.

(Committee on Public Health and Human Services concluded at 4:10 p.m.)

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CERTIFICATE

I HEREBY CERTIFY that the proceedings, evidence and objections are contained fully and accurately in the stenographic notes taken by me upon the foregoing matter, and that this is a true and correct transcript of same.

MICHELE L. MURPHY
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