

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

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

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

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

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

10 COUNCILWOMAN BASS: Thank you
11 very much.

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

16 (Video played.)

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

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

4 Councilman Oh.

5 COUNCILMAN OH: Thank you very
6 much.

7 I feel the pressure of the many
8 expert witnesses and their graciousness
9 in coming here, so I will forego an
10 opening statement and simply ask that you
11 give us three to five minutes of the most
12 important thing you have to tell us.

13 Councilmembers may have questions, and
14 with 28 witnesses, the time will be
15 moving quickly.

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

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

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

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

11 COUNCILWOMAN BASS: Thank you,
12 Councilwoman.

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

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

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

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

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

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

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

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

25 Now, research has showed that

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2 the number of drug overdose deaths has
3 continued to soar as doctors continue to
4 prescribe painkillers freely. On
5 average, 130 people were killed a day in
6 2014 from drug overdoses, and about half
7 of them are from opioids. That's
8 OxyContin, Percocet, Vicodin.

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

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

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

12 Thank you.

13 COUNCILWOMAN BASS: Thank you.

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

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

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

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

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

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

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

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

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

12 Other stops included Pittsburgh
13 to talk with the DEA there about the new
14 360 strategy, to Baltimore to interview
15 Bankole Johnson, a leading specialist in
16 the field of addiction, and to
17 Washington, DC to meet with Michael
18 Botticelli himself at the Office of
19 National Drug Control Policy.

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

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2 look at just how extensive and widespread
3 this problem is.

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

11 That willingness should
12 demonstrate just how serious this problem
13 is.

14 Thank you.

15 COUNCILWOMAN BASS: Thank you.

16 Please state your name for the
17 record.

18 MS. NAKANO: Members of
19 Council, good morning. My name is Denise
20 Nakano. I'm an anchor and reporter at
21 NBC10 and I've been with the station for
22 13 years.

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

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

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

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

25 We learned that the struggle

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

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

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

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

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2 One Philadelphia police officer
3 shared with me the struggles of his
4 22-year-old daughter. She had been
5 battling heroin addiction for four years.
6 She tried to get off the drug, relapsed
7 four times. He found insurance only
8 covered inpatient care for 30 days in the
9 City. She went to the facility, came
10 back out much too quickly. He had to
11 actually put her on a plane to Florida,
12 set her up with about three Percocets so
13 she could make it through the trip to get
14 help that she needed in a 90-day
15 inpatient program in Florida.

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

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

25 Thank you so much for asking

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

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

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

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

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

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

15 So if you want to comment on
16 that.

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

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2 failure, is what they say.

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

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

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

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

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

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

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

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

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

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

8 COUNCILWOMAN BASS: Absolutely.
9 Councilwoman Sanchez.

10 COUNCILWOMAN SANCHEZ: Thank
11 you.

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

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

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

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

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

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

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

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

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

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

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

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

7 So thank you.

8 COUNCILWOMAN BASS: Thank you,
9 Councilwoman.

10 The Chair recognizes Councilman
11 Derek Green.

12 COUNCILMAN GREEN: Thank you,
13 Madam Chair.

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

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

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

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

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

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

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

17 So thank you.

18 MR. LATTANZIO: You're welcome.

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

21 Councilman Taubenberger.

22 COUNCILMAN TAUBENBERGER: Thank
23 you, Madam Chair.

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

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2 problem, bringing it to light.

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

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

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

25 MR. LATTANZIO: I think that

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

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

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

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

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

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

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

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2 pharmaceutical companies.

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

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

25 COUNCILMAN TAUBENBERGER: You

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

8 MS. ZALOT: Absolutely.

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

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

19 MR. NAKANO: Eighty percent of
20 heroin users --

21 COUNCILMAN TAUBENBERGER:
22 Eighty percent of heroin users
23 actually start --

24 MS. NAKANO: On painkillers.

25 COUNCILMAN TAUBENBERGER: On

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2 painkillers.

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

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

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

18 They are -- well, they were
19 considering -- I have to check what the
20 latest is with it, but considering a
21 72-hour script for prescription
22 painkillers. So you go to the hospital,
23 you have an injury, and you only get a
24 script for 72 hours instead of you
25 walking out with a 30-day supply of an

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

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

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2 it's a much different situation.

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

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

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2 around our region.

3 COUNCILMAN TAUBENBERGER: Thank
4 you very much.

5 Madam Chair, thank you.

6 COUNCILWOMAN BASS: Thank you.

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

21 So thank you so much for being
22 here.

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

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2 additional stories and get resources.

3 COUNCILWOMAN BASS: Wonderful.

4 So we can just go to NBC10.com and see

5 the video and get more information.

6 Thank you.

7 MR. LATTANZIO: Thank you,

8 Councilwoman.

9 COUNCILWOMAN BASS: You're very

10 welcome.

11 MS. NAKANO: Thank you.

12 COUNCILWOMAN BASS: We're going

13 to have the next panel come forward. Can

14 we have the Clerk call the next panel.

15 THE CLERK: Gary Tennis,

16 Dr. Thomas Farley, Roland Lamb, and

17 Dr. Arthur Evans. And I understand

18 Dr. Rose Julius is joining the panel for

19 questions, if necessary.

20 DR. EVANS: For Q and A.

21 (Witnesses approached witness

22 table.)

23 SECRETARY TENNIS: Thank you,

24 Councilwoman Bass, and thank you,

25 Councilman Oh. You came up to my office

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

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

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

12 COUNCILWOMAN BASS: Thank you.

13 SECRETARY TENNIS: You are
14 right to be putting the attention on this
15 problem. We are in -- this is nationally
16 the worst drug overdose epidemic in the
17 history of all humanity. It is about
18 1,000 Americans a week that are dying of
19 overdoses. We would not tolerate this
20 for a minute if we had ISIS terrorists
21 roaming the streets, killing 1,000
22 Americans a week. We wouldn't tolerate
23 this for a minute if it was Ebola or some
24 exotic disease, but because of the stigma
25 around this disease, we continue with

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

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

24 While we have descended into
25 this worst overdose epidemic ever,

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

15 COUNCILWOMAN BASS: That's all
16 right.

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

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

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

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

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

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

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

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

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2 Medical Society, your medical schools are
3 working to get those guidelines
4 implemented kind of where the rubber
5 meets the road. They very much urge
6 physicians and other prescribers to look
7 at other things. There are other things
8 other than opioids to treat pain.
9 Sometimes you have to have them.
10 Sometimes they're necessary, but we
11 didn't need to quadruple it. And you
12 don't have to eliminate all pain. You
13 can restore functionality, and that's
14 what it's about. That's number one.
15 Warm handoff to treatment. So
16 we have been pushing hard, and
17 Philadelphia has been stepping up more
18 and more to have police carrying
19 Naloxone, because often police, no matter
20 what anybody tells you, because they're
21 out driving around, they're often the
22 first ones on the scene, and a minute or
23 two is life or death in an overdose
24 situation. And police across the state
25 have gotten -- we're coming up on 1,000

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2 lives saved by police across the state.

3 So I urge you to make sure that every

4 police officer in Philadelphia has it. I

5 think they do, but I'm not sure.

6 But, more importantly, once we

7 save the life, it's critical that we get

8 them to treatment. So we've worked --

9 and I know Roland Lamb is working on this

10 and Dr. Evans. We've sent out

11 requirements to all of our county Drug

12 and Alcohol Directors to work with your

13 emergency physicians and treat these

14 people like you would treat someone with

15 a massive coronary. When they come in

16 and you save their lives, you don't hand

17 them a card and say, You know, maybe you

18 ought to go get treatment for your heart

19 disease, you're going to die. You say,

20 Okay, we saved your life, now meet this

21 addiction counselor, meet this recovery

22 specialist, we're going to run tests on

23 you and we're going to start you in

24 treatment now. And we're having success

25 with that. I was just talking to the SCA

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

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

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

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

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

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

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

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2 Take-back programs. We've
3 started doing take-back here. I would
4 urge you to put them all over. We have
5 collected -- and, by the way, Becky
6 Berkebile is here, one of my heroes,
7 because she got the Attorney General's
8 Office working with the National Guard in
9 2015. I think they collected 47,000
10 pounds of prescription drugs across the
11 state, lest there be any question about
12 the overprescribing.

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

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

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

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

23 Thank you.

24 COUNCILMAN OH: Thank you very
25 much, Chairwoman.

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

19 Thank you.

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

25 COUNCILWOMAN BASS: Do you have

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2 time for questions today?

3 SECRETARY TENNIS: Do I have
4 what?

5 COUNCILWOMAN BASS: Time for
6 questions.

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

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

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

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

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

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

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

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

24 COUNCILWOMAN BASS: Exactly.

25 SECRETARY TENNIS: You want to

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

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

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

24 SECRETARY TENNIS: That's
25 exactly right.

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

6 Oh, I'm sorry. Councilwoman
7 Sanchez.

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

14 Let me just strongly encourage
15 the state to be as proactive of a partner
16 on this. No one wants to discriminate
17 around recovery houses and all the other
18 pieces, but when we talk about state
19 licensures and all of those things, many
20 times at the local level our hands are
21 tied at the state level. So I'm glad
22 that you're looking at Fred and some of
23 the things we've learned. I have about
24 300 recovery houses in my district that I
25 inherited.

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2 SECRETARY TENNIS: Thank you.

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

22 SECRETARY TENNIS: That's
23 correct.

24 COUNCILWOMAN SANCHEZ: You
25 license the mental health providers. You

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2 license --

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

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

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

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

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

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

25 SECRETARY TENNIS: I

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2 understand.

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

15 SECRETARY TENNIS: That's true.

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

19 SECRETARY TENNIS: I know.

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

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

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

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

21 SECRETARY TENNIS: Go get them.

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

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

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

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

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2 SECRETARY TENNIS: I do.

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

10 SECRETARY TENNIS: Okay. Thank
11 you.

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

25 Thank you very much.

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

4 COUNCILWOMAN BASS: Thank you
5 so much for being here.

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

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

11 Good morning, Councilwoman
12 Bass --

13 COUNCILWOMAN BASS: Good
14 morning.

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

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2 Services for the Department and CBH.

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

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

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

9 Philadelphia is the fifth
10 largest city in the United States and the
11 largest city in Pennsylvania. Our
12 department's Office of Addiction Service
13 estimates that there are between 122,000
14 and 155,000 persons in Philadelphia in
15 need of treatment. The Department
16 provided care for more than 27,000 people
17 for addictions treatment in Calendar Year
18 2014.

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

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2 needed attention on the overdose crisis,
3 Philadelphia has been addressing
4 drug-related overdose for some time. The
5 DEA Philadelphia field office reported
6 drug-related overdose deaths in
7 Philadelphia have risen 43 percent since
8 2009, with a corresponding 45 percent
9 increase in heroin-positive toxicology
10 results.

11 In 2014, 655 persons died of a
12 drug overdose, representing a 33 percent
13 increase within a single year. This
14 represents a rate greater than that of
15 most major cities with similar
16 demographics. Though Philadelphia has
17 seen a growing heroin overdose epidemic
18 in 2013 and '14, we saw a unique increase
19 in the epidemic. Since 2009, there was a
20 45 percent increase in heroin-positive
21 toxicology results of decedents. In
22 addition with the growing heroin threat,
23 Philadelphia saw an additional unique
24 challenge in the epidemic in 2013, with
25 the first fentanyl epidemic since 2006.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

16 COUNCILMAN OH: Identify
17 yourself for the record, please.

18 DR. FARLEY: Good afternoon --
19 or good morning. I'm Tom Farley, Health
20 Commissioner. Thank you for drawing
21 attention to this very severe problem of
22 abuse, addiction, and overdose from
23 opioids. This is a national problem, but
24 it is also very much a local problem. In
25 2015, there were nearly 700 deaths from

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

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

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

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

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

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

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

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2 Intellectual disAbility Services and
3 other organizations in these three areas.

4 Thank you.

5 COUNCILWOMAN BASS: Thank you
6 for your testimony.

7 Any questions?

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

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

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

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

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

25 COUNCILWOMAN SANCHEZ: Okay.

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2 Thank you.

3 COUNCILWOMAN BASS: Thank you.

4 Very good information to know.

5 Councilman Oh.

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

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

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

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

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

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

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

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

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

9 Thank you very much.

10 DR. EVANS: Thank you.

11 COUNCILWOMAN BASS: Thank you
12 very much.

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

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

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

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

25 COUNCILWOMAN BASS: Thank you

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2 so much for being here.

3 DEPUTY COMMISSIONER LAMB:

4 Thank you very much.

5 COUNCILWOMAN BASS: Thank you.

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

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

12 (Witnesses approached witness
13 table.)

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

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

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

11 COUNCILWOMAN BASS: Thank you
12 for being here.

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

22 First, let me address the scope
23 of the problem here in Philadelphia. In
24 2014, over 650 people died of overdoses.
25 That continues to be a problem through

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2 2015, and this year, there was over 77
3 that we can directly relate in the first
4 quarter of deaths related to morphine or
5 opioid overdoses that caused deaths.

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

14 Of the total drug seizures this
15 year, heroin had a street value of \$14.6
16 million of these drugs that were seized,
17 about 37 percent of all the drug seizures
18 in Philadelphia. For the same period in
19 2015 -- that's January to now -- we
20 arrested about the same amount of
21 dealers, 1,142, but only seized about
22 \$6.2 million in heroin last year.

23 During the same period, our
24 OxyContin/oxycodone has increased from
25 7,800 worth of street value to about

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2 11,500 in seizures in the same period
3 last year. Guns and money, we've got
4 about the same amount, 175 guns each year
5 to date off of drug dealers, related to
6 drug-related endeavors, and another \$2.5
7 million each year to date in actual cash
8 seizures from drug dealers.

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

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

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

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

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

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

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2 medications and installed drop boxes in,
3 I think, 13 now -- we're going to have
4 21 -- drop boxes in police districts
5 throughout the entire City where anybody
6 24/7 can come in and drop off their
7 excess medicine. And I'm sure the
8 District Attorney will discuss that as
9 well. And this has been -- the DA's
10 Office has really helped us with this
11 program a lot.

12 And, finally, in November of
13 2013, Pennsylvania Senate Bill 1164,
14 which authorized naloxone to be used by
15 police officers out on the street, was
16 passed, and in anticipation of this, the
17 Philadelphia Police Department worked
18 with the Fire Department and Deputy
19 Commissioner Laster to get everything
20 hashed out so our guys and girls out
21 there on the street can start carrying
22 this. We began carrying it in January
23 27, 2015, and to date, there are 813
24 naloxone overdose kits in the hands of
25 Philadelphia police officers. These

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2 officers are assigned to East Division
3 and Northeast Division, where we
4 predominantly see our heroin problems.

5 There have been 129 lives saved based on
6 this - 112 in East Division and another
7 17 in Northeast Division.

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

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

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2 This concludes my testimony.

3 I'd be happy to answer any questions you
4 have at this time.

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

21 Mr. District Attorney, welcome.

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

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

5 COUNCILWOMAN BASS: We
6 appreciate it.

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

10 COUNCILWOMAN BASS: Thank you.

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

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

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

11 Consider that since 2009,
12 Philadelphia has seen a 43 percent
13 increase in drug overdose-related deaths.
14 Philadelphia has also seen a 45 percent
15 increase in overdose deaths where heroin
16 was present in an individual's system.
17 Nearly 350 fatal drug overdoses in
18 Philadelphia involved heroin in 2014.
19 Indeed, more than half of the 655
20 drug-related overdoses in Philadelphia
21 involved heroin. Heroin overdoses
22 represent a citywide problem.

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

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

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

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2 about people abusing the system.

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

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

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2 addicted to heroin were originally
3 addicted to prescribed painkillers, and
4 we have to address the pharmaceutical
5 companies who are profiting off of this
6 death. But at present, drop boxes are at
7 13 different police districts across our
8 city - the 1st, 3rd, 5th, 6th, 7th, 12th,
9 14th, 15th, 19th, 22nd, 25th, and 26th
10 and the 35th. Soon all the remaining
11 police districts will be equipped with
12 drop boxes. To date -- and we've
13 implemented -- we put the first ones in
14 January. To date, we have collected over
15 200 pounds of prescription drugs.

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

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2 get into drug treatment. They work, but
3 we need more treatment beds. We have
4 more addicts, unfortunately, and the
5 demand for beds far outpaces the supply.
6 But fortunately as a result of Governor
7 Wolf's expansion of Medicaid, more people
8 are able to receive drug treatment. In
9 the Governor's proposed Fiscal Year
10 '16-'17 budget would provide treatment
11 for more than 11,000 addicted
12 Pennsylvanians.

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

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

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

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

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

20 Any questions? Not yet? Okay.
21 All right. Sir, you want to
22 state your name for the record and begin
23 your testimony.

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

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

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

11 The Vietnam War lasted from
12 1955 to 1975, and in that entire war, we
13 lost just over 52,000 arrest holders,
14 right? Today we're losing just over
15 46,000 people per year as a result of
16 overdoses.

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

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2 highly addictive, caused mass confusion,
3 mass destruction to neighborhoods. And
4 now we're going through this particular
5 heroin epidemic. I'm not going to
6 address the opioid piece yet, and just
7 let me give you an idea of how it
8 compares. This particular heroin
9 epidemic dwarfs the two former epidemics.
10 I want you to understand that. Because
11 it's got a feeder system to it that the
12 other two epidemics didn't have, and
13 that's the misuse and abuse of
14 prescription opioids. We're losing over
15 125 people a day to that. So I really,
16 really want to put it into perspective
17 for you.

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

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

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

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

25 We initiated in November a

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

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

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

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

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

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

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

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

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

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

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

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

21 Chief Nestel.

22 CHIEF NESTEL: Good morning,
23 ma'am.

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

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2 CHIEF NESTEL: Likewise.

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

10 CHIEF NESTEL: Yes, ma'am.

11 Thank you.

12 COUNCILWOMAN BASS: Thank you.

13 CHIEF NESTEL: Good morning.

14 I'm Thomas J. Nestel, III. I'm the Chief
15 of the SEPTA Transit Police. I wasn't on
16 the original list of speakers. I was
17 drafted by Councilman Oh. I've told
18 Councilman Oh that I come to listen and
19 learn.

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

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

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

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

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

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

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

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

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

14 I have no other remarks.

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

17 COUNCILWOMAN SANCHEZ: Speak
18 into the mic.

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

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

12 As a state agency with health
13 and oversight responsibility, the Office
14 of Attorney General is always looking for
15 new ways to combat the drug problems. In
16 2015, we created the Drug Control
17 Programs Unit to combat drug problems by
18 using a holistic approach. You'll hear a
19 lot of things that I say are repeated
20 today, because a lot of law enforcement
21 is on the same page. Treatment,
22 education, and enforcement are equally
23 important, and we are adding to our
24 investigative resources by bringing more
25 education and working with treatment

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2 partners.

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

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

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

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

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

5 The Office of Attorney General
6 has also expanded the Education and
7 Outreach section of the office. Drug
8 control programs is working to improve
9 education and outreach presentations and
10 educate friends and family members of
11 addicts about Narcan and treatment
12 resources. The Office is creating new
13 drug brochures that include treatment
14 resources. It is not enough to educate
15 people on the dangers of drugs and not
16 give them information about treatment and
17 recovery. Our office has worked hard to
18 build relationships with the Department
19 of Drug and Alcohol Programs and
20 treatment professionals statewide. We
21 have to stop the siloed approach in
22 government and we need to start working
23 together.

24 Our office has created working
25 groups regionally that are comprised of

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2 treatment professionals, law enforcement,
3 and hospital emergency departments.

4 Non-fatal overdoses is the number one
5 thing that we can't seem to get a grip on
6 or get a number on, because no one is
7 tracking that. We don't know if people
8 aren't checking into hospitals, and we
9 can't get those numbers. We know the
10 people who have died. We don't know the
11 people still alive fighting the
12 addiction. It is vital to combatting the
13 current drug threats for different
14 agencies to come together and share
15 resources. We cannot do it alone.

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

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

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

16 Thank you.

17 COUNCILWOMAN SANCHEZ: You may
18 proceed.

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

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

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

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

21 If you go back to the '60s and
22 '70s, there are parts of the City,
23 primarily inner city neighborhoods, that
24 were impacted by heroin then. It waned
25 for a while. It came back with a

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2 vengeance in the '90s when new sources of
3 supply from South America came forward.
4 Cheaper, more pure heroin was available
5 on the streets, and we saw this uptick
6 again. In this period from 2005 to 2007,
7 we saw over 100 Philadelphians die from a
8 drug that hasn't been mentioned yet
9 today, fentanyl, which is a mimicker of
10 heroin and other opioids. So during that
11 period, we began the effort of outreach
12 with the public health communities to see
13 if we could get enough information on it,
14 and for a while, we were able to sustain
15 a little bit of effort on that. But now
16 that we're into the second decade of the
17 21st century, we're seeing this problem
18 all over again, with even new threats,
19 even more recent threats. On top of the
20 prescription drug problem, on top of the
21 historic South American heroin influx
22 into our region, on top of all that, we
23 also have Mexican-sourced heroin coming
24 into this part of the country as well,
25 increasing the supply levels and,

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

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

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

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

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

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

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

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

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

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

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

14 When we see the volume of
15 heroin that runs through the City, it's
16 shocking. Last year our task forces
17 seized in excess of 100 kilograms, over
18 220 pounds, of heroin in just their
19 investigations, and that's a fraction of
20 the law enforcement work overall. So we
21 need to be forthright and diligent in
22 addressing the supply side of it, but at
23 the same time, we also need to be
24 supportive and involved and engaged with
25 those that are attempting to address this

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2 from the demand reduction side as well.

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

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

25 COUNCILWOMAN SANCHEZ: We

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2 really appreciate it.

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

5 I really appreciate it. I want
6 to just kind of note the value of having
7 all of our law enforcement folks
8 acknowledge that this really -- we do
9 need to break down these silos.

10 Unfortunately, I know all of the
11 panelists all too well. Mr. Tuggle, who
12 taught me a lot about how bad it is, and
13 the numbers, when we talk about 125
14 people a day, so while we're having this
15 debate, there are people dying. And so
16 this sense of urgency is hugely
17 important. Nestel, who is on the front
18 ground all the time doing this stuff.

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

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

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

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

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2 (Witnesses approached witness
3 table.)

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

14 DR. STAHLER: It's an exhibit.

15 COUNCILWOMAN SANCHEZ: Thank
16 you. You may proceed.

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

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

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

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

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

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

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

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

24 Importantly, the combination of
25 medications and counseling, which we

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

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

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2 treatment.

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

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

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

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

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

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2 get people into treatment and to keep
3 them in treatment.

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

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

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

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

6 Thank you.

7 COUNCILWOMAN SANCHEZ: Thank
8 you.

9 You may proceed.

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

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

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2 long-term home, health, and hospice
3 career.

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

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

25 We're a rural community. We

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

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

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

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

12 And one of the aspects that
13 I've been listening for this morning is
14 the social determinants that drive
15 substance use, people that are looking
16 to -- how do I cope better, how can I
17 break my depression, all of those
18 factors, because we're a community where
19 the social determinants are at a very
20 high level. We are a depressed economy
21 in our community. We are -- from 2000 to
22 2014, they now did a study on income loss
23 among our counties in the United States.
24 We're number two.

25 So all of those are factors.

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

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

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

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

9 But we made a difference. In
10 2011, we had dropped our overdoses 69
11 percent. Over a five-year period, we
12 have equalled out at 50 percent drop in
13 overdoses. Our school incidences were
14 about 7.4 for substance use per 1,000
15 drops. That's dropped to 3.4, and we're
16 getting -- as I said, we already have 450
17 people in treatment that we didn't have
18 in 2010. So all of those factors are
19 working. We work with the travel groups,
20 the military groups. And I just want to
21 read one statistic from our Fort Bragg,
22 the largest military base. They've been
23 doing Project Lazarus as Operation Opioid
24 Safe for six and a half years, and they
25 have out of 140,000 people that they can

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

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

20 Thank you.

21 COUNCILWOMAN SANCHEZ: Thank
22 you.

23 We're going to hear from our
24 last panelist.

25 DR. STAHLER: Thank you,

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

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

25 These are horrendous

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

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

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2 funeral?

3 I said, Yes.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 Councilman Oh is going to make
13 a housekeeping statement.

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

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

16 Thank you very much.

17 COUNCILWOMAN SANCHEZ: So we
18 will take Dr. Work.

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

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

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

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

25 As you know, the number of

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

13 I also remember well when the
14 homicide rate in this city broke 400 in
15 2006, and there was anger and uproar.
16 And I cannot imagine the outcry if the
17 homicide rate, which has only been in the
18 200's for the past several years, shot up
19 into the 600's.

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

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

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

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2 essential for the City government to
3 address the opiate and overdose epidemic
4 in the City. The first is to have the
5 Mayor and the Commissioner of Public
6 Health declare a public health emergency
7 regarding the opiate and overdose
8 epidemic. You probably recall this was
9 done in the past by Mayor Ed Rendell when
10 he issued Executive Order 4-92 declaring
11 a public health emergency and allowing
12 legal syringe exchange to combat the HIV
13 epidemic going on in the City's IVDU
14 population. That allowed Prevention
15 Point to bring down the HIV rate among
16 the City's IV drug users from
17 approximately 50 percent, 5-0 percent, to
18 5 percent for the past several years.
19 That order was needed because syringe
20 exchange at the time was illegal in the
21 State of Pennsylvania.

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

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

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

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2 organizational support and funding from
3 the City.

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

20 Thank you very much for your
21 time.

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

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

6 COMMISSIONER KICHLINE:
7 Kichline. It's not easy.

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

12 COUNCILMAN OH: And Councilman
13 John McBlain.

14 COUNCILWOMAN SANCHEZ:
15 Councilman Oh.

16 COUNCILMAN OH: Thank you,
17 Chairwoman.

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

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

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

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2 problem. So thank you for being here.

3 That's what I wanted to say,
4 Chairwoman.

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

8 Thank you. Thank you for your
9 time.

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

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

8 By way of background, I'm a
9 physician anesthesiologist who practiced
10 medicine in Philadelphia for over 20
11 years. Frustrated by seeing too many of
12 my patients fall through the cracks in
13 our system, I returned to school to
14 obtain my Master's in Public Health from
15 the Johns Hopkins Bloomberg School of
16 Public Health. I'm honored to serve the
17 820,000 residents in Montgomery County as
18 their County Commissioner and hope
19 through dialogues like the one that we're
20 having today, we can find ways to work
21 together across county lines to combat
22 this terrible epidemic.

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

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2 significantly to accidental deaths among
3 those who misuse heroin and prescription
4 opioid drugs. According to a 2015
5 report, Pennsylvania ranked ninth in the
6 United States in drug overdose deaths.
7 Between 2009 and 2014, deaths due to
8 opioids in Montgomery County increased by
9 72 percent. Just over half were
10 attributed to heroin. And I would point
11 out that I just got some information
12 that's not in here yet, but we are also
13 seeing a big increase in fentanyl just in
14 the last few months in Montgomery County.
15 Just some news from our Coroner's Office
16 this week.

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

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

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2 Montgomery County, and in late 2014,
3 Commission Chair Josh Shapiro established
4 the Montgomery County Overdose Task
5 Force, bringing together various
6 disciplines to develop a multifaceted
7 approach to reducing opioid overdose
8 deaths that includes prevention,
9 intervention, treatment, and problem
10 evaluation. Shortly thereafter, in early
11 2015, the Task Force developed an
12 implementation plan that encompassed a
13 positive community-based focus on
14 short-term and long-term recommendations.

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

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2 practices and evidence-based models.

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

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

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

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2 educated on the dangers of medication
3 misuse and heroin. We involved our
4 school district in the community
5 awareness exercise. Fifteen out of our
6 22 school districts participated in an
7 overdose billboard contest, creating
8 advertising displays that are currently
9 up on Montgomery County billboards about
10 the dangers of substance misuse. We've
11 had a promotional and social media
12 campaign, including development of an
13 online platform of educational materials
14 related to opioid misuse, naloxone
15 access, prescribing guidelines, and
16 current up-to-date resources, and that is
17 at montcopa.org/overdoseprevention.

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

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2 under the standing order signed by
3 Physician General Levine in April of
4 2015.

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

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

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

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

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

5 It is important to remember
6 that many cases of opioid dependence
7 begin with the pharmacological treatment
8 of pain via prescription medication.

9 Over time, opioid use changes the
10 functions of the brain, leading to
11 physical dependence and tolerance. Under
12 certain circumstances, opioid dependence
13 will progress to opioid addiction.

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

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

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

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

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

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

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

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

24 We continue to utilize
25 community outreach to educate everyone in

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

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

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

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2 prescription to manage their pain.

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

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

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

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

4 Thank you.

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

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

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

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

12 Thank you.

13 DR. ARKOOSH: Thank you.

14 COUNCILMAN OH: Thank you very
15 much, Councilman.

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

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

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

14 COUNCILMAN GREEN: Thank you.

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

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

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

11 But I want to read into the
12 record a report, and the statistics are a
13 little bit dated because it was written
14 in the Philadelphia Inquirer in early
15 2015, and obviously there's been a
16 proliferation even since that time, and
17 that's been a year and a half. But this
18 sort of frames the issue I think from a
19 regional perspective as to why this isn't
20 a Philadelphia issue, and to reference
21 your point, that there's been a
22 perception that the drug problem is in
23 Philadelphia. Well, it's not, and I
24 think this frames it.

25 Though the death rate from drug

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

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

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

25 More than raw numbers of

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

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

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

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2 with opioid use disorders increasing in
3 all ages.

4 If one looks specifically at
5 overdose deaths in Chester County, in
6 2015 there were 72 accidental overdose
7 deaths, up from 62 in 2014, with 66
8 involving of those 72 involving heroin
9 and/or opioid pain medications. The
10 demographics of those who died from
11 opioid heroin overdose was primarily
12 single white males, ages 45 to 54. These
13 deaths occurred in 36 of our 73
14 municipalities, not just the large urban
15 centers. This is an example of the
16 geographic widespread use and
17 availability of opioids in the county.

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

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2 occurred through other first responders,
3 hospitals, and others.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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2 tons. In 2013, it's 138 tons. And over
3 90 percent of the consumption of
4 opioid-based drugs are in the United
5 States. This is simply not used
6 internationally the way it's used in this
7 country. And much of this was initiated
8 by the Veterans Health Administration
9 Joint Committees on Healthcare in 1998.
10 They called it "Pain is a Fifth Vital
11 Sign," and as a result of that study,
12 there's now a requirement, which we all
13 see in many physicians' offices, of the
14 standard use of the familiar 0 to 10 pain
15 scale. And we've had a robust
16 conversation with our medical community
17 about really revising what is absolutely
18 needed and focusing less on this pain as
19 a fifth vital sign statistic.

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

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

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

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

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

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

25 I'm here to speak to this, not

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

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

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

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

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

13 We know that a significant
14 number of our residents are coming to
15 Philadelphia to purchase and use heroin.
16 That means we know that it is our
17 residents that are contributing to the
18 traffic on your streets, contributing to
19 impaired driving on your roads,
20 contributing to crime in your
21 neighborhoods and, unfortunately, in
22 difficult situations, they are
23 contributing to the strain on your
24 emergency services, your emergency room,
25 and your Coroner's Office. As Bucks

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

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

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

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

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

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

19 COUNCILMAN OH: Friend of mine.

20 COMMISSIONER ELLIS-MARSEGLIA:

21 Yes. That's what he said.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

19 COUNCILMAN OH: Thank you very
20 much.

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

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

8 COUNCILMAN McBLAIN:

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

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2 and support the Metropolitan Caucus.

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

17 In 2015, Delaware County lost
18 104 residents to heroin. We had over 200
19 total drug overdose deaths, which include
20 other opioids, fentanyl, as you've heard
21 about, and other types of drugs. So far
22 in 2016, we've lost 32 individuals to
23 heroin.

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

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

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

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

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

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

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

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

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

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

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

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

25 One of the members of our Task

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

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2 is almost incomprehensible.

3 As you pointed out, in the
4 1970s, heroin was thought to be an inner
5 city problem, a problem that affected
6 other communities, not in the suburbs.
7 But that's exactly what's happening now,
8 and I think it's a real problem to
9 convince a lot of parents that their
10 child could be suffering from an opioid
11 addiction and a heroin problem.

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

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2 Since 2013, we have installed
3 40 drop boxes throughout the County,
4 including one at our government center,
5 and we have collected over 7,000 pounds
6 of prescription drugs. We also take a
7 mobile drop box to community events such
8 as drug take-back days, giving other
9 people a chance to safely and anonymously
10 dispose of the drugs.

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

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2 So we've appointed a realtor to
3 our Task Force, and he launched a program
4 to educate homeowners to lock up their
5 medications during open house events when
6 someone is trying to sell a house.

7 People know to lock their jewelry and
8 other valuables, but never realized that
9 people were stealing meds out of their
10 bathroom medicine chest when no one was
11 looking.

12 Police administering Narcan:

13 In perhaps our largest initiative,
14 Delaware County was the first county in
15 the Commonwealth to implement a nasal
16 naloxone program for law enforcement
17 after David's Law was passed in 2014.
18 That law was named after David Massi, a
19 27-year-old man from Upper Chichester who
20 overdosed in 2013. Until then, only
21 emergency medical personnel could use
22 Narcan, but it was often the police who
23 were the first to arrive on the scene.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

8 COUNCILMAN OH: All right.

9 Thank you very much. And, again, I truly
10 appreciate you coming into Philadelphia
11 to testify and setting that great example
12 of coming into our house to work with us
13 together. Anything we can do to help
14 with any of our institutions, we would
15 love to do. And I see that you're
16 already on top of this with your task
17 forces and whatnot, and we've heard from
18 our task force that we need to fund the
19 task force. And I will look forward to
20 the dialogue that we're going to have in
21 the future, and perhaps maybe the answer
22 is already there through our task forces
23 getting together in some type of
24 coalition or council to advise us on how
25 to put in a five-county or five-county

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2 and Southern New Jersey strategy that we
3 can work on.

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

7 COUNCILMAN McBLAIN: Thank you,
8 Councilman.

9 COUNCILMAN OH: Fantastic.

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

19 Thank you very much.

20 (Short recess.)

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

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

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

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

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

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

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

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

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

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2 question.

3 DR. STAHLER: Just ask.

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

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2 existed.

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

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

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

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

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2 think there's a receptive audience there.

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

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

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

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

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

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

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

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

5 COUNCILMAN OH: Thank you very
6 much.

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

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

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

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

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

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

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

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2 the problem.

3 COUNCILMAN OH: Yes.

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

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

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

8 Well, I wanted to try out up
9 here.

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

15 COUNCILMAN OH: Thank you very
16 much.

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

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2 those people do we have an opportunity.

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

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

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

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

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2 then developed a stomach problem, had to
3 go to the general hospital, was admitted
4 for the weekend and then returned back to
5 the residential treatment. Insurance was
6 denied. Why was it denied? Because it
7 had on her record that she had been
8 discharged from residential treatment;
9 therefore, it was not medically necessary
10 anymore. Well, she was only discharged
11 because she had to go into the general
12 hospital. But it's things like that.
13 And so then you're faced with having to
14 pay \$8,000 a week for residential,
15 \$10,000 a week, you know, sometimes,
16 depends on the program. You can appeal,
17 but you may or may not be successful, and
18 it will take months. So then what
19 happens is then somebody, not -- because
20 you're worried about the financial
21 aspects. Somebody leaves treatment
22 before they're ready. They come back to
23 the community. They relapse and start
24 the cycle again.

25 So it's things like that that

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2 are very difficult to deal with.

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

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

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

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

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

25 COUNCILWOMAN SANCHEZ: Right.

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

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

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

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

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

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

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

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

25 DR. STAHLER: Well, if there's

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

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

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

15 COUNCILWOMAN SANCHEZ: Karyn
16 Lynch, we called you.
17 She was outside making a phone
18 call.

19 (Witnesses approached witness
20 table.)

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

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

5 In 2015, the Philadelphia Fire
6 Department medic units made nearly
7 270,000 responses for medical care. We
8 average 700 medical calls daily. The
9 Fire Department Emergency Medical
10 Services consists of 50 medic units.
11 This includes 40 advanced life support
12 medic units, staffed with at least one
13 paramedic, and 10 basic life support
14 medic units, staffed with two emergency
15 medical technicians. All of our engines
16 and ladders function as first responder
17 units and always are staffed with a
18 state-certified emergency medical
19 technician.

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

24 Our responses to overdoses:
25 Emergency Medical Services addresses the

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

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

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

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

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

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

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

25 Our paramedics and EMTs become

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

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

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

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

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

1 5/20/16 - PUBLIC HEALTH - RES. 160052
2 overdose has occurred. Prevention is key
3 to addressing this debilitating disease.
4 Targeting adolescents through social
5 media, early intervention, prescription
6 drug monitoring programs, prescription
7 drug disposal programs, which numerous
8 law enforcement agencies have already
9 said they are doing, and adequate
10 treatment. This has to become a
11 multidisciplinary effort. Heroin use
12 must be unattractive for everyone.

13 The Department actions: In
14 2015, the Fire Department distributed
15 Narcan to all its basic life medic units.
16 In 2016, this year, we distributed Narcan
17 to all engines and ladder companies.
18 This is a total of 183 Fire Department
19 vehicles equipped with Narcan. That
20 means all 50 medic units, 56 engines, and
21 27 ladder companies all have Narcan on
22 them.

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

1 5/20/16 - PUBLIC HEALTH - RES. 160052
2 and administering Narcan for persons with
3 symptomatic opioid overdoses. This seems
4 to be the easy part of the problem.
5 Responding and actually reviving them is
6 the easy part, it appears to be. The
7 tougher issue is getting individuals the
8 help that's required to move towards
9 recovery and stability. We will work
10 towards transporting every patient who
11 receives Narcan to a medical facility for
12 further treatment.

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

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

1 5/20/16 - PUBLIC HEALTH - RES. 160052
2 hospital.

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

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

1 5/20/16 - PUBLIC HEALTH - RES. 160052
2 want to deal with it right away because
3 they want to make sure what's in their
4 system. So they don't have the capacity
5 to say what is your drug screen, what do
6 you have in your system.

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

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

18 This concludes my testimony.

19 COUNCILMAN OH: Thank you very
20 much.

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

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

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

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

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

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

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

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

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

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

25 Now, I strongly suggest that

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

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

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

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

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

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2 help themselves.

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

8 Thank you for your time.
9 COUNCILWOMAN SANCHEZ: Thank
10 you.

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

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

1 5/20/16 - PUBLIC HEALTH - RES. 160052
2 was introduced by Councilman David Oh to
3 declare 2016 as the Year to Combat the
4 Heroin Abuse Epidemic in Philadelphia.

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

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

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

25 To enhance the Department of

1 5/20/16 - PUBLIC HEALTH - RES. 160052
2 Prisons clinicians' diagnostic accuracy
3 at the time a citizen is incarcerated at
4 State Road, the Department of Prisons
5 conducted a City Institutional Review
6 Board-approved study in 2013 to produce a
7 profile of drug use by the Department of
8 Prisons' population shortly before
9 incarceration.

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

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

1 5/20/16 - PUBLIC HEALTH - RES. 160052
2 not require pharmacologic intervention to
3 mitigate withdrawal discomfort, over
4 7,000 newly admitted individuals received
5 prescription medications and close
6 monitoring, which we call the withdrawal
7 protocol, to assure that withdrawal is
8 accomplished without avoidable adverse
9 effects.

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

1 5/20/16 - PUBLIC HEALTH - RES. 160052
2 are assisted at the Department of Prison
3 in withdrawal from methadone after birth
4 of the child.

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

17 So in addition to that
18 protocol, we also have our OPTIONS
19 program, which is our substance abuse
20 program. In addition to medical
21 substance abuse treatment, the Department
22 of Prisons also provides substance abuse
23 education programming through the OPTIONS
24 program. OPTIONS stands for Opportunity
25 for Prevention and Treatment

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2 Interventions for Offenders Needing
3 Support, and is a pre-release-based drug
4 and alcohol educational program. The
5 OPTIONS/New Directions program is a
6 90-day program that utilizes the Hazelton
7 Substance Abuse Educational Curriculum
8 and is delivered using a group modality.
9 Hazleton is based on cognitive behavioral
10 therapy and is evidence-based. The
11 program goals are designed to educate and
12 support abstinence and recovery, as well
13 as to teach and reinforce the coping
14 skills that allow for positive community
15 reintegration.

16 In addition to CBT, individuals
17 are afforded the opportunity to
18 participate in anger management groups,
19 education, literacy classes, vocational
20 training, and work assignments, domestic
21 violence education classes,
22 self-inventory and journaling
23 assignments, peer support groups,
24 individual treatment and discharge
25 planning, committees and are encouraged

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

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

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

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

6 For Calendar Year 2015 to
7 Calendar Year of April 2016, OPTIONS
8 provided educational treatment services
9 to 3,132 court-stipulated individuals and
10 1,452 pretrial individuals who
11 voluntarily sought treatment. The
12 individuals are inclusive of duplicated
13 admissions to PPS, or Department of
14 Prisons, custody and the program. It is
15 understood that relapse may be -- may
16 occur as part of the recovery process,
17 and individuals and returning citizens
18 are supported in this process.

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

1 5/20/16 - PUBLIC HEALTH - RES. 160052
2 provider. OPTIONS staff assists pretrial
3 individuals and pretrial engagement with
4 treatment providers in preparation for
5 treatment upon release, at which time
6 returning citizens are enrolled for
7 benefits by the treatment provider.

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

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

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

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

1 5/20/16 - PUBLIC HEALTH - RES. 160052
2 prison setting safely, and I just wanted
3 to point out that in that role, I have
4 the opportunity to review a lot of
5 medical records and really review the
6 care that our inmates receive in all of
7 the hospitals in the area, and we have
8 some of the best hospitals in the
9 country, as you know, here in
10 Philadelphia. And an observation from
11 that would be that our inmates with heart
12 disease, for instance, will always see a
13 cardiologist regardless of the problem
14 being treated at the hospital. And with
15 asthma, they will see a pulmonologist. I
16 do find that our patients with heroin
17 addiction and substance use disorders in
18 general do not receive that attention for
19 that disorder as a routine. It's not
20 really incorporated into their discharge
21 planning.

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

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

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

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

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

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

1 5/20/16 - PUBLIC HEALTH - RES. 160052

2 make some remarks.

3 COUNCILMAN OH: Thank you very
4 much.

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

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

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

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

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

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

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

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

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

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

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

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

25 I'm going to echo many of my

1 5/20/16 - PUBLIC HEALTH - RES. 160052
2 other colleagues who have said that they
3 highly recommend that we get naloxone in
4 the hands of many service providers, law
5 enforcement officers, and individuals
6 living with addiction as possible. I'm
7 hopeful with the partners represented
8 today here, along with the Philadelphia
9 City Council's support, we can proceed
10 towards a time when we look back at the
11 opioid epidemic as something we banded
12 together to address in a comprehensive
13 and creative way and helped stave off.

14 Thank you.

15 COUNCILMAN OH: Thank you.

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

1 5/20/16 - PUBLIC HEALTH - RES. 160052
2 of the Public Health and Human Services
3 Committee for hosting.

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

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

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

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

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2 talk about -- we got to get them housed.

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

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

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

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

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

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2 and maintenance, job development and
3 placement, education and training, income
4 and health benefits attainment,
5 resolution of any criminal barriers that
6 may interfere with achieving the goals I
7 just mentioned. The services we provide
8 include housing attainment and
9 stabilization; intensive case management
10 24 hours a day, seven days a week;
11 recovery services, including mentors,
12 groups, and individual support;
13 co-occurring trauma-specific therapy and
14 illness self-management support and
15 services; independent life skills
16 training; parent and family support and
17 stabilization, including Child Protective
18 Services case support, community
19 involvement, and transportation.

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

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

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

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

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

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

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

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2 across the City as well.

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

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

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

20 MS. BROCKINGTON: Yes.

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

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

17 MS. BROCKINGTON: Absolutely.

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

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

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

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

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

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

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

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

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

9 MS. BROCKINGTON: Great. Thank
10 you.

11 MR. TICE: Thank you.

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

16 (Witness approached witness
17 table.)

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

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

25 COUNCILWOMAN SANCHEZ: And

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

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

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

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

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

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

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

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

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

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2 using, the introduction to risky
3 behavior, including STDs and, most
4 importantly, it provides an opportunity
5 for agencies across the City, for
6 non-profits across the City to observe
7 that data. The 15 data in fact from the
8 2015 survey is now available, and it's
9 posted on the web, and it gives all the
10 opportunity from the Health Department to
11 Behavioral Health to non-profits that are
12 seeking funding to address the needs of
13 young people throughout the City. It
14 gives them an indication of all types of
15 data related to our young people in risky
16 behavior. So we can see when students
17 are reporting that their use of opiates
18 or their introduction to opiates is -- at
19 what age it occurs, what it is, and so on
20 and so on.

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

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

11 COUNCILWOMAN SANCHEZ: Is that
12 self-reporting?

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

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

21 And at that, I'll close.

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

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2 our young people.

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

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

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

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2 something focused at the high school
3 level.

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

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

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

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2 school day, then there is the requirement
3 that --

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

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

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

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

24 COUNCILWOMAN SANCHEZ: Okay.
25 I'm sorry. Councilman Oh.

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2 COUNCILMAN OH: Yes.

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

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

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

5 So to reframe, because I know I
6 threw a lot at you, what is in our public
7 schools uniformly, if anything? Is it
8 the kind of thing I think most parents
9 would imagine is in there? And what
10 about our charter schools? Do we have
11 any ability to put a consistent program
12 in for health ed, drug prevention, and
13 does that program include actual gateway
14 to services?

15 MS. LYNCH: Okay. So I will
16 try and take those questions as I heard
17 them, and if I miss anything, please let
18 me know.

19 First of all, health is a
20 required course for graduation in
21 Pennsylvania. And so each of our schools
22 offers health. Frequently health is
23 offered in the senior year, which means
24 that a student has to make their way to
25 their senior year in order to receive

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2 that service. And so one might say that
3 because it's not offered until the senior
4 year, then for younger children,
5 especially freshmen in high school, the
6 things that they are going to learn in
7 the course of their day as they go about
8 their business and then they attend
9 school and they live in their
10 communities, they're going to know far
11 more than they need to know before they
12 get to their senior year.

13 So the effort to try and
14 increase the access to just health class
15 at a much younger age for entry into high
16 school or even pushing it into middle
17 school is something that we're about
18 trying to do. That's number one.

19 Number two, the survey results
20 that we are able to receive -- and this
21 is a major agreement that we have with
22 the CDC. It not only allows us to
23 compare the risky behavior of
24 Philadelphia's children with behavior of
25 children in other large jurisdictions

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2 across the country, but it allows us to
3 see what indicators, what use students
4 are engaging.

5 For example, the drug of choice
6 in Philadelphia among our young people is
7 marijuana, much more so than it is
8 opiates, and many will say that marijuana
9 use over time could be the entry drug to
10 the use of opiates. And so when we talk
11 with, when we work with, when we engage
12 with the Health Department, Behavioral
13 Health or any of the assistance programs
14 that Behavioral Health has contracted, we
15 look at that data and we see the types of
16 programs and services that need to be
17 geared toward the students that are
18 attending our schools so that we are able
19 to arrest their risky behavior. If
20 marijuana use is high and opiate use is
21 low but marijuana use leads to opiate
22 use, then we are designing programs and
23 services within our schools that are
24 saying to our young people, Young people,
25 marijuana use leads to; Young people,

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2 avoid marijuana. And the messages that
3 we are sending are related to what the
4 data is telling us. As a result, you can
5 see that in Philadelphia, we've had over
6 time some improvements, because we've
7 looked at the data and geared the
8 programs toward it.

9 I would say that obesity among
10 young people is one such example. So
11 from the study, we saw that obesity was
12 increasing. We put measures into place
13 as a community called Philadelphia to
14 address that problem of obesity, and now
15 obesity is lower. Same with smoking
16 cessation.

17 Regarding charters, you know
18 that charter schools are their own
19 intermediate unit, and so our ability to
20 engage them in services really -- they,
21 for the most part, design and develop
22 what those services are going to be, and
23 when it comes to this area of health
24 service or monitoring drug behavior or
25 even the requirement to participate in

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2 the survey, it is not there. The Risk
3 Youth Survey is done just with School
4 District of Philadelphia schools.

5 So I'm not really positioned to
6 be able to share what the details are
7 about how our charter schools are
8 addressing the needs of children that are
9 here in Philadelphia. And the needs are
10 all the same across. I am in no way
11 saying that School District of
12 Philadelphia students have a very
13 different experience from those in
14 charter schools. I'm just not that
15 familiar to be able to testify about it.

16 COUNCILMAN OH: Thank you.

17 COUNCILWOMAN SANCHEZ: Thank
18 you, Ms. Lynch.

19 We wanted to ask the prison
20 officials to come up. I also had a
21 question for them.

22 MS. LYNCH: Thank you so much.

23 COUNCILWOMAN SANCHEZ: Have a
24 good weekend.

25 MS. LYNCH: You too.

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2 (Witnesses approached witness
3 table.)

4 COUNCILMAN OH: I visited the
5 women's prison. I had visited the men's
6 prison, and I've been to the prison a few
7 times in different capacities, but as a
8 Councilman, I visited the prisons. And,
9 first, I am generally concerned with the
10 lack of attention on girls and women in
11 our city in almost every aspect,
12 including drug addiction and all that
13 stuff. So I wanted to go to the women's
14 prison, and it was like different when I
15 went to the women's prison than when I
16 went to the men's prison.

17 The women's prison, when I went
18 with an official and I went to a living
19 area, they were sharing showers, rooms,
20 and they seemed quite well adjusted to me
21 and they seemed pleasant and more
22 optimistic than I thought they would.
23 And I asked about it and I spoke with
24 some of them, and I've told people at
25 community meetings, I don't know if it

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2 was a set-up or whatever. I just go
3 there. They bring me to a location. I
4 meet people.

5 But my perception was that they
6 were doing well and they were optimistic
7 and got along well and they were in kind
8 of a good spot kind of in their life,
9 which ties into my question, which was,
10 how many of them will be back? And the
11 answer I got was, A lot of them will be
12 back, because they're drug addicted. And
13 so they've been treated. They're off of
14 drugs. They got a place to live and a
15 place to socialize and a place to talk to
16 each other about seeing their kids again,
17 and now that they're clean, rebuilding
18 their lives and that type of thing. But
19 when they are done their term, they are
20 just out, without necessarily a driver's
21 license, a job, a place to go, a home to
22 stay in, and everything else that you
23 were kind of alluding to and the other
24 people about the housing. And so likely
25 back to the same community, the same

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2 problems, the same situation and

3 everything else. And I just wondered if

4 we know -- and that's the other thing.

5 It's not a state prison, for those who

6 don't know. They might be out in a week.

7 They might be out in two months. They

8 might be out in six months. We really

9 don't know unless they're serving county

10 time. Then we know they're doing like

11 six months, for example.

12 But if we know that they're
13 going to leave in 30 days, is it possible

14 or is it already there that there would

15 be a transitional service to make sure

16 they have perhaps a place to stay, the

17 electricity has been paid, they got a

18 driver's license, all of those types of

19 things and that they've been in touch

20 with a non-profit or a

21 government-sponsored entity where they go

22 to housing, you know, all of those type

23 of things? Naltrexone obviously is

24 pretty expensive, but keeps you from

25 using drugs again once you're out. A

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2 thousand dollars, works for 30 days. I
3 mean, what are the strategies around if
4 they're in a good spot; for example,
5 they're mentally good, they're looking
6 forward, they're reconnecting, to getting
7 them into a better situation as part of
8 their being released from prison?

9 DR. LEPLEY: Sure.

10 MR. BAGBY: I'm sorry,
11 Dr. Lepley. I'm just going to give you
12 the social service aspect. Dr. Lepley
13 will give you the clinical.

14 Under incoming Commissioner
15 Carney, we are looking to expand our
16 Discharge Planning Unit. As you stated,
17 we are a county facility, so our timing
18 of when someone is going to be discharged
19 is not always accurate. But we are going
20 to expand in our Discharge Planning.

21 But as far as IDs, we do have
22 an ID restoration program. So if anybody
23 in the county does need ID, because we
24 know that reentry, one of the biggest
25 barriers that people have is not having

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2 any ID. So we do provide IDs at the
3 county level. We also have what's called
4 our SMI Pilot Program where we looked at
5 a number of targeted SMI clients,
6 seriously mentally ill, who didn't have
7 medical assistance benefits. Through an
8 agreement with the state Department of
9 Human Services, we have an MOU where we
10 can have their benefits activated before
11 they're released. So before they're
12 released, everything is in COMPASS
13 application platform. Then they come
14 down to our RISE branch, because as you
15 know, due to the change in Charter, RISE
16 comes under the Department of Prisons
17 now. So once they're released, they
18 report to RISE at 990 Spring Garden.
19 They get their medical assistance
20 activated and they also get the
21 wrap-around services.

22 I think, in some of the
23 conversations that happened earlier, is
24 that we do a great job of assessing those
25 individuals, what their needs were and

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2 things like that, but I think sometimes
3 we need to assess the community, because
4 we take them out of a contaminated
5 environment. We have them on county
6 State Road. We provide the services. We
7 stabilize them, but then we release them
8 or they get discharged back into the
9 community that doesn't support that type
10 of recovery.

11 We have a situation actually at
12 RISE, we have a component where we do
13 offer housing. So we did have an
14 individual in housing, but the
15 environment that he was -- the housing
16 apartment he was at was so bad that he
17 chose to go back into a rehabilitation
18 center instead of staying in housing.

19 So I think that from a social
20 service aspect, we do a great job of
21 assessing the individuals, but we
22 probably need to do a better job of
23 assessing the communities that they're
24 returning into.

25 DR. LEPLEY: From a clinical

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2 standpoint, I think that sense of
3 well-being that you're observing is
4 misleading or it's an illusion, in a
5 sense. It's a function of the revolving
6 door. Certainly the environment is not
7 unfamiliar to most, because many of the
8 women and the men who are addicted to
9 heroin and other drugs are in and out and
10 in and out.

11 I think one challenge that I
12 encounter when treating the women, I was
13 the Medical Director at RCF for two years
14 and now I work in the prison Health
15 Services wing, but I found that I would
16 see a lot of women and patients who would
17 acknowledge that they use drugs
18 recklessly and endlessly and over and
19 over again, but many truly had difficulty
20 internalizing and accepting that they had
21 an addiction disorder. The ones who
22 really accept that did seem to have a
23 chance at doing well. But a lot of
24 people with addiction disorders, from a
25 clinical standpoint, truly view

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2 themselves as victims of circumstance.
3 And they do have very difficult
4 backgrounds. Many are victims of trauma.
5 But to go back to my earlier point, I
6 think a lack of continuously reenforcing
7 that this is a medical problem sort of
8 makes it difficult for a person to truly
9 internalize and accept that I have this
10 disorder, that I have this problem. They
11 would rather view it as a victim of
12 circumstance or a scenario in life,
13 because if that changes, then maybe they
14 have a chance. And there's a stigma with
15 addiction that was well talked about here
16 that I think is a barrier to a person
17 accepting that I have this disorder. And
18 we do have a long history. I mean, it's
19 heartening that we are discussing this in
20 a public health forum today, but we do
21 have a long history of viewing this as a
22 criminal justice issue. And certainly if
23 having this disorder means I'm going to
24 be incarcerated over and over again,
25 people do not want to truly accept that,

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2 that that's my problem. That might be
3 the other person's problem, but I have
4 this bad back and if I could just get on
5 the right combination of medicines.

6 I think that mindset is really
7 there for a lot of people who suffer from
8 this disorder, and I do think that a
9 potential solution is a broader approach
10 from primary care and all doctors that
11 come together and say, You have this
12 disorder, you have this disorder. Right
13 now we rely on people to make the
14 diagnosis themselves, to sort of hit
15 bottom, and then they seek treatment. I
16 think if we were making the diagnosis
17 earlier in the course of the illness, we
18 would prevent this revolving door that
19 you -- I think that's what you were
20 seeing. I think a lot of people it's
21 just become incorporated into their
22 illness.

23 I do think inpatient
24 rehabilitation treatment centers also
25 have a similar problem, where people

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2 bounce in and out, in and out. They say
3 what they're supposed to say, but it
4 truly just has become part of their
5 illness. And in those cases, just my
6 opinion from a clinical standpoint, I
7 think those individuals haven't really
8 internalized and accepted that I have
9 this disorder and this is what I need to
10 do.

11 COUNCILWOMAN SANCHEZ: I got to
12 visit Red Hook's Community Court and a
13 lot of the cases were drug-related cases,
14 folks who were addicted, and the judge
15 let me sit through the courtroom process.
16 And they have their Community Court's
17 counselors upstairs, assessments and
18 stuff, and I watched people come in. The
19 judge sent them upstairs. There was an
20 assessment done. And even people who had
21 like 19 different charges, you saw them
22 willing to do some sort of restitution
23 and get a small victory. And there was
24 one gentleman who came in who kind of had
25 relapsed, and he came in front of the

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2 judge and he said, I need a shot at
3 restitution. He came -- he
4 self-reported. He came in and was like,
5 I fell off the wagon, I need to come in
6 here, and asked the judge to give him 20
7 community hours. You know, he wanted to
8 come in and make right, even though he
9 had made all these mistakes. And it was
10 just so powerful to watch, because
11 instead of criminalizing it and Judge
12 Calabrese at Red Hook, incredible
13 nurturing type of person, you know, he
14 wanted to have a victory, and his victory
15 was, one, being able to come in and
16 say -- because he wasn't being a
17 criminal. He was coming into a court
18 that wasn't going to judge him. And his
19 willingness to say, Judge, I need
20 something to provide that restitution so
21 I can feel better about myself. And I'm
22 glad that we're decriminalizing some of
23 this stuff and really looking at it this
24 way, but my question because in the
25 county system, because you don't know how

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2 long people are going to stay, what are
3 the incentives that we're creating?

4 Because I know part of our challenge was
5 the reimbursements for people that were
6 in the system. So it becomes kind of a
7 financial situation. I think we've
8 gotten better at that at the prisons,
9 although I'm almost scared to ask the
10 question for fear of the answer.

11 What are the things that you
12 would say as the clinical person at the
13 prisons we should be providing in-house
14 to help? And I absolutely think that --
15 I don't care if it costs \$1,000. We
16 should be providing that. But what are
17 other things do you think we can provide
18 there to better help people transition
19 back?

20 DR. LEPLEY: I think that's
21 what we need to do, is partner with
22 providers in the community, treatment
23 centers in the community and allow for
24 that transition. And the model described
25 in the OPTIONS program is the standard of

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2 care. There's been a lot of talk of
3 medication and medication-assisted
4 treatment, and those are important
5 components to assist in treatment, but
6 the treatment really is psychologic
7 counseling, psychology therapy. That is
8 what's going to develop the rational
9 brain to overcome this diseased
10 instinctive brain that was discussed very
11 early in today's proceedings. That video
12 really described it well. You really do
13 need to develop the rational brain and
14 the higher brain to override that
15 instinctive drive that the person with
16 addiction has.

17 And so I would say that we
18 should be, from a clinical standpoint,
19 doing more to recognize addiction before
20 the patients themselves are aware of the
21 problem. Because I can see the behaviors
22 before the patient is willing to
23 acknowledge it or before he or she sees
24 it themselves. So just like in the
25 community, I would say earlier

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2 intervention would lead to inflated
3 statistics, but would be a positive
4 thing. And I think increasing the
5 counseling that people get would be
6 beneficial, because that is really the
7 standard of care.

8 Councilman Oh asked earlier
9 about what's the best treatment. The
10 best treatment is what doctors receive
11 when they have substance problems, and it
12 involves a very intense counseling
13 process.

14 And so I'm of the opinion that
15 the solution lies in counseling, 12-step
16 programs. People need to get well in the
17 communities that they live in. When they
18 are in jail -- and that will happen
19 because -- and that can be healthy,
20 because people do need to be accountable
21 for their behavior, but as a clinician,
22 if we can have a better handle on where
23 they're coming from and, more
24 importantly, where they are going, we can
25 certainly reach out to providers in the

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2 community and provide for a better
3 transition.

4 I think as a clinician, I could
5 do more to interact with the OPTIONS
6 program to maybe make them aware of
7 behaviors that we're seeing in medical
8 that indicate symptoms of addiction.
9 Maybe they're not using drugs in the
10 jail, but they are looking for a pill to
11 help them relieve anxiety, and those
12 patients are going to struggle when they
13 leave. And there is a place for
14 medication as well, and I think it's been
15 explored, things like the Vivitrol. An
16 injection of Vivitrol before a person
17 leaves certainly could be life-saving in
18 some circumstances, but medication alone
19 is not the solution.

20 COUNCILWOMAN SANCHEZ: Thank
21 you. Thank you both for coming.

22 (Thank you.)

23 COUNCILWOMAN SANCHEZ: And
24 adding your voice to this.

25 We have our last panel of

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2 folks, Melissa Green-Cannon and Deborah
3 Young. We're not sure if Ronald Pope is
4 still in the room.

5 Thank you so much for being
6 patient and waiting.

7 (Witnesses approached witness
8 table.)

9 COUNCILWOMAN SANCHEZ: I
10 greatly appreciate it.

11 You can proceed with your
12 testimony. Identify yourself for the
13 record, and thank you.

14 MS. CANNON: My name is Melissa
15 Cannon. I'm here as a parent of an
16 addict. Thank you for giving me this
17 opportunity to put a face, a real face,
18 to this problem.

19 I live in the suburbs, but my
20 daughter lives here in the City. And I
21 don't even know if you can call it
22 living. She slept on the streets last
23 night.

24 My daughter has been an addict
25 for over seven years, and she's only 22.

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2 I've come to terms with I will probably
3 get that dreaded phone call one day that
4 my daughter is dead.

5 Some of the obstacles that
6 we've faced over the last few years have
7 been that she had private insurance.
8 When she finally reached out for the very
9 first time and wanted to get help, I
10 tried to get her into rehabs. They
11 wanted me to walk in with \$1,500, which I
12 didn't have, which meant at that point
13 after spending hours in the emergency
14 room to get evaluated, she's like, I'm
15 done, and she would go back into that
16 world and I wouldn't hear from her again
17 for a while. That happened numerous
18 times.

19 We were then told, Well, if she
20 had medical assistance, then she'd be
21 able to get in easier. So I called her
22 dad and I said, Take her off your
23 insurance. The next time she wants to
24 get help, they'll put her on medical
25 assistance and she'll get into rehab. So

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2 that's what he did.

3 The next time she reached out
4 we took her to the emergency room like we
5 were told we needed to do, sat there all
6 night. She started to go into
7 withdrawal. The emergency room doctor
8 did nothing to help. At 8 o'clock in the
9 morning when the case manager came in,
10 did the assessment, said she needed
11 rehab, there were no beds available,
12 because rehabs are limited to the number
13 of medical assistance beds they have.
14 But they started the process and at least
15 she became covered through medical
16 assistance. Then I find out that it's
17 done by county and she's only eligible to
18 go to rehab that our county has
19 contracted with. Well, those beds are
20 all taken, but yet in four counties over,
21 there may be seven beds open for medical
22 assistance, but because I don't live in
23 those counties, she can't go there.

24 The stigma I've heard talked
25 about earlier as well is huge. I've kind

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2 of kept this a secret for a long time,
3 and I've realized that I can't do that
4 anymore, not only because it doesn't help
5 her but it doesn't help me either. The
6 things that people say on social media
7 are horrible. I read a statement the
8 other day. Someone said, Oh, they're all
9 just junkies, they should just die
10 anyway. They have no idea the struggle
11 that we go through trying to get them
12 help. There's that brief window when
13 they have that moment of clarity where
14 they know they need to get help, and it
15 just disappears so fast.

16 We have a system that makes
17 addicts criminals. I heard a few things
18 about how in Bensalem you can go in and
19 you can tell them that you want to get
20 help, they'll help you. My daughter is
21 not going to walk into a police station
22 because she has warrants. If she walked
23 into a police station, they run her name,
24 she's going to jail. She's not getting
25 help.

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2 The other thing that we found
3 when I was able to get her in rehab,
4 because of the numerous traumas and
5 things like that that she has witnessed
6 and experienced, the minute the drugs are
7 gone and that reality hits her, it's just
8 too much. I know a few of the things
9 that she's been through, and they
10 devastate me. I can't even imagine
11 having lived through them, and that just
12 being a few of them.

13 But when she gets to that point
14 and it's so overwhelming, she just
15 leaves. She wants the drug again because
16 it's easier and it's what she knows at
17 this point.

18 People are like, Well, they
19 make the choice. My daughter consciously
20 makes a choice at certain times to stay
21 in this life, in this addiction, because
22 I tell her if you -- she calls and wants
23 to come home and I say, If you go to
24 rehab, you can come home. I can't have
25 her in my home using. But she doesn't

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2 really have a choice. Her brain doesn't
3 let her make choices like we would. She
4 doesn't think like we do anymore.
5 Because what normal person after
6 overdosing and then taking two doses of
7 Narcan and 15 minutes of CPR to bring her
8 back would want to continue that? She
9 died. She was -- a week and a half ago,
10 she was admitted into the hospital
11 because she had an infection in her arm.
12 She now has an incision about seven
13 inches long, about the size of a
14 grapefruit wide and about three inches
15 deep in her arm. It's an open wound that
16 they had to clean out the infection.
17 That's how much of it they had to take.
18 I brought her home to my house after they
19 released her, because if she goes back to
20 where she was, she'll die. The places
21 that she stays in are not clean and safe
22 for her to recover from something like
23 that.

24 Two days later she lied to me
25 and met up with a friend, and I told her

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2 if she wasn't home by a certain time, she
3 couldn't come back to my home. She's not
4 back. She's now back living in
5 Philadelphia.

6 That picture you see isn't my
7 daughter anymore. And I know there's no
8 simple answer on how to fix all of this,
9 and I know she has to want it more than I
10 do for her, but there are just so many
11 obstacles.

12 I think some of the things that
13 need to be addressed are to get rid of
14 those lines with insurance companies.
15 That's a huge thing. I've seen a
16 petition that I've signed where you can
17 have someone involuntarily placed
18 somewhere for drug addiction. That's
19 not -- right now to 302 someone, drug
20 addiction isn't a legitimate reason for
21 that to happen, and it makes no sense,
22 because if she said, I'm going to kill
23 myself, I can do it, but her slowly
24 killing herself daily with this disease,
25 it's just -- I don't understand that

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2 concept.

3 We need to stop prescribing
4 opiates to kids. I went to a task force
5 meeting at a school and found out that
6 you can become addicted to opiates after
7 only three doses, which isn't even a full
8 day. If you get it every six hours,
9 that's four doses. Before you're done
10 your first day, if you're going to be one
11 of those people who becomes addicted to
12 opiates, it's that easy.

13 When my daughter was 14, she
14 was in the hospital for pancreatitis and
15 they gave her morphine, and I think that
16 turned that little trigger on for her.
17 She had already been experimenting with
18 other drugs, and I know that she was
19 using -- from her telling me things, I
20 know that she used Percocets and things
21 like that before she got to heroin.

22 No one sets out to be a heroin
23 addict. It's not a choice that people
24 make.

25 The other thing, my daughter is

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2 now a criminal with a criminal background
3 due to her addiction, and the charges
4 that she has now, she's never been
5 arrested or convicted of robbing anyone,
6 breaking into anyone's house. Her
7 charges are all, I guess, what someone
8 could say a victimless crime, but she's
9 the victim because the things that she
10 does hurt her and nobody else.

11 I actually had her arrested
12 originally to try and get her into rehab.
13 The police officer said, We can do this
14 and hopefully you can get her into rehab.
15 Now she had a felony drug charge because
16 she had drug paraphernalia in her purse
17 that she openly admitted to and openly
18 gave to the police officer. And I
19 thought, Okay, this is our way, we're
20 going to get her help. She spent three
21 months in jail. They released her to
22 drug rehab. They picked her up from the
23 jail, took her to rehab. Two days
24 later -- she went there on a Friday. On
25 Saturday, she walked out of the rehab,

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2 and that's the night she overdosed.

3 I guess I'm lucky that she's
4 still here, because as long as she's
5 still alive, there is hope. But all the
6 things in place right now work against
7 her. She's lost so many friends, and
8 that's not enough for her to change
9 either. I don't know what the answer is,
10 but we have to figure it out before we
11 lose more kids. They're just -- they're
12 dying faster than they should be.

13 Thanks for letting me come and
14 speak today.

15 COUNCILWOMAN SANCHEZ: Thank
16 you. We're going to keep praying for
17 you.

18 You can proceed. Identify
19 yourself for the record.

20 MS. YOUNG: My name is Deborah
21 Young, Justice for Families and Children.
22 I'm also -- I volunteer at PRO-ACT
23 Recovery Center and also with Project
24 Home, a number of other organizations to
25 help people that are homeless and are in

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2 recovery.

3 I hear the stories too much,
4 too much. Nationwide there's 2,000 kids
5 every single day trying prescription
6 drugs, 2,000. Seventy percent of our
7 children are getting them at home or,
8 like she said, from the hospital. They
9 start them at the hospital. Why are our
10 children getting drugs when they leave
11 the hospital? There's other things out
12 there you can do for our children. And
13 it's a trigger.

14 My daughter also was given
15 Percocets. I mean, I took them from her.
16 I stopped her from -- but she didn't get
17 addicted to them.

18 I'm 11 years in long-term
19 recovery. I started off with pot, then I
20 went to crank back then, and then I went
21 to alcohol was my drug of choice. But it
22 is a drug. These children need help.
23 They start at a very young age. Our 8,
24 9, 10, 11, 12-year-olds doing drugs, from
25 marijuana to prescription drugs to

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2 alcohol to hard-core heroin, you know.
3 And it is very hard to get people in to
4 get recovery, to get detox. It's
5 extremely hard. I get calls all the time
6 to get people help. If I have to spend
7 eight, ten, 12 hours sitting with
8 somebody or a whole day to try to get
9 them in somewhere, to get them help, I
10 will do that, because if I lose that
11 person, they might be dead the next day,
12 because they can't get the help. They
13 can't get into that detox.

14 There's certain counties, like
15 she said, you got to live in there. But
16 there's beds all the way in another
17 county, but you can't get them in there.
18 And what are you going to do when that
19 person comes to you and asks you for the
20 help and you can't get them the help
21 because they don't have insurance or
22 there's no beds? And I can't tell you
23 how many times I've heard there's no
24 beds, how many friends I've lost. In the
25 last two years I've lost 13 friends in

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2 two years. That's a lot of people.

3 Our kids are doing drugs,
4 prescription drugs. I went out to my
5 neighborhood, because I live near a park,
6 and I did my own little survey with these
7 teenagers and I asked them. You know,
8 they know me from the neighborhood. They
9 see me all the time with other people in
10 the neighborhood. Sixty kids, 60 kids
11 told me they would have no problem
12 getting drugs within 15, 20 minutes.
13 They could get them from home or they
14 could get them from their friend.
15 Prescription drugs, that's where it's
16 starting.

17 Our kids are dying. They're
18 overdosing.

19 I'm trained for the Narcan.
20 That's a good thing, but then they're
21 just going back out there and doing it
22 again. There's got to be some kind of
23 policy where you give them Narcan and
24 they got to go into somewhere afterwards
25 to get the help. I mean, people got to

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2 make the decision that they want to do
3 it, but nobody is in their right mind
4 when they do drugs. I was not in my mind
5 when I was drinking back when I tried
6 crank. My first drink I was 12 years
7 old, 12 years old. And then that's all
8 it took.

9 Our children need help and they
10 need it now. They need people out there
11 on the streets letting these kids know
12 they have somewhere to go. Me and my
13 sponsor went out and put flyers in all
14 the pizza places where it said where they
15 can go get help.

16 There needs to be more funding
17 to get people a bed. A bed. That's all
18 it takes is one bed when that person
19 needs help. There is not enough beds in
20 Philadelphia. There's not enough
21 recovery houses. When they come out of
22 there, where are they going to go? They
23 don't have no jobs. They don't have --
24 there's not enough recovery houses to
25 take people in. I would love to own a

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2 string of recovery houses to help people.
3 I don't have the money for that to open
4 these recovery houses. When they come
5 out of there and they have nowhere to go,
6 the despair, the depression, the
7 helplessness takes them right back out
8 there.

9 It's just -- I lost my cousin.
10 She was found hanging. She was on
11 methadone for a lot of years. Why are
12 people on this methadone for a lot of
13 years? She could not get off of it. She
14 hung herself.

15 My friend Johnny, my best
16 friend, kept fighting to come back in and
17 out, in and out. He got one last bag and
18 it killed him. He couldn't pay for to go
19 in treatment anymore. He already spent
20 thousands of dollars. Because he had a
21 company. He wasn't making a lot of
22 money, but he couldn't keep affording
23 going back in there. He's not here.

24 How many children -- and I have
25 friends that lost their children. A

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2 parent should never, ever outlive their
3 child. The worst pain in the world is
4 going to your child's funeral, and I've
5 seen that pain.

6 This is where -- we need more
7 beds. We need more people out there.
8 You know, PRO-ACT is an awesome recovery
9 center that goes everywhere to help
10 people. There needs to be more funding.
11 I appreciate what you are both doing
12 here. I appreciate -- David Oh, I was at
13 your 17th and Lehigh meeting. I spoke
14 there.

15 There needs to be more funding
16 to help people, to help her daughter, to
17 help hopefully not your grandchild,
18 anybody's grandchild down the road. You
19 worry about this constantly. I worry
20 about this constantly, my kids, my
21 friends' kids, everybody's kids. There's
22 too many kids dying. There's too many
23 kids on these pills, and they're going to
24 go to heroin, and then they're going to
25 get that one bag of dope bad and they're

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2 going to be dead. That's where we need
3 the funding. We need to have people out
4 in the street. We need to get beds. We
5 need to open recovery houses. We need
6 this. Not one more child dead. Not one
7 more child.

8 COUNCILWOMAN SANCHEZ: Thank
9 you.

10 Thank you both.

11 Councilman, I didn't know if
12 you for the record wanted to put anything
13 on the record before we close out what
14 has been a very passionate day of
15 testimony.

16 And we thank you both. Thank
17 you for sharing your stories. There's
18 nothing to be embarrassed about. All of
19 us have been impacted. I had an uncle
20 who was addicted who hung himself. I had
21 a younger cousin who died of an overdose.
22 This touches everyone. It doesn't matter
23 the race. It doesn't matter the economic
24 ladder.

25 And so I want to thank

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2 Councilman Oh for doing this. And I
3 represent the epicenter of this, and
4 Chief Nestel for hanging in there with
5 us, because he sees it every single day.
6 And we will make sure that we do -- we
7 have some next steps and that we try to
8 do some of the things that have been
9 highlighted here today. Some are more
10 simpler than others, but clearly the
11 titanic has to be challenged about how we
12 do and how we treat folks.

13 So thank you very much.

14 Councilman, I didn't know if
15 you wanted to --

16 COUNCILMAN OH: No. I just
17 wanted to thank you both for coming out
18 and sharing your story. I know that it
19 is deeply personal, but your efforts are
20 going to help other people and they're
21 certainly helping us here in how we're
22 going to approach this problem, as with
23 all the people who came today, from our
24 doctors and our professors and our police
25 officers and our providers and everyone

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2 who is trying to do this good work, our
3 reporters. It is clearly a challenge for
4 us, but I think that we can do a better
5 job than we have been doing. And I truly
6 appreciate our elected officials from our
7 surrounding counties to basically venture
8 out here. I mean, if we can address the
9 problem that you just talked about, that
10 would be one less barrier to helping
11 someone to have a better life.

12 I would like to say that I did
13 invite Buddy Osborn here and there were
14 other people as well, who unfortunately
15 just time-wise just couldn't stay, Bernie
16 Strain, who lost his son because his son
17 was given Percocets for burning a hand
18 and then his girlfriend's mother gave him
19 a methadone pill. An 18-year-old, never
20 got a chance to be an addict. He just
21 overdosed there.

22 The folks that have come out to
23 support this, I do truly appreciate. You
24 know, what we're going to do from here,
25 so you know, is we're going to recess

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2 this hearing. We will then wait to get
3 the notes of testimony. We'll get a
4 video of everyone's testimony, and then
5 we'll begin to break it down, look at
6 what was said, try to group things
7 together, reach out to some other folks
8 and begin to see if we can put a process,
9 a better process together. Some of the
10 things are pretty easy, although it's not
11 up to me, but certainly if our Mayor
12 would do that proclamation, I think that
13 things people said could be done, could
14 be very impactful.

15 So I do appreciate that. And
16 one of the things I was very struck by is
17 so many of the people that we met, and
18 I'm just saying, who have really put a
19 lot of heart into this issue, really
20 working with their children or their
21 niece or someone, many of them came from
22 backgrounds where they didn't have a
23 professional license or they weren't --
24 didn't have a great job. They didn't
25 graduate with a Ph.D., and I was just

1 5/20/16 - PUBLIC HEALTH - RES. 160052
2 struck by how many of them said something
3 like, And I'm nobody. And I think that's
4 just very sad when you run into a mother
5 or someone who is really trying to help
6 their child and they're just saying, I'm
7 doing the best I can, but I really don't
8 know what to do and why would she listen
9 to me, I'm nobody. And I think that is
10 one of the kind of things that we have to
11 think about as to how we address those
12 situations, because, I mean, certainly
13 I'm nobody more important or better than
14 any of the people that I've met who said
15 that, and we do have to try to address
16 why they feel that way and how we can
17 ensure that they have confidence to take
18 action. They don't know the solution.
19 We don't know the solution. A lot of
20 folks here don't know the solution, but
21 we're putting our heads together to see
22 if we can do something better.

23 So thank you very much.

24 MS. YOUNG: And I thank you. I
25 appreciate everything you're doing,

1 5/20/16 - PUBLIC HEALTH - RES. 160052
2 because there's a lot of people out there
3 that need help, and this is the right
4 step at getting everybody together.
5 There's so many people here today. I
6 heard so many great ideas about helping
7 others, you know, and I just really
8 appreciate what you're doing. I really
9 do. Thank you.

10 COUNCILWOMAN SANCHEZ: Thank
11 you.

12 The Committee on Health and
13 Human Services will be recessed. This
14 resolution will be recessed to the call
15 of the bill sponsor.

16 Thank you. Thank you all.
17 Have a very good weekend.

18 MS. YOUNG: Thank you.
19 (Committee on Public Health and
20 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
RPR-Notary Public

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