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HOUSE DEMOCRATIC POLICY COMMITTEE
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House of Representatives
COMMONWEALTH OF PENNSYLVANIA

HOUSE DEMOCRATIC POLICY COMMITTEE HEARING

Topic: Ending Overdose Deaths – Harm Reduction As A Drug Policy

Teamsters Temple Banquet Hall – Pittsburgh, PA

October 8, 2019

AGENDA

2:00 p.m. Welcome and Opening Remarks

2:10 p.m. Panel One:
- Mary Hawk, DrPH, LSW, Associate Professor of Behavioral and Community Health Sciences, University of Pittsburgh Public Health
- Stuart Fisk, CRNP, Director of Center for Inclusion Health, Allegheny Health Network

2:20 p.m. *Questions & Answers*

2:30 p.m. Panel Two:
- Chief Tim Komoroski, Chief of Police, Millvale Police Department
- Simon Taxel, Crew Chief/Rescue Tech/Public Safety Driver, Pittsburgh Bureau of EMS

2:40 p.m. *Questions & Answers*

2:50 p.m. Panel Three:
- JoEllen Marsh, Law Enforcement Assisted Diversion Program Lead, CONNECT Pittsburgh
- Michael Krafick, Certified Recovery Specialist Supervisor, Armstrong-Indiana-Clarion Drug and Alcohol Task Force
- Laura Drogowski, Critical Communities Initiatives Manager, Office of Mayor William Peduto

3:10 p.m. *Questions & Answers*

3:20 p.m. Panel Four:
- Devin Reaves, Executive Director, Pennsylvania Harm Reduction Coalition
- Aaron Arnold, Executive Director, Prevention Point Pittsburgh

3:40 p.m. *Questions & Answers*

3:50 p.m. Closing Remarks

Testimony of Simon Taxel for 10/8/19 House Democratic Policy Committee Hearing

Western Pennsylvania is on the forefront of what is known as the 3rd wave of the opioid epidemic. The first wave of the crisis originated in the mid 1990's when prescription drugs like oxycontin flooded our communities. When the damage caused by the excessive prescription of opioids could no longer be ignored, multiple regulatory agencies started to crack down. The number of new opioid prescriptions has been falling precipitously for almost a decade now. If the problem was simply going to be solved by reduced supply, then the second and third wave of the crisis should never have happened. Unfortunately, that is not the case. When prescription opioids started to become scarce, many who suffer from opioid addiction turned to heroin. This represents the second wave of the crisis. The third wave began around 2014 when synthetic fentanyl became abundant in the illicit drug supply. Fentanyl, is considerably more potent than heroin and it has contributed to a substantial increase in the number of overdoses and deaths. There was almost a 10% increase in drug related deaths between 2016 and 2017 alone. According to the Centers for Disease Control the drug overdose death rate in Pennsylvania was 44.3 per 100,000 in 2017. This was the third highest in the country only surpassed by West Virginia and Ohio. Today, opioids and illicit fentanyl have become the leading cause of death among adults between age 20 and 50. As a paramedic I have attended to many of these deaths and I am tired of it. I am tired of bearing witness to the lives of my peers being snuffed out needlessly and I am tired of telling parents, family members, and friends that there is nothing more that I can do to try and save a life. Preliminary data released by the medical examiner shows that in 2018 there were 437 opioid related deaths in Allegheny County. This represents a 41% decrease from 2017. This is excellent news but there were still 437 deaths which is 437 too many. Every drug related death represents a policy failure and every drug related death could have been prevented. We must start to take responsibility for the lives that are being lost throughout the commonwealth and the country.

As community stakeholders and legislators, we have a responsibility to do everything in our power to save lives. The first step in this process is the re-definition of addiction. Addiction is not a moral failure, and "just say no" is a woefully insufficient and overly sophomoric paradigm. We must make every effort to transcend our personal biases and the stigma associated with people who suffer from substance use disorder. Author and physician Gabor Maté wrote that "addiction is neither a choice nor primarily a disease, genetic or acquired. It originates in a person's attempt to solve genuine human problems: those of emotional loss, of overwhelming stress, of lost connection. It is a forlorn and ultimately futile attempt to solve the dilemma of human suffering." The true roots of this crisis are founded in pain and suffering, both physical and psychological. I cannot pretend to stand here and offer solutions to the economic hopelessness, trauma, and inequality that have become endemic in our community and the commonwealth at large. I can however, present a few harm reduction strategies that are proven to save lives.

I am proud to say that The Pittsburgh Bureau of EMS was the first EMS agency in the commonwealth to establish a Narcan leave behind program. Since early 2018, we have been empowered to provide free doses of intranasal Narcan to at risk community members and or their families. There are numerous other community partners such as Prevention Point Pittsburgh and the Allegheny County Department of Health that also have long standing Narcan distribution programs. We are fortunate in this region that there is a robust framework for the distribution of Narcan. The circulation of Narcan throughout the community has saved lives and the decrease in overdose deaths in 2018 reflects that. It is important to note that the majority of people saving lives and reversing overdoses with Narcan are other members of the drug using community. We are quick to call these individuals addicts and junkies, minimizing their intrinsic value as human beings, but in many cases, they are the true heroes in this crisis. There has been one unexpected challenge associated with saturating at risk populations with this medication. The number of 911 calls associated with opioid overdose have decreased substantially. A cursory review of this data might lead one to believe that we have turned the corner on this crisis. I believe that to be substantively false. The number of individuals using and overdosing on opioids has continued to rise, they are just not calling 911. There is no doubt that empowering the drug using community to save lives is a valid and worthwhile endeavor. Unfortunately, we are losing an important and valuable touch point to engage with people who are often incredibly disassociated from society at large. We are going to have to work to come up with novel solutions and programs to continue to engage with and provide outreach to people who use drugs, even as their need for us acutely decreases.

I want to be explicitly clear now. There is abundant evidence that the availability of Narcan does Not increase or normalize drug use. Those individuals that use opioids do not want to ever receive Narcan because it immediately causes unpleasant and painful withdrawal symptoms. There is a long-standing urban legend that Narcan parties, where people intentionally engage in risky behavior because they believe that they have a safety net, occur. This is nothing more than an unsubstantiated rumor that is used to increase the stigmatization of some of the most at risk members of our community. As we begin to discuss legislation that empowers additional harm reduction programs like legalizing the distribution of fentanyl test strips and increased needle exchange we must ignore histrionics like this and stick to the scientific evidence. Fentanyl test strips are a low cost but potentially high impact measure. It has been shown that when people who use opioids are able to test their drugs for fentanyl they will adjust their behavior and use less, use with other people present, or ensure that Narcan is available. This saves lives. Each strip costs around $1. I challenge each and every one of you to go speak with your constituents and ask them if $1 is too much to save a life. It is my vision that in the future I will be able to provide fentanyl test strips to people that need it as well as clean syringes in addition to the Narcan. This will help to prevent the spread of communicable diseases like HIV and hepatitis as well as preventing fatal overdoses. Additionally, we must work to increase access to medication assisted treatment. While MAT continues to be looked down upon as just substituting one drug for another, even in some recovery communities, methadone, suboxone, and buprenorphine work and are proven to increase and facilitate recovery. We should also be discussing overdose

prevention centers. Creating safe spaces were people who inject drugs can go to use, brings them out of the shadows. This may be perceived as politically problematic, but the reality is that safe injection sites keep used needles off of our streets, help to prevent the spread of communicable diseases, provide an opportunity for engagement with the drug using community, help to connect people with recovery services, and save lives. In the long run programs and spaces like this save the community enormous amounts of money due to reduced healthcare costs.

Addiction is colorblind and does not discriminate. However, the social determinates of health do. The criminalization of drug use has historically had a disproportionately negative impact on poor communities of color. The crisis of opioid use and overdose was rarely considered a public health problem until it started to significantly impact middle- and upper-class white communities. When the majority of individuals engaging in dangerous drug use were poor people of color the widely accepted solution to the problem was incarceration not treatment. While the overall rate of drug use is the same among all racial and economic groups the war on drugs has been fought almost exclusively in predominately black, urban neighborhoods. We cannot forget this, and our legislative response must also work to right the wrongs of the past. This means that when we revamp the antiquated paraphernalia laws and make test strips and syringes legal, those people that have been incarcerated for possessing them must have their sentences commuted and or vacated. It means, that when the courts start mandating treatment in lieu of jail the people that were previously jailed are provided the same opportunities.

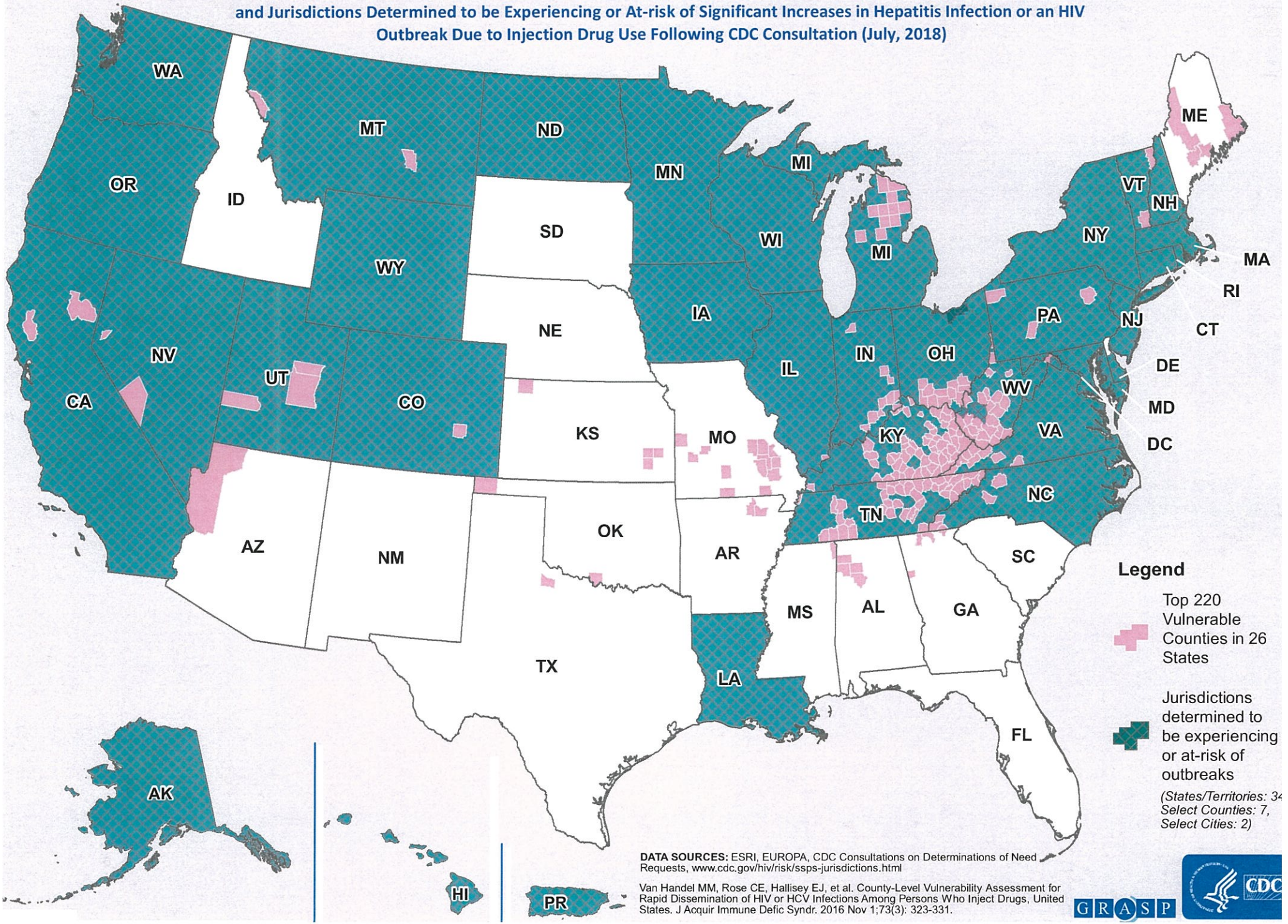
Recently I took care of a young woman who was suffering the ill effects of long-term injection drug use. She appeared to be experiencing a systemic infection known as sepsis that can be life threatening. She was resistant to treatment and transport but under threat of arrest for outstanding warrants she agreed to go to the hospital. In the emergency room she received IV antibiotics and was due to be admitted to the hospital for further treatment. The Allegheny County Sheriffs never came to ensure that she staid at the hospital or take her to jail. After a few hours she fled the hospital against medical advice. This person was forced to choose between potentially life saving medical care and incarceration. I have gone out looking for her numerous times in an effort to connect her with services, but I have not found her, and I do not know if she is even alive. This is a clear example of how the criminalization of drug use is harmful, maybe even more harmful than the drug use itself.

As we navigate through the response to this epidemic, we must remember that supply side prohibition and criminalization has little to no impact on the rates of drug use and addiction. In 2014, The Pew Charitable Trusts examined publicly available data from federal and state law enforcement, corrections, and health agencies. The analysis found no statistically significant relationship between state drug imprisonment rates and three indicators of state drug problems: self-reported drug use, drug overdose deaths, and drug arrests. The findings, which were sent to

the President's Commission on Combating Drug Addiction and the Opioid Crisis in 2017, reinforce a large body of prior research that cast doubt on the theory that stiffer prison terms deter drug misuse, distribution, and other drug-law violations. The evidence strongly suggests that legislators and policymakers should pursue alternative strategies that are proven to work better and cost less. The ingestion of mind-altering substances is a response to real suffering, an attempt to make unlivable conditions livable. Consider this: at least 70% of women who experience substance use disorder are survivors of sexual trauma. We are not going to be able to solve this problem through prohibition, incarceration, and interdiction. This is public health not politics and we have a moral obligation to use evidence-based solutions to save as many lives as possible. Harm reduction strategies including Narcan distribution, fentanyl test strips, syringe exchange, safe injection spaces, and medication assisted treatment are proven to reduce the mortality and morbidity associated with opioid use. As we begin to embrace a compassionate harm reduction centered strategy for combating this epidemic, we cannot let ourselves forget the racial disparity that exists in this response. White people with substance use disorder are frequently described as the victims of unscrupulous pill pushing physicians while people of color with the same illness have been and continue to be characterized as criminals. Law professor Ekow Yankah, said "It is hard to describe the bittersweet sting that many African-Americans feel witnessing this national embrace of addicts. It is heartening to see the eclipse of the generations-long failed war on drugs. But black Americans are also knowingly weary and embittered by the absence of such enlightened thinking when those in our own families were similarly wounded. When the face of addiction had dark skin, this nation's police did not see sons and daughters, sisters and brothers. They saw "brothas," young thugs to be locked up, rather than "people with a purpose in life." This has to change. Moving forward our response to this epidemic must be framed by the need for racial and social justice as well as scientifically informed compassion. The failed war on drugs has been fought against people, the majority of whom are poor people of color, and significantly increases harm. We must now focus on fundamentally reducing the demand for illicit drugs which necessitates doing the hard work of building a healthier society.

Vulnerable Counties and Jurisdictions Experiencing or At-Risk of Outbreaks

County-level Vulnerability to Rapid Dissemination of HIV/HCV Infection Among Persons who Inject Drugs (September, 2015) and Jurisdictions Determined to be Experiencing or At-risk of Significant Increases in Hepatitis Infection or an HIV Outbreak Due to Injection Drug Use Following CDC Consultation (July, 2018)



DATA SOURCES: ESRI, EUROPA, CDC Consultations on Determinations of Need Requests, www.cdc.gov/hiv/risk/ssps-jurisdictions.html

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GRASP

CDC

Syringe Services Programs (SSPs) Fact Sheet

The opioid crisis is fueling a dramatic increase in infectious diseases associated with injection drug use.

Reports of acute hepatitis C virus (HCV) cases rose 3.5-fold from 2010 to 2016.[1]

The majority of new HCV infections are due to injection drug use.

Over 2,500 new HIV infections occur each year among people who inject drugs (PWID).[2]

Syringe Services Programs (SSPs) reduce HIV and HCV infections and are an effective component of comprehensive community-based prevention and intervention programs that provide additional services. These include vaccination, testing, linkage to infectious disease care and substance use treatment, and access to and disposal of syringes and injection equipment.

Helps prevent transmission of blood-borne infections

For people who inject drugs, the best way to reduce the risk of acquiring and transmitting disease through injection drug use is to stop injecting drugs. For people who do not stop injecting drugs, using sterile injection equipment for each injection can reduce the risk of acquiring and transmitting infections and prevent outbreaks.

SSPs are associated with an estimated 50% reduction in HIV and HCV incidence.[3] When combined with medications that treat opioid dependence (also known as medication-assisted treatment), HCV and HIV transmission is reduced by over two-thirds.[3,4]

SSPs serve as a bridge to other health services, including HCV and HIV testing and treatment and medication-assisted treatment for opioid use disorder.[5]

Helps stop substance use

The majority of SSPs offer referrals to medication-assisted treatment,[6] and new users of SSPs are five times more likely to enter drug treatment and three times more likely to stop using drugs than those who don't use the programs.

SSPs prevent overdose deaths by teaching people who inject drugs how to prevent overdose and how to recognize, respond to, and reverse a drug overdose by providing training on how to use naloxone, a medication used to reverse overdose. Many SSPs provide "overdose prevention kits" containing naloxone to people who inject drugs.[7-12]

Helps support public safety

SSPs have partnered with law enforcement, providing naloxone to local police departments to help them respond and prevent death when someone has overdosed.[13]

SSPs also protect first responders and the public by providing safe needle disposal and reducing the presence of discarded needles in the community.[14-19]

In 2015, CDC's National HIV Behavioral Surveillance System found that the more syringes SSPs distributed per the number of people who inject drugs in a geographic region, the more likely the people who inject drugs in that region were to dispose of used syringes safely.[20]

Studies in Baltimore[21] and New York City[22] have also found no difference in crime rates between areas with and areas without SSPs.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

CS 300156-G July 19, 2019

Endnotes

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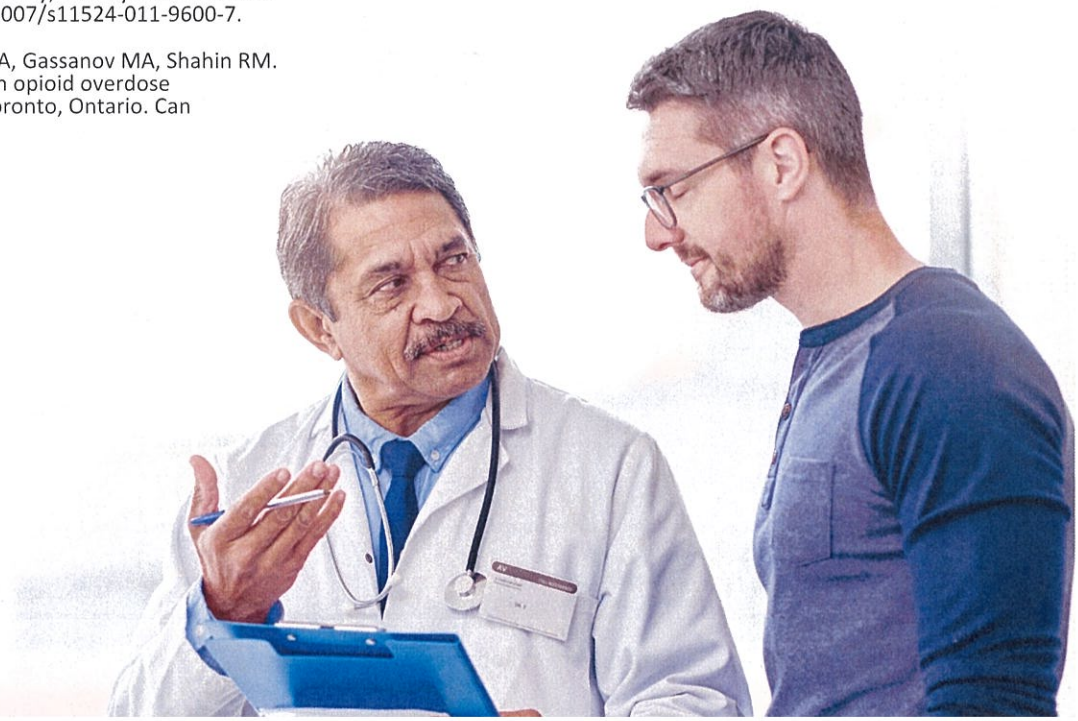
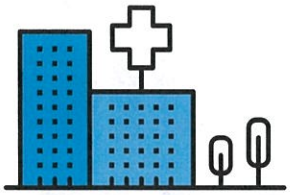


SSPs [SYRINGE SERVICE PROGRAMS]

A vital part of efforts to address the Opioid, HIV and Hepatitis C epidemic.

PAHRC
PENNSYLVANIA
HARM REDUCTION
COALITION



WHAT IS A

SYRINGE SERVICE PROGRAM?

A community-based public health program that provides comprehensive harm reduction services such as:

REFERRAL TO SUBSTANCE USE DISORDER TREATMENT INCLUDING MEDICATION-ASSISTED TREATMENT

PURPOSE: to get PWID the necessary help to discontinue drug use with evidence-based treatment

REFERRAL TO MEDICAL, MENTAL HEALTH,AND SOCIAL SERVICES

PURPOSE: to get PWID the necessary help to live life

HIV AND HEPATITIS C TESTING, PREVENTION TOOLS, LINKAGE TO TREATMENT, AND VACCINATIONS.

PURPOSE: to detect and prevent the further spread of Hepatitis and HIV, reduce costs for treatment and death

PROVIDES NALOXONE TO PEOPLE AT RISK FOR OVERDOSE

PURPOSE: to prevent fatalities by overdose

SAFE DISPOSAL OF SYRINGES AND NEEDLES

PURPOSE: to reduce needle stick injuries to first responders and public

FREE STERILE NEEDLES, SYRINGES AND OTHER INJECTION EQUIPMENT - OUT OF PUBLIC SIGHT.

PURPOSE: to reduce the spread of HIV and Hepatitis C and the exposure of injection in public places.

EDUCATION ABOUT OVERDOSE AND SAFE INJECTION PRACTICES

PURPOSE: to prevent infection, spread of disease and overdose

PAHRC | Pennsylvania Harm Reduction Coalition
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www.paharmreduction.org

SSPs DON'T increase illegal drug use or crime but DO reduce HIV and Hepatitis C.

KNOW THE FACTS

- 64% increase in overdose deaths from 2015 to 2017
- 2017 Fentanyl related overdose deaths totaled 3,629
- SSP clients are 5x more likely to enter treatment
- HIV can survive in a used needle for up to 42 days
- The estimated lifetime cost of treating one person living with HIV is more than $400,000
- 1 in 3 PWID have Hepatitis
- Over 75% of users will use an unsterilized syringe

PWID - People who inject drugs

SYRINGE SERVICE PROGRAMS IN PENNSYLVANIA

A vital part of efforts to address the Opioid, HIV and Hepatitis C epidemic.

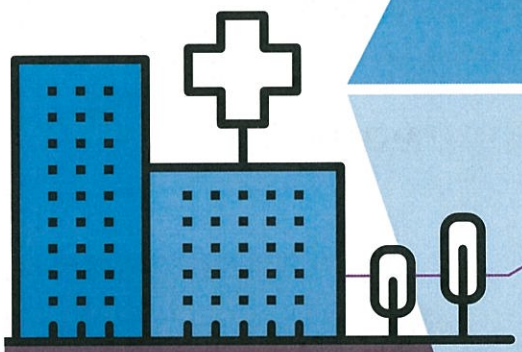
PAHRC
PENNSYLVANIA
HARM REDUCTION
COALITION

PENNSYLVANIA
HAS THE 3RD HIGHEST RATE
of drug overdose deaths in the USA.

We need to legalize SYRINGE SERVICE PROGRAMS

WHAT DOES IT COST?

NOTHING. According to the CDC, SSPs are proven to be a cost-saving preventive intervention, **SAVING** the healthcare system over **$400,000** for a lifetime of HIV medications, and **$80,000** for one course of the new Hepatitis C medications.



WHY IT MATTERS?

PA is ranked 10th in the US for new HIV cases.

In PA, HCV incidence increased 233% in the past 4 years, primarily by injection drug use.

Pennsylvania's 5456 overdose deaths ranks #1 in the nation, a 64% increase in overdose deaths from 2015 to 2017.

WHAT IS NEEDED:

To amend the Controlled Substance, Drug, Device and Cosmetic Act of 1972 to allow the distribution of sterile syringes.

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2018 REPORT TO ALLEGHENY COUNTY BOARD OF HEALTH

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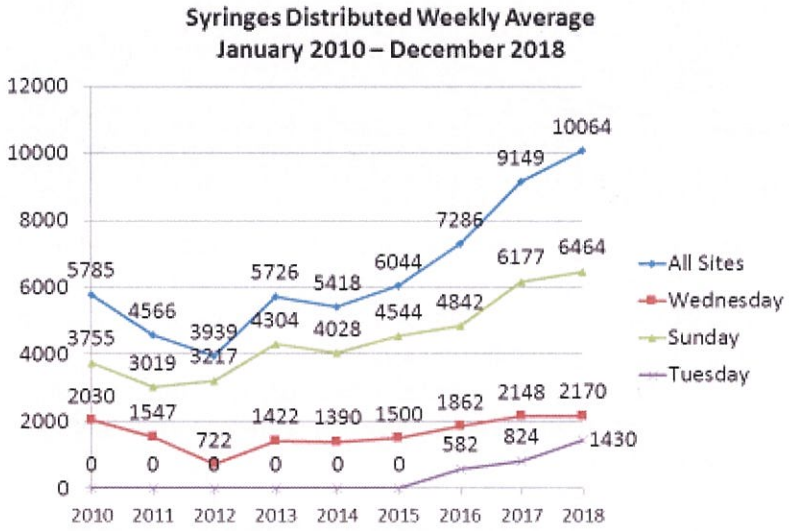
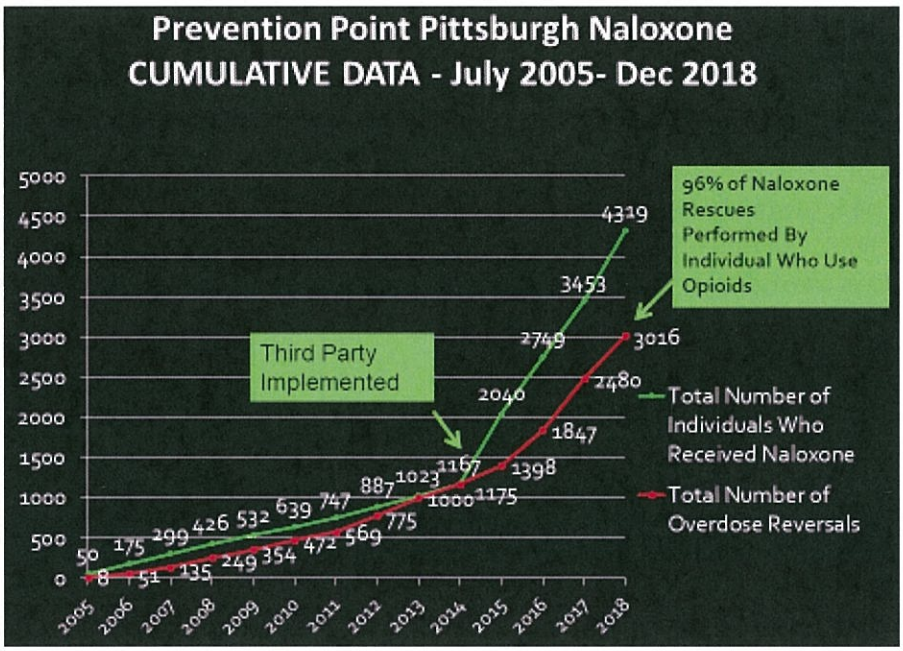
PPP has been the sole provider of legal syringe access services in Western Pennsylvania for 22 years and is the largest provider of community-based overdose prevention education and training and free naloxone distribution services in Western PA. Additional services include: health promotion and risk reduction counseling, provision of safer sex materials and other sterile injection equipment to reduce the risk of infectious disease transmission, case management including assistance getting into treatment and referrals to other services, safer sex and injection education, medical waste disposal, HIV/Hepatitis C/STD testing, and basic wound care.

Syringe Services:



- 523,340 syringes were distributed during 2,526 interactions
    - For comparison, PPP distributed 376,270 syringes in 2016 and 475,750 in 2017
- 2,067 unique individuals received syringe services during in-person encounters or via secondary distribution; 211 individuals participated in syringe services for the first time
- Demographics of syringe services participants:
    - Age - 3.5% 18-24, 22% 25-34, 31% 35-44, 17.5% 45-54, 21% 55-64, 5% 65+
    - Gender - 32% Female, 67% Male, 1% Transgender
    - Race – 16.5% Black, 83% White, .5% Asian
    - Ethnicity - .4% Latinx

Overdose Prevention Services:



- 2,019 naloxone kits (4,038 doses) were distributed; 534 overdose reversals were reported
    - 866 individuals received naloxone for the first time; 544 refills were provided
- For comparison, 698 people received naloxone from PPP for the first time and PPP distributed 3770 doses to new and returning individuals in 2017
- In October of 2017, PPP began piloting fentanyl test strip distribution at the Sunday site
    - Over the course of 2018, PPP expanded this project to offer fentanyl test strip distribution at all sites

Case Management & Referral Services: (Services Navigator positions was vacant for 7 months in 2018)

- 741 case management contacts were made with program participants
    - 599 risk reduction counseling sessions occurred
    - 69 individuals received help accessing substance use treatment
    - 73 individuals received referrals to basic needs, benefits, or other social services

Testing Services: (Some data loss due to change in tracking systems by testing manager at Allies)

- 29 unique individuals were tested and linked to confirmation and treatment services
    - 28 HIV tests – 1 reactive
    - 22 HCV tests – 3 reactive
    - 25 syphilis tests – 1 reactive