PENNSYLVANIA HOUSE

JUDICIARY COMMITTEE HEARING

HOUSE JUDICIARY COMMITTEE PUBLIC HEARING

ON HEROIN EPIDEMIC

GLEN MILLS SCHOOLS, GLEN MILLS, PENNSYLVANIA

Public hearing in the above captioned matter held at the Glen Mills Schools, 185 Glen Mills Road, Glen Mills, Pennsylvania, on Thursday, November 7, 2013, commencing at approximately 10:06 a.m., before Barbara McKeon Quinn, a Registered Merit Reporter and Notary Public, pursuant to notice.

BEFORE:

RONALD MARSICO, MAJORITY CHAIRMAN
REPRESENTATIVE JOSEPH HACKETT
REPRESENTATIVE SHERYL M. DELOZIER
REPRESENTATIVE MARK KELLER
REPRESENTATIVE MICHAEL REGAN
REPRESENTATIVE DOM COSTA
REPRESENTATIVE TOM KILLION
REPRESENTATIVE TODD STEPHENS
REPRESENTATIVE BECKY CORBIN
REPRESENTATIVE DUANE MILNE

INDEX OF SPEAKERS

CHAIRMAN MARSICO: I'm Ron Marsico, Chair of the House Judiciary Committee. I want to welcome everyone, welcome my colleagues.

I just wanted to give Dr. Randy Ireson a few minutes to give us a welcome.

Do you want to come up here, Doctor, and maybe grab the mike over this way? Or you can use mine, actually. Do you want to use this?

DR. RANDY IRESON: Good morning. I'd like to, on behalf of the Glen Mills School's Board of Managers, our faculty and all our staff, I'd like to welcome you to the Glen Mills Schools.

And if it's your first time here, I would like to just give you a little background on our school. We are the oldest existing school of our type, founded in 1826, who helps troubled youth.

We've been on this campus since 1889 and we welcome you to see our program. If you'd ever like to come back or you'd like today to see what we do, I think you're going to see there's something really special going here and we welcome the House Judiciary Committee and we hope you enjoy your day at Glen Mills.

Thank you.

CHAIRMAN MARSICO: Thank you, Doctor.

Representative Killion, I believe, has

joined us and here's a spot up here, Tom.

Once again, we thank you for your hospitality here at Glen Mills. This committee and this staff is a firm believer in what Glen Mills School is all about.

So we thank you and you do an exceptional job here and you have an exceptional staff.

So we're going to go ahead with the beginning of the hearing. Before we do that, I'm going to have each member introduce themselves, starting on my far left.

REPRESENTATIVE KELLER: Thank you, Mr. Chairman. I'm Representative Mark Keller. I represent the 86th District.

REPRESENTATIVE DELOZIER: Good morning everyone. My name is Sheryl Delozier, state representative for the 88th District and it's the Eastern portion of Cumberland County in Central Pennsylvania.

REPRESENTATIVE COSTA: Representative Dom Costa, City of Pittsburgh, Allegheny County, 21st District.

REPRESENTATIVE REGAN: Representative Mike Regan from the 92nd District, which is York and Cumberland Counties, and I am a proud staff alumni of the Glen Mills School.

REPRESENTATIVE CORBIN: Representative Becky Corbin. I represent the 155th District in Central Northern Chester County.

CHAIRMAN MARSICO: Making a grand entrance.

Anyway, to my far right is Representative Tom Killion who represents this part of Delaware County. So welcome, Representative Killion.

I'm going to turn the program over to Representative Joe Hackett who represents parts of Delaware County, the 161st District, who's actually going to chair the hearing today.

So, once again, I just want to say thanks everyone for being here and the hospitality at Glen Mills.

Representative Hackett.

REPRESENTATIVE HACKETT: Thank you, Mr. Chairman, and on behalf of all the residents and the concerned parties here today, I'd like to welcome you to Tom Killion's district.

Tom, thank you very much. A big thank you to Glen Mills, a great success in the community.

Today we have a great many highly intelligent, well-qualified testifiers that we're looking forward to hearing their testimony here today.

The Judiciary has been very active over the period of this session in trying to combat or to get some type of control on this well-known epidemic, not only in this county, not in even Southeastern Pennsylvania, but the entire Commonwealth of Pennsylvania and no doubt these United States of America.

Again, I thank you for attending. I'm looking forward to some great dialogue. Let's face it, folks, there's no doubt that heroin addiction is an epidemic here in this Commonwealth.

It is a difficult, difficult problem that law enforcement has to deal with. The situation is very bad in many counties throughout the Commonwealth where tasks force have been established in an effort to combat this problem. This heroin addiction problem has led to burglaries, robberies and even very close to home deaths.

I look forward today to gaining a wealth of information, but I look forward today to working with the Chairman from Judiciary and the committee in doing our job, which is what we do, and that is to make the laws and create legislation that will help the situation and this epidemic going on in the Commonwealth of Pennsylvania.

So, thank you, Mr. Chairman.

I think first up would be Jon Duecker,

please, from the Bureau of Narcotics Investigation from our Pennsylvania Attorney General's Office.

Go ahead, Jon.

JON DUECKER: Thank you.

Good morning, Representative Hackett, Chairman Marsico, and members of the committee.

On behalf of Attorney General Kane, I thank you very much for allowing us to come here and discuss this, what we believe as an office to be the number one narcotics threat in Pennsylvania.

My formal written testimony has been submitted for the record, and what I'd like to do, instead of reading something or testifying formally, I want to go through a PowerPoint that we created in the office that we share with other constituents as well, but it's meant to elicit questions as we go through both in terms of, you know, what heroin is and why we view this as the number one threat in Pennsylvania, which is not unique to Pennsylvania.

I would argue that it's probably the number one threat nationwide right now. And along with heroin is the prescription pill issue that I'm sure we'll get into.

The first cell of slides here are not meant to offend anybody in terms of their simplicity.

I'm sure that most of the folks here understand kind of what heroin is and where it came from and why we view this as a particularly egregious threat.

The bottom line, though, is that from a sociological standpoint what we believe -- why we believe heroin to be the threat it is, is, especially with the youth and a new demographic that we'll get into shortly, it's because of the pharmacological effects that it has on the youth now.

Maybe ten, 20, 30 years ago it was a cocaine threat, but for the first time ever heroin has eclipsed cocaine statewide and to some degree nationwide as the drug of choice, which is probably the third or fourth major epidemic that we've had in the United States.

I'm not going to read through these slides. These are just meant to, as I said, elicit questions as we go forward. Some of this is more of a pharmacological background.

There are three main producers of heroin worldwide, Southeast Asia, Southwest Asia and the Mexico/South America.

Historically, the Golden Triangle of Burma, now Myanmar, Laos and Thailand through China was the historical source of opium and heroin probably 75

years or so ago.

That's been eclipsed now. In terms of worldwide production, Afghanistan is still the number one producer in gross tonnage. For our purposes though, for the purposes of the threat to Pennsylvania and the United States generally, the heroin is now coming from -- it's being produced in Mexico, and much of it is still being produced in South America, but predominantly it's Mexican heroin.

What most people don't realize is that heroin was actually bought by the United States from Mexico around the turn of the century as a narcotic analgesic.

And, Members, if there's any questions a as we go through this, I'm more than happy to stop and address something as you see fit.

This is what it looks like on the street. Oftentimes you can tell where the heroin comes from by what it looks like. For example, the black tar heroin is obviously a Mexican product. It's been historically their type of heroin. It's not very pure. It's usually smokeable. It can be injectable.

From the black tar, you go to the brown heroin. Most of the heroin that you find coming out of Afghanistan through Pakistan through the Middle East is

brownish in color. It's not as refined as the heroin that we find now coming from both China or through China from the Golden Triangle.

But now we're finding that the heroin that we're getting from Mexico especially is extremely pure. And I'm going to address this in a slide or two, but Philadelphia has been known historically as having the cheapest, purest heroin and the most widely available heroin historically anyway.

But as the Mexican cartels continue to push bulk quantities of heroin into Pennsylvania and Philadelphia, we're seeing that trend increase significantly.

This is what heroin looks like as it comes across the border. What we're seeing in Pennsylvania is bulk heroin that we haven't seen before.

Oftentimes heroin, just like cocaine and other drugs, are cut with adulterants so that, if a kilo of heroin comes in pure and raw in bulk form, it can be cut several times over to make two or three kilos to increase the profit.

By cutting it, however, it also decreases the purity. What we're finding in Pennsylvania and, again, nationwide is that the purity on the street is extremely high, and that's another intelligence

indication that we're getting bulk quantities of heroin, where in the past we may not have been getting such high quantities.

The other thing that we're seeing statewide is our agents are coming across bulk quantities of heroin in the rural areas.

There was an article this morning in the Philadelphia Inquirer about prescription pill abuse and heroin. And one of the points it made was that the trends we're seeing in the user demographic is actually going out into the rural areas.

That's the same for heroin as it is for prescription pills, and we'll get into why those two are connected.

CHAIRMAN MARSICO: What's the street value of one of those packets?

JON DUECKER: It depends on where you find it. The street value for a kilo of heroin in Philadelphia could be under -- it could be anywhere from about $70,000 to $100,000. That same kilo up in Erie might be twice that much.

It all depends on where it's coming in. I indicated in the formal written testimony that Philadelphia's considered both a destination and a source for the heroin.

What I mean by that is, Philadelphia is known throughout the mid-Atlantic and upper east coast, and the whole east coast for that matter, as a place to come and get and use heroin because it's so widely available and so pure and it's so cheap.

So you're going to find a lot of the heroin that comes into Philadelphia being used in Philadelphia and that drives the price down.

When you get up to Erie, when you get up to Scranton, when you get up to Pittsburgh to some degree, depending on how that heroin's coming into those cities or those areas, the price is going to go up just because of the typical, you know, market driven forces of trying to get it into those areas.

But, generally speaking, in Pennsylvania it can go anywhere from 175,000 a kilo, which is very, very cheap, up to close to $200,000, depending on where it originated, if it was South America or Mexican, how pure it is, how many times it's been cut, and so on and so forth.

REPRESENTATIVE HACKETT: Let's continue that question with the cut.

What chemical are you finding out, or if not chemical, what other product are you finding out that they're using for the cut?

JON DUECKER: Well, there's a couple different ways to cut it or step on it. What we see typically statewide is that it's cut with something that's not going to affect the user.

They don't want it to -- the typical dealer does not want to affect the user adversely, because then his user goes away, whether it's through sickness or death or whatever, overdose.

So when you hear of the horror stories of heroin being cut with things like rat poison or some other adulterants that are actually going to poison the user, that's either a mistake or it's something nefarious that is outside the typical trafficking mentality.

What we typically see it being cut with is benign things like baby formula or, you know, some other white powder substances that are not going to harm the user.

What we have been seeing also to increase its effectiveness, if it's been cut on so many times that the purity is actually somewhat lower than the users are used to, they'll cut it with fentanyl.

The problem with that, though, is that the user doesn't know that fentanyl is in it, and you can actually overdose from fentanyl as well. Fentanyl is an analgesic that's used in hospitals and it's one of the

few drugs that's actually measured in micrograms as opposed to milligrams. So it's a very powerful drug.

So when they cut it with fentanyl, they're actually -- they're putting the user at risk. So a lot of the times that you see heroin overdoses throughout the state, it's because they may have cut it too much with fentanyl.

This is a picture, and this is typical, this is a picture of a body carrier that actually came in with pellets ingested.

Recently we had a case where one of our interdiction officers down in Philadelphia came across a body carrier that had -- a female from Mexico -- that had 65 or 69 of these pellets, and each one of these pellets is about 100 or 130 or so grams. This particular smuggler had close to 100 in her system.

The problem with -- for the smuggler, though, is that, as they are smuggling, once they ingest these pellets of heroin, they have a very short time frame to get it to the market, because one of those can rupture inside and kill the person almost instantly, or the person will start to pass them, which puts that person at risk to law enforcement.

These are the same pellets that were taken out of that person that had the x-rays done.

From a cultural standpoint or a trade craft standpoint, swallowers are not -- usually not willing participants in the trafficking. They're usually extorted into doing this somewhere down in Mexico or Colombia or wherever else.

And once they decide to do this, they actually have to practice swallowing, because this is not -- this is an art; it's not a science. These people have to practice for months on end sometimes to get used to swallowing such large quantities.

And, of course, once they swallow the last one, they have a short time frame to get it to market. And one of the ways that we can detect this coming into the country is just by virtue of their, you know, what they display in terms of being nervous and scared to -- scared of law enforcement and scared of the medical effects of having one of these rupture inside.

This is how it's sold on the street. The stamping of heroin is not new. It's been -- it's been around for a long time. The reason why stamps came out was, as a typical street corner in Philadelphia would sell heroin, you may have the four corners of the street selling four different brands.

And the way for the heroin user to know, to remember which brand was either very good, you know,

encouraging him or her to go back to that brand, or not so good, encouraging him or her to go to some other brand, is by branding it.

So you can see -- right now we have our intelligence structure and the office is actually compiling a database of stamps statewide. These are -- these are just typical stamps.

What you see, though, on the bottom left is, those are what they call bundles. A bundle is ten stamped bags and then they turn -- they have ten bundles that turn it into a brick or a rack and that's how they sell it on the street.

Each one of these is probably about .02 grams of heroin. It's a single use amount of heroin.

There's some belief that the name of the stamp is actually also an indication of how powerful or how pure the heroin is.

So if you have something that says pure suicide or, you know, mega death, or something that gets the user to think that this is really strong stuff -- at the end of the day, most users want as pure heroin that's not going to kill them as possible.

And, again, the trafficker, the street dealer, is not going to sell -- not wittingly and not knowingly -- sell heroin that's going to kill, through an

overdose, kill a typical user.

These are the three ways of taking heroin. What's interesting is that in the past the injection method, which is still the best method from a user standpoint, the injection method was not just the preferred, it was really the only way of doing it.

Now because heroin is so pure, you can smoke it and snort it. Usually what we see statewide, though, from a user perspective is that they will start out snorting it, then smoking it, then injecting it.

This is a fairly busy slide. The bottom line is that the overdoses that we see generally with heroin is because the heroin is so pure and the user has not acquired a suitable or an adequate level of tolerance to it. And as we see the pure heroin coming in from Mexico, we're seeing a lot more overdoses.

Another overdose issue that we have is, as a kid or young adult starts out with prescription pills, that person is not considered and is -- and from a physiological standpoint -- is not adequately tolerant to heroin.

But when they go from prescription pills to heroin, they're going -- they're kicking it up so fast in terms of the opioid effect, that that's why we see a lot of overdoses in young adults.

Again, this is another busy slide. The bottom line is that heroin is both physically and psychologically addictive. It doesn't take many uses of heroin to become physically addictive.

And what you'll see a lot and what this article in the Inquirer this morning addressed was, once a user becomes physically addictive, oftentimes they'll take heroin just to stay well or just to keep from getting sick.

The physical withdrawals of a heroin user is something that they will continue to use heroin for years on end just to avoid.

Again, we used to use heroin in the United States around the turn of the century as a legal painkiller. It went to heroin from morphine because they thought that heroin was actually less addictive and it didn't take very long to determine that that was not the case. Heroin is far more addictive.

This is in Southwest Asia and Afghanistan. Believe it or not, one of the things that was off limits when we went into Afghanistan back in 2001 after the terrorist attacks in New York City and Washington, DC, that the defense department had a policy of not -- not going after targeting the opium fields.

And the reason why was because we relied

on a lot of the drug lords for intelligence and for support against the Taliban.

But every year since 2001, it's been a bumper year and has increased production from the year before. And there's no reason to believe that, once we withdrew completely the military withdrawals from Afghanistan, that we're not going to see that trend continue.

Now, the good news for the United States is that we don't use -- for the most part, we don't use Southwest Asian heroin. That market is predominantly Europe. And if it does come into the United States, it's usually coming through the United States on its way to Canada.

The unfortunate news for Philadelphia is that Philadelphia is one of the port systems that we believe is actually a major importation point for point of entry for this type of heroin in North America.

What they do is they -- they grow these poppies, they slice the poppies open, it oozes kind of an opium tar. They scoop the tar off and then they produce it.

From Afghanistan, these are the typical trafficking routes. Afghanistan produces far more heroin than any of the three that I mentioned in terms of gross

tonnage.

The reason why we don't see it in the United States is because historically the United States is what they refer to as a high-end consumer, and, because this heroin is really not very good in terms of quality, it cannot compete against the Mexican and the Colombian heroin.

The other trend that we've seen nationwide is that we don't see anywhere near as much Chinese or Golden Triangle heroin. Probably ten, 15 years ago that was a big deal and it's no longer a big deal because the Mexican cartels have taken that market over.

And this is -- this is a Mexican gentleman that's doing whatever he has to do to cultivate it as well.

This is a slide about the trafficking networks that actually come into the United States. This slide is probably two or three years old. It's an official slide from the U.S. Department of Justice.

The reason why I have it up here and what we'll get into shortly is the impact or the influence that the Mexican cartels have in Pennsylvania.

There are some out there in Pennsylvania, both in terms of law enforcement and others, that don't believe that the Mexican cartels are present in

Pennsylvania or have the influence to the degree to which they actually do, and we'll get into why we believe that's not the case.

The two primary cartels that we believe are actually in Pennsylvania is the Sinaloa cartel, which is the largest in Mexico, and the Gulf cartel, which is the most brutal in terms of its methodology to keep other cartels out of its trafficking networks.

This statement, the first statement that they're the most pervasive organized crime threat to the United States is actually a Department of Justice assessment. And we share that.

The single greatest threat to Pennsylvania in terms of drug threat is heroin, and the single greatest trafficking threat is the Mexican cartels.

In terms of overall use of heroin is not used by quite as many people as cocaine, but in terms of trending, like I said earlier, heroin has overtaken cocaine as the drug of choice throughout Pennsylvania.

I just wanted to also mention, when you get down to the oxycodone/hydrocodone threat, oxycodone and OxyContin are the Percocets of the world. It's a stronger narcotic analgesic than hydrocodone, which is Vicodin.

The FDA just recently looked at selling

Vicodin going from 10 milligram maximum to 80 milligram maximum. So the FDA is actually, to some degree, working in opposite to our efforts to clamp down on prescription pill abuse by making what I would view as the single greatest abused opioid and that's Vicodin. That's hydrocodone, which is a Class III or a Schedule III drug. They're making it actually more available in higher doses.

This is a slide that I used to indicate that it's not just my personal assessment, it's not the attorney general's assessment. This is a collective assessment based on the intelligence that I've seen on the classified side, as well as the case work that we see on the special agent side out in the field, that the cartels are here, they've been here for a while, and it's not unreasonable to assume or to state that if we see -- if we see heroin coming from Mexico, it's Mexican cartel heroin.

Now, what we may not see is the cartel members themselves selling it or trafficking it on the streets. What we do see is the cartels actually taking the money back to Mexico, which could be anywhere from several tens of billions to over $100 billion a year.

What we haven't seen yet and we're waiting for -- and when I say we, we're talking about the

northern tier states of the United States -- we haven't seen a spillover of violence from the Mexican cartel, what they refer to as the cartel war down in Mexico.

So far in the last ten years, I think over 100,000 people have been killed just between the cartels and between the cartels and law enforcement.

We haven't seen that threat of violence to that degree in the United States, but what law enforcement is waiting for is some spillover, whether it's just inside the border, southwest border of the United States, or as far north as Chicago, or Philadelphia, or New York City.

We're waiting for that to happen or at least we're looking for signs that it might be happening.

The cartels, the Mexican cartels, have done a very good job at squeezing out their competition. But they've done so less with violence or threat of violence and more so with just a very solid business model.

The reason why law enforcement does not see, typically see the cartels or the Mexicans operating at the street level is because the cartels themselves have figured out a way of using our organic trafficking networks that have been used forever.

So the typical law enforcement is going to

encounter the same people that they saw dealing drugs from the Colombians in past and they're not going to see a change in the demographic and who's trafficking.

But we know that they're out there and we know that the cartels are not as risk averse -- or they're much more risk averse when it comes to getting the money from Pennsylvania back to Mexico.

So they're not going to -- they're not going to contract out getting their money back. They're going to come in and get it themselves.

Getting to the money though is our chief focus and it's also the biggest impediment to getting at these guys right now.

These are cases -- and I think I'm going to finish with this. In the back of your packet, there are some details of these cases.

These cases, if you'll see, go back before we actually -- before General Kane actually was elected and came into office. But these are cases that specifically refer from the attorney general's office back to the Mexicans and back to the cartels.

If you look to -- in your packet, if you look to Broken Doll, Operation Broken Doll. One of the ways that we found out that this was actually a cartel-driven issue, aside from the fact that these dolls were

being imported from Mexico, was one of the targets of the investigation actually got out of Pennsylvania, got back to California, and got back into Mexico before we could stop her and she was executed within a week.

So that's another real good intelligence indication that there is some risk to this game when you're talk about the cartels.

I'm just going to hit very briefly on the prescription pills. I'm sure we're going to get into this.

Our view is that the prescription pills, that the abuse of prescription pills for the first time ever is actually filling the space between something like alcohol and marijuana and heroin.

For a long time there's been a debate about whether marijuana was a gateway drug to harder narcotic drugs like heroin or cocaine, and that's debatable.

But what I think is quickly becoming not so debatable is that the true gateway from alcohol to marijuana to heroin is probably the prescription pills.

One of the problems that we're seeing, though, is that kids are going very quickly from prescription pills because it's a very -- it's a very expensive habit to maintain.

But they're doing so so quickly that they're not capable, their systems are not capable of handling that kind of high when they go to heroin.

From a policy standpoint, what we're trying to do is we're trying to go after the industries that allow the abuse of these drugs in the first place.

And through General Kane's leadership, what we're trying to do is we're trying to figure out a way of getting the industries on board to help us identify ways that they can -- that they can on the front end help us target this kind of abuse.

An example of that is when Purdue changed their OxyContin formula to make it less abusable through smoking or crushing and snorting.

The problem with that though is when you talk -- that drug is still considered a -- it's not generic yet, so they still have the ability to do that exclusively.

When you talk about Vicodin, though, which is hydrocodone, that's a generic drug now and you can get -- you're usually prescribed a pill. And if you have any kind of prescription pill coverage with your insurance company, you can get 60 of them for about two dollars. And then that pill is then sold on the street for, you know, it's usually a dollar a milligram.

With that, I can finish up and answer questions as you have them.

REPRESENTATIVE HACKETT: Any questions?

Representative Regan.

REPRESENTATIVE REGAN: Hello, sir. Thank you for being here; I appreciate it.

I'm a former law enforcement officer and one of the things that I noticed throughout the years was a reluctance of law enforcement agencies to work together to try to combat a bigger problem.

We might have had the attorney general's office doing their drug investigations, alongside of DEA, who was doing their own separate investigations, alongside of the state police who were doing their own separate investigations, and the small county drug task forces that all existed were doing their own separate investigations.

I've often thought that how much more effective it would be if we all worked together for a common goal. And I'm going back a few years.

But I wanted to ask you, what are you doing in the attorney general's office to coordinate efforts with all the other entities to combat this very serious problem?

JON DUECKER: That's a good question. I

get asked that all the time. I get asked that by other law enforcement agencies as well, you know, how are you going to be different than your predecessors were.

General Kane and I both have a luxury in that respect in that we don't have a legacy with the agency. So what we've been trying to do since January is start from square one with a lot of the agencies that either we had strained relationships with, no relationships with or good relationships with. We're trying to make them better or create them as we go forward.

My background before I came into the office is as much as intelligence as it is law enforcement. So I'm looking at it from the standpoint that we're only as good collectively as the information that we get from each of the agencies.

The state attorney general's office and our agents have a very narrow authority and very narrow perspective in this particular -- combating this particular threat. So we understand that we can't really go beyond the borders of the state jurisdictionally.

What we're trying to do, though, is go beyond the state strategically and work with our southwest border partners, our -- you know, the attorney general's office down in Arizona, the attorney general's

office in Texas. We're building relationships with DEA here in Pennsylvania.

So far -- and my approach and Attorney General Kane's approach is, it doesn't matter who gets credit for what cases, we're more interested now in going after organizations. We can knock off the street dealers all day long and by tomorrow they're going to go back.

What we're trying to do is we're trying to take a strategic approach based on intelligence, based on what the real threat is, based on the trends that we see, both at the local level as well as the federal level, and we're trying to work cooperatively.

And it's not just DEA, it's not just the FBI, it's the Homeland Security investigations capability which has a whole range of areas that our attorney general's office looks at in terms of criminal jurisdiction.

But we're working with them as well because there's nothing that happens in Pennsylvania that's not happening in the region, and there's nothing happening in Pennsylvania that's not happening nationwide. So we're trying to bring all of these different partners in.

I worked for the DEA for a while as a special agent so I understand what their perspective is,

I understand what their strategies are, I understand what their focus is.

And it helps to some degree understanding, you know, what their mandate is from their own leadership to work with them, because I don't see our mandate is competing with anybody else's. In fact, we're all consistently working towards the same goal so.

We just had a case in Philadelphia that is a great example of that. I can't get into the specifics because it's still ongoing, but it was a joint case with DEA that actually went to Mexico in terms of the organizational structure, and it was a very, very success -- it's a case model in my view of how we're going to do things forward statewide.

REPRESENTATIVE REGAN: I appreciate that information. I think it's encouraging to know that you're reaching out. Because I think, you know, many times that's all it takes, is just reach out.

And I think that Ronald Reagan said that you get more things accomplished if no one cares about who gets the credit. So I'm hopeful that you will do that and that General Kane will take those steps to reach out to those other agencies to fight this problem.

I do have just one more followup, Mr. Chairman, if you don't mind.

And that is, during my time, I remember a case specifically where we had a small town in Pennsylvania that heroin dealers from Philadelphia came into that town, they set up shop and they initially started out by just giving heroin away to kids.

I think ultimately the DEA indicted I think 70 people in this case in a very small town. I think 30 kids from a high school that had a population of like 80 were charged in this thing.

So these cases -- in this town specifically, there was a very small police department. I think maybe two guys that were police officers.

And these, you know, drug dealers, obviously they're smart and they come in, they take advantage, they can sell their product for a much higher price.

But two drug dealers came into the small town of Pennsylvania and basically decimated a town. 70 people indicted, 30 high school kids who were addicted to heroin.

I'm wondering from an undercover -- I mean, I know there's only so much you can divulge, but are you trying -- are you in and working with these local departments trying to get them to share the information of what's going on in the town with you so you can nip

this thing in the bud, these things in the bud before they get to that, get that big that they're so difficult to stop?

JON DUECKER: I have a couple comments.

The first one is, absolutely. One of the things that we're trying to do is we're trying to look at the state comprehensively as an enterprise in terms of the threat. So by doing that we're going out to each of these communities.

Pennsylvania is unique in that respect, you know, unique vis-a-vis other states because it's a Commonwealth, we're very fractious in terms of the political subdivisions, we're very fractious in terms of law enforcement.

The state police owns quite a bit of the land mass in terms of jurisdiction, but, you know, when the sun goes down, there's gaps statewide.

We're trying to work with local law enforcement. Nothing happens in a small town like that in a vacuum however. So if you're talking about a Pottstown, or any other small town like that, they're getting -- as you indicated, they're getting heroin from Philadelphia.

What we're trying to do is we're trying to not just inform the local law enforcement, not just help

them out in terms of, you know, a case work; we're trying to also integrate that small department with our DNI agents in Philadelphia so that they can start making connections as a matter of course.

So that instead of -- instead of us going into that small town when they have an issue, that small town can reach out and talk to our regional director or our special agents in whatever region they happen to be in to share information and try to set up a system where it's not just what they're seeing, not just what they're combating in that small town, but trying to knock off the traffickers getting the product into that small town.

That's the first thing.

The second thing is, from a school standpoint, high schools in the state of Pennsylvania, we have 501 school districts statewide. They're very, very, very difficult to get into. Very difficult to get into.

And whether it's an academic culture or it's a, you know, it's the schools protecting their students -- I would argue that in this case they're really not protecting the students -- there is a significantly, shockingly high degree of a use and abuse of heroin, of prescription pills and other things in schools, acid, molly, which is MDMA, and the problem is is that we don't have a robust reporting mechanism.

We don't have anything that's required for the schools to report to us anything, and I think that we should look into that. It's very tough for us to get into the schools.

What I'm trying to do as a matter of informing the general on the actual threat is, I'm trying to set up a statewide system of high school student focus groups that they can inform us how to get into, culturally and socially, how to get into student groups and identify the real threat inside the schools so that we can better educate them on what the threat is, we can target certain aspects of the culture and not necessarily violate the school's responsibility to protect them during the school day.

So, as I said, though, we have a lot of schools, we have a lot of school systems, we have a lot of competing interests. I would argue, though, that with the opioid threat and the heroin threat that's bearing down on the State of Pennsylvania, that's one area that we really have to address.

REPRESENTATIVE REGAN: Thank you very much. Thank you for being here.

Thank you, Mr. Chair.

REPRESENTATIVE HACKETT: Thank you, Representative.

Representative Delozier.

REPRESENTATIVE DELOZIER: Thank you very much.

I just have a question along the lines that you were just talking about with the schools, and that was where my thoughts were going in the sense that obviously administrators are not police officers, they're not law enforcement, and the addition -- and you have very specialized units that understand exactly what you went through and all of where we're getting all of these drugs.

The outreach, I guess, and education process, is there something that could be done that we could help with getting that education out there to educate our administrators?

They know there's a drug problem if there is one. But giving them some backup to say, Well, look this is the path you need to take, this is how you can report it, this is where you need to go.

I know many schools may not want to admit they have a problem. Getting over that hurdle might be a first part of it.

But I think the safety of the children and trying to keep them off drugs and we've had all of these campaigns talking about keeping children off drugs. But

it's gotten very tricky and nobody wants to talk about it.

And I guess my question is really based on the fact of how much more education can we put out there, useful education rather than just a campaign with a slogan that sounds good, to educate our administrators to really bring that message home, how dangerous it is, as well as give them some backup to be able to report what they see without a stigma of what's in their schools.

JON DUECKER: I understand. I accept the fact that there's competing interests in terms of protecting the students against drug abuse and maintaining the reputation of a given school. Especially at a high school level where a lot of the local high schools are trying to compete to get their students into Columbia, Penn, you know, wherever else.

And those are almost mutually exclusive to some degree.

I have a high school student myself. I have a grade school student and I have two that have graduated from high school, and I can tell you that I learned more from them around the dinner table in terms of what's going on in high school than I'm going to get from a principal at a high school, unfortunately.

In fact, what I get from the principal,

generally it's not -- it's not just that high school, it's the high schools I talk to -- there is no problem, we have it under control, and that cannot be further from the truth.

I reached out to a local high school recently to, as I said, to start this dialogue in terms of trying to get together a focus group of students first because I wanted to talk to the students and have them tell -- I don't want to talk at them or even really talk to them outside of educating them on the threat.

I want them to tell me how best to combat the threat in the schools that they go to. Most students just want to be -- they want to be away from the stuff for the most part.

The challenge for us is social media, the challenge for us is not the message necessarily, but the way to get it to them. You know, kids nowadays communicate via text and they communicate via Facebook and they communicate to some degree Twitter.

So we have to come up with not just the message that's going to resonate with them, but the avenue to get the message to them, and that's a huge challenge for us. Because most of the agents that work for me, I'm kind of sorry to say, don't have Facebook or, you know, they don't use Twitter or they don't understand

texting to the degree that the kids do.

It's a huge challenge. I think that -- I think that the legislature could help us with the schools and I think that's it's going to be, at least in the short to midterm, it's going to be an uphill battle to get schools willing to talk to us.

I've talked to maybe a half a dozen to a dozen schools right now and I'm batting about 50/50 in terms of their willingness to talk to me about the true threat.

Now one of them, on the good side, one of them actually sent me some photos of something that he picked up in the school that day on how the kids were actually getting their drugs into school undetected.

So that's huge for us. That gives us a data point that we can then put together and we can inform other schools, we can inform local law enforcement.

Our agents don't typically go into schools. Our only contact with students maybe is when we do something from an enforcement standpoint outside of school.

We would love to just get anecdotal information from the school system or from the students themselves so that we can start to put these data points

together and figure out from the typical 15, 16, 17 year old perspective what the real threat is.

But schools are sanctuaries. You know, it's very hard to get into that sanctuary in terms of trying to get information from the sanctuary leadership so...

REPRESENTATIVE HACKETT: Any other questions?

Representative Regan for followup.

REPRESENTATIVE REGAN: Has a tip line been examined?

JON DUECKER: We do have a tip line.

REPRESENTATIVE REGAN: In schools?

JON DUECKER: No. We have a tip line. There's tip lines that we've started to create for different functional areas. For example, diversion investigations. Diversion is where they take the prescription pills and divert them to illegitimate purposes.

So like for pharmacies or so on and so forth we have diversion tip lines. We have tip lines for other use like consumer production.

We have thought about a tip line for schools. We've thought about having an anonymous way to give us tips via the Internet or via social media as

well. So we are looking into that.

REPRESENTATIVE REGAN: It would be something that relates to school security, which is a hot topic right now. It could be implemented through the Office of Safe Schools, but it would be something I'd like to talk with you offline, if we could.

JON DUECKER: Absolutely. I can tell you that, just like when you talk about drugs in schools, you talk about security in schools, that's oil and water. A lot of the administrations don't even like to contemplate having somebody that looks like he's from law enforcement to be anywhere near the school.

REPRESENTATIVE REGAN: That's right.

JON DUECKER: I think that's somewhat an ignorant position, because most kids, they don't respect much in a lot of cases, the way I did when I was growing up, but what they do respect is they respect a show of force.

And a lot of them, a lot of students, and my kids included, actually respect that kind of overt indication that there are -- there's law enforcement that is actually looking for things or concerned enough to be there.

Again, it goes back -- not to be too hard on the administration, it's too hard oftentimes to

coordinate that kind of show of force in 501 school districts wide, you know.

REPRESENTATIVE REGAN: Yeah, right.

JON DUECKER: So we have to pick them off as we see them and deal with students.

What we hope to get is we hope to get enough of the administrations of major school systems on board with our approach that we somehow guilt other ones into cooperating as well, because there's a lot of peer pressure at that level of professionalism, too.

REPRESENTATIVE REGAN: You're so right. Okay. Thank you.

JON DUECKER: Thank you.

REPRESENTATIVE HACKETT: Thank you, Representative.

Jon, you brought up some great points. Thank you for attending here today. I, too, have a law enforcement background and worked under cover and purchased, sold narcotics and I know how big of a problem this is.

This has recently hit very close to home within the past six days. My good friend's son had overdosed and passed away.

Thank you for being so candid. I mean, it's not too often we get people appearing before

committees that are candid and are willing to step out and realize that there is an epidemic here.

We as legislators, though, look out to you to send us some suggestions how we can help to enact some laws that will basically drop the hammer in the face of an epidemic.

It's great being on a committee with my buddy Regan over here and also Costa, because of being past law enforcement, they ask all the questions before I can get to them, and I really appreciate that. And they were greatly answered, too.

So thank you, Jon. I appreciate it and we'll call up the next panel.

JON DUECKER: Thank you.

REPRESENTATIVE HACKETT: Looks like next up is Kenneth Martz, Director of Treatment, Prevention and Intervention for Pennsylvania Department of Drug and Alcohol Programs and Cheryl Dondero, Deputy Secretary, Pennsylvania Department of Drug and Alcohol.

Welcome.

Did you flip a coin who's going to go first?

CHERYL DONDERO: I think I will. Thank you.

REPRESENTATIVE HACKETT: Okay.

CHERYL DONDERO: Thank you.

Thank you, Chairman Marsico, and members of the committee, for convening this public forum to address this critical, much-needed information sharing on the epidemic of heroin and related drug and alcohol addictions.

I'm Cheryl Dondero. I'm the fairly new, about three months, Deputy Secretary for the new Department of Drug and Alcohol Programs. I'm a career state employee.

I'm also a recovering drug addict and alcoholic, about 23 years. So I grew up in the '70s and all that came with that. I inherited my disease from my grandfather and my father and passed it on to my son.

The Department of Drug and Alcohol programs, and I think for ease of acronyms I'll refer to it as DDAP throughout my testimony, it was created through legislation Act 50 on July 1st of 2012 to bring the drug and alcohol treatment, addiction and related issues to the forefront of state government by recognizing it as a cabinet level agency under the governor.

It was prior a bureau under the Department of Health. So bringing it to the level of the cabinet level agency validates the governor's commitment to this

issue.

As you talk about this -- and I mentioned my son. I have two boys, a 21-year-old professional musician who travels the world and the country under the genre of EDM, electronic dance music, known to be one of the primary places that heroin designer drugs are at the forefront of just that group of kids gathering.

I also have a senior in Cedar Cliff High School and just yesterday there was a lock-down drug sweep, dogs, everything that you can imagine.

My oldest son, when I found out that he had a drug problem -- and even with everything that I knew and my history, I was shocked.

He was the, you know, the head of the church youth group, he played in the church band and he had me completely snowed and got pulled on a random drug screen at the high school due to one of his extracurricular activities.

And with everything that I knew, all the contacts that I have in state government and in the treatment community, the difficulty that I had to find him treatment just astounded me.

And I thought, if I'm having this much trouble, how does the average mother, father, friend, navigate this world of managed care and health insurance

and treatment community to find treatment for their loved ones.

I'm going to be turning this over to Ken Martz as we go along and we're going to kind of play back and forth, but I just want to thank you for this forum and we look forward to talking to you about many of the things that the department is doing to both combat the heroin epidemic and then to make treatment accessible for those who need it.

So with that, I'll turn it over to Dr. Ken Martz, who is our go-to clinical expert in the department.

DR. KENNETH J. MARTZ: Good morning, everyone. Thank you for the opportunity to speak on this matter. It's very invaluable.

It is an issue that is close to my heart as well. I am also a licensed psychologist. I've been working in the addictions field, primarily in the treatment side, for over 15 years, as well as cross addictions with gambling, mental health issues, et cetera.

So just for a word of background again for folks that may not be as -- have a background, what is drug and alcohol treatment and prevention?

It's a broad spectrum, just to be clear

about that. It starts with prevention, one of which is -- two are the two functions of my bureau.

One is prevention, taking a look at school kids particularly, getting them before they get addicted; teaching the things that I always sat around and saying, Why did I never learn these things in school?

You know, how do I deal with stress? How do I deal with what I'm struggling to do something other than going out and using drugs to escape?

So coping skills, how to -- refusal skills, how do I handle my friends trying to pressure me and do that peer pressure thing, some simple things like that that really can be very helpful in heading off the beginning of a substance abuse disorder.

Those that have gotten addicted can move very quickly into -- down that path. I was at a presentation yesterday with one of my colleagues and she had pictures with her that have permission from the families of their children who have died from this disease.

And the pictures are of young men and women that look like all the kids in our neighborhood that was just two months before they overdosed or suicided from this terrible disease.

So it is a hidden disease in some ways

still that we imagine we have a stigma of, Oh, it's that addict out in the corner that's homeless. And it's not. It starts somewhere much closer to home.

Nobody woke up one morning and said, You know what I'd like to be today when I grow up? I'd like to be an addict. You know, no one did that.

Folks started into this a little more slowly. These are our kids, our children, our family and our friends.

One in four folks, one in four families in the Commonwealth in the United States has someone who's in addiction in their family.

So this is also a life and death issue. One in four folks will die from this disease, so it's very serious.

Just a word or two on treatment. You know, you will hear some issues about medication can be of some assistance, but you need to also focus on the mental health issues, the behavioral health issues, how to deal with their depression, their anxiety, how to deal with all the issues of coping skills, their trauma issues, behavioral practice, et cetera.

So try and take a look at a whole person about how to engage this problem on the individual level, but we'll also talk a little bit now about what's going

in the state level and some of the interventions and recommendations as well.

DDAP believes that one of the things that's very important is that there needs to be a close collaboration with our department as well as law enforcement and we've been growing efforts in this manner over the years.

We have identified some national trends that have been relatively stable over the course of the past ten, 15 years, but one of the things that has been very unstable in the past 15 years has been prescription drug abuse and particularly opiates.

And so this is -- the prescription drug abuse goes hand in hand with this conversation about where are we at with the heroin tissue.

Ten years ago, prescription drug abuse was like .03 percent of the addiction drug of choice and now it has grown to be one of the top three. It's is now grown to be one of the top three causes of -- top cause of overdose deaths.

And so one of the things that happens is, these are the things that you keep hearing about, the Vicodin, the Percocet, the OxyContin, the fentanyl. And so folks start off with prescription drugs because it's more easily available to start.

There's an old commercial that was out about five years ago, it had a drug deal on the corner and said -- the drug dealer says, You know, you used to think it was me getting your kids hooked on drugs. If you think it's me, my business has been slow. Check your medicine cabinet.

So this is one of the issues that we're trying to take a look at is -- and that's part of our response as well, is the response to the prescription drug abuse.

Because we agree with what was said earlier this morning, it has become the gateway. So they start off in the prescription drugs, but then when's it's no longer available, they turn to what's cheaper and more readily available.

You don't need a doctor's prescription, you don't need to go through all those hoops, you can get it on the street and much more cheaply. And so heroin has been seeing a spike also because of this.

Very important to take a look at these issues.

We know that treatment is very effective. We know that treatment, if you do intervene and try to intervene, every dollar spent in treatment saves $7.00, because there's a lot of serious impact, not only for the

families but also for criminal justice.

And if we don't treat these folks, they're going to spiral down into crime and other issues to support their addiction.

We know that there's been a trend -- you can see in our testimony, Page 3. If you monitor the sentencing from Pennsylvania Sentencing Commission, there has, again, been a trend upwards for heroin.

There's been a trend also -- we've been seeing a trend, although we don't have complete data on that, in the last year or so of where there's again been a bit more of a spike.

We've been working closely since we've been in the department with the Pennsylvania Commission on Crime Control and Delinquency, Department of Education, trying to work closely with DOC, parole and probation, to intervene and close some of these gaps.

One of the things we need to be careful of is that we know that there are responses when there are changes to the system.

So, for example, when we intervene and stop the flow of heroin, when we stop the flow of prescription drugs, which we have again and in a few moments we'll be reviewing some of that, the approaches to deal with that, we need to be careful.

Because if I'm addicted and you cut off my supply, what am I going to do today? First off, I'm going to find another supplier or I'm going to end up at in treatment.

And at this point, one of the things we know is that nationally there are only enough beds -- there's only enough treatment available for ten percent of the folks who need it.

In Pennsylvania, we have much stronger insurance laws. We do a little better with the math. We treat about 13 percent, which is about 1 in 8 of the folks that need it.

So it's a long way to go and, again, we have some strategies that we're hoping will support with that as well.

So we need to be prepared, though, as we up our enforcement and our intervention with this issue that there will also be a spike, a brief spike, in the need for treatment to manage those that are -- that have their supplies cut off.

So we want to be prepared for a response for the full picture. And so some of the -- so we'll be taking a look at some of the things we can do to respond with prescription drug monitoring.

CHERYL DONDERO: Some of the exciting

issues that the department is working on, and I'll tell you, every day that I come to work and are able to impact and work on some of these things that I know at the end of the day save lives it's just an honor to be working for this department.

So there's -- one of the things that we're working on is coordinating with the legislature, the district attorney's association, the governor's office on what is soon to be passed, we hope, a version of prescription drug monitoring legislation.

Right now, it's pretty limited to law enforcement. So this legislation will create a system that all doctors, pharmacists, law enforcement will have access to.

So if someone shows up at a doctor's office and they're complaining of a sore shoulder and asking for a Vicodin prescription, that doctor will be able to look up that patient, see what other doctors they're seeing, what other drugs they're on, and determine if this might be a legitimate need for pain medication or someone who is doctor shopping.

It also hopefully will open the door for that doctor to start a discussion about family history, drug use, and hopefully one of the other issues we're really working on is expert screening, brief intervention

and referral to treatment.

Doctors are the key person; they see these people, they can talk to them about how much they're using, how much they're smoking, how much they're drinking, and make that initial assessment that maybe this person needs to be referred to more significant treatment.

I just saw an article that was in PennLive the other day that the United States is the user of 99 percent of the Vicodin worldwide and 80 percent of all other narcotics.

You know, if you think back to when you started going in the doctor's office and seeing those smiley faces, if you're happy, no pain, if you're frowning you have pain, and there was a real push that doctors were required to make sure that people are pain free.

And that's really, if you can think back, that's when this Vicodin, you know, the prescriptions -- I had shoulder surgery. In spite of me telling my doctor that I was a recovering addict and did not want to take narcotics, I got a prescription for 100 Vicodin with three refills.

I mean, this is -- when did it start that pain was not okay? I mean, if you get hurt, you have

pain. So this easy access to Vicodin, all different pain medications.

And if you have 100 Vicodin and you're susceptible to addiction through family history or some other way, at the end of that cycle, you're going to already have a start of some physical dependency to that, you know, and people who have that predisposition to it, that drug has a different effect on them.

It makes you feel something. It doesn't just take away your pain. You start to feel good, want more. If you don't take it, you feel like crap so of course you're going to say, Oh, I probably need another prescription.

So we're hopeful that this legislation will be passed in the next several months.

With that, as Ken mentioned, if suddenly people who have been doctor shopping and getting large numbers of prescriptions for narcotic pain medication and that access is cut off, where do they go?

They're either going to need treatment or they're going to go to something that's easily available, much cheaper, to heroin. So immediately we might see a big spike in the need for treatment when this legislation takes effect.

Another initiative we're really proud to

roll out, in December, the governor will be using a new drug take-back box that will be in the Capitol Police Barracks in the Capitol in Harrisburg as a launch of what is called the Drug Take-Back Box Initiative.

So the department in coordination with the Pennsylvania Commission of Crime and Delinquency, the D.A.'s association, the Department of Health, has secured funding for about a thousand of these take-box boxes.

They look like mailboxes. Pull the thing down, put your drugs in, in the containers, in the bags, whatever they are. It's the push to get these drugs out of mom and dad, grandma's medicine chest.

So many of our kids took their first drug, got their first high with one of those pills that they got out of the medicine chest. You know, my son's a senior in high school and he tells me about these pharm parties.

It's kids bring every drug they can find in the medicine chest, throw them in a bowl and you take a handful, and that's your kind of entrance into the party. Let's see what happens.

Again, so in addition to stopping what might be a regular access to these drugs, we're hoping that it stops that first-time use that so many kids are getting because they have access to prescription drugs

that are prescribed to somebody else.

The department is also starting, we're in about the third month, and this was started in response to the spring of this past year, spike in fentanyl-related heroin deaths that were documented in Pennsylvania.

So I'd be neglect if I didn't mention our secretary, Gary Tennis, who has got to be the most passionate, unwavering, doggedly persistent person in the state when it comes to the disease of addiction.

He comes from -- he's a lawyer, he was a district attorney, so he comes from the law enforcement, and is one of the -- what happened with him is he started to realize that the tough drug laws and the three strikes you're out was not doing anything. These people were just coming back.

So he started to see that if offenders were put into treatment, DUI offenders, nonviolent people who were convicted of nonviolent crimes and getting them into treatment, that that's what started to work.

So on behalf of him, I would just like to say that, you know, this issue -- any time the department is called to any event like this where we can educate, talk about the things we are doing, we are honored to do that.

In addition to the take-back boxes, we're working with a whole bunch of parties, from Geisinger pain clinics, to the various departments that have anything to do with physicians or pharmacies, Department of Health on prescriber training.

Doctors -- and I'll be the first to say that my addiction was able to continue for many years because doctors believed what I told them. Doctors didn't understand that I was seeing this doctor and that doctor and that doctor. So they're not aware.

Even when I on my own say, I can't take narcotics; what else can I take, doctors will tell me, If you really have pain, it's okay. They just don't understand.

On average doctors get maybe a day, couple hours of course work around addiction. I think there's one doctor training program in the state and it is in Pennsylvania, University of Penn -- correct, Ken?

DR. KENNETH J. MARTZ: That's right.

CHERYL DONDERO: -- that actually gives a course on addiction. Other than that, doctors don't necessarily understand unless they're a certified addiction doctor.

So the quickest way, if you go in to a doctor and you have pain, quickest way is that

prescription with multiple refills. Doctors are stressed; they don't have a lot of time; their funding has been cut; the reimbursement has been cut.

So one of the keys to fighting this disease and fighting this problem is educating our doctors about what addiction is, who's susceptible and how they play a critical role in not starting someone down that road and also intervening when appropriate.

I started to mention the Overdose Task Force that was created in response to the fentanyl overdose. So it's kind of morphed into an overdose response for any overdose spike or trend that is indicated in the state.

And we've got people from the Department of Health, we've got law enforcement, we've got the coroner, so that we can respond both through the department in terms of the addiction, making sure that there's communication between the treatment facilities in the department; law enforcement is safe.

Fentanyl, for instance, has a transdermal effect. So we're finding that our law enforcement who were responding to these fentanyl deaths were actually getting sick from handling the drug.

So there's a lot of aspects to that. The coroners are a big piece of that. Any time somebody dies

of an overdose, the department is notified. We get a full list of all the drug screens and we can start to identify trends.

With anything that's related to methadone, we refer to our Methadone Death and Incident Review Committee who looks at all methadone-related deaths where methadone is a contributing or primary factor with a goal to helping make methadone treatment safer and more effective.

We're starting to find that a lot more of the methadone deaths, and I would predict as we go forward and we're getting more regular reports, that most of the methadone-related deaths are from methadone prescribed by private doctors or pain clinics, not methadone treatment providers.

Let me see. I think I'll turn it over to Ken for a few more of the treatment-related initiatives that the department is embarking on.

DR. KENNETH J. MARTZ: Just I'll mention also regarding the FDA, there was also a news statement released just by the FDA, I believe it was last month or in September, taking a look at long-lasting opiate prescriptions.

And one of the things that they said was, taking a look at the issue of, particularly because it is

known that even when taken as prescribed, that there is a risk of misuse, abuse and addiction, that they wanted to change the requirements.

So they changed the labeling requirements on the long-acting opiates. Particularly that, that it would no longer be recommended for mild to moderate levels of pain.

So that it would still be maintained for severe pain so it would be available for those that are legitimately in severe pain. But for lower levels of pain, if there are alternatives that don't have that risk of addiction associated, that they should be used alternatively.

So this is being addressed from a number of different directions and being recognized particularly again as the spike has shifted.

And so that prescriber training issue, again, is key, because think about it. If only one medical school in the country even gives a required education in addiction, these are the folks that are coming in and prescribing these that don't know what some of the effects and potential risks.

So it's one of the things we're working very closely with trying to support and create an educational program that can be expanded out as well with

that.

Another key one of our roles is wherever we can find ways to do so and bring resources together. So, for example, there's a great opportunity in the past year from LifeSkills Training, which is out of the Blueprints folks which are the evidence-based practice experts out in Colorado.

What they did was they offered to come in, come into Pennsylvania, they would train our teachers in the LifeSkills curriculum. LifeSkills is an evidence-based program. It is excellent for prevention of drug and alcohol abuse, and tobacco as well.

So we reached out. We coordinated with the Pennsylvania Department of Education. Fifty schools signed up to get this free training at no cost to them. They can get the materials paid for, for the first three years I believe it is.

So, again, trying to reach out wherever we can to encourage education, treatment and appropriate practices, as well as the collaboration with law enforcement and other departments to stay ahead of the issues.

Another close collaboration we made with PCCD and PDE is with regards to the PAYS, the Pennsylvania Youth Survey. This is a survey that goes

out into our schools every two years and it has been -- up to this point, it had been a sampling.

And one of the issues with that is, again, there's a cost associated, a cost to get the reports, costs for the staff to come in and a administer.

So in close collaboration with our three departments, we have made additional funding available so that any school across the state that is willing to participate this year will be paid for. It will be available at no cost to them.

So that has been out there. We've been encouraging and supporting that as best as possible. We really need schools to participate, because one of the things it will tell us is how prevalent is the different drugs of choice and what are the trends going on in our schools.

The earlier we can intervene before these folks -- before these kids -- get addicted and go down that path, the easier it is to intervene and head them off before they have to go through ten, 20 years of struggling and suffering or struggling to death.

So another couple of issues, closing issues to begin to think about. We need to continue our current, some of these current initiatives. We've laid out a broad approach trying to reach a number of

different areas.

It's not a-one-size-fits-all, not a single magic pill to resolve this issue. So we need to look at it holistically and address across prevention, treatment, intervention, as well as enforcement.

I want to continue to take a look at coordination with doctors and physicians, psychologists and the mental health side as well, continuing these coordinations.

We know that the funding is certainly needed to develop the systems to respond to these spikes to the crossover addiction, and we expect that Pennsylvania will be able to achieve some reforms from the Medicaid program as outlined in Healthy PA.

So the state may be in a position to increase the access to quality affordable care for uninsured Pennsylvanians, which will help the coverage for drug and alcohol treatment, which is one of the key issues there.

So, again, we need to -- enforcement is important. We need to arrest it where it's at, but we need to be working closely in conjunction, which we are doing, with parole and probation and PCCD to get them the treatment that they need.

My prior work, I spent ten years running

behind the walls treatment programs in the State of Maryland. So that was a primary focus. We know that 80 percent of the folks that are in our prisons are there because of drug and alcohol.

We know that 50 percent of the folks going to central booking are there under the influence. So it's a very serious issue that we need to address and work closely with law enforcement, with parole and probation, and get them the treatment they need in addition to that.

Any other issues?

CHERYL DONDERO: I talked a little bit about the Commonwealth's move towards Healthy PA, which is Governor Corbett's response to the Medicaid expansion.

So ideally, there is a hope that every Pennsylvanian will have health insurance, either MA or private health insurance through that exchange.

So right now there's an act, it's Act 106, that if your doctor writes you a prescription for 30-days inpatient and 45 outpatient visits, managed care or your private medical insurance is required to honor that.

We know that that is not being done consistently across the state. We know that a lot of people don't even know about that benefit, that that is

available to people.

So one of the components of Act 50 that created the Department of Drug and Alcohol programs says that the department is authorized and required to direct all other Commonwealth agencies that have any policies, procedures that have a relation to drug and alcohol treatment, to direct them on to how those policies can better serve the citizens of Pennsylvania in regards to access to drug and alcohol treatment.

So, for instance, we coordinate a lot with DPW, Department of Public Welfare, all the time. We're trying to get a faster, easier process to get someone to apply for MA and to get that decision.

We're working with probation and parole about paroling people right into treatment. We're working a lot through our single county authorities, and that's where we get the block grant from the federal government that we, the department, disburses to 47 single county authorities.

So all 67 counties are covered, but some of them are what's called joinders, and they administer that money to contract with treatment providers to deliver treatment in their area.

We are working with the Department of Education. We've been talking a lot about schools. The

Department of Education is doing fabulous things in regards to students and assessing them and getting them -- trying to intervene when necessary to not only drug and alcohol, but a lot of other things that can cause a student to be at risk for not graduating.

One of the things now Secretary Dumaresq has initiated, along with First Lady Susan Corbett, is the Opening Doors Initiative, and we are working closely with them.

So they envision kind of an intervention dashboard for middle school students, because we know that that's when you get them. Okay? Once they're in high school, their habits are well entrenched.

So in middle school, when these students are exhibiting risk factors of failing science and math, attendance problems, there's a couple of other Department of Education identified risk factors that, if continued, make a student very unlikely to graduate.

So the department is working closely on a portion of that intervention database that relates to drug and alcohol, getting that student assessed. Maybe the drug and alcohol problem is with the parent or loved one and that's why they're not getting to school. So we're real excited about working with them on that.

Ken mentioned earlier that we treat about

one in eight people who need treatment, and that's only the people we know about. Due to the stigma and other issues, there's a lot of people out there who may be suffering, who have a fear of identifying themselves as needing help, maybe through their job, maybe through their families. There's some reason they haven't -- or maybe they're just right there.

You know, they have a bad day and then think Oh, I really need to get some help. But the next day they say, Oh, it's not so bad; I don't need treatment. So that back and forth goes on for a long time.

In the past year, starting with the last two years of the Rendell administration, funding for drug and alcohol treatment has been cut $10.3 million. If you lay over that the consumer price index, plus just -- if you're familiar with personnel costs, the benefit factor, and just the cost of paying your employees, if you lay that over that $10.3 million cut, it is an immense decrease in available funding.

So it's harming our communities, it's harming -- there's a direct correlation to that cut in funding to the increase in heroin and other addictions and overdoses.

So we would love your support in any way

that you can in trying to advocate for additional funding for drug and alcohol services, treatment, prevention and all of those things.

It's the only disease -- you think of any disease. It will be unheard of to tell someone with diabetes, Well, you didn't follow your diet and exercise three times a week, so we're not going to treat you any more because you had your chance.

We would will never tell someone with cancer you can have either radiation or chemotherapy, but we don't have enough money for both.

There's no other disease that has the stigma attached to it that has that kind of -- and there's just not enough money for all of it.

And we know that if you undertreat addiction, you just create a better addict. You've got to treat at the level of addiction that is assessed, and if you treat lower than that, you're just creating somebody who is more at risk, a better addict, more tolerance and it just continues.

And at some point that person will be looked at as a three strikes, you're out. Well, you had three times to try it. I had four inpatient stays before it took and I needed a six-month residential women's program to make it work for me.

If somebody had said to me after that second one, I know that I would be dead. I know that for a fact. So it's so important that there be funding available to treat people at the level that they need.

And if someone needs inpatient treatment and they get outpatient, it's not going to be effective, and you've just continued the cycle for not only that person, their family, their children and it just continues.

REPRESENTATIVE HACKETT: Cheryl, thank you.

CHERYL DONDERO: So with that --

REPRESENTATIVE HACKETT: With that, you were just going to wrap it up.

CHERYL DONDERO: I was.

REPRESENTATIVE HACKETT: Cheryl, thank you very much. Ken, thank you very much.

CHERYL DONDERO: You're welcome.

REPRESENTATIVE HACKETT: I noticed two other members that came from their other meetings and were able to make it to the scene here at Glen Mills today.

We have Representative Duane Milne from Chester County and Representative Todd Stephens from Montgomery County coming in from the back.

CHERYL DONDERO: Anyone that wants to reach us or Secretary Tennis, we'd love to hear from you, hear your ideas, and we'll add that to our list of things that we're working on.

REPRESENTATIVE HACKETT: Thank you, Cheryl. And Ken, thank you very much for all your help. We appreciate it.

Are there any questions of the board members here this morning?

Representative Milne.

REPRESENTATIVE MILNE: Thank you, Representative Hackett.

I certainly commend your leadership in helping put this panel together on a very important topic that we're addressing here this morning.

My question actually pertains to those school surveys for a couple of different reasons.

One is, my school district has done those surveys and the results, of course, can be quite alarming to the parents and can really certainly raise some eyebrows in the community, particularly communities where I generally represent that are considered more affluent types of communities in the state, and it's not the kind of expectation certainly that parents, stakeholders and other community leaders expect to see.

So I'm curious, if you could elaborate a little upon your experience with administering those surveys and also to put a slight challenge out there with them.

How confident in terms of statistical modeling are you about the kind of results you are obtaining with those? Because those, of course, are self-identified results and self-reported results.

And generally anybody who has kids, we know sometimes what can happen when kids are asked to take some of those kinds of instruments.

So if you would comment on that, I'd certainly appreciate it.

DR. KENNETH J. MARTZ: Excellent question. Thank you.

I've actually been in on a number of meetings with PCCD, who is really taking the lead on that initiative, and they have done some excellent work. They've been connecting with researchers and bidding that out to make sure that we have some of the top researchers that can be analyzing the data.

They have put extensive work into analyzing how the questions are asked. You know, so, for example, the questions get asked in different order. Simple things, like if the questions get asked in

different order so that -- you know when you're taking a long test and you start to fade out after a while and you start to, Well, I'm just going to answer.

Well, they will sort, they will shift the questions' order so that you can make sure that there is a consistent flow and consistent answering response tendencies.

There will also be a setup in there that will be sample questions that the average person would not answer. For example now, I won't elaborate for tough security issues but, for example, that will help to identify if a student is being misleading.

There are some questions in there that are targeted at exactly that issue so you can identify some of those issues.

One of the strengths also is that they will be filled out anonymously which gives -- they absolutely are self-report, but to the extent that you can maintain some anonymity, it creates an opportunity to say -- there's a lot of things folks will answer on paper that they wouldn't answer face to face if I had to speak it out loud.

So actually there's a lot of benefits to that design. No design is perfect. And I agree, it does create a certain tension of balance of we want to know

the issue and how pervasive it is, it's also scary to get the information. But if you don't get the information, then we can't do anything about it.

We go back to the issue that we talked about earlier this morning where the administrator says, Oh, we don't have any problem here, it's no problem, but then you don't come in and intervene so the kids continue to struggle.

So there's no simple answer to that, but the conversation is to the extent that we can get the information, we can intervene and help to address it.

REPRESENTATIVE MILNE: Certainly. And certainly if nothing else, it certainly serves the role of creating awareness and sparking the need for conversations on that.

Thank you very much.

Thank you, Representative Hackett.

REPRESENTATIVE HACKETT: Thank you, Representative.

Are there any other questions on the committee?

Doctor, thank you very much. We appreciate you testifying here today.

DR. KENNETH J. MARTZ: Thank you very much.

REPRESENTATIVE HACKETT: Ladies and Gentlemen, we're running about 30 minutes behind. We're going to try and pick that up a little bit.

The next committee up will be our Honorable Jack Whalen, Delaware County District Attorney; Sharon McKenna, Assistant District Attorney, Delaware County District Attorney's Office, of course, chief of narcotics and forfeitures; Marianne Grace, executive director of Delaware County; and Dr. Fred Hellman, medical examiner, Delaware County Office of the Medical Examiner.

Thank you very much, and good morning. Thank you for attending.

Jack, I'm sure you all drew straws to see who would go first.

JACK WHELAN: Thank you.

REPRESENTATIVE HACKETT: I'd also like to make note that this is the third hearing for the Judiciary Committee -- I'm sorry -- second hearing of three that we're going to hold throughout the State of Pennsylvania to gain more knowledge as it pertains to this heroin epidemic.

Any time you're ready.

JACK WHELAN: Well, thank. Thank you, Chairman Marsico, members of the House Judiciary

Committee for allowing me the opportunity to be heard this morning.

The impact of prescription drug abuse has affected not only our communities here in Delaware County, but certainly nationwide. Prescription drugs such as OxyContin and Percocet have been proven to destigmatize drug use among teens. And why is this?

These drugs are FDA approved, they're doctor recommended to those who have a true medical need. They're not smuggled into our country and packaged for sale on our streets. They're made by legitimate drug manufacturers and they're sold in our pharmacies.

This is not to say that those individuals are engaging in criminal behavior. These drugs do have a very legitimate medical purpose when prescribed and managed appropriately.

These drugs don't have the dirty, the negative connotation or stigma that you find with heroin, cocaine and other street drugs. Therefore, we cannot assume that our children understand the nature and the very seriousness of the abuse of these pharmaceuticals.

Limiting the availability and supply of heroin is probably missing the issue and will not decrease demand. There's an ever-increasing demand of heroin because the users are already addicted opioid

abusers.

There's no denying the obvious nexus between the rise in availability and the abuse of prescription drugs such as OxyContin and the rise of heroin addiction.

Use begins with semisynthetic opioids, for example, pharmaceuticals that contain oxycodone. Once introduced to the synthetic opioid by way of legitimate medical need through our illegal means, the abuser turns addict and begins to get their supply and drugs in several ways.

They go doctor shopping, which is a common phenomenon where the same individual will seek out prescriptions of controlled substances through various physicians without being truthful to the physicians, without telling them that they already obtained a prescription from the neighboring doctor.

They also can get it from a relative. They'll purchase it from a friend, but they also can do it the old-fashioned way and get street dealers to sell them oxycodone pills.

What we've learned from two Delaware County prosecutions of doctors who were running pill mills is that heroin addiction is developed from prescription drug abuse.

Heroin is not the first drug of choice, it's an abuse based on opioids. In one case, a pill mill was shut down, we learned that each patient was receiving approximately 120 to 130 pills per visit.

The doctor, he was a sole practitioner, he was prescribing narcotics to approximately 20 to 30 patients per day. That equates to approximately 2,400 to 3,900 pills per day that were prescribed by one doctor in Delaware County.

We have learned from our addicts in recovery who have graduated from Delaware County's treatment court is that the introduction to prescription drug abuse, it's very clean and easy.

Much of the public, including our own children, do not appreciate the danger that narcotic prescription drugs pose. Eventually after abusing narcotic pharmaceuticals for a period of time, the user's body has developed a physical dependence and the user is addicted.

Once addicted, the addict realizes that heroin can bring about the same or a similar high and the cost is much cheaper.

The constant supply of oxycodone has flooded our streets and we need to look at ways of limiting it. Limiting the demand for heroin is directly

related to limiting the supply of oxycodone and other diverted narcotic pharmaceuticals.

Further, we must educate the public of the grave danger of pharmaceutical diversion use and abuse. Delaware County, here in Delaware County, we have a population of over 500,000 people.

Following treatment data is only telling a portion of the story. Treatment data shows that most individuals in treatment are white males between the ages of 25 to 34.

Our law enforcement officers, county and local, have reported that opioid abuse has been found in young and middle aged of all races and socioeconomic status.

Executive Director Marianne Grace will provide within her testimony the Delaware County Office of Behavioral Health statistics regarding heroin treatment, and Dr. Hellman will provide data for fatal heroin overdoses experienced here in Delaware County.

But the wolf in sheep's clothing is not heroin, it's synthetic opioids, narcotic pharmaceuticals.

Using our limited resources to deploy undercover narcotic officers and utilized techniques normally employed to ferret out illegal drug trafficking will not allow us to attack the issue at its core.

Giving law enforcement and state licensing board the authority and access to investigate unscrupulous doctors, pharmacists and patients would prove to be the most efficient way of ferreting out what appears to be the limitless supply of diverted OxyContin on the street.

Today law enforcement faces the same obstacles on a routine basis. A grieving parent, an annoyed neighbor, a concerned citizen that will contact law enforcement to provide information in usually one of two of the following formats: A doctor who is prescribing an otherwise healthy young adult oxycodone on a monthly basis with no apparent medical need.

The neighbor who lives near the doctor's office who complains that the foot traffic to the doctor's office begins at 8:00 a.m. and remains constant until closing hours, and all patients appear to be a rough crowd.

Another example from Delaware County within the past year is that we learned that a young adult male died from a fatal overdose of prescribed oxycodone written by a doctor who continued to prescribe oxycodone to the patient even after the patient was hospitalized for a nonfatal overdose.

That same doctor was notified of the prior

overdose by the treating hospital and yet continued to prescribe oxycodone.

Our concern is that the administrative agencies and law enforcement agencies do not have the same tools to access and conduct such investigations.

Drug enforcement has entered a new frontier and the legal system is trailing behind. For many, many reasons we're supporting the House Bill that has been proposed involving the database so that pharmacies and doctors are required to have one central database.

We could also be able to utilize that through law enforcement purposes where appropriate and where constitutional.

Thank you.

REPRESENTATIVE HACKETT: Thank you, Mr. Whalen.

And, for the record, so everyone knows here, House Bill 1694, the database bill, we did pass that bill about two weeks ago in the House. So thank you all very much for your support for that.

Next up.

MARIANNE GRACE: Thank you.

I'm Marianne Grace. I'm Delaware County's executive director and I wanted to say thank you to

Chairman Marsico and also to Representative Hackett, and I also wanted to say hello to Representative Killion.

Before I start, too, I just really need to express my sympathy over the loss, Representative Hackett, that you just mentioned on a friend of yours, the family member.

I had read that obituary in the paper and saw this handsome 18 year old's face which certainly caught my eye in the obituaries, and the details were not included, but I was concerned that that might be what the issue is.

So when I heard you say that, I thought that it must have been that young man from our community, so I extend my sympathy.

REPRESENTATIVE HACKETT: Thank you.

MARIANNE GRACE: I'd like to talk to you today about something that we're doing in Delaware County, and I'm so appreciative that you've put this together.

And, you know, so many times you do things and you're going to come to it and you think, Oh, you know, I'm going to present and what am I going to hear.

I am so pleased to have been able to be here today and to hear the other presenters and so the, you know, what is going on, you know, the presentation on

the heroin, listening to the Department of Drug and Alcohol.

I really -- I thank you so much for the opportunity, because it's going to be so much more meaningful for me in my work and the work that we do.

I'm Delaware County's executive director, and actually I've been with the county since 1990. I started with the Office of Drug and Alcohol Programs.

At the time when I started -- we heard today that it's DDAP, the Department of Drug and Alcohol Programs. When I started it was the Bureau of Drug and Alcohol Programs. So I think that there really is a significant commitment to the issue by creating the department. So I applaud the administration on the creation of the department.

So, as I said, it was 1990 that I started, and while the issues were certainly demanding at the time, they have just increased, you know, a thousand fold and the demands that we're having are some of the things that I want to talk about.

Primarily what I'm going to speak about is the Heroin Task Force that we created in Delaware County. And this is a task force that we created over a year ago.

Our medical examiner that you're going to

hear from, Dr. Hellman, brought the issue to our attention, to Jack Whalen's attention, to County Council's attention, and to mine over the number of deaths that he was seeing from heroin and opioid deaths and that it was an alarming increase in deaths.

And we looked at each other and we said that we really need to do something. And with that what we did is we created the Heroin Task Force.

What we learned just one year ago from our medical examiner, Dr. Richard Hellman, that he was seeing an alarming number of heroin-related deaths.

In 2007, he reported 19 heroin fatalities in Delaware County. That number rose over five years to 61 fatalities in 2011. That represents a shocking 320 percent increase in deaths over five years.

Delaware County is a small county. We know -- we're all neighbors. We have just a little over 550,000 people in Delaware County, but geographically we are a small county.

So these are all our neighbors. So that when I read in the paper about an 18 year old dying, it's one of Joe's friends and neighbors. And this is something that's happening to all of us.

What I'm hearing about the hesitancy to talk about the scourge, I know that that's a fact, but it

almost still surprises me, because this is something that's touching all of our lives.

In my own personally, through our family, through marriage, one of the younger cousins is going through the same thing himself. And it always surprises me. This kid is a really great golf player. I said how can he be throwing that away when you're a good golfer. But none of that makes a difference. So good kids are making bad choices.

From 2007 to 2012, we lost 232 people to heroin. All ages, good kids from good families. That's more than we lost to car accidents and gun violence combined.

Drug dealers are killing our children and we need to stop this public health crisis. Because that's what it is, it is a public health crisis.

Out of concern for our residents and particularly our young people, counsel partnered with the district attorney's office to form a heroin task force in September of 2012.

Members of the task force represent government, law enforcement, the business community, treatment providers, parents and educators. The goal is simple: To reduce the number of heroin-related deaths and its devastating impact on families and our

communities.

In one short year, this task force has learned a lot. I'm the mother of two children, two grown children, and I'm someone who's very involved in my community. But I frankly have been shocked over some of the things that we've learned.

We quickly learned that heroin abuse is inextricably linked to prescription drug abuse, and you've heard this over and over today.

So as I say, it's really been so beneficial for me to be here today and have this be so affirming because I know we're on the right track.

In fact, according to the Centers for Disease Control, more people now die from an overdose of prescription drugs than die from an overdose of cocaine, heroin or other illicit drugs.

So that legislation is so important, and really I applaud the House on that and hopefully it will move through the Senate as well.

Surprisingly, these drugs are being prescribed every day to young people, for dental extraction, sports injury or some other problem.

Young people and their parents think these drugs are safe because a doctor prescribed them and a pharmacist provided them.

While medications do help when used the right way -- and I think that is important. Medication for people who need it, it's important that that medication be available.

But many people are surprisingly naive about the dangers when abused and that the prescription drugs can be fatal. So our Heroin Task Force is trying to raise awareness about the danger of prescription drugs.

That's what the goal is, that we raise awareness, that we educate, and that we prevent prescription drug abuse so that we ultimately prevent the heroin use.

We have a program that we've taken to schools and we present in the community called Realities of Prescription Drugs and Heroin Abuse. We don't sugar-coat the message.

It's clear that there needs to be more hard-hitting education at the school level with companion programs for parents. It's my understanding that in Illinois this year they passed legislation to create a Heroin Youth Task Force to address the problem in high schools.

Perhaps Pennsylvania could create a similar youth task force statewide

While stricter law enforcement will address the supply of drugs, it will take education and awareness to reduce the demand.

Next we learned that these narcotics are often obtained out of the family medicine cabinet. How many of you have these narcotics in your medicine cabinet? I know that I did.

You get to this age, you're having a surgery, your children are having teeth extracted, you've had a minor surgery and the doctors are prescribing these opioid drugs, and you take a few of them and then they end up in your medicine cabinet.

According to the CDC, 70 percent of those who abuse prescription drugs report that they get them out of the medicine cabinet of a family member or friend.

So we used part of the federal grant -- we received a federal grant for -- a $625,000 federal grant over five years and this will support the task force. So we were really very excited to receive that grant.

And as part of that grant, we've purchased medicine drop boxes. We've purchased 11 drop boxes so far to provide people a safe, anonymous way to dispose of expired and unused prescription drugs.

These drop boxes -- I'm sure you've seen

them and in the material that I've handed to you we have pictures of it -- the drop boxes look like a mailbox and we've used them to get the message on it so they're very colorful, we have graphics on it, they catch people's attention, to get the message that prescription drugs need to be disposed of properly.

You don't want to flush them down the toilet, that's not the good way to get rid of them, and there needs to be a permanent way for people to get rid of the prescription drugs.

So we have these and we've had them installed in police departments and we had one installed in the Government Center in Media.

On October 8th, the boxes were placed in ten police departments plus one in the lobby of our Government Center. After just three weeks, one of our CID detectives did the first pickup and collected 138 pounds of unwanted and expired prescription drugs.

So there was certainly a demand in Delaware County for this type of a resource. I believe that a statewide safe disposal program would prevent many of these narcotics from falling into the wrong hands.

And I do know, and we've been participating in this as well, generally twice a year there was a drug take-back and Delaware County had been

participating in the drug take-back. Many of our police departments were participating.

So twice a year there would be a place that you can go and you can get rid of your prescription drugs. But that's where we learned of the Heroin Task Force.

Because people would say to us, you know, we all go out there, we'd be happy they were there, and they would say, Well, this is great, but what do I do in the intervening months?

And that's where then we came up with the idea, Jack and County Council came up with the idea, let's have these permanent drop boxes, and we can see in just three weeks how overwhelmingly needed they are.

On that same note, the Task Force also worked with our local real estate association. I think this was really very interesting and this is part of -- we wanted to have a business person on our task force and Jack knew a realtor.

So we put a realtor on our task force after learning that medications were being stolen out of medicine cabinets and bedside tables during open house real estate showings.

Most people know to lock up their jewelry and valuables during open houses, but few people think

their pills will be stolen, but that's what's happening.

So what we did there and through this relationship that we have, Jack Whalen, members of County Council presented at the -- the realtors do a seminar, they do monthly seminars where they bring realtors in from the region.

And we presented a seminar to the realtors on this issue. Many of the realtors were not aware and, you know, as I say, they are aware about protecting the valuables in the home, but they weren't aware of warning people about their medicine cabinet.

Finally, we've learned that the heroin epidemic is not only taking a human toll but an economic one as well. Drug abuse is a burden on law enforcement, our court system and our human services and our families.

While today's hearing focuses on law enforcement strategies, as Delaware County's executive director, I can say that the resources devoted to drug treatment are inadequate.

We have experienced success with our treatment court but the key is treatment. And we did hear that previously with the presentation that we got from the department.

In Delaware County, the Office of

Behavioral Health provides drug and alcohol programs for the uninsured or underinsured. According to OBH's 2012 annual report, admission for heroin use increased 680 percent from 2009 to 2012.

The numbers for heroin are really dramatic. Going from 98 clients in 2010, 98 clients, to 400 in 2011 to 667 in 2012.

So from '10 to '12, we've gone from 98 people seeking admission for heroin abuse to 667 in little Delaware County. The largest increase was for the 25 to 34 year old age group.

Treatment admissions for other opiates also increased dramatically over the last three years, from 33 admissions for 2009/2010 to 229 admissions in 2011/2012. That's a 693 percent increase.

Again, the largest increases were for 18 to 24 year olds and 25 to 34 year olds. These are our young people. These are our future and these are the ones who are suffering from this scourge and a number of them dying.

Sadly, our Office of Children and Youth Services is reporting an increase in referred cases of drug positive newborns. In the fiscal year 2012/2013, CYS received 42 new referrals involving positive drug screens of mothers and/or infants at the infant's birth.

This is an average of 3.5 cases per month. In the first four months of the current fiscal year, CYS has received 20 referrals of drug positive mothers and/or infants. This is an average of five cases per month.

According to Crozer Medical Center's Department of Pediatrics, one of our large health systems in Delaware County, in 2012, thirty babies were born addicted and needed intensive care.

That's an estimated expense for their medical treatment of $1.9 million for thirty babies. The bottom line is, we can't begin to measure the toll that this heroin epidemic is taking on our communities.

And I want to say, too, I'm so proud of Delaware County and I think that we are on the cutting edge of so many things, but also I know that we are not unique in this problem.

And while this is a problem in Delaware County, it's a problem in the southeast region, and from what I've heard today, it's a problem throughout the state.

So I think that you can take the numbers that I'm giving you here today and you can extrapolate them statewide. I do not believe we are all unique in this problem.

Once we formed the Heroin Task Force, people in the community came forward and they wanted to be involved so we formed a broader coalition. That coalition just met on October 29th. We heard from parents, providers and recovered addicts.

They had many suggestions for more halfway programs and easier access to affordable treatment, to education for doctors and dentists so they don't overprescribe.

We know that our economy and quality of life suffer because of crimes like prescription fraud, doctor shopping, pharmacy robberies and other types of drug-related violence.

We know that heroin abuse affects more than the user. It affects our whole community and we need to channel the resources to put an end to the demand for drugs.

Legislation won't solve every problem with heroin, but stricter laws, particularly against drug dealers, and adequate funding for education in our schools, prevention programs and mental health and substance abuse treatment will go a long way to reduce usage.

We believe that the work of the Delaware County Heroin Task Force will make a difference, and we

look forward to working with our state leaders on this critical issue.

I want to mention to you, we've heard a lot about people saying how do you achieve this, how do you do it? And one of the things that I want to remind for all of us that I think what's so important is our relationships are important.

In Delaware County, we have a relationship with our intermediate unit. And when you say, How do you get to the schools, we have -- for many purposes it serves us to work well with our I, and our I is the conduit to the schools.

And we have a wonderful relationship with them. They're eager to work with us on issues, on this issue, issues of school safety, and it really works so well.

So I really want to, you know, recognize them. I want to recognize the education, the efforts of education in Delaware County and to just bring that out, that that's what I think is so important that, for all of us who are invested in our communities, that we recognize the importance of those relationships and we work to make those relationships, because it's certainly nothing that any of us can do alone, but I believe that all of us working together and, you know, an old expression you're

rowing the boat in the same direction, that we really can make an impact.

So, again, I thank you. I thank you so much for this opportunity and for the work that you're doing here. So thank you very much.

REPRESENTATIVE HACKETT: Thank you, Marianne, for that compelling testimony.

I do have one request. We might as well hit the nail on the head here as we work our way through this committee. It's pertaining to the drop boxes. I'm getting some calls in my office, and I'm sure some of the other members are, too.

It's about the actual transportation of those prescription drugs to the drop box, wherever it may be. So if it's for a family member and it's really not their prescription.

I know we have laws in place that may limit that possession of that person's prescription drug with another person. And also there's been some calls in the office about at the actual drop box it has the person's information on the pill bottles and they're curious about that.

They would like to know do they peel the labels off there or do they do it ahead of time and then they're transporting script drugs without information on

it.

So when you get some free time, if your committee could look at that and maybe address those issues I'd appreciate it.

MARIANNE GRACE: Yes, we certainly will. And I do know that, and myself looking at the prescription I thought, Ooh, it's got my name on it.

But those prescriptions -- it is taken, they are destroyed, but I understand what's being raised, and I think one of the things -- and we'll make this known to people.

Even just taking a marker if you would choose, just if you feel uncomfortable, although there's no reason to feel uncomfortable, but if you were to choose it and even just to, you know, to take your name off it.

But I know that we have -- it's secured and, Jack, you might want to talk a little bit about that.

JACK WHELAN: Yes. The drop boxes are secured, they're bolted to the floor, they're locked. They're in direct observation of the police department. These are going to be in every single police department when they're under observation.

If the department is closed, if the window

where the police clerk is there is closed, that box will not be available to the public. But every time the police department is open, it will be available.

Criminal Investigation Division comes out, empties the box on a periodic basis, takes the box under their possession and control, stores it in a locked facility at the courthouse and then incinerates them.

So we're recommending that they take the label off of it or black it out as Director Grace has indicated. However, if they do not, we feel confident that it's not going to fall in the hands of any unscrupulous individual that would try to steal those prescription medications.

REPRESENTATIVE HACKETT: Thank you very much. I guess we'll move on and we'll get to questions at the end of the panel testimony.

DR. FRED HELLMAN: First of all, good morning. Chairman Marsico, Representative Hackett, Representative Killion, good to see you.

And I wanted to thank you for the opportunity to speak to the House Judiciary Committee about this very critical issue that's confronting the Commonwealth and certainly Delaware County is no exception to what we're seeing.

My name is Rick Hellman, and I'm a

forensic pathologist and I've been serving as the chief medical examiner for Delaware County now for over 13 and a half years.

I want to start off by saying it's truly been a privilege for me to work in Delaware County. This is my 25th year practicing forensic pathology, and even though I went to college in Delaware County, I really didn't know much about kind of government; I was busy studying I guess.

And in the process of having the opportunity to work with some really terrific people where, you know, excellent communication, effective team work, and putting our heads together to tackle different issues of the day have proven to be very fulfilling.

This issue of substance abuse is, you know, something that I deal with daily in my practice for the County and it's tormenting. Director Grace is absolutely correct, it is a scourge that we're experiencing and something that we have been tracking within the medical examiner's office throughout my tenure.

I thought when I came to Delaware County I said, you know, there seem to be a lot of drug deaths but not illicit drug deaths. I was seeing prescription drug deaths, a lot of oxycodone, and I hadn't seen that

before.

And actually in talking with the Chair of Council at the time, Wally Nunn, and our D.A. at the time, Patrick Meehan, we decided to go ahead and do a press conference addressing the issue.

And that was actually in the region the first, you know, notation of the problem of OxyContin abuse, and that was in 2001.

Since that time, we've seen periodic, you know, periods where there has been, you know, different types of prescription drug patterns of abuse. Methadone occurring several years thereafter.

But one thing that I've noticed -- or a couple things I've noticed over the ensuing years is that, in addition to the prescription drug abuse problem, that there has been a progressive upticking of heroin abuse.

You know, from 2007, when I saw about 19 cases of heroin-abuse-related deaths, there has been initially a gradual increase, but then a marked increase in heroin-related deaths.

You know, from 2007 to 2009, the numbers went from 19 to 37. And then by, you know, a couple years thereafter, 61. And over the years since 2011, we've seen sort of a plateau.

But of the 130, 140 drug-related deaths that we see every year in the county now, I would estimate that nearly half of those involve heroin now.

And so I've been trying to keep tabs of what we've been seeing over on a month-to-month basis. We generally have a lag from 6 to 8 weeks as the toxicology laboratory is doing their analyses.

So I have data up through about the middle of September, and right now I would estimate that we're at numbers that are approaching those from two years ago, in 2011. So clearly this is a major problem.

There have been identified relationships between the abuse of semisynthetic and synthetic opioids as a gateway to the subsequent abuse of heroin, and I think that the Heroin Task Force is one very important approach to tackling this problem in Delaware County.

Now, in the interest of time, I want to sort of cut to the chase as to a few ideas that we may want to consider going forward.

One, of course, has already been dealt with through the House with House Bill 1694 and the controlled substances database.

And I understand that it is currently in the Senate and so we're hopeful that soon that will become law, because I feel that's very critical for

physicians to understand prescribing patterns.

I've had the privilege over the last eight years or so to serve on the Commission of Public Health for the State Medical Society and to serve as the Chair of that commission for many of those years.

And so the issue of prescription drug abuse and other abuse patterns has been one of the topics that has been paramount in our efforts.

Understandably, physicians and particularly primary care physicians are gate keepers here. And so it's important for organized medicine to be, you know, a player. They are a stakeholder in all of this, in the education of our physicians.

So there are several bullet points that I've noted in the handout to you, and one of the benefits of the controlled substances database has been noted in other states is that it provides a tool for prescribers to review medications already received by a patient before prescribing additional medications to that patient.

In addition, it enables prescribers to identify doctor shoppers who seek to divert medications and it helps prescribers to avoid feeding the supply.

And my understanding is that this diversion of prescription meds now is a

$25-billion-a-year business in this country.

The database identifies patients at risk for abusing medications and provides the most referral to appropriate therapy. It also enables prescribers to prescribe medications to those who truly need it unhampered.

And that's a point that I also want to mention. As we've discussed this within the state medical society, you know, really narcotics, Schedule II drugs, it's a double-edged sword. Because there clearly is a very important medical application of these medications when appropriately used.

The problem, of course, is the other side of that sword, and it requires careful oversight by physicians and communication with their patients, and it also requires the cooperation and the responsibility of the patients understanding the potency of these medications.

The database also provides a tool for pharmacists to review all medications purchased, not just those filled in their stores, before filling a prescription.

Finally, there is a need to support the legislation that's currently in the PA legislature for the database and for the education of prescribers, which

is an ongoing process within the state medical society.

Now, the next thing that I would like to speak to you about is something a little different and I brought some materials. This is something that -- actually through conversion several of us were thinking of at the same time.

And within the Commission on Public Health, we were developing this idea of a media literacy campaign. Ultimately, it was the drug-free PA that took on that initiative, got grant funding and currently has a program that has been going on with the education of select teachers through the Commonwealth.

So what is media literacy? This is basically the different media that is used to advertise to our youth and to us. And the curriculum trains teachers on how best to relate the influences of social media and advertising on choices that teens make to use alcohol, tobacco and drugs.

It also addresses specifics of advertising techniques, as well as how best to counter messages given by celebrities. The learning objectives for the chapter of the curriculum on prescription and over-the-counter drugs helps teens to understand the differences between prescription drugs, supplements, over-the-counter drugs and illegal drugs.

It helps teens to understand why the myths that teens believe about prescription drugs and over-the-counter drugs are wrong, i.e., the myth that these can't hurt you.

You know, over-the-counter drugs, I mean drugs that you can get in your drugstore without a prescription can hurt you. Benadryl can kill you. Okay?

It strengthens the research skills of finding ads about prescription drugs and over-the-counter drugs and it facilitates basically the media critiques of celebrities and prescription drug abuse, both positive and negative.

What we found is that this curriculum improves teacher skills significantly, and there have been some followups with the teachers, finding out what their thoughts are regarding this curriculum, and it's been overwhelmingly positive.

100 teachers participated in last year's seminars, which are held yearly in three major cities across the Commonwealth, King of Prussia, State College and Pittsburgh.

Each teacher receives Act 48 continuing education credits for attendance. And the teachers left the seminars excited by their new teaching skills.

Now, a high school curriculum is currently under development and will be available next year. We need funding to facilitate this extension to the elementary schools, but clearly this is a way to educate our youth and educate the parents about the good and the bad and the ugly side of advertising and how it affects our choices.

Now, the last thing that I'd like to talk with you about regards novel initiatives to help people who are addicted to drugs. And I had a really compelling conversation with a fellow last night.

He, himself, was a dealer and an addict, heroin as well as other drugs, for many years. And in his case he found God. And he acquired a mission and his mission was to care for people who are addicted to, you know, various types of either prescription drugs and/or illicit substances.

And some of the things that he has found, as well as others, is that it's important to enhance strong personal relationships with those who are addicted and that oftentimes those who are addicted have holes in their lives and in themselves, that they're suffering not only physical pain but oftentimes psychic pain; that oftentimes these are individuals who suffered physical abuse, emotional abuse, verbal abuse, sexual abuse, and

so that healing is multifactorial.

Now, there are programs such as Team Challenge and the Emporium, which is the program I was alluding to, which are spiritually based and have been proven to be effective.

This particular individual, his name is Dan Blust, has found that in his program in a small anecdotal series, we're talking about 70 percent cure.

Drug use, as he has noted, is the only way to pause a painful experience. Mr. Blust never talked to an addict who did not have an underlying personal cause for their use.

He believes that, when treating an addict, we must reveal that cause and work with them to a solution, and he recommends focusing one's efforts on personal rehabilitation programs as a start, initially by educating parents and teachers, which is in line with the Straight Talk program approach, which is promulgated by Drug Free PA.

And the Straight Talk For Parents, again, one of the programs offered by Drug Fee PA, teaches parents how to talk to their teens about tobacco, alcohol, drug abuse and prescription drugs.

Now I've brought with me a couple of the materials that Drug Free PA provides, one of which is

Straight Talk For Parents, okay, which gives their approach on how they educate parents so that the parents can help to educate their children.

The other is the media literacy program that Drug Free PA provides, and this is state funded. But right now it's in a very limited cohort, and in at least my experience in caring for at this point -- I mean, I've examined in Delaware County upwards of 5,400 individuals and I would say that roughly 20 to 25 percent have died by drug abuse.

This I believe also can be a very effective program, particularly as spread throughout the Commonwealth.

Thank you for your attention.

REPRESENTATIVE HACKETT: Thank you, Doctor.

Sharon, next up.

REPRESENTATIVE HACKETT: Any other questions from the members?

Representative Stephens.

REPRESENTATIVE STEPHENS: Thank you very much for the information about what you guys are doing in Delaware County. It's been very helpful.

Just kind of a quick question. I don't want to take up a lot of time.

But D.A. Whalen, do you have a rough idea on what the costs in terms of your drug take-back boxes and everything else, that whole program, or anyone who wants to speak to it.

JACK WHELAN: The boxes go for about $800.00 a box. However, what we've learned is that there's eager businesses that are willing to sponsor the boxes.

So half of the boxes so far, although some have been paid by a grant, half of them have been paid from realtors across Delaware County that want to sponsor the box.

So we're now opening it up for business to come in and see if they want to sponsor the box and we put a tag on the top of the box that says Sponsored by X Business, and it's been very successful.

We're seeing a ground swell of support over this program and, as indicated earlier, we had no idea that it was going to be so well received where hundreds and hundreds of pounds of drugs already have been taken off of the street.

REPRESENTATIVE STEPHENS: Okay. Terrific.

I know reference has been made to House Bill 1694. I'm not sure if you're aware of the amendment

that was added to that late in the game that added the requirement of a search warrant for law enforcement to utilize that database for Schedule IIs.

Do you have any comments on that particular requirement?

JACK WHELAN: No. Because we certainly live and die by the constitution, and if we need probable cause to access this information, I believe that's appropriate.

We have no problem with generating probable cause where relevant, in order to access this information. We use search warrants all the time for information. So I believe certainly you should have probable cause, so I don't have a problem.

REPRESENTATIVE STEPHENS: Okay. The current database that's in existence at the AG's office doesn't have that requirement. So does that -- you're okay with adding that requirement in this case?

JACK WHELAN: Again, when I did learn of that amendment, and I didn't have a problem with it because, again, I understand the concern out there of the privacy issue associated with that particular database.

So I think from a law enforcement standpoint, it should be necessarily confidential, and I agree with that, because you don't want individuals being

able to access what prescription medications you may be on, so you want to keep it confidential.

And for law enforcement to be able to access that confidential database, I believe they should have probable cause, so I'm okay.

REPRESENTATIVE STEPHENS: All right. Great. Okay. Thank you.

REPRESENTATIVE HACKETT: Representative Regan.

REPRESENTATIVE REGAN: Thank you, Representative Hackett. I'll keep this brief.

My first was to comment first saying I want to compliment you folks in Delaware County.

Because I had the opportunity to be in a hearing with you regarding school safety, and it seems like you are one of those counties that aren't afraid to admit that a problem exists, and you get out in front of it before it gets out in front of you, and I compliment you on that. And I really appreciate the fact that you're so proactive.

JACK WHELAN: Thank you.

REPRESENTATIVE REGAN: This is for Mr. Whalen, and I asked this question earlier to the gentleman from the attorney general's office and that is about cooperation with federal, state and local

departments specifically as it relates to heroin distribution.

And are you working with the other agencies and can you speak a little bit? I would appreciate your candor in how this is working out for you.

JACK WHELAN: Sure. We, on a regular basis, and Chief of our Narcotics Unit, Sharon McKenna, seated to my left, and we work on a regular basis with drug enforcement administration, with the attorney general's office, and we are aware of deconfliction issues where we share information in order to avoid a duplicate of efforts and also for the protection of those agents and police officers that are involved in investigating and ultimately arresting in our prosecution.

We want to make sure that we're on the same page and an officer is not exposed to danger because of various undercover officers investigating individuals that may be engaged in illegal drug activity.

So there is a deconfliction system in effect and we do share data and work with the attorney general, the FBI and the Drug Enforcement Administration on a regular basis.

And, in fact, in my testimony we made

reference to shutting down a pill mill in Delaware County. That was a cooperative effort of various law enforcement agencies including the Drug Enforcement Administration.

So we actually have a good relationship with all of them and look forward to working with them in the future.

REPRESENTATIVE REGAN: That's great. I shouldn't be surprised to hear that you're doing it the right way.

And this final followup should be very brief.

Marianne, could you please tell me the members of your Heroin Task Force.

MARIANNE GRACE: We do have a listing in what we've handed out to you that have all of them listed, but we have our County Council, we have representatives from our -- Chairman of County Council is on the Heroin Task Force, as well as another one of the council members, Dave White. So Mario Civera and Dave White, Jack, myself, we have our prevention provider.

In Delaware County, we work with Holcomb Behavioral Health for our prevention. Their director, Beth Mingey, is on the Heroin Task Force. We have representatives from our Office of Behavioral Health.

We have, as I said, the realtor, so we were including the business.

We have representatives from the YMCA. We wanted to make sure that those community groups who are also touching the lives of people in the community, that they were involved. So we have one of the YMCA directors is on the Heroin Task Force, as well as parents on the Heroin Task Force.

So we've tried to get a representative and a broad array of people and yet keeping it small enough that we could really accomplish tasks.

So we're probably at about, you know, I think there's maybe 15 or so people that are on the Heroin Task Force. And then the idea with the coalition was, having formed this task force, a lot of people have come up to us and said, Well, I want to help too.

And we couldn't have a task force that's so big that it's unwieldy. So we thought, Well, let's have a coalition. And so the coalition then, there's provider agencies, there's people in recovery, probation officers. So a much broader number of people on the coalition because so many people are interested in helping in this initiative.

REPRESENTATIVE REGAN: Great. Thank you so much for all you do. Thank you for being here today.

REPRESENTATIVE HACKETT: Thank you, Representative. Any other questions from the members?

Thank you very much for testifying here today and taking time out of your busy day.

We're going to take a five-minute restroom break. So we're going to run to the restrooms and we'll be back sharply in about five minutes.

Thank you.

REPRESENTATIVE HACKETT: Next up before the panel to testify is Mr. Rick Dunlap, Superintendent of Upper Darby School District. He's here as a father. And Tricia Stouch. She is here as a mother.

Tricia, that's probably one of the best titles you're going to get. Here as a Mom. They don't get any better than that.

DR. RICHARD F. DUNLAP: Representative Hackett, Representative Marsico, and the rest of the Representatives on the panel, again, thank you for allowing us the opportunity to come before you to share our stories and work together to solve this problem that we face.

I'm speaking as a school official and as a parent who lost his son to a drug overdose. My son lost his life by ingesting a lethal cocktail that was a combination of prescription drugs and alcohol.

He lost his life at the age of 19, four years ago this past September 6th. My son's death prevented him from becoming hooked on the drug heroin for which this public hearing is all about.

I'm quoting some statistics from different sources, the Center for Disease Control, the United States Department of Health and Human Services and the United Nations Office on Drugs and Crime 2013 World Overview.

In 2008, around 12,000 youth, our young adults, between the ages of 16 and 24 lost their lives to an overdose involving painkillers.

That number has tripled from 1990 to 2008. Statisticians are forecasting that in the year 2013 that number will be close to 30,000 of our young adults. We are losing a generation of our children.

Last year it was reported that 81,000 people made trips to the emergency room for heroin-related overdoses. Last year alone 4,125 people overdosed and died from the result of a heroin overdose in the United States.

The reason that I mention painkillers is because they are the evolution, the predecessor, or so-called drug of choice for many users who then move on to heroin.

Abuse of prescription drugs or prescription narcotics dwarfs that of heroin. Legal painkiller prescriptions in 2010 were sufficient to medicate every American adult around the clock for a month, the Center for Disease Control and Prevention reported that two years ago.

Most of those prescriptions were intended for medical purpose, yet enough were diverted so that 12 million Americans ages 12 or older engaged in nonmedical use of prescription killers, basically to get high.

Only 3.6 percent of the people who use painkillers for nonmedical purposes go on to heroin, and this is a quote from the Substance Abuse and Mental Health Services Administration, which was reported this past August.

At the same time, the rate of heroin use was 19 times higher among those who had used painkillers than those who had not.

One of the most significant effects of heroin use is addiction. With regular heroin use, tolerance to the drug develops. Once this happens, the abuser must use more heroin to achieve the same intensity.

As higher doses of the drug are used over time, physical dependence and addiction to the drug

develop. Heroin does not discriminate. It is in our wealthiest communities, it is our in poorest communities, and every place in between.

It is in all of our schools. And although it seems to be destroying a whole lot of our young folks, it does not discriminate by age.

I can tell you as a former high school principal and currently as a superintendent, I have dealt with school-related situations involving heroin.

The reason we have a problem on our hands is also worth repeating. Heroin is cheaper. It is easier to use and readily available. It is also one of the most addictive substances on the face of the earth.

Combine all of the above and we have a very perfect, very deadly storm. I say we because this is our entire problem. It is not just a problem to be handled singularly by law enforcement, the government or government agencies, our medical industry, our schools or social services.

This pandemic affects all aspects of our society, especially our families. Globally between 102,000 and estimated to 247,000 people died from drug overdoses in 2011.

One of the best things that we can do is to educate, and I mean radically educate, our entire

society of how this disease of heroin addiction affects us all.

It affects us all beyond our emotional and social feelings. This disease hits all of us in the pocketbook. It destroys people's lives beyond the loss of a loved one.

The injustice of treatment options available to people differ based upon their insurance capabilities and their wealth. We need to increase access to substance abuse treatment. We need to improve prescription drug monitoring programs, which are the electronic databases that track all prescriptions for opiates in the state.

Using prescription drug monitoring programs, public insurance programs and Workers' Compensation data to identify improper prescribing of opioids, we need to set up programs for public insurance programs, Workers' Compensation programs and state-run health plans that identify and address improper patient use of opioids.

Passing, enforcing and evaluating pill mill doctor shopping and other state laws to reduce prescription opioid use is so important. Forcing state licensing boards to take action against inappropriate prescribing also needs to be dealt with.

I can tell you that my wife Helen and I, along with DEA agents from the regional office in Philadelphia, members of our family and our son's friends provide parents and students with information on why they should say no when tempted by drugs and alcohol.

You see we tell them our story. We call it Tim's Story. It is the story of our son's journey with addiction. We give students information on how to navigate the difficult decisions that they face as young adults.

We convey this message by sharing our family's difficult journey through our son's drug addiction. We cover disease -- the disease process circumnavigating the insurance world and rehab. And on top of that we share Tim's tragic story.

While telling Tim's Story, the focus of our program is about giving students information on how to make difficult decisions, by doing what is right for themselves, their families and their friends.

The night before we speak with the students, we meet with the parents of the school. The DEA runs the lion's share of this meeting by providing parents with current information about the use of drugs, types of drugs and current practices of drug abuse in our geographic area.

They also provide parents with information on the hidden signs of drug abuse and what they train their field agents to look for in drug abuse cases. They also provide a short video to the parents which talks about the current mission of the Drug Enforcement Agency.

We share Tim's Story with the parents and we break up this presentation to show what we're going to cover with the students the next day.

The day of the student presentation to the student body we share Tim's Story. We share Tim's Story and we incorporate the history of drug abuse in our society. The rehab process, insurance, family decisions and the tragedy of Tim's overdose.

The entire focus of Tim's Talk is about making the correct decision for yourself, your family and those who love and care for you, as well as making of right decisions for your peers which has a huge impact on middle school and high school age students.

The talk also focuses on skills to use in dealing with peers about this difficult subject. Following the presentation, many of our family members and friends of Tim are available to speak with individual students.

I do want to add on to a couple things that were said today. When Mr. Martz spoke about the

PAYS survey and, Representative Milne, you had asked some questions about that.

I can tell you that that is a very worthwhile tool for schools to use. Yes, some of that information can be alarming, but it can also add to how you program and you work through your school system to combat this and what you can do on your level in your schools to reach out to your parents, your community and your student body.

There are keys -- and I know that Mr. Martz was very eloquent in how he answered the question -- but there are keys in that survey that if students answer it a certain way, that survey is discarded, is discounted.

It's very accurate data and it's very important data. I've worked in three different school districts where that survey has been used, and I tell you we try to capitalize on that as much as we can.

The problem is that survey is done every two years, it's about a year later when you get the data, but it's still useful data. Because even when you look at the trends of data that's out by the CDC or the United States Department of Health and Human Services, they don't really get that data established until it's actually a couple years after they take it, but it's very

worthwhile.

I also want to talk a little bit about the health insurance and what Cheryl Dondero spoke about. You know, the average stay for treatment is 30 to 90 days.

Most insurance agencies will guarantee and say we're going to pay for 45 but you get 30. But you also deal with the mental health piece of the disease and, you know, obesity is also a deadly disease in our society.

So I try to use this as an analogy. Once somebody loses ten pounds, they feel they have it under control and they're ready to move on.

A lot of times youth and adults will sign themselves out of treatment facilities, because they feel like they got it.

Statistics show that it takes the average American five to six times, for various reasons, to get through rehab to be able to conquer that disease and be able to maintain a healthy lifestyle where they don't relapse.

Studies have shown, and there's some work that's been done here in the state of Pennsylvania, and I believe her name is -- I forget her first name, I think her name is Decker and she does a lot of work with

insurances within our state government.

And she's been actually able to show that, if people are in a treatment facility for a minimum of 90 days and they treat as what Cheryl talked to, at the level of the addiction, they have a 96 percent chance of beating that disease the first time and not relapsing.

That's so much different than having to do it five to six times, 30 days here, bouncing in and out of different facilities, and it comes down to the care and the work that's done in getting someone through that process in treating them at the level of the addiction that they have.

That is so important, and I think that if that's something we can focus on for the rehab aspect of this, it's greatly going to reduce the number of deaths that we see.

One other little caveat. You know, when we talk about our son's story, and I've heard this so many times, it's not just on the corner of 17th Street in Kensington where you pick up your heroin. You can get it anywhere.

Our son -- and we found out about three days after he had passed and I'll share this tidbit of his story because I'm sure that my counterpart's story is very same to ours.

The Thursday before our son passed away, I noticed in the car he was acting different, and I can tell you that after a year of going through rehab with him, I could tell -- and just from the journey that we went through -- I could tell if he was using just by looking at him.

And I could tell something wasn't right with him, and when I started to question him, he looked at me and he said, Honest, Dad, I'm not using.

I said, Son, I can tell something's not right. And he just returned and was starting college again and he said, No, I'm okay. There's just a lot of pressure on me right now, Dad, with school, but I'm good, I'm clean.

That Friday morning -- and I do have to say this, my wife and I, we don't hold anyone responsible for our son's death. There were a lot of things that we did right as a family, there are a lot of things that we did wrong.

So it's on us and it's on our son with the decisions that he made, but it's important that I share this with you.

That Saturday morning, I was cleaning out the garage and he was going over to his girlfriend's house. And everybody knew the situation with our son and

we were at that point where we were building that trust back, he was going over to his girlfriend's house.

And he said, What time do I have to be home tomorrow, Dad? I said, We have to leave here to 11:30. We were going to do something that was very important to him the next day.

And I said, You got to be home at 11:30. He said, All right, Pops, I'll be home at 11:30 tomorrow. He said, I love you. I said, I love you, too. Make good decisions. You know your mother and I are going to text you, we're going to call you, if there's any problems, let us know so we can deal with it.

At 8:32 that Sunday morning, I got a phone call, and I could tell you, before I got into education, I served as an officer in the United States Marine Corps and -- pardon me -- I've seen some things in this world and one thing that has resonated with me is the cry that a mother makes when something happens to one of her children.

And I can tell you it is no different in third world countries as it is here in the greatest country in the world. And when that phone rang and I heard that cry, I knew what it was.

Well, that Wednesday after our son's death and we came back, the state police came back, and we told

them you could search our house. We had been searching him, we had been searching our house.

We had to lock our doors because of what we were going through, because of the stealing that was going on to support this habit. I mean, it was very difficult.

All of a sudden I found an index card with some phone numbers on it in our son's textbook and I turned it over to the state police, because I knew that there was an investigation going on.

About a year after that, we were actually doing a Timmy Talk at a high school out in Chester County and I received a call from my son's football coach.

A DEA agent lived across the street from him and the DEA had worked in conjunction with the Pennsylvania State Police, the Delaware State Police and the DEA in Wilmington, Delaware.

And here they busted a doctor who was writing prescriptions to students at West Chester State University who were taking those prescriptions back and selling them, and that doctor was receiving a cut.

Now I'm not taking a swing at doctors, please. There are great in our society and there are bad in all aspects of our society, so that's not the finger that I'm pointing.

But what I'm saying to you is this. That this epidemic, this pandemic that we face goes through all aspects of our society.

That doctor who was then arrested and is in prison today for writing those scripts and doing that kind of behavior. I felt it was important to share that, because this disease does not leave anyone out.

I appreciate the opportunity of being able to come before you and share. And even though I haven't gotten into the nitty-gritty of our son's journey, I can tell you in working with parents and many different families who have suffered through this where they have lost a child, it's sadly to say, it is the same story over and over again.

And I'm going to let my counterpart, Tricia, share her story about her experience.

Thank you.

REPRESENTATIVE HACKETT: Thank you, Rick. And on behalf of the Judiciary Committee, we are so, so sorry for your loss. Thank you very much for coming forward and giving Tim's side of the story.

Also joining the panel here, I think it's appropriate to mention my good friend Theresa Agostinelli.

Theresa, thank you for coming up and just

lending that little bit of support there.

Theresa is a licensed clinical social worker here at Glen Mills Counseling Center. So I just wanted to welcome you aboard and thank you for your support.

And, Mom, go ahead.

TRICIA STOUCH: Thank you.

Thank you for allowing me to share Pamela's story with you. This is Pamela before her senior portrait they take in 11th grade.

She became an addict in 12th grade. I just wanted to put a face to who I'm talking about.

And thank you for your work in protecting our children from abuses and drugs and legal assistance.

Pamela's struggle began when she was a senior in high school. I'm very fortunate in that Pamela left a journal on her addiction journey.

Many of my questions were answered by Pamela's words. She writes first about being curious about drugs and their effects. Then she shares how her longtime friends no longer wanted her around. She felt that they didn't want her around.

She goes on to share that she could not get in with another clique. They were all set by the time they're in high school. So she began to hang out

with the outcasts, as she called them. The outcasts were using prescription drug medications.

I lost Pamela on March 27, 2010. She was 19 years old. I'm a stay-at-home mom. I was Pamela's softball coach, I was at all her school functions, I knew all her friends and I knew their parents.

I taught my kids to work. Pamela began work at the age of 14. She bought her own car at the age of 16. She paid her own insurance, bought her phone, paid for her phone, her clothes and her entertainment.

At age 18, she was managing our local Pizza Hut. She was a high school graduate and completed her first year of college. Not what society would think an addict would be doing.

After her high school graduation, I knew there was a problem. I figured she was experimenting. I just thought once I got her up into college and away from the people that I didn't know she was hanging around with that things would get better.

Little did I know when I dropped her off at college she was detoxing. There were many phone calls from her crying and not feeling well. I figured it was homesickness and she would be all right after a few weeks.

After her second semester, she called me

and told me she transferred herself into another school and was coming home. After she came home, things got much worse.

She was not coming home and we were not getting along. This was not my daughter and I realized something was very wrong. When I confronted her, she attacked me physically. Pamela would never hurt a fly in her whole life.

A month later, I got her to go into a rehab and she stayed for two days and signed herself out. She disappeared for four days. I didn't know where she was. She came home and I didn't know what to do. I was lost. I didn't know what was going on. I didn't know what I was dealing with.

She came to me about a month later and said she had called and got herself a bed in a rehab, that she needed help. After the 30 days, she went to outpatient and she went to her meetings.

She began relapsing. She met other addicts. She got in more trouble after completing rehab than before she went in. She stole from me, she lost her driver's license and she got arrested for theft.

I learned there was nothing I could do. We had already run out of money for medicines, therapists and doctors. We couldn't afford another rehab.

I was not as educated then as I am now. 30 days is not enough. That's all my insurance would cover.

I know now Pamela was not ready to come home. She needed more time and she needed more structure. She needed more counseling and she needed more clean time. She came out of rehab believing that she beat the addiction.

She got another job. She got her license back. She enrolled back into school. Things were looking good. She was relapsing and kept relapsing until the last time.

If Pamela had cancer or another disease, I could have gone anywhere and gotten anything that she would have needed. My insurance would have picked up everything, would have helped her, would have helped my family.

I can't begin to describe the horror of seeing your child gone to this world. Calling a funeral home. Choosing a casket, a cemetery plot, flowers, mass readings, prayers and songs, standing beside her casket saying my last goodbye.

Who plans for that? When society hears of a family living with an acceptable disease, they cannot do enough. There are fund-raisers, community support and

people who care.

We had none of that. Starts at home, right? We as her parents must have done something wrong, must have been our fault. My husband and I are your typical middle class family. We get by the best we can and we are not addicts.

I had to find out all I could what happened to my little girl. We are a world of pills. Take this if you have pain, take this if you can't sleep, take this if you are overwhelmed.

My doctor asked me if I needed something to deal with my grief. Someone offered me a pill at Pamela's funeral.

I learned this was a disease and it took me a long time to accept it.

Addicts choose to use. At first they do choose to use. They do not choose to have these drugs take over their brains. Whether given to you by a friend, as a teenager trying to fit in or prescribed by your doctor. Once addicted your brain fights and craves these drugs until the day you die.

That's what makes it a disease, a disease of the brain. When Pamela passed, I felt very alone. Eventually and sadly, I wasn't alone any more. I began to meet other parents who had lost their children. It's

a pain in my heart every minute of every day.

I began going to schools, I talked to our senior class, I talked to principals and counselors, I told my story to a reporter. I had a school-wide art contest and began a Pamela's golf outing and scholarship award.

I was invited to our join Heroin Task Force and have been honored to work with District Attorney Jack Whalen, County Council and the other members of the task force. They have been sincerely and truly caring about what is happening in our schools, in our communities with this epidemic.

A few of us are working on becoming a chapter of a Narcotics Overdose, Prevention and Education task force. The program is a dream of mine. I saw the vision when Pamela passed. And I wanted to sell them to the schools but they wouldn't let me in very long.

This program teaches parents how to safely handle medications. It teaches the children what to be aware of and what they're dealing with. It teaches them -- it gives them a place to go.

They have a website. They can ask Adam or ask Amy if they have questions. They encourage calling and being a hero if one of your friends is having a problem.

I had the pleasure of touring Moira's Place, which is a recovery house for women, and it teaches life skills to get back into society. I wish Pamela had that offered to her.

Again, I did not know. I didn't know we had a safe place where she would go. Nobody told me. My insurance wasn't going to tell me.

My wish is for parents, families and friends to begin talking. Do not say, Not my child. To educate our young children on addictions through our Narcotic Overdose, Prevention and Education, the acronym NOPE.

Fourth, fifth and sixth grade is not too young. This is when they're starting. If you have a suspicion, do not be embarrassed to ask for help. I've learned that I'm not -- I'm not embarrassed and I'm not ashamed.

I am not going to let a year and a half of my daughter's life define her. She was much more than that. I just didn't know how serious and what I was dealing with.

We must remove the stigma. We must remove the shame. We must question our doctors and ask for nonaddictive medications for ourselves and our children. We must lock up our medications. We must not deny there

is a problem.

It's an honor for me to speak to you today and thank my angel Pamela. I love and miss my beautiful girl every day.

Thank you.

REPRESENTATIVE HACKETT: Thanks, Tricia. On behalf of the Committee, you have our deepest condolences and we're here for you.

Theresa, do you want to add anything? Very briefly.

THERESA AGOSTINELLI: Good afternoon, and thank you very much for allowing me this opportunity.

Tricia is a good friend of mine. Not everybody has the opportunity to make sense of the death of a child, and I'm speaking quickly out of the other side of the process.

I have the privilege of walking with families after the death of a child due to overdose, suicide, mental health issues. One of my clients being my own mother who I've walked with her for several years after the loss of two sons, my two brothers, due to mental health illness, suicide and drug addiction.

One of the things that we find in this field is that many with substance abuse issues have also been suffering with mental health issues which we call

dual diagnosis.

There's a large policy gap for those struggling with those two, because both are not treated simultaneously and should be. And I also have found that there is such a stigma, as we've heard.

Insurance companies make a mess of being able to help people get in to treatment whether it be inpatient, outpatient, individual counseling.

People can't understand their insurance policies and now, with these new policy institutionalized issues, people have no idea.

And so one of the things that's important is that we learn to work with the insurance companies, we learn to understand mental health illness along with substance abuse issues, and as the Chairwoman for the Delaware County Women's Commission, I can also give you statistics and demographics and issues that are specifically related to women and children.

I deal with women who are in counseling for having drug addicted babies. I work with CYS to health reunite mothers. It is absolutely horrifying what people have to go through. So as a grief therapist I can tell you, most people don't get to make sense of what happened and so folks like Tricia who I'm helping with NOPE, I'm also on the board of her Pamela Stouch's

Foundation.

She's a hero in this field and I do want to thank you for the opportunity to just have me come up here and speak briefly.

Thank you and good afternoon.

REPRESENTATIVE HACKETT: Thank you, Theresa.

Are there any questions of the members?

Go ahead, Rick.

DR. RICHARD F. DUNLAP: As Dr. Hellman, the county coroner pointed out, I think it's important also to mention, in 1997 the Food and Drug Administration proposed using a way of advertising prescription medications on broadcast television, which almost no other country does as freely as we do.

Industry spending on direct-to-consumer advertising rose tenfold in five years and prescriptions written for opiate painkillers, such as Vicodin and OxyContin, rose more than 500 percent.

So when he was talking about the way that we go about sharing this information to our public, there's definitely a correlation to that.

And I just felt it was important to reinforce what he said thinking about that also.

REPRESENTATIVE HACKETT: Thank you, Rick.

And thank you again to the panel. We look forward to working with you as we progress with legislation to help this epidemic.

Thank you.

Next up we have Dr. Richard DiMonte and Nicole Kapulsky.

Good afternoon. We're running about an hour behind and I want to thank all the testifiers for hanging in there and the audience too and the members for staying with us today on such an important issue.

Please proceed when you're ready.

DR. RICHARD DiMONTE: Thank you, ladies and gentlemen, for giving me the opportunity to be before you today. My name is Dr. DiMonte. My specialty is addiction medicine. My subspecialty is detox in the treatment of opiate dependent patients.

We should have been having this conversation ten years ago. I saw this started ten years ago with the influx of OxyContin patients.

Heroin addicts don't choose to be heroin addicts. They also start from prescription medication. A lot of these people are in the criminal justice system and they're getting improper treatment. They're relapsing and going back into the jail system, costing us money.

I myself have been using a drug called Vivitrol. It's an opiate blocker to treat these patients along with psychosocial support and 12 step to keep these people from relapsing.

There are other options available. We have methadone. Methadone was invented in 1964 by Dr. Dole. It's actually a harm reduction therapy.

What happens is Dr. Dole figured that, if we give them the drug of their choice and sent them to counseling that these people would not relapse, they would not use needles, spread disease or commit crimes.

In 2003, another drug came out, buprenorphine, Suboxone, a partial opiate. Now we're using the same harm reduction program but we're in the doctor's office. We figure, if we give them the drug, our drug of choice, that they won't go out and rob, steal and such.

Me, I use naltrexone, extended release naltrexone release. What it does, it's non-narcotic. It's a once-a-month injection. It blocks the opiate receptors so that they have decrease in cravings, they do not relapse and they can work their 12-step program.

I've had much resistance from the judicial system about me having my patients who are on probation and parole using this drug along with the concurrent

program.

I think it should be implemented. The relapse rate in an opiate addict first year is over 80 percent. We are not addressing these problems and treating these people properly.

This would save -- it would save a ton of money on the system, it's less cheaper in the long run than methadone. It's not a life-long treatment with Vivitrol as methadone or Suboxone maintenance is.

I have a patient with me today, Nicole, who's going to speak later on, is a prime example of a person who goes through my program with Vivitrol itself.

And I would like to offer that to the people on probation and parole. I would like them to be accepting of it and allow these people to fully recover, to let their brains heal by not giving them opiates, methadone, partial opiates, Suboxone, by giving them a non-narcotic treatment.

REPRESENTATIVE HACKETT: Thank you, Doctor. It's good to see you again, too.

THE WITNESS: You, too.

REPRESENTATIVE HACKETT: Nicole, good to see you. I didn't know you would be testifying this soon after the other hearing that I was at.

But feel free to jump in there. Let's

hear the story.

NICOLE KAPULSKY: Hi, my name is Nicole Kapulsky. I'm 36 years old. I have three children. My son Nicholas is 17, Dominic is 12 and Christopher is ten, and I have my niece Chloe in the back, too.

I didn't start off with pain medicine, pills, anything like that. The first drug I ever did at the age of 32 was heroin. Never drank, never, you know, did any kind of recreational stuff.

I went through a bad divorce, moved back home, ended up meeting a friend from high school who told me about heroin. So lo and behold, I tried and it kept my mind off of everything, my divorce, you know, the kids, everything.

It went on for a couple months. I went to rehab. I stayed for the 30 days. I left rehab to relapse within four weeks.

I went on to using drugs again. A couple weeks later I overdosed in my parents' bathroom. I don't remember how it happened. I just know that my mom called 911, they busted in the door and they dragged me out.

I kept going on with the heroin for a couple more weeks until I couldn't take any more. I had missed Christmas with my kids, New Year's with my kids.

I Googled ways to get clean on my own.

The first thing I saw was Dr. DiMonte's name and Vivitrol. That day I made an appointment and I went in and talked to Dr. DiMonte with my father, after begging and pleading with him for help.

Dr. DiMonte told us about Vivitrol. I figured this is great. I'm going to get off drugs 100 percent, I'm not going to be on anything that's a narcotic. I'm going to get my kids back, I'm going to get my life back.

A week later I went in, I got my Vivitrol shot, and everything from that point started falling into place. I did have court for overdosing. This went on for months.

Dr. DiMonte would write letters, my therapist would write letters saying how good I was doing, and because of all of the help from both of my doctors, I only got probation.

I moved on to getting my children back and now I have a job, I have my three kids and I have my niece, and it's all because of Vivitrol.

Vivitrol saved my life. And if they could put Vivitrol in more probation programs, more of these people wouldn't fail. I feel like probation is here to make us fail. They tried to make me fail and I didn't.

My probation officer went on for weeks

trying to make me fail. Dragging me in there day after day, drug testing me. And I kept telling her, I'm on Vivitrol. I'm not going -- you're not going to make me fail.

So I just really think that Vivitrol is a great drug to help other people recover from being a heroin addict.

REPRESENTATIVE HACKETT: Thank you.

Doctor, do you want to jump in there?

DR. RICHARD DiMONTE: Do you mind?

REPRESENTATIVE HACKETT: No. Go ahead.

DR. RICHARD DiMONTE: More than half my patients were somehow involved in the judicial system. I have seen and have been working for ten years out in the Media area and working with the Delaware County courthouse, they have to -- the program is designed for failure.

I mean, it has to be changed. There has to be more access to drug court. A lot of these crimes are committed due to patients or people's addictions and that's not being addressed.

They're being thrown in prison and they figure, if they keep incarcerating them, these people are going to get better.

They're not going to get better. They

need proper treatment. It needs people like me and the outside, probation, parole, judges work together to try to put together the best program we can for these people.

If we can keep them sober, their repeat offenses will decrease, but we don't address that. We concentrate on hot hearings, oops, violation of probation, off.

REPRESENTATIVE HACKETT: Doc, how about Vivitrol, FDA approval or not?

THE WITNESS: Yeah. I've been using it since 2006. Okay? It first came out in 2006, but it had the FDA indication for alcoholism.

I started using it immediately in my opiate addicts and got a great response. In 2010, they did get the FDA approval for opiate abuse so...

REPRESENTATIVE HACKETT: Let me get my head around this. As you see right in front of us, Nicole.

So, Nicole, you're a regular girl, wife --

NICOLE KAPULSKY: Yes.

REPRESENTATIVE HACKETT: -- mother, children.

NICOLE KAPULSKY: Yes.

REPRESENTATIVE HACKETT: From the area?

NICOLE KAPULSKY: Yes. I live in Glen Mills.

REPRESENTATIVE HACKETT: Very in the area. Okay. So I don't know.

You try heroin and it gets you the first time, you're hooked.

NICOLE KAPULSKY: Yep.

REPRESENTATIVE HACKETT: Your life is crashing down. You hook up with Doc and Vivitrol.

NICOLE KAPULSKY: Yep.

REPRESENTATIVE HACKETT: And you're saying you have no addiction right now?

NICOLE KAPULSKY: No.

REPRESENTATIVE HACKETT: How long were those shots of Vivitrol? You said they were monthly.

DR. RICHARD DiMONTE: Once every 28 days. And of course, they're getting psychosocial support and I do encourage them to work the 12-step program.

But what it does is, it's used to prevent relapse. When you see people in recovery, part of relapse is, they might be at a meeting and they're just in the wrong situation at the wrong time, and you have a weakness and then they go back on the roll.

When you block them over a 28-day period, we don't have to worry about that. So they can

concentrate on their actual recovery work itself with taking that relapse out.

Now I give the shot once every 28 days. In my opinion over the years, I've tried three, six and nine month. My greatest, not cure but recovery rate is at a year.

It takes about eight months for the brain to go back to normal, brain chemistry, after opiate abuse. So about a year is the best result out.

Now I have people that go further but that's on average.

REPRESENTATIVE HACKETT: Thank you. Chairman Marsico with a question.

CHAIRMAN MARSICO: Just a question on the cost of the injection.

What's the approximate cost per injection?

DR. RICHARD DiMONTE: It's about 1,100. So you figure a year -- a 30-day stay in a rehab versus a year worth of treatment. There's equivalent costs.

CHAIRMAN MARSICO: Any side-effects?

DR. RICHARD DiMONTE: Tender at the injection site. That's about it.

But I mean, I haven't had to discontinue it due to any adverse effects, allergic reactions and such, and I've had thousands of people on it.

REPRESENTATIVE HACKETT: So the courts, though, in these cases are sending folks to -- I just want to get this right.

They're sending them to rehab but as part of that rehab or -- I just want to try and put this right without offending anybody.

CHAIRMAN MARSICO: I think what the problem is that the courts -- it seems to me what you're saying is the courts are not recognizing the treatment, the injections of the drug; correct?

DR. RICHARD DiMONTE: Correct.

CHAIRMAN MARSICO: They're not recognizing it.

DR. RICHARD DiMONTE: Correct.

REPRESENTATIVE HACKETT: But they are recognizing the drugs, the other two drugs that we were talking about, the Suboxone and methadone. So they recognize those as some type of treatment form, right?

DR. RICHARD DiMONTE: Right.

REPRESENTATIVE HACKETT: Okay.

DR. RICHARD DiMONTE: But they're not recognized in -- I tell you personally that a few of my patients were threatened with violation of their parole if they went on this drug.

And, I mean, I don't think -- I don't know

where you guys stand with it -- I mean, that they should be making -- any court system -- should be making medical decisions on their treatment.

That should be left in the hands of us, the physicians. But these programs are set up by the courts.

REPRESENTATIVE HACKETT: Okay. Any other questions of the committee? Let's start at the end.

Representative Corbin.

REPRESENTATIVE CORBIN: Thank you. You said Vivitrol originally got FDA approval for alcoholism.

How would you parallel it to Antabuse and what's the difference in the pharmacology?

DR. RICHARD DiMONTE: Well, Antabuse basically is a deterrent used that one of the side-effects is, if you combine Antabuse with alcohol you get very ill, you get nausea, vomiting from it.

Vivitrol is naltrexone. Naltrexone has been around since the '70s in an oral form, but the problem with the oral form is, especially with people with addiction, is unless you take the pill, it's not going to do anything.

So with the injectable, we took that decision out of the addict's hands and whatever. And

basically what it does is, it blocks -- in your brain are mu receptors.

These receptors are where the opiate goes to -- turns on, releases dopamine, and that's where they get this high or euphoria. Heroin works the same as pain medication and such.

What naltrexone does is it puts a cork in there. So if you were to ingest something, the molecule can't get to the site to turn it on so they don't get high.

And it works with alcohol. Alcohol releases, it's called beta endorphins in the brain. Those beta endorphins will increase on the receptor site and turn it on.

It blocks the receptor so, even though it cuts down the cravings because the beta endorphins can't get to where they need to go, but they don't get sick from it and such.

REPRESENTATIVE CORBIN: Thank you.

REPRESENTATIVE HACKETT: Thank you, Representative.

Any other questions? Representative Keller.

REPRESENTATIVE KELLER. Thank you.

So I'm clear on this, how long is a

patient on Vivitrol?

DR. RICHARD DiMONTE: It varies from patient to patient.

REPRESENTATIVE KELLER: What's the longest length?

DR. RICHARD DiMONTE: I have some as long as three years and they're doing fine. And I mean, and they were long, life-long career heroin addicts.

REPRESENTATIVE KELLER: Well, can I ask you, what is the norm?

DR. RICHARD DiMONTE: What is the norm that I've seen? Probably nine -- nine months to a year.

REPRESENTATIVE KELLER: Okay.

DR. RICHARD DiMONTE: That's why I encourage them to be on -- all the time that they're on it, they are working with my counselors and such and 12 step and doing what they need to do.

On a side note, I mean, they do much better than these patients that are on Suboxone and methadone. That's truly -- from my personal experience, very few people recover from those type of drugs.

REPRESENTATIVE HACKETT: Doc, one more question from the committee.

Are there any other physicians around that are prescribing and using Vivitrol that you're aware of?

And where are you located?

DR. RICHARD DiMONTE: Across from the courthouse in Media.

REPRESENTATIVE HACKETT: I probably should have known that. Go ahead.

DR. RICHARD DiMONTE: I have been, through the past two to three years, lecturing on this theory of opiate blockade therapy and trying to train doctors on how to do it.

They're a little reluctant because, one, you have to be off of opiates for seven days before you can go on the injection. If you're not off opiates for seven days, you'll precipitate withdrawal within about ten to 15 minutes.

So you have to learn how to detox people and a lot of physicians don't know how to do that outpatient. But there's a handful of about three or four on board right now.

REPRESENTATIVE HACKETT: Within this immediate area? Are we talking state, country? What would you say?

DR. RICHARD DiMONTE: It's been so new out that the next biggest guy, Pittsburgh. This area is inundated with -- and I do write the drug, but Suboxone doctors, that's their treatment of choice and it's easy,

it's quick and it's lucrative.

So I've been trying for the last ten years -- well, at least since 2006 -- to try to change the philosophy of how we treat opiate addiction by going from agonist to antagonist, from blockade to blockade. So I'm getting people on board with the theory. And it's working.

REPRESENTATIVE HACKETT: And, Nicole, I'd say you're a fan, right?

NICOLE KAPULSKY: Yes. Yes, I am.

REPRESENTATIVE HACKETT: Any other questions?

Representative Stephens.

REPRESENTATIVE STEPHENS: As long as we're doing a commercial for this drug, who manufactures it?

DR. RICHARD DiMONTE: Alkermes.

REPRESENTATIVE STEPHENS: Okay. Thank you.

Why is it more lucrative? Why is the other drug more lucrative than this drug? Talk to me briefly about the economics there.

DR. RICHARD DiMONTE: In all seriousness?

REPRESENTATIVE STEPHENS: That's what I'm hoping.

REPRESENTATIVE REGAN: This is a hearing.

DR. RICHARD DiMONTE: Suboxone, there's very few guys that can write the drug itself. You have to have a special license.

It's against federal law for physicians to treat opiate addicts with opiates. There's a law. There was a Data 2000 Act when Suboxone came out that said you could do it but a very limited amount of people.

So you were allowed your first year of 30 patients. Then after that 100 patients about a year after that. There's very few guys that do it and it's a very much wanted product. So it can be cash-only business. Guys charge a lot of money for it, office visits.

REPRESENTATIVE STEPHENS: That's due to a federal law?

DR. RICHARD DiMONTE: Yeah. Basically what's going on is -- first of all, I can't find out, and it's been for the life of me, why they limit it.

We have an opiate epidemic. There's very few guys that treat opiate addicts, medical doctors. It was usually left up to the psychologist, the rehabs.

But the medicine is starting to get involved now by combining theories, therapies, psychosocial from the psychology world and the medical assisted treatment from us.

But then they limit us to 100 patients. Like you have to turn people down who want Suboxone therapy, but you have to turn them down and essentially they're relapsing a lot, these patients.

It's not like your normal patient comes in for a cold. Say you have a 100, you're treating somebody, they relapse. You don't see them for a couple months and then they come back for treatment. Well, according to the law, I have to turn them away even though I have a relationship with them, because of a federal law.

REPRESENTATIVE STEPHENS: Thank you.

DR. RICHARD DiMONTE: You're welcome.

REPRESENTATIVE HACKETT: Thank you. Any other questions from the committee?

Doctor and Nicole, thank you very much for attending here today.

DR. RICHARD DiMONTE: Thanks for having us.

REPRESENTATIVE HACKETT: Looks like our last two testifiers for the panel. Thank you for sticking around.

We ran a little bit over today, but I think it's an important issue and, you know, we took all that into conversation.

Next up is Michael Noon, first assistant district attorney for Chester County District Attorney's Office, and Kevin Steele, first assistant district attorney for the Montgomery County District Attorney's office.

Welcome, gentlemen.

MICHAEL NOON: Good afternoon. Thank you, Representative Hackett. Thank you, Chairman Marsico, and members of the committee.

It is clear that the war on drugs has shifted significantly. The front line is no longer the street corner in the bad part of town or the dark alley that you hope to never have to walk down.

The front line has quickly become your home, your grandparents' home, their medicine cabinet, the school hallway.

We heard from many people throughout the course of the day today how prescription drug abuse has led us to a situation where it is an epidemic.

And I agree with everyone who has said that the heroin problem and the prescription drug abuse epidemic do go hand in hand.

It's very important from a law enforcement standpoint for law enforcement to adjust to the new dynamics of what is this evolving war on drugs.

We are here as first assistants in neighboring counties to where we are right now to speak on behalf of those foot soldiers who are at the front line.

One of the aspects of prescription drug abuse that makes it so difficult is that they are not inherently illegal. As has been pointed out, they can have valid uses when prescribed and monitored by physicians.

However, we are at a point where our country is flooded with prescription drugs. There's been a tenfold increase in the use of prescription drugs due to the idea that many medications need to be utilized to address legitimate pain issues, legitimate health problems.

But that has created a situation where there is now a flood essentially of these medications out there, and they're not being controlled by the people who either receive them or they're being further disseminated by people who are unscrupulous.

I have tremendous respect for physicians, but there are doctors out there who run pill mills. There are people out there who are just the same as drug dealers, but they don't look like what you would think a typical drug dealer would look like.

It's our job as law enforcement officials to adjust to the ever changing dynamics of this war on drugs.

I had many of the same numbers that you've heard throughout the course of the day today from the National Council on Drug Control Policy. I can sit here and rattle off statistics about how for people over the age of 12, there are an average of -- between 12 and 13, that's when the drug of choice becomes prescription drugs.

That more people die as a result of prescription drug overdoses than overdoses of heroin, cocaine, including both crack cocaine and powder-coated cocaine, ecstasy or methamphetamines combined.

But it has been a long day and you've heard many of those statistics already from people who are also on the front line.

What I think are our takeaway point from a law enforcement perspective is that we do look to the legislature for assistance in having the tools necessary to combat and effectively fight this war.

Because make no mistake, people are dying. We've just heard heart-wrenching stories from parents who have experienced the worst imaginable outcome than they could ever imagine.

We've seen it. As prosecutors, I've also during my career been a criminal defense attorney. I have represented people who have struggled to pull themselves out of the abyss of addiction.

They're not bad people. But due to desperation, due to bad influences, due to momentary bad decisions, they have found themselves in the abyss of addiction.

I can tell you I've had -- I've received calls in my office late at night from a young man who was 16 years old who, when I last heard was in an inpatient rehab facility. He had checked himself out. He was wandering the streets. He called me because my business card was the only thing that was in his pants pocket. And he didn't want to get high any more.

Thankfully his story had a happy ending, but many of these stories do not have happy endings.

From a law enforcement standpoint, we recognize, or we try to recognize the difference between the individual who needs a helping hand, and there are very influential and effective tools such as drug court.

I can tell you one of the things I'll be doing later this afternoon when I get back to the D.A.'s office is dealing with some responsibilities for the Chester County drug court.

That kind of intensive rehabilitation, coupled with consequences, can be very effective when people are invested in that outcome.

But we also want to recognize and thank you for things like prescription drug monitoring systems. Our ability to try and figure out who are the drug dealers.

Because the statistics that have been released by the National Council on Drug Control Policy reflect that only five percent of people who abuse prescription drugs get those prescription drugs from what would traditionally be considered a drug dealer.

The overwhelming majority of people get those drugs for free oftentimes from friends, they steal them from family members when they go to grandma's house or they go over for a sleepover.

I have spoken at schools as recently as last week and told parents, show of hands, who here has crack cocaine in their house? Who here has heroin in their house? Who here has prescription drugs in their house?

How many of you ask when your son or daughter goes to a sleepover, What kind of prescription pills do you have in your medicine cabinet? That's an awkward thing to have to ask someone, but it's the kind

of thing that a parent should ask.

So combined, the legislature can and does help by allowing law enforcement to have access to the prescription drug monitoring system, by allowing laws such as the Good Samaritan Law when an individual is present and their friend or colleague overdoses from drugs to stay with them so there's some amnesty for that person so they can call 911 and get help.

We, as prosecutors, need to try to recognize the difference between the drug addict who needs help and the drug dealer who needs to be punished, and we need to be able to figure out who is the modern drug dealer.

How do we attack that person and how do we get the information on who that person is so that we can effectively prosecute those crimes.

We're all in this together and we all have different skills that we bring to the battle. But it is an ongoing war, and one that we will not see the end of any time soon.

So I thank the Committee and I thank everyone else who has been here today to bring their specific skill sets to the discussion, because the discussion must continue and the war must continue to be fought.

Thank you.

REPRESENTATIVE HACKETT: Thank you, sir.

KEVIN STEELE: Good afternoon. Thanks for having me. My name is Kevin Steele. I'm the first assistant in Montgomery County.

By way of background, before I took over the role as first assistant, I was captain of the narcotics unit for a number of years and also had a little stint out in Dauphin County where I was a deputy district attorney and supervised by a certain Ed Marsico, who assigned me to work with the Harrisburg vice unit and working on drug cases in our state capital.

So I've been working with the drug crime section and drug crime detectives for a number of years. So I give you that by way of background and I hope that this can be somewhat of a conversation on things that you want from those in law enforcement and what we're seeing on a daily basis to help you with this moving forward.

And as you've heard throughout the day and as I know you recognize because you're doing this, it's a significant problem and a significant problem that we're facing on a daily basis.

A couple quick things that I've seen with this that I think help me get in a good perspective of what we're dealing with are cases that I've dealt with

over the years where one example was two brothers, one gets out of a drug rehab.

They go, they get drugs, they both shoot up heroin together and one dies from it. The other brother watches his brother die and, because he's under the influence, he can't do anything to help him.

So I get involved with the detective. We're meeting with the surviving brother with the goal of trying to figure out, you know, where they got the drugs from, you know, go after the person that was dealing the drugs.

And as I was speaking to him about what had happened, I leaned back and I said, Now after everything you've been through, after watching your brother die, if I put heroin in front of you right now, what would you do?

And he dropped his head and he said, I'd use it, and he cried. And, you know, that -- that to me shows the impact of what this drug does to people.

And you've heard it. It's, you know, one use and you're chasing the dragon and people going after that to try to get that high.

And the impact of that on their lives is something that we, I think all of us have to look at and be proactive on. We've got to stop it before they start

going down this track.

And, you know, the devastation that comes from it, you know, can be seen in case after case. I don't know how you all came in for the hearings, but King of Prussia Mall in Montgomery County, right across the street from it there's a hotel.

A young couple drives from Altoona. They get a hotel room there. The boyfriend leaves the girlfriend and her two young children in the hotel room, goes down the city, you know, buys heroin. They come back; they use it.

She overdoses and dies. He is not the father of the children. You know, you have two small children that no longer have a mother because she overdosed on this.

So, again, we get involved in this. And one of the things that I wanted to know in that case and has been spoken about earlier today, it is reflective of the purity levels that we're dealing with.

I asked a laboratory that we send a lot of our drugs to, National Medical Services, to test for purity in the heroin bags that were not used. 96, 97 percent pure.

For someone who is not using a lot of that, that can kill, and did. You know, she was not an

avid user; he was. And that's what we're seeing.

You know, that impact on the suburban areas of the city and rural areas, it's amazing where you see this impact going into different communities and how it's getting there.

A couple of you are former police officers. One of our undercover detectives who goes with me every year when I teach all the new prosecutors all over the state at basic prosecutor school about drug investigations and prosecutions, and we tell all of the young prosecutors about this, because it shows what the dealers of this poison are thinking about.

He is, in an undercover capacity, he is buying cocaine. And the dealers say, You know, hey, we want to sell you some heroin.

Yeah, well, I don't really have a market for that right now. And they were doing the deal near a school.

And one of the dealers points to the school, which was elementary, middle school area, he says, Give it away in there and you will have customers for life.

That's the mentality of the people that are trying to make profit off of that, you know, and that's where, from the enforcement end, you know, we got

to be hammering them.

And those guys got hammered. They won't be dealing drugs for a long, long time in our community unless they get something going in the prison, but hopefully we'll get that on the phone.

So we see this and we are working -- and the southeast region, I'll anticipate a question that you asked a couple times earlier.

We're working together on this, and we work closely with, you know, the other counties. We have the narcotics enforcement team, we have a Montgomery County drug task force that's 400 officers.

We're working with the City of Philadelphia, because a lot of what we're dealing with is coming out of the City of Philadelphia. And some of the things that we're seeing in Montgomery County that's reflective of that work with them is trying to identify where the people arrested in Philadelphia for possessory offenses are coming from.

Now Montgomery County, 800,000 people in our county, fairly affluent areas throughout the county. And since January 2013, 108 Montgomery County residents arrested in Philadelphia for heroin possession.

They came from Eagleville, Ardmore, Abington, Fort Washington, Wynnewood, Lansdale, Lafayette

Hill, Hatboro, Jenkintown, Oreland, Rockledge, Royersford, Hatfield, Willow Grove, Telford, Souderton, King of Prussia, Huntingdon Valley, East Greenville.

All right. That's all over our county.

I didn't see Horsham on the list, Todd.

So you have all of these people that are going down and doing this, and that's just the people that got caught in the city, you know, doing that or caught down there. Not necessarily coming back out.

And more along the outlines of education, okay, what are they buying down there? Jon, when he started out this morning, showed you some of the bags that are out there and the bundles that are being sold.

All right. Some of the stamped bags coming out of the southeast now, and I tell you these names because think about how it's being tried to get sold and who the target audience on these things are.

Okay. Over the past ten months, bags found in the southeast, I'm a boss, 99 problem, Lucifer, Dragon Death, Gucci, Sprite, Timeline, Power Up, Goldie, Cartel, Night Night, Escalade, Versace, Superstar, Red Devil, Sugar House, Gorilla, Superpower, Deadline, Snapple, White House, Snickers, Bugsy, Victoria Secret, Rolex, Fab Boy, CPR, China White, Times Up, My Turn and Venom.

So, you know, those are the bags, that's how they're being stamped. If people get a good high off of it, they're going back and looking for that type of heroin.

And we've heard from addicts that, when they hear about a heroin killing people, that with a certain bag stamp on it, that instead of going the other way on that, people are going towards that type of bag, because it must be a really good high and it must be really pure.

So all the aspects of where we think it should be the opposite reaction, run away from something that might kill you, they're doing that and going down that track.

And I think when you look at that and when you think about those ramifications, we have a serious problem, we have an epidemic, you recognize this in these meetings that you're having, I applaud you for it, because we have to be doing more and it's got to be proactive.

And you've heard it from a number of people today on this course that it goes and I am in agreement with this. You know, it starts with the prescription drugs and then leads to heroin.

And I can -- I could read pages, I could

tell you so many cases where, you know, it is good people that are going down this course, good kids that are going down this course, and doing this.

I got a trial starting in two weeks on a doctor from one of our rural areas who was, I guess I have to say allegedly, but I'm confident that the case will go the right way, that was just taking, taking money for prescription after prescription.

And family members are going to him and saying, Don't give them any more drugs, because they're addicted to it. He says, Oh, I don't want them to go through withdrawal, and he's writing scripts for them.

And that attitude is only greed, you know, that they're dealing with this to keep these people going down the track and keep these people addicted to it.

And when the police officers were at his medical office, at his medical office, they are in uniform at the medical office, they have addicts showing up with cash, going past them to try to get in to get prescriptions.

And so this is the addictions that they're dealing with. One person showed up so high on drugs, she got arrested for DUI, you know, driving under the influence of the prescription drugs, of that.

So that's the mentality and the things

that we're dealing with. And we're working very hard in law enforcement to combat it but, you know, this is a team effort from all the folks you've heard from today.

And as a prosecutor, we like to finish last, so I appreciate you giving me this opportunity at 2:00.

I said to Mike about 12:10, I think we're up.

MICHAEL NOON: There are three things that district attorney's offices, specifically Chester County District Attorney's office has done and district attorney's offices can do that are outside the scope of the traditional find the bad guy, prosecute him, lock him up.

First of all, the drug disposal boxes. You've heard about them throughout the course of the morning. They're a very effective tool.

The Pennsylvania District Attorneys Association has recently authorized a number of drug disposal boxes to be throughout the Commonwealth, and I'm very happy to say that Chester County will have ten of them located throughout our county so that we can effectively try to dispose of medications safely in a way that keeps them out of the environment and out of the hands of people who would try to get them to abuse them.

And I would like to also publicly thank Representative Corbin for your support out in front of this initiative and I would also like to thank Representative Milne for your support of this initiative in Chester County.

This is something that we will be rolling out county wide in about a month and we're looking forward to hopefully having as much success with it as our counterparts in Delaware County and Montgomery County have had already.

Secondly, Safe Schools. I heard earlier one of the presenters talked about the use of the intermediate unit. We recently had a Safe Schools Summit in Chester County.

I sat on a planning committee with that, along with members of the intermediate unit, and we addressed all day long a variety of topics ranging from active shooters, to cyber bullying, to prescription drug abuse, to drug addiction and detection in our schools.

This is something that was targeted through administrators, faculty, and it was a very successful program.

This was our second annual Safe Schools initiative and it's something that we're looking forward to continuing in the future, and we can bring all the

resources of law enforcement to an environment in a school so that we can foster the relationship with schools to try and get ahead of this problem.

And, lastly, there was some discussion earlier about cooperation among various organizations and entities. Chester County participates in the HIDA, which is the High Intensity Drug Trafficking Area.

It covers basically Philadelphia, Camden and suburban Philadelphia, and it is a joint, federal, state and local initiative that deals with effectively gathering intelligence and effectively going after drug dealers.

And our district attorney, Tom Hogan, is the recent intelligence chair of that committee.

So we're in a position where we're able to get intelligence information on how are these drugs coming into Philadelphia, what's the going rate, what's the purity, how are they being distributed, what are the drug trafficking organizations that are in the area, how are they getting the material in, where's the money going.

All of those things are things that we're able to try and get ahead of as well. So those are just three examples of things that local prosecutors' offices can and do to try to get ahead of drug problems by doing

things beyond just locking up the bad guy after the crime has been committed.

Thank you.

REPRESENTATIVE HACKETT: Thank you, Michael, and thank you, Kevin.

Are there any questions of the committee?

Representative Milne.

REPRESENTATIVE MILNE: Thank you very much, Representative Hackett. Mr. Noon, good to see you, as always.

MICHAEL NOON: Nice to see you.

REPRESENTATIVE MILNE: Appreciate everything that you're doing for the Chester County District Attorney's office and our citizens who are at large in the county.

MICHAEL NOON: Thank you.

REPRESENTATIVE MILNE: I think the Chester County District Attorney's office really has carved out a terrific reputation for a lot of innovative and I think far-reaching kind of initiatives.

I wanted to tap on your points about some of the collaboration between entities in this war that we're all trying to engage in.

I was very struck this morning about the connection back to the real estate agents that's

apparently evolved out of the Delaware County Heroin Task Force, and that was a really interesting nexus I really had not thought about and the access and availability because of the open houses that was identified by having that kind of specialty focus on the task force.

What kind of -- and I'm referencing your very poignant example from Montgomery County that some of the physicians that regrettably betray the trust of society and the patients and obviously their oath of what they're supposed to be doing for taking care of people.

But what kind of contacts or relationships, discussions, do happen between say the district attorneys' organizations and say the Pennsylvania Medical Society, or the Chester County Medical Society in our particular case, that try to zero in a little bit on this particular niche of the problem?

MICHAEL NOON: Sure. That's an excellent question.

First of all, we talk about it among ourselves as well. And Kevin will tell you, I've burned up his cell phone calling him with different favors or information or things like that.

Among ourselves, the suburban Philadelphia counties, because we're all very similarly situated, we get together on a regular basis, the leadership of those

offices, to discuss various issues, to get behind different things that we need to get behind in the war on crime collectively, whether it's new developments in electronics and technology that can be utilized to fight crime or whether it's certain legislative initiatives that we may like to pursue.

So there's open dialogue among the prosecutors and that's been a tremendous resource for all of us.

Now specifically as it relates to issues such as the medical field or pharmacies, we have reached out -- we've tried to reach out to pharmacies regarding, for example, the prescription drug disposal boxes for some of their support on that. The boxes themselves will be located at police departments for obvious security concerns.

But we also have very close contacts with the community. Obviously, the district attorney as an elected official tends to know people across the spectrum of the county that they represent.

So we do reach out to individuals to try to foster those relationships. And the thing about that is that doctors don't -- one bad apple ruins the bunch as they say.

Doctors don't want unscrupulous physicians

out there preying upon victims, and really drug addicts are victims of their disease. And anyone who betrays the first edict of a physician, which is do no harm, and is trying to profit off of that, in my experience, sometimes the most offended people by that are fellow physicians.

So we have had success with doctors, even if it's just something that they want to provide a tip. By fostering that relationship with the community, and that's really a huge part of what a prosecutor does.

A prosecutor is the person who is representing the Commonwealth of Pennsylvania, and by representing the people of Chester County, we are able to try to foster that relationship so that physicians feel comfortable coming to us.

And we have had members of the community across the spectrum of jobs come in to meet with us. So by encouraging that kind of open communication, that's what really is going to allow us to get a grasp on all the different aspects to this problem.

Because as you've seen this morning, there are a lot of different aspects. Everyone who's come up here and sat at this table has had a different view of the problem. But it's situations like this, where we all have the benefit of hearing those different views, that we can actually do something with that information.

KEVIN STEELE: And I could say we plagiarize off of each other all the time. So if somebody has a good idea with this and, you know, the drop boxes and what we've been able to do in combining with a pharmaceutical association, when we unveiled it, you know, they were standing with us at the press conference, you know, talking about the importance of it.

So it is a lot of the collaboration and working together with your different associations within the county.

REPRESENTATIVE MILNE: Well, the first edict of life is imitation's the sincerest form of flattery, so there you go.

REPRESENTATIVE HACKETT: Thank you, Representative. Thank you for your question.

Just a couple housekeeping notes here.

Number one is that I think we're running out of our four-hour tape limit over there, so we'll keep moving things along real quickly.

I'm also required to let you know that we did receive written testimony from the Honorable Frank T. Hazel, Delaware County Court of Common Pleas, and also Mr. David C. Hughes and we'll enter those into the record.

We have some comment from Representative Delozier.

REPRESENTATIVE DELOZIER: I would simply just thank you for your time and you mentioned treatment court and actually today in Cumberland County, I'm missing being here, is our treatment court graduation, and I try to get down there, because the stories that go through that court and our judge that works with that court is very, very passionate about the success of treatment court.

So it's a simple thank you for your support of that option for many people, and you hear those that are graduating how many times it did take them, how many times they tried, but they had the support of not only the prosecution but the defense.

On both sides they wanted them to get better and they wanted them to get the treatment that was necessary so they weren't in jail.

So thank you for the support of that. I know in Cumberland County it's a phenomenal program and they work very, very hard on both sides of our court system to make sure it's a success.

So thank you for that and hopefully that will continue and more treatment courts will be available too in other areas of the state.

Thank you.

KEVIN STEELE: We think that's being smart on crime. It's working well.

REPRESENTATIVE HACKETT: Thank you, Representative.

Representative Stephens.

REPRESENTATIVE STEPHENS: After working for Kevin for ten years, I never had an opportunity to question him, so I didn't want to miss it, but I'm going to make it quick.

Increasing the standard for access to the Schedule II database from where it is now to requiring a search warrant, what's your opinion on that?

KEVIN STEELE: First off, we're very appreciative of the work that has been done along those lines and, you know, working towards the bill.

From an enforcement, and I put this from kind of a line position on things, to be able to gather intelligence is helpful. So lesser standards on that would be helpful for investigative means.

And that's a lot of what we have to do with limited resources, you know, working together with the attorney general's office, working with agencies that have access to these things, and we do that now, but to put further requirements on it will make it more

difficult for us to investigate some of those cases and try to develop where the problems are.

REPRESENTATIVE STEPHENS: Do you share his opinion?

MICHAEL NOON: I do. There are certain unique aspects of prescription drug abuse which make it very difficult to gather useful intelligence.

This is not the equivalent of the street drug dealing, so the traditional means of surveillance, of getting CIs into organizations are challenged in the context of prescription drug abuse.

We have seen, and I can't get into too much information on it, but in investigations where we've tried to get information and build a case against someone who is providing prescription medicine to people inappropriately, mechanisms that have been put in place by that person that have been very difficult to overcome.

For example, the introduction of a confidential informant. It would be very difficult to do that when someone requires five years of medical records from all prior providers and 5 or 10 or $15,000 cash up front before you even walk in my door.

And so those traditional methods of building a case to try to -- we're dealing with people

who are intelligent. They've built up blocks to those traditional avenues of investigation that lead to the development of an effective case that we can prosecute.

If we are able to access in a reasonable way information and through another avenue, that would allow us to try and circumvent those blockades that have been put up in front of law enforcement.

So we need to try to stay a step ahead of the bad guys, and these bad guys are different in many ways than the traditional street corner drug dealer.

And so by having a prescription drug database that allows law enforcement to access it as easily as they can under the constitutional constraints of the law, obviously, that would provide us with an effective, a more effective way to get that information so that we can build prosecutable cases against them.

KEVIN STEELE: It's that proactive approach. Like you want to try to stop this before it goes down the track, before those drugs get into some kid's hands and then you know what the next step is, heroin. So we got to try to fight it any way we can here.

REPRESENTATIVE STEPHENS: Thank you.

REPRESENTATIVE HACKETT: Thank you very much.

Are there any other questions from the members?

Okay. Appearing to be none, thank you, gentlemen, very much for attending today. Ladies and gentlemen, I would like to thank all the attendees and the presenters today.

As a reward for you guys sticking around and putting up with us, upstairs there is a lunch set out by Glen Mills and that would lead me into another kudo to Glen Mills. Thank you very much for opening your doors for us here today.

It was a very worthy hearing that we had here with the Commission, and thank you for all the members, so many members showing up. You guys realize how important this is.

We know this is not a quick fix. There's no silver bullet. We just have to work in a combined effort with the family, friends, doctors, law enforcement and counselors.

Chairman Marsico, thank you for the honor to head up the committee today.

CHAIRMAN MARSICO: You did a good job.

REPRESENTATIVE HACKETT: Thank you very much. Look forward to working with everybody.

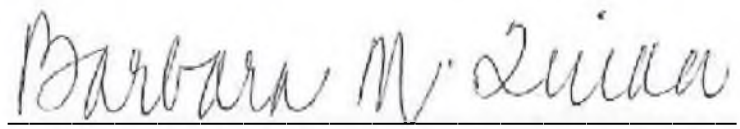
Thank you.

(Hearing ended at 2:04 p.m.)

CERTIFICATION

I, BARBARA McKEON QUINN, a Registered Merit Reporter and Notary Public in and for the Commonwealth of Pennsylvania, hereby certify that the foregoing is a true and accurate transcript of the hearing on the date and place herein before set forth.

I FURTHER CERTIFY that I am neither attorney nor counsel for, not related to nor employed by any of the parties to the action in which this hearing was taken; and further that I am not a relative or employee of any attorney or counsel employed in this action, nor am I financially interested in this case.



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