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Testimony of

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Regarding HB 1692, Involuntary Treatment for Drug and Alcohol Treatment

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Good Morning. My name is Dave Freed, District Attorney of Cumberland County. I am also a Past President of the Pennsylvania District Attorneys Association and currently serve as its Communications Chair.

On behalf of my colleagues at the PDAA, thank you very much for the opportunity to testify today about HB 1692, legislation which we support.

I don't need to remind anyone about the scope of our opioid and heroin crisis. But let me provide you with two facts, simply to demonstrate that this crisis is not subsiding. According to the Center for Rural Pennsylvania, there has been a nearly 20 percent increase in drug overdose deaths between 2013 and 2014. Moreover, Pennsylvania leads the nation in drug overdose deaths of young men.

Let me make this very pointed observation, which shouldn't surprise anybody: the overdose problem is a crisis; there is no exaggerating its seriousness; there is no sugar-coating the despair that accompanies it; and there are no magical solutions or silver bullets.

A few weeks ago, a few of us from the District Attorneys Association travelled to Washington, D.C. and met with elected officials and staff in both the United States House and Senate. The first question we were consistently asked about was this crisis. And our responses were almost always the same: to beat this crisis, we need more treatment. Those of you who work with us on a regular basis will not be surprised by that answer. The PDAA has long been an advocate for drug and alcohol treatment, and, Chairman DiGirolamo, we have worked very closely with you for decades to advance this important issue.

HB 1692 is about treatment; it is about trying to get more people into treatment. It is about identifying the most at-risk individuals and providing a formal process to move them to treatment.

I understand the reservations that some have with the legislation: should we be "forcing" people who don't necessarily want treatment into treatment? While that is a fair question, my answer would be that for those who are at risk of death or serious injury, we have a moral obligation to help them get better. Otherwise, many—too many—will die. If we know an individual is an addict, is a danger to himself or herself, cannot stop using heroin, and will as a result die, then what are we supposed to do?

As background, we have to remember that right now our county prisons may be seen as treatment facilities of last resort. But they are not. They are detox centers, and they are overwhelmed. They do an amazing job, but we need dedicated treatment professionals outside the prison environment to pick up after detox is done.

With the great assistance and vision of Secretary Gary Tennis, Physician General Rachel Levine, and others, we are starting to see use of a warm hand-off protocol, in which overdose survivors are taken directly from the emergency department to a licensed

drug treatment provider. Not only is the warm hand-off a good idea, it is necessary. Think about it, if you have a massive coronary and go to the emergency room, doctors will do everything they can to save you and then move you to the appropriate physician to treat your heart problem. That is exactly the kind of procedure that needs to occur here. The process should be seamless. It should be standard, and frankly it should not be optional. I would encourage you to explore with Secretaries Tennis, Dallas and Murphy and Dr. Levine how to get every medical facility on board with the warm hand-off. Perhaps the regulatory and licensing process may be an appropriate way to accomplish this goal.

I also believe that our Good Samaritan Law should be amended. As you know, Act 139 of 2014 provides blanket immunity for drug possession to those who call 911 during someone's drug overdose, assuming they comply with certain conditions, such as staying with the person who is overdosing. The immunity flows to the person overdosing in certain situations. This was legislation the PDAA helped to draft and worked hard to see it enacted. The legislation also included language which allows pharmacies and others to dispense and use Naloxone, a life-saving antidote to heroin overdoses. While it is a very good law, we have learned that it is not perfect. Some individuals, unfortunately, who are either saved with Naloxone or who cannot be prosecuted because of the Good Samaritan immunity just say no to treatment. Prior to enactment of Act 139, many of these individuals could have been charged, and ultimately enrolled in intermediate drug treatment programs or drug courts.

We do not want to prosecute these individuals; we want them to get the help they need. Our criminal justice system, our intermediate punishment programs, and our drug courts provide both the leverage and the treatment options that can help these addicts get better. If we can find something else to act as that leverage, lives will be saved.

This is where the warm hand-off can be helpful. Can individuals who receive Naloxone be sent to see addiction specialists; can someone who nearly overdosed but has no obligation to cooperate with law enforcement nonetheless be referred to treatment? We need to explore whether the warm hand-off can fix everything.

Indeed, those who are saved with Naloxone or who benefit from our Good Samaritan law often have advanced drug addiction. They may need, in some circumstances, intensive treatment, perhaps residential treatment. If they do not get treatment, the vast majority will die. So while we can acknowledge that in some instances mandated treatment may not be ideal, doing nothing will lead to more overdoses and more deaths.

This is where the strength of HB 1692 comes into play. We could, following a Naloxone save, for instance, begin the process of getting that person into treatment. Alternatively, if the warm hand-off become more of a hot hand-off, such that addicts who are not subject to prosecution because of Act 139 or who are alive because of a

Naloxone save receive the assessments and treatment as a matter of course, then our collective goal of saving lives and preventing deaths will have been achieved.

We now know of instances in which individuals have been saved twice and even three times with Naloxone. I learned earlier this week from my colleague Craig Stedman, Lancaster County's District Attorney, that an individual was saved four times with Naloxone in a single week. Saving people with Naloxone is only the first step. It is not sufficient; it is not enough.

We also know of instances where our police are frustrated because an addict cannot be prosecuted because of Good Samaritan but—also because of Good Samaritan—has no incentive to enroll in drug court because the criminal justice system cannot be leveraged to provide that important incentive.

Recently I was at a meeting with a police chief, school superintendent, and high school principal discussing a situation in the school. The Chief brought up the situation of a 17-year-old student who had recently dropped out of school and was addicted to heroin. The Chief stated in no uncertain terms that the teenager was headed for an overdose. This was on a Monday morning. The next night police were dispatched to that student's house because of an overdose. Naloxone was administered, and a young life was saved. Quite a story. But there is more.

Two weeks ago I received a copy of an open letter that teen wrote to the other students in the school. In it she described her struggle, told her classmates how lucky they are and urged them to stay clean. The teen also made clear that she REFUSED treatment after the Naloxone save. Shortly after leaving the hospital, however, she was involved in a serious traffic accident, emerged mostly unscathed, and saw that as a sign for her to seek treatment.

That teen is lucky, even though she faces a lifelong struggle. But had she not been in that car crash she would likely be a statistic today. We need to ensure that she and others get the treatment they so desperately need. We value their lives enough to save them. But that save should not end with the administration of Naloxone.

We have to do something about this problem. We have a group of individuals who came extraordinarily close to dying, who will likely die if we do not intervene. We need to be bold, because life is precious, and there are fewer things as important as preventing the loss of life.

HB 1692 will help us save lives. If there is a model that can achieve the same goals as HB 1692, we would support that effort as well. And we need to tighten up the unintended consequences of Act 139.

My colleagues and I want to continue to work with you. Our opioid and heroin overdose problem is a public health crisis. It affects every county in Pennsylvania, and everyone needs to step in and change their practices. Law enforcement already has

with Act 139, and we will continue to make appropriate adjustments. Our medical community has begun as well, with the emphasis on prescribing guidelines.

My colleagues and I were very pleased to see that Governor Wolf has hosted many roundtables about our opioid crisis. Several of my colleagues attended some of these roundtables, and we greatly appreciate the Administration's attention to the crisis.

As we think about what else we need to do, I would suggest that we consider regulating pain clinics. Creating standards about who needs to be present, what can be prescribed and for how long, as well as ensuring appropriate regulatory oversight, can only help stop the bad actors.

Thank you for your time and consideration, and I look forward to answering any questions.