BEFORE THE HOUSE REPUBLICAN POLICY COMMITTEE AND THE HOUSE DEMOCRATIC POLICY COMMITTEE JOINT HEARING ON PENNSYLVANIA'S DRUG ABUSE EPIDEMIC

AUGUST 30, 2016

WILLIAMSPORT, PENNSYLVANIA

TESTIMONY OF CHARLES E. KIESSLING, JR., RN, BSN, PHRN, CEN

LYCOMING COUNTY CORONER AND PRESIDENT

PENNSYLVANIA CORONERS ASSOCIATION

Good afternoon Chairmen Benninghoff and Sturla and Members of the Committees. My name is Charles E. Kiessling, Jr., RN, BSN, PHRN, CEN. I have served as the Lycoming County Coroner since 2000 and for the last eleven years have served as a flight nurse on the Geisinger Life Flight service. I have also been an EMT since 1978. (A complete bio is attached.) I am currently the President of the Pennsylvania Coroners Association with membership of the 64 county Coroners and the 3 county Medical Examiners. I am pleased to be here today to give you the PSCA perspective on the present drug epidemic in our Commonwealth.

Thank you for allowing me to appear here today to discuss this very important issue which not only affects the drug user, but also impacts friends, families, co-workers and society.

Along with my testimony I have included a copy of the 2015 PSCA Report on Drug Deaths, which had previously been emailed to all Legislators.

The CDC has stated that our country is in the midst of an overdose epidemic.

The New York Times quoted Dr. Hamilton Wright of Ohio stating "Of all the nations of the world, America consumes the most opium in one form or another. The habit has this Nation in its grip to an astonishing extent. ... The drug habit has spread throughout America until it threatens us with a very serious disaster." What is astonishing about these comments is not that they were said, but when they were said. These remarks were made in 1911 by the first appointed US Drug Czar (appointed by President Theodore Roosevelt).

Drug related deaths have continued to increase. In 2014 that number reached at least 2,489 individuals. The year 2014 showed an average increase of about 20% over the prior year for many counties. In 2015 the number of drug related deaths increased to 3,505 or a 30% increase over the prior year. If, initial data for 2016 is any indication, the number of deaths will continue to increase.

Ten (10) people die every day in Pennsylvania from drug related causes. Not known are the number of persons who overdose but survive. In addition, this number may be somewhat conservative since many hospitals will throw away admission blood after three days, leaving nothing to be forensically analyzed in case of death.

The age of the deceased ranges from under 2 months to 94 years of age. The majority of deaths are found in the age group 30 – 39 years old, but with the vast majority occurring between the ages of 30 – 49 years old. Men represent 2/3rds of the deaths. Deaths are split along racial lines in accordance with the percentages represented in the Commonwealth. The typical decedent is male, single, either never been married, divorced or widowed.

Most deaths are the result of multiple prescription drugs either alone or with the addition of heroin or cocaine, to a lesser degree. In addition, there has been a significant increase in the number of heroin deaths which were accompanied by the addition of fentanyl or acetyl fentanyl. Also, the use of cocaine to which levamisole has been added continue to increase. Lastly, there is an increase in the presence of THC found in marijuana and synthetic cannabinoids. The latter drug is also seen increasingly in statistics reported by the PSP on impaired driving. And it is now reported that the elephant tranquilizer, carfentenil, has been found in Ohio cutting the heroin. This drug is 1000 times more potent than heroin and presents a risk to Coroners, first responders, forensic pathologists, law enforcement and any who may come in contact with as much as a grain of salt size

of the drug which can be absorbed into the skin or accidentally inhaled. The immediate result is an overdose which will take several applications of Narcan to potentially overcome the effects.

Found in 14% of the toxicology reports of the drug related deaths are the opioids generally prescribed to treat addiction or overdose events, methadone, buprenorphine (found either as suboxone or subutex), naloxone, naltrexone. Methadone is prescribed in clinics under the regulation of the Substance Abuse and Mental Health Services Administration (SAMSHA) and the Pennsylvania Drug and Alcohol Programs. To prescribe buprenorphine, the prescriber only needs to secure a DEA authorization.

As stated by US Senator Tim Murphy at the beginning of hearings he is chairing into the issue of Examining The Growing Problem Of Prescription Drug And Heroin Abuse: State And Local Perspectives, March 26, 2015:

> "Buprenorphine can more safely maintain a person's dependence by reducing the need for illegal opioid use, such as heroin, and thereby the risk for overdose. But make no mistake, buprenorphine is a highly potent opioid, which according to SAMSHA, is 20 to 50 times more potent than morphine. So it is worth considering that our national strategy to combat substance abuse is to maintain addiction by either prescribing or administering a heroin-replacement opioid. ... And unlike clinics that administer methadone, there are no requirements for buprenorphine clinics to offer or even discuss non-addictive treatment alternatives, no requirement to develop treatment plans, no requirements to protect the public against it being diverted for illicit use."

Statewide drug related deaths occur throughout the year with a slight increase in October. (In 2014 the slight increase was in May.) Deaths generally increase on the weekends and 2/3rds of the deaths occur between the hours of 4 PM and 8 AM.

There are several ways in which these drug related deaths may be characterized and each requires a solution which considers the unique variables. There is the group of children either born with NAS or toddlers exposed to drugs and those drugs used for treatment who in error access them with fatal results. There is the group of teens and younger adults who are experimenting with drugs, perhaps as a matter of peer pressure. There is the vast majority of adults who perhaps believe that the American Dream has passed them by, have become addicted and see no clear path to recovery or have been unable to readily access the means of recovery. There are the elder citizens who are generally not experimenting with illegal drugs but are overdosing on prescribed medications. And, lastly, there are the veterans who have volunteered to serve our country and who come home with medical issues and mental health issues for which they have been receiving inadequate treatment in the form of a cocktail of drugs – a sleeping pill, anti-anxiety medication, an anti-depressant, and an anti-psychotic and sometimes, even a stimulant.[1]

While the Federal Mental Health Parity Law requires parity for addiction treatment, that parity remains elusive. There are insurance companies who don't do admitting paperwork on a weekend, there are a scarcity of pain management practices or clinics, and there is an apparent lack of facilities with beds to provide long term treatment or to accept mothers with their small children, so as to not needlessly further tear apart families during the healing process.

Perhaps an example will clarify the lack of parity further. In the first example,

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[1] *The Military's Prescription Drug Addiction,* The American Conservative, Kelley Beaucar, October 3, 2013

--- you suffer shortness of breath and collapse. A family member gets you to the hospital. While in the ER you are told you suffered a heart attack. Now imagine that the next response is to hand you a brochure giving you a list of cardiologists, their phone numbers and their addresses. You are told you should make an appointment to see one of them and discharged. Sounds ludicrous and it doesn't happen.

In the second example,

-- you suffer a drug overdose and are taken to the ER. You are successfully revived. The next response is that you are handed a brochure giving you a list of addiction treatment programs, their phone numbers and addresses and told you should give one of them a call. Sounds ludicrous. Unfortunately it happens all the time. Does anyone honestly believe the brochure makes it much further than the exit door? And, if someone is actually motivated enough to make a call, they may be told they can be seen in 2 days or 2 weeks or more.

The Legislature should look at the establishment of having addiction counselors immediately available to talk with the addict to encourage treatment and provide an immediate bridge to treatment.

There needs to be a stronger tying of an overdose incident with the treatment process. It needs to be remembered Narcan must be administered on a timely manner, it may not work with synthetic opioids, or if heroin is cut with other drugs, such as, W18. Heroin can outlast the Narcan and require re-dosing or manually taking over respiratory support for the person. Even if you give Narcan, you should still call 911. Otherwise, this safety net may be made out of tissue paper.

Since we don't have any data on the number of times Narcan is given to a person, I can only say anecdotally that Coroners hear reports from first responders, law enforcement and others of too many cases like the following:

An individual was brought into the ER for an overdose, was revived and left the ER. The person got high again, overdosed and was brought back to the same ER only 7 hours later.

This leads to the realization that Narcan, on the one hand can save a life and the person may decide they have hit rock bottom and seek help. On the other hand, Narcan merely becomes an enabler allowing the person to seek the next high. It becomes Russian roulette. Will the addict be saved and seek treatment or not? Narcan can be only a change in the date of death.

The Legislature should review the possibilities of involuntary civil commitment for an addict. Studies have shown no difference in treatment outcome rates for voluntary or involuntary commitments to a treatment facility. There are Constitutional rights which will need to be addressed. Involuntary commitments have been found to meet Constitutional requirements when the person who is suffering addiction is fully involved in the process. An example might be:

> (1) A family member, friend, doctor, clergy, or member of law enforcement may petition the court for the civil commitment of a substance dependent individual.
> (2) A hearing shall occur during which:
> (a) the respondent is present; and
> (b) the respondent may be represented by counsel of his choice; if the respondent is indigent, counsel shall be appointed to represent him; and
> (c) the respondent's counsel represents the interests of the

respondent in an adversarial fashion, including but not limited to cross-examination of state witnesses and production of expert and non-expert witnesses on behalf of the respondent.
(3) If the court finds by clear, cogent, and convincing evidence that the respondent is a substance dependent individual and as a result of the substance dependence is dangerous to himself or others, it shall order for a period not in excess of ninety days commitment to and treatment by an inpatient facility.
(a) "Dangerous to oneself" is defined as actions in the relevant past which indicate a substantial risk of physical harm to oneself, including threats or attempts of suicide or serious bodily harm or other conduct demonstrating that the person is a danger to himself.
(b) "Dangerous to others" is defined as actions in the relevant past which indicate a substantial risk of physical harm to other persons, including homicidal or other violent behavior by which others are placed in reasonable fear of serious physical harm.

And while we are fortunate to have Congressman Marino here today, I would like to mention the need that we have discussed to not treat prisons as a substitute for treatment. Our prisons are ill-equipped to provide necessary addiction treatment. When a person leaves prison he or she will likely try to get high again based on the same amount of drugs as when they entered prison. The likely result is death.

Also, the Congressman is encouraged to do all he can to stop the CMS Final Rule, CMS-2390-P. This rule takes away flexibility from the Medicaid managed care patients by arbitrarily providing a 15 day monthly limit on patients in residential addiction treatment facilities. Staying longer will result in the loss of Medicaid coverage for addiction treatment **and the loss of coverage for any more general medical needs, like treatment for diabetes, hypertension or cancer.** Congress needs to act.

There needs to be a scalpel brought to the discussion of broad based policies to stem the tide of this drug pandemic. Take for example, an elderly women who has been diagnosed with pain generating medical issues. She has been given a prescription to relieve the pain while waiting 4 months to get another appointment with a specialist. This prescription is only valid for two weeks. After two weeks she has to get a relative to take her to the doctor to get another two week supply. She has no diagnosed tendencies to abuse or divert the drugs for another use, she has been caught in a system to try to stop abuse.

Another example is a mother with a child who has been diagnosed with ADHD. She can get a thirty day supply of the needed drugs, but to get a refill she must travel at least half an hour and on the precise day the prescription runs out to get a refill. Again, there are no indications of drug abuse or diversion of the use of the drugs for another purpose, she has been caught up in a one-size-fits-all system to stop drug abuse.

Can we not trust any of our physicians to exercise judgment in filling prescriptions? Shouldn't the ABC-MAP Act of 2014 provide the information necessary to catch those who would abuse their ability to prescribe?

Another obvious conclusion from reviewing the data relates to the number of drugs found in an individual's toxicology. While the average number of drugs in a toxicology assessment, both prescription and illegal, is about 3 per person, there are too many instances where an individual may be found with multiples of a classification of drugs. An example is the toxicology of one individual who had five antidepressants in their toxicology. Why would anyone take such multiples of one type of drug? Perhaps part of the answer may be found in the current use of drugs for off-label purposes. For example, antidepressants are prescribed by various physicians for treatment of

disorders other than depression -- anxiety, sleep issues, pain, headaches, smoking cessation, premenstrual syndrome, premature ejaculation[2]. In fact the CDC has indicated that the rate of use of antidepressants has increased nearly 400% since 1988.

Another concern is when a patient is hospitalized after a nonfatal prescription opioid-related overdose, leaves the hospital or ER, and then continues to receive opioid based treatment. Perhaps there is not communication that the patient has been treated for an overdose to the prescribing physician, perhaps the patient has made no connection between the condition for which the opioid treatment is prescribed and the overdose. Perhaps this nonfatal overdose should represent an opportunity to identify and treat substance use disorders.[3]

It should be clear that there is a widespread commitment to share drug information with patients, but it is equally unclear whether the reason for the medication prescription is generally recorded or shared. The prescription label gives the name of the drug, the dosage and the number of times to take. It does not give an indication of the purpose served by its taking. Perhaps, there is a need for a Patients Drug Bill of Rights, such as suggested in the N Engl J Med, July 28, 2016, to provide for safe medication ordering and use – "the right patient, right drug, right dose, right time, right route ... {and the } right indication."

The Coroners have provided the number of deaths from this terrible scourge. But, I would speculate that deaths are only the tip of the iceberg. To truly know the extent of the drug problem there should be information from EMTs, ERs and Hospitals on the numbers of people who have presented as an overdose, but who have not died. Let's be honest, once you are dead no treatment program is going to work. You need to get into treatment before the problem becomes an inevitability.

It is time to search for solutions that recognize the different faces of the drug issue, the addict, the family, those who will get caught in any broad based, one-size-fits all remedies. As Albert Einstein is quoted to have said, "Insanity is doing the same thing over and over again and expecting different results." No one can be a passive observer in thinking we can solve this problem by the same thought process which created it.

Again, thank you for permitting me to be here today. The Coroners are committed to working with you to bring some meaningful solutions to the issues.

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[2] *5 Surprising Uses for Antidepressants*, Wyatt Myers, www.everydayhealth.com

[3] *Patients Continue to Receive Prescription Opioids Following Overdose*, MD Magazine, www.hcplive.com

Charles Kiessling is a registered nurse who graduated from the Williamsport Hospital School of Nursing (1984) and completed his Bachelor of Science in Nursing from Lycoming College (1997) in Williamsport. He worked as an emergency room nurse at Williamsport Hospital for 21 years and for the past 11 years as a flight nurse with the Geisinger Life Flight Program. Charles served as Deputy Coroner in Lycoming County from 1986 and was elected Lycoming County Coroner since 2000. Charles has been and EMT since 1978 and active in volunteer fire and EMS serving as Assistant Chief with the Old Lycoming Twp. Vol. Fire Company. Charles is President of the PA Coroner's Association and Liaison to the PA Coroner's Education Board. He is a member of the International Association of Forensic Nurses, the National Emergency Nurses Association, the International Association of Coroners and Medical Examiners. He established the first Child Fatality Review Team in Lycoming County in 2001 and has been an active member of Safe Kids Lycoming County appointed to as serve as Chair in 2011. Charles established the Lycoming County Cribs for Kids Program in 2008 providing cribs to needy parents throughout Lycoming County. Charles has actively promoted Safe Sleep Practices for infants through various public education programs. He has supported the efforts of PA Representative Garth Everett prompting the PA House of Representatives to recognize November as "Infant Safe Sleep Month" for years 2010, 2011, 2012, 2013, 2014 & 2015 which has provided media coverage to promote safe sleep awareness.

Certifications held:

Board Certification in Emergency Nursing (CEN)

Prehospital Registered Nurse (PHRN)

Advanced Cardiac Life Support (ACLS)

Pediatric Advanced Life Support (PALS)

Neonatal Resuscitation (NRP)

PA Firefighter I