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# Heroin:

## Combating this Growing Epidemic in PA

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*Findings Compiled from Statewide Hearings  
Examining Addiction Treatment and Recovery Services*

**December 2015**





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The Center for Rural Pennsylvania is a bipartisan, bicameral legislative agency that serves as a resource for rural policy within the Pennsylvania General Assembly. It was created in 1987 under Act 16, the Rural Revitalization Act, to promote and sustain the vitality of Pennsylvania's rural and small communities.

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## Table of Contents

Introduction .....	1
Public Hearings: A Focus on Treatment .....	4
Addiction is a Chronic Disease .....	4
Treatment Must Be Individualized and Clinically Driven .....	4
Full Continuum of Care .....	7
Integrating Pain Management Education in Medical School Curriculum .....	8
Workforce Issues .....	9
Other Related Issues .....	10
Access to Naloxone .....	10
Treatment Courts .....	10
Education .....	11
Mandatory Minimum Sentencing .....	12
Seamless Transition from Incarceration .....	12
Heroin Overdose Death Reporting .....	12
Presenter Recommendations .....	13
Glossary of Terms .....	14
Appendix A: Public Hearing Dates/Locations .....	15
Appendix B: List of Testifiers/Other Legislators in Attendance .....	16



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## Introduction

The Centers for Disease Control and Prevention reported 8,257 heroin-related deaths in 2013, which was a dramatic increase from the 5,925 heroin-related deaths reported in 2012. Overall, the number of drug-related overdose deaths increased nationwide from 41,340 in 2012 to 43,982 in 2013.

The Pennsylvania State Coroners Association reported that 2,489 individuals died from drug-related causes in 2014, a 20 percent increase from 2013. The Association also reported that initial data for 2015 indicated the number of deaths would continue to increase.

In January 2015, then-U.S. Attorney General Eric Holder cited troubling statistics on the dramatic increase in drug overdose deaths nationwide, in particular those related to heroin, and how these deaths “represent a growing public health crisis.” In late October, 2015, President Obama traveled to West Virginia to announce a federal initiative to combat the opioid crisis. In his comments he stated, “This crisis is taking lives, it’s destroying families, it’s shattering communities all across the country - it doesn’t discriminate.” Across the country numerous states including Ohio, Maryland, Connecticut, Wisconsin, Vermont, and Massachusetts have declared heroin and opioid abuse and resulting deaths to be a public health crisis.

In Pennsylvania, legislative and executive branch agencies are working closely on policies and programs addressing education, prevention, treatment, recovery, and law enforcement. Following its 2014 series of statewide public hearings, and the release of its report, *Heroin: Combating this Growing Epidemic in Pennsylvania*, the Center for Rural Pennsylvania conducted a second round of statewide public hearings in July and August 2015 to take a closer look at heroin and opioid addiction, specifically treatment and recovery services in Pennsylvania.

These hearings were held July 21 at Saint Vincent College in Latrobe, July 29 at The Commonwealth Medical College in Scranton, and August 18 at the Yorktowne Hotel in York.

The public hearings in 2014, hosted by the Center's Board of Directors and attended by legislators from around the state, were held to get a better overall understanding of the complex issue of heroin/opioid abuse and overdoses. More than 50 experts and concerned citizens presented testimony at the four hearings to identify and discuss ongoing approaches in education and prevention, law enforcement, and treatment in the state.

The Center's report, *Heroin: Combating this Growing Epidemic in Pennsylvania*, summarized the testimony from the four hearings and provided recommendations and considerations offered by the participants. Some of the recommendations were to support two pieces of legislation that were currently before the General Assembly. Both bills were subsequently passed by the legislature and signed into law.

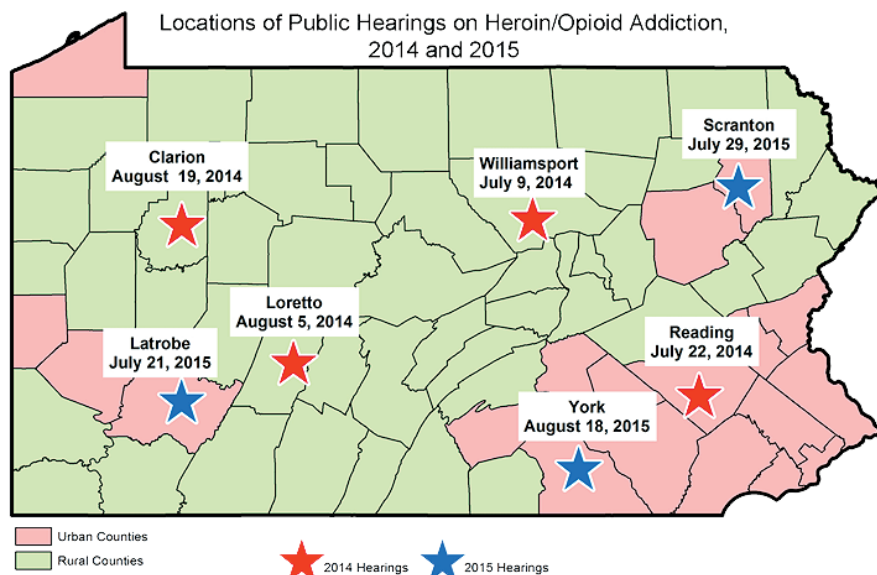
Senate Bill 1164, now Act 139, or David's Law, provided legal protection for witnesses, or Good Samaritans, seeking medical help at the scene of an overdose. In addition, it allowed naloxone, a synthetic drug that blocks opiate receptors in the nervous system and known as the brand name Narcan, to be prescribed to a third party, such as a friend or family member, and administered by law enforcement and firefighters.

Senate Bill 1180, now Act 191, expanded the types of drugs monitored under the state's existing Prescription Drug Monitoring Program to include Schedule II through V controlled substances. It also created a board within the Department of Health to establish and oversee an electronic data system listing all controlled substances that are prescribed and dispensed in Pennsylvania.

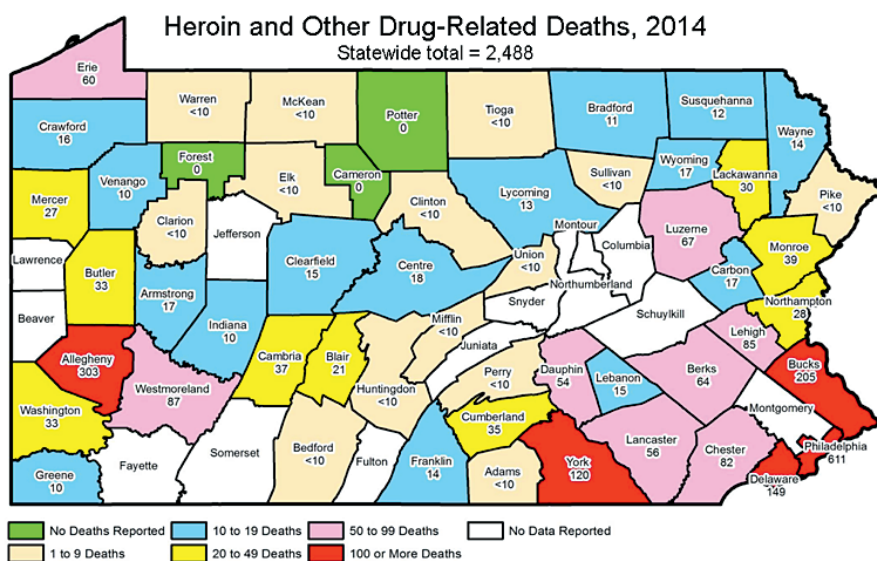
While the passage of Acts 139 and 191 was an important step in addressing the heroin/opioid epidemic, it could not be the last step, since drug-related overdose deaths continued to rise.

The Centers for Disease Control and Prevention (CDC) in 2015 reported that heroin overdose deaths in the United States, fueled by lower heroin prices and the increased abuse of prescription opiate painkillers, nearly quadrupled between 2002 and 2013. According to the CDC, reversing these trends will require a wide-ranging response from

Locations of Public Hearings on Heroin/Opioid Addiction, 2014 and 2015



Heroin and Other Drug-Related Deaths, 2014  
Statewide total = 2,488



Data source: Pennsylvania State Coroners Association.

multiple partners, from improving opioid prescribing practices and expanding access to effective treatment, to working with law enforcement to disrupt the heroin supply, to increasing the use of medications, such as naloxone, to reverse drug overdoses.

In April 2015, Pennsylvania's Physician General Dr. Rachel Levine signed a standing order permitting emergency responders to carry and administer naloxone to overdose victims. Due to concerns that only medical personnel should administer the drug, some police officials did not



participate in the program. (Note: On October 28, 2015, Dr. Levine signed a statewide standing order for naloxone, which basically provides a naloxone prescription to all Pennsylvanians.)

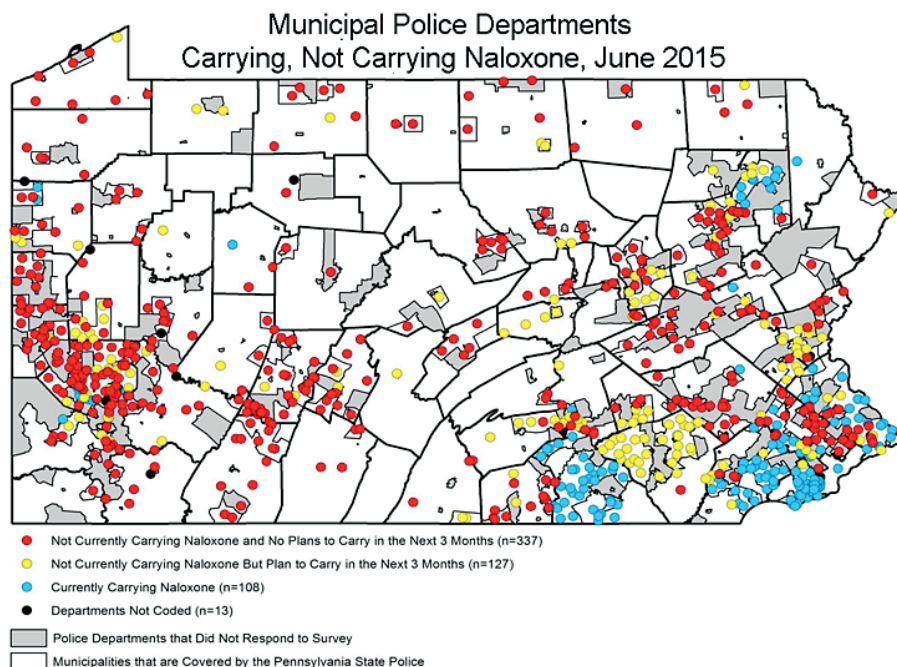
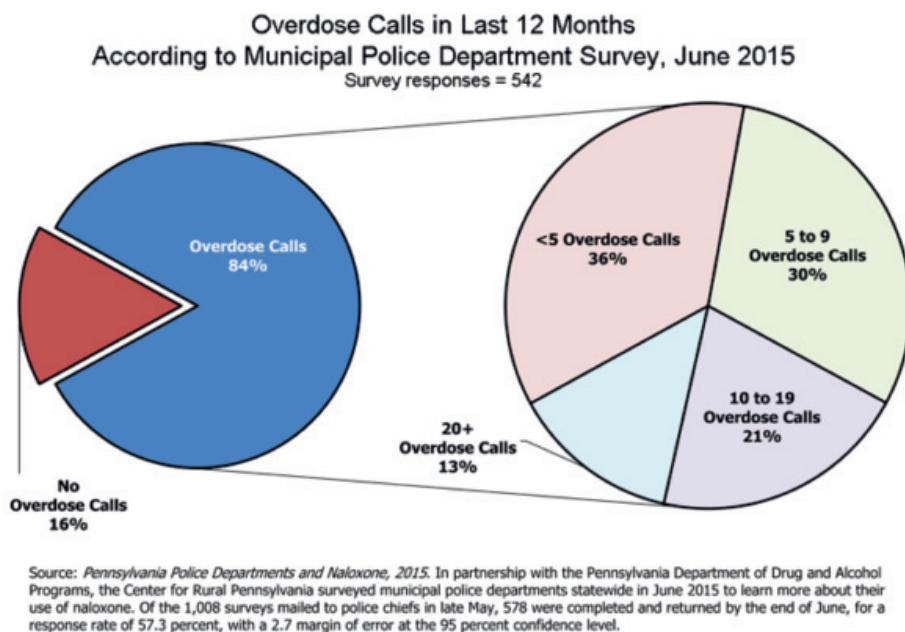
Upon hearing these concerns, the Center for Rural Pennsylvania and the Pennsylvania Department of Drug and Alcohol Programs (DDAP) conducted a survey of municipal police departments in June 2015 to learn more about their use of naloxone. Since the passage of Act 139, it was unclear how many police departments were carrying the medication. According to the survey, 82 percent of the 582 local police departments that participated in the survey said they were not currently carrying naloxone, yet 84 percent of departments had responded to one or more drug-related overdose calls.

Some of the reasons police departments cited for not carrying the medication were reliance on other first responders, such as EMS, cost concerns, difficulty in accessing training, and potential liability.

DDAP has used the survey information to reach out to police departments to address their concerns with naloxone. According to follow-up data gathered by DDAP, departments that are carrying naloxone are using it, as police departments have reported 377 overdose reversals statewide from November 2014 to November 6, 2015.

To help determine what other actions may be taken to continue fighting this public health epidemic, the Center's Board of Directors scheduled the second round of public hearings in July and August 2015. These hearings focused on heroin/opioid addiction treatment and recovery services. Over the course of the three hearings, 40 experts, including treatment professionals, family, law enforcement officials, government officials, and educators, presented testimony on a range of issues related to treatment and recovery services, and what could be done to help addicts get the treatment they need.

Following is a summary of the testimony presented during the hearings, and the recommendations made by the presenters.



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## Public Hearings: A Focus on Treatment

While the rallying cry has been made regarding the devastation that heroin and opioid abuse brings to individuals, families, communities and society in general, it has not been heard, or accepted, by all. There remains considerable stigma against those struggling with addiction. Some people, for example, view addiction as a choice, or a conscious decision. Others question why government is spending precious limited financial resources on those who opt to abuse drugs.

From many of those testifying at the three hearings held in July and August 2015, the message was clear: heroin and opioid addiction are chronic illnesses and need to be treated as such.

### Addiction is a Chronic Disease

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*“I was never a bad person, but drugs made me do bad things.”*

**Ashley Potts**  
Certified Recovery Specialist,  
Washington County Drug and  
Alcohol Commission

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Dr. Neil Capretto, Medical Director of Gateway Rehab, provided the definition of addiction from the American Society of Addiction Medicine as follows:

*Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors.*

*Additionally, addiction is characterized by the inability to consistently abstain; impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.*

Other health care and treatment professionals who testified at the hearings agreed that addiction is a chronic disease: a disease that should be treated comprehensively and

individually.

Cheryl Andrews, Executive Director of the Washington County Drug and Alcohol Commission, said: “We need to treat this illness from a disease model rather than one that is currently viewed as a moral deficiency or as criminal behavior or even a matter of self-choice.” She stressed that an individual who has this chronic disease should not be excused from the consequences of his or her actions; but neither should society be excused from providing appropriate health care. The bottom line is that the disease must be treated.

### Treatment Must Be Individualized and Clinically Driven

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*“The treatment of opioid abuse is not an easy process. It's not easy for the patient and it's not easy for the providers. As Dr. Scheinman mentioned it's a team effort, it's not just seeing a psychiatrist in their office, and you're going to be cured of your addiction. It's also not a cure, it's a recovery.”*

**Physician General Dr. Rachel Levine**

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Pennsylvania Physician General Dr. Rachel Levine testified that individualized treatment must be clinically driven to meet the patients' needs, adding that there is no “one-size-fits-all” treatment method.

Kellie McKevitt, Executive Director of Behavioral Health Services of Southwestern Pennsylvania Human Services, agreed that individualized case plans are needed for success. “Individuals need the right type of treatment, in the right quantity and frequency, for an appropriate length of time.” Treatment plans from years ago don't work with heroin and opioid addicted patients, according to McKevitt.

Today, treatment providers use theory and research based methods that offer skill building and resource acquisition, such as cognitive behavioral therapies. Cognitive behavioral therapies involve addressing thinking patterns, developing motivation to change, providing incentives for abstinence, building skills to resist drug use, replacing drug-using activities with positive activities, improving problem-solving skills, developing natural supports and facilitating better interpersonal relationships.

Dr. Capretto affirmed that behavioral treatments educate patients about the conditioning process and teach

relapse prevention strategies. He stated that medication-assisted treatment, which may include methadone and buprenorphine, may also benefit the individual as they operate on the opioid receptors to relieve the craving. The combining of the two treatments enables patients to stop using opioids and return to a more stable and productive life.


To the right is a chart that Dr. Capretto provided on the types of medications used to treat opioid dependence.

Dr. Capretto cited research from the Center for Substance Abuse Treatment from the federal Department of Health and Human Services, which concluded that retention in treatment is critical to recovery as it may be the single most important indicator of medication-assisted treatment. Retention permits patients and health care providers to engage the individual in counseling, stabilize their abstinence, organize a chaotic lifestyle that contributed or supported the addiction, diagnose and treat co-morbidity, and improve family, social and work relationships.

Dr. Capretto explained that maintenance in treatment helps to: reduce mortality from overdose and infection; reduce opioid and other illicit drug use; reduce transmission of HIV, HBV, and HCV; improve the general health and well-being of patients; reduce drug-related crime; and improve social functioning and ability to stay in work.

Several testifiers related that, recently, naltrexone, commonly known as Vivitrol, has shown great success in medication-assisted substance abuse treatment. Naltrexone is an injectable prescription medication that blocks the effects of narcotic medicines and alcohol. This monthly injection, which costs approximately \$1,000 per shot, is usually administered over a 6-month period. Unfortunately, due to the novelty of the medication, many physicians are hesitant to include it in their treatment program. When used, this medication is to be seen as yet another tool and not a substitute in the recovery process.

Amanda Cope, a registered nurse with Positive Recovery Solutions (PRS), a private physician group based in western Pennsylvania, offered testimony on PRS's implementation of naltrexone and the development of a mobile



## FDA Indications for Medications used in Treatment of Opioid Dependence

		FDA Indication
<b>Methadone</b>	agonist	For <u>maintenance treatment</u> of opioid addiction. <sup>1</sup>
<b>Suboxone</b> (buprenorphine/ naloxone)	partial agonist	For the <u>maintenance treatment</u> of opioid dependence. <sup>2</sup>
<b>ReVia</b> (oral naltrexone)	antagonist	In the <u>treatment</u> of detoxified, formerly opioid-dependent individuals. <sup>3</sup>
<b>VIVITROL</b> (Extended release, i.m. naltrexone)	antagonist	For the <u>prevention of relapse to opioid dependence</u> , following opioid detoxification. <sup>4</sup>

All medications are FDA approved as adjunct to psychological and social therapy

1. Methadone PI, Roxane Laboratories; 2. Suboxone PI, Reckitt Benckiser; 3. ReVia PI, Duramed Pharmaceuticals, Inc.; 4. VIVITROL PI, Alkermes, Inc.

unit to expand the reach of treatment services. Ms. Cope explained that PRS, which has brick and mortar suboxone clinics, learned that many patients could not follow up with the monthly injections of naltrexone because they had to travel great distances to receive the medication. In 2015, PRS launched its mobile unit to solve this problem. The unit is equipped with a private waiting area, a restroom for urine specimen collection, a private assessment room, and a private injection room. The first appointment for a patient includes a new patient assessment to gather a complete drug history, past medical history, medication check, urine drug screen, confirmation of drug and alcohol counseling, and other pertinent information. At the time of the hearings, PRS had contracted with Blair, Indiana, Clarion, and Armstrong counties to provide services to unfunded patients. The unit is available to each county on a biweekly schedule.

Several testifiers also noted the need to address the unique treatment and recovery challenges faced by young adults with addiction. Andrew Schmitt, Facility Director at Mazzitti and Sullivan Counseling Services, referred to the lack of outpatient programming for young adults who struggle with opioid addiction. “Young adults lack brain maturation, prior life experience, independence or resources to expand a support system. In short, they are limited from a physiological, financial, environmental and



societal standpoint,” he said. “From a treatment perspective, I am of the belief that inpatient or residential programs have made positive strides in being able to more adequately treat and work with the young adult population. However, I have not seen the same progress made with outpatient or community services.”

Christopher Cook, Project Manager-HOPE Program at Cove Forge Behavioral Health System, explained that by having peer supports available, individuals with addiction know they are not alone in their recovery. Soon, it becomes evident that others have faced the same obstacles and challenges. This connection of support reinforces that there is hope and recovery is possible. With the number of young opioid addicts on the rise, these peer support groups are critical.

Regardless of the treatment plan devised for the individual, the plan can only work if the services are accessible, available and affordable.

The federal government reports that, due to the lack of funding, only about 1 in 10 individuals who need addiction treatment are able to access it. In Pennsylvania, it is approximately 1 in 8. According to the National Institute on Drug Abuse (NIDA), every dollar invested in addiction treatment programs yields a return between \$4 and \$7 in the reduction of drug-related crime, criminal justice costs and theft. When savings related to health care are included, total savings can exceed costs by a ratio of 12:1.

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) finds that 926,000 individuals in Pennsylvania have a drug or alcohol use disorder.

At the York hearing, Dr. Kenneth J. Martz, Special Assistant to the Pennsylvania Department of Drug and Alcohol Programs (DDAP) Secretary, was asked about the availability of and access to inpatient treatment beds. In response, Dr. Martz submitted the following information to the Center for Rural Pennsylvania:

*Access, infrastructure, and funding are three changing dynamics that impact a system’s ability to provide the necessary treatment.*

*Another consideration is that the bed availability should be adjusted downwards as the system moves toward getting addicted individuals sufficient lengths of stay. Consider also that once providers know that clients will be entering treatment consistently and at adequate rates, they will lead the way to increase capacity and open new programs.*

The chart below shows there is a need in Pennsylvania for greatly increased treatment capacity. Any progress in this direction saves an average of \$7 for every \$1 invested, according to DDAP. While some individuals may need less time in treatment, NIDA indicates that the best outcomes are produced when treatment lasts for at least 90 days. Dr. Martz reiterated that the length of stay and intensity of treatment are key factors in determining recovery.

Estimated Treatment Need (SAMSHA)	Treatment Utilization Estimates (PA prior year utilization)	Estimated Need by Level of Care	Estimated Lengths	Slots Needed Based on Treatment Length	Current Capacity Beds/Slots (March, 2015)	Estimated Deficit
926,000	14% Detox	129,640	7 days	2,493	1,126	1,367
	23% Residential	212,980	2 months	35,496	6,874	28,622
	54% Outpatient	500,040	4 months	166,680	78,021	41,670

In addressing the issue of affordability, Jack Carroll, Executive Director of the Cumberland/Perry Drug and Alcohol Commission, stated that care should focus on what is medically necessary for the individual, and not be based on an arbitrary funding protocol.

Deb Beck, President of the Drug and Alcohol Service Providers Organization of Pennsylvania, discussed health insurance concerns surrounding treatment and recovery services. She asked that the state aggressively enforce the federal Mental Health Parity and Addiction Equity Act. The law was enacted in 2008 and requires health insurance plans to provide treatment for mental illness and addictions in parity with other illnesses. She explained that the law places parity requirements on a myriad of self-insured plans, federal employee plans and health exchange plans operating in the state. Ms. Beck said: “It also enhances Pennsylvania’s own insurance laws requiring provision of addiction treatment through group health and other plans purchased in the state.”

Mr. John Knowles, Senior Marketing Representative for Clearbrook Treatment Centers in Luzerne County, also discussed Pennsylvania’s parity law, Act 106 of 1989, which mandates minimum benefits for the treatment of drug and alcohol addiction. The law requires specific coverage for these services in certain group policies or contracts. Mr. Knowles stated that, currently, however, the act only represents a portion of the insured public. Mr. Knowles indicated that a gap in the bill excludes non-group policyholders, individuals in self-funded plans, individuals insured by out-of-state employers, and Medicare and Medicaid recipients. Many law enforcement, judiciary and health professionals are unaware of the gaps in the mandated coverage, which can lead to

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misconceptions about how and when to place a patient in treatment.

Mr. Knowles and others also commented that those who are covered under the Affordable Care Act may be faced with large out-of-pocket and deductible charges. It is not unusual for a working class patient to have a \$5,000 threshold before being able to access the benefit. In addition, some people are enrolled in non-group policies and, therefore, are not eligible for mandated benefits under Act 106.

Another issue that was repeatedly mentioned by testifiers was the need to restore funding to counties for addiction treatment. Ms. Beck noted that funding for addiction treatment provided through the Behavioral Health Services Initiative (BHSI) and Act 152 of 1988 to counties has been reduced by \$11.5 million since fiscal year 2008-2009, a 22 percent reduction. Ms. Beck stated: “At the same time, the prescription drug and heroin problem in Pennsylvania has reached epidemic levels, with hundreds of preventable emergency room admissions, overdoses and overdose deaths reported across the Commonwealth.”

During the 2014 public hearings on heroin, several SCA administrators for drug and alcohol treatment noted that treatment funding had been cut by 25 percent over the past few years while requests for services have quadrupled.

Ms. Beck then called for the enactment of an emergency addiction treatment fund for long-term residential treatment for people addicted to prescription drugs and street opiates. “The drug companies that manufacture and make billions on the sale of these drugs should be required to contribute to this fund,” Ms. Beck said. “After all, their product has caused many unnecessary injuries and fatalities and is driving the street opiate problem as well.”

## Full Continuum of Care

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*“You must wrap the supports around the people and take the services where they are.”*

**Cheryl Andrews**  
**Executive Director,**  
**Washington County Drug and**  
**Alcohol Commission**

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Dr. Levine stressed that treatment and recovery services for addicted individuals should encompass a full continuum of care. She said: “According to the National Institute of Drug Abuse, an individual with a fully-developed addiction typically will require three to six months residential treatment, followed by the full continuum of outpatient treatment and recovery supports.” These supports can range from non-hospital rehabilitation to halfway houses

to outpatient peer counseling to medication-assisted treatment.

Dr. Capretto offered that effective coordination of care combines the strengths of various systems and professions, including physicians and addiction counselors, and 12-step programs and community support service providers. The 12-step program is a set of recovery steps to achieve and maintain abstinence for people suffering from addiction.

Kami Anderson, Executive Director of the Armstrong-Indiana-Clarion Drug and Alcohol Commission, provided information on the Commission’s Recovery-Oriented Systems of Care (ROSC) in its tri-county rural service area. In 2008, the Commission created the Certified Recovery Specialist (CRS) program, specifically for individuals who are in long-term recovery and who want to provide recovery support services to others battling addiction. The CRS Credential was created in 2008 and is certified by the Pennsylvania Certification Board (PCB). PCB is a private, non-profit corporation that offers voluntary credentialing to substance abuse and other behavioral health professionals. The Armstrong-Indiana-Clarion Drug and Alcohol Commission now employs four full-time CRS staff who assist clients with drafting a recovery plan and engaging and supporting clients with other recovery essentials.

Ms. Anderson related that, through successful grant application efforts, the Commission used a \$600,000 federal Office of Rural Health Policy Grant to create a “warm hand-off program,” which placed mobile case managers and a peer recovery specialist in each of its service area hospitals. Patients being treated by the hospital for overdose and/or substance use disorders are assessed by the case manager, who can then provide a direct transfer from the hospital to a treatment facility. The peer recovery specialists provide necessary support to the patient, education to family members, and addiction education to the hospital staff.

Washington and Westmoreland counties have also instituted pilot projects involving mobile case managers who are available in local hospitals to ensure a “warm hand-off” following an overdose situation. When possible, these case managers conduct screenings and assessments at the hospitals. The Westmoreland County Drug and Alcohol Commission, which established its pilot in 2014, reported working with 80 individuals, 31 percent of whom followed up with treatment services.

Mr. Michael Donahue, Administrator of the Luzerne-Wyoming Counties Drug and Alcohol Program, said his Single County Authority (SCA) is also further developing its ROSC. The main objective of establishing recovery centers for individuals who are attempting to maintain a drug-free lifestyle and training and hiring a CRS is to provide additional support to those who leave the centers to con-

tinue their recovery efforts.

Shawn Ann McNichol, a Recovery Program Specialist with the Recovery-Advocacy-Service-Empowerment (RASE) Project, said that the project has developed the Recovery Specialist Program (RSP), which is designed for individuals in drug or alcohol treatment who need one-on-one counseling to help them succeed in the recovery process. Often, these are individuals who chronically relapse and struggle to complete their treatment. Participants in the program are matched with a peer recovery specialist who regularly meets with them; helps them through the tough times; and shares the skills and tools necessary to live successfully while maintaining sustained recovery.

William Hoban, Director of the Lackawanna/Susquehanna Office of Drug and Alcohol Programs, said that within the behavioral health policy arena, programs are trying to align their services with a recovery-oriented approach, one that supports long-term recovery for individuals and families and promotes community health. “This movement represents a shift away from a crisis-oriented, acute-based model of care to a public health/recovery management model that emphasizes the reality and hope of long-term recovery, and recognizes the many pathways to healing for people with addiction,” he said.

A comprehensive service delivery approach was presented by Cheri Walter and Liz Henrich of the Ohio Association of County Behavioral Health Authorities. Ohio uses a comprehensive service delivery approach to provide treatment and recovery services to individuals with addictions. They described Ohio’s “Recovery is Beautiful Program,” as one that provides hope and encouragement while changing the conversation in regard to mental illness and addiction. The program, which is supported by the executive, legislative, and judicial branches of government, is based on a five-year blueprint that moves Ohio toward a recovery-oriented system of care focusing on prevention and wellness, crisis services, treatment, and recovery management. It also involves five principles to move the Recovery-Oriented System of Care forward as follows:

Ohio’s approach is similar to the approach of Project Lazarus, which was highlighted by Mr. Fred Brason during the 2014 Center-sponsored heroin hearings. The Project Lazarus model is based on a wheel concept with the following seven spokes: community education, provider education, hospital emergency department policies, diversion control, pain patient support, harm reduction



and addiction treatment. The model reinforces the concept that “we are all in” when fighting the heroin/opioid epidemic. (See page 11 of *Heroin: Combating this Growing Epidemic in Pennsylvania*.)

## Integrating Pain Management Education in Medical School Curriculum

Throughout all of the hearings, several participants reported that 80 percent of heroin users begin with the abuse of prescription drugs. Many felt that the over-prescription of pain management drugs, which is partly the result of the absence of pain management education in the medical school curriculum, is a serious concern.

Pennsylvania Department of Drug and Alcohol Programs Secretary Gary Tennis reported that he and Dr. Levine are working with medical schools across the state to see that substance abuse is integrated into their curriculum.

Some colleges are already taking this step. Dr. Steven Scheinman, President and Dean of The Commonwealth Medical College in Scranton, said the college has been working with SAMHSA to make these changes. In addition, the college plans to develop a certificate program in behavioral health and substance abuse to train primary care physicians and first responders.

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Mr. Hoban said his SCA's program, Partners in Prevention, partners with a number of local colleges and universities to provide programming and information on the dangers of opioid use and addiction to the young adult population. The program is founded on building community coalitions and increasing education about opioid pain medication. Through the program, opioid prescribing guidelines were disseminated to more than 100 area dentists.

Secretary Tennis noted that, at the state level, DDAP formed a Prescribing Practices Workgroup in 2014. This group, in conjunction with the Pennsylvania Medical Society, promulgated the following three sets of prescribing practices for doctors and dentists who prescribe opioids; the Use of Opioids to Treat Chronic Non-Cancer Pain; Emergency Department Guidelines; and the Use of Opioids in Dental Practices.

Dr. Levine also noted that her office has taken the lead by further expanding the prescribing practices to include continuing education in the areas of obstetrics, geriatrics, and sport medicine.

In addition, she is working with community stakeholders on the issue of voluntary continuing education credits for other health care providers, such as nurse practitioners, physician assistants, nurses, pharmacists, podiatrists, dentists and osteopathic physicians. The four areas being emphasized are: Prescribing Guidelines; Naloxone Accessibility; Achieving Better Care by Monitoring All Prescriptions Program (ABC-MAP) Implementation; and Warm Hand-Off. These modules will consist of four hours of continuing education and will count toward continuing education credits for all of these providers. The credits will also count toward the quality and safety credits required for physicians and some other providers.

Secretary Tennis stated that DDAP, in conjunction with the Department of Health (DOH), is working with health care professionals to identify individuals with substance abuse problems when they enter an emergency room or a doctors' office and how to get them into an appropriate level of care.

## **Workforce Issues**

Several testifiers noted the need to build the treatment workforce.

Dr. Margaret Jarvis, Medical Director for Marworth, an alcohol and chemical dependency treatment center, said that it is also important to support the education of doctors who are trained to handle treatment medications like methadone, buprenorphine, and naltrexone, and how to treat heroin/opioid addiction. "It takes specialized knowledge and experience to handle these medications well," she

said. Therefore, offering financial support for addiction medicine fellowships or loan forgiveness to addiction medicine doctors who practice in rural Pennsylvania could help increase the number of full-time addiction medicine doctors.

Dr. Scheinman of The Commonwealth Medical College said the college has been working with more than 80 regional partners and agencies on a Behavioral Health Initiative for over a year. A needs assessment revealed that northeastern Pennsylvania needs more psychiatrists, as well as additional capacity for addiction treatment. The college has an application pending for a Psychiatry Residency Program that would be based in the Scranton and Wilkes-Barre area, and is working to integrate mental and behavioral health into the primary care setting using tools such as tele-mental health.

Tom Callahan, Executive Director of White Deer Run, a network of treatment programs, testified to the challenges facing counselors who treat those with addiction. Since he entered the field in 1979, he has observed counselors spending more time filling out forms and processing paperwork, and spending less time with their clients. In addition, he is seeing an experienced and effective workforce dwindling. Between the long hours, low wages, burnout and retirement of seasoned professionals, counselors are in short supply. The experience and training requirements necessary to replenish the field are causing potential candidates to pursue other careers.



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## Other Related Issues

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*“As reported by the Centers for Disease Control and Prevention, increased access to naloxone is essential to stop our citizens from dying at a rate of seven deaths a day.”*

**Dr. Rachel Levine**  
**Pennsylvania Physician General**

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While the hearings focused on treatment and recovery services, other issues surrounding the heroin and opioid epidemic were addressed.

### Access to Naloxone

Dr. Levine applauded the passage of Act 139 of 2014 to expand the availability of naloxone, as well as the passage of Act 191 of 2014, which expanded the Prescription Drug Monitoring Program, known as the Achieving Better Care by Monitoring All Prescriptions Program (ABC-MAP). Further, she encouraged all prescribers to write naloxone prescriptions for their patients and families who might be at risk. (Note: On October 28, 2015, Dr. Levine signed a statewide standing order for naloxone, which provides a naloxone prescription to all Pennsylvanians.)

According to Dr. Levine, naloxone has been safely used by medical professionals for over 40 years and cannot be abused.

Delaware County District Attorney Jack Whelan also praised the passage of Act 139, saying that when the law went into effect on November 29, 2014, Delaware County was ready with the purchase of 900 doses of nasal naloxone, putting two doses in every Delaware County police vehicle. Almost immediately, Ridley Township Patrolman Shawn McGee, who also presented testimony, became perhaps the first law enforcement officer in Pennsylvania to administer naloxone under David's Law. Patrolman McGee said that this opioid overdose reversal antidote is just another tool that helps him to perform the job he was sworn to do.

In August, District Attorney Whelan said that Delaware County police had made 81 saves with naloxone since November 2014. “From a law enforcement perspective, we have not seen any drawbacks to using naloxone, nor have we encountered an issue that could not be resolved,” said District Attorney Whelan.

Several SCAs, including Lackawanna/Susquehanna, Luzerne, and Wyoming, noted the establishment of naloxone programs in their counties.

Mr. Hoban of the Lackawanna-Susquehanna SCA said its naloxone distribution program for first responders was developed through a collaborative partnership by the Lackawanna County District Attorney's Office, Marworth Treatment Center, and Pennsylvania Ambulance. The program has been operational since March 2015, and, at the time of the hearings, had 16 police departments participating and four overdose reversals.

While some of those who testified at the hearing said that lives are being saved with naloxone, others indicated that there has been resistance in administering and carrying the medication. Some law enforcement officers are having a moral dilemma when dealing with drug overdoses. Others expressed concern about the unpredictable reaction someone may have after receiving naloxone.

Dr. Levine indicated that all municipal police, fire and emergency medical service personnel should carry naloxone. She said that while these resistance concerns are valid, they should not deter emergency service personnel from carrying naloxone. “Opioid overdose does not just happen to ‘drug addicts.’ Older Pennsylvanians can be forgetful and take too much of a prescribed medication. Children can get into the medicine cabinet and ingest dangerous levels of prescription painkillers.”

Dr. Levine stated: “As reported by the Centers for Disease Control and Prevention, increased access to naloxone is essential to stop our citizens from dying at a rate of seven deaths a day.”

### Treatment Courts

In Pennsylvania, 35 counties have some type of specialized court for drug offenders.

Lackawanna County Deputy District Attorney Shane Scanlon highlighted the specialized treatment courts established by Judge Michael J. Barrasse in Lackawanna County in 2000. He said the Lackawanna County Treatment Court represents a comprehensive effort to target non-violent offenders to combat drug use and its affiliated criminal activity. Through a unique partnership of the criminal justice community, social service organizations, local governments, and individuals, the court provides a judicially supervised, rehabilitative treatment program to address drug addiction and crime.

The four-phase program, which lasts an average of 18 months, has served 284 clients between the ages of 18 and 60 (average age, 27), with heroin and/or other opioids as the most prevalent drug abused. Alcohol and synthetic drugs, however, are also becoming more of an issue. The program's retention rate is about 89 percent and there is an





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## Mandatory Minimum Sentencing

Prosecutors and other law enforcement officials testified in Scranton and York to losing one of the greatest tools they had – mandatory minimums for drug dealers. Based on a U.S. Supreme Court case, the status of mandatory minimums in Pennsylvania is unclear pending further legislative action. However, in their testimony, Deputy District Attorney Scanlon and Chief Deputy Prosecutor David Sunday requested that limited mandatory minimums be re-instated for prosecutors to get the “worst of the worst” off the streets. Once drug traffickers are identified, prosecutors need the tools to remove them from the streets and incarcerate them for longer periods of time.

Prosecutors and law enforcement officials who testified at both series of public hearings stressed that most drug dealers are not users. They said that selling drugs is a lucrative and sometimes violent business. In some instances, addicts will trade stolen weapons for drugs.

## Seamless Transition from Incarceration

SAMHSA reported that 70 percent of the individuals in our prisons have untreated or undertreated substance abuse problems. Secretary Tennis testified that DDAP is looking at ways to divert individuals into treatment before they enter the criminal justice system. Research has shown that incarceration does not break the cycle of addiction. Over the last 10 years, it has become evident with our growing prison population that other avenues for non-violent offenders needed to be pursued, stated Secretary Tennis.

Mr. Jack Carroll of the Cumberland/Perry Drug and Alcohol Commission commented that the state correctional system and county jails are instituting programs using work release, house arrest, electronic monitoring, day reporting, and drug testing, in combination with substance abuse treatment programs, as a cost-effective alternative to incarceration. He said these programs are successful and need to be expanded. Funds that are saved from reduced prison bed stays need to be reinvested into substance abuse treatment and probation and parole programs.

Pennsylvania Secretary of Human Services Ted Dallas indicated that incarcerated individuals in Pennsylvania cannot receive Medicaid benefits. His goal is to begin working with the Department of Corrections so that prior to an inmate’s release, the inmate can start the process for Medicaid eligibility and, once released, become immediately re-enrolled in Medicaid.

Ms. Anderson of the Armstrong-Indiana-Clarion Drug and Alcohol Commission stated her agency was the first to implement the Medical Assistance County Jail Pilot Program for individuals incarcerated in county prisons.

Through the program, inmates are assessed and then transferred directly to a residential treatment facility on the date of their release.

## Heroin Overdose Death Reporting

Several presenters stated there is no uniformity in how heroin deaths are tracked. Sometimes, drug overdoses are listed legitimately as heart failure or are not reported as the actual cause of death to spare embarrassment to the family. It is also important to note there are a number of mitigating factors when determining the cause of death. Dr. Martz of DDAP testified that overdoses are often the result of a poly-substance addiction, which creates a problem for coroners in tracking heroin deaths.

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***“Our country’s current opiate epidemic is the result of a four-fold increase in sales of opioid painkillers, combined with a street supply of heroin that has never been more potent, and has never been cheaper. These patterns developed over a period of 10 to 15 years. We’re simply not going to solve it overnight, and no single county or statewide agency will be able to solve it alone. We need a comprehensive, coordinated, and sustained response in order for us to reverse current trends.”***

**Jack Carroll  
Executive Director,  
Cumberland/Perry Drug  
and Alcohol Commission**

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## Presenter Recommendations

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*“We face a new and ironic challenge. We know how to cure substance abuse. The new challenge is: are we willing to do what it takes to achieve these cures? Right now, the answer seems to be: we can’t afford it. Name another disease where our response is: we can’t afford to treat it. There are very few diseases where we surrender to costs.”*

**Secretary Gary Tennis  
Pennsylvania Department of  
Drug and Alcohol Programs**

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The Center heard from more than 40 state and local officials, law enforcement personnel, health care and treatment providers, educators, recovering addicts and parents. These presenters offered the following recommendations on treatment and recovery services in Pennsylvania.

- **Recognize that addiction is a disease and those suffering from this disease should be afforded proper treatment.** Treatment must be clinically driven according to each individual’s needs. This could take several months and require varying levels of care to overcome substance abuse. Treatment must focus on what is medically necessary for the individual, and not be based on an arbitrary funding protocol. The National Institute on Drug Abuse identified 90 days as the minimum for care as compared to the traditional 28- or 30-day inpatient recovery program.
- **Restore funding to counties for addiction treatment and recovery services.** Single County Authority administrators continued to stress the need for funding restoration. As stated at the 2014 hearings, drug and alcohol treatment funding has been cut by 25 percent over the past few years while requests for services have quadrupled.
- **Ensure compliance with Act 106 of 1989.** All group health plans, including health maintenance organizations, are to provide coverage for the treatment of alcohol and drug addiction once a certification of a medical problem and referral is made by a licensed physician or psychologist. Several presenters stated that the Departments of Health and Insurance should ensure that all health plans are in full compliance with this Act as the lack of coverage is an obstacle to receiving proper treatment.
- **Enforce the federal Mental Health Parity and Addiction Equity Act.** The Act requires insurance groups that offer coverage for mental health or substance use disorders to provide the same level of benefits they provide for general medical treatment.
- **Require continuing medical education credits on pain management and prescribing practices of opioids for professionals licensed to prescribe in Pennsylvania.** According to a National Survey of Primary Care Physicians, nine out of 10 doctors reported prescription drug abuse as a moderate to large problem in their communities, and 85 percent believed that prescription drugs are overused in clinical practice. However, participation in current educational efforts regarding pain management and opioid prescriptions is voluntary.
- **Expand the pilot program of early intervention through warm hand-off services statewide.**
- **Ensure rapid enrollment of Medicaid benefits to individuals being released from incarceration to provide a continuum of care and ongoing treatment.**
- **Establish a uniform manner in which overdose deaths, and specifically heroin deaths, are reported.**
- **Continue to fund pilot programs for the medication-assisted treatment option naltrexone (Vivitrol).** Naltrexone is not an opiate. It is administered as a monthly shot and is less likely to be diverted on the street.
- **Expand the use of naloxone among local Pennsylvania police departments.**
- **Reinstate mandatory minimum sentencing requirements.** Prosecutors advocated for a 5-year minimum for anyone caught dealing more than 10 grams of heroin and 7 years for the second offense. Prosecutors also requested limited mandatory minimums for dealers when a drug delivery results in death.

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*“As a person of faith, I believe things will improve, but until they do, we say goodbye to too many people claimed by addiction. Our family will continue to fight for the few that we can, and hope and pray for positive outcomes.”*

**Anthony Anguilli, Parent**

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## Glossary of Terms

**Abstinence Based Recovery:** A treatment approach that focuses on complete abstinence from any drug use, thereby breaking the cycle of addiction. To achieve remission, complete withdrawal of all drugs and alcohol is required. Abstinence based recovery promotes withdrawal in a safe, controlled environment, with immediate support for the patient.

**Achieving Better Care by Monitoring All Prescriptions Program (ABC-MAP):** Pennsylvania's expansion of the pre-existing prescription drug monitoring program, aimed at helping regulatory and law enforcement agencies in detecting and preventing fraud and abuse.

**Act 106 of 1989:** Requires all group health plans, including health maintenance organizations, to provide coverage for the treatment of alcohol and drug addictions. A person seeking addiction treatment through insurance coverage needs only a certification of the medical problem and referral by a licensed physician or psychologist.

**Act 139 of 2014:** Known as David's Law, provides legal protection for witnesses, or Good Samaritans, seeking medical help at the scene of an overdose. In addition, it allows naloxone, a synthetic drug that blocks opiate receptors in the nervous system, to be prescribed to a third party, such as a friend or family member, and administered by law enforcement and firefighters.

**Act 152 of 1988:** Provides state funding for non-hospital residential detoxification and rehabilitation services for individuals eligible for Medical Assistance.

**Act 191 of 2014:** Expanded the types of drugs monitored under the state's existing Prescription Drug Monitoring Program to include Schedule II through V controlled substances. It also created a board within the Department of Health to establish and oversee an electronic data system listing all controlled substances that are prescribed and dispensed in Pennsylvania.

### **Criminal sentencing levels in Pennsylvania: Levels 1-4**

- **Level 1:** provides sentence recommendations for the least serious offenders with no more than one prior misdemeanor conviction. The primary purpose of this level is to provide the minimal control necessary to fulfill court-ordered obligations.
- **Level 2:** provides sentence recommendations for generally non-violent offenders and those with numerous less serious prior convictions, such that the standard range requires a county sentence but

permits both incarceration and non-confinement. The primary purposes of this level are control over the offender and restitution to victims.

- **Level 3:** provides sentence recommendations for serious offenders and those with numerous prior convictions, such that the standard range requires incarceration or County Intermediate Punishment, but in all cases permits a county sentence. The standard range is defined as having a lower limit of incarceration of less than 12 months. Included in Level 3 are those offenses for which a mandatory minimum sentence of 12 months or less applies and for which a state or county intermediate punishment sentence is authorized by statute.
- **Level 4:** provides sentence recommendations for very serious offenders and those with numerous prior convictions.

**Federal Mental Health Parity and Addiction Equity Act (MHPAEA):** Requires coverage for the treatment of alcohol and drug addiction. The law requires many insurance plans that cover mental health or substance use disorders to offer coverage for those services that is no more restrictive than the coverage for medical/surgical conditions.

**Heroin:** An illegal and highly addictive drug processed from morphine, a natural occurring substance extracted from the seed pod of certain varieties of poppy plants.

**Heroin Opiate Positive Experience (HOPE) Program:** A program of Cove Forge Behavioral Health System to help opiate dependent patients support their brain during their early recovery, as the effects of opioid dependency on this part of their body can be incredibly damaging.

**Intermediate Punishment Programs:** Provide for the strict supervision of the offender, which limits the offender's movements, monitors the offender's compliance with the punishment, or is a combination of both. Also provides for strict supervision of the offender due to criminal offenses involving drugs or alcohol.

**Methadone:** A synthetic analgesic drug that is similar to morphine in its effects but is longer acting, and is used as a substitute drug in the treatment of morphine and heroin addiction.

**Naloxone (Narcan):** A synthetic drug similar to morphine that blocks opiate receptors in the nervous system.



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**Naltrexone (Vivitrol):** An injectable prescription medication that blocks the effects of narcotic medicines and alcohol.

**NOPE Program (Narcotics, Overdose, Prevention and Education):** A program dedicated to educating communities about the dangerous consequences of prescription drug misuse and abuse as well as other substance abuse and drug overdose.

**Opiates:** Drugs with morphine like effects, derived from opium.

**Opioids:** Any synthetic narcotic that has opiate-like activities but is not derived from opium.

**Recovery-Advocacy-Service-Empowerment (RASE) Project:** RASE is an independent, non-profit “recovery community organization,” comprised entirely of staff and volunteers from the recovery community and serving those in the south central Pennsylvania region.

**Schedule I and II controlled substances:** Drugs, substances, or chemicals, with no currently accepted medical use, having a high potential for abuse.

**Schedule III, IV, and V controlled substances:** Drugs that have a moderate to low potential for abuse that are currently accepted for medical use.

**Substance Abuse and Mental Health Services Administration (SAMHSA):** An agency within the U.S. Department of Health and Human Services that leads public health efforts to advance the behavioral health of the nation.

**Warm hand-off:** An approach in which the primary care provider does a face-to-face introduction of a patient to the behavioral health specialist to which he or she is being referred.

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## Appendix A: 2015 Public Hearing Dates/Locations

### Tuesday, July 21, 2015

Saint Vincent College  
The Fred Rogers Center  
300 Fraser Purchase Road  
Latrobe, PA 15650  
Hosted by Senator Gene Yaw, Center board chairman, and Br. Norman W. Hipps, O.S.B, Ph.D., President, Saint Vincent College

### Wednesday, July 29, 2015

The Commonwealth Medical College  
Medical Sciences Building  
525 Pine Street  
Scranton, PA 18509  
Hosted by Senator Gene Yaw, Center board chairman, and Steven J. Scheinman, MD, President and Dean, The Commonwealth Medical College

### Tuesday, August 18, 2015

Yorktowne Hotel  
Ballroom  
48 E. Market Street  
York, PA 17401  
Hosted by Senator Gene Yaw, Center board chairman and the Center for Rural Pennsylvania Board of Directors

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## Appendix B: List of Testifiers/Other Legislators in Attendance

*The Center for Rural Pennsylvania thanks the following individuals and organization representatives for attending the hearings and providing testimony.*

Kami Anderson, Executive Director, Armstrong-Clarion-Indiana Drug and Alcohol Commission

Cheryl Andrews, Executive Director, Washington Drug and Alcohol Commission

Anthony Anguilli, Parent

\*Dr. Colleen Barry, Johns Hopkins University

\*Phil Bauer, Parent and Advocate for Prescription Drug Safety

Deb Beck, President, Drug and Alcohol Service Providers Organization of Pennsylvania

April Billett Barclay, Chief, York County Adult Probation Department

Tom Callahan, MA, Executive Director, White Deer Run

Anthony Canterna, MD, Positive Recovery Solutions LLC

Neil A. Capretto, DO, F.A.S.A.M., Medical Director, Gateway Rehabilitation Center

Jack Carroll, Executive Director, Cumberland/Perry Drug and Alcohol Commission

Christopher Cook, Program Manager - HOPE Program, Cove Forge Behavioral Health System

Amanda Cope, RN, Positive Recovery Solutions LLC

\*Greg Crawford, Graduate Student

Ted Dallas, Secretary, Pennsylvania Department of Human Services

Michael Donahue, C.A.D.C., Administrator, Luzerne-Wyoming Counties Drug and Alcohol Program

Pam Gay, York County Coroner

Robert R. Gorman, Medical Physician Assistant, Positive Recovery Solutions LLC

Liz Henrich, Associate CEO, Ohio Association of County Behavioral Health Authorities

William Hoban, Administrator, Lackawanna/Susquehanna Office of Drug and Alcohol Programs

Colleen D. Hughes, Executive Director, Westmoreland Drug and Alcohol Commission, Inc.

Dr. Lauren S. Hughes, Deputy Secretary for Health Innovation, Pennsylvania Department of Health

Margaret Jarvis, MD, Medical Director, Geisinger Health System, Marworth Alcohol and Chemical Dependency Treatment Center

Wes Kahley, Chief, York City Police Department

John Knowles, Senior Marketing Representative, Clearbrook Treatment Centers, Luzerne County

Eric Kocian, Ph.D., Assistant Professor, Criminology, Law and Society, Saint Vincent College

Michael Krafick, Certified Recovery Specialist, Armstrong-Clarion-Indiana Drug and Alcohol Commission

James Laughlin, Chief, Penn Township Police Department

Dr. Rachel Levine, Pennsylvania Physician General

Kenneth J. Martz, PsyD, CAS, Special Assistant to the Secretary, Pennsylvania Department of Drug and Alcohol Programs

Sean McGee, Patrolman, Ridley Township Police Department

Kellie McKevitt, Executive for Behavioral Health Services, Southwestern Pennsylvania Human Services

Shawn Anne McNichol, MA, Recovery Program Specialist, RASE Project

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Rich Mrocza, Director, Carbon-Monroe-Pike Drug and Alcohol Commission  
Ashley Potts, Certified Recovery Specialist, Forensic Case Manager, Washington Drug and Alcohol Commission  
Brian S., In Recovery  
Shane Scanlon, Lackawanna County Deputy District Attorney  
Steven J. Scheinman, MD, President and Dean, the Commonwealth Medical College  
Andrew Schmitt, LSCW, Mazzitti and Sullivan Counseling Services Inc.  
\*Andrew T. Sullivan, President, Mazzitti and Sullivan Counseling Services Inc.  
David Sunday, Chief Deputy Prosecutor, York County District Attorney's Office  
Gary Tennis, Secretary, Pennsylvania Department of Drug and Alcohol Programs  
Cheri Walter, CEO, Ohio Association of County Behavioral Health Authorities  
Jack Whelan, District Attorney, Delaware County  
Jeff Zerechak, Director, Wayne County Drug and Alcohol Commission  
\*Written testimony submitted

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## Other Legislators In Attendance

Senator Lisa Baker – Luzerne, Pike, Susquehanna, Wayne and Wyoming Counties  
Senator Mike Folmer – Dauphin, Lebanon and York Counties  
Senator Mario Scavella – Monroe and Northampton Counties  
Senator Judy Schwank – Berks County  
Senator Patrick Stefano – Fayette, Somerset and Westmoreland Counties  
Senator Pat Vance – Cumberland and York Counties  
Senator Scott Wagner – York County  
Senator Kim Ward – Westmoreland County

Representative Karen Boback – Lackawanna, Luzerne and Wyoming Counties  
Representative Seth Grove – York County  
Representative Kate Klunk – York County  
Representative Sandy Major – Susquehanna and Wayne Counties  
Representative Kristin Phillips-Hill – York County  
Representative Mike Regan – Cumberland and York Counties  
Representative Kevin Schreiber – York County



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