The Montgomery County Investigating Grand Jury Report:

The Opioid Epidemic

IN THE COURT OF COMMON PLEAS OF MONTGOMERY COUNTY
PENNSYLVANIA - CRIMINAL DIVISION

IN RE: COUNTY INVESTIGATING GRAND JURY	:	**MD 2363-2015**
	:	
	:	**INVESTIGATION # 22**

FINDINGS AND ORDER

AND NOW, this 15th day of May 2017, after having examined the Report of the Montgomery County Investigating Grand Jury of MD 2363-2015, Investigation Number 22, and reviewing the record, this Court finds that the said Report is within the authority of the Investigating Grand Jury and is otherwise in accordance with the provisions of Act 42 Pa. C.S. § 4541 et. seq. In view of these findings, the Court hereby accepts the Report and files the Report as public record.

BY THE COURT

HON. THOMAS C. BRANCA,
Supervising Judge

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INTRODUCTION

Right now, in Montgomery County, a once-in-a-generation drug epidemic is unfolding that threatens our lives, our safety, and our community.

The opioid epidemic has created headlines across the country, but in our investigation over the past year, we have heard evidence about the damage it is doing in our own backyard. We have heard the testimony of users, families, law enforcement, counselors, public health experts, and others; we have heard statistics, and we have looked into the eyes of mothers who have lost their children. We learned about the "Perfect Storm" of circumstances that helped to create this epidemic, from the over-prescription of opioid painkillers to the cheap and powerful heroin that now floods our streets. We have seen how this epidemic confounds all the stereotypes about drug users: these are not strangers on the margins of society, but our friends, our co-workers, our neighbors, our children, our parents. The people who need our help are all around us**.**

This Grand Jury has been convened to examine the opioid crisis in Montgomery County, and in this Report we will detail these facts and attempt to describe the human tragedy that this epidemic has left in its wake. We will also describe the heroic efforts of many – law enforcement, health care professionals, and others – to combat this crisis. Many creative and hardworking people are on the front lines; they have found some real solutions, and we must support them and give them the resources they need. We will make recommendations about laws that need to be changed and policies that should be implemented.

But the bottom line is, we as a community must do more. We need to recognize this crisis as a profound and immediate threat, and we must respond accordingly. More resources, better targeted, must be put in the hands of first responders and health care providers. Addicts

must have access to adequate treatment facilities – there is no other way. We also recommend that the legislature restore mandatory minimums for higher-level drug traffickers, to keep them off our streets and provide law enforcement with the means to investigate and destroy trafficking organizations. These solutions come from all sides of the ideological spectrum, because this issue knows no politics.

But before we go into the details, we should consider the urgency. Right now, there are members of our community who are desperate for help. One of these people may end up in a Montgomery County emergency room tonight, the victim of an opioid overdose. If they survive, we will face a critical moment: either this person will receive meaningful help, or they will walk out of the hospital and start it all again tomorrow. We may not have a second chance. The resources must be in place right now.

The question is not whether we should take action. The question is whether we can act fast enough to save our neighbors' lives.

I. THE STATISTICS: A BRIEF SUMMARY

The opioid epidemic was described to us by Dr. Theodore Christopher, Professor of Emergency Medicine at Jefferson University Hospital and President-Elect of the Pennsylvania Medical Society, as "one of the largest public health crises that faces … our country today," and the numbers provide the proof. According to the Centers for Disease Control ("CDC"), more than 33,000 Americans died from opioid overdoses in 2015, the last year for which full statistics are available. That works out to approximately 91 victims per day, a disturbing figure that becomes even more troubling when placed in context: the number of fatal overdoses has nearly

quadrupled since 1999.[1] Most of that explosive growth has occurred during the past five years, and the year-to-year increase in opioid abuse and fatalities has only grown larger. From 2014 to 2015 alone, the number of fatal overdoses jumped by 16 percent, and while the numbers from 2016 have not yet been finalized, from all indications that trend has continued and perhaps even accelerated.[2]

If anything, the growth of the opioid epidemic here in Montgomery County has been even faster and more intense. Fifteen years ago, only a few relevant statistics were even compiled: the County Coroner's office reported in 2002 a total of 39 drug-related deaths, 25 of which were ruled to be accidental, and of those accidental drug-related deaths, the Coroner found traces of opioids in the bloodstream of 18 victims. Since then, the growth of these figures has been shocking. In 2015, there were 177 drug-related deaths, a surge of *351 percent* since 2002; the number of accidental drug-related deaths increased even more, by *480 percent*; and the number of these accidental overdose victims with opioids in their blood – that is, accidental and fatal opioid overdoses – increased by *533 percent*, to 114 victims.[3]

Just as with the national statistics, the lion's share of this growth has taken place over the past five years, and the pace of growth continues to increase. Just a few weeks ago, we heard the final 2016 statistics from the Coroner's Office, and the results are again startling. In just one year, Montgomery County has experienced a *40.67 percent increase* in the number of drug

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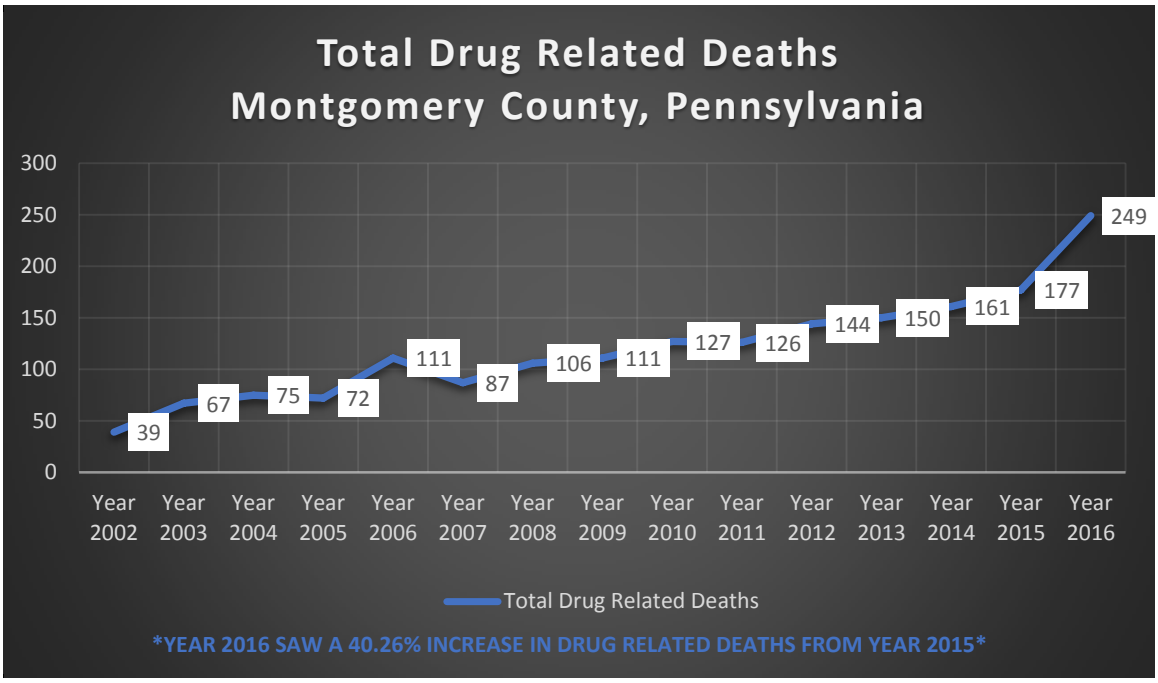
[1] *See* CENTERS FOR DISEASE CONTROL and PREVENTION, Data Overview, http://www.cdc.gov/drugoverdose/data/index.html; citing CDC, Wide ranging online data for epidemiologic research (WONDER), available at http://wonder.cdc.gov; *see also* CENTERS FOR DISEASE CONTROL and PREVENTION, Understanding the Epidemic, https://www.cdc.gov/drugoverdose/epidemic (hereinafter "*CDC Figures*").

[2] In 2014, about 28,000 Americans died from fatal opioid overdoses, approximately 5,000 fewer than the following year. *CDC Figures*.

[3] Report of the Montgomery County, Pennsylvania, Coroner's Office, Overdose Death Statistics by year.

related deaths, for a total of 249. Of those, 224 were ruled by the Coroner to be accidental, and of those accidental drug-related deaths, 205 victims were found with opioids in their blood. That amounts to an increase of about *80 percent* over the previous year.



Montgomery County has never seen anything like this before – quite literally. More people died in this county from drug overdoses in 2015 than in any previous year where statistics are available. But the 2016 figures were much bigger, smashing the record, and the rate of growth itself is unprecedented. In simple terms, we are facing a very big problem, and it is getting bigger.

II. THE HUMAN COST

Behind the statistics are hundreds of real people, victims of a powerfully addictive[4] narcotic, who are now dead. We have heard some of their stories, about their lives, the disease that killed them, and the friends and families they left behind.

The current crisis is best understood by telling a few of these stories. Each stands alone, but together the following three examples powerfully illustrate the way this addiction has spread, why it is so dangerous, and how the pattern might be stopped.

A. A Life Lost: When Treatment Isn't Available

We begin at the end of the road, where an addict had no place to turn and believed he was out of options.

On the evening of January 24, 2017, a man who we will only identify here as A.A. walked into a Turkey Hill store in Lower Providence Township and asked to use the bathroom. He told the cashier that he had just sought treatment at an inpatient drug addiction center across the street, but had been turned away. About 20 minutes later, when the man hadn't emerged from the bathroom, the cashier became concerned and went to look for him. The man was still in the locked bathroom stall, but he did not respond when the cashier spoke to him. The cashier called 911; the police soon arrived and forced open the stall door. There was the man, slumped over two empty packets of heroin in the toilet, a syringe on the ground next to him. Police administered Naloxone (an antidote for opioid overdoses) and attempted CPR, but he did not

[4] We learned that the reason why opioids are so addictive is because they alter brain chemistry. Specifically, the opioids attach to opioid receptors in the brain. This causes the body to stop sending pain signals to the brain which, in turn, alleviates pain. As the brain and the body adjust and adapt to the pain relief, a tolerance is developed; more and more of the drug is thus needed to sustain the same level of pain relief. This leads to dependence and addiction.

revive. Paramedics pronounced him dead at the scene. Later, the coroner reported that this man had died from an overdose of heroin and Fentanyl, a powerful synthetic opioid.

The man carried no identification, and no one recognized him. But police were soon able to confirm the story he told the cashier – he had walked into the front gate of the treatment facility, and asked for treatment, but he was turned away. So he left, and overdosed just a few minutes later.

The man remained unidentified for about a week. Eventually, an officer in Cheltenham used facial-recognition software to come up with a possible identity, and detectives were able to confirm the identification through the dead man's sister. Two days after he died, A.A. would have celebrated his 35th birthday.[5]

B. John Decker: A Young Athlete's Life Destroyed by Painkillers

The tragic story of John Decker tells the other side of the story, how an addiction begins and develops. His life illustrates a common path to opioid addiction, starting with prescription painkillers and ending with illegal pills, heroin, and even death. John's story also shows the special vulnerability of young people, even when they are surrounded by supportive family and friends.

In his father's words, John was an "amazing" high school athlete, with blue eyes and a ready smile.[6] He was an All-American lacrosse player and an All-State football star. He was good enough at basketball to be named to the all-league second team. But with his athletic success came a series of painful injuries. First, when he was 16, he tore an ACL during a basketball game and underwent surgery. He was prescribed powerful opioid painkillers, and told

[5] We learned of A.A's story from Lieutenant Michael Jackson of the Lower Providence Township Police Department.
[6] John's story was told to us by his father, Thomas Decker.

to "get ahead of the pain" – in other words, to take the pills, as a first option, before the pain became too intense. Neither John nor his family was warned about the dangers of these opiate painkillers, or the need for close monitoring.

John eventually recovered, and resumed playing lacrosse at Cornell University. Unfortunately, he continued to battle a series of injuries. He tore his ACL again during a summer tournament, and once again he was prescribed opioids for the pain, without any meaningful information or warnings. Nor was John asked about his prior opioid use.

At about this time, John was arrested with two friends in Bucks County as they tried to purchase opioid pills illegally. This was the first indication for John's family that something was wrong. John entered an ARD program,[7] which allowed him to expunge his record if he completed a program and stayed out of trouble for a period of time. As part of this program, John was "interviewed pretty intensely by a drug counselor" who assured his parents that their son was not an addict.

John's injuries continued. After graduating from Cornell, he enrolled at Drexel's business school, and continued playing lacrosse. Once again, he injured his knee, and once again he had surgery, and doctors prescribed opioid painkillers. And finally, John suffered a third ACL tear while playing basketball. This time, he didn't have surgery, but his lifestyle permanently changed – he couldn't play basketball anymore, he couldn't run as he used to. And once again, even without surgery, the doctors prescribed opioid painkillers.

With all of these opioid prescriptions, his doctors never warned John about the addictive power of these drugs, and did not monitor their use. After the last injury, John – in his early 20s

[7] "ARD" stands for "Accelerated Rehabilitative Disposition." It is a diversionary program in Pennsylvania that allows for an alternative to the standard criminal process for persons without a criminal record who have committed a relatively minor and non-violent crime. *See* Pa. R.Crim.P. 300 *et seq.*

– had already used opioid pain killers, off-and-on, for years. He had already been arrested for trying to buy painkillers illegally. Without careful attention, there was real danger.

John to this point had showed no outward signs of addiction, with the exception of his one arrest. But now trouble began to surface. At a party with his father, John noticeably slurred his speech and "didn't seem right." A few weeks later, one of John's friends called John's father and reported that he was taking heroin. John's parents confronted him; he didn't deny using heroin, but boasted that "I can stop any time I want." Another roommate reported that John was abusing pills; he actually used a hammer to pulverize them and extract the powder for snorting. John's family arranged for him to see a psychiatrist, and later John assured them he was no longer using.

At this point, John was working as a financial analyst. He told his parents that he wanted to quit his job, but when they advised him to stay until he found somewhere else to work, John became angry and stopped talking to them. A few months later, some of John's friends called his parents and told them John's drug use was out of control, and together his family and friends staged an intervention. They were able to convince John to enter rehab, which he did, for 30 days. But just a few days later, John started using again.

At this point, John's life seemed to spiral out of control. He attended a few AA meetings, but not very seriously. He quit his job and moved back home with his parents. John managed to get another job, and it started off well, but he was apparently still taking pills, so he told his family he was going to detox by himself. That did not go well – he spent a few days "bouncing off the walls," acting erratically, and at one point he jumped into his car and drove off. While gone, his unstable behavior continued, until he was nearly in an accident. Some onlookers managed to stop his car and drive him home, but no sooner was he home than he drove away

again. This time, his father called him and told him to come home, "the police are looking for you." This wasn't yet true, but it convinced John to come home. He was so agitated that his family called an ambulance to take him to Bryn Mawr Hospital, where he stayed for several days.

A few days after returning home, John was detained by police at a gas station for acting erratically. His family convinced him to go into rehab again, this time to a facility in Maryland. He only lasted two weeks there – the staff kicked him out, because he refused to participate in the program and spent most of his time in bed. His lawyer convinced him to reenter another treatment facility almost immediately, and this stint lasted three weeks. Finally, he was released to a halfway house in Philadelphia.

The move to the halfway house seemed to suit him. John's employer took him back, and the structured life kept his addiction in check for several months. But eventually he moved out, and his addiction surfaced again. John was prescribed Suboxone, a drug that can help ease opioid cravings, but he disliked its side effects and soon stopped taking it. John's family decided to stage another intervention, and he agreed to enter rehab again, but as soon as he got there he escaped out of a bathroom window.

Amazingly, John still had his job, even though he apparently was taking heroin three times a day – in the morning after waking up, once in the afternoon, and once before going to bed. But John's habit was eating up his salary, and his roommates told his father that John was stealing from them to support his habit.

Things were going so badly by December of 2014, John's mother told him not to come home for Christmas. His family was aware that they might be enabling his drug use; but they were moved by a Christmas Eve sermon about forgiveness, and they asked John to visit. So

John came to visit on Christmas, and on January 1, after being kicked out of his apartment by his roommates, John came to stay for a few weeks. He was still working – at least there was that.

John's parents went on a long-planned one-week vacation in January. They told John, if anything was missing when they returned, they'd have him arrested. But when they came back home they found John dead in the bathroom. They also found heroin paraphernalia – needles, plastic bags, rubber bands. An autopsy showed that John died from an overdose of heroin and Fentanyl.

John's journey from his first painkiller to his fatal overdose took more than 10 years, but the path was terrible in its predictability, and in missed opportunities. There is no doubt – we will lose family and friends when doctors overprescribe painkillers without monitoring, and when inpatient treatment lasts a maximum of 30 days. John's story is a stark warning.

C. John Becker: A Police Officer Who Became Addicted

"Prior to taking that first pill I was a model … human being, a good police officer." These are the words of former Hatboro Police Sergeant John Becker, who was a 17-year veteran of the police force. His addiction to opioids started when he was 41 years old. It ended up ruining his career.

The journey started, once again, with prescribed painkillers. Becker was an avid runner, who ran up to eight miles per day to keep in shape. He eventually developed plantar fasciitis in his left heel, a common but painful condition that required surgery. The operation was a success, and for the first two weeks Becker's recovery progressed normally. But one morning, he woke up with every joint in his body exploding in excruciating pain. Doctors were unsure what, exactly, was causing the problem; in the meantime, they prescribed opioid painkillers. The first

two opioids Becker tried made him sick, but there are several options, and eventually he began to take OxyContin every day. It did not make him sick, and it helped with the pain.

Becker spent the next 13 months going to various medical specialists and physical therapists, trying to figure out what was wrong with him. No one could find an answer. But the pain was real, and the OxyContin helped. As time went by, Becker developed a tolerance for the drug, which meant he had to take a bigger dose to get the same benefit. This is one of the characteristics of opioids which makes them so powerfully addictive, but he told us that none of his doctors had discussed with him the long-term strategy for taking these pills, or provided him with an exit plan. Instead, he just took an ever-increasing amount of OxyContin, starting with two 20 mg pills per day, and rising to three 40 mg pills per day within a few months. This is a 300 percent increase in dosage.

Looking back, Becker told us he crossed the line to drug abuse after about six months. He exceeded his prescription by four or five more pills per day to satisfy his habit. While most addicts must purchase their fix on the street or through phony prescriptions, Becker's status as a police officer gave him too-tempting access to these drugs, and he succumbed to that temptation. Becker was a Detective Sergeant who worked regularly with the Montgomery County Narcotics Enforcement Team ("NET"), and as a result he had conducted numerous drug investigations and was connected to drug informants who had worked with the NET over the years. Becker started to use one of these informants to buy his pills. Becker would tell his informant that he was working on a drug investigation, and give the informant money to buy pills from a dealer. After the purchase, the informant would give the pills to Becker. But there was no investigation – Becker just wanted the pills.

Even that wasn't enough. Becker was also the department's evidence custodian, and he had seized a lot of drug evidence over the years, including narcotic pain medication. He started to raid these supplies, too.

As his addiction progressed, Becker continued to see doctors for his painful joint condition, and finally in January 2011, he received a firm diagnosis. It turns out that he suffered from a rare hereditary autoimmune disease known by its acronym, TRAPS, and that his foot surgery had triggered its symptoms. A rheumatologist put him on a variety of (non-opioid) medications to manage the condition and reduce the pain, and the plan was to reduce the dosage of opioids and eventually wean him off.

Of course, the doctors did not know that Becker had become addicted, and they did not understand the extent to which his life had changed. Becker had gone through all the narcotics in the evidence room. He was using his informant to buy him opioids, and when that informant was only able to buy other kinds of drugs – like Xanax, or even cocaine – Becker would take that, too. He told us he had become what is known as a "garbage head," which means he would take anything. As his problem got worse, he sometimes couldn't remember entire days. He would do things like go to his nephew's sporting event, pass out in a chair and drool on himself. He took guns from the evidence room, and sold them to buy more pills. He was nearing the end of his rope.

Finally, during the same month that he was properly diagnosed with TRAPS, he finally got caught. He set up a drug deal through his informant (the deal was across the Bucks County line in Warminster, but Becker didn't care, because he just wanted the drugs for himself). The informant met the dealer in a parking lot, and gave her money; but she didn't have the pills yet, because she was waiting on her supplier. Becker watched all this unfold from his own car, and

after the informant told him what had happened, he became incensed. He screamed at the dealer to give him the pills. The dealer repeated that she didn't have the pills yet; Becker threatened her, saying that if she didn't get the pills to him by the next day, she might go to jail. But the dealer called the police instead, and an investigation began.

As suspicion grew that Becker had been the rogue detective who had threatened the drug dealer, detectives were incredulous. Not John Becker, who was such a solid law enforcement officer and citizen. His co-workers, and his family, knew he had been battling pain and had been prescribed opioids, but no one knew he was an addict, and no one knew the things he had done to feed his addiction. When confronted by detectives, Becker felt relieved that the whole thing was over. He confessed to everything and ended his career as a police officer. The next morning, he told his now-wife what he had done.

John Becker began to put his life back together at Mirmont Treatment Center in Delaware County. Mirmont has a "first responder" program that fit Becker perfectly, a peer-facilitated group approach designed for police, firefighters, and EMS personnel who are battling addictions. Becker received inpatient therapy there for 34 days; he told us that the first two weeks of his treatment were filled with guilt and shame, but through this specialized program he found a way to face up to his behavior and move on.

After leaving inpatient treatment, Becker attended intensive outpatient therapy and secured a sponsor. He enrolled in a 12-step program and attended those meetings every day. As Becker told us, "treatment's [just] the beginning, but it's what we do when we get out … that determines whether or not we're going to stay sober." Becker was able to transition from being a patient to a volunteer for other first responders. He enrolled at Drexel University and earned

degrees in Behavioral Health Counseling and Human Services. He was hired by Mirmont to do first responder outreach.

In the meantime, Becker was formally arrested and charged with 37 counts of felony theft, arising from the items he stole from the evidence room, as well as abusing his position as a police officer. He ultimately pled guilty. His fiancé stood by him, and one month before sentencing, they were married. As a result of all the gains he had made in treatment and in helping other first responders fight addiction, the judge gave him a sentence of 15 days' incarceration, house arrest, and probation. Becker told us this sentence was a "gift," and "I thank God every day that I'm not in jail still."

Becker left Mirmont after a year and became the director of First Responder Services at Sprout Health Group, located in California and New Jersey. In the end, John Becker's story gives us hope that addiction treatment can work, that people can put their lives back together and contribute to society.

III. THE PERFECT STORM OF SUPPLY AND DEMAND

In order to better comprehend the opioid epidemic – and how to address it – it's important to understand the conditions that created this crisis.[8]

A. Background: The Heroin Trade

Heroin and other opioids are derived from the poppy plant, which is generally not grown in the United States. In the 1950s and 1960s, when heroin abuse first gained widespread public attention in this country, its primary source was poppy grown in the so-called "Golden Triangle" of Southeast Asia, which includes the countries of Thailand, Laos, and Myanmar (Burma).

[8] We learned about the history of the heroin trade from Lieutenant Stephen Forzato, supervisor of the Montgomery County Narcotics Enforcement Team.

Heroin trade from the "Golden Triangle" to the United States grew during the Vietnam War. At that time, the purity level of heroin found on American streets was two to three percent – the rest consisted of "cut," that is, various substances used to dilute the product's strength and increase the drug sellers' profit. Users mostly injected this relatively weak heroin into their veins – snorting would not provide the same strong high. Still, this less potent product produced more than its share of deadly overdoses, usually when a batch of unusually strong heroin (say, four or five percent) found its way onto the street, and unaware users, whose bodies were tolerant of a low level of heroin, suddenly flooded their systems with two or three times that amount.

At that time – the 60s and 70s – heroin was more common among urban drug users than in other parts of our community. Among other reasons, many American drug users were simply averse to injecting themselves with narcotics, which was necessary with weaker heroin. And of course, there were many other choices for people who wanted to get high – cocaine, speed, and methamphetamines were more popular.

In the 1970s, Saigon fell, and suddenly drug trafficking from the "Golden Triangle" became much more difficult. The poppy growers turned to Mexico, which had the advantage of proximity to the lucrative U.S. market. But these fields were also more vulnerable to American law enforcement efforts; working with Mexico, in the 70s and 80s, American drug enforcement destroyed a significant portion of the poppy crop through aerial spraying. Soon a different area of the world emerged as another center of illegal opioid production, the so-called "Golden Crescent" of Afghanistan, Pakistan, and Iran.

B. The Arrival of Opioid Painkillers

Still, without a growing demand in this country, the influx of heroin was limited. Over the past 25 years, that demand has increased sharply with the advent of opioid painkiller prescription and abuse.

In 1995, OxyContin, a very strong opioid, arrived on the market as a prescription for people who were suffering intense pain – cancer patients, for example, or those suffering with serious back issues. It is powerful medicine. Perhaps because it is so effective, and because doctors understandably want to help their patients who are in pain, it quickly became a common prescription. We also learned that other factors helped drive this trend: Doctors are often "rated" by insurance companies, and one of the most important quality-control questions has been how well doctors manage their patients' pain. Even Medicare rates hospitals on that metric. Doctors are under pressure to help their patients with any pain they have, and that has been a strong incentive to prescribe opioids.

The problem, as we have already seen, is that opioids are very addictive. People build up a tolerance, and they need more pills just to get the same effect. Their mind and body begin to crave the opioids. If they stop, they get sick. One other feature of opioid painkillers helps to feed this cycle – users can hammer the pills to extract the powder, which they can inject or snort. These quicker ways to ingest the drug result in a rapid, powerful high, and hasten the addiction process.

C. The Increase in Heroin Trafficking

But OxyContin pills, and the other opioid painkillers that have reached the market over the past 25 years, are expensive. The street price for OxyContin is about a dollar per milligram

in pill form – for example, a 30 mg pill will cost $30. This gets expensive quickly for an average addict, who needs several pills per day. Heroin is a cheaper alternative.

Drug traffickers have taken advantage of this opportunity, flooding the U.S. market with very pure heroin smuggled over the border in large kilogram powder blocks. These packages are larger than bricks, but still small enough to make smuggling relatively easy. And because the trafficking cartels have learned to grow, transport, and sell their own product, the heroin that floods the market today is both cheap and very potent. The potency is important, because now users can snort it, reducing some of the stigma of heroin abuse – many people are not willing to inject themselves, but snorting is easier and less dramatic. The cost savings are also dramatic. A kilogram of heroin that used to sell 20 years ago for approximately $100,000 now sells for about $55,000.

The savings is passed on to the user. A kilogram of heroin equals 1000 grams; each gram – as small as a packet of sugar – can produce 33 small bags of heroin, each of which contains one dose. Each of these bags sells for $10 – much less than $30 for one pill.

These trends are reflected in drug enforcement across the country. Heroin is now the Drug Enforcement Agency's ("DEA") primary focus, because heroin abuse is growing faster than any other sector of narcotics. The DEA reports that bulk seizures (large amounts of heroin that are seized while being transported, rather than on the street) have increased exponentially – 5,000 kilograms were seized in 2014 alone, a bulk value of about $275 million. While this increase suggests that law enforcement is getting better at tracking and stopping heroin shipments, it also means that traffickers are transporting more heroin than ever. Indeed, from 2010 to 2014, the average bulk heroin seizure in this country more than doubled, from .86 kilograms to 1.74 kilograms. That strongly suggests that drug traffickers are transporting larger

quantities, mostly north from Mexico to big markets like Philadelphia, New York City, and Washington, D.C.

Of special concern to our investigation is the explosive growth of heroin use in suburban and rural districts, and Montgomery County in particular. We have already seen how the county Coroner's Office has seen a shocking spike in opioid overdose deaths over the past five years. Law enforcement has seen a corresponding rise in local trafficking activity. Lieutenant Stephen Forzato of the Montgomery County Narcotics Enforcement Team told us about increasing seizures of bulk heroin that are occurring right here in Montgomery County. These seizures tell us that the heroin industry is spreading out of its traditional urban centers, a trend driven by several factors. Most obviously, demand is increasing here. While heroin used to be considered an urban problem, confined to "needle parks" and a shadowy subculture of addicts, this is no longer the case: the easy path to abuse created by lax prescription of opioid painkillers, the low price of the drug, its potency and ability to be snorted, have turned heroin into the drug of choice for the average addict. The pool of users is diverse, reaching from wealthy professionals to the bottom of the economic ladder. Where 20 years ago cocaine was the biggest drug problem in the county, deadly and addictive heroin has now taken its place.

Heroin trafficking has also infiltrated our county as a reaction to law enforcement patterns. During the past several decades, law enforcement has become adept at locating and raiding urban stash houses. We have learned from law enforcement that Mexican drug trafficking organizations are now targeting suburban and rural areas for their operations so that they can more easily conceal their activities. For one thing, there are simply far fewer law enforcement officers in these areas, and it will take some time before these new trade and storage patterns can be effectively countered.

D. Fentanyl: A Powerful Synthetic Killer

Another way that heroin traffickers have increased profits, and killed many opioid users, is through use of Fentanyl.

Fentanyl is a synthetic opioid, prescribed for severe chronic pain like end-stage cancer. It is commonly administered through a patch that time-releases the drug into the user's system. Fentanyl is incredibly powerful, up to 60 times more powerful than heroin. Even experienced and closely watched Fentanyl users are in danger from it – if a patient uses two patches rather than one, for example, the result can be fatal.

But Fentanyl is relatively cheap to manufacture, and as a result, it has become a huge and deadly part of the current opioid problem. Drug cartels manufacture Fentanyl in Mexican labs, and use it to "cut" heroin. Sometimes it even replaces heroin – as Lieutenant Forzato told us, law enforcement is arresting drug traffickers who are bagging up Fentanyl and selling it to the unsuspecting user as heroin and in many cases these unsuspecting users are overdosing and some are dying. He further explained:

> That's what we are seeing here in Montgomery County. I would have never thought I'd see it. I thought it would be Philadelphia or New York City. I hear about these overdoses, hospital emergency rooms getting filled up. Unfortunately, we are seeing that here with straight pure Fentanyl.

We have already described the deaths of two opioid addicts who were found with Fentanyl in their system: A.A., who died in the bathroom of a convenience store because he was turned away from treatment; and John Decker, the young athlete whose life spiraled out of

control after his painkiller addiction led to heroin abuse. There are many others. There is no doubt that Fentanyl is deadly, and it is out on our streets right now.[9]

All of this taken together – the rise of opioid painkillers, the flood of cheap and potent heroin, the use of deadly Fentanyl – has created the ideal conditions for a deadly heroin epidemic. Lieutenant Forzato described this to us as "the perfect storm" of supply and demand, each powering the other, leaving untold victims in its wake.

IV. THE PATH OF ADDICTION, AND CURRENT STRATEGIES

There is no easy answer to the current opioid epidemic. There are so many stages to an addiction, and so many people and institutions involved, for good and for ill: the addict, the dealer, the EMT, the therapist, the doctor, the insurance company, the hospital, the family, friends and neighbors.

Rather than a single solution, there are a series of steps that must be taken together, each involving a different stage of the process. Some of these steps are already being taken, or are in the pipeline, but don't yet have full institutional or political support. We have been consistently amazed at the creativity of people who are doing their best to stem the tide of addiction even as we speak. These people need our support, and we need to learn from them. We have also been impressed with the policy ideas that have been presented to us by law enforcement, healthcare professionals, and others who are involved in this crisis.

In order to clearly set out the practical problems we face and potential strategies to solve them, we will follow the process of addiction itself – stage by stage – and discuss how the intervention of policy might work, and what form it might take.

[9] There are other, newer, more potent synthetic opioids entering the market all the time. For example, we heard about a new synthetic drug called "W-18," which "some estimate to be a thousand times more powerful than Fentanyl."

A. The Prescription of Opioid Painkillers

For many addicts, the path of addiction begins with a doctor's prescription. (As we have already seen, this was the entry point for both John Decker, the young athlete, and John Becker, the police officer.) Any strategy to fight the abuse of opioids must come to grips with this prescription-to-addiction pipeline – how does it work, and how can it be stopped?

Dr. Theodore Christopher, the Professor of Emergency Medicine at Jefferson University Hospital and President-Elect of the Pennsylvania Medical Society, testified that the opioid epidemic – which he called "an epidemic of unbelievable proportions," comparable to the AIDS/HIV epidemic of the 1980s and 1990s – has its roots in the over-prescription of opioids when they first arrived on the market about two decades ago. At the time, the medical community was focused on the power of these drugs to alleviate pain, but comparatively little thought was given to the consequences of providing such addictive drugs as a common medication.[10]

1. Medical Guidelines and Regulation

As opioid abuse has skyrocketed, there have been efforts to stop routine over-prescriptions. For example, in March of 2016, the CDC released non-mandatory guidelines to physicians recommending greater use of non-opioid pain therapy whenever feasible, and to use lower dosages when opioids are prescribed. A state task force has also worked to create guidelines here in Pennsylvania, and the Pennsylvania Medical Society is working to ensure compliance with these new rules, and to develop professional sanctions for doctors who fail to comply. These guidelines are not mandatory, however, and there is still room for abuse. Dr.

[10] Even today, as we learned from Dr. Christopher, doctors in the United States prescribe more opioid painkillers than any other country in the world.

Christopher told us that opioid prescriptions have been declining in Pennsylvania over the past year or so, and he believes voluntary compliance with these guidelines is working and will continue that trend.

Part of the recent decrease in prescriptions might also be attributable to a new and important statewide database, the Prescription and Drug Monitoring Program, or "PDMP." Dr. Christopher explained this program to us, and if properly used, this will be an effective tool for avoiding the over-prescription of opioids. This program was created by a 2014 state law,[11] and it requires all physicians and pharmacists to register and submit all prescriptions even before they are finalized. Whenever a doctor plans to prescribe an opioid, he or she *must* first search the PDMP database to see whether this patient has a history of opioid prescriptions. In addition, the doctors must check the system whenever they suspect a patient of opioid abuse, as well as the first time the doctor prescribes any controlled substance to a particular patient. The PDMP, when fully functional, will be an efficient way to find abuse.[12] Dr. Christopher reported that the PDMP is still incomplete, because many doctors have not yet registered with the system. He also told us that the Pennsylvania Medical Society is working to educate physicians across the State about the PDMP, and that eventually there will be sanctions for doctors who fail to register.

On the other hand, Dr. Christopher told us that he sees opioid addicts in his Emergency Room every day, begging for pills. These people can be very convincing, and often weave stories out of half-truths – for example, that they've been prescribed opioids for pain and have run out, their doctor is unavailable, they are in pain, please, just this once. Naturally doctors are tempted to give these patients the opioids they crave, to alleviate their obvious suffering. But as

[11] Act 191, P.L. 2911, "Achieving Better Care by Monitoring All Prescriptions," enacted 2014.
[12] *See* Pennsylvania Department of Health, Pennsylvania Prescription Drug Monitoring Program, Advisory Memo #348 to Health Alert Network, dated August 9, 2016.

Dr. Christopher told us, the new guidelines set strict rules for prescribing opioids in such situations, and for the long-term health of the patient, it's important that these rules be followed.

2. Education

Because the opioid epidemic is a relatively recent phenomenon, part of the problem is a lack of information – doctors must be educated about the dangers of these drugs, and patients must also be warned that these painkillers are terribly addictive. Fortunately, there have been significant strides made on both fronts.

Dr. Christopher of the Pennsylvania Medical Society told us about professional efforts to educate doctors and patients about the need to be careful with opioids. Doctors who seek to renew their license to practice medicine are now required to participate in at least two hours of training in the proper use of these drugs. In addition, the Society has started a new program to raise awareness, for both doctors and their patients, called "*Be Smart. Be Safe. Be Sure.*" In the "Smart" phase, the Society urges doctors to have conversations with their patients about the risks of opioid addictions, and to explore alternative methods of pain management. Once the decision is made to prescribe these drugs, doctors are directed to engage in "Safe" practices – to keep dosages as low as possible with few refills, to carefully advise their patients how to use the drugs safely and to properly discard any extra pills once the pain has subsided. In the third and final phase of the program, doctors are encouraged to speak with their patients about how to recognize the early signs of addiction, and how to protect themselves.

As we listened to victims of the opioid crisis and their families, we were startled by how many addicts started out by abusing prescribed painkillers. Virtually none of these patients had received adequate counseling or warning about the risks of these dangerous drugs. Hopefully, the efforts of the medical community to educate physicians, impose meaningful sanctions when

the rules are not followed, and to inform patients, will lead to better communication and more prudent prescription practices. Dr. Valerie Arkoosh, a Montgomery County Commissioner,[13] physician, and member of the Montgomery County Overdose Task Force, told us that "the Pennsylvania Medical Society is doing a really good job" of advising doctors on these issues, and it is important that this trend continue.

B. Abuse of Opioids by Young People

Not all opioid addicts start with prescribed painkillers. According to the Foundation for a Drug Free World, every day 2,500 young Americans use a prescription pain pill without a prescription for the first time.[14] Often, this first pill is taken in a social setting, at a party, or with friends.[15] Sometimes it's as easy as raiding the parents' medicine cabinet. All such use of illegal substances is dangerous, but the powerful addictive qualities of these drugs add a whole new level of risk. As Lieutenant Fozato said to us, "Imagine your first drug you get introduced to is a pill that could addict you for the rest of your life. That's what they're dealing with today."

1. T.J. Wadsworth: A Young Adult Addicted to Heroin

We heard from a woman named Marissa Wadsworth about her son, T.J., whose road to addiction did not involve prescription painkillers. T.J. had always been a smart, curious and friendly kid, active in his church and a good student. He told his family that he understood the

[13] At the time she testified, Dr. Arkoosh was the Vice Chair of the Montgomery County Board of Commissioners. She currently serves as the Chair.

[14] Prescription Pain Killer Abuse, Teen Drug Use & Abuse, *www.drugfreeworld.org/drugfacts/painkillers*.

[15] Generally, young users do not start with street heroin – because of the social stigma, and the psychological leap required to venture into dangerous places infested by heroin sellers. This is fortunate, not only because heroin is such a dangerous drug, but because a first-time user exposed to powerful street heroin (or even worse, substitutes like Fentanyl) faces a very high risk of overdose.

risks of drug use and would avoid them. In high school, however, he started hanging out with a group of friends who were known as "party kids." T.J. started drinking, and using marijuana; when confronted by his mother, he first denied smoking weed, but eventually he admitted it and asserted there was nothing wrong with what he had done. He assured her that he would never start using more serious drugs. During T.J.'s senior year of high school, while smoking marijuana with friends, someone offered him a pill. T.J. thought it would be fun; to this day, his mother believes that his judgment was compromised because he was high, and that "it was that one pill and that one bad decision that sealed his fate."

T.J. went to college, and for the first two years his grades were decent. He joined a fraternity; during breaks, he worked at a part-time job. But T.J.'s family first noticed something was wrong during the summer before T.J.'s junior year. His brother found a box, hidden in T.J.'s mattress, containing what turned out to be small plastic bags of heroin. When confronted by his parents, T.J. vehemently denied the box was his – he assured his family that he was holding it for a friend. "Unfortunately, we believed T.J., that it wasn't his," Mrs. Wadsworth told us several years later.

There were other signs of trouble that summer, the summer of 2013. He was fired from his job – his employer told Mrs. Wadsworth that T.J. had called in sick too many times. He got another job with a family friend, but this friend soon called and told T.J.'s mother that he "wasn't acting normal." T.J. got a third job that summer, with a tree company, but he was soon fired because he had fallen asleep on the job. Looking back, Mrs. Wadsworth said, she and her family should not have let him go back to college, where he would be on his own again. But T.J.'s mom had no idea heroin was involved – apart from these work issues, he seemed to be functioning as usual.

T.J.'s situation seriously deteriorated once he was back at school. His mother later found out that T.J. stopped going to classes altogether before the semester was over. His friends were concerned, but they did not contact his parents or school administration. When he came home for Christmas break, T.J.'s behavior was strange. He would "nod off" in the middle of a conversation, a classic sign of heroin use. He went with friends to a music festival, and when he returned, T.J.'s behavior was so erratic that his mom sensed something was really wrong. She arranged for a drug intervention, that is, a confrontation staged to convince the user to enter an inpatient drug treatment facility. In order for the intervention to work, T.J. couldn't leave the house, and he could not be told about it beforehand.

Mrs. Wadsworth told T.J. not to leave; he protested, but eventually went into the basement, where his bedroom was. She found strips of Suboxone in T.J.'s shoe, a substance that is often used to help wean addicts off opioids. In the meantime, T.J.'s father sat at the top of the basement steps, making sure he did not go anywhere. But in the middle of the night, T.J. somehow escaped through a narrow bedroom window, "liked a caged animal. That's how bad he had to get out of the house. The screen was all dented up." T.J.'s father went into his room in the basement, and under the dresser he found needles, rubber bands, and small plastic bags – classic heroin paraphernalia. Mrs. Wadsworth called T.J. and told him to come home immediately or they would shut off his phone, and after about half an hour, he came back.

About 24 hours later, T.J.'s family staged the intervention with help from the Malvern Institute, a nearby drug treatment center. At first, T.J. denied having a problem and refused to go. But confronted with the proof of his heroin use, his family and friends convinced him to enter the inpatient program. T.J. was reluctant, but he entered Malvern Institute on January 2, 2014.

He was dead by May.

The inpatient program lasted four weeks. T.J. did well, but as his mother explained, it simply wasn't long enough to be effective. When he re-entered the community, T.J. took a construction job and began attending outpatient group therapy almost every day, as well as a 12-step recovery program. This lasted about three weeks, but he never found a sponsor – an important part of the process – and he stopped attending the meetings. One night in March, when T.J. didn't come home, his mother became concerned and began calling various numbers she found on his wireless statement. She eventually tracked him down and convinced him to come home at about 1 a.m. Within a few days, she had found more signs of heroin use: small plastic bags in the toilet, rubber bands in the dryer.

One day, Mrs. Wadsworth found T.J. in the basement, sitting in the dark, crying. He told her that he hated what drugs had done to his life. He wanted his normal life back.

Mrs. Wadsworth contacted T.J.'s therapist, who told her to bring him back in to the treatment facility. T.J. did not want to go, and he left within a few hours of his arrival. Once again, his parents managed to track him down; when they found him, he was obviously high, and they brought him back to inpatient treatment once again.

This time, he only stayed for two weeks, and came home on a Friday afternoon in May. He insisted he was fine. The following Tuesday night, he went out with some old friends, and then came home and went to bed. Phone records later showed that he made some calls and sent out texts during the night. His mother went to work on Wednesday, but became concerned when T.J. did not answer his phone in the late morning. She came home from work right away and found his bedroom door locked. Mrs. Wadsworth called 911, and when police arrived, they knocked T.J.'s door down and found him dead of a heroin overdose. He was just 21 years old.

During his first inpatient stay – when he was inside the Malvern Institute for four weeks, and buying into the program – T.J. candidly told his therapists about the drugs he'd taken and his progression toward heroin. He had started with pills with friends, at parties, and became hooked. It wasn't until the spring of his second year in college that he tried heroin. Once he had made the switch, he was dead within a year. And this death spiral occurred even though T.J.'s warm and caring family offered him plenty of support.

2. Preventing Opioid Abuse by Our Kids

Drug abuse by teenagers and young adults is, sadly, nothing new in this country; but opioids pose a special risk, because of the increased danger of addiction and overdose. We need to do everything we can to prevent young people from taking that first pill, and when they're hooked, we need to help them kick the addiction. Once again, there is no single solution. Experience has shown, however, that effort in a few key areas will pay off.

a. <u>The "NOPE" Program</u>

First, of course, is education. We heard testimony about public awareness measures that have started in Montgomery County, including one program called "Narcotics Overdose Prevention and Education," or "NOPE." NOPE is a partnership among the District Attorney's Office, local law enforcement, and members of the community, created to stage opioid awareness events in middle schools, high schools, and colleges. T.J. Wadsworth's mother, who now works with NOPE, told us that at each event, students hear from the District Attorney's Office, police, a therapist, and two family members of people who have died from addiction. As Mrs. Wadsworth described it, "the goal of NOPE is to get the kids before they take the first pill, and then if they do see a friend in trouble, to tell someone so they can get help." Mrs.

Wadsworth describes these presentations as very emotional experiences, and many young people have shared their own experiences and have sought referrals. Dr. Arkoosh, the Montgomery County Commissioner, told us that over 5000 students have been reached in our public schools through this program.

b. The Prescription Drug Disposal Program

In addition to reaching out to our young people, we need to decrease the availability of these drugs. One important new initiative to accomplish this is the "Prescription Drug Disposal Program," a partnership among public safety organizations and the private sector with a common-sense aim: to take leftover medicine out of our homes and away from addicts or curious young people.[16] The program consists of staged collection events throughout the year for people to drop off their unused medications at locations throughout the county; there are also drop boxes located in various police stations, where people can drop off their unused medications at any time.

The Prescription Drug Disposal Program began in 2010, and it has been remarkably successful. More than 28,000 pounds of medicines have been collected and destroyed. As word spreads about the program, its momentum has grown – at the "Take Back Day" in October 2016, more than 6,000 pounds of medicines were collected.[17] Obviously, not all of these collected prescriptions were opioids, but it helps to get *all* unused drugs out of the medicine cabinet and

[16] The program is a joint venture between the Montgomery County District Attorney's Office and the Police Chiefs Association of Montgomery County, with additional financing from the Pennsylvania District Attorneys Association and Pennsylvania American Water.
[17] Prescription Drug Disposal Program, Montgomery County, *www.montcopa.org/1766/PrescriptionDrugDisposal*.

properly disposed of. And every opioid painkiller passed to the Prescription Drug Disposal Program is one less pill that might tempt a young person or an addict.[18]

c. Law Enforcement

The other key component in the fight to reduce addiction among young people is effective law enforcement. We will have more to say on this subject below, but it is worth noting here that there can be no effective fight against addiction without strong criminal penalties for drug dealing, and law enforcement with the resources needed to carry out those laws effectively.

During our investigation, we heard time and again how easy it was for addicts to buy pills and heroin illegally, on the streets or from friends, despite significant efforts by police and other enforcement agencies. We also learned how sophisticated drug trafficking organizations will change supply patterns and practices in response to enforcement activity. Our community may never be able to eradicate the sale of illegal drugs, but to the extent we can reduce this component of the addiction process, we must do what we can.

This is not a plea for "mass incarceration" of non-violent offenders, but a recognition that the supply of opioids must be cut off to the extent possible. That means taking drug dealers off the streets by attacking their supply chain, deterring new dealers, and gathering information about new trafficking organizations and patterns. Much of this law enforcement activity must be accomplished on the federal level, especially the shipment of large quantities of opioids across

[18] The Grand Jury also learned that opioids that are simply thrown away, or flushed down the toilet, pose a threat to our environment and the water system in particular. *Id.* The Prescription Drug Disposal Program thus is an effective tool not only for preventing addiction, but for keeping our community clean and free of contaminants.

our borders. But here in Pennsylvania, we must implement and enforce smart criminal laws that help police do their jobs.

C. Addiction Treatment

After someone has become addicted to opioids, the focus must shift from prevention to treatment. The success of any treatment depends largely on the addict's desire to fight the disease, and their willingness to submit themselves to a difficult and long-term process. We have heard several personal accounts of this process, and we have been impressed with the level of personal commitment necessary to achieve long-term sobriety. It is not easy.

As we heard these stories, however, it became clear that there are several important ways that the community can help every addicted person who makes the decision to seek treatment.

1. Availability of Treatment

We earlier recounted the story of A.A., who died of an overdose in a convenience store bathroom after being turned away from a treatment center across the street. There was no room for him. Of all the factors contributing to the opioid epidemic and the dramatic recent increase in overdose deaths, the lack of available treatment beds is perhaps the simplest and most heartbreaking.

The scarcity of treatment beds came up repeatedly during our investigation, from every kind of witness. Addicts who made the decision to seek help testified about long delays before they could enter a treatment facility. We heard about therapists and social workers making desperate calls, trying to find a bed for their clients who were at a point of crisis. Magistrate Judge Andrea Duffy, who sees opioid addicts in her courtroom on a regular basis, told us that she often makes scrambling calls from the bench, trying to find a treatment center with a vacancy

while the defendant sits in her courtroom. Dr. Christopher explained that he and the other emergency room doctors are often frustrated with the difficulty in finding space in a treatment facility for a patient who needs it. Dr. Christopher further explained that even if the patient initially agrees to enter inpatient treatment at the doctors' urging, "it's really hard to keep them here … while somebody tries to find a bed for them to go into treatment."

The wait can be long. Hope Stein, a Certified Recovery Specialist who owns and operates Hope Therapeutic Services in Montgomery County, testified that many patients who seek inpatient treatment currently face a delay of up to six weeks. The waiting period increases at certain times of the year – particularly over the holidays, when family gatherings (or the lack of contact with family members) often lead drug users to face their situation more squarely. Even in busy times of the year, a delay of a month or more is unacceptable, said Ms. Stein: "[W]e're telling an addict that, 'You have to wait.' We're telling them, 'Go out and use some more, and it's okay to die.' So I can't tell somebody that." Ms. Stein recounted that in critical situations she will counsel her clients to go to a hospital, and she will get on the phone with the hospital staff, pleading to let the patient stay. Ms. Stein also told us that she "will literally call every facility, every mission … and either be put on a waiting list or ask for the soonest bed or ask for a favor."

Obviously, frantic calls from a therapist or a judge or doctor or a family member cannot take the place of a rational placement system. While there is no way to magically expand the availability of treatment beds, we did hear about the need to create a real-time database to keep track of treatment vacancies, which would make placement easier and less arbitrary. Dr. Christopher, in particular, stressed that such a database would be extremely helpful. He believes that a real-time, comprehensive database would streamline the process, and noted that

Philadelphia Mayor Jim Kenney recently included funding for such a program in his proposed budget.

John Becker, the ex-police officer who now counsels other first responder addicts, also told us briefly about a program implemented in the Boston area, in which treatment facilities agree in advance to accept any person referred by law enforcement, whether or not they have insurance. We do not know much about this program, but the idea of a pre-arrangement between law enforcement and hospitals and treatment centers, either locally or spread over a wider geographical area, strikes us as promising.

2. Length of Stay and Insurance Issues

One thing we have learned, repeatedly and from many witnesses, is that short inpatient stays are less effective than longer stays. In fact, the length of a patient's stay in rehabilitation is one of the most important factors in determining whether the program will work. Unfortunately, we have also learned that long stints in rehabilitation are the exception rather than the norm.

Hope Stein, the Recovery Specialist, told us that in Pennsylvania, insurance companies most often pay for detox stays of only three to five days. If someone is a heavy user of opioids, five days might not even be enough to clear their system of drugs, let alone carry out a meaningful recovery program. At the end of such a stay, an addict might still be going through painful withdrawal symptoms. Ms. Stein reported that such people may decide that such short detox stays are worse than useless – all it accomplishes is pain, and when it's over, the addict will still have the cravings and the dependence on opioids.

Even slightly longer stays, say 14 days or a month, will likely not accomplish anything. We heard time and time again that only a long-term program stands a good chance of success. Thomas Decker, the father of the young athlete John Decker who eventually overdosed on heroin

and Fentanyl, despite several attempts at inpatient rehabilitation, told us that meaningful inpatient programs must last longer than 30 days – shorter terms, like the 15 days maximum covered by many insurance policies and Medicaid, are "a joke and maybe a death sentence." John Becker, the ex-police officer and now a drug counselor, agreed that "all the research tells us that the best outcomes come from longer treatment experiences."

a. One Story of Inadequate Treatment

We heard from a man we will identify only as J.C., now 36 years old, who has been addicted to opioids since he was 15. His addiction began, he told us, simply as a result of hanging around with the wrong crowd, starting to use alcohol and marijuana at 12 or 13, and eventually turning to opioids and specifically heroin. J.C. described going in and out of treatment programs, staying sober for a month or two, only to relapse. He never fully "bought in" to any of these short treatment programs, and he always told himself he could manage his opioid use. For awhile, this was almost true – although he dropped out of school temporarily, he managed to get himself sober for a time, and graduated from the University of Pennsylvania with a degree in Organic Chemistry. He even earned a master's degree from Temple. But this was temporary. He relapsed, lost his job, and he "couldn't stop." To feed his habit, he began to steal, and eventually found himself in the criminal justice system.

J.C. told us that the most important element that was missing from his various attempts at rehabilitation over these years "was just time." He testified, "I think a big thing in the beginning is just time away from drugs. … [I]t was always seven to ten days, and then ten to 14, and, like, maybe 21 days, but never would you get the 90 days or anything like that."

The cycle of addiction finally ended for J.C. when he found himself in Montgomery County Drug Court. We will describe Drug Court in more detail in the next section of this

Report, but in short, this program targets low-level offenders who are truly addicts rather than criminals. A qualifying person will receive long-term treatment and supervision, avoid prison time, and if he or she completes the program successfully, they will not have a criminal record. In the first phase of the program, a participant will typically receive inpatient treatment from three to six months. J.C.'s inpatient stay was actually shorter – it was only a month and a half – but, following Drug Court protocol, that first stage was followed by a long stay in a halfway house, with intensive supervision, meetings or therapy almost every day, frequent urine tests, and even weekly meetings with the supervising judge. This intensive therapy lasted an additional eight months, and was followed by still more supervision, meetings, and drug tests, although on a less intensive level.

When J.C. testified before this Grand Jury, he had graduated from the Drug Court program only two weeks before. He had been clean and sober for 15 months. He stressed to us that the key component of the Drug Court program, that he'd never had before, is access to long-term treatment and intensive supervision. It is clear to us that this was absolutely critical to his success, and it is critical to the success of any serious treatment program.

b. <u>The Insurance Problem</u>

There is little mystery about how a treatment program should work to give the patient the best chance for success. A new inpatient addiction recovery patient must first spend a few days in detox mode, clearing out their system via a gradual "tapering" of opioid doses. At this stage, the patient will also receive medication to help with withdrawal pain. Once the detox is accomplished, the patient will move to residential rehabilitation, where they begin the process of acclimating to a life without opioids. This is the phase of treatment where a long stay is so critical. Afterwards, a successful rehabilitation program will transfer the patient to a form of

long-term intensive supervision, like a halfway house, which includes a structured living environment as well as frequent therapy and support meetings. Long stays in an intensive outpatient center, or at least extensive meetings and therapy once the patient has been released from rehabilitation, help to lock in the gains made during inpatient treatment.

Unfortunately, good treatment can be expensive, and lengthy treatment costs even more. Many addicts have no medical insurance, and without it, inpatient treatment is often not an option. Even where an addict (or their family) has insurance, the coverage is often inadequate. As John Becker, the ex-police officer, explained, longer inpatient stays are "completely in contrast to what the insurance companies want to do."

Hope Stein, the Recovery Specialist, helped illustrate several insurance problems that plague addiction treatment. Even if a policy theoretically covers inpatient addiction treatment, it may impose a high deductible – many thousands of dollars – before coverage kicks in. Or the patient's financial contribution may be in the form of a co-pay. Ms. Stein gave the example of an insurance policy that requires a patient to contribute as much as $600 per day for the first five days of an inpatient stay, before full coverage begins. That adds up to $3000, exactly the kind of financial roadblock that can prevent an addict from even getting started with serious treatment.

Even if someone manages to get into treatment under a decent insurance policy, there can be fights about money down the road. John Becker described the kinds of disagreements that can arise, as the insurance company keeps a close eye on costs:

> [I]t becomes a battle between the treatment center arguing for clinical and medical reasons why you need to be in treatment and the insurance company saying, 'He's been there for two weeks. … [I]s it medically necessary for them to be in residence? You know, are they going to die if they're released from treatment?'
>
> And usually the answer is, 'Well, not immediately.'

> ‘But, you know, physically they’re not in any immediate harm. So send them home.’ …
>
> And then the clients never know if they’re going to be able to stay or they’re going to be put out.

These roadblocks are not easy for an addict or their family to navigate, even if they have considerable resources and expertise. Thomas Decker, the father of the young athlete John who died of an overdose after years of battling his addiction, is a prominent Philadelphia lawyer. He is the Vice Chairman of a major law firm in the city, and was formerly the CEO of that firm. Mr. Decker was only able to obtain satisfactory inpatient coverage for his son after threatening the insurer with litigation. If the process was difficult for him, imagine how difficult it is for the average person to gain coverage.

Bickering with the insurance company can also have a negative effect on the treatment process itself. As John Becker explained, this kind of lingering uncertainty can prevent a patient from fully committing to a treatment plan – if they might be kicked out in a day or two, what’s the point of doing the hard work of recovery? And a patient who is facing ejection from treatment may resort to dishonesty, for example, feigning suicidal thoughts or withdrawal symptoms, simply to prevent the insurance company from cutting off coverage.

Some insurance policies do not cover addiction treatment at all. We heard about one father, for example, with a son battling a heroin habit, who had chosen his insurance because the family needed strong “behavioral health” coverage, to cover their daughter’s severe mental illness. The father believed, not unreasonably, that this “behavioral health” coverage would encompass addiction treatment. It did not. The son’s treatment had to wait for months as the family tried to change its policy, every day bringing danger of a relapse or an overdose.

Without strong insurance coverage (or the means to pay for treatment privately), the addict's path to recovery is much more difficult, and often a family spends a large portion of their savings without a good result. We heard from a woman who we will only identify here as C.B., who started using heroin as a teenager and was an addict for 17 years. C.B. tried to quit several times – her first stint in rehab, at age 18, lasted only five days. Her family's insurance never paid for longer term treatment. Once, her family spent a large amount of money for a 30-day inpatient stay, to give C.B. a fighting chance. But she soon relapsed. C.B. finally got the help she needed through Drug Court, and we will tell more of her story later in this Report; for now, she provides an example of someone whose insurance did not pay for effective treatment, and her family's attempt to pay for it themselves ended in a too-short inpatient stay.

Common sense tells us the cost savings of successfully enabling an addict to overcome his addiction through sufficient long-term inpatient treatment will undoubtedly surpass the costs of repeated emergency room visits, recurring stints in short-term rehabilitation facilities, as well as the likely time spent in prison. It seems clear that successful long-term treatment of an addict's battle with substance abuse is more valuable than regularly paying for repeated visits to hospitals and failed stints in short-term treatment. Moreover, if an addict can turn his or her life around, like John Becker, J.C., and C.B., and become a productive, job-wielding member of society, the benefits to the community as a whole are immeasurable.

Our country is currently debating the best way to ensure that health insurance is available, affordable and adequate. This topic is mind-bogglingly complex, and obviously beyond the scope of this Report. But the problem of opioid addiction presents a particularly important health and insurance issue – it should be part of the discussion. If health insurance

policies that adequately cover addiction treatment were widely available and affordable, this would be an important step forward.

c. Quality Control of Treatment Centers

Finally, it is important that addicts receive good quality inpatient care. This is not a given. John Becker told us that there are many substandard drug treatment centers all over the country, and that these businesses are largely unregulated – "It's not that difficult to open up a treatment center." Mr. Becker offered his opinion that treatment centers should be more closely regulated. He also informed us that the Joint Commission[19] offers an accreditation process, which is "designed to ensure that … the patients are taken care of properly." Most treatment centers are not accredited; if an institution has earned this certification, it is a reliable sign of quality. Most families are unaware of the accreditation process, and choose a treatment center more arbitrarily (if there is a choice to be made at all).

The benefits of quality control are obvious, and information about the merits of particular treatment centers should be available to prospective patients so that they can make an informed choice.

D. *The Opioid Overdose and Hospitalization*

An opioid overdose is a critically important event in several ways. Most obviously, it is a healthcare emergency requiring prompt medical intervention. As we will see, patients who get such help are now likely to survive, due to a powerful antidote called Naloxone. But once the immediate medical crisis has passed, this is still a critical time. The patient, facing a moment of extreme vulnerability, is often more ready to accept help than ever before. And that vulnerability

[19] The Joint Commission is a well-known independent, not-for-profit organization that offers accreditation and certification to different types of health care organizations throughout the U.S.

occurs at exactly the moment the patient has contact with law enforcement or the health care system: the police officer on the scene, the EMT who responds to a 911 call, or the doctors and nurses in the local emergency room. Once the patient's life has been saved, there is a unique opportunity to move the drug user into addiction treatment.

1. Naloxone[20]

Naloxone, a prescription drug, is a life-saving antidote for an opioid overdose. It efficiently blocks the receptors in the brain to which opioids attach, and which will cause the user to stop breathing if an overdose occurs. As Commissioner Arkoosh explained, Naloxone "reverses that binding of the opioid to that receptor and can get a person back breathing again."

Commissioner Arkoosh also told us that Naloxone is a safe drug that has long been used in operating rooms and other settings where opioids are administered. One of its important properties is that it will cause no harm if administered mistakenly, that is, to someone who is not actually suffering an opioid overdose. Because it is so safe, Naloxone can be administered by non-medical professionals – like friends and family of someone suffering an overdose – and it can be made widely available without risk of causing harm.

But Naloxone must be administered quickly, before the user stops breathing. The key is to make the drug widely available, to publicize its effectiveness, and to have it on hand when an overdose occurs.

There is no doubt that Naloxone is effective, or that it has saved many lives. For example, the witness we have identified as J.C., who started using heroin at the age of 15, overdosed three times – all towards the end of his addiction, as he spiraled out of control – and

[20] The generic name of this drug is Naloxone; Narcan is the commonly-used brand name. It can be administered in two ways: injected, and via a nasal spray. Two doses of the nasal spray cost approximately $130, while two doses of the injected form cost much more, about $500.

three times Naloxone saved his life. The witness C.B., who was an addict for 17 years but is now a drug counselor and pursuing a masters degree, had her life saved by Naloxone twice.

We have heard one recurring concern regarding Naloxone: its very effectiveness may enable heroin use, because users are confident that they will not die from an overdose. They don't change their behavior. This concern was raised by several witnesses, including Kathleen Wampole, whose grandson J.J. Wampole died after his fourth overdose from heroin that was laced with Fentanyl. J.J.'s story is tragically familiar. He did well in school, made friends easily, and intended to continue his education after he graduated. Along the way, he experimented with marijuana and soon started to abuse prescription pills and finally heroin. The first time he was arrested, he spent time in jail and immediately afterwards entered an inpatient treatment program. This lasted only a week, and he soon began using heroin again.

Mrs. Wampole told us that J.J. overdosed four times. The first time, her husband kicked down the bathroom door and found J.J. curled up on the floor, his lips blue. The Wampoles called an ambulance, and J.J. was soon revived by Naloxone. His second overdose happened as J.J. sat outside the house in a friend's car; Mrs. Wampole recalled hearing the screams, and soon an ambulance arrived and revived J.J. again with Naloxone. J.J.'s third overdose occurred inside a CVS bathroom – once again the EMTs and police administered Naloxone and saved J.J.'s life.

Only 24 hours after J.J.'s third overdose, he overdosed again, and this time there was no one to save him. He was alone in the house, and Mrs. Wampole and her husband found him dead in the bathroom. He was flown to St. Luke's Hospital where physicians said they could not save him, and the Wampoles had to make the painful decision to remove him from life support. His heart kept beating for seven more hours. J.J. was only 27 when he died. Shortly before his final overdose, he told his grandmother that his addiction was

> like chains. Chains are wrapped around me. And it just pulls me, and pulls me, and pulls me … and [I can't] stop.

Mrs. Wampole was thankful that Naloxone had saved her grandson's life three times. But she worries that opioid users know that Naloxone is readily available – she recalls J.J. telling her about it. J.J. was revived with Naloxone three times, but he was given no meaningful addiction treatment and no real information about how to seek such treatment. Many heroin users who are saved by Naloxone, like J.J., quickly overdose again. Naloxone is a wonderful life-saving medicine, and it should be widely used and distributed, but it is no substitute for a long-term plan for recovery.

a. The Standing Prescription Order

In 2014, the Pennsylvania General Assembly passed Act 139, the so-called "Good Samaritan Act." Among its other provisions – which are designed to encourage opioid users in a health crisis to seek medical help, without fear of criminal prosecution[21] – this law allows access to Naloxone in several different ways, including standing prescription orders issued by public health officials. Pursuant to this provision, Commissioner Arkoosh, acting as Montgomery County's interim Medical Director, signed a standing order allowing pharmacies throughout the county to distribute this drug upon request to members of the public. As Commissioner Arkoosh explained,

> So, for instance, if you're a parent and you're worried about your child succumbing to an opioid overdose, without having to call anybody … you can go to one of our participating pharmacies … and you can say, "I would like a prescription of Naloxone."

[21] As Pottstown Sergeant Edward Kropp, Jr., explained to us, under the Good Samaritan Act, "if somebody overdoses on drugs and somebody else calls for help … or takes them to a medical facility … and stays and renders aid and cooperates with police, then the person who overdosed as well as the Good Samaritan are given immunity from any prosecution for possessing any drugs or paraphernalia."

> And the pharmacist will collect the information. And they will dispense it like any other prescription, but the prescribing doctor on that prescription would be me.

Commissioner Arkoosh reported that at the time of her testimony, there were 24 pharmacies participating in the Naloxone prescription program. These pharmacies had dispensed 278 naloxone kits to the public. Each of those kits represent the possibility of a saved life.

b. Providing First Responders with Naloxone

Naloxone should be widely available to the public, and in addition, it should be in the hands of first responders. To that end, the Montgomery County Overdose Task Force and the Department of Public Safety have started a program to equip the county's municipal police departments with this medicine. When Commissioner Arkoosh testified before us in June 2016, 26 of 49 police departments were carrying Naloxone. David Brown, the Deputy Director for Emergency Services, told us that by November that number was up to 44. As of February 2017, it has been reported that all Montgomery County police departments are equipped with Naloxone.

Deputy Director Brown also testified that his department provides police with online training in the use of Naloxone, and additional in-person training upon request. Once the training is complete, the Department of Public Safety issues a kit for every active, on-duty patrol car in the participating department. In addition, the program generates valuable data. Every time a participating agency uses Naloxone, that agency files a one-page report with the Department, which uses this information (along with data gathered by various other agencies) to track trends.

In all, Deputy Director Brown reported that police use of Naloxone has saved 134 lives in Montgomery County in just the past 20 months leading up to his testimony, and there is an 89

percent survival rate for those who were administered Naloxone by police through this program.[22]

It is critical that all police officers be equipped with Naloxone, not only to save the lives of opioid users, but to ensure their own safety. Lieutenant Forzato explained that there has been a rise in seizures not only of heroin, but of Fentanyl and other synthetic opioids in recent years. These synthetic opioids can be extremely potent: Fentanyl may be 50 or 60 times more powerful than heroin, and we heard about a new substance, W-18, that has a potency well beyond that. A one-time ingestion of these drugs – especially by a person who has not built up a tolerance for opioids – can be fatal. A police officer who accidentally breathes in one of these substances may be in grave danger.[23] Such an accident may happen during a major, pre-planned seizure; it may happen during a seemingly routine traffic stop. For that reason, too, police officers must be equipped with Naloxone and trained to use it.

2. Helping an Overdose Victim Transition to Treatment: The Warm Handoff

Too often, an overdose victim will walk out of the hospital and begin using again almost immediately. We have already described the fate of J.J. Wampole, revived by Naloxone after his third overdose, only to die in his grandparents' bathroom after yet another overdose *24 hours later*. What might have happened if J.J. had been shown a different way? Imagine if doctors and nurses and social workers, together with his friends and family, had provided him with a firm plan after his second-to-last overdose, and urged him to seize it – an immediate bed in a quality treatment center. Would he have taken this step? His life might have been saved.

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[22] *See* Brown, D., *Report of Montgomery County Department of Public Safety, Law Enforcement Naloxone Opioid Antidote Program*, 11/30/16.

[23] In fact, Lieutenant Forzato told us, the DEA issued a warning in June 2016, that law enforcement officers should proceed with great care in handling or testing opioids; as a result, Montgomery County police will no longer perform opioid field tests.

There is clearly a need for intervention at this stage, for information and a bridge to treatment for people after they have been hospitalized, or administered Naloxone by first responders. Commissioner Arkoosh and others told us about a recent initiative called the *Warm Handoff* program, guided by the Montgomery County Overdose Task Force, designed to fill this need. As the Commissioner described it, "the idea is that when someone is brought to the emergency department after having received Naloxone, that [they would receive] a visit from a certified recovery specialist, who would talk with them and encourage them to go straight from that emergency department to treatment." These recovery specialists, who are themselves "almost always individuals who have overcome a personal addiction," would also be mobile, arriving on the scene whenever emergency responders administer Naloxone outside of a hospital setting. The specialist would also provide the opioid user with information about insurance coverage.

Recovery specialist Hope Stein emphasized to us that a *Warm Handoff* is especially critical because at this stage, the opioid user is often experiencing withdrawal symptoms. Naloxone does not address these miserable effects – including severe stomach pain, cramping, chills, vomiting, and excessive sweating – known together as being "dope sick." A "dope sick" patient will have every incentive to begin using opioids again right away. A proper treatment regimen, beginning with a full and tapered detox, or at the very least a dose of Suboxone (which helps with withdrawal symptoms), is necessary to break the cycle.[24] Indeed, some treatment of withdrawal symptoms is necessary even to have a meaningful conversation with an opioid user who might be convinced to seek treatment.

[24] This phenomenon is confirmed by officers in the field. Lieutenant Michael Jackson and Sergeant Edward Kropp told us that, in their experience, opioid users who are treated for overdoses routinely return to drug use almost immediately.

Commissioner Arkoosh reported that the *Warm Handoff* program, which requires close partnership among first responders, hospitals, and substance abuse professionals, has not been fully implemented: the county has eight hospitals, and at the time of the Commissioner's testimony in June 2016, four of them were "actively starting to implement this program." We are hopeful that the start-up process can be completed quickly, and we note that similar programs are being developed around the state.

We found widespread support for the *Warm Handoff* program. Even when the system is fully operational, however, there will still be gaps. The most obvious challenge is the lack of available beds in treatment centers. Dr. Christopher of the Pennsylvania Medical Society reminded us that there are only 55 treatment centers in the state, and these facilities are overwhelmed by the number of prospective patients seeking help. This is one more reason why a real-time database of available beds is so critical – we must at least maximize the reach of the facilities we do have.

3. Forcing an Addict into Treatment: The Hard Handoff

The success of the *Warm Handoff* initiative ultimately depends on the willingness of the opioid user to seek treatment. Sometimes, however, the drug user will not be cooperative. After listening to much testimony and reviewing the evidence, the Grand Jury believes that we should consider ways to involuntarily commit recalcitrant, serial opioid abusers.

Recently, this topic was explored by a task force in Western Pennsylvania, organized by the U.S. Attorney's Office in the Western District. In its detailed report, this task force recommended that the families of hardcore opioid users be empowered to involuntarily commit those who overdose into inpatient treatment centers – much like when someone is committed to a facility due to mental illness. The benefits of such a program are obvious. We heard from

several witnesses about their heartbreak when a loved one, descending into the bottom of an addiction, simply refused to be treated. We also heard from first responders who repeatedly administered Naloxone to the same person or group of users, sometimes more than once in a single day. Their frustration was palpable, and understandable. There must be a way to intervene when the necessity of immediate treatment is obvious to everyone.

As a short- term response to every survived overdose, the report of the Western District task force recommended development of a *Hard Handoff* protocol: "This hard handoff would require the overdose survivor to spend 72 hours under monitored care while receiving medical treatment."[25] We agree that such a protocol makes sense as a baseline minimum for detox and observation, but a process for involuntary commitment will allow for longer treatment in extreme cases.

Other states have enacted variations of the *Hard Handoff* policy. Kentucky's law, for example, apparently allows anyone to file a petition naming a substance abuser, outlining the reasons for concern, and requesting commitment. This petition triggers a psychiatric examination, after which a judge decides whether to commit the targeted person for up to a year. The person filing the petition is responsible for the costs of the treatment, although there are state and private programs that may help, along with any applicable insurance.[26]

Here in Pennsylvania, several representatives have recently introduced a bill allowing for involuntary inpatient drug treatment where a judge finds that the targeted person suffers from drug (or alcohol) abuse, "presents an imminent danger or threat of danger to self, family or

[25] T. Miller, A. Lauer, B. Mihok and K. Haywood, *A Continuum of Care Approach: Western Pennsylvania's Response to the Opioid Epidemic*, University of Pittsburgh Institute of Politics, at 31.
[26] R. Lord, *Task Force: Opioid Crisis Fixes Include Hard Handoff*, Pittsburgh Post-Gazette (Oct. 6, 2016).

others" as a result of that drug use – or there is a "substantial likelihood of such a threat in the near future" – and the individual "can reasonably benefit from such treatment."[27] We have seen reports that other members of our legislature are drafting other bills to accomplish a similar purpose.

We are aware that this kind of legislation must be approached carefully. Any involuntary commitment procedure must strike a well-reasoned balance between the right of the individual to determine the course of their own life, and the interest of the community in safeguarding its citizens and providing adequate care. We are also aware that there are practical problems involved – for example, there may be a shortage of secure treatment facilities for involuntary patients. But in the final analysis, any response to the opioid crisis that fails to include a mechanism for involuntary commitment will be incomplete, and will result in the loss of life.

V. CRIMINAL JUSTICE STRATEGIES

The opioid epidemic is not simply a public health crisis, but a challenge for our criminal justice system as well. As we will see, there is overlap between the two – a smart legal system will funnel some defendants into treatment programs. But criminal justice has its own set of goals and concerns, and plays a distinct role in ending the opioid crisis.

During our investigation, we heard from a number of law enforcement officials. We were uniformly impressed with the work they are doing, from dangerous undercover work to data analysis and more. None of the other strategies to end the opioid crisis can work without law enforcement laying the groundwork, doing their jobs every day.

[27] *See* "Involuntary Drug and Alcohol Treatment Act," Proposed House Bill 384 of the Pennsylvania House of Representatives, Legislative Session 2017-2018. This bill would assign implementation of its provisions to the Pennsylvania Department of Health and the Pennsylvania Department of Drug and Alcohol Programs.

One example of excellent police work that impressed us was the investigation into the practice of Dr. Richard Ruth. Dr. Ruth was a 78-year-old physician, with his office in Franconia Township. He was overprescribing powerful pain killers – such as oxycodone and Percocet – to drug addicted patients. This is actually an understatement: Dr. Ruth would prescribe these painkillers to anyone complaining of pain, sometimes even without a physical examination or anything approaching a reasonable standard of care. There was evidence of one particular patient who was prescribed 39,180 oxycodone pills over the course of a year and a half.

We learned about the Dr. Ruth investigation from Lieutenant Forzato, who spoke with many of Dr. Ruth's "patients" and was astounded at their descriptions of the practice. For example, Lieutenant Forzato spoke to one patient and recounted the conversation this way:

> I said, 'Did Dr. Ruth ever do a physical exam?'
>
> He said, 'Well, he talked to me.'
>
> I said, 'Did he ever order an X-ray?'
>
> And he said, 'No.'
>
> 'How about an MRI?'
>
> 'No.'
>
> 'Did he ever ask you to go to physical therapy?'
>
> 'No.'
>
> 'Did he ever tell you to take an aspirin?'
>
> 'No.'
>
> 'How about Tylenol with codeine?'
>
> 'No.'

Lieutenant Forzato then described how Dr. Ruth immediately prescribed oxycodone to this patient and told him to "[t]ake these pills. They'll make you feel better."

We can't solve the opioid crisis if peddlers like Dr. Ruth are allowed to thrive. He enabled addicts, and created addicts, all to reap some quick profits. But in the end, after a thorough investigation, he was convicted by a jury and sentenced to 15-30 years in prison.

Dr. Ruth's case serves as a good example of the role law enforcement must play as we deal with the opioid epidemic – illegal trafficking in opioids, whether it takes place in a doctor's office, on a street corner in Pottstown, or on an interstate highway as a truck carries kilogram blocks of heroin and Fentanyl, must be shut down to the extent possible.

A. Statutory Initiatives

1. Mandatory Minimums

One traditional response to increases in drug activity – whether heroin, cocaine, methamphetamines, or anything else – has been to increase criminal penalties. The purpose of such penalties is to send a strong message: this kind of drug dealing will not be tolerated. Hopefully, potential dealers will be deterred from entering the business, and current drug dealers will quit. Less obviously, strong penalties also help law enforcement investigate crimes. A dealer who is caught and who faces a long prison term has a powerful incentive to cooperate with police and bargain for a lower sentence.

The use of mandatory minimum sentences has, in the past, provided this kind of targeted serious punishment. Pennsylvania used to have a series of minimum sentences for drug activity: the minimum sentence for someone selling drugs within a drug-free school zone was two years; the minimum for drug dealing while in possession of a firearm was five years; mandatory

minimums also were triggered by the amount of drugs seized, and were higher for certain kinds of drugs.

But Pennsylvania no longer has these mandatory minimum sentences. In 2013, the Supreme Court of the United States declared most mandatory penalties to be unconstitutional, and eventually state courts applied that new principle to Pennsylvania's system of mandatory minimums.

The principle behind that 2013 Supreme Court decision, in a case called *Alleyne v. United States*, is fairly simple. As most of us know, the prosecution in a criminal case must prove all elements of the defendant's crime to a jury beyond a reasonable doubt. That is a constitutional principle, but until *Alleyne* and related cases, it was thought that it didn't apply to sentencing – the prosecution did not have to prove beyond a reasonable doubt, for example, that a defendant sold drugs within a school zone. The prosecution needed only to prove that kind of "sentencing fact" to the judge (not a jury) by a preponderance of the evidence (not beyond a reasonable doubt). To prove something by a preponderance of the evidence is relatively easy: the prosecution must show only that it is more likely true than not. After *Alleyne*, the sentencing fact must be submitted to a jury and proven beyond a reasonable doubt, just like the elements of the crime**.**

In Pennsylvania, mandatory minimums were determined the old way – by a judge, and using the preponderance standard – so under *Alleyne* these laws were unconstitutional. But that doesn't mean that *all* mandatory minimums are improper. The laws can simply be rewritten to comply with *Alleyne*, so the jury decides all sentencing facts beyond a reasonable doubt. To use the school zone example, the question of whether the drug deal occurred in a school zone can be submitted to the jury, to be decided under the reasonable doubt standard.

During our investigation, we heard from Greg Rowe, Chief of Legislation and Policy for the Philadelphia District Attorney's Office, who also acts as the legislative liaison for the Pennsylvania District Attorney's Association ("PDAA"). He explained that the PDAA has been working hard to restore the mandatory minimum sentences that were erased by *Alleyne*. But the state legislature has not yet been successful in its efforts.[28]

To understand the way mandatory minimum sentences impact drug dealers and the public, we also heard from several seasoned members of law enforcement. Sergeant Edward Kropp, Jr., of the Pottstown Borough Police Department, told us that the growing drug business has contributed to a dramatic upswing in violent crime, as gun-toting drug dealers protect their lucrative traffic through use of force. Indeed, it was reported that on a particular night in November 2014, police responded to three different shootings in a matter of hours. Police even ran out of evidence markers that night, and were forced to use paper bags instead. One shooting victim was airlifted to a hospital, and a parking lot in an apartment complex was sprayed with bullets in a potentially deadly crossfire. A police investigation found the cause of this violence to be a rivalry between two drug gangs.[29] That night in November 2014, police seized 273 bags of heroin from a vehicle operated by a gang member.[30]

Sergeant Kropp, a 10-year veteran of plainclothes drug investigations, told us that the current absence of mandatory minimum sentences for drug dealers is the "biggest negative factor" in his investigations. He explained that these minimums provided powerful incentives

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[28] As discussed below, however, strides have been made recently.

[29] E. Brandt, *Special Report: How Two Towns Are Facing* Crime, The Pottstown Mercury (6/7/15); E. Brandt, *34 Arrested in Drug War*, The Pottstown Mercury (5/14/15); M. Dennis, *Wiretap Revealed Planned Hit*, The Pottstown Mercury (5/14/15); Mercury Staff, *Authorities Name Key Players in Gang Wars*, The Pottstown Mercury (5/14/15).

[30] E. Brandt, *Multiple Pottstown Shootings, Robbery, Have Police Scrambling*, The Pottstown Mercury (12/1/14); M. Dennis, *Pottstown Man Arrested With 273 Bags of Heroin, Cocaine*, The Pottstown Mercury (12/2/14).

for low-level dealers to cooperate with police in exchange for leniency. But now the threat of significant punishment is greatly diminished, so dealers are willing to risk convictions rather than help law enforcement. Sergeant Kropp also stated, not surprisingly, that when dangerous drug dealers are caught, the shorter prison terms resulting from the lack of mandatory minimums quickly places them back on the streets in no time.

Lieutenant Erick Echevarria, supervisor of Montgomery County's Violent Crime Unit, gave us further insight into mandatory minimum sentences and the policies they serve. Lieutenant Echevarria, who stated that "heroin is everywhere" in our county, was closely involved in investigating the Pottstown gang warfare of 2014-2015. He said he was "amazed" how fast the "criminal element" became aware of the lack of mandatory minimums, noting that "it's almost a joke to them that they can sell drugs, go to jail for a little while, and then get out." He, like Sergeant Kropp, testified in no uncertain terms that the lack of mandatory minimum sentences deprives law enforcement of a valuable investigative tool. To this end, he stated how, in his opinion, the suspension of mandatory minimums was particularly ill-timed, occurring just as the heroin trade has exploded. He backed up these points convincingly by playing for us a recorded telephone conversation between two drug dealers (one of whom was in prison), in which the traffickers discussed the lower penalties they'd likely have to face and seemed to dismiss the possibility of being caught as a mere nuisance. The exchange between the drug dealers during the recorded call was as follows:

AC: What they said, there's no mandatory minimum?

AS: You said what?

AC: You said there's no more mandatory minimum?

AS: Fuck no

AC: What????

AS: No mandatory minimum for school zones, firearms, nothing dog, nothing, they passed that law 2014, last year they passed that shit man

AC: Damn, good fuckin money[31]

When mandatory minimum sentences are available, it is important to be able to distinguish between opioid users and sellers; only dealers should face these tough penalties. Detective Iran Millan, a 22-year veteran of law enforcement in both Philadelphia and Montgomery County and currently a member of the Montgomery County Narcotics Enforcement Team, explained how an experienced investigator can spot the difference. The detective testified that 10 grams of heroin, while not an excessive amount to the untrained eye and certainly easy to carry around, is an amount that *only* a dealer would hold. One gram, which is the size of a sugar packet, can be packaged into 33 small individual plastic bags, each sufficient for a hit, and each costing $10. Ten grams can easily fit into a pocket, but it amounts to *hundreds* of doses. A user would never carry around that much, both because users generally don't have the resources to buy a lot of heroin at one time, and because heroin has an expiration date – it soon becomes unusable after being exposed to moisture in the air. Someone caught with 10 grams is a drug dealer; Detective Millan has never seen, in his entire career, a mere user holding 10 grams at one time. In fact, he would consider anyone caught with five grams or more to be a dealer.

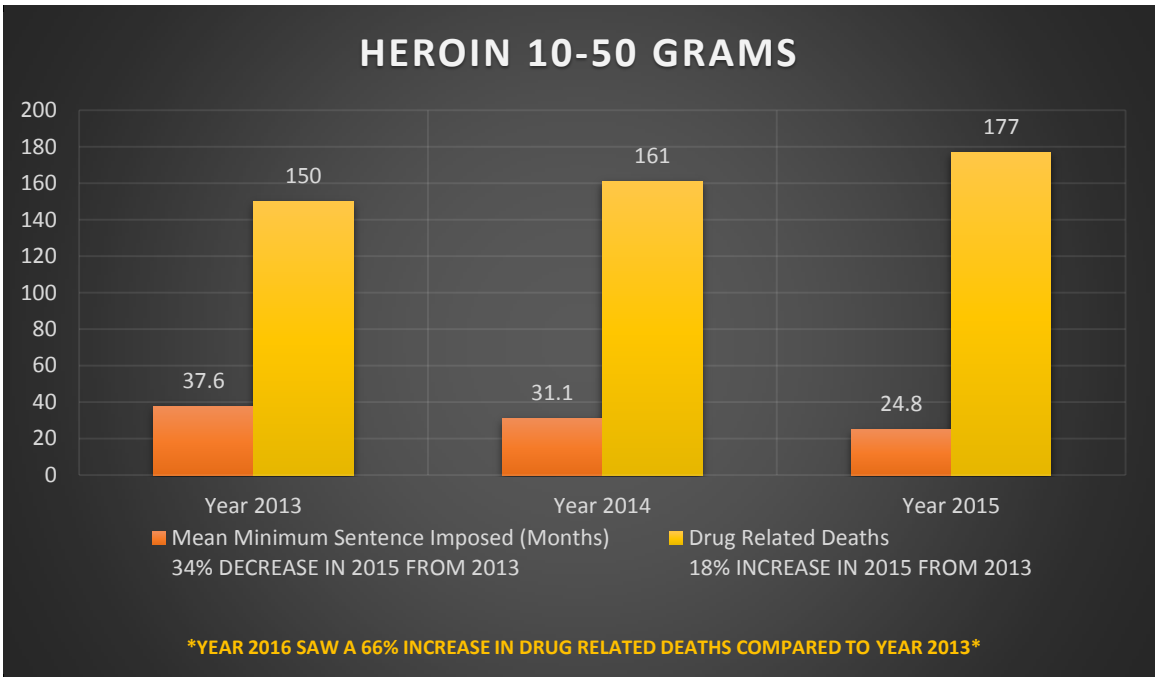
Our point is that mandatory minimum sentencing laws can be written to ensure that they apply only to dealers. The General Assembly should do just that. Assistant District Attorney Rowe explained that in 2015, State Representatives Todd Stephens and Mike Vereb and State Senator John Rafferty introduced bills that would reinstate mandatory minimum sentences for

[31] The two drug dealers involved in the recorded call are identified by their initials, "AS" and "AC."

opioid dealers in a way that complies with *Alleyne*.[32] While the House bill passed overwhelmingly, the Senate bill never made it out of the Judiciary Committee for a vote. Since then, two years have passed, and there has been no legislative progress until just recently when nearly a dozen State Representatives introduced another *Alleyne*-compliant bill to reinstate mandatory minimum sentences for opioid dealers.[33] Once again, the House bill passed. It has been referred to the Senate Judiciary Committee for a hearing, to take place on May 22, 2017.

Meanwhile, while this most recent effort to restore mandatory minimum sentences plays out in our legislature, on the street, opioid trafficking continues to grow as sentences decline. In fact, the Pennsylvania Commission on Sentencing reported that in the two-year period since *Alleyne* was decided, from 2013 to 2015, there was a 34 percent decrease in the average minimum sentence in state prison for heroin dealers who were selling 10 to 50 grams of heroin.[34] As these prison sentences decreased, there has been a concomitant increase in overdose deaths. The following chart demonstrates these troubling statistics**.**

[32] *See* House Bill No. 1601, Session of 2015 (Introduced by Rep. Vereb); House Bill No. 1632, Session 2015 (Introduced by Rep. Stephens); Senate Bill 1062, Session 2015 (Introduced by Sen. Rafferty).
[33] *See* House Bill No. 741, Session of 2017 (Introduced by Reps. Stephens, McGinnis, Barrar, Milard, Quigley, D. Costa, Marsico, Wheeland, Maher and Corr).
[34] Correspondingly, there was an almost-25 percent decrease in the average maximum sentence for heroin dealers who were selling between 10 to 50 grams of the drug. *See* Pennsylvania Commission on Sentencing, Annual Report, 2013, 2014, and 2015.



We believe that action needs to be taken on the mandatory minimum bills that have been proposed, and it needs to happen in *this* legislative session.

2. The Good Samaritan Act

We have already briefly discussed the Good Samaritan Act, enacted in 2014. It encourages drug users to seek out health care when a medical emergency, like an overdose, strikes. To that end, the law provides limited immunity from arrest and prosecution to those in possession of drugs and/or drug paraphernalia who seek overdose-related medical care. It provides a similar immunity to those who *help* an overdose victim (say, by calling an ambulance or driving them to a hospital). A different provision of this Act widens access to the life-saving drug Naloxone by enabling pharmacies to distribute this medicine via a standing prescription order to family, friends, or anyone in a position to assist a potential overdose victim. Further, as explained by Paul Brown, the Deputy Director for Emergency Services, the Act provides immunity to those who prescribe, distribute, and administer Naloxone to those who need it.

Although this law is well-intentioned and generally effective, we have also seen that it can be frustrating, especially to law enforcement. When overdose victims and their companions are immediately allowed to return to the streets, in all likelihood they will quickly return to their old ways. Sergeant Kropp of Pottstown recalled one residence to which emergency responders were summoned where there were four overdoses in a single month, and another residence where three people overdosed, and another died, in *one night*. Lieutenant Jackson of the Lower Providence Police Department recounted similar experiences – returning to the same house three times in two days for an overdose emergency, twice for the same person and then once for a roommate. All three times, the police successfully administered Naloxone, but the "Groundhog Day" quality of these encounters led the lieutenant to wonder whether it would be better to force these people into jail for a few days to detox and perhaps receive treatment.

Commissioner Arkoosh, who is very familiar with the Good Samaritan Act and who signed the standing prescription order for Naloxone, agreed that these encounters can be frustrating for law enforcement. The Commissioner argued, however, that the law is necessary because the first step must be to save lives – no dead person will benefit from treatment. On the other hand, Commissioner Arkoosh emphasized that the "Warm Handoff" initiative is designed to fill this gap and reduce so-called repeat customers, by encouraging any opioid user who has contact with first responders or medical personnel to seek immediate inpatient treatment.

While not perfect, we believe the Good Samaritan Act is a wise law. Its immunity provisions made it doubly important, however, to have the "Warm Handoff" in place. That way, we can save lives, treat addicts, and break the cycle.

B. Helping Addicts When They Reach the Criminal Justice System

Earlier in this Report, we described how an overdose victim who seeks medical help stands at a moment of maximum vulnerability, and might be convinced to seek treatment for their addiction. The same is true for an addict who is arrested. When faced with the prospect of jail and a criminal record, many addicts will willingly accept the help that they have previously rejected.

We have learned about several programs in Montgomery County courts that are designed to move addicts into treatment. These programs are aimed at people who are not drug dealers or hardened criminals, but drug users who have an addiction problem. We have seen these programs have an important and lasting impact on people's lives.

1. Drug Treatment Court in the Montgomery County Court of Common Pleas

The Drug Treatment Court program, which recently completed its 11th year of operation, is aimed at nonviolent drug offenders who would benefit from an intensive, closely supervised, long-term treatment plan. A defendant who successfully completes this program – which is a significant accomplishment, given its many requirements – avoids jail time or a criminal record, and stands a fighting chance of overcoming addiction.

Cara McMenamin, a prosecutor who currently serves as the District Attorney's liaison to the program, explained to us how the program works. An interested defendant applies to the program, and the District Attorney's representative filters out any violent offenders, drug dealers, or those facing gun charges, among other requirements. Qualifying defendants then meet with the coordinator of the program, who interviews the applicant and describes the process to the applicant. If the coordinator concludes someone is a good candidate, the applicant next meets with a clinical evaluator, to determine whether the Drug Treatment Court program is clinically

appropriate – that is, whether it's likely to help. The evaluator also determines the level of care needed in each case, and draws up a plan, which is then approved by the program team. The prospective participant has no choice – either accept the terms of the plan, or there will be no entry into the program.

The first stage of the program itself is inpatient addiction treatment. Ms. McMenamin echoed what we heard from many witnesses – that short inpatient stays are not effective. Accordingly, the Drug Treatment Court's inpatient phase typically lasts anywhere from 90 days to six months (although there are occasional shorter stays in unusual cases). The program is funded by the county, so ability to pay or insurance issues do not pose an obstacle. Once the inpatient phase is complete, the participant transfers to closely monitored outpatient status.

The Drug Treatment Court program is implemented with a team approach. In addition to the representative from the District Attorney's Office, the team includes an assistant public defender, a probation officer, the Drug Treatment Court coordinator, and representatives from treatment service providers. The team also includes, and is supervised by, Common Pleas Court Judge Steven T. O'Neill. The program team meets every week to discuss the progress of every participant.

Once the offender successfully completes inpatient treatment, they begin intensive outpatient treatment and monitoring, including a weekly meeting with the entire program team (including Judge O'Neill). The outpatient portion of the program consists of five phases. In Phase I, the participant is subjected to frequent and random urine testing by the probation officer. They must also attend a 12-step program designated by the court, such as Narcotics Anonymous or Alcoholics Anonymous, and must obtain a sponsor to help support them during their recovery journey. The participant has individual therapy meetings and group therapy meetings at least

every week, and must also have a job or participate in therapeutic community service. But during that first phase, the employment piece of the program is limited to part-time work, because the offender's time will be dominated by treatment.

Phase 1 ends, and the next phase begins, when the team decides the participant has made tangible progress and is ready for the next step. Phase 2 follows the same basic pattern, but with slightly less supervision and more freedom, and each phase follows in the same direction. There is no set timetable for each phase, but each usually lasts between three and six months. The final phase of the program, called "Wings," continues with treatment therapy and drug testing, but without the weekly meetings with the court, and minimal oversight from the probation officer. Finally, all participants are required to participate in a six-month Alumni phase.

A participant who graduates from the Drug Treatment Court program has demonstrated over a long period of time (at least 15 months) a commitment to its goals, under close supervision. The statistics demonstrate that this program works. According to Assistant District Attorney McMenamin, 80 percent of people arrested nationwide who are involved with drugs – a strong majority of all arrestees – will commit another crime if their addiction goes untreated. The Drug Treatment Court, by contrast, has only a 27.5 percent recidivism rate. And even though the program is rigorous, 63.7 percent of participants graduate from Drug Treatment Court. That is a tribute to the kind of wrap-around, heavily involved support provided by the team to each program participant.

Perhaps just as impressively, the program is cost-effective. While it is expensive for the court to pay for extended inpatient treatment stays – the average cost is $6000 to $8000 per participant – prison costs much more. Assistant District Attorney McMenamin told us that the Court pays about $20,000 per year to house someone at the Montgomery County Correctional

Facility. In addition, as a matter of common sense, addicts who are not in prison still cost the county money, in emergency services, police activity, lost productivity, and a host of other ways.

The Drug Treatment Court's success stories go beyond the balance sheet, and we heard about several of them. The addict we have identified as C.B., for example, started abusing drugs when she was 16 years old, and she was addicted to opioids for 17 long years. She is a four-time overdose survivor. C.B. was in and out of rehabilitation facilities many times during these years, often for just a few days. She was a willing participant in rehab, but her stays were too short to overcome her denial, her stubborn insistence that she could handle it on her own. As she explained to us, a stay of a few days or even a month "wasn't enough time to kind of process what I was going through and get the education and the insight that I needed in order to recover." As soon as she was released from the structured environment of a treatment center, C.B. would almost immediately return to her addiction. She stated:

> I always wanted to get better… I always wanted to be in treatment. That's where I felt safe. I could actually look at people in the eyes again… I just didn't know how to recover on the outside.

C.B.'s addiction cycle was finally ended by Drug Treatment Court. She was admitted into the program after her second DUI arrest, and began with a 98-day stay in an inpatient facility. This was far longer than any of her earlier inpatient stints, and it was exactly what she needed. After her release, she worked through the supervised portion of the program, and eventually graduated and made a successful transition to life on the outside. She was recently accepted into the master's degree program in counseling psychology at a local college, and works as a drug counselor. She described her progress as "amazing" and observed, "I am showing up in my life… in every way possible, my dreams have come true."

We also heard from the man we previously identified as "J.C." that his path to recovery likewise ran through Drug Treatment Court. J.C., who managed to earn a degree at Penn even while battling addiction, had similarly cycled unsuccessfully through many earlier treatment programs. But he eventually hit rock bottom, unemployed, charged with a series of petty crimes; he overdosed three times, including once when he was found almost dead in his car in the Kensington section of Philadelphia, a center of heroin dealing. J.C. told us that Drug Treatment Court made a difference for him not merely because it offered him long-term treatment and supervision, but also because he feared the consequences of failure – he did not want to go to jail. He graduated from the program just two weeks before he testified before us. He had been sober for 15 months. A year and a half ago, he told us, he believed it was his "fate to just die in Kensington with a needle in my arm" but Drug Treatment Court allowed him to move on to a different kind of life.

In all, we were impressed by the Drug Treatment Court program. Its combination of close long-term supervision, a lengthy inpatient stay, and serious consequences for failure, all contribute to its record of success. Our one concern is that space in the program is so limited: Assistant District Attorney McMenamin told us that there is currently a waiting list of about 60 participants, and J.C. told us he had to wait several months before he could begin.

2. The Drug Education and Addiction Prevention Program ("DEAP")

Another program that is currently being developed and, in fact, is currently in effect at the Magisterial District Justice level in Lower Providence Township, Montgomery County, is the Drug Education and Addiction Prevention program ("DEAP"). A collaborative effort between the Lower Providence Township Police Department and the Montgomery County District Attorney's Office, this program is aimed at identifying young offenders, those between the ages

of 18 to 26 years of age, who have been arrested for drug possession and related, low-level related crimes; it offers them an alternative to arrest and criminal prosecution. Lower Providence Township Police Lieutenant Michael Jackson explained that the goal of this program is to provide education and treatment to young offenders in the hopes of preventing them from becoming addicts or, even worse, a death statistic. As we have already learned throughout the course of this investigation, intervention at the early stages of drug use and/or addiction is a key component to both prevention and recovery, especially for those addicted to heroin or other deadly opioids.

The program is voluntary. If an offender chooses not to enter the program, or enters the programs but fails to successfully complete the program, he will be prosecuted for his crimes; if the offender successfully completes the programs, his arrest will be expunged. In order to successfully complete the program, the following steps are required: (1) the offender must qualify for the program following an evaluation by the police department liaison officer assigned; (2) if accepted, the participant, along with a family member, must attend a kick-off meeting at the Magisterial District Court where they meet with the police department liaison officer, the magisterial district judge, and the assigned assistant district attorney, at which time the program will be explained to the participant and he will be required to sign a memorandum of understanding and a waiver; (3) the participant must undergo drug and/or alcohol screening at a participating drug and alcohol rehabilitation center to determine whether he should enter treatment – either inpatient or outpatient – or continue on to the next step of the program; (4) the participant must tour the Montgomery County Coroner's Office, where they will learn first-hand the grim reality of drug addiction and the dangers of overdosing; (5) the participant must observe several hours of Montgomery County Court of Common Pleas Drug Court, where he will hear

the stories of those who have been arrested and jailed and who are currently struggling to overcome addiction, and; (6) the participant must remain drug-free and have no negative contacts with law enforcements for a period of six months following completion of the previous requirement. Upon graduation, each participant will have his arrest expunged.

Lieutenant Jackson explained that the hope in providing education and treatment to young, low-level, one-time drug offenders is that these offenders will have a new outlook and a path to a drug-free life. He further stated that the organizers of this program hope that they are intervening with those offenders before they become full-blown addicts and before they become drug court applicants.

VI. THE MONTGOMERY COUNTY OVERDOSE TASK FORCE

We have discussed many programs here, some of which are the result of work done by the Montgomery County Overdose Task Force ("MCOTF"). The Task Force was created in 2014 by then-Montgomery County Commissioner Josh Shapiro, after local police chiefs had alerted him to the county's growing heroin problem. The purpose of the MCOTF is to coordinate county efforts to fight the opioid epidemic (and other issues of drug abuse) and prevent overdose deaths. Commissioner Arkoosh told us that the MCOTF is comprised of individuals who represent law enforcement, treatment facilities, overdose survivors and families, as well as the county government and other concerned community members.

We have heard about the sustained and determined efforts being made by county government and other agencies to address the opioid public health emergency here. The MCOTF explores programs, policies, and protocols in the prevention, treatment, and recovery for those suffering from Substance Abuse Disorder. Currently, its primary focus has been targeting the opioid/heroin epidemic in Montgomery County.

The MCOTF has put forth a multi-disciplinary action plan in order to target the epidemic directly. This plan includes three areas of focus: 1) education; 2) awareness; and 3) treatment. It promotes its goals in various ways:

- Providing education in the county's schools and in the community at large. Through these efforts, and working with the District Attorney's Office, over 5,000 students have been educated about the risks of opioid medications and the inherent risk of addiction. For example, as part of the program, county high school students participated in a billboard design competition.
- Encouraging safe prescription practices among doctors. The MCOTF is working with the medical community and the Pennsylvania Medical Society to cut down on the over-prescription of opioids.
- Supporting the District Attorney's Prescription Drug Disposal Program. This drug take-back program has established 32 disposal locations at municipal police departments, where anyone can dispose of unused medications, 24 hours a day. The PDDP has also sponsored successful community take-back events.
- Collecting, analyzing and evaluating data. The MCOTF data subcommittee is comprised of representatives from the Department of Public Health, the District Attorney's Office, surrounding police departments, the Office of Probation and Parole, and other county departments.
- Initiating the "Warm Handoff" program. The MCOTF continues to work with hospitals, police, and other first responders to develop a protocol to get overdose survivors into treatment immediately.
- Promoting the use of Naloxone by police departments. The MCOTF has equipped all police departments with this life-saving overdose antidote, and has provided training in its use.
- Making Naloxone available to the public. Through awareness and the standing prescription order, the MCOTF aims to make this antidote widely available to concerned citizens.
- Working with insurance companies. The MCOTF encourages insurance companies who do business in the county to cover the cost of Naloxone and to generally provide adequate coverage for addiction treatment.

The role of the MCOTF as the focal point for the county's efforts to stop the opioid epidemic is a useful organizational tool. As we see from the list above, centralizing these efforts has already paid dividends and provides a clear path to implementing new strategies and improving older programs.

A. Data Collection

One of the most effective tools for public health and public safety officials at the federal, state, and local levels is the identification, collection, use, and dissemination of data regarding opioid/heroin abuse in our communities. The CDC collects data and publishes guidelines and standards on a regular basis. In addition, Pennsylvania health officials, including the Pennsylvania Department of Drug and Alcohol Programs, collect and use data to create and support initiatives throughout the Commonwealth. Moreover, data is collected at the local level to assist law enforcement and public officials in an effort to target the epidemic and attempt to save lives locally. It is well-known that comprehensive data is critical in monitoring changes in opioid use and misuse and overdose deaths. Comprehensive data collection will provide better surveillance for public safety and health personnel across the board to improve prevention and response efforts. Moreover, data collection is an important tool to have. It has become clear that the common goal is to give us a big-picture view of the problem in order to develop and initiate more effective ways to attempt to save lives.

We have heard testimony about data in Montgomery County that is being collected from many different offices and/or departments. The Grand Jury has reviewed data on the federal, state, and local levels. The MCOTF encompasses a data subcommittee where each of the stakeholders share data related to the epidemic, allowing data-driven policies and more effective assessments of what works and what does not.

Deputy Coroner Alexander Balacki, a member of the MCOTF data subcommittee, has maintained data in the Coroner's Office regarding drug-related deaths in Montgomery County since 2012. He explained that the data subcommittee is comprised of many stakeholders from across the county, including representatives from the Department of Public Health, the District

Attorney's Office, surrounding police departments, Office of Probation and Parole, and other county departments. He further explained that each member of the subcommittee maintains his or her own data and generates his or her own statistics. We learned that this information gets funneled together during the meetings, and; that decisions are then made based on the data being shared.

Deputy Coroner Balacki also explained that data from the Coroner's Office is categorized by total drug-related deaths occurring per year. He prepared the data according to drug type found in a person's blood and the cause of death. Specifically, the death statistics are categorized yearly as to the following: total drug-related deaths; accidental drug-related deaths, and; suicide drug-related deaths. The statistics are then further categorized according to the type of drug or drugs found in the decease's blood.

The Montgomery County Detective Bureau Narcotics Enforcement Team and Homicide Unit also collect data as to the occurrence of fatal and nonfatal overdose incidents from its 49 police departments. This data has been collected since 2014; Investigator Nicholas Devine of the Narcotics Enforcement Team maintains the data. The data collection is a useful investigative tool for law enforcement to target trends and emergent drug-related incidents in the county. However, Investigator Devine identified gaps in the collection process that affect the accuracy of the conclusions. One such gap is that not all police departments report incidents of overdoses in their jurisdictions to the Montgomery County Detective Bureau. Another shortcoming is that the conclusions drawn by the police officers as to the cause of an overdose is oftentimes premature; police officers may report that an overdose death was caused by a particular drug before the case has been confirmed by the coroner.

The Montgomery County Department of Public Safety maintains its own data as to the use of Naloxone by first responders.[35] This data is significant in that it provides investigators information on trends of overdose and overdose deaths in Montgomery County. It also helps the Department of Public Safety predict any rates of increase or decrease in opioid use in Montgomery County, and can in turn share that information with the other county offices such as the Commissioner's Office, the District Attorney's Office, Adult Probation, the Department of Health, and local police departments.

David Brown, Deputy Director for Emergency Medical Services for the Montgomery County Department of Public Safety, reported that police departments' use of Naloxone has saved more than 134 lives in Montgomery County in just the past 20 months. According to the Law Enforcement Naloxone Opioid Antidote Program report, there is an 89 percent survival rate for those who were administered naloxone by police departments through this program.[36] Deputy Director Brown stated that the Pottstown Borough Police Department has reported the most use of Naloxone of all police departments in Montgomery County—despite the fact that the borough just signed onto the program in July 2016.

Deputy Director Brown recommends a county-wide "comprehensive records management" system in place in the future. He estimated that the Department of Public Safety keeps close to three-quarters of the data; he believes that their data collection could be improved. He believes collaboration between all county offices and agencies is needed to develop and implement one data-sharing resource in order to succeed in the fight against this opioid epidemic.

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[35] *See* Report of Montgomery County Public Safety, Law Enforcement Naloxone Opioid Antidote Program, 11/30/16, Brown, David, Deputy Director for Emergency Medical Services.
[36] *See id.*

B. OverdoseFreePA

An effort toward a comprehensive records management system could be realized with a partnership between the MCOTF and an organization called *OverdoseFreePA.* The University of Pittsburgh School of Pharmacy created the organization called *OverdoseFreePA* in 2014. This organization is funded by the Pennsylvania Commission on Crime and Delinquency; it is a free service offered to any county within Pennsylvania. It provides unified, free data analysis for any participating county. More specifically, it works as a central clearing house of information to users and county stakeholders across Pennsylvania to reduce opioid overdose deaths in the region. It offers collaboration with participating counties to assist them in tailoring strategic plans to help reduce overdoses and overdose deaths. In addition, it provides coalition management to assist programs like the MCOTF to evaluate, implement, and manage the county's initiatives.

OverdoseFreePA could be a valuable, cost-free resource to the MCOTF to improve its ongoing efforts and to improve comprehensive data collection and dissemination in Montgomery County. The data analysis from *OverdoseFreePA* would include data submitted by any stakeholder in the county, such as the coroner's office, law enforcement, and the department of public safety. Moreover, *OverdoseFreePA* would collect, analyze, and funnel all data submitted to it for Montgomery County into one unified database. This would in turn be a valuable resource and tool for Montgomery County and the stakeholders of the MCOTF in continuing their efforts to prevent overdoses and overdose deaths in Montgomery County.

VII. RECOMMENDATIONS

The following recommendations are being offered as building blocks to current initiatives and proposals for new strategies that provide a hands-on, practical approach to conquering the opioid epidemic, with the hope of having an immediate impact on helping to save lives.

A. State-Wide Treatment Bed Availability Online System

As we mentioned earlier in this Report, of all the factors contributing to the opioid epidemic and the dramatic recent increase in overdose deaths, the lack of available treatment beds is perhaps the most heartbreaking. One would think that this would be a simple fix. Unfortunately, it is not. We heard repeated testimony regarding the lack of bed availability for those who are seeking treatment, and the difficulty of identifying treatment facilities that have treatment bed availability. Sometimes the lack of beds can have deadly results. We know now the tragic story of A.A., who died from a heroin/Fentanyl overdose in the restroom of a convenience store after being denied admission into a treatment facility. We have heard about tremendous hurdles in locating inpatient treatment centers for those seeking help, citing that bed availability changes from moment to moment on any given day.

In this age of internet technological advances, we must find a way to create a focused approached to bring this bed availability information to those in need in real time. It is strongly recommended that the MCOTF research and collaborate with its partners and perhaps other stakeholders throughout the state, in creating a comprehensive online system that works in real-time and updates the availability of beds in treatment centers for those seeking assistance. This online system should be accessible so that doctors, first responders, treatment specialists, and family members and friends can locate treatment facilities for those who are seeking help in order to save lives.

*B. **Establish Treatment Protocols***

1. The Warm Handoff Initiative

We heard countless tragic stories from first responders and family members about lives lost to addiction. All expressed their frustration there was no outreach treatment protocol in place at the time, like a *Warm Handoff* program. As we mentioned in this Report, right here, right now people are suffering and one of those people may end up in a Montgomery County emergency room tonight. We believe the *Warm Handoff* program is a critical and necessary initiative that must be fully implemented in all of our Montgomery County hospitals and emergency centers. We are aware of the on-going effort by the MCOTF and others to develop this outreach treatment protocol and we applaud their efforts. However, time is of the essence, and there are missed opportunities every day in facilities that have not implemented this program.

a. Mobile Response Unit

We believe the *Warm Handoff* program should include a *Mobile Response Unit* that is tasked with directly responding to overdose victims who may not make it into an emergency room but who are treated by our first responders and police for an overdose. We have learned that authorities in Dauphin County, Pennsylvania, have implemented a program, similar to the above recommended *Warm Handoff* program that included a mobile response unit ready to directly respond to overdose victims 24 hours a day.[37] Dauphin County Commissioners approved the creation of the unit and the hiring of case workers to address the heroin epidemic in the field. This initiative creates a real, hands-on approach to reaching out to addicted individuals and assisting them in locating a treatment facility and dealing with insurance eligibility

[37] "Dauphin County to send mobile caseworkers to all drug overdoses" By: Christine Vendel, www.pennlive.com.

requirements. More importantly, however, members of the mobile response team will be able to identify those who have a need and assist them to get help.

It is recommended that the MCOTF and other stakeholders in this fight against opioid abuse work with its partners and local government to create a similar *Mobile Response Unit* as part of the above recommended *Warm Handoff* program. This *Mobile Response Unit* should include trained caseworkers who are certified treatment specialists and who are available 24 hours a day to respond to overdose victims and to assist victims and their families in navigating through what we have learned is a challenging and sometimes insurmountable effort to obtain proper treatment. Moreover, the certified treatment specialists would work with substance abuse victims and their families to guide them through treatment options and insurance requirements in an attempt to seamlessly move overdose victims from hospital beds, jail cells, or other locations, into treatment.

2. The Hard Handoff Initiative: The Involuntary Drug and Alcohol Treatment Act

We have learned from police officers, EMS personnel, and family members about overdose victims who are literally being brought back to life from overdose emergencies time and time again with Naloxone, sometimes multiple times within a 24-hour period.

Sadly, many people who have overdosed from an opioid, who have been given Naloxone, and who have been saved by the drug, are still not seeking treatment. Instead, they are seeking their next high. Many of them overdose again and medical assistance is again needed. Sometimes these people die. We have heard from many people – including family members, those who have suffered from addiction, and others – who have reported a level of frustration in that those suffering from the disease of addiction are not physically and/or mentally able to help

themselves to seek treatment. These people have uniformly told us those suffering from addiction are truly a danger to themselves.

As Sergeant Kropp explained, he and his fellow officers respond to overdose emergencies on an almost-daily basis. He recalled one incident where three different people overdosed and one died in a single residence; he recalled several incidents in 2016, where someone overdosed from heroin, was brought to the hospital, and within hours after being released, overdosed again. Lieutenant Mike Jackson reported similar types of incidents in his township. Some aggressive protocols, such as a *Hard Handoff*, should be considered in order to help save lives in this time of crisis.

Notably, legislation was recently introduced into the Pennsylvania House of Representatives that would support involuntary treatment requirements and procedures for individuals suffering from alcohol and drug abuse, like opioid addiction, who pose an imminent danger or imminent threat to themselves, their families, or others.[38] This bill, called the "Involuntary Drug and Alcohol Act," would impose duties of implementation on the Department of Health and the Department of Drug and Alcohol Programs. This legislation is currently pending in the Human Services Committee of the Pennsylvania House of Representatives. The law would allow loved ones and/or family members to involuntarily commit those in their care who have experienced an opioid overdose, those who are destined to be in imminent danger, or those who are an imminent threat to themselves, family, or others, as a result of drug abuse, like heroin or Fentanyl.

To the extent that the bill does not become law, we recommend that the effort continue to evaluate this type of measure, recognizing that this type of legislation must be approached

[38]*See* House Bill No. 384, Session of 2017-2018.

cautiously; recognizing the need for more treatment beds to support such measures; there must be a careful balance between the right of an individual to determine the course of his own life, and the interest of the community in safeguarding its citizens and providing adequate care. We are hopeful that this proper balance can be found.

C. Mandatory Minimum Sentences for Dealers, Traffickers, and/or Suppliers

As we previously recounted, efforts were made in 2015 to enact a law that would restore mandatory minimum sentencing provisions – in a way that would be compliant with the *Alleyne* decision – for those drug dealers trafficking in substantial amounts of controlled substances, like heroin and Fentanyl. Unfortunately, while the bill passed in the Pennsylvania House of Representatives, it did not make it past the Judiciary Committee in the Pennsylvania Senate. Just recently, however, another attempt was made. This time, the bill was sponsored by almost a dozen Representatives – as compared to the three legislators who introduced the 2015 bills. Once again, the bill was passed in the House of Representatives; it is scheduled for a hearing in the Senate Judiciary Committee. We remain hopeful that the bill will become law. As we have learned from several members of law enforcement, mandatory minimum sentences for those trafficking in substantial amounts of controlled substances, including heroin and Fentanyl, are a necessary element to fight this opioid epidemic.

Law enforcement has reported that the absence of mandatory minimum sentences has hurt its ability to reduce the heroin and opioid supply to the community. Moreover, drug dealers are returning to the streets after receiving far less time in jail for their offenses due to the absence of mandatory minimum sentences; thus, they continue to supply and deal heroin and other opioid substances.

We have learned from some seasoned police officers that the lack of mandatory minimum sentences is the "biggest negative factor" in drug investigations. We have also learned that in the past, the threat of longer prison sentences for drug dealers provided law enforcement with a critical tool in dealing with lower-level dealers because they often cooperated with law enforcement and provided information about those individuals who were supplying drugs, like heroin and Fentanyl. As a result of the absence of mandatory minimum sentences, however, these lower-level dealers now have no incentive to cooperate with police. The supply of heroin and opioids has, thus, increased in our communities.

It is recommended that the Pennsylvania General Assembly take action and pass into law mandatory minimum sentencing statutes. The implementation of mandatory minimum sentences for those who traffic, supply, and deal in substantial amounts of controlled substances – like heroin, Fentanyl, and other synthetic opioids – would send a strong message to these criminals. The CDC has recommended strategies that would support law enforcement in the reduction of illicit opioids in our communities. Allowing drug dealers and supplies to return to our communities because of the absence of mandatory minimum sentences allows for the heroin and opioid supply to continue.

We, as a community, must do everything we can to help eradicate this poison from our streets and to keep our communities safe from those who profit on dealing this poison; this includes our legislature. As we mentioned before, this epidemic knows no politics. Our legislature should support these public safety efforts and pass the legislation necessary to hold those accountable who deal and supply heroin and substances like Fentanyl.

D. Increased Collaboration and Better Data Collection with our Regional Partners

We have learned that the University of Pittsburgh, Institute of Politics, along with 75 other regional members, including the U.S. Attorney's Office for the Western District of Pennsylvania, collaborated and formulated a regional response to the opioid epidemic for Western Pennsylvania. The result of the collaboration was a report titled, "Continuum of Care Approach," which is a community-based continuum of care model that was authored by the abovementioned organizations – including U.S. Attorney David Hickton – after two years of meetings and collaboration. U.S. Attorney Hickton stated the effort was aimed toward "integrat[ing] public health and public safety, taking into account all of the present challenges, to build an effective and sustainable model which can be replicated in other towns, cities and states."[39] The continuum of care model demonstrates how Western Pennsylvania is moving forward with their efforts to thwart the opioid epidemic.

Montgomery County is moving forward with many initiatives through its MCOTF. It has also been widely publicized that neighboring counties, including Philadelphia, have all instituted initiatives and separate task force programs tasked with the job of understanding the epidemic – taking into consideration all its challenges – and building an effective response to the epidemic. We have also learned that there are no borders to this epidemic; it affects every zip code in the region. The supply of heroin and opioids moves across all city and town lines, and the death toll continues to climb in almost every county in the southeast region of Pennsylvania.

Like the joint Western Pennsylvania approach, it is recommended that a similar approach be created for Southeastern Pennsylvania because we share the same public health and public

[39] *See* A Continuum of Care Approach: Western Pennsylvania's Response to the Opioid Epidemic, By: Terry Miller, Aaron Lauer, Briana Mihok and Karlie Haywood, University of Pittsburgh Institute of Politics

safety crisis. To this end, it is recommended that a regional taskforce be formed – in addition to the more localized county taskforce already in existence – consisting of public health, public safety, and private corporation stakeholders, such as insurance and pharmaceutical companies and researchers from Southeastern Pennsylvania.

Together, this team of collaborators can share information, identify the areas which need immediate action, and identify and develop future goals. The regional task force will enable Southeastern Pennsylvania to work together more effectively toward the common goal of saving lives and eradicating the heroin/opioid epidemic through health and safety protocols.

In order to support its effort for a regional task force we recommend that Montgomery County become a member of *OverdoseFreePA.* This organization, which is funded by the Pennsylvania Commission on Crime and Delinquency, promotes collaboration between partner organizations and Pennsylvania communities involved with overdose prevention and recovery activities. It is a free service offered to communities to provide support in that community's efforts to target and prevent opioid abuse.

The collaboration is geared toward developing resources and information that can be used by all Pennsylvanians to learn more about overdose prevention and the way substance abuse affects people. The goal of *OverdoseFreePA* is to increase community awareness and knowledge of overdose and overdose prevention strategies, as well as to support initiatives aimed at decreasing drug overdoses and deaths within participating communities.

An essential function of *OverdoseFreePA* is that it provides unified free data analysis for any participating county. This data analysis would include data submitted by any stakeholder in that county, such as the coroner's office, law enforcement, and the department of public safety. If Montgomery County was a participating partner, *OverdoseFreePA* would collect, analyze, and

funnel all data submitted to it for Montgomery County into one unified database. We know that several stakeholders in the MCOTF are already keeping their own data – the Department of Public Safety, the Coroner's Officer and the Montgomery County District Attorney's office. Partnership with *OverdoseFreePA* would provide a means to merge all this data into one unified database and also allow Montgomery County access to data and information from our regional partners in southeast Pennsylvania as well as from other parts of the Commonwealth.

E. Pre-Arrest Drug Court for Young Offenders at the Magisterial District Court

We learned about a program called Drug Education and Addiction Prevention program ("DEAP") that was launched on March 1, 2017. The program is aimed at identifying young offenders who are arrested for drug possession and other low-level related crimes, and offers them an alternative to arrest and criminal prosecution. The program provides education and treatment in an effort to prevent young offenders from becoming addicted to drugs and becoming another death statistic. We have learned that intervention at the early stages of drug use and/or addiction is critical for prevention and recovery.

It is recommended that other police departments and Magisterial District Courts throughout the county –with the support from the District Attorney's Office – work together and research and evaluate similar programs to be implemented in their jurisdictions. We have learned that early intervention and support for young offenders could saves lives, and the DEAP program is designed to do just that. It is our hope that this program will provide an alternative for young adults being saddled with a criminal record, while at the same time providing them with education and awareness about the grim reality of using drugs.

Many times it is the police officer on duty who encounters those who are desperately seeking treatment for their addition. Or sometimes, it's a family member who walks into a

police station desperate to speak to someone about getting their loved one treatment. It is recommended that community stakeholders, like MCOTF, work with law enforcement and together create a program that will equip our police officers with the necessary information and resources to give out to those seeking help. This program could provide officers with tangible materials and information for dissemination, with the goal of assisting people in obtaining treatment. Part of this could be periodic meetings between police department designees and members of the MCOTF so that information can be shared regarding current resource and treatment protocols available. We need to arm our officers, who are on the front lines with those suffering from addiction—especially those suffering from opioid addiction—with the ammunition to assist those who so desperately need treatment options.

F. Collaboration with Pennsylvania Medical Society and Insurance Industry

We have heard from many witnesses that physicians over-prescribing pain medication has contributed greatly to the opioid epidemic and we have learned about the efforts that have been promulgated by the Pennsylvania Medical Society to tackle the current crisis. We have also learned that without strong insurance coverage (or the means to pay for treatment privately), the addict's path to recovery is much more difficult, and often a family spends a large chunk of their savings without a good result. We know that it is long-term comprehensive treatment that has the best chance of success.

But being admitted into a long-term inpatient treatment facility is not enough; the addict must receive quality care while there. Unfortunately, however, this is not always the case. As we heard from former police officer John Becker, treatment centers are largely unregulated; most are not accredited. There must be more quality control of treatment providers.

If the medical community and insurance industry work together, they can open many doors to understanding, awareness, and real change. It's time to look forward and not behind and work together on how we can best effectuate change and reverse this epidemic. It is clear from the testimony of Dr. Christopher that the Pennsylvania Medical Society has implemented several initiatives to target this epidemic and bring awareness and education to their physicians and the public. It is recommended that a representative from the Pennsylvania and/or Montgomery County Medical Society, as well as a representative from the insurance industry, be invited to join the MCOTF. In expanding the membership of the MCOTF, and thereby widening the entities or agencies lobbying on behalf of those suffering from opioid addiction, we are hopeful that not only will more addicts receive long-term inpatient treatment, but also that they will receive high quality care from an accredited facility. These additional voices should be included in the discussion so that, together, we can tackle this epidemic for the good of all.

VIII. CONCLUSION

When we started this journey more than a year ago, there was a vast disparity among us as to the level of knowledge about the opioid epidemic plaguing our nation and Montgomery County in particular. Some knew nothing of the crisis; others may have heard about it peripherally, but paid no mind to it because it didn't affect them; others were all-too-familiar with the problem due to their work in the healthcare industry. Our collective knowledge at the time was a mere sampling of the level of awareness and knowledge of our community as a whole.

We, as a group, now know that this epidemic is a public health emergency, because opioid addiction is a disease that changes brain chemistry; it is a crisis of the criminal justice system, because these drugs are illegal to sell or ingest, and their abuse creates the incentive to

commit other crimes, and; it is a community problem, because it rips apart our families and friendships. For every addict who dies alone, there is someone whose life is emptier without them.

Just as this epidemic combines these different types of emergencies into one large problem, its solution will require a sustained multi-pronged effort, involving a wide range of individuals and entities, that combines different kinds of solutions.

First and foremost, we must treat the addict. Addicts need long-term, quality treatment from an accredited facility. In order to facilitate treatment, we must target key transitional moments where an addict might accept help, such as in the aftermath of an overdose. We must also educate the community about why these drugs should be avoided, and how to recognize the signs of abuse. Additionally, we must provide effective medical care when an overdose emergency arises; this necessarily entails that Naloxone be readily available not only to all first responders but also to members of the public. Moreover, we must prosecute those dealing in significant amounts of controlled substances; restoring a mandatory minimum sentencing scheme would serve the dual purpose of assisting law enforcement in their criminal investigations and ensuring that those who are trafficking in large amounts of controlled substances are off the streets for an extended period of time, thereby making our community safer. Finally, we must help families cope and reduce the stigma of addiction so that addicts seek the help they need before they face a life-threatening emergency.

Only by doing all of these things, with strategies that cross political fault lines, will we have a chance at success. We have no other choice. We have to act. And we have to act now.

IN THE COURT OF COMMON PLEAS OF MONTGOMERY COUNTY PENNSYLVANIA- CRIMINAL DIVISION

IN RE: COUNTY INVESTIGATING GRAND JURY	:	**MD 2363-2015**
	:	
	:	**INVESTIGATION # 22**

REPORT

TO THE HONORABLE THOMAS C. BRANCA, SUPERVISING JUDGE:

We, the Montgomery County Investigating Grand Jury, MD 2363-2015, having been duly charged by this Honorable Court to investigate allegations of any and all types of criminal activity within said County, and having obtained knowledge of such matters from witnesses sworn by the Court and testifying before us, and finding thereon reasonable grounds to believe, and so believing, that a summary with recommended proposals for legislative, executive, and/or administrative change is necessary to the public interest, upon our respective oaths not fewer than 12 concurring, do hereby make this Report to the Court.

[redacted]
Foreperson,
Montgomery County Investigating
Grand Jury

Dated: 5-12-17