Heroin extends grip in society

Addiction has climbed in the last decade, with mortality in Pa. and N.J. exceeding the average.

Jul 08, 2015

By Don Sapatkin

INQUIRER STAFF WRITER

Primed by widespread use of prescription pain pills, heroin addiction and overdose deaths have increased rapidly over the last decade, touching parts of society that previously were relatively unscathed, federal health officials reported Tuesday.

Between 2002-04 and 2011-13, heroin use doubled among women (vs. a 50 percent rise among men) and more than doubled among whites (vs. a decline in other races and ethnicities combined). It also went up faster in households with incomes between $20,000 and $50,000 than in those with more or less, and among the privately insured.

People addicted to prescription opioid painkillers were 40 times as likely to move on to heroin.

“We are priming people to addiction to heroin with overuse of prescription opiates,” Tom Frieden, director of the Centers for Disease Control and Prevention, said at a news conference.

Death rates from heroin overdoses nearly tripled just between 2010 and 2013 nationally and in Pennsylvania, according to federal mortality data. They quadrupled in New Jersey.

For years, officials have focused their worry on misuse of prescription opioid painkillers such as Vicodin and OxyContin.

Meanwhile, heroin has become a popular alternative. It is essentially the same chemical as that in the prescription painkillers, but costs roughly five times less on the street, Frieden said.

And while heroin typically is injected, newer users increasingly are snorting and smoking it - an option that can work when the drug is unusually pure. The Philadelphia region has some of the purest and cheapest heroin in the country, according to the Drug Enforcement Administration.

The link between use of prescription painkillers and heroin is not new. Nor is the sharp increase in heroin-overdose mortality (and the even sharper, and larger, rise in overdoses from pain pills, although there is some evidence of a leveling off in recent years).

Between 1999 and 2013, heroin-related deaths have doubled or tripled in every

Pennsylvania and New Jersey county in the Philadelphia region except for Philadelphia, where rates are high but relatively unchanged.

Heroin-overdose mortality is well above the national average in both states.

But the new report - drawing on an analysis of annual face-to-face surveys of about 67,000 Americans, the government's main source of data on illegal drug use - confirms and expands upon the findings of smaller studies.

Nearly 3 in every 1,000 Americans said that they used heroin in the previous year. That's up from under 2 per 1,000 about a decade ago, a 62 percent increase, which translates to hundreds of thousands more people, government researchers said.

Use more than doubled among ages 18 to 25, while rising 58 percent for ages 26 and older.

All but 4 percent of the people who used heroin in the last year also used another drug, such as cocaine, marijuana or alcohol, according to the report.

The death rate from heroin nearly quadrupled to 2.7 per 100,000 people nationally between 2002 and 2013, when it claimed about 8,300 lives. In 60 percent of those cases, the cause of death was attributed to heroin and at least one other drug, often cocaine, according to Chris Jones, lead author of the new report.

But it is the highly addictive painkilling opioids , prescribed and sometimes overprescribed by physicians who are not highly trained in pain management, that concern officials most, Frieden said.

"A few doses and someone can have a life of addiction, a few too many and someone can die of an overdose," the CDC chief said.

Between 2011 and 2013, about 663,000 people said they had used heroin in the last year, officials said at Tuesday's news conference. About 12 million have used prescription opioids .

Once reserved for cancer and end-of-life pain, these narcotics now are widely prescribed for conditions ranging from dental work to chronic back pain.

Frieden called for more judicious use of the painkillers by physicians who, he said, should seek other ways to manage some forms of chronic pain; expanding the use of naloxone, an emergency medication that can reverse the effects of an overdose; and greater efforts by law enforcement to disrupt heroin distribution networks.

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Inquirer wire services contributed to this report.

Leading the anti-drug effort

Head of Phila. DEA sets dual priority: “Heroin and prescription opioids.”

Aug 06, 2015

By Don Sapatkin

INQUIRER STAFF WRITER

Placed purposefully around Gary Tuggle’s new office are small treasures picked up on past assignments:a Don Quixote statue recognizing his work in Trinidad, a Baltimore Ravens cap from his hometown, and, from a visit to Colombia, three dried opium poppies.

“I use them as inspiration,” he said of the flowers whose seed pods are the source of heroin. “Every time I look at them, it reminds me of how bad the problem is in this country, and how much needs to be done to combat it. “

In June, Tuggle reported to work as special agent in charge of the Drug Enforcement Administration’s Philadelphia Field Division, which covers Pennsylvania and Delaware.

Tastes in illicit drugs vary around the country. Methamphetamine is the drug of choice in some western states (and pockets of rural Pennsylvania). Baltimore, where Tuggle began his career as a police officer and spent the last two years with the DEA, has long been big on heroin.

Heroin is at least as big in Philadelphia. But the drug available on the street now is hardly comparable to that of past years.

“When I was a cop in Baltimore,” 25-plus years ago, “purity was 2 to 5 percent,” said Tuggle, 51. Now it is over 85 percent.

Philadelphia heroin is more than 90 percent pure - the highest average found over the last two years in the United States, he said. Meanwhile, prices per kilo have been cut in half over a quarter-century.

Cocaine has also been a major drug here, but its price has recently gone up as heroin’s has been coming down, Tuggle said.

Historically, he said, Baltimore’s heroin problem was “generational. “ He dates it to the 1970s and ‘80s, when industry began to leave, and poverty and despair became more entrenched. He saw it growing up on the city’s east side.

“A lot of people couldn’t make the adjustment,” he said. Philadelphia followed a similar pattern.

Those communities of older, largely African American, heroin addicts are still around. But they have been joined by growing numbers of younger users, predominantly white and from rural or suburban counties, who got hooked on prescription painkillers containing synthetic opioids . Low on OxyContin or the cash to buy it, desperate to avoid withdrawal sickness, they try heroin - the exceptionally pure stuff can be snorted or smoked - and get addicted.

“Oxy would go for approximately $1 per milligram on the street, so 30 milligrams cost $30,” Tuggle said. “Heroin is $5, $10, $15 on the street” for an equivalent dosage. But heroin, lacking the quality control and precise dosage labeling of pharmaceuticals, can be more deadly, especially for inexperienced users.

Because of the “gateway” role played by prescription painkillers, sometimes written for legitimate reasons, Tuggle refuses to single out heroin as his top priority.

“Heroin and prescription opioids ,” he said, “you can’t say one without the other. “

The dried stalks on his table stand in for both. Heroin is derived from the opium poppy, while synthetic opioids like oxycodone and Percocet attach to the same receptors in the brain, mimicking the effect. Together, they were responsible for more than 23,000 overdose deaths nationwide in 2013, a number more than quadrupling over 15 years, according to federal data.

Tuggle, who recently moved to Center City, was speaking from his 10th-floor office at DEA division headquarters in the federal building at Sixth and Arch Streets, sun streaming through huge windows overlooking the Ben Franklin Bridge.

This is his eighth assignment in 23 years with the DEA, which he joined after a short stint with what is now the Bureau of Alcohol, Tobacco, Firearms and Explosives. That has given him a variety of perspectives on drug issues - some of them academic, from an M.B.A. and a master’s in government from Johns Hopkins University that he picked up along the way.

Each location was unique. From Miami in the early 1990s, he worked on cases involving Colombian drug cartels. In a Caribbean posting, he got to see the corruption-infused “narco-democracy” that the trafficker Charles “Little Nut” Miller built on the tiny island of St. Kitts, using fees he charged those cartels to safeguard their drugs en route to the United States.

His next assignment was Chicago, where he saw the same drugs killing kids.

The narcotics business has changed a lot since then. “Drug cartels used to be linear. Pablo Escobar controlled everything,” Tuggle said. Then the Colombian cartels started using Mexicans to smuggle their goods across the border. Mexican cartels grew, and viewed the Colombians as mere suppliers. Street dealers here started buying from whichever distributor could provide the highest purity for the lowest price.

The evolving business model made tracking illegal imports like heroin more difficult. But the rapid growth in prescription opioids presents additional challenges. The pills can be stolen from a pharmacy or sold by a patient. Legitimate use can turn into addiction if not carefully managed. A handful of doctors sell painkillers for cash, leaving their patients addicted and vulnerable to heroin.

Tuggle said his staff of 300 would target the traditional criminal gangs, “but we’ll also go after the ‘rogue providers’ that are putting these illicit opioids on the street. “

Although his field is law enforcement, Tuggle is aware that demand drives supply, and considers raising public awareness about the risks of prescription painkillers to be part of his job. He says his past postings have broadened his perspective. They also have taught him to think beyond the next undercover operation.

In Baltimore, he said, he organized a trip to Colombia for four local police chiefs. They flew down in black ops helicopters, and met and talked with farmers as well as law enforcement officers. The goal was motivation and education.

“You had four police chiefs,” he said, who would “come back and communicate about the issue.”

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Many police forces not using OD antidote

Aug 22, 2015

By Mari A. Schaefer

INQUIRER STAFF WRITER

Ten months after police in Pennsylvania received the go-ahead to carry naloxone, the lifesaving antidote used to reverse opioid overdoses, a survey by the Center for Rural Pennsylvania show that many municipal departments have not yet opted to carry the drug.

The center surveyed the 1,008 municipal police chiefs in the state. Of them, 57.3 percent returned the questionnaire, which was designed to find out where coverage gaps exist and why departments declined to use naloxone.

The State Police, which serves large swaths of the state, already has its troopers carry Narcan, the common brand name for the drug.

The survey was mailed in May and the results were tabulated in late June, according to the center. The center did not report whether the responses came from rural or urban police departments.

Of the surveys that were returned, 82 percent of the departments reported they had not yet opted to carry Narcan.

The center reports that while drug overdoses are widespread, police departments cite cost and the fact that emergency medical service workers carry Narcan as the main reasons they do not provide the drug to officers.

“The survey indicated to us there still needs to be an educational program for police departments,” said Barry Denk, director of the Center for Rural Pennsylvania.

When responding to emergency calls for an overdose, police were on the scene first for about 70 percent of the calls, according to the survey.

Twenty-eight percent of departments who responded indicated that they would begin to provide Narcan to officers within the next three months. Of the departments that have access to Narcan, 28 percent said they used the drug in the last 30 days.

Other reasons cited for not carrying Narcan were concerns for officer safety, access to training, demands on officers' time, liability, elected officials not supporting the program, and opioid /heroin use not being a problem for the community, according to the survey.

Gary Tennis, secretary of the Department of Drug and Alcohol Programs, said initial reluctance was seen in other states when police use of Narcan was approved.

"It is just a question of creating momentum," he said. Once police understand it fits within the duty of "protect and serve," they use it, he said.

Tennis said his department has about $500,000 in funding for Narcan kits available to municipalities. A provision in the law protects officers from any liability, Tennis said.

Fatal heroin overdoses are on the rise across the state. According to the state's coroner's association, in 2014 there were 2,489 people who died from a drug-related cause, up 20 percent from 2013.

In response to increases in heroin deaths, Pennsylvania joined at least 17 other states in allowing police to carry Narcan. Police in New Jersey began using the drug in 2014.

In Delaware County, the first county to permit police to use the drug, police have revived 84 people since the law went into effect in November.

"It is critical for saving lives," said District Attorney Jack Whelan.

County officials initially purchased 900 doses of nasal Narcan at a cost of $16,000 to distribute to 42 municipalities, the county Park Police, and the Sheriff's Department.

The county is also using drug-forfeiture money as a funding source, said Whelan.

"Cost should not be a factor," Whelan said.

"All chiefs have to embrace this administration of Narcan," said David Montella, chief of Upper Providence Township police, where officers have saved two residents. It is vital that officers be trained with the drug just like they are with defibrillators, he said.

"Time without adequate oxygen results in brain-tissue damage, if not death," Montella said.

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Overdose reversals

The state reports 289 revivals using Naloxone.

Sep 01, 2015

By Don Sapatkin

INQUIRER STAFF WRITER

Police in Pennsylvania have revived 289 people using overdose-reversal medication that they were approved to carry late last year, the Wolf administration announced Monday.

“Pennsylvania has been seeing a sharp increase in drug overdoses across the state. Having naloxone kits in the hands of our first responders, who are often first on the scene, can make the difference between life and death,” Gary Tennis, secretary of the Department of Drug and Alcohol Programs, said in a statement.

About 2,400 residents died from drug overdoses in 2013, the most recent figures available. A majority of those deaths were likely due to opioids - mainly prescription pain pills or heroin.

Naloxone is an emergency medication that immediately blocks the effects of an opioid overdose, restoring breathing. Police, who often arrive before paramedics, can administer it easily, often via nasal spray.

The medication, which is also sold under the brand name Narcan, is not a narcotic and has no effect on conditions not caused by opioids . It typically is administered when a subject is found unconscious and barely breathing, when there is no time to wait for an emergency medical technician.

It is impossible to tell how many of the 289 people revived by the police would have died otherwise. Some might have come around on their own or been taken to a hospital and received treatment there.

Delaware County, the first in the state to equip local police departments after the law changed in November, has reported at least 84 overdose reversals. Pennsylvania State Police began carrying the medication in the spring. Monday’s news release from the state said that 27 of the state’s 67 counties had reported that local police were carrying naloxone or would be soon.

But 82 percent of local departments that responded to a Center for Rural Pennsylvania survey in May said they were not yet carrying the medication, center officials said earlier this summer.

The change in Pennsylvania law also allows families and friends of opioid users to purchase naloxone by prescription. Experts say that most overdoses are observed by someone else, who could save them.

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Pill-disposal day moved for papal visit

To Turn in Drugs

Sep 08, 2015

By Don Sapatkin

INQUIRER STAFF WRITER

If the traffic box, ticket blocks, and worn-out socks aren't enough to illustrate the disruptive power of the pope in Philadelphia, try this:The papal visit is moving National Prescription Drug Take-Back day.

Yes, the big effort to get people to turn in their unused medications - 2.4 tons were collected over the last four years - is scheduled for Sept. 26.

Except in the Drug Enforcement Administration's Philadelphia Division, which covers Pennsylvania and Delaware, where it will be Saturday.

"I think it is safe to say that greater Philadelphia will be gridlocked," said Patrick Trainor, a local DEA spokesman. Some people would be unable to reach drop-off boxes, the agency would have a harder time collecting the drugs, and, of course, much of the region's law enforcement would be on pope duty.

New Jersey is sticking with the original date. Bucks and Montgomery Counties have gone off on their own. More on that later.

Most Americans have unused drugs sitting in medicine chests. Using them in the future, without a physician's guidance, can be unsafe. Flushing them down the toilet pollutes the drinking-water supply. Leaving them on the shelf invites abuse, particularly of prescription pain pills - teens may experiment with them, guests may swipe them, friends may ask to "borrow" them.

Doctors wrote 259 million prescriptions for opioid painkillers in 2012, the Centers for Disease Control and Prevention reported last year, and there were 46 prescription opioid overdose deaths per day. That doesn't include overdoses from heroin, to which prescription narcotics are often a gateway.

Nearly 65 percent of people 12 and older who illicitly used prescription pain pills such as Percocet and oxycodone got them from a friend or relative, most of them for free, according to the 2012 National Survey on Drug Use and Health.

To reduce the supply, the DEA in 2010 began working with local agencies to sponsor biannual "take-back" days, when residents could safely empty their medicine cabinets. It skipped this year's spring event. But some highly organized counties - like Bucks, which pioneered collection efforts in Pennsylvania, working in recent years with Montgomery County - went ahead on their own.

Having twice-yearly drop-offs "creates healthy community habits," said Donna Foisy, cochair of the Bucks County Medication Collection Project. "Change your clock, check your batteries, clean out your meds. "

During the last national take-back day, in September 2014, Bucks collected 7,201 pounds of drugs - nearly twice as much as any other Pennsylvania county and a quarter of the statewide total. Philadelphia, by contrast, took in 557 pounds, according to the DEA.

Take-back days across the country are organized by community organizations, which plan and publicize them; local law enforcement, which hosts the drop-off boxes and delivers the contents to a central county location; and the DEA, which in most cases picks up and disposes of the county's haul.

When the DEA announced earlier in the summer that the next National Prescription Drug Take-Back would be the same day that Pope Francis visits Independence Mall, the agency's Philadelphia Division quickly got permission to hold it Saturday instead.

Bucks and Montgomery Counties decided that their complex joint operation needed more time, Bucks District Attorney David Heckler said. Bucks alone has around 50 drop-off locations, twice as many as any other county in the state; each site must be staffed by law enforcement. The two counties will hold their prescription drug take-back day Oct. 17.

The DEA's New Jersey Division, headquartered in Newark, is staying on the national schedule.

"We do not perceive any issues," said Andy McNeil, spokesman for the Camden County Prosecutor's Office. "We encourage any residents of Camden County who have unwanted prescription drugs to drop them off on or before Sept. 26. The majority of police departments have permanent drug drop boxes at their stations that are available year-round."

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Where/When

National Prescription Drug Take-Back day is Sept. 26. But the pope's visit that day has changed some local schedules:

Dates

Most of Pennsylvania and Delaware: This Saturday.

New Jersey: Sept. 26.

Bucks, Montgomery: Oct. 17.

Times

All three Saturdays: Drop-offs from 10 a.m. to 2 p.m.

Other days: Some police stations maintain permanent drop-off boxes during regular hours. (Call to find out.)

Find locations

Most of Pa., N.J., and Del.: www.dea.gov or 1-800-882-9539.

Bucks, Montgomery: Locations posted on county websites as the date approaches.

Targeting prescription abuse

Too many pills, too little oversight

Oct 18, 2015

By Don Sapatkin

INQUIRER STAFF WRITER

Pat McGuckin barely recognized her 39-year-old son. Once a personal trainer and bodybuilder, Michael now was exhausted, his limbs bloated, his mood so volatile that he ripped the phone off her wall.

He told his worried mother that he was in pain from a car accident but that a doctor was helping him.

On Oct. 21, 2007, his younger brother found Michael in bed, his body cold. A few days later, their mother stared at the words on the death certificate, struggling to understand what had killed her son.

She dialed Richard J. Hollawell, a friend of Michael's since childhood in Northeast Philadelphia.

"I said, 'Rick, it says 'adverse reaction to prescription drugs. ' How could that be? He was under a doctor's care,' " Pat McGuckin recalled.

Hollawell soon would learn from medical records that his friend was being prescribed nearly 200 narcotic pain and anxiety pills every week in dosages that easily could be fatal, an expert said. And the doctor who wrote those prescriptions operated on a cash-only basis, which meant no insurance company could flag the extreme pattern.

For Hollawell, now a lawyer in South Jersey, that call - and what he said he discovered about his old buddy's care - triggered what has become an eight-year quest. In seeking justice for three casualties in the national epidemic of painkiller overdoses, he is taking aim at the small number of doctors who play an outsize role in the crisis.

Hollawell had known Michael McGuckin ever since the boys, both students at Our Lady of Calvary grammar school, would hang out at the McGuckin home next door, playing video games. They followed different paths as adults, but kept in close touch.

Several years after McGuckin died, Hollawell got a call about the death of a second childhood friend. The cause was heroin, but his addiction began with pain pills, almost 20,000 prescribed over four years.

His source was the same as McGuckin's, a physician with a solo practice near Rittenhouse Square named Thomas C. Barone.

Hollawell pursued medical-malpractice lawsuits in both cases. McGuckin's went to trial four years ago but was settled for $1 million against Barone before the jury's verdict could be read in court. The second was also settled, for more than $800,000, two years later.

A third suit, involving another death, was filed last month.

“He got them all sick instead of helping them,” Hollawell said. “He literally gave them an illness, and that illness was addiction. And they never came back from it. “

The cases illustrate key issues in the deadly drug crisis: Many addictions begin in medical offices, when patients seek help for pain. Without appropriate monitoring, patients can obtain astonishing quantities of drugs that hook them, kill them, or lead them to prescription opioids ‘ street relative, heroin.

Anyone, from any background, can fall prey to prescription-drug addictions.

Meanwhile, as a frustrated Hollawell would learn, regulators and other officials charged with protecting the public can be slow to act.

In Barone’s case, state action came four years after the first of Hollawell’s three complaints. A fourth death was found by state investigators. Barone has temporarily lost his medical license and cannot practice.

He did not respond to repeated efforts by The Inquirer to reach him by phone, in person, and by mail.

Expert witnesses at the 2011 civil trial painted vividly different pictures of Barone’s treatment of Michael McGuckin.

“I found it to be appropriate. I found it to be caring. I found it to be within the standards of care,” Gerald Hansen, a physician at Abington Memorial Hospital who is board-certified in family medicine and pain management, testified for the defense.

Warren Wolfe, a trained pharmacist and board-certified family physician who practiced in Cherry Hill for 40 years, said the treatment was “reckless. “ Barone failed to record basics such as the patient’s weight and temperature, review records from other doctors, and ignored obvious signs that the patient was in trouble, Wolfe said. “He is seeing Mr. McGuckin every two weeks, with the same pain, giving him more and more medicine. . . . There is no treatment plan,” said Wolfe, who is now retired in Virginia. “There are so many other things he could have done. “

Barone has never been charged criminally and did not admit guilt in negotiating his license suspension.

His license could be reinstated next summer, at the end of an 18-month suspension.

CALL FOR HELP

Not long after Pat McGuckin called Hollawell to help her understand what had happened, she showed him prescription bottles that the family had found in Michael’s bedroom. Hollawell was no expert in narcotics, but he recognized some of the names on the labels: highly addictive opioid pain relievers as well as antianxiety medications known to enhance the high that users get from opioids . TV news was reporting about Florida “pill mills” so notorious they drew customers from around the nation.

“That’s when the alarms started to go off,” he said. “I just knew that they were dangerous drugs.”

Hollawell, a partner in the small Marlton firm of Console & Hollawell, was a personal-injury lawyer who had handled some medical malpractice, but this case required him to

dig into a world that was almost entirely new to him.

At first he was driven by emotion. “I went to elementary school with Mike,” he said. “I was on Little League baseball with Mike. “

As a youngster, he often went home for lunch with Mike to his boisterous household, always full with six McGuckin children and all their friends.

The boys went through high school together. After Fordham University and Widener Law School, Hollawell got married, and McGuckin was there.

McGuckin started at Temple University but quit after a year and a half to concentrate on bodybuilding. He won trophies and paid his expenses by training others. But after hurting his back in a 2005 car crash and starting on painkillers, he began to spiral downward.

Reviewing the medical records after he died, the family pieced together what had happened.

Warning signs that might suggest drug abuse were included in Barone’s brief medical notes. The doctor wrote that McGuckin told him he had lost pills in his luggage on a trip. Another time his patient said he had accidentally spilled the pills down the drain. He also claimed they were stolen when his car was towed.

Each time, Barone wrote new prescriptions.

Barone testified he did eventually have concerns that McGuckin might be lying about how many pills he was taking. He asked McGuckin to bring in his pill bottles, but McGuckin did not.

“I could have decided at that point that I can’t treat him anymore,” Barone testified during the civil trial. “But he expressed to me how appreciative he was, thankful for the care that I gave him, the treatment that I gave him, and that he really was not getting adequate treatment or care from his other doctors. So I felt that responsibility that I could not abandon him. “

Pat McGuckin sees it differently.

“You trust a doctor to do the best for his patient,” she said in an interview at her home, where Michael grew up. “He didn’t. He was just ‘Here, here’s your prescription, see you. ‘ I’m heartbroken that a doctor would do that. “

Barone testified that he never performed routine checks such as recording Michael McGuckin’s height and weight, or ordering blood work or urine tests. He decided McGuckin had a “possible lumbar disk bulge/herniation,” but said he had not needed diagnostic tests to confirm it.

Yet he doled out more and more pills.

By the time McGuckin died, Barone was writing on average 210 Percocets (10 mg.), 104 OxyContins (80 mg.), and 70 Xanax (2 mg.) every two weeks.

“That’s a huge dose,” Larry Axelrod, a physician whose South Philadelphia practice is devoted to workers’ compensation injuries, said in an interview. Knowing nothing else about the case, he guessed that the patient had died. Axelrod is hired by insurers to review other doctors’ records when excessive prescribing is suspected. But Barone would

not have been flagged by any insurer. He accepted only cash, a practice typical of pill mills, a spokesman for the U.S. Drug Enforcement Administration said.

'ROGUE PROVIDERS'

More than 100,000 people have died in the U.S. of opioid overdoses in the last decade, according to federal data. No one knows how many deaths can be attributed to "rogue providers," as Gary Tuggle, special agent in charge of the DEA's Philadelphia Division, dubs the doctors, dentists, and others who prescribe drugs without proper care.

But Tuggle would characterize the problem this way:

"It's really big," he said, explaining that if even just 1 percent of the more than 50,000 providers registered to prescribe narcotics in Pennsylvania "go off the reservation to become rogue distributors, that's a lot. "

Barone began practicing in Center City in 2004. He grew up in North Jersey and graduated in 1995 from the Philadelphia College of Osteopathic Medicine, where he is currently teaching as a part-time clinical associate professor. (Asked about his status, a spokeswoman emailed on Friday that "his role at the College is solely academic, which does not require him to have a license - he has no contact with patients nor oversight of any prescription medication. ")

Barone, 46, is board-certified in family medicine but not pain medicine, and had admitting privileges at Thomas Jefferson University Hospital until the state's first action against him last year. In spring 2013 he was elected to a two-year term as a trustee of the Pennsylvania Osteopathic Medical Association, an independent group.

He did not respond to repeated messages left in person and by phone at his former office in the Medical Tower office building on South 17th Street. He signed a receipt for a certified letter sent to his home a few blocks away.

Arthur K. Hoffman, a lawyer in Harrisburg who represented Barone in his license-suspension case, said he was not authorized to comment.

A DIFFERENT KIND OF CASE

A typical case of medical malpractice involves a direct line between cause and effect: A physician fails to diagnose a cancerous nodule, the patient develops cancer.

Hollawell's lawsuits were different. Patients who are addicted to prescription drugs often lie to doctors and pharmacists to feed their habit, which means jurors might blame them for their own deaths.

"People just think it's your fault," Hollawell said. "Everybody was telling us how difficult it would be to prove the case. "

Hollawell disagreed. "You get hooked, your behavior changes, all you want to do is get what the doctor's giving you. "

Talking to jurors after the McGuckin trial - though it was settled before their verdict was recorded - showed Hollawell his argument was persuasive. But he faced a tougher test when he took on the case of another childhood friend, Nicholas Rallis.

Rallis died at age 40 of a heroin overdose. When his body was found in an empty Kensington warehouse in September 2011, it had been more than two years since he had received a painkiller prescription from Barone.

Today, experts attribute much of the recent surge in heroin use to people who started on prescription opioids . Hollawell said he always has been certain this was true for Rallis.

“Barone made him the addict,” he said. “He would have never encountered heroin had he not met Barone. “

Back at Archbishop Ryan High School, Hollawell knew Rallis as a smart kid who would go on to be an A student at Drexel University. “He had a nice job with Coca-Cola in finance,” the lawyer recalled.

Rallis started seeing Barone for treatment of a back injury in 2005 and recommended the doctor to McGuckin, Hollawell said. In the four years Rallis was his patient, Barone wrote prescriptions for 19,935 pills, according to records compiled by Hollawell.

Some time after his last visit to Barone, he turned to heroin. His mother, Lorraine McNulty, thinks it was because heroin is much cheaper than prescription medication.

McNulty said her son tried hard to beat drugs, including two stints in rehab.

“I watched him cry many times when it was just him and I over the way his life had turned out and how he wanted to cure himself from this disease and demon,” she said.

Rallis would have turned 45 on Oct. 4. His mother keeps a series of unanswered text messages she sent her son the day he died: “Hi, what are you up to? . . . Are you at a meeting? . . . Are you OK: have not heard from you. “

On his birthday, she pulled out her phone, read the messages, and cried.

MALPRACTICE SETTLEMENT

When Hollawell threatened to file a lawsuit on behalf of Rallis’ estate, the doctor’s malpractice insurers settled for $825,000, according to court records.

Both Pat McGuckin and Lorraine McNulty said what they really wanted was to stop the doctor from practicing medicine, permanently.

Back in 2010, Hollawell said, he shared his evidence against Barone in the McGuckin case with the state Board of Osteopathic Medicine, which issues and oversees licenses. He later did the same with the records he compiled in the Rallis case and again in his most recent lawsuit.

It took four years and a fourth death, which state investigators found on their own, before the board suspended Barone’s license in September of last year. It then negotiated a consent agreement that required him to get additional training in prescribing narcotics and a skills assessment during the 18-month suspension.

Barone admitted no wrongdoing. Neither the February consent decree nor the osteopathic board’s one-paragraph public announcement mentioned any deaths.

The board can revoke licenses but rarely does so. A request to interview board chairman Jeffrey A. Heebner, a family-practice doctor in Montgomery County, was denied. A

spokeswoman for the Department of State said that as a matter of policy no members of any of Pennsylvania's 29 licensing boards speak to reporters.

OPIOIDS FOR MIGRAINES

Joey Caltagirone went to see Barone for migraines in 2005. Medical guidelines generally recommend against using opioids for migraines, because they can cause even worse headaches when patients go off them.

But Caltagirone left that first appointment with a prescription for 100 Percocets, according to the lawsuit filed by Hollawell in Philadelphia Court of Common Pleas.

Over the years he got more narcotics, but the headaches continued, said his father, Joe. His marriage crumbled. He lost his room-service job at the Marriott Downtown, where his father still works.

Worried about him being alone, Caltagirone suggested that he live with him in Kensington a few years ago.

"He was my best friend. A beautiful boy. Kind heart. Quick to laugh. My soul mate," the father said.

Though Joey could not use his health insurance for his visits to Barone's cash-only practice, he did use it to pay for the medications. In 2009, Express Scripts, the pharmacy benefit manager, notified Barone that his patient was getting large quantities of narcotics, including fentanyl, oxycodone, and Percocet.

His father repeatedly found Joey collapsed on the floor. One day, Joey told him about his doctor and the drugs. His father called Barone:

"I said to the doctor, 'Why does he have to take Percocet every single day when all he has is migraines? This is insane. ' " He said Barone told him that he would reduce the dosage.

Eventually, father and son went together to see a specialist at Thomas Jefferson University Hospital's Headache Center. "He said to Joey, 'You have been taking lethal doses of medication, and we are going to get you into a hospital,' " Caltagirone said.

Shortly after his release, medical records show, Barone wrote Joey a prescription for methadone, an opioid he had never taken before. Methadone is best known as a highly regulated treatment for addiction, but can be prescribed by any doctor for pain. The risk of overdose is particularly high.

Six days after the first prescription, Barone wrote a second for twice as many tablets. Three days later, on May 15, 2014, Joey Caltagirone died at age 39.

Manner of death, according to the medical examiner's report: methadone toxicity.

"Too much methadone can kill you," Stephen M. Thomas, a pain specialist from Pittsburgh, testified at Barone's license-suspension hearing in Harrisburg five months later.

Barone knew that the patient had been behaving like an addict for years, with his pill-taking "out of control," Thomas said in a phone interview Friday. "It is one thing if I put paper on a fire that is already burning. It is another thing if I put gasoline on," he said,

adding that the death was entirely predictable.

A few days after Joey died, Barone called the Caltagirone house. “He said, ‘Can I talk with Joey?’ “ the father recalled. “I said ‘He died. ‘ “

The doctor then asked if he could come to the funeral, he said, and added a request:

“He said, ‘Sometimes the family is hostile against the doctor. Can you make sure that I’m all right?’ “

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Pa. young mens overdose deaths lead U.S.

New Jersey ranked fourth. In the eight-county region, more than 100 from ages 19 to 25 die annually.

Nov 20, 2015

By Don Sapatkin

INQUIRER STAFF WRITER

Inquirer staff writer Chris Palmer contributed to this story.

Pennsylvania leads the nation - and New Jersey is fourth - in drug overdose deaths among young adult men, according to a new analysis, raising the level of urgency about an epidemic that over the last decade has killed more than twice as many Americans as homicide.

Bucks and Gloucester Counties led their respective states in overdose fatality rates among males ages 19 to 25 - each of them nearly three times Philadelphia’s rate. In the eight-county region, more than 100 young men a year are dying from overdoses of both illicit and legal drugs.

The state numbers are included in a report on teen substance abuse released Thursday by the Trust for America’s Health. The public health nonprofit examined federal statistics for 2011-13 filtered by age and sex. An Inquirer analysis did the same at the county level.

Pennsylvania, with 30.3 deaths per 100,000 young-adult male residents, was less than one-tenth of a point higher than No. 2 New Mexico.

But when all ages and genders are combined, Pennsylvania ranks ninth, with a death rate that is two-thirds that of the worst state, West Virginia. New Jersey’s overall rate is below the national average.

The difference has to do with the far-higher overdose rates in middle age. But state-by-state variations depend on numerous factors, including occupation. For instance, West

Virginia disability-claims records suggest many coal miners were prescribed addictive painkillers.

The new report focuses on teens and young adults, to make the point that stepped-up prevention efforts when youngsters are still in high school could have a major impact on deaths later on. Overdose fatality rates for ages 12 to 18 are one-tenth those of young adults.

“The opportunity to do prevention work is when they are still in school, that captive audience,” Jeffrey Levi, the foundation’s executive director, said in an interview.

Patterns of drug use as teens transition into adulthood are not well understood, Brian Bumbarger, a founding director of the EPISCenter at Pennsylvania State University, said Thursday.

The report praised the work of Bumbarger’s center (the acronym stands for Evidence-based Prevention and Intervention Support), a statewide collaboration of several agencies and efforts. It also scored states on how many of 10 recommended policies they had adopted, from bullying prevention to mental-health funding. New Jersey was one of only two states with a perfect 10; Pennsylvania was above average with seven.

The indicators mainly seemed to indicate how little is known about teen addiction.

But why would young adults in Pennsylvania be any different from those elsewhere? And what explains the higher rates in the suburbs? Bucks, Montgomery, and Delaware Counties all have much higher fatality rates than Philadelphia (Chester County is also lower). Gloucester, Camden, and Burlington Counties are above the New Jersey average.

Jeanine M. Buchanich, who studies overdose data at the University of Pittsburgh’s Graduate School of Public Health, said that patterns in some parts of Pennsylvania seem to be an extension of neighboring Appalachian states, where prescription painkiller addiction is greatest.

Over the last decade, painkillers have become a major gateway to heroin. Some people who are addicted to synthetic prescription opioids move on to the substance derived from opium poppies to avoid withdrawal sickness when they can no longer afford the pricier pain pills.

Buchanich cited a couple of reasons for the suburban death rates. One is essentially the result of “competing risk”: Philadelphia loses so many young men through homicide that overdose rates are lower.

The other, which she attributed to research by the journalist Sam Quinones for his recent book Dreamland: The True Tale of America’s Opiate Epidemic, is that Mexican drug importers years ago targeted suburban areas, where painkiller use was already high, in an effort to avoid urban drug gangs.

Overdose deaths have leveled off in some parts of the country in recent years. “Unfortunately, Pennsylvania is not one of those places so far,” said Buchanich, who has seen more recent data than what were used for the new report on teens and young adults.

A separate, just-released Drug Enforcement Administration analysis of overdose fatalities in Pennsylvania noted that some of the cheapest and purest heroin in the nation passes through Philadelphia. Extremely potent heroin can be snorted or taken orally.

Roland Lamb, director of Philadelphia's Office of Addiction Services, pointed to a report that "heroin tablets" disguised as the prescription opioid oxycodone, complete with similar markings, had been seized in New Jersey last year.

"The idea is that with swallowing, you have less of an aversion" compared with injecting it, he said.

A decade ago, Mike Pelone started taking OxyContin and Percocet that he purchased on the street while living in Bucks and Montgomery Counties.

A 2005 graduate of Wissahickon High School, he went through rehab three times. In August 2010, after 90 days of sobriety, "he scored some heroin, got high, and died," said his father, Michael J. Pelone. He was 23.

Despite the tragic end to a five-year struggle, Pelone said, Mike's family had learned to accept his addiction as a form of chronic disease, as the medical profession has in recent decades. He wishes everybody would.

"There are no annual parades or ribbons to wear for them," Pelone said. "Just a robust stigma remains, with plenty of 'what ifs' and 'whys' from the folks who know so little of drug addiction."

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SEVERAL MOVES THIS WEEK

Thursday's report, "Reducing Teen Substance Misuse: What Really Works," comes amid a flurry of activity to combat overdoses.

The Food and Drug Administration on Wednesday approved a nasal-spray version of the opioid overdose-reversal medication naloxone, which is increasingly being carried by police and other first responders and is known as Narcan.

The Pennsylvania Health Department recently announced a "standing order" for the medication, essentially meaning that pharmacies can provide it without a prescription to families and friends of people who are at risk of overdose. New Jersey allows this as well.

The American Medical Association on Tuesday called for a ban on direct-to-consumer advertising for prescription drugs and implantable medical devices, arguing that they are a factor in increasing health-care costs and encouraging patient demands for inappropriate treatment. Research shows that prescription pain relievers are not effective for chronic pain, but they are heavily advertised and frequently prescribed by doctors.

Federal advertising restrictions were loosened in 1997, and drug sales soared over the next decade. New Zealand is the only other country that allows prescription medication commercials on television with minimal regulation.

Also on Tuesday, the Obama administration released its 2015 National Drug Control Strategy. It encourages Congress to permit Medicare to review and restrict inappropriate prescribing. Private insurance companies and state Medicaid programs have used such reviews for years to reduce the use of addictive drugs. - Don Sapatkin

Doing more to fight addiction

Nov 30, 2015

By Katie McGinty

I have seen firsthand the destruction of addiction. Alcoholism has hit my family, close friends, and relatives, causing heartbreak and snatching away lives, relationships, and careers.

My family and I aren't alone. An addiction epidemic is taking hold throughout Pennsylvania and the country as more people are turning from prescribed painkillers to the cheaper alternative of heroin.

Pennsylvania has moved from 14th to ninth among the states in drug overdose deaths per capita. Recent headlines highlighted the horrific reality that young men in Bucks County are dying from overdoses at a greater rate than anywhere in the country.

In August, Washington County made national headlines when eight overdoses took place in the short span of 70 minutes. In 24 hours, there were a total of 18 overdoses that resulted in the deaths of three people.

In 2014, 119 people died in Erie County as a result of heroin.

Last year, the Reading Eagle named heroin the "Local Newsmaker of the Year" as Berks County saw heroin overdoses rise for a fourth consecutive year to double the number in 2010.

In less than a week, Delaware County saw a total of nine heroin-related overdoses.

Heroin respects no borders. It does not discriminate. It knows no race or ethnicity. It is a drug that is affecting families of all incomes and backgrounds in Pennsylvania.

The heroin crisis traces its roots to prescription painkillers such as OxyContin and Vicodin. Doctors began prescribing these narcotics to manage pain, but as the pills ran out, people turned to a cheaper option - heroin. The average cost of a bag of heroin is $10 and sometimes even cheaper.

We need to fundamentally change our approach in dealing with this heroin epidemic - which means treating it as a health issue, not simply as a criminal justice issue. We need to shift away from locking up heroin abusers and instead move them into treatment services to combat their addiction. This is not only the most compassionate way to tackle this issue; it is the most effective way to do so.

First, we need increased access to mental-health resources under the Affordable Care Act, and we must ensure that health insurance is fully covering substance abuse and behavioral disorders. Ensuring access to treatment for individuals struggling with opioid or heroin addiction will be an important component of any effort to address substance abuse.

We need to pass two pieces of legislation introduced by Sens. Bob Casey (D., Pa.) and Ed Markey (D., Mass.) that would expand funding for states and counties to pay for treatment of addicts and allow medical professionals increased access to buprenorphine, a drug used

to treat opiate addicts.

More must also be done to increase the preparedness of first responders, such as giving them access to naloxone, also called Narcan, to administer to those experiencing an overdose. According to the Centers for Disease Control and Prevention, Narcan has saved more than 26,000 lives in the United States. With Gov. Wolf's leadership, state troopers now carry and have administered Narcan to save lives.

Lastly, we need to prevent overprescription of painkillers. A team approach, in which the patient works with the prescribing doctor, a mental-health provider, and an addiction specialist to monitor progress, makes sense. This way, pain is effectively managed and narcotics use is diminished as the patient returns to health.

Addiction is a costly and all-consuming disease that can control those closest to us. It is time to take immediate steps to help families and their loved ones fight the heroin epidemic sweeping the state.

Mothers, fathers, spouses, brothers, and sisters across the commonwealth and country are struggling every day to save loved ones trapped in addiction's death grip. Let's act now - decisively and effectively - to help and to heal.

Katie McGinty is a Democratic candidate for U.S. Senate from Pennsylvania. katie@ katiemcginty

Guidelines help ER doctors limit meds

A Temple study says the rules are a straightforward way to control prescriptions of risky, addictive opioids.

Temple: Guidelines in ER control abuse of risky pain meds

Dec 30, 2015

By Tom Avril

STAFF WRITER

Emergency rooms are increasingly a prime spot for patients seeking powerful pain medications, with doctors caught between the desire to help people in pain and the need to discourage addiction and even overdoses.

Temple University Hospital reported Tuesday that it had found a straightforward way to limit prescriptions of these opioid drugs, such as Percocet, Dilaudid, and Vicodin: a set of guidelines that helps ER doctors determine when to say no.

Among patients with dental, neck, back, or unspecified chronic pain for which opioids are not advised, the number getting prescriptions dropped below 30 percent immediately after the guidance was distributed in January 2013 - down from 52.7 percent beforehand.

These findings, published in the Journal of Emergency Medicine, came from more than

13,000 patient visits to Temple's main location on North Broad Street and its Episcopal Campus on East Lehigh Avenue.

Patients who needed pain medication still got it, said lead study author Daniel A. del Portal, an assistant professor at Temple's Lewis Katz School of Medicine. The guide helped physicians explain to patients why, for certain kinds of pain, they were better off with non- opioid drugs.

"It facilitates the conversation," del Portal said. "It gives us a tool to use. "

Nationwide, abuse of opioids has soared in recent years, now accounting for more deaths from overdose than heroin and cocaine combined. And when the overdoses are not fatal, patients often are able to go back to doctors for more, according to another new study this week, led by researchers at Boston Medical Center.

In a national sample of nearly 3,000 patients who suffered a nonfatal opioid overdose, 91 percent were able to get subsequent prescriptions for the drugs, the authors reported in Annals of Internal Medicine.

Temple is not alone in trying to tackle the problem by spelling out when such drugs are a poor choice. Various medical societies and state governments also have weighed in.

But so far, prescribing practices have not changed much in response, said Marc R. Larochelle, the lead author of the study of overdose patients.

The Temple study was unusual in that it saw improvement both immediately after the guidelines were issued and a year later, Larochelle said. From January to July 2014, the opioid prescription rate for patients with dental, back, or other chronic pain was 33.8 percent - well below the original 52.7 percent.

"It's actually pretty impressive," said Larochelle, an assistant professor at Boston University School of Medicine. "It seems that they had a lasting effect. The question is, is this translatable on a large scale? "

Temple's del Portal said guidelines are not enough to get the job done. It is also important to have strong networks of substance-abuse counseling and mental health treatment, among other resources.

Most states also have electronic databases to help physicians tell if patients are filling opioid prescriptions from multiple doctors, though sometimes these programs are designed more for use by law enforcement, he said.

One reason that emergency rooms are a common source of opioid prescriptions is that physicians usually do not know the patients and are less able to tell if the drug is medically necessary. Emergency room physicians also may not be readily able to tell if patients are getting more pills elsewhere.

Some emergency patients ask for opioids by name because they are in severe pain and believe them to be the strongest weapon, del Portal said. Physicians, who are increasingly evaluated through patient satisfaction ratings, may be reluctant to say no.

But for dental pain, a dental block (an injected anesthetic) is a better option. And for back and neck pain, an anti-inflammatory drug like ibuprofen is more effective and safer, del

Portal said. In addition to the dangers of addiction and respiratory arrest, opioids also can lead to hallucinations.

The Temple guidelines go beyond listing which conditions are not best treated with opioids. They also state that emergency physicians should not refill prescriptions, leaving that task to primary-care doctors or pain specialists, who can follow the patient over the long term.

Emergency physicians also should not write a new prescription for a patient who says the old one has been lost, the guidelines state.

Inappropriate prescribing of opioids has consequences for others beside the patient, del Portal said.

Every time someone seeks an opioid refill in the emergency room, other patients have to wait longer to be treated, he said.

In addition, opioids can end up in the wrong hands.

"You see kids come in with drug overdoses, and we know we didn't prescribe them a bottle of Percocet," del Portal said.

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Temple Guidelines

Here is a recently updated version of the guidelines for prescribing addictive pain medicine (opioids) at Temple University Hospital's emergency department.

Objective: To appropriately relieve pain for patients and attempt to identify those who may be abusing or addicted to opioids and refer them for special assistance.

GUIDELINES FOR TREATING NON-CANCER PAIN

1. Opioid analgesics may be appropriate for acute illness or injury when less addictive therapies such as NSAIDs (nonsteroanti-inflammatoryatory drugs) or acetaminophen are contraindicated or deemed inadequate to reasonably control pain.

    a. Physicians should prescribe the least addictive medications that are expected to provide appropriate analgesia. When appropriate, the physicians should consider prescribing Schedule III or Schedule IV drugs instead of Schedule II drugs (see table).

    b. Emergency physicians should not prescribe long-acting opioids such as OxyContin, extended release morphine or methadone.

2. Discharge prescriptions are limited to the amount needed until follow up and should not exceed 7 days' worth.

3. The patient should not receive opioid prescriptions from multiple doctors. Emergency physicians should not prescribe additional opioids for a condition previously treated in our ED, in another ED, or by another physician.

4. Emergency physicians should not replace lost or stolen prescriptions for controlled substances.

5. Emergency physicians should not prescribe opioids to patients who have run out of pain medications. Refills are to be arranged with the primary or specialty prescribing physician.

6. Opioids are discouraged for dental and back pain, whether acute or chronic.

   a. Non- opioid alternatives such as dental block or NSAIDs may be offered.

7. Opioids should not be used to treat migraines, gastroparesis, or chronic abdominal/pelvic pain.

8. Patients with chronic non-cancer pain should not receive injections of opioid analgesics in the ED.

9. Physicians may consider drug screening as needed to guide treatment decisions.

10. Patients with suspected addictive behavior may be referred to detoxification resources.

OPIOIDS BY DEA DRUG SCHEDULE

The U.S. Drug Enforcement Agency classifies opioid drugs by their potential for abuse and psychological/physical dependence.

Schedule I (highest potential). Includes heroin and other illegal drugs.

Schedule II (high potential for abuse, severe dependence potential). Includes Hydromorphone (Dilaudid), Oxycodone (Percocet), Hydrocodone (Vicodin) and Fentanyl.

Schedule III (lower potential for abuse than II, still high potential psychological dependence). Includes Tylenol with codeine (Tylenol 3).

Schedule IV (lowest potential for abuse/dependence). Includes Tramadol (Ultram).

SOURCE: Temple University Hospital

Schools can get heroin antidote free

Feb 02, 2016

By Kathy Boccella

STAFF WRITER

Pennsylvania school districts will be eligible to receive one free carton of Narcan nasal spray - which can reverse the effects of a heroin overdose - under a partnership between the state and the Radnor-based maker of the drug, Gov. Wolf announced Monday.

Pennsylvania would be the first state to implement the program, sponsored by Adapt Pharma and the Clinton Health Matters Initiative, part of the Clinton Foundation.

Pennsylvania public high schools also will have access to new educational materials and training developed by the National Association of School Nurses.

Narcan nasal spray is the only FDA-approved, ready-to-use, needle-free nasal spray version of naloxone hydrochloride, used for the emergency treatment of opioid overdose.

The state Health Department, through school nurses, will help with the distribution. Each carton contains two doses of the drug.

Adapt Pharma has provided a grant to the National Association of School Nurses to develop educational materials for nurses, students, and families to prevent drug overdoses.

At a news conference, state officials noted that in rural areas, it might take longer for emergency responders to reach patients, and so stocking the drug on school grounds could prevent deaths.

State officials said they did not keep track of in-school overdoses. Thom Duffy, executive director of marketing at Adapt, said he was not aware of any in Pennsylvania; however, some schools have been stocking the antidote.

Last week, Delaware County officials said the county's police officers would be the first in the state to use the newly developed Narcan spray.

Each of the nearly 400 police vehicles will be equipped with two 4-milligram applicators at a cost of $37.50 per dose.

In just over a year, police have saved 170 lives with naloxone, Delaware County officials said. They also said the number of heroin deaths continues to rise, with 191 drug overdoses in the county last year.

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To end painkiller epidemic, make it personal

Feb 04, 2016

By Ed Rendell

Last year, 44,000 people died of drug overdoses, and 52 percent of them were related to prescription drugs. More than two million Americans are dependent on opioid painkillers, and every day, 44 Americans die of an overdose of these drugs.

When the cost of these painkillers becomes too great, addicts will turn to lower-cost heroin. In 2007, there were 373,000 heroin addicts in the United States, and 2,400 deaths resulted from heroin overdoses. By 2014, those numbers ballooned to 914,000 addicts and 10,500 overdose deaths. The overdose death rate among people ages 25 to 34 was five times higher in 2014 than it was in 1999.

As you read these statistics, you are probably stunned, horrified, saddened, and angry. But you'll put your newspaper or device down and go about dealing with the challenges of your life. As bad as these facts are, they don't affect you - it's not personal.

On Jan. 16, it became personal for me and for hundreds of Philadelphians when John

Decker died. John was an incredible young man who had it all. If you read his obituary, one thing is clear: If John Decker, a gifted athlete and financial analyst, could fall victim to opioid painkiller addiction, then any young person could.

Most importantly, the three people to whom John's death was the most personal - his wonderful mom and dad, Tad and Candy, and his loving sister, Samantha - have decided to do something about this problem.

Tad asked me to speak at John's memorial service. I decided to try to find out what has caused this explosion of addiction, what our government is doing to stop it, and what we should be doing but are not. I found that in the early 1990s, opioid painkillers were prescribed only for long-term use by terminally ill patients suffering from diseases like cancer. They were prescribed on a short-term basis only for people recovering from surgery.

In the mid-'90s, all this changed as a result of an aggressive marketing campaign by pharmaceutical companies. Doctors responded by prescribing opioid painkillers for long-term, chronic, nonmalignant medical conditions like lower back pain. It often led to ridiculous treatment. A friend of mine told me that after his hernia operation, his doctor wrote a prescription for 30 Percocet pills. Ridiculous! He didn't need them and took only Motrin.

So what has our government done to slow down the epidemic? Virtually nothing. In fact, you can make a case that it has responded to special interests and failed to take deterrent action. Last year, the Food and Drug Administration unbelievably authorized the use of OxyContin for 11- to 16-year-olds. The Centers for Disease Control and Prevention have delayed issuing a directive aimed at curbing overprescription of opioid painkillers. Six U.S. senators wrote the CDC that they were "troubled by reports that the delay occurred after opposition from companies that have a significant financial stake in the role of opioid painkillers. "

However, despite this gloomy picture, I believe there is a clear path to dramatically reducing the use of opioid painkillers and heroin. The only question is, will our leaders have the courage to stand up to these special interests and go down that path?

First, Congress should pressure the FDA to reverse its directive allowing OxyContin to be prescribed to 11- to 16-year-olds. Second, it should continue to pressure the CDC to issue those guidelines.

Third, Congress should immediately pass the Comprehensive Addiction and Recovery Act, whose main sponsor is Sen. Amy Klobuchar (D., Minn.). The act would strengthen the prescription-drug monitoring programs that exist in most states, and make those programs interoperable across state lines and available to all doctors and pharmacies.

These monitoring programs are essential to curbing overprescription. They can tell the authorities when an individual goes to three different doctors in the same week for the same drug or when a single doctor issues far too many unnecessary prescriptions for painkillers.

The act would also provide additional funding to create drug courts, which have had some success in getting addicts into treatment. Treatment isn't always successful, but it can

be, and today, only one in 10 addicts is in a treatment program. It would also provide additional funding for treatment programs and to make naloxone, a powerful antidote for overdoses, available to first responders.

I believe we can curb this epidemic if we all make it personal. We need to pressure Congress, our state legislatures, and our government agencies to act. We should demand that medical schools include the dangers of overprescription in their curriculums so that young doctors understand the role their profession has played in aiding this explosion. We should demand that the American Medical Association and local prosecutors crack down on "dirty docs" who overprescribe for their own financial gain.

It has to be personal for all of us to succeed. Our goal is simple: no more John Deckers, no more kids anywhere.

Ed Rendell is a former governor of Pennsylvania and a former mayor of Philadelphia. rendell@ballardspahr.com

Wolf: Bolster medical school teaching on opioids

Feb 23, 2016

By Jonathan Tamari WASHINGTON BUREAU

Gov. Wolf plans to urge Pennsylvania medical and dental schools to bolster their teaching on pain management and opioid addiction to help fight prescription drug abuse, he said Monday.

Speaking at a White House briefing, Wolf said he hoped Pennsylvania would follow Massachusetts, where medical and dental schools last year agreed to start requiring students to demonstrate skills aimed at preventing painkiller abuse.

"That is a really good idea that Pennsylvania can learn from," he said. "Twenty percent of all doctors in the United States come through Philadelphia. Pennsylvania can play a big role in making sure that that becomes integrated into the teaching. "

Wolf spoke alongside Massachusetts Gov. Charlie Baker and Michael Botticelli, President Obama's director of national drug control policy, at a briefing on efforts to stem the surge in opioid addiction.

Pennsylvania saw 2,400 deaths from drug overdoses in 2014, Wolf said. The commonwealth ranked ninth in such deaths from 2011 to 2013, according to one study.

Wolf and Baker both said one key to fighting addiction is cutting down the number of painkiller prescriptions and the amount of such drugs in circulation. "I've never seen an issue in my life with the kind of negative momentum that this one has," said Baker, a Republican.

In November, Massachusetts' four medical schools, working with the Massachusetts Medical Society and Baker's administration, developed 10 "core competencies" that

students would be required to show. Dental schools in Massachusetts announced a similar agreement this month.

The topics include considering pain management options, discussing risks with patients, evaluating addiction risk, recognizing signs of abuse, and treating addiction as a chronic condition.

Some schools already covered those topics, but the agreement was aimed at making the education more uniform.

Wolf heard about the idea at the National Governors Association meeting in Washington last weekend. He has not taken formal steps to implement the idea, but a spokesman said he had asked his staff to look into it.

"I don't think that this is something that you need to legislate," Wolf said. "Medical schools are waking up, like the rest of us, to this problem, and they want to make sure their graduates are prepared. "

Staff at two Philadelphia schools said they already cover opioid addiction, but would be open to new ideas.

The Philadelphia College of Osteopathic Medicine "would look at all possible resources that would allow the institution to provide the best possible training," spokeswoman Renee Cree wrote in an email.

Anita Gupta, an anesthesiologist and pain specialist at Drexel College of Medicine, said pain management and addiction are integrated into the school's curriculum, "but I don't believe anything we're doing now is enough. "

She said she welcomed the governor's interest, but added, "No one wants regulation or mandates on how to educate future doctors. "

Gupta said medical students would benefit from more clinical experience with patients who suffer from chronic pain. Drexel's one-month pain rotation is optional.

Wolf also touted several other ideas already in place in Pennsylvania, including giving state police naloxone, a medicine that can counteract overdoses. Over the last year or so, more than 600 Pennsylvanians have been saved by naloxone administered by local and state emergency responders, his office said.

The state Health Department is also working to build on existing prescription guidelines and monitoring programs.

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Staff writers Stacey Burling and Sam Wood contributed to this article.

After video of OD on bus comes an arrest

Feb 24, 2016

By Caitlin McCabe

STAFF WRITER

Taken by a SEPTA camera, the video is shocking.

It shows a young man, surrounded by a dozen other riders on an afternoon bus in Delaware County last week, shooting heroin into his arm.

Then he slips into a daze and collapses on the floor.

Minutes later, police and paramedics bound aboard the bus, administer the drug Narcan, and revive the passenger.

Upper Darby police released clips of the video Tuesday, an unusual step designed to highlight both the potentially devastating effects of the heroin epidemic and the lifesaving steps responders now regularly employ.

“There is a lot of value in seeing how people who are addicted will go to whatever ends to use drugs,” Upper Darby Police Superintendent Michael J. Chitwood said. At “1 p.m. on a Thursday afternoon, 30 or 40 people on a bus . . . it’s devastating. “

The video’s release also coincided with his department’s newest strategy on opioid abuse: arrests. On Tuesday, police arrested Michael Meeney, the Middletown Township 25-year-old saved last week on the Route 111 bus, on heroin possession charges.

The case reflects the opioid epidemic coursing across the country. On Monday, Gov. Wolf was one of two governors at a White House briefing to discuss the surge and what states and municipalities can do about it. Pennsylvania recorded 2,400 drug overdoses in 2014, Wolf said.

Charging people for drug use could be complicated by Pennsylvania’s Good Samaritan Law, passed in 2014 to prevent law enforcement from prosecuting a person who calls for help amid a drug overdose. The law is designed to grant immunity to the person who called for help or the person overdosing, as long as they cooperate with authorities.

Most overdose victims are not arrested, Chitwood said. Usually, the focus is on immediate medical treatment.

Chitwood said officers arrested Meeney because he injected the drug and passed out in a public place. Police also allegedly found four small bags of heroin in his wallet, which led to the possession charges.

Chitwood said Meeney was charged in part to force him into treatment - ideally, ordered by a judge, he said.

“OK, we saved a life, for what? “ Chitwood told reporters at a news conference. “So that [he] can continue down a path of addiction? “

Chitwood said the incident began Thursday around 1, when Meeney boarded the bus as it headed toward Chadds Ford. Within minutes, he pulled out a needle and injected heroin

into his arm, the video shows.

When Meeney collapsed in the aisle, other passengers called 911.

Upper Darby police and paramedics used Narcan, the FDA-approved nasal spray used to reverse the effects of opioids . It was the 58th time Upper Darby police had successfully used Narcan since December, the department said.

Meeney was treated at a Delaware County hospital, and released. Police later obtained an arrest warrant and served it on him Tuesday. After not posting bail, Meeney remained jailed Tuesday night.

Chitwood said he did not show the video just to talk about Meeney's arrest. "Hopefully, as a result, he can get help," he said.

Some law enforcement agencies across the country have begun moving away from arresting drug users, using different strategies to encourage them to seek help.

Chitwood said he and Upper Darby Mayor Tom Micozzie have been in talks to create a haven at the police station for people who voluntarily seek help for drug addiction. In theory, he said, a person who asks for help would be linked to social workers, rehabilitation centers, or counseling programs to help with treatment.

But Chitwood said he believed users often do not seek help after they are saved by Narcan. When not barred by the Good Samaritan Law, he said, Upper Darby police will arrest users after they are medically treated, in the hope that a court may order their attendance at a drug-treatment program.

"The only way a guy like this is going to get [help], he has to go through the system," Chitwood said. "He's not going voluntarily."

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Fighting the gruesome grip of heroin

As a suburban family learned the hard way, a magnet for lost souls in Phila. is not so far.

Mar 02, 2016

By Barbara Laker

STAFF WRITER

The day Heaven Harkins' brother brought her back from the dead started out like so many they had shared.

It was the Saturday of Easter weekend last year. Fresh out of rehab and drug-free for three months, Heaven, 21, and Jason, 24, drove from their family's comfortable suburban home to "The Ave" in Philadelphia's Kensington section, ground zero for dope's lost souls.

The siblings scored 14 bags of heroin for $120 and parked their black Ford Focus at the ShopRite on Aramingo Avenue in search of the euphoria she desperately missed and he knew just as well.

Heaven pulled a couple of bags of white powder out of her bra, mixed the heroin with water, filled a syringe, and plunged the needle into her arm. Her eyes closed, her head slumped forward.

"She just died," Jason recently recalled.

"Her face was white. Her lips were purple. She was like a body in a casket. I felt her heart. Nothing. She was dead. "

Jason frantically called 911.

The dispatcher told him to pull her out of the car, elevate her head, and do CPR.

Jason, who hadn't yet injected, carried his sister onto the pavement, tilted her head back, crossed his hands to pump her chest, and blew air into her mouth.

"All of a sudden she let out a big gasp of air," he said.

Paramedics arrived and gave Heaven a dose of Narcan, an opioid overdose antidote, then took her to a hospital.

Now alone in the car, Jason shot up before driving back to the hospital to get his sister.

"As soon as I walked out the door, I got high again," Heaven, now 22, recently recalled.

"I was sick. I had no choice. If heroin was in my pocket, I was going to use. "

Number-one cause

Opioid overdoses are now the number-one cause of accidental deaths in the state and the nation, killing more people each year than car accidents. Pennsylvania leads the nation in drug overdose death rates among young adult men - and Bucks County, where the Harkins family lives, ranks first in the state on that score. The death rate from overdoses in Bucks has more than doubled in the last 15 years.

Unlike drug epidemics of the past, opioid abuse often starts in a suburban physician's office with a prescription for an opioid painkiller before escalating into street dealing of pills and then heroin. Another difference: More parents are talking about what once was taboo in hopes of reaching others who believe heroin could never claim their children.

Eddie and Paula Harkins, both 48, describe Jason and Heaven as "perfect children," driven high school students, constantly busy with activities and part-time jobs. Jason picked up the saxophone at age 3, playing in bands and Mummers parades when he wasn't playing football or softball or boxing. Heaven played softball, too, and loved ballet, jazz, and tap.

They both graduated from Bensalem High School and went on to Bucks County Community College.

For both, the road to heroin started with Percocet, a prescription opiate, but it was a road they traveled separately.

A doctor prescribed Percocets to Jason after he suffered a severe back injury from softball. Before long, Jason was hooked and needed more than the prescription provided.

"One day I saw him buying some from someone and we realized we were both doing it," said Heaven, who got her supply from friends. "Everybody in the neighborhood" would pop pills in the woods near the family's charming 1752 home, with an inground pool and waterfall pond.

After about 10 months, the siblings and their friends switched to heroin, first sniffing it, then shooting up.

"The Percs got to be $30 a pill, and heroin was $10 a bag," Jason said.

Jason and Heaven got to know Kensington Avenue, a favorite haunt of heroin addicts. The newbies are easy to spot, with their wide eyes, clean clothes, and backpacks. The longer they stay, the more they deteriorate. Many are homeless and sleep on the street, in alleys, or in what they call abandominiums.

Paula and Eddie had no idea that their children were scoring drugs in the very neighborhood they had worked so hard to escape.

Paula, who grew up in a rowhouse on F Street, got pregnant in high school and had her son Stephen when she was 17.

She and Eddie married in 1989, and Eddie adopted Stephen. They moved to Bucks in the early '90s and built a solid middle-class life. Eddie is now an information technology specialist for the Federal Reserve Bank of Philadelphia, and Paula is a dealer at the Parx casino.

Stephen, now 31, is in prison for selling marijuana and threatening the police officer who arrested him, they said.

It didn't occur to them that Heaven and Jason could get in even more trouble.

The first signs were subtle.

"They were sleeping a lot and didn't seem to want to do much," Eddie recalled. "They hid it well."

But then cash started to go missing. Heaven and Jason pawned flat-screen TVs, phones, laptops, stereos, a food processor, artwork, even Jason's beloved $4,000 saxophone. Anything for their next $10 hit.

Once he got addicted, Jason said, he needed heroin just so he wouldn't feel sick.

"To withdraw from heroin is hell on Earth," he said as he stood in the kitchen on a recent Saturday, pacing and smoking cigarettes.

"You feel like you're going to die, like you want to rip your legs off and just end it. "

Tried rehab and failed

The kids tried rehab and failed. They continued to steal. Their parents thought maybe tough love was needed. They kicked them out and dead-bolted the door. When they were at work, Jason and Heaven would sneak into the four-car garage and sleep on pool floats and outdoor cushions.

Paula and Eddie kept their despair from family and friends.

"I used to hide it from everyone and that eats you alive," she said.

"I didn't understand why. Just why? What did I miss? Everything went to the kids. Did I spoil them? Did I give them too much? Where did I go wrong?" she asked.

"I was just so scared they were going to die. All we did was worry. "

Michael Armstrong, a family friend who works at Liberation Way, a Yardley drug treatment center, described the family as "remarkable, loving, very honest, and very genuine. "

He praised their courage for sharing their story: "People would be naive to think that this couldn't happen to their family. It can happen to any family. "

Eddie Harkins said he once would have judged parents with two addicted children.

"I was one of those people," he said. "I would have blamed the parents. But then it happened to us. I've learned how bad it is for so many people. I can't believe the number of families who are going through this. "

Desperate for money

As Jason and Heaven grew more desperate for money, they rented their car to drug dealers. It wasn't really even theirs to rent. Heaven made the $8,000 down payment, but then everything she had or stole went to heroin. Her parents took over the payments, and tried to hide the car or trap it behind their own vehicles to keep their daughter from driving. "But Heaven always found a way to steal it back," her mother said.

Then Jason, Heaven, and her former boyfriend swiped artwork that their parents had stored for the owner and pawned it for $2,800. They were charged with theft.

Right after they left court on the case last Aug. 20, they headed to Kensington.

Heaven shot up a bag of heroin and started babbling about the car registration. Jason tried to take the wheel, but she pulled out of the Walgreens parking lot onto Kensington Avenue under the El. Jason was looking down at his phone, so he didn't notice that his

sister had started to nod off and pass out.

She slammed into a parked police cruiser. One cop was in a nearby store, the other was standing on the sidewalk and saw what happened.

Heaven and Jason were arrested.

Their father calls the crash "the best thing that ever happened to me. The car is gone. And for now, the kids are safe," he said.

Heaven, charged with aggravated assault, reckless endangerment, and DUI, was sent to rehab. Now she lives in a halfway house in Port St. Lucie, Fla., and works at a treatment center in nearby Jensen Beach.

"I'm never around drugs, and really it's not hard at all," she said with a confidence that she says she wouldn't have if she still lived where she used heroin. She wants to stay in Florida, go to school, and become a counselor.

She came home recently for court on her aggravated assault case. The visit coincided with her 22nd birthday, so family and friends celebrated at home with pulled pork sandwiches, pasta salad, cookies, chips, and iced cakes.

Jason has been in treatment at Liberation Way in Yardley since December. He is prescribed suboxone, a synthetic opioid that helps prevent heroin cravings, and he can come home for visits.

Still suffering from the severe back pain that started him on Percocet, he chose to not sit in the kitchen, only to pace or stand, while taking several smoke breaks outside on the deck.

"He's grown up a lot in the last year," his mom said. "I'm very proud of him. "

Jason said he hasn't used heroin since the August crash. "You have to want to get sober," he said.

Is it forever?

"Never say never, right?" he responded.

His mom looked down, her expression changing from pride to anguish.

When his back pain is at its worst, he thinks of the relief that Percocets gave him.

"My fear is that I will worry about this the rest of my life," his father said.

"I don't want someone showing up at my door with bad news. I don't want to bury my kid."

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Pa. drug deaths far outpacing the nations rate

The biggest increases since 1979 were among white women ages 35 to 44, an analysis found.

Mar 11, 2016

By Don Sapatkin

STAFF WRITER

Accidental drug deaths among whites, women, and people ages 35 to 44 are much higher and rising far faster in Pennsylvania than nationally, according to a detailed analysis released Thursday that covers more than three decades.

The examination by researchers at the University of Pittsburgh goes well beyond the already worrisome data showing that the state's overdose fatality rates have exceeded the national average by more than 50 percent in recent years. Between 1979 and 2014, for example, U.S. death rates rose sixfold, data from the National Center for Health Statistics show.

Yet in Pennsylvania, these deaths increased by a factor of 14. (New Jersey's fatal overdoses went up slightly more than the national average.) White Pennsylvanians? Up 16 times. The state's women? Up 17 times.

The paper, published in the open-access journal PLoS ONE, did not address reasons for the differences. What's happening in Pennsylvania may simply reflect national trends, but amplified. Overdose fatalities everywhere are trending toward younger people and whites, who often live in the suburbs, as more prescriptions for potentially addictive pain pills are written there. Women are more likely to be prescribed opioids for pain.

About 5 percent of prescription drug users move on to heroin to avoid withdrawal sickness, other research has found.

And Pennsylvania has unusually cheap, pure, and easy-to-find heroin, Jeanine M. Buchanich, a coauthor of the new study and a research assistant professor of biostatistics at Pitt's Graduate School of Public Health, said in an interview.

Overdose risk is especially high when tolerance has declined - typically when someone is released from jail or rehab, or returns to a group of old friends after a period of abstinence.

That apparently is what happened to Jennifer Rose Werstler, who had been living in a halfway house in Florida following her release from rehab in West Palm Beach.

A judge in Chester County insisted that the former manager of a burger place in Newtown Square return home for a hearing on drug paraphernalia possession charges. Her parents, who live in the house where she grew up in East Goshen Township, said they pleaded for understanding, fearful that she would meet up with old friends.

The judge turned down the request, so Werstler flew home and went to court. She went

out the next night to celebrate her birthday with friends, who scored some heroin in Philadelphia. A video camera captured her two friends leaving a Kentucky Fried Chicken store. Werstler was found unconscious by an employee in a bathroom stall.

She died in the emergency room on May 9, 2014. It was her 20th birthday.

Release from rehabilitation is a dangerous time because addiction affects the brain's "ability to make a decision and impulse control," said Beverly J. Haberle, executive director of the Council of Southeast Pennsylvania, the regional affiliate of the National Council on Alcoholism and Drug Dependence. When a substance abuser returns to familiar surroundings - and users - "the automatic response to that kind of feeling is to use," she said.

The federal data used for the new study have been around for years but independent researchers have not published analyses that went this deep or back so many years for any state, said Buchanich. The paper examined accidental drug poisonings for ages 15 to 64 in various demographic groups beginning in 1979; earlier data are not comparable.

When it comes to drugs, 1979 seems like another world. It would be nearly two decades before the government permitted prescription drug advertising on TV, considered a key driver in the demand for opioid painkillers once reserved for cancer pain.

In 1979, four black women died of accidental overdoses throughout Pennsylvania; in 2014, there were 101 deaths among black women. For white women, 34 in 1979 and 719 in 2014. Chester, Burlington, and Camden Counties recorded three deaths apiece in 1979; their respective totals for 2014 were 71, 64, and 62. Even in Philadelphia, there were just 17 overdose deaths in 1979, compared with 480 recorded 35 years later.

Among black men statewide, death rates peaked among 55- to-64-year-olds. For white males, it was ages 25 to 34.

Buchanich speculated that those differences were due to choice of drugs. African Americans are more likely to use crack and cocaine, and "they are living longer as drug users," she said, while prescription pain pills and heroin may cause "a more rapid acceleration in whites to accidental overdose death. "

Men die at far higher rates than women locally and nationally. But women are narrowing the gap, especially in Pennsylvania. For women who are white and ages 35 to 44, the 2014 overdose fatality rate was 141 times greater than in 1979.

Although it was unclear why women would be worse off in Pennsylvania, "women in general are more likely to pursue health care and they are more likely to be prescribed these therapies" - opioid painkillers - "for a medical reason," said Cynthia Reilly, a pharmacist and director of the Pew Charitable Trusts' Prescription Drug Abuse Project.

She said that women also are more likely to be prescribed benzodiazepines like Valium, which make overdoses more likely when used in combination with opioids .

Women also move on to more potent painkillers more rapidly than men, Buchanich said, a process known as telescoping.

While death rates have plateaued or declined in some states, "my sense in Pennsylvania is that we haven't reached our peak yet," she said, noting that the state's overall fatality rate

increased an average of 8.3 percent annually over the last 35 years.

Caleb Alexander, a physician and pharmacoepidemiologist at Johns Hopkins Bloomberg School of Public Health, didn't see much positive news in the study.

"At the end of the day, things are getting worse for everybody, but they are getting much worse for certain groups," Alexander said.

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	1979	2014
Bucks	0	117
Chester	3	71
Delaware	1	124
Montco	9	125
Phila.	17	480
Pa.	134	2,458
Burlington	3	64
Camden	7	123
Gloucester	3	62
N.J.	105	1,154
U.S.	3,848	39,964

SOURCE: National Center for Health Statistics, ages 15-64

A NEW PAIN PRESCRIPTION

Guidelines aim to halt steep rise in addiction. But some patients are worried.

Mar 20, 2016

By Don Sapatkin

STAFF WRITER

As a teen growing up in Lansdale, Pat Allan may have experimented with painkillers.

But what put him in serious trouble, his family believes, was the Vicodin prescribed after his wisdom teeth were removed in high school. He escalated into abusing prescription

opioids bought on the street and their cheaper cousin, heroin.

He was 30 years old when New York City police called to say he had been found dead of an overdose. His little sister Kay listened on her dad's speakerphone.

When her own wisdom teeth came out the next month, she declined the Vicodin.

"My whole family does," said Kay, now a 20-year-old nursing student at Penn State.

Last week, the federal government made its biggest move yet to educate Americans on the dangers of prescription painkillers, issuing detailed recommendations on their use.

The Centers for Disease Control and Prevention's "Guideline for Prescribing Opioids for Chronic Pain" unrelated to cancer is aimed at primary-care doctors. The 12 points range from trying nonaddictive therapies first to testing patients' urine to offering the overdose-reversal medication naloxone for families of high-risk patients to have at hand in case of disaster.

They say initial prescriptions should be for limited amounts. Research shows that many unused pills wind up in the hands of a child or sold on the street.

The guidelines largely agree with existing recommendations from other medical groups. But how they were announced guaranteed attention, especially from doctors: publication in the prestigious Journal of the American Medical Association, which also ran five related pieces. A sixth was published in the New England Journal of Medicine.

"They give us a lot more visibility," said Michael Ashburn, an anesthesiology professor at the Hospital of the University of Pennsylvania and director of the Penn Pain Medicine Center.

More than 20,000 deaths

More than 20,000 Americans a year die from prescription pain-medication overdoses. Thousands more die of heroin use, which some seek to avoid withdrawal sickness.

"That's a small city each year that's dying from these things," Ashburn said.

In the 1980s and '90s, physicians realized that pain was generally undertreated. Many worried about giving patients addictive painkillers, but pharmaceutical marketing reassured that their pain medications were safe. The government allowed direct-to-consumer prescription drug advertising for the first time, fueling demand.

Opioid prescriptions skyrocketed, reaching 259 million - more than a bottle for every adult - in 2012, and then declining slightly. Many were long-term scripts for drugs like Percocet that were intended for short-term use.

There still are no gold-standard randomized trials of these drugs' effectiveness for chronic pain. Other studies have shown little benefit, and even harm for most, but not all, patients.

"Every day I have had new caution, new concern about prescribing narcotics," said Charles Cutler, a family physician in Norristown and president-elect of the Pennsylvania Medical Society.

For decades, doctors "focused on pain when we should have focused on function," said

Chris Echterling, medical director for vulnerable populations for WellSpan Health, a central Pennsylvania hospital group.

“If your goal is to go biking, then we can get you biking with a little back pain,” he said, using other therapies without overdose risk. “If you solely track the pain out of context of function you may not be improving things. “

Charles P. O’Brien, founding director of Penn’s Center for Studies of Addiction, said most doctors have little or no training in addiction, let alone prescription opioids .

O’Brien said the first thing he teaches medical residents is to respect the addiction potential of opioids . That doesn’t mean not to use them, he said, but to understand when they are appropriate and what to expect, like withdrawal.

“Physical dependence is a normal adaptation; you take a drug and your body adapts to it and changes. When the drug stops, your body reacts to that change,” O’Brien said.

“Addiction is getting a high, doctor-shopping, doing all those things. It’s pathological. “ Genetic differences, he added, influence who goes from the first to the second.

State guidelines

In the absence of federal guidelines, many state medical societies created their own. Massachusetts Gov. Charlie Baker last week signed a law limiting initial opioid prescriptions to a seven-day supply.

New Jersey has voluntary guidelines in the works. Pennsylvania, where death rates from prescription-drug overdoses are lower - but rising faster - than the national average, released a series of recommendations for different specialties over the last year. They are posted at www.pamedsoc.org/opioidguidelines.

Pennsylvania’s guidelines make no mention of federal recommendation No. 9 - checking the Prescription Drug Monitoring Program, a database designed to detect doctor-shopping - because it is one of only two states that doesn’t have one. (That should change in August.)

Patients adjusting

But patients who fear losing the drugs they need are worried about the new guidelines. “Three days or less will often be sufficient” is one example of a recommendation that some say could make doctors cut off needed medication.

Julie Odell says the nerve condition brought on by walking into a steel beam four years ago causes her so much pain - “as if somebody stabbed you with a screwdriver in the back of your head and the tip came out your eye” - that she’d have to give up her job teaching college writing without Vicodin tamping it down.

The 51-year-old from Roxborough has tried numerous alternatives: Botox, nerve ablations, acupuncture, yoga, Alexander technique, massage, physical therapists, chiropractors, IV lidocaine, and nearly 20 medications. That would more than satisfy the guidelines, so she’s not worried about losing her access to Vicodin.

But she worries about people who can’t try so many options, like some of the people in her chronic pain support group on Facebook. “These are people in tiny towns, no specialist for

200 miles," Odell said.

"I think she has reasonable fears," said Echterling, the WellSpan physician based in York, Pa., who nevertheless strongly supports the guidelines.

Ashburn, the pain doctor at Penn, frames the question of whether and how much to prescribe this way: "Being liberal likely increases the risk of death, which of course is irreversible. . . . If you end up prescribing a little bit too low," he said, "you have an opportunity to adjust the prescription and make it right."

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Inquirer Editorial

Heroin loves the burbs

Mar 22, 2016

An alarming increase in drug-overdose deaths is finally putting more focus where it's needed - on suburban and rural communities once considered immune from addiction problems more typically associated with America's inner-city neighborhoods.

Pennsylvania, which ranks first in the nation in drug deaths among young men and third overall nationally, has become a battleground. University of Pittsburgh researchers say overdose deaths in the state increased 14-fold between 1979 and 2014. That's more than double the national rate of increase.

The study indicated that white women have been particularly susceptible, with their overdose deaths statewide jumping from only 34 in 1979 to 719 in 2014. In Philadelphia, overdose deaths among white women during that period rose from 17 to 480.

Such numbers illustrate the importance of the Comprehensive Addiction and Recovery Act, which the U.S. Senate passed earlier this month. The bill would commit $725 million over the next five years to train first responders to handle overdoses and create more drug treatment programs.

An amendment sponsored by Sen. Pat Toomey (R., Pa.) would help prevent Medicare enrollees from doctor hopping to get addictive drugs. But Toomey wouldn't support an effort to add $600 million to CARA's funding. That's unfortunate given the assessment of the Centers for Disease Control and Prevention that heroin and opioid overdoses now kill more people than car accidents.

Opioid addictions often start when a doctor prescribes a painkiller for a backache or recovery from a minor surgical procedure. Last week, the CDC heeded the call to issue opioid prescribing guidelines. In a recent Inquirer commentary, former Gov. Ed Rendell criticized pharmaceutical companies for aggressive marketing campaigns that play a role in physicians' overprescribing opioids .

About 5 percent of patients become addicted to the painkillers, studies show. Withdrawal

sickness may kick in when their prescriptions run out, so they move on to heroin, which is cheaper, can be bought on the street, and, in cities like Philadelphia, is often of much higher quality.

Many heroin shoppers take what they bought in the city back home to the suburbs to get high - and too often to die. One suburb trying to prevent overdose deaths is Upper Darby, which has started a program that invites drug addicts to go to the police station without fear of arrest to get connected with treatment programs.

Meanwhile, Pennsylvania hopes its new prescription monitoring system will be operational by late summer. That's good news. Pharmacies and physicians will be required to identify every patient who has been prescribed and purchased addictive drugs. That will provide a database that can be used to help determine which patients may be addicts.

Opioid blocker helps keep ex-cons clean

Opioid Addiction Treatment

Mar 31, 2016

By Don Sapatkin

STAFF WRITER

Giving former inmates with histories of addiction monthly injections of a medication that blocks the effects of opioids cuts relapse rates by a third, according to research at five medical centers.

Release from prison is among the riskiest times for former addicts, with the loss in physical tolerance and behavioral control so common that often "they relapse the same day," said Charles P. O'Brien, senior author of the study and founding director of the University of Pennsylvania's Center for Studies of Addiction.

Over the 1 1/2 years of the comparison study, seven participants in the non-treatment group overdosed, three of them fatally, compared with none in the medication group.

The paper, published online Wednesday evening in the New England Journal of Medicine, comes amid a slew of federal actions aimed at stemming an epidemic of opioid abuse that is blamed for 78 deaths a day.

The Centers for Disease Control and Prevention last week issued guidelines for primary care physicians to reduce prescriptions for narcotic painkillers, which are responsible for most of the deaths; others die from heroin. On Tuesday, President Obama announced a series of moves to expand treatment, improve physician training, and cut illegal access to the drugs.

Large numbers of people in the criminal justice system have histories of substance abuse, and O'Brien said that he had been urging for years that a medication to prevent relapse be issued upon release. Some systems treat prisoners with maintenance opioids such as

methadone and buprenorphine under certain circumstances, but few issue the newer, long-lasting opioid blocker tested in the new study.

The researchers recruited volunteers with a history of incarceration and substance abuse who did not want to be on the better-known opioid maintenance therapies. They were assigned randomly to two groups.

The 155 people in the control group received the "usual treatment": substance-abuse counseling and referrals to community treatment programs.

The 153 in the treatment group were also given monthly injections of extended-release naltrexone, a non-narcotic opioid "antagonist" that works by blocking opioid receptors. Heroin or any other opioid would have no effect while the person is using the blocker medication, sold under the brand name Vivitrol.

The injections ended after six months. At that point, 43 percent of the treated group had relapsed compared with 64 percent of the controls, and the median amount of time before relapse was 10 1/2 weeks as against five weeks. It also calculated that five people had to be treated in order to prevent one relapse. Many public health initiatives, such as vaccines and screenings, require treating hundreds of people to save one individual from disease.

The participants were tracked for an additional year, with the effects of the medication waning over time until the two groups were roughly equal. That suggested continuing treatment longer might be more effective.

Research shows that the three main kinds of medication-assisted therapy - methadone, buprenorphine, and Vivitrol - are far more effective than programs such as Narcotics Anonymous or even residential treatment that is based entirely on counseling without medication. But the counseling is critical to the drug therapy's success; adding medication helps former users to focus more intently on changing their lives. That may be even more important for people getting out of prison.

"They have no family support," said Akia Feggans, director of behavioral health for Philadelphia Fight, an AIDS services organization that works with recently released prisoners. "It's more than just willpower," Feggans said. "It's learning, 'how do I deal with being angry, how do I deal with a family that is dysfunctional. ' " The usual reaction, she said, would be to "go back to what you know": using drugs.

O'Brien said there were two key messages in the study findings.

"If someone is scheduled to get out of prison with a history of opioid addiction, you could give them one injection, and at least for the next month, they cannot relapse," he said. A colleague at Penn is just starting a study with prisoners in Philadelphia that will give Vivitrol before release.

The second message, he said, is that doctors must be trained in pain management, as well as dealing with addiction to pain medicine. O'Brien said many physicians have never heard of naltrexone.

Among the announcements made by the Obama administration on Tuesday was the agreement by 60 medical schools to include instruction on prescribing opioids . The list includes just two schools in Pennsylvania: Penn, which has required instruction for

decades based on O'Brien's work, and the Philadelphia College of Osteopathic Medicine. On the list in New Jersey: Rowan University School of Osteopathic Medicine and the Rutgers Robert Wood Johnson Medical School.

Laura Bamford, a physician who prescribes substance-abuse treatment at Fight and another clinic, said that release from prison is "a perfect time" to give extended-release naltrexone but cautioned that it would not be appropriate for everyone.

Because it blocks the effects of opioids , for example, someone must be clean for one to two weeks, depending on the opioids they had been abusing, or the medication will send them into withdrawal. Methadone and buprenorphine, on the other hand, contain substitute opioids that are tightly controlled.

For someone who has not used opioids , Bamford said, it is hard to understand the challenges of stopping. The brain must be retrained.

Most addicts "don't want to be using heroin or pills," she said. "It is not a conscious decision to go out and get high every day, like it is not a conscious decision for someone with diabetes to have high blood sugar. "

Both are slip-ups, and medication helps people avoid them.

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By keeping cravings at bay, medication-assisted substance-abuse treatment allows addicts to focus on the critical behavioral changes they must make to avoid relapse. Most insurance covers the medications.

Naloxone (brand name Narcan) has been in the news recently as an overdose-reversal "rescue" medication. It is not used for treatment by itself.

There are three main treatment medications:

Methadone

Method of action: An agonist, it activates the same opioid receptors as pain pills and heroin, but dispensing is tightly controlled.

Regulation: For substance-abuse treatment, pill can be given only at daily visits to certified centers until patients reach certain milestones.

Pros: Avoids withdrawal. Can be tapered.

Cons: Can be abused and lead to overdose. "Methadone maintenance" has been stigmatized over the years; some see methadone as a substitute drug.

Buprenorphine

Method of action: Partial agonist activates opioid receptors less fully. It also blocks other opioids .

Other formulation: The brand Suboxone combines buprenorphine with naloxone in a daily film placed under the tongue. The overdose-reversal part has no effect when taken

orally, but will trigger withdrawal when crushed and injected, preventing abuse.

Regulation: Physicians can prescribe it to limited numbers of patients with a special license. The Obama administration plans to relax that standard.

Pros: Private physicians can write weekly or monthly scripts. Avoids withdrawal. Can be tapered.

Cons: Current regulations limit its use.

Naltrexone

Method of action: This opioid antagonist blocks receptors, preventing other opioids from attaching.

Other formulation: The more commonly used extended-release version, sold as Vivitrol, is a monthly injection. (The brand drug was used in a new study of former inmates with abuse histories.)

Regulation: It can be prescribed by any provider.

Pros: Long-acting version avoids daily temptation to skip a pill and use. Not a narcotic; can't be abused.

Cons: To avoid withdrawal at the start, patient must be opioid -free for seven to 14 days, depending on the drug that was abused.

- Don Sapatkin

Against Opioid Abuse

Technology helping fight opioid abuse

A company in Wayne has come up with technology that would make abuse of prescription painkillers more difficult.

Apr 03, 2016

By Linda Loyd

STAFF WRITER

America is in the midst of an opioid epidemic, and Egalet Corp. thinks it can help.

The Wayne company has developed technology that makes it harder for prescription painkillers to be altered for a quick high.

The company's "abuse-deterrent" technology arrives at an auspicious time; the federal government is calling for stricter guidelines governing the distribution of opioids , and many companies are trying to find the right niche as new rules are developed.

Egalet is one of more than a dozen companies working on abuse-deterrent formulations of oxycodone, hydrocodone, and morphine, and its stock has been on a wild ride.

Egalet's stock was the best performer among Philadelphia-area publicly traded companies last year, but hit a 52-week low in March, a sign of how volatile a small pharma stock can be.

What is unique about Egalet's process is its plastic-like injection technology, similar to what is used to manufacture bottle caps and car bumpers. It produces tablets that cannot be broken into small particles to chew, crush, or dissolve.

Attempts to melt the pills result in a goopy gel too thick to get into a syringe to inject. But if swallowed normally, the pills erode gradually in the gastrointestinal tract.

Combatting opioid dependence and overdose "is a complex problem," said Jeffrey Dayno, a neurologist and Egalet's chief medical officer. "We don't think abuse-deterrent formulations are the only solution, but we certainly believe they should be part of the solution. "

Prescription painkillers have come under scrutiny because addiction and overdose deaths have reached epidemic levels, according to the Centers for Disease Control and Prevention. Sales of prescription opioid painkillers quadrupled since 1999.

The Food and Drug Administration on March 24 released draft guidelines for manufacturers to develop less-costly generic versions of abuse-deterrent prescription opioids .

Currently, the opioid medicines with abuse-deterrent features are brand-name drugs that can carry higher co-payments, such as $20 to $30, rather than $5 for a generic, depending on the insurance plan.

"The FDA looks forward to the day, hopefully soon, when the majority of opioids in the United States are marketed in effective abuse-deterrent forms," FDA commissioner Robert Califf told reporters on a conference call.

"Abuse deterrent doesn't mean abuse proof," cautioned Douglas Throckmorton of the FDA's Center for Drug Evaluation and Research. "There is not yet technology to prevent opioid abuse" by taking more than one pill, or more than prescribed. "There may always be some potential for abuse. "

Most addiction begins by swallowing pills whole, said Andrew Kolodny, director of Physicians for Responsible Opioid Prescribing. "If all our opioids were harder to crush for snorting or injecting, that would be a good thing," he said. "But it doesn't make a very big dent in an addiction epidemic because the drugs are not less addictive. "

The FDA said it will not remove older opioids from the market until it knows whether the new products reduce abuse. Companies will be required to conduct follow-up studies to measure "the real-world impact" of their products, the FDA said.

The CDC last month issued new voluntary standards, urging doctors not to prescribe opioid alternatives for chronic pain other than for cancer, palliative, and end-of-life care.

When prescribing opioids , physicians were advised to use the lowest possible effective dosage and to limit the quantity, the CDC said.

The FDA has approved five opioids with abuse-deterrent features, and may approve

as many as five more - including Egalet's first product - in the next 12 months, said Ken Trbovich, a specialty pharmaceutical analyst with Janney Montgomery Scott in Philadelphia.

Egalet's Arymo, an extended-release, long-acting morphine tablet, has been accepted for review by the FDA. If approved, Arymo would be manufactured by Halo Pharmaceutical in Whippany, N.J., and could be available by the end of the year, the company said.

"There is significant interest from the pharmaceutical industry in developing abuse-deterrent opioids ," Trbovich wrote in a client note. "But our analysis reveals they are not all equal. We think some are in a better position than others. . . . We think Egalet will be successful with Arymo. "

Trbovich said that regulatory approval could be slowed because the FDA is reviewing a number of applications for abuse-deterrent opioids . The FDA division for anesthesia, analgesia, and addiction products "has been stretched thin" and may not act "as swiftly as it normally would," he said.

Chiara Russo, specialty pharmaceuticals analyst at Cantor Fitzgerald, said Egalet's technology, has the "potential to be a best-in-class" formulation. The technology "creates an extremely hard, plastic-like material that has proven to be very difficult to manipulate using physical or chemical means," she wrote in a client note.

Egalet was founded in Vaerlose, Denmark, where researchers in the late 2000s discovered that the injection molding technology when mixed with the active opioid ingredient had "very robust abuse-deterrent" properties," said Robert Radie, Egalet's president and chief executive officer.

Given that the majority of opioid abuse occurs in North America, especially in the United States, Egalet moved its headquarters to Wayne.

Radie, the former CEO of Topaz Pharmaceuticals in Horsham, became Egalet's first U.S. employee in March 2012.

"There wasn't any reason not to base the company here," Radie said, at the company's new offices on Lee Road. The Philadelphia region is a hotbed for biotechnology and pharmaceutical development. "It was home to me, so it made sense to have the U.S. headquarters here. "

Egalet has about 50 employees in Wayne, 25 in Denmark, and a sales force of 71 who work on contract.

"We expect to continue to grow," Radie said. "We continue to build out our manufacturing capabilities and support functions for our commercial efforts and sales. "

Egalet is developing a second abuse-deterrent drug, Egalet-002, an extended-release oxycodone, currently in Phase 3 patient testing.

The company is also working on an attention deficit hyperactivity (ADHD) stimulant drug with the same heat and pressure technology to create a crush-resistant pill. ADHD pills are also prone to abuse.

Last year, Egalet acquired two commercial products that are being sold to treat pain:

Oxyado is an immediate-release abuse-deterrent oxycodone that can cause a burning sensation if someone tries to crush and snort it.

Sprix nasal spray is a nonsteroidal anti-inflammatory drug (NSAID) - not an opioid - being marketed for short-term treatment of moderate to severe pain.

Charles P. O'Brien, a physician and addiction specialist at the University of Pennsylvania, said he welcomed "any method that could reduce the likelihood of abuse.

"The way that a drug is taken is a big factor in the abuse liability and the propensity to become addicted," he said. Many drugs, not just opioids , are abused including attention-deficit medications for children through snorting, crushing, dissolving, or injecting to get "more rapid onset, pleasure, and euphoria.

"I think this is a good idea," O'Brien said, about efforts to create abuse-deterrent medicines. "My position is it's good to try it. Good luck."

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BY THE NUMBERS

18,893 – U.S. deaths from overdose of opioid pain medications in 2014, up from 16,235 in 2013.

500 – Percent increase in total consumption of oxycodone, including OxyContin, from 1999 to 2011.

900 – Percent increase in people seeking treatment for opioid addiction between 1997 and 2011.

80 – Percent of heroin users who began their drug use with opioid pain medicines.

SOURCE: Centers for Disease Control and Prevention.

Addressing opioid crisis as a top threat

At the conference, Wolf said high schools will get the drug naloxone.

Apr 13, 2016

By Don Sapatkin

STAFF WRITER

The prescription-drug addiction crisis has been more than two decades in the making. Now, all levels of government are scrambling to stop a public health disaster that Pennsylvania's top drug official described Tuesday as the worst since the 1918-19 flu.

Meetings in Philadelphia highlighted the urgency, with physicians gathering in the morning and a top federal drug official appearing at another panel in the afternoon. Meanwhile, Gov. Wolf announced Tuesday that all public high schools will get free supplies of the drug Narcan to reverse overdoses of opioid painkillers and heroin.

Gary Tennis, secretary of the state's Department of Drug and Alcohol Programs, called the U.S. epidemic the worst public health threat since the Spanish flu nearly a century ago. He predicted that within a few years, annual drug fatalities will exceed the 58,000 American military deaths during the entire Vietnam War.

Michael Botticelli, the White House official in charge of drug policy, struck a different tone before the afternoon panel at the National Constitution Center. "I'm moved by the tragedy of this epidemic but also moved by the hope of this epidemic," he said, noting that President Obama has made it a top priority and has put $1.1 billion to expand treatment in his proposed budget.

Botticelli's appointment last year as director of the White House Office of National Drug Control Policy was symbolic. He openly discusses his 27 years of recovery from alcohol addiction.

The emergency overdose-reversal drug naloxone was discussed throughout the day. Wolf announced that his administration had partnered with Adapt Pharma, which sells the rescue drug as Narcan, to supply all public high schools in the state free. The Irish company has its U.S. headquarters in Radnor.

But not all schools are likely to accept it, Tennis said, adding that some prefer to keep a drug-free public image.

And Philadelphia City Councilman David Oh announced a series of community meetings around the city about the opioid crisis focusing both on illicit pain pills and heroin. (See the schedule online at http://bit.ly/1YsqkiJ.)

Nearly two dozen doctors and other health officials from around the region spent the morning at the Philadelphia County Medical Society sharing observations and ideas. Physicians were long criticized for failing to adequately treat pain, and the response, more prescriptions of pain pills, ended up leading many patients to addiction.

But how do you hold the line on prescribing pills without harming people who genuinely need the pain relief these medications provide?

The answer is often complicated - but not always.

Andrew Gurman, an orthopedic surgeon from Altoona, Pa., who is president-elect of the American Medical Association, recalled a study by a small hand-surgery practice in Iowa. The doctors routinely prescribed 30 pills after surgical procedures for conditions such as trigger finger and carpal tunnel.

When they surveyed their patients, they discovered that most took fewer than half the pills prescribed.

"The total amount of unused opioid analgesics from these 250 patients was 4,639 tablets," the doctors wrote in the Journal of Hand Surgery. They could be swiped and sold on the street. The practice halved its routine initial prescription to 15 pills.

The overdose-reversal drug naloxone has sparked a lot of interest as well as confusion.

The U.S. Centers for Disease Control and Prevention issued opioid guidelines for primary-care physicians last month. They included a recommendation that doctors prescribe naloxone to patients who are getting pain pills legitimately but could be at risk for overdose.

At the roundtable, one doctor worried about legal liability for prescribing naloxone. Tennis, the Pennsylvania drug official, said that not prescribing it was a far bigger legal risk.

The reversal medication is often prescribed to family members, since someone who is overdosing would be unable to revive themselves. That third-party practice is unusual, and required a change in state law. The Wolf administration went further - as have several other states - in issuing a "standing order" that does not require a prescription.

But many pharmacists don't understand how it works, said Rachel Levine, the state's physician general, who has been speaking with pharmacy groups. She also said that insurance coverage varies.

The state's Medicaid program will cover naloxone prescribed to either the patient or a family member, she said. Aetna will as well, a spokesman said Tuesday. Independence Blue Cross will cover only the patient, a spokeswoman said.

A legal change also allows police - often the first to respond to an overdose - to carry naloxone. But only seven counties - including Chester, Delaware, and Philadelphia - are doing so countywide, Tennis said. About half the counties - among them Bucks and Montgomery - have partial coverage, he said.

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Peter C. Madeja

His workers comp claims firm seeks to prevent opioid abuse.

Apr 24, 2016

By Jane Von Bergen

For many, the path from opioid use to heroin addiction begins at work when an injury sustained on the job is treated, or rather, over-treated, with painkillers such as Oxycontin or Vicodin.

"So, the original injury might have been a back, a knee, a shoulder that obviously you would hope could be treated, and [the worker] healed and returned to employment,"

explained Peter C. Madeja, 57, chief executive and president of Genex Services L.L.C. in Wayne.

Genex handles workers' compensation claims for businesses as they try to keep medical costs down and return employees to work.

In March, at a time of increased public attention to the issue, Genex introduced a new service, Medication Safety 2.0, to monitor and prevent opioid addiction.

What happens to the injured workers?

"If there were too many narcotics prescribed, in many situations an addiction developed as a secondary issue. And that became even more damning than the original injury. We're often brought in where there is a related issue of addiction or abuse.

Because you monitor the workers' compensation claims, you get to see all patients' prescription histories. What does Genex's new service do with that information?

We make sure that in the treatment of that individual, the medical community is using evidentiary medical guidelines. You show them the medical guidelines to indicate why you might not want to prescribe [an opioid] for a patient with these circumstances, diagnoses, symptoms, and medical conditions.

How do you communicate this to doctors?

Between our nursing staff and our physician advisers, we'll work proactively with the physician to try to create a better solution. We'll actually accompany the injured worker to appointments.

Any other strategy?

If we see the patient is treating with a number of physicians, there's where one of the issues has come in. Physicians don't always know that, and all of a sudden [the patient is] getting prescriptions from three physicians. The benefit of our involvement is we're able to spot that.

You read about companies forcing injured employees back to work too quickly, or firing them when they get hurt. What do you see?

You're dealing with a pretty big system, so when it goes wrong, it can [still] be a pretty large number. Often overlooked is that most employers we see and deal with are really interested in the welfare of the individuals. They want to make sure that they get the right care and are treated right.

At first, you and some partners owned Genex. Then you sold it to a large public company. Next, it was owned by a series of three more public companies. Finally, in 2007, you, your team, and private equity investors repurchased Genex, which was recapitalized with new investors in 2014. Through that, how did you maintain Genex's culture?

You have to decide where you put a stake in the ground as to what's really important to the integrity of your company, your culture, and your ability to serve your customers well, versus meeting the interests of that new owner/investor, who obviously has bought the company and should have a right to do as they see appropriate. As a leader, you're trying

to balance that.

You've survived as a leader through many changes. Any advice on managing up?

Communicate when things are going well, but equally, communicate when there's a problem. [Investors] like it when they feel like they have a sense for what's going on in the business. Try to put yourself on the other side of that equation. They've made a significant investment in your business. They're responsible to people who have given them money to invest on their behalf.

Interview questions and answers have been edited for space.

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PETER C. MADEJA

GENEX SERVICES

Home: Villanova.

Family: Wife, Wynn; daughter, Davis, 18.

Diplomas: Boyertown High School; University of Pennsylvania, history, master's in education.

Early goal: Teach history and coach.

What happened: Also interested in business. A job opened at PMA Insurance; he advanced from there.

What he's reading: Mysteries by Lee Child and Jonathan Kellerman; "Killing Reagan" by Bill O'Reilly; a biography of Frank Sinatra.

First job: Detailing cars.

Business: Manages workers' compensation claims for businesses; nurses, doctors work with employees.

Where: Wayne.

Ownership: Privately held by management, investors.

Revenue: Between $400 million and $450 million.

Employs: 2,900, 300 here.

Buying spree: Integrated Care Management, Comprehensive Industrial Disability Management Services Inc., and Alpha Review Corp., all in 2015.

Genex CEO Peter Madeja on recruiting, retaining nurses. www.philly.com/jobbing

Opioid bill with local link gets OK

May 12, 2016

By Jonathan Tamari

WASHINGTON BUREAU

The House passed a bill Wednesday aimed at combating opioid abuse and named for a Gladwyne resident who died after struggling with addiction.

The John Thomas Decker Act would require the Department of Health and Human Services to study and report on the information given to young athletes about the dangers of opioid abuse, alternative treatments, and how to seek help, according to the measure's sponsor, U.S. Rep. Patrick Meehan, a Republican from Delaware County.

The bill is named for a 30-year-old who died in January. His family believes it was caused by an accidental drug overdose as John Decker grappled with heroin addiction.

Decker became addicted to pain pills after multiple surgeries for a knee injury, sustained while playing basketball. It started with an OxyContin prescription, according to his family.

"Nationwide, young people who play sports and suffer injuries have become a demographic particularly susceptible to addiction," Meehan said.

Adolescent men who play sports, he said, are twice as likely to be prescribed painkillers and four times more likely to abuse them than non-athletes.

Democrats have criticized Republicans for, in their view, talking about the opioid crisis but refusing to approve more funding to address the issue.

The bill was approved as part of a package of measures aimed at dealing with opioid addiction. It must be reconciled with a Senate package before it can head to President Obama.

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Additive may explain overdoses

W-18 is believed to make heroin so strong that the antidote is ineffective.

May 24, 2016

By Sam Wood

STAFF WRITER

Anita Gupta first suspected that the Philadelphia heroin trade could be taking a deadlier turn months ago, when she saw overdose patients at Hahnemann University Hospital who didn't respond as they should have to the antidote drug emergency workers gave them.

"The symptoms were worse than we were used to seeing," said Gupta, an anesthesiologist, pharmacist, and pain specialist at Drexel University College of Medicine. "We were getting patients with symptoms of near-death, and often required multiple doses of the antidote naloxone. "

Now she and other physicians think they may know what's to blame: A synthetic opioid called W-18 that law enforcement officials say may be circulating in Philadelphia. It's so powerful that it can cause death in microscopic doses, according to a recent Drug Enforcement Administration bulletin warning that the substance is said to increase the strength of heroin and cocaine.

"It put a name to what was already going on," Gupta said. "My suspicion is, W-18 is something we're already dealing with. "

The opioid epidemic - whether doctor-prescribed painkillers, heroin, or both - is considered the worst drug crisis the United States has ever faced. About 78 people die each day from opioid overdose, according to the Centers for Disease Control and Prevention. A half-million have died from opioids since 2000.

Naloxone, marketed as Narcan, frequently brings drug users back from the brink of a fatal overdose.

But W-18, along with a handful of other synthetic opioids that can be added to heroin without the user's knowledge, may be too strong for naloxone to reverse. And, local physicians say, it's even throwing off seasoned drug users.

"We're seeing more unexpected overdoses in patients who were chronic, stable users, suggesting there's a contaminant in the heroin they were using," said Jeanmarie Perrone, director of medical toxicology at the Hospital of the University of Pennsylvania.

Most hospital laboratories are not equipped to spot W-18, Perrone said. Law enforcement officials say they haven't been able to prove that W-18 has killed anyone here.

"It scares the living crap out of us, but we haven't seen it yet," said Patrick Trainor, spokesman for the DEA's Philadelphia office.

But according to a police informant quoted in the DEA's unclassified bulletin, users were "dropping like flies" from W-18- tainted heroin. Drug dealers were giving naloxone to

overdosing customers, according to the source. The DEA said it was not known whether the dealers were charging extra for saving their lives.

In internet forums, veteran opioid users warned against W-18. One commenter dismissed it as “not as pleasurable as heroin. “ Another cautioned that “the margin between high and death is incredibly small. “ A Reddit commenter compared W-18 to “chemical warfare” against users.

Though W-18 is often described as 10,000 times more potent than morphine, the claim is based on experiments with mice more than 30 years ago. It has never been officially tested on humans.

W-18, first synthesized more than 35 years ago, has been rising in visibility in recent months. In September, federal agents discovered more than 2 1/2 pounds of W-18 in the home of a Florida man implicated in an international fentanyl drug ring. (Fentanyl is a legal opioid , available by prescription, that sometimes is added to heroin to make it stronger.) In December, police seized nearly nine pounds of W-18 in a raid in western Canada.

W-18 is one of several so-called novel opioids , typically manufactured in China, that dealers purchase online. They’re so novel that they are not yet restricted by the DEA and remain legal to possess in the United States.

These legal synthetics have caused “upwards of 50 deaths” nationwide during the last four months, according to Barry Logan, director of the Center of Forensic Science and Education. The center is the nonprofit research arm of NMS Labs, which tests for the substances at its Willow Grove headquarters.

NMS confirmed one death in Illinois caused by W-18 and is investigating its role in another.

“The bigger problem right now is the designer opioid U-47700 and the designer fentanyl, furanyl, fentanyl,” Logan said, adding that NMS had detected the two substances in a string of fatal overdoses that reached from Florida to Maine.

Philadelphia doctors are braced for more overdoses, with or without the novel opioids .

“With so many people dying already, we don’t need this,” said Ted Christopher, chair of the department of emergency medicine at Jefferson Health. “The opioid epidemic is already a catastrophe, and this raises the ante.”

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FDA approves anti-opioid implant

A six-month option is both familiar and groundbreaking, but not without critics.

May 27, 2016

By Don Sapatkin

STAFF WRITER

With effective therapy for opioid addiction in short supply, the Food and Drug Administration on Thursday approved a new option that is both groundbreaking and familiar.

Probuphine, a six-month implant the size of a matchstick, will be the longest-acting therapy on the market. The medication that it dispenses, buprenorphine, is one of the most common for addiction to pain pills and heroin, currently available only in daily doses.

The new formulation, from Braeburn Pharmaceuticals, a small, Princeton-based company, is intended for people in stable, long-term recovery who have been on low amounts of the oral medication for at least six months.

The company said it would move quickly to manufacture Probuphine and expected to begin shipments within a few weeks. Braeburn plans to build a plant in Durham, N.C.; meanwhile, production is being outsourced to a company in Texas, with packaging by Sharp Packaging Services in Allentown.

Michael Frost, an addiction specialist whose private practice in Conshohocken was one of 23 sites nationwide for the most recent clinical trial, said the implant allowed patients to "start focusing less on my medication and more on other parts of my recovery, personal relationships, going back to school. "

Kyle Kampman, a psychiatry professor at the University of Pennsylvania who oversaw another site, said a major advantage was avoiding the daily choice of continuing treatment or getting high. The implanted drug, which contains enough opioid to keep users from going into withdrawal, cannot be diverted for street sales, he said.

Critics have dismissed it as no better than what is available now, usually sold as Suboxone.

The FDA rejected the implant in 2013, mainly for a lack of evidence of its effectiveness. The latest clinical trial was limited to patients already stable in recovery. Those data led an advisory committee in January to vote 12-5 for approval, saying the implant was about as effective as the oral version.

Behshad Sheldon, Braeburn's president and CEO, said in an interview shortly before Thursday's approval that the implant had significant advantages over current versions of the drug. A key one is overdose protection.

Maintenance buprenorphine allows patients to do the long-term behavioral work that is necessary to sustain recovery.

But the temptation to skip a daily dose and do heroin one more time remains even as the body's tolerance declines, creating conditions for an overdose.

"You don't know if a year from now, they are going to break up with a boyfriend and then slip and make a mistake and then die," Sheldon said.

More than 28,000 Americans died of opioid overdoses - prescription painkillers or heroin - in 2014, according to the latest federal data. The vast majority were not in treatment at the time, but the period immediately following abstinence - typically release from prison or rehab - is known to be high risk.

" Opioid abuse and addiction have taken a devastating toll on American families. We must do everything we can to make new, innovative treatment options available that can help patients regain control over their lives," FDA Commissioner Robert M. Califf said in a statement Thursday. "Today's approval provides the first-ever implantable option to support patients' efforts to maintain treatment as part of their overall recovery program. "

The FDA said Probuphine should be used as part of a complete treatment program that includes counseling and psychosocial support.

Braeburn, which is financed largely by the New York-based venture fund Apple Tree Partners, has weekly and monthly injections of buprenorphine in clinical trials.

Probuphine, which uses new technology licensed from Titan Pharmaceuticals of San Francisco, consists of four one-inch-long rods that are implanted under the skin on the inside of the upper arm, providing slow release for six months. It is pronounced Pro-BYOO-feen, for "providing buprenorphine. "

There are three main types of medication-assisted treatment, all shown to be more effective than 12-step and other abstinence-based programs.

Naltrexone works by blocking the effects of opioids ; patients must be completely free of the opioids before starting or they will experience withdrawal.

Methadone is a replacement opioid but is more powerful than buprenorphine and is dispensed daily under tight controls at clinics. Specially trained physicians can write prescriptions for buprenorphine, but can treat no more than 100 patients.

Buprenorphine is most commonly sold in a tamperproof version called Suboxone that must be dissolved under the tongue. It contains a small dose of naloxone, the emergency overdose-reversal medication. The naloxone is released only if the drug is crushed and abused, sending the body into withdrawal.

About 1.3 million Americans take some daily form of buprenorphine; Braeburn estimates at least one quarter meet the criteria for the implant.

The company has not announced pricing but said it would be "lower than other long-acting medications currently on the market. " That could mean up to $6,000 for six months.

Sarah Wilson said her doctors prescribed opioid painkillers after a 2008 car accident but balked at the higher doses she required, so she bought them on the street, leading to addiction.

She was successfully treated with buprenorphine but enrolled in an implant clinical trial

near her Jacksonville, Fla., home. The effects of her car crash remain. “Yes, the pain is bad,” said Wilson, 40, “but mostly I’m just grateful to be here.”

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Opioid fight starts with a dental chair

Why Dentists Write Too Many Scripts

May 29, 2016

By Paul Jablow

FOR THE INQUIRER

The dentist and the ex-cop first met about five years ago at a pain management seminar at Tufts University.

“He asked me what I was doing there,” recalls Carlos Aquino, who spent 23 years on the Philadelphia police force before retiring in 1995 as a sergeant specializing in narcotics investigations. “When I told him, he understood. “

Elliot Hersh, a professor at the University of Pennsylvania dental school who specializes in pharmacology, understood so well that he soon had Aquino lecturing his students on the dangers of overprescribing painkillers, including opioids such as Percocet and Vicodin.

“He said he wanted me to scare the hell out of them,” said Aquino, who also worked for the Drug Enforcement Administration and now advises pharmacies on DEA compliance issues.

Every fall, Aquino spends a couple of hours with Hersh’s pharmacology class, explaining what can happen to patients who overuse opioids and to dentists who illegally prescribe them. Hersh devotes 12 hours to this subject in an 88-hour course.

They are part of a nationwide push to get dental schools to help fight opioid addiction.

In April, U.S. Surgeon General Vivek Murthy announced a campaign that included a special plea to dentists and other medical professionals.

A Harvard research team reported recently in the Journal of the American Medical Association (JAMA) that “dentists are among the leading prescribers of opioid analgesics,” particularly for surgical tooth extractions.

Hersh points out that some dentists are prescribing opioid combinations that are both unnecessary and less effective than other painkilling drugs. “There are some cases where the pain is so bad you need an opioid ,” he says, “but it shouldn’t be the first thing you prescribe. Opioids have their place but only in special situations. “

Hersh said he has found that Advil is usually at least as effective as Vicodin for dental pain. He and his frequent research collaborator Paul Moore of the University of Pittsburgh

are hoping to conduct a larger study to confirm this and similar findings.

Back in 2011, they wrote in the Journal of the American Dental Association, dentists were prescribing 12 percent of immediate-release opioids in the United States.

In another study published in JAMA in 2011, data from 2009 showed that dentists were the largest source of opioid prescriptions for patients age 10 to 19. Hersh says this is the age when wisdom teeth are likely to be removed surgically.

The downside of opioids is well-known: They are potentially addictive, can lead to the use of street drugs such as heroin, and can have side effects such as nausea, vomiting, constipation and dizziness. Drugs prescribed for adults can find their way into the hands of children.

Why, then, do dentists frequently prescribe them?

In some cases, Hersh says, nonsteroidal anti-inflammatory medicines have side effects that some patients can't tolerate. Naproxen and Aleve, for example, can cause stomach issues. Acetaminophen should not be prescribed for anyone with liver disease.

But except for these cases, Hersh blames habit: Some practitioners have been writing opioid prescriptions for years and haven't kept up with the effectiveness of alternate drugs.

In other cases, they are anticipating a pain level that might occur in only a small minority of patients. For this he cites "patient expectation" as a major cause of overprescribing.

"They want a strong pain reliever and they have a perception that something with an opioid is better. And the dentists and physicians cave in. "

Patient demand is a bigger factor in recent years with the spread of clinician-rating sites on the internet: An unhappy patient delivers a bad rating that can damage a dental or medical practice.

And then there are the patients seeking opioids to feed a drug habit - which in many cases started with a painkiller prescription.

George Downs, dean emeritus at the University of the Sciences, says that in about 85 percent of cases, a well-trained physician, dentist or pharmacist should be able to spot addiction.

Hersh says that warning flags include patients who come a long way to see a dentist for no discernible reason, who want to pay only in cash, or who claim to have a list of ailments that preclude about every over-the-counter pain management drug.

"Some of them know their pharmacology better than the physician or the dentist," he says.

Aquino said that in his law enforcement career he saw cases in which patients were so desperate to get drugs from a dentist that they sliced their gums so they would get infected.

Improvements in electronic record-keeping are making doctor-shopping more difficult, Hersh says, but there is still room for error.

State health guidelines adopted last year and endorsed by the Pennsylvania Dental

Association call on dentists to refer patients with chronic pain to pain management specialists.

Aquino says he warns dental students to stick with what they know.

“Your field is dentistry, not pain management,” he tells them. “But if you get involved in pain management, you’d better do a lot of education on it.”

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Elliot Hersh, a professor at Penn’s dental school who specializes in pharmacology, says these factors all contribute to unnecessary opioid prescribing:

They’ve always done it that way. Clinicians who were trained in the 1970s and early ‘80s and haven’t kept up with new research may not realize that alternatives work as well - if not better - for postsurgical dental pain.

The image of controlled substances. Some patients and providers assume that because opioids are regulated far more tightly than over-the-counter pain relievers, they must be really effective.

Enhanced placebo response. Because these drugs are viewed as being very strong, some patients believe they are more effective, even though clinical studies indicate otherwise. But the belief leads to a placebo response, making the patient seek the drug again.

Prescribing for the most severe outcome. In outpatient surgery like removing impacted wisdom teeth, the dentist often must prescribe medication when the patient is still numb from anesthesia. Anticipating the worst leads to prescribing a drug combination including opioids when studies indicate that perhaps only one-fifth of patients truly need it.

Patient expectations and demands. Dentists may fear getting negative online reviews from patients accusing them of failing to sympathize with their pain. Rather than risk possible damage to their practice, they may write the prescription.

Sharing heartbreak, struggle, hope

Twice a month, mothers of addicts meet with women in recovery to eat a homemade meal and tell their stories.

Jun 22, 2016

By Anndee Hochman

FOR THE INQUIRER

Some insomniacs count sheep. Lori Quintavalle used to count treatment centers.

Her son Alec, now 24, had cycled through at least 10 alcohol-and-drug rehabs. He’d stay clean while in a program, but once he was out for a week or two, he’s relapse. At one point, he slept in his car in a Walmart parking lot in Florida; other times, he’d text Quintavalle,

begging for money. More than once, he overdosed; only a shot of Narcan dragged him back from death.

Keriann Meyers was a homeroom mom who planned rollicking kindergarten birthday parties and made chocolate chip cookies dipped in crumbled Heath bars. Then her marriage imploded, her husband moved out, and she tried heroin for the first time.

“I did it once, and I fell in love,” says Meyers. Each day became a chase for the drug, a frantic dance to avoid the dope-sickness that felt like flu, but a thousand times worse. “Every day was the same: How can I get money to get high? I’m still astounded by how far you can fall so fast. “

Every other Friday night at Interim House, a women’s substance-abuse treatment program housed in a former convent in Mount Airy, mothers of addicts and women in recovery (often mothers themselves) come together and tell one another their stories. In the midst of a heroin and opioid epidemic that snatched nearly 700 lives in Philadelphia in 2015, the group is a small island of survivors - those who have watched their children struggle with addiction, and those who battle the disease hour by hour, day by day.

Quintavalle started the moms’ group three and a half years ago, when her son was in a Utah rehab. She and others in her parents’ support group were anticipating the December holidays with sadness or dread. Some of them also had daughters or sons in recovery; some had kids who were living on the street. All jumped when their phones shrilled in the middle of the night.

Quintavalle took up a collection among the moms and raised enough to buy each Interim House resident a gift bag of toiletries, books, and fuzzy socks. The moms brought the bags, along with a meal, and sat down with the Interim House women for a sharing circle on a Friday night.

It was supposed to be a onetime gathering, a pay-it-forward gesture from the mothers of addicted kids to women who had been there and done that.

But they didn’t want to stop; now, Mama Bears is an every-other-Friday ritual involving as many as a dozen mothers from across the region and nearly all the 25 residents of Interim House. The women share a home-cooked dinner, then sit in a circle, pass a stuffed bear from lap to lap, and talk.

“My son is an opiate addict,” Cindy Munger tells the group on a recent Friday night. “He’s 24. He’s out of rehab again. If it weren’t for you and what I’ve learned here, I wouldn’t be as good a mom. “

Meyers is next; she arrived at Interim House on May 26 straight from jail in Chester County - a probation violation related to a previous DUI. “Today, I have 58 days clean,” she says. “I’ve had a rough week. But I’ve been hearing such good things about the moms’ group, and I feel grateful. “

She passes the bear, grown shabby from so many Friday night hugs. One woman has knitted the stuffed animal a blue poncho; another gave it a lavender scarf. Tonight, the bear wears a rosary and a fuchsia hair extension. Some women clutch it as they speak.

“I have a son who’s an addict,” says Sue Crathern of Oreland, her voice quavering. “He’s in

the midst of his fourth relapse. But coming here gives me strength to watch how you guys struggle for your recovery. “

The circle continues: Gail Campbell says that her son, who has been living in her Berwyn home for several weeks before moving in with friends, was still in bed at 3 in the afternoon Sunday. That left her frustrated. “I was trying to find some compassion,” she says. “Addiction is not a choice. “

Crystal Keller, an Interim House resident from Northeast Philadelphia, tells the group that her oldest son’s 16th birthday spurred her to seek treatment for a five-year addiction to Percoset, Adderall, and alcohol. “When I got here, I was so broken. I was scared of my own head, my own feelings. . . . I’ll never forget the first day I woke up normal. My heart wasn’t pounding. I was not searching for drugs anymore. I felt human again. “

Kathy Wellbank, program director of Interim House for 22 years, believes the moms’ group helps banish the shame of addiction; it’s a place where both sides can share their stories without judgment. It’s also a locus of unconditional love. “The women will say, ‘I can’t believe people from the outside really care about us. ‘ “

For moms like Quintavalle, the group is a source of forgiveness. “There’s nothing worse than being the parent of an addict,” she said in an interview. “You have this beautiful child, and then there’s this hurricane that comes in and destroys your family. . . . Then [an Interim House resident] will come up to you, hug you, and say, ‘It’s not your fault. ‘ “

For everyone in the circle, Mama Bears fills a void: the empty space gouged out by addiction, the place where there should be toddlers to cuddle, teenagers to hug, or moms to extend a reassuring hand.

“When I’m with these women, I feel closer to my son,” says Munger.

“They bring a mom-presence, a kind of trust,” says Meyers.

The mothers show Interim House residents that time and effort can heal a strained relationship between parents and their grown children. The residents remind the moms that recovery from addiction is difficult, but possible.

The group also muddies stereotypes: A few residents of Interim House are older than the moms who visit. Many have kids of their own. And several of the visiting moms know addiction from the inside.

“I’ve been in recovery. I haven’t had a drink or a drug in 31 years,” Campbell tells the group. “I haven’t had a drink today, and that’s the most important thing - living one day at a time. “

In the end, no one in this room wears just one identity. They are daughters, sisters, spouses, parents. Their children are in foster care, or living with a relative, or in boarding school, or rehab, or on the run. One woman has a quarter-century clean; another has 55 days. They live in big houses in Wayne or Blue Bell; they bunk two to a room in a former convent.

But tonight, after a dinner of deli sandwiches and homemade salads, and an hour of frank and tearful talk, someone pushes the coffee table out of the way, backs the couches against the walls, and puts on music. It’s the Cupid Shuffle: Now kick . . . now kick . . . now walk it

by yourself. Feet cha-cha in sneakers or flip-flops. A tattooed shoulder shimmies; hips rock to the beat. For the duration of the dance, there is no way to tell who's who.

Harrisburg sets special session on opioid abuse

Jun 24, 2016

By Colt Shaw

HARRISBURG BUREAU

Taking a significant step to deal with what he has called a statewide crisis, Gov. Wolf said Thursday that he would call a special session of the legislature this year to address the prescription opioid epidemic.

The session will convene "by the end of the summer, if not early fall," said House Speaker Mike Turzai (R., Allegheny), and will focus on finding solutions to an issue rippling across nearly every community.

The announcement came as lawmakers from both parties and the governor gathered in the Capitol rotunda to renew attention on a problem that has grown dramatically in recent years.

Almost two-thirds of the 47,000 overdose deaths nationwide in 2014 were opioid -related, according to the Centers for Disease Control and Prevention. That year, Pennsylvania recorded about 1,600 overdose deaths from opioid medications and 800 from heroin, the state Coroners Association reported.

Wolf has traveled around the state during the last year for roundtable discussions with experts and others on how to prevent or reduce opioid abuse.

"Our fellow citizens are looking to us for action," he said Thursday, calling such addiction "a Pennsylvania problem. "

Other states have made opioids a front-burner health issue. Gov. Pete Shumlin of Vermont devoted his entire 2014 State of the State address to opioids . Gov. Christie has spoken passionately about them.

In Pennsylvania, special legislative sessions have historically been reserved for the most important issues facing the state. Only four times since 2000 have lawmakers convened to brainstorm on a critical issue.

G. Terry Madonna, a professor of public affairs at Franklin at Marshall College and a longtime Capitol observer, said such sessions have a "checkered history" of efficacy.

"Many have not produced much in the way of meaningful legislation," he said.

Still, Madonna said he would be surprised if this session did not produce results, given the attention to the epidemic.

At their news conference, legislators noted that there has been some progress. A legislative task force was formed two years ago to focus on opioid abuse and deadly overdoses. And on Thursday, the House passed three bills that in part grew out of that task force's recommendations.

One sets a seven-day limit, with exceptions, on the prescription of opioids in emergency rooms. Another would require health insurers to cover "abuse-deterrent" opioid medication. The third would require doctors and other health providers to further their education in opioid effects before prescribing the drugs to patients.

The House has also passed a bill setting guidelines for the proper disposal of unused prescriptions. All now move to the Senate for consideration.

The topic could get direct action from the legislature before then. Among other measures, Wolf is pushing for an additional $34 million in next year's budget to treat more than 11,000 residents who currently are receiving no treatment.

The budget deadline is July 1.

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DEA:Drug deaths a worst epidemic

Report shows rapid jump in OD deaths

Jul 13, 2016

By Don Sapatkin

STAFF WRITER

Drug overdose deaths in Pennsylvania jumped more than 23 percent last year, the Drug Enforcement Administration reported Tuesday, by far the biggest increase in at least a decade and a sign that the addiction epidemic remains out of control.

An analysis of drug-related fatalities by the DEA's Philadelphia Field Division found a 5 percent rise in deaths involving heroin, along with an astonishing increase - up 93 percent in one year - in the presence of the synthetic opioid fentanyl in the bodies of people who died of overdoses. It also found a resurgence in cocaine, which was detected in 41 percent more cases. Most people had multiple types of drugs in their bodies, coroners found, so it's not always possible to blame one substance.

"The nation and the commonwealth are in the throes of the worst drug epidemic in the country's history," Gary Tuggle, special agent in charge of the Philadelphia division, said at a news conference.

He said his division is the only one in the country to produce a state report, so comparable DEA data for New Jersey and other states were not available. Annual mortality data from the U.S. Centers for Disease Control and Prevention have not yet been updated for 2015.

Pennsylvania had the eighth-highest overdose death rate in the nation based on 2014 CDC data.

But Tuggle said his colleagues in DEA offices across the country have told him that they, too, are seeing considerable increases.

Just a few years ago there was short-lived evidence of a plateau. A raft of state and federal actions - from making the overdose-reversal medication naloxone more available, to new guidelines on prescribing the painkillers that can lead to addiction - have been taken since then. Yet deaths keep climbing.

The U.S. Senate on Wednesday is expected to approve and send to President Obama a comprehensive bill to expand treatment and prevention programs. The compromise measure passed overwhelmingly by the House last week leaves out nearly $1 billion in funding sought by the administration; Republicans said money would be added during the regular appropriations process.

“This problem is growing,” Jeremiah A. Daley, executive director of the Philadelphia-Camden High Intensity Drug Trafficking Area, an interagency antidrug program, said at the Philadelphia news conference. He described the new numbers as “absolutely stunning and very discouraging. “ He said that Southeastern Pennsylvania was in an “acute crisis. “

Opioid addiction cuts across racial, geographic, and economic lines. The DEA reported that white males ages 30 to 39 accounted for 15 percent of last year’s drug-related deaths, the largest demographic group, even though they made up less than 5 percent of the state’s population.

Philadelphia historically has had high drug overdose fatality rates, but some suburban counties drew nearly even with the city in recent years, CDC data showed, as overdoses from prescription drugs such as Percocet and hydrocodone rose quickly in higher-income areas.

Philadelphia has once again pulled ahead, with 720 drug-overdose fatalities last year, the DEA reported, a 10 percent increase over 2014. That equals 46 deaths per 100,000 residents, the highest rate in the state.

Another disturbing surprise was in Delaware County, where officials have aggressively sought to reduce overdoses. The county was among the first in the state to distribute naloxone to first responders in late 2014, soon after state law was changed to allow it.

But Delaware County had 202 overdose deaths last year, up 41 percent from 2014, for a rate of 36 per 100,000 residents.

County-level numbers vary from year to year, so short-term changes do not necessarily indicate a trend.

Locally, Bucks County reported 117 drug-related deaths last year, up 4 percent, for a rate of 19 per 100,000 residents. Chester County’s 63 deaths was unchanged from the previous year and remained the lowest in the region, with a rate of 12 per 100,000. Montgomery County’s 136 deaths represented a 16 percent decline for a rate of 17 per 100,000.

The DEA said that 3,383 Pennsylvanians died of drug overdoses last year, a rate of 26 per 100,000.

Coroners found heroin in 55 percent of those who died. Fentanyl, which is many times more powerful and is mixed into heroin by drug dealers to make their product both cheaper and stronger, was detected in 27 percent of cases, and cocaine in 24 percent.

Fentanyl is a prescription painkiller but is more frequently showing up in forms created in illegal laboratories, Tuggle said, often shipped from Mexico, China, and India. Pennsylvania coroners for the first time detected another form of the drug, acetyl fentanyl, which has no medical purpose. It was found in only 4 percent of cases but often would not be part of the standard toxicology screen.

Also found were several prescription opioids , such as oxycodone (19 percent) and hydrocodone (6 percent).

There is evidence that use of prescription opioids is declining nationwide, but drug officials and addiction specialists say that the changes in law and prescriber practices responsible for that decrease are likely leading to more heroin use as people addicted to pills seek a way to avoid opioid withdrawal.

At Tuesday's news conference at the William J. Green Federal Building, down the block from Independence Mall, three career law-enforcement officials - Tuggle, Daley, and Zane D. Memeger, U.S. Attorney for the Eastern District of Pennsylvania - stressed the importance of expanding treatment.

Catching people before they make the move to heroin is critical, Tuggle said. He recalled some of the drug crises that have struck America in the past, from opium in the mid-1800s, to LSD in the 1960s and crack cocaine in the 1980s.

"Heroin has something that the others did not," he said. "It has a feeder system: prescription opioids ."

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Wolf: Pa. plans 20 opioid treatment sites

Jul 15, 2016

By Don Sapatkin

STAFF WRITER

Pennsylvania will open 20 centers around the state by fall to coordinate care for people addicted to opioids , the Wolf administration announced Thursday.

The centers - six of them in Southeastern Pennsylvania - will not be new locations, but instead are existing organizations that will function as navigational hubs to coordinate a range of services for Medicaid patients. By integrating treatment for substance abuse, mental health, and physical health, their mission is to help ensure patients get all the

types of care proven to promote recovery.

The concept, which is being tried in a handful of states, in some ways resembles the "medical home" model that has been gaining popularity in primary care.

Having a single provider take responsibility for coordinating a patient's needs is especially critical in the disjointed addiction treatment system. Patients who are released from detox but fail to follow up with medication-assisted treatment to lessen their craving for heroin, for example, are at very high risk of relapse and overdose.

Adam C. Brooks, who studies the effectiveness of different types of addiction treatment for the Treatment Research Institute in Philadelphia, called the proposal "a holistic approach for recovery. "

When he first heard about the governor's proposal a few months ago, he was impressed that it included money not only for interdisciplinary teams but also for evaluating outcomes and teaching local providers about the coordinated approach to keeping people in treatment.

"What I like about what they are doing is the focus on how you build support around people so they get the most out of it and not drop out, and get the best chance," Brooks said last month.

Nearly 3,400 Pennsylvanians died of drug overdoses last year, the Drug Enforcement Administration's Philadelphia Division reported Tuesday, a 23 percent increase over 2014. Coroners detected opioids - prescription painkillers and heroin - in more than 80 percent of the cases.

"We all know someone impacted by the opioid epidemic, and one thing has become abundantly clear - opioid addiction is an illness," Gov. Wolf said in a statement announcing that his administration was moving ahead with the plan. "In order to address this illness, we need to think about addiction treatment in a different way. Treating underlying causes gives people the best chance they have to beat their addiction. "

The administration had sought $34 million in the state budget to open 50 "Centers of Excellence. " Legislators approved $15 million, and along with $5 million in federal matching funds, the state Department of Human Services can open 20 centers by Oct. 1, said Kait Gillis, a department spokeswoman. She said the agency's actuaries were determining whether projected savings from the program could provide funding for more.

The centers will serve only patients on Medicaid, the state-federal program for low-income and disabled people. Opioid addiction disproportionately affects white, rural, and suburban Americans, many of whom start with pills prescribed by doctors for pain and end up buying more illegally on the street or, in some cases, moving to heroin.

The downward spiral of addiction can cause them to lose their homes, jobs, and health coverage, leaving many uninsured or on Medicaid. Many also have what are known as "co-occurring" conditions - mental illness or medical problems that complicate substance-abuse treatment and may need to be handled by another facility.

The team approach of the Centers of Excellence is intended to integrate all three, both in the short term and after release from treatment.

“Since opioids are so powerful, those who try to recover need different types of help in order to beat the disease. In fact, this approach has gained huge momentum as the most modern and successful way to support recovery, especially from opioids ,” Human Services Secretary Ted Dallas said in a statement.

“The intense cravings, detoxification, and withdrawal symptoms involved in quitting make addiction difficult to overcome. As our strategy involves both behavioral therapy and [Food and Drug Administration] approved medication that individuals take to help curb cravings and manage withdrawal symptoms, it can improve the odds of recovery. “

Gillis said that 116 organizations had applied to be Centers of Excellence, which will be licensed to prescribe one of the three medications approved by the FDA to assist in treatment: methadone, buprenorphine, and naltrexone.

She said that that the new centers’ staffing and focus on coordination would allow them to treat about 4,500 people who currently are not able to access treatment. Hundreds of thousands of Pennsylvanians who need treatment for all kinds of substance abuse don’t get it for various reasons, according to government estimates, although Pennsylvania does better than many other states.

Among the 20 centers announced Thursday are these six in Southeastern Pennsylvania:

Penn Foundation Inc., Bucks County.

Crozer-Chester Medical Center-Community Hospital, Delaware County.

Resources for Human Development Inc./Montgomery County Methadone Center.

Thomas Jefferson Narcotic Addiction Treatment/Maternal Addiction Treatment, Philadelphia.

Wedge Medical Center Inc., Philadelphia.

Temple University, Philadelphia.

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