Center for Rural Pennsylvania Testimony

Alice Bell, Overdose Prevention Coordinator

Prevention Point Pittsburgh

My name is Alice Bell. I have run the Overdose Prevention Project in Pittsburgh, PA since it began in 2002. In the past fourteen years, I have provided training on overdose prevention and response, including Narcan administration instruction, to thousands of individuals in the County Jail, at the syringe exchange site, treatment programs, homeless shelters, family support groups and community forums. I have listened to hundreds of accounts of overdose deaths witnessed, and, since we started the naloxone program in 2005, we have 1108 documented reports of successful rescues with naloxone prescribed through our program. Most of those reports I have heard, myself.

A man, in his 50's in jail came up to me after the training and said, "If I would have known about this a year ago, I think my daughter would be alive today." An 18 year old told me that he'd never used drugs at all himself, and he'd never had any training or experience in giving an injection, but when his mother overdosed on heroin he figured it out. Fortunately, she had naloxone, he told me: "She had all this paperwork to tell you how to use it, but I didn't exactly have time to read it. I just filled the syringe from the bottle and jabbed it in her leg and she woke up. She'd be dead otherwise."

An older couple, sent to the syringe exchange by the husband's pain doctor. "He has to take a lot of pain medication," his wife says, "and doesn't always take it like he's supposed to. His doctor wanted us to learn how to use naloxone." I think how much easier it would be for them if their doctor just prescribed it in his office, but I'm happy to offer the training. Since that time, a number of medical practices have started prescribing naloxone when they prescribe opioids for pain. But the deaths are piling up and Pennsylvania needs to take emergency measures, as 25 states and territories have already done, to make this life saving medication more readily available.

Overdose death is now the number one cause of injury death in the U.S., taking more lives each year than automobile accidents and the Centers for Disease Control and Prevention have declared fatal opioid overdose an epidemic. More than 12,000 people have died in Pennsylvania from accidental drug overdoses since 2001; over 1600 died in 2010 alone. We lose over 110 Americans every single day. [1]

I believe greater access to naloxone would save countless lives in Pennsylvania.

Naloxone is an FDA-approved prescription medication and opioid antidote that rapidly reverses the effects of overdose by displacing opioids from opioid receptors in the brain and thus blocking the effects of opioids, returning a person who has stopped breathing to life. There are no euphoric effects from naloxone, and thus no potential for abuse. Naloxone only works on people who have opioids in their system and is benign in individuals who do not.[2]

[1] CDC. Vital Signs: Overdoses of Prescription Opioid Pain Relievers—United States, 1999-2008. MMWR 2011; 60: 1-6 Drug overdose deaths have more than tripled in the US since 1990.

[2] Naloxone Injection http://www.nlm.nih.gov/medlineplus/druginfo/meds/a612022.html Retrieved November 24, 2013.

Naloxone has been used for almost five decades in emergency and operating rooms and is extremely effective. Every second counts in an overdose, so it is imperative that we get it in the hands of those most likely to witness an overdose, those most likely to be on the scene, most often friends and families. Naloxone is easy to administer. In fact, a recent study concluded that, after a brief, basic training, laypeople did just as well as medical professionals in recognizing the symptoms of an overdose, determining when to use the medication, and safely administering. [3]

The Centers for Disease Control and Prevention report that naloxone distribution programs across the country have saved more than 10,000 lives by laypeople administering naloxone to people suffering an overdose.[4] Following 15 years of skyrocketing overdose rates, Massachusetts initiated naloxone distribution programs across the state and **counties with naloxone distribution were able to drop their overdose rate almost in half.[5]**

Multiple peer-reviewed studies have demonstrated that naloxone distribution does not encourage nor increase drug use or riskier drug use.[6] Rather, naloxone distribution has been shown to prevent overdose from occurring to begin with. A NIDA funded study showed that overdose prevention education and naloxone distribution programs are extremely cost-effective. It costs more to bury our loved ones than it does to arm our community with the antidote to save their lives.[7]

The American Medical Association, American Public Health Association, National Conference of Insurance Legislators, US Conference of Mayors, and federal agencies, including Office of National Drug Control Policy, Food and Drug Administration, National Institute on Drug Abuse, Department of Justice and Substance Abuse Mental Health Services Administration, have all gone on record stating that naloxone is an important tool in reducing and preventing deaths from opioid overdose.

I have listened to countless stories of lives saved by our program. I have also listened to the anger in the voices of parents, those learning about naloxone too late and those who describe having a child come home from treatment and going into their room at night to make sure they are still breathing, incredulous that they do not have access to this medication, not understanding why it is not available in every home first aid kit. I am at a loss to explain this to them. If they lived in New York, they could get naloxone, or in Kentucky, or Georgia, but not in Pennsylvania? We have the opportunity to join the other 25 states and territories in our nation that have passed legislation to make it easier for people to have access to this lifesaving medication.[8]

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[3] Green TC, Heimer R, Grau LE. (2008) Distinguishing signs of opioid overdose and indication for naloxone: an evaluation of six overdose training and naloxone distribution programs in the United States. Addiction 103(6):979-89).

[4] Eliza Wheeler, et al., Community-based opioid overdose prevention programs providing naloxone - United States, 61 MORBIDITY & MORTALITY WKLY. REP 101 (2012).

[5] Alex Walley, et al., Opioid overdose rates and implementation of overdose education and nasal naloxone distribution in Massachusetts: interrupted time series analysis, 346 BMJ f174 (2013).

[6] Seal KH, Downing M, Kral AH, Singleton-Banks S, Hammond JP, Lorvick J, et al. (2003)

[7] Phillip O. Coffin, MD, and Sean D. Sullivan, PhD, Annals of Internal Medicine, Cost-Effectiveness of Distributing Naloxone to Heroin Users for Lay Overdose Reversal

[8] Corey Davis, J.D., M.S.P.H., Network for Public Health Law, Legal Interventions to Reduce Overdose Mortality: Naloxone Access and Overdose Good Samaritan Laws, pg.2. For a graphical representation of these laws, please see the relevant LawAtlas map at http://www.lawatlas.org/preview?dataset=laws- regulating-administration-of-naloxone.

House Bill 2090 contains the necessary provisions to allow programs like ours to make naloxone more widely available. It also contains language that would facilitate development of similar programs throughout the state as well as encouraging physicians and drug treatment programs to implement overdose prevention efforts by providing naloxone. Senate Bill 1376 contains similar language and both of these bills also contain Good Samaritan language that would encourage those reluctant to call 911 in an overdose situation to do so without fear of arrest, which in itself could save many lives. Senate Bill 1164 has much weaker Good Samaritan language and would be less effective in encouraging calls to 911, but the provisions regarding naloxone are equivalent to the two other bills and any of these three bills would make naloxone more broadly available. Let's use this opportunity wisely and arm individuals, families and communities with the tools they need to protect the lives of their loved ones.

We recognize that these efforts do not solve all the problems that heroin and prescription opioids bring to our communities. The larger problems are complex and require a multifaceted response. We need to reduce the ease of access to prescription opioids, which involves making changes to the way that we treat and manage pain in the long term. But, in the short term, efforts to reduce the availability of prescription pain medication has led us to a problem of heroin in suburban and rural areas. This creates a very real need for increased access to effective treatment, and evidence based prevention strategies to address HIV and Hepatitis C. Rural Pennsylvania is especially vulnerable to a potential public health crisis brought on by exploding hepatitis C rates, all of which could be mitigated with proven, cost-effective strategies already at our disposal. Thank you for the opportunity to testify and share with you the decades of experience of Prevention Point Pittsburgh. We stand ready to work with the Center for Rural Pennsylvania and other stakeholders testifying today to implement these strategies and save the lives of fellow Pennsylvanians.

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