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Before the Senate Finance Subcommittee on Health Care
Field Hearing on Opiate Abuse in Southwestern Pennsylvania

October 15, 2015

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## Introduction

Chairman and members of the Committee, thank you very much for inviting me to speak with you today about the epidemic of opioid abuse in Southwestern Pennsylvania, which has devastated the lives of thousands of individuals and families, and has led to record numbers of overdose deaths in our region.

I am an addiction psychiatrist and the medical director at Gateway Rehab, which is our region's largest nonprofit addiction treatment provider. Our mission is to help all affected by addictive diseases to become healthy in body, mind and spirit. With 20 locations throughout Western Pennsylvania and eastern Ohio, Gateway Rehab treats more than 1,500 patients daily.

I have worked full time at Gateway since 1989 but started in the field of addiction in 1981 at St. Francis Hospital in Pittsburgh. I am board certified in general psychiatry, addiction psychiatry and addiction medicine, and I am a fellow of the American Society of Addiction Medicine.

I served as a co-chair of the Western Pennsylvania U.S. Attorney's Working Group on Drug Overdose and Addiction, and currently serve on the board of directors of the Pennsylvania Society of Addiction Medicine, the Allegheny County Overdose Prevention Coalition, and the Beaver County Prescription Drug Abuse Coalition. I also consult with many professional and grassroots groups focused on addressing the addiction problem in our community.

During my career at Gateway Rehab, I have directly been involved in treating more than 15,000 individuals in our region with prescription opioid and heroin addiction. I have personally witnessed, on a day-by-day basis, the evolution of our current opioid epidemic, which began in the late 1990s. The sad reality is that, today there are more people in our community with addiction from opioid pain pills and heroin than at any other time in our history and, if this problem is not addressed adequately, it will continue to worsen.

## Our Region's Opioid Epidemic

When I finished my residency in psychiatry in 1985, there were 22 accidental drug overdose deaths in Allegheny County, which, at that time, appropriately was viewed as an unacceptable tragic loss of lives that must be corrected.

With a rising opioid problem beginning in the late 1990s, Allegheny County saw triple-digit overdose deaths for the first time in 1998 with 104. This number remained over a hundred for the next three years and then reached more than 200 in 2002, remaining such every year since. However, in 2014, Allegheny County set a new record with 307 accidental drug overdose deaths (OverdoseFreePA 2015).

Moreover, based on population, most surrounding counties are now seeing higher overdose death rates than Allegheny County. Drug overdose deaths are now the leading cause of accidental death in our region, far exceeding traffic fatalities.

## Causes

Several factors have contributed to our current opioid epidemic; however, by far, the primary factor in our region leading new individuals into opioid addiction is prescription opioid pain pills.

In the mid to late 1990s, the medical profession came under increasing criticism for not adequately treating pain, and there was a greater national emphasis to treat non-cancer pain with opioids. However, much of this emphasis was coming from pharmaceutical companies who sold opioid pain medications. Also, many physicians declared that abuse and addiction of opioid medications was essentially a non-issue (Van Zee 2009). Then, in 2000, the Joint Commission declared pain as "The Fifth Vital Sign." These circumstances resulted in a very quick and dramatic rise in the medical community prescribing opioids for pain.

From 1999 to 2011, consumption of hydrocodone more than doubled and consumption of oxycodone increased by nearly 500 percent (Jones 2013). Unfortunately, during that same time, we saw the rate nationally of unintentional death from prescription opioids nearly quadruple (Chen, Hedegaard, Warner 2014), and the Centers for Disease Control and Prevention in 2014 described this as the "worse drug overdose epidemic in U.S. history (Paulozzi 2010).

Historically, most drug trends would start in other parts of our country and then reach Southwestern Pennsylvania several years later. However, with the prescription opioid abuse problem, Southwestern Pennsylvania was one of the first and hardest hit areas of our country. This was largely due to the demographics of our region, which included an older population and a large blue collar, working population that both have higher rates of medical problems resulting in pain. This led to heavy marketing of physicians in our area by pharmaceuticals to prescribe more opioids.

In March of 1999, I saw my first patient come to Gateway with OxyContin addiction. By July 2000, I had seen more than 300. By the end of 2005, I had seen more than 2000 people in our region with OxyContin addiction. OxyContin significantly accelerated and expanded the opioid addiction problem in our regional at a level never seen before.

By the end of 2001, we were seeing large numbers of people, of all ages and from all social economic levels, coming into treatment with opioid addiction from virtually every community in our region. As many of these people continued to use more opioid pain pills, over time they developed tolerance, which resulted in them needing larger daily amounts to keep from going into opioid withdrawal and getting sick. The average person we were seeing was using more than 150 mg of Oxycodone per day, and some more than double that amount.

The price of Oxycodone on the street at that time was approximately 70 cents to a dollar per milligram. It was costing most people hundreds of dollars a day to support their opioid pill addiction. We then started to see a growing number of people who could no longer afford their opioid pills switch to a "new" heroin that would give them a similar and often stronger effect than opioid pills for about a quarter of the daily cost. This trend continues today and has created thousands of new people in our region addicted to heroin.

Of the several thousand heroin users that I have interviewed since 2000, well over 90 percent have told me they started with opioid pain pills. This is the primary reason why, 20 years ago in 1995, heroin use was essentially unheard of in the vast majority of communities in our region, especially the suburbs and the rural communities. Now, today, fueled by opioid pill addiction, heroin addiction has spread like an infectious disease into every community in our region.

We first started seeing this "new" heroin in the mid-1990s. Most heroin in our region prior to that point, I am told, averaged about 10 percent purity. That was still strong enough to cause severe addiction and death from an overdose, but the only way to get an appreciable effect from 10 percent heroin was to inject it intravenously. However, fears over contracting HIV in the late 1980s led to an increased reluctance by many to use a drug intravenously. In the mid-late 1990s, we starting seeing people come into treatment reporting they were using this "new" type of heroin, which would give a very strong effect by simply snorting intranasally.

This "new" heroin was much stronger, usually greater than 40 percent purity, and often, in our area, reached levels of 70 – 90 percent purity. Besides just giving a much more powerful opioid effect, this stronger heroin allowed people to get an appreciable effect from snorting intranasally, without injecting intravenously. However, almost all new heroin users that I have seen in the past 20 years that started out by snorting heroin, well over 80 percent switched over to intravenous use within 6-12 months because, as they developed tolerance to heroin, they learned that using heroin intravenously gives a quicker and stronger effect. As large numbers of individuals addicted to heroin switched from snorting it to injecting it, several thousand new people in our community developed Hepatitis C.

Two other destructive trends we are seeing, which have magnified the opioid problem in our region, include adding fentanyl to heroin and opioid enhancement with sedatives.

Although heroin is very potent and results in high rates of addiction, and it alone is very capable of causing an overdose death, in what is believed to be an effort to create greater demand for their product, some drug traffickers are adding fentanyl to heroin. Fentanyl is about 70 – 100 times stronger than morphine per milligram and is much stronger than heroin alone. Due to its high opioid potency, fentanyl-laced heroin generally leads to a greater street demand and, unfortunately, spikes in overdose deaths because it is more lethal. I have talked to people who were using more than 20 bags of heroin per day who went unconscious with the needle still in their arm after only using one or two bags of fentanyl-laced heroin. We have seen several spikes in overdose deaths in our community in the last several years due to fentanyl-laced heroin.

Another growing trend, which I believe is largely unrecognized and/or neglected by much of the medical community, is the growing number of people with opioid addiction to pain pills or heroin who also take large amounts of sedatives to boost the effects of their opioids. The majority of these sedatives are benzodiazepines, drugs such as Xanax, Ativan and Klonopin. Adding these sedatives to opioids will definitely boost the effect, but it also increases the danger of an overdose death.

A significant proportion of overdose deaths we are now seeing in our area are showing a combination of opioids and sedatives. Over the past two years, approximately 50 percent of the individuals coming to Gateway to seek treatment for abusing opioids also are addicted to sedatives and, if not detoxed properly, sedative withdrawal can result in seizures and possible death.

Some have referred to our current opioid epidemic crisis as a "perfect storm" that resulted from the dramatic rise in opioid pain pills at the same time the "new" and stronger heroin was introduced. These factors, along with the enhancing effects of fentanyl and sedatives, have continued to fuel this storm of opioid addiction in our community to now the highest level ever seen.

## Recommendations

Unfortunately, there is not one easy, clear solution to this problem. It is clear that properly addressing this problem will require a large, multidimensional collaborative effort from many parts of our community. The Western Pennsylvania U.S. Attorney's Working Group on Drug Overdose and Addiction, under U.S. Attorney David Hickton, which I co-chaired along with Dr. Michael Flaherty, released a comprehensive 51-page report in September 2014, which discussed this issue in detail and offered many recommendations (U.S. Attorney's Working Group on Drug Overdose and Addiction 2014).

One other obvious and important area of focus is the proper and safe use of opioid pain pills. There is consensus within the medical community that it is important to treat pain properly, and that no individual with legitimate pain should be neglected. The challenge, though, is to treat pain adequately while minimizing the potential for addiction, not only in the patient but also in the community. This will require several measures, including better education of the medical community and the public, along with better management and monitoring of opioid pain medications. This would include not only an assessable state prescription drug-monitoring program (PDMP) for health professionals, which we hope to soon have in Pennsylvania, but, also, a national monitoring program for all scheduled prescriptions to minimize interstate drug diversion, which is a significant problem in our tristate region.

Use of PDMPs by a health professional is an integral part of practicing responsible medicine. A responsible physician would not order antihypertensive medication for a patient without first checking their blood pressure or order insulin without first checking blood glucose. Therefore, in light of our current opioid epidemic, a responsible physician should not order powerful opioids without first checking a prescription database.

One study (Baehren 2010) showed that physicians who check a PDMP changed their original decision about the prescribed medication more than 40 percent of the time. The majority of these changes were to prescribe less medications, but in some cases more because it helped build trust with legitimate patients. Another study (Feldman, Williams, Coates 2012) found that use of a PDMP increased physician confidence that the medications they prescribed were medically warranted.

In light of the significant problem we have with prescription medicine abuse in our community, I believe the actions called for in Stopping Medication Abuse and Protecting Seniors Act [S. 1913] or lock-in bill are very much needed. The patient would continue to have adequate access to necessary medical care and medications in a manner that would likely improve the quality of their medical treatment, and reduce the likelihood of them progressing into addiction. It would also help to protect the public safety by minimizing the possibility of drug diversion in the community. In addition, it would likely result in saving taxpayer dollars.

For those individuals currently struggling with addiction, it is very important to offer them evidenced-based, comprehensive treatment of adequate intensity, and for a significant period. For those seeking help, comprehensive treatment should be readily available and not difficult to access. This would include reducing or removing the barriers that restrict Medicare patients from non-hospital, addiction treatment programs, which would not only improve their access to treatment but would also save taxpayer dollars

It also will be very important to increase professional and public overdose prevention training, and increase the availability and use of naloxone to help decrease the tragic number of overdose deaths.

I believe that over time such efforts can not only improve our ability to better treat patients with legitimate pain but, also, help reduce the problem with opioid addiction in our community.

Thank you, again, for your time and for inviting me to discuss this important topic.

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