



The Mayor's Task Force to
COMBAT THE OPIOID EPIDEMIC IN PHILADELPHIA



**Final Report &
Recommendations**

MAY 19, 2017



Mayor James F. Kenney, City of Philadelphia



MESSAGE FROM MAYOR KENNEY

The opioid epidemic affects all of us in Philadelphia. Drug overdoses, and overdoses involving opioids, are now a leading cause of death in our city. Opioids are also destroying families and relationships and undermining the quality of life in Philadelphia.

Our country has seen waves of drug use and addiction in the past, and it has made the mistake of managing them primarily as problems of law enforcement, leading to many unnecessary jail terms but little progress. With this new tragic turn in drug use, we have to be smarter and more compassionate.

In order to address this epidemic in a thorough and systematic way, I convened a Task Force of stakeholders working in public health, substance use disorder treatment, medical care, law enforcement, advocacy, and managed care, as well as representatives from the community. This Task Force, co-chaired by Commissioner Thomas Farley of the Department of Public Health and former Commissioner Arthur Evans of the Department of Behavioral Health and Intellectual disAbility Services, has committed over the last several months to identify ways that we can individually and collectively turn the tide on Philadelphia's opioid epidemic. This outstanding report contains recommendations that can do just that.

However, a report cannot itself solve this crisis. It will take a sustained commitment from the City and all of its partners, as well as from the general public, to implement this report's recommendations and drive down opioid use, addiction, and overdose. I hope you will join me in making that commitment.

Philadelphia has faced many crises over the years, but has overcome them when residents and leaders from businesses, community organizations, and government work together. If we work together again, I am confident that we can end the opioid crisis, too.

A handwritten signature in black ink that reads "James F. Kenney". The signature is written in a cursive, flowing style.

Mayor James F. Kenney

TABLE OF CONTENTS

Executive Summary	2
Foreword	4
Preface from Task Force Co-Chairs	5
The Opioid Crisis: Background on the Problem	6
Prescribing and Use of Pharmaceutical Opioids	6
Heroin and Illicit Opioids	7
Opioid Use Disorder	8
Overdoses	8
Impact on Families	10
Impact on the Criminal Justice System	11
Actions Taken by DBHIDS in Response to the Opioid Epidemic	12
Treatment Services	13
Recommendations	15
Prevention and Education	15
Treatment	18
Overdose Prevention	22
Involvement of the Criminal Justice System	24
Implementation, Monitoring, and Evaluation	26
Appendix I: Glossary of Terms	27
Appendix II: Task Force Subcommittee Members	29
Appendix III: Details on Task Force Process	31
Appendix IV: Compiled Task Force Metrics	33
Appendix V: Additional Recommendations for Involvement of the Criminal Justice System	34
Appendix VI: How to Get Help	36

EXECUTIVE SUMMARY

This report describes a public health crisis in Philadelphia caused by prescription and illicit opioids, and characterized by high and increasing rates of opioid use disorder and overdose death, as well as their devastating personal, family, and societal consequences. The Mayor's Task Force to Combat the Opioid Epidemic considered the causes of this crisis and its potential solutions and makes the following recommendations:



The Task Force was charged with developing a comprehensive and coordinated plan to reduce opioid use disorder and its associated morbidity and mortality in Philadelphia, and with drafting a report of findings and recommendations for action for the mayor. It conducted its work through meetings of the full Task Force as well as meetings of five subcommittees, each of which addressed a different aspect of the epidemic.

The Task Force also held four Community Listening Sessions across the city to hear directly from Philadelphians affected by the opioid epidemic. More details on the Task Force process and Community Listening Sessions are in Appendix III.



PREVENTION AND EDUCATION

1. Conduct a consumer-directed media campaign about opioid risks.
2. Conduct a public education campaign about naloxone.
3. Destigmatize opioid use disorder and its treatment.
4. Improve health care professional education.
5. Establish insurance policies that support safer opioid prescribing and appropriate treatment.

TREATMENT

6. Increase the provision of medication-assisted treatment.
7. Expand treatment access and capacity.
8. Embed withdrawal management into all levels of care, with an emphasis on recovery initiation.
9. Implement “warm handoffs” to treatment after overdose.
10. Provide safe housing, recovery, and vocational supports.
11. Incentivize providers to enhance the quality of substance use disorder screening, treatment, and workforce.



OVERDOSE PREVENTION

12. Expand naloxone availability.
13. Further explore comprehensive user engagement sites.
14. Establish a coordinated rapid response to “outbreaks.”
15. Address homelessness among opioid users.



INVOLVEMENT OF THE CRIMINAL JUSTICE SYSTEM

16. Expand the court’s capacity for diversion to treatment.
17. Expand enforcement capacity in key areas.
18. Provide substance use disorder assessment and treatment in the Philadelphia Department of Prisons.

TASK FORCE GUIDING PRINCIPLES

The recommendations in this report were guided by the following eight principles:

1. Prioritize intervening at the earliest possible time.
2. Recognize the diversity of the city and the varied populations affected by the epidemic, including race, ethnicity, gender, age, sexual orientation, pregnancy, and parenting status.
3. Ensure that the voice of lived experience is included.
4. Support recommendations with data.
5. Find a balance between actionable recommendations and aspirational recommendations.
6. Speak to all organizations and entities that could contribute to solutions, rather than just the mayor or City government.
7. Consider return on investment and maximize the impact of resources expended.
8. Be subject to continuous, ongoing, and frequent evaluation and monitoring with quantitative metrics.

FOREWORD

I am honored to have served as an ex-officio member of the Mayor’s Task Force to Combat the Opioid Epidemic in Philadelphia. A diverse task force membership, deep community engagement, and key leaders’ commitment to the process provided an impressive foundation for the development of this report.

Our Task Force’s starting point evolved from a list of recommendations in common from similarly focused task force reports developed across the United States. This critical first step—to start with the end in mind—illustrated the credibility and seriousness of the city’s leadership team. Thus all involved understood the importance of their individual and team role in meeting the high expectations of the mayor, the public, and city commissioners. Based on the clear guiding principles that were also provided, all were encouraged to develop recommendations of the highest caliber.

I encourage you to read this report in its entirety and to pay particular attention to the process followed and final recommendations. I ask that if you model future opioid planning on Philadelphia’s report, you consider, as our leaders did, the importance of community input, task force membership composition, and an evidence-based approach.

As the regional administrator for the Substance Abuse and Mental Health Services Administration (SAMHSA) located in Philadelphia, responsible for Pennsylvania, Delaware, Maryland, Washington DC, Virginia, and West Virginia, I often share the SAMHSA messages that behavioral health is essential to health, prevention works, treatment is effective, and recovery is possible. I have been heartened to see each of these important points observed as a plan has been developed to help all Philadelphians. The value of this report will be realized as it is shared and in turn becomes the starting point for progress in your organization or jurisdiction—starting with the end in mind.



Jean Mackey Bennett, PhD, MSM, MSN, RN

Regional Administrator for Region III
(DC, DE, MD, PA, VA, WV)
Office of Policy, Planning, and Innovation
United States Department of Health and Human Services
Substance Abuse and Mental Health Services
Administration

PREFACE FROM TASK FORCE CO-CHAIRS

As the commissioners of the City of Philadelphia Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) and Department of Public Health (PDPH), we were honored to serve as co-chairs for the Mayor’s Task Force to Combat the Opioid Epidemic. We are grateful for Mayor James F. Kenney’s leadership, as he recognized the devastating effects of the opioid epidemic on Philadelphia and called for a plan to combat it.

During the early months of 2017 we convened over 100 experts, stakeholders, and community members to develop a plan that would meet that challenge. Coming together as a single unit allowed us to harness our collective expertise and put us in a stronger position to respond.

We are proud of the work conducted by members of the Task Force and its five subcommittees, and are grateful for their dedication and innovative ideas. Furthermore, we are thankful for community members who voiced their comments, which are embedded throughout this report.

While not every recommendation received unanimous support from all Task Force members, the recommendations in this report reflect the consensus of the Task Force and its co-chairs. Each organization involved in the Task Force will also be critical to the implementation of these recommendations, and to addressing the other issues related to the opioid epidemic that this Task Force could not cover.

We look forward to continuing the conversation with community members, stakeholders, the private sector, and City leaders.



A handwritten signature in black ink, appearing to read "Arthur C. Evans, Jr., PhD".

Arthur C. Evans, Jr., PhD
Commissioner, 2004–February 2017
Department of Behavioral Health and
Intellectual disAbility Services



A handwritten signature in black ink, appearing to read "Thomas Farley".

Thomas Farley, MD, MPH
Health Commissioner
Philadelphia Department of Public Health

THE OPIOID CRISIS

The crisis caused by opioids encompasses opioid use, opioid use disorder, and related morbidity and mortality. Each of these is a problem of its own and each leads to many other individual and social problems. Opioid use and addiction are not new issues, but they have reached epidemic proportions in the city and demand a new and coordinated response.

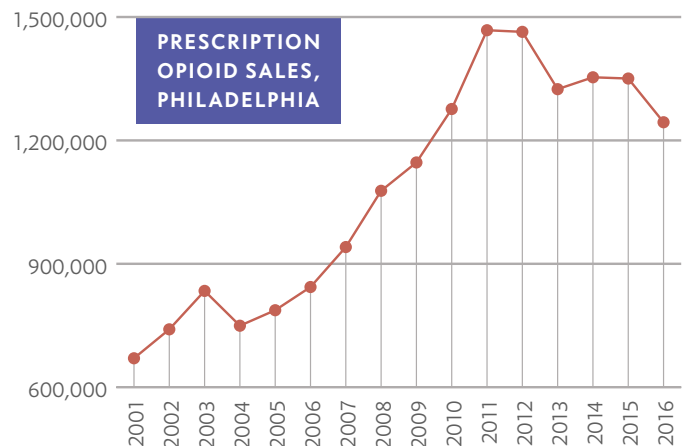
PRESCRIBING AND USE OF PHARMACEUTICAL OPIOIDS

While heroin use has a long history, it is the rise in use of prescription opioid pain medication beginning in the late 1990s that has fueled this current crisis.¹

Nationally, four out of five new heroin users have their first exposure to an opioid from a prescription opioid pain medication, such as Vicodin, Percocet, and OxyContin.²

Data from the Drug Enforcement Agency suggest that opioid sales in Philadelphia more than doubled between 2000 and 2012. Despite the attention that opioids have garnered over the last several years and a greater collective understanding of the risks, opioid sales in Philadelphia have only begun to decline since 2012 (see chart at right).³ These data indicate that health care providers continue to prescribe opioid pain medication in greater quantities than are medically appropriate given the risks of these drugs.⁴

Nationally, nearly 70 percent of adults in the United States have used opioid pain medication in their lifetimes and approximately 30 percent have used these drugs in the previous year.⁵ Using state and national data, we estimate that between 100,000 and 200,000 people in Philadelphia receive more than one prescription for an opioid pain medication each year.



PRESCRIPTION OPIOIDS IN PHILADELPHIA

Opioid sales more than doubled between 2000 and 2012.

ESTIMATED MISUSE OF PRESCRIPTION OPIOIDS IN PHILADELPHIA

50,000 people

While some of these prescriptions are medically warranted (e.g., for cancer-related pain or individuals receiving hospice care), many are for non-cancer, chronic pain, for which opioid treatment is not recommended. This exposure is dangerous because the probability of long-term opioid use increases with each day of use, including within the first week following an initial prescription.⁶ Use of prescribed opioids can lead to subsequent opioid use disorder. Data from the National Survey on Drug Use and Health suggests that, in Philadelphia, between 50,000 and 60,000 people over age 12 misused a prescription opioid pain medication in the previous year.⁷

The Philadelphia Department of Public Health and Department of Behavioral Health and Intellectual disability Services recently released guidelines to promote judicious opioid prescribing, and have distributed these guidelines to physicians and other prescribers in the Philadelphia area.

HEROIN AND ILLICIT OPIOIDS

Because of the expense of prescription opioid pain medication, some users transition to heroin, which is inexpensive and more readily available.⁸

Nationally, four out of five individual who begin using heroin have made this transition from initial prescription opioids.⁹ While more than 90 percent of people who use prescription opioids for nonmedical purposes do not transition to heroin use,¹⁰ given the large number of people receiving prescription opioids, a significant number of individuals make the transition to heroin.

ESTIMATED HEROIN USERS IN PHILADELPHIA

70,000

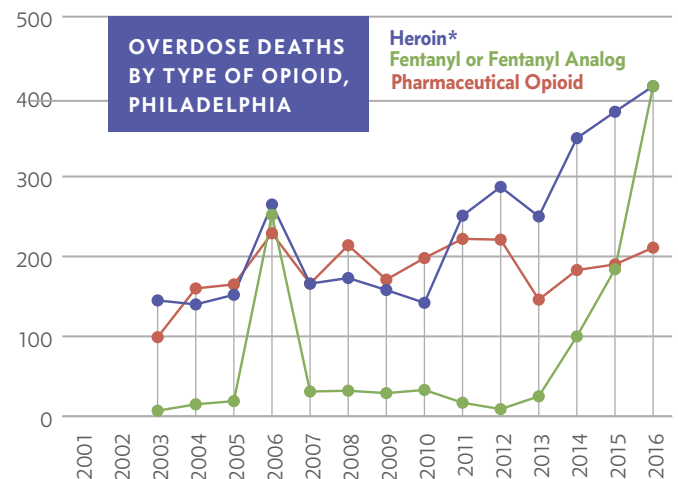


This transition is particularly likely to occur in Philadelphia because heroin in the Philadelphia-Camden area is especially pure and cheap. In 2014, Philadelphia's heroin averaged 65 percent purity, the highest in the country among all samples tested.¹¹ Based on national data showing that 20 percent of heroin users seek or participate in treatment for their heroin use, we estimate that there are at least 70,000 heroin users in Philadelphia.¹² This is likely a conservative estimate, as it does not include individuals who may have obtained care in the private treatment system.

In 2014, the synthetic opioid fentanyl began to appear in testing of opioid overdose victims, indicating that criminal drug networks were producing the drug and selling it on the street to heroin users. By 2016, fentanyl was found in nearly half of drug overdose deaths (see graph below).

FENTANYL

By 2016, fentanyl was found in nearly half of overdose deaths.



OPIOID USE DISORDER

The physical and psychological impact of opioid use disorder on the residents and communities of Philadelphia is difficult to measure but cannot be overstated.

Approximately 14,000 people were treated for opioid use disorder in Philadelphia's publicly funded system in the 12-month period from October 2015 through September 2016.¹³ The patients actively seeking and participating in care still represent only a fraction of those with opioid use disorder, including those who use heroin and those in need of treatment.

NUMBER OF MEDICAID RECIPIENTS IN PHILADELPHIA TREATED FOR OPIOID USE DISORDER IN ONE YEAR

14,000

DEATHS

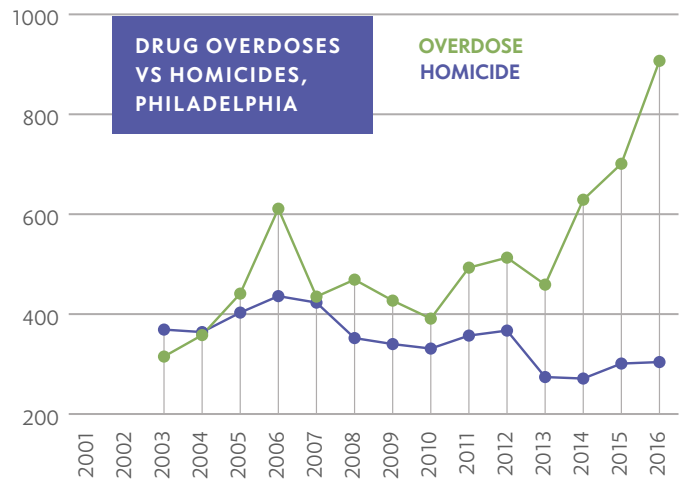
In 2016, opioid overdoses were three times the number of homicides.

OVERDOSES

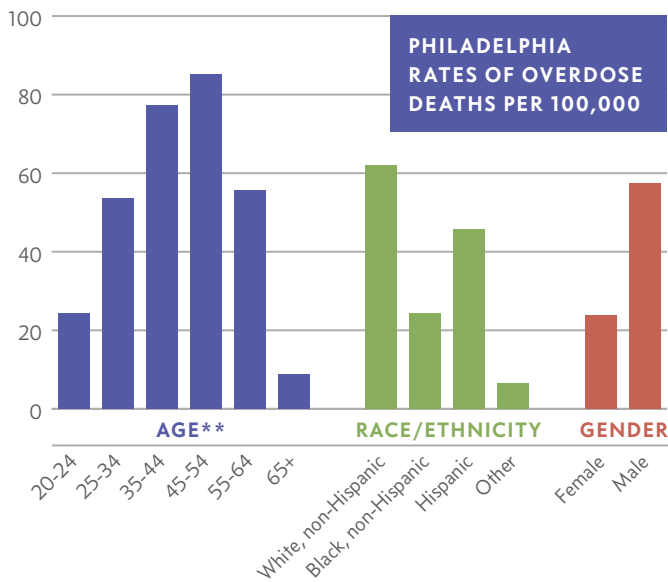
In Philadelphia, 907 died due to drug overdose in 2016—an increase from 702 in 2015 and three times the number of homicides (see graph below).¹⁴

In 2015, Philadelphia's rate of 46.8 drug overdose deaths per 100,000 residents far outpaced other large cities, such as Chicago (15.4) and New York City (11.2).¹⁵

Approximately 80 percent of drug overdose deaths in Philadelphia involve opioids, including prescription opioids, heroin, and fentanyl. The increasing presence of fentanyl, a potent synthetic opioid pain medication that is 50 to 100 times stronger than morphine, is contributing to overdose fatalities. In 2016, fentanyl was found in 412 drug overdose decedents in Philadelphia, a sharp increase from nine deaths in 2012.¹⁶



Fatal opioid overdoses predominantly occur in Philadelphia in non-Hispanic white males, although no demographic or socioeconomic group has been unaffected (see chart below). The peak age group for overdoses is 45-54, which represents a distinct change from earlier periods when opioid overdose deaths were far higher in those age 20-29 than any older age group.¹⁷ This older age group for fatal overdoses likely represents a consequence of recruitment of adults into drug dependence by over-prescribing of opioids.



* Rates are calculated using Philadelphia county population denominators from the 2015 American Community Survey five-year estimates. Rates are adjusted to the 2000 U.S. Standard Population age distribution.
 ** Age-specific death rates are shown. Deaths among persons ages 10-14 and 15-19 years were too few to calculate a rate.

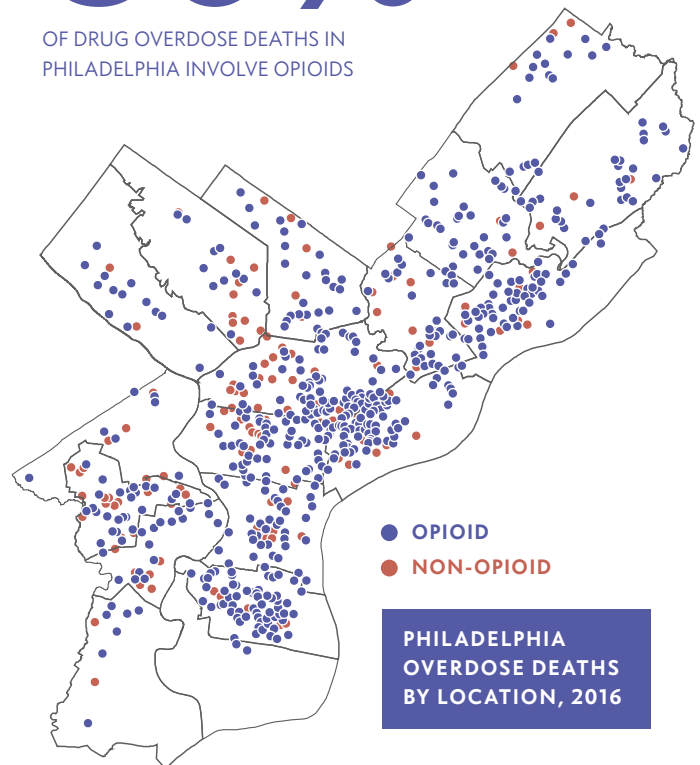
Similarly, while many overdoses happen in the Kensington and North Philadelphia neighborhoods, overdoses have occurred in every corner of the city (see map).¹⁸ In addition to fatal overdoses, thousands of non-fatal overdoses occur each year in Philadelphia.¹⁹ While lives are saved through the use of naloxone, a medication that reverses opioid overdoses, these overdoses continue to be traumatic and burden the city’s emergency medical services, part of the Philadelphia Fire Department, and hospitals.

In 2014, Dr. Rachel Levine, Pennsylvania’s Physician General, signed a statewide “standing order” enabling any Pennsylvanian to obtain naloxone from a pharmacy without an individual prescription. This order was part of Act 139, which both allows first responders and community members to administer naloxone to someone who they are concerned has overdosed on opioids and provides immunity from prosecution to those reporting or responding to an overdose (a “Good Samaritan” provision).

In Philadelphia, naloxone has been widely used and distributed: it was administered approximately 4,000 times by the Fire Department and 200 times by Philadelphia police in 2016. Additionally, approximately 5,500 doses of naloxone were distributed from a syringe exchange program in Philadelphia to people who use drugs and are at high risk for overdosing.

80%

OF DRUG OVERDOSE DEATHS IN PHILADELPHIA INVOLVE OPIOIDS

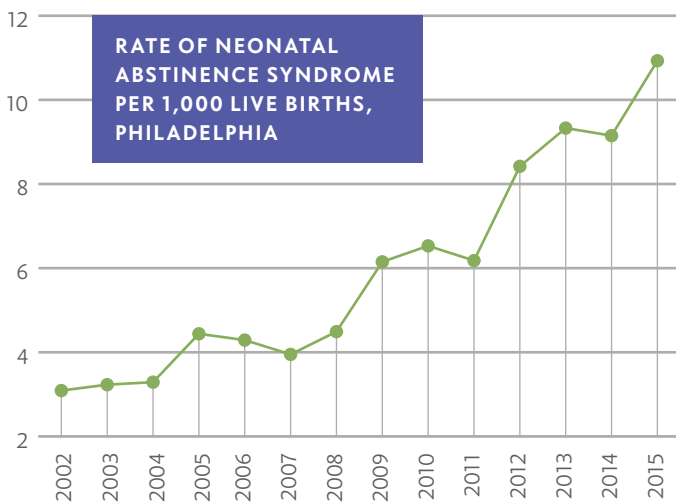


IMPACT ON FAMILIES

Opioids negatively impact not only the addicted user, but also the family around them, which may include parents, partners, children of any age, unborn children, siblings, and extended family.

Philadelphia families are burdened with grief and loss to overdose, stigma associated with opioid addiction, and the multigenerational dynamic of the disease of addiction. The consequences of alcohol and drug misuse that impact families include compromised physical health and mental health, increased health care costs, loss of productivity at school and/or work, reduced quality of life, increased crime and violence, as well as child abuse and neglect.²⁰

Opioid use during pregnancy can lead to neonatal abstinence syndrome (NAS) and may interfere with a child's brain development and result in later consequences for mental functioning and behavior. In the United States, the incidence of NAS increased 383 percent during 2000–2012 along with increased opioid misuse.²¹ In Philadelphia, the rate of NAS increased more than three-fold from 3 per 1,000 live births in 2002 to 11 per 1,000 live births in 2015 (see chart below).



Adverse childhood experiences (ACE) are stressful or traumatic events that are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance misuse. The Philadelphia Urban ACE Study surveyed almost 2,000 Philadelphians in 2012–2013 for urban ACE indicators, one of which was growing up with substance abuse in the household. Among the findings was data that almost 40 percent of Philadelphians surveyed experienced greater than or equal to four ACEs and approximately 35 percent grew up with substance abuse in their household.²²

Substance use becomes increasingly likely across adolescence, with rates peaking among people in their twenties, and declining thereafter. Youth and young adults are especially at risk. The majority of people with a substance use disorder started using substances during adolescence. Using substances during adolescence or young adulthood affects brain development which is not complete until a person reaching their mid-twenties. About three quarters (74 percent) of 18- to 30-year-olds admitted to substance use disorder treatment programs began using substances at the age of 17 or younger.²³

NEONATAL ABSTINENCE SYNDROME
In Philadelphia, the rate of NAS increased more than three-fold from 2002 to 2015.

IMPACT ON THE CRIMINAL JUSTICE SYSTEM

People with substance use disorder interact with the criminal justice system in many ways. Prevalence of substance use disorder is higher among prison populations than among the general population.²⁴ Incarceration itself is also a risk factor for developing substance use disorder.²⁵ The Philadelphia Drug Treatment Court, established in 1997,²⁶ seeks to address some of these underlying causes of crime by directing some people to substance use disorder treatment instead of incarceration.

Substance use disorder in the criminal justice system

The Philadelphia Department of Prisons processes over 30,000 individuals for intake each year, averaging over 6,000 people per day. The incarcerated population has significant disease burden, including about 40 percent who participate in behavioral health treatment (primarily pharmacologic care), 17 percent who are seriously mentally ill, 14 percent who have Hepatitis C and three percent who are HIV positive. The Department of Prisons does not test for drug use on admission, but can estimate drug use among its population based on a 2014 study. Seventy-four percent of inmates tested positive for use of one or more drugs on admission to jail. Of those who tested positive for drug use, 14 percent tested positive for opioids (15 percent of females tested and 12 percent of males tested).²⁷

The Department of Prisons generally does not initiate medication for individuals with opioid use disorder, although inmates who are already receiving methadone in the community can continue to receive it while incarcerated. However, pregnant women with opioid use disorder are started on methadone for the duration of their pregnancy. Together, about 300 inmates receive methadone in the prison system annually. In March 2017, the prison started maintaining inmates with opioid use disorder who enter prison on prescribed buprenorphine.

Beyond medication-assisted treatment, the Department of Prisons offers withdrawal management support (commonly referred to as detoxification or detox) and enrollment in its cognitive behavioral therapy treatment program, called Opportunities for Prevention and Treatment Interventions for Offenders Needing Support (OPTIONS). The Department of Prisons provides withdrawal management about 8,000 times annually; in the second half of 2016, about two-thirds of withdrawal management admissions included opioids. About 1,500 people also participate

in substance use disorder counseling annually through the OPTIONS program. The risk related to withdrawal management in prison is that upon release into the community where opioids are widely available, inmates who participate in withdrawal management will experience reduced tolerance to opioids, and so are at greater risk for overdose. Resources to increase access to medication-assisted treatment during incarceration would address some of these risks for overdose, and have the broader benefit of enabling people to begin treatment while incarcerated.

WITHDRAWAL MANAGEMENT

The Department of Prisons provides withdrawal management about 8,000 times annually.

Incarceration history among people with substance use disorder

The prevalence of psychiatric disorders, including substance use disorder, is higher among inmates than in the general population. Early-onset substance use disorders increase risk of incarceration due to tendency to engage in drug-related criminalized behavior.²⁸ Substance use disorders that co-occur with other serious mental illness also increase likelihood of arrest for nonviolent or drug-related offenses.²⁹ In addition, incarceration may lead to onset of psychiatric disorders, including substance use disorders, due to challenges encountered during incarceration and post release.³⁰ In Philadelphia, of the 3,172 people who died of an unintentional drug overdose during 2010–15, 782 (25 percent) were incarcerated in the Philadelphia Department of Prisons at least once during the same time frame.³¹

Role of the Philadelphia Treatment Court

Philadelphia Treatment Court is a Municipal Court that addresses cases for the drug-involved criminal justice population. The court is designed to treat substance use disorder as a root cause of criminal activity, providing an alternative or supplement to normal legal proceedings. Treatment Court can offer post-plea deals that deliver a network of treatment and supportive services (such as recovery housing, vocational training, and employment placement) according to the needs of the participant. If appropriate, medication-assisted treatment (MAT) and trauma counseling is provided.³²

Over twenty years, Philadelphia Treatment Court has enrolled more than 4,800 participants and has successfully graduated more than 3,100 participants. In the past five years, 890 participants have been accepted to Treatment Court, representing 74 percent of all referrals.

Treatment Court accepts individuals with primary diagnoses of substance use disorder who have been charged with nonmandatory felony drug offenses and have less than two nonviolent prior convictions. Self-reported opioid use among Treatment Court participants has increased from approximately 22 percent in 2015 to 37 percent as of March 2017.³³

Most Treatment Court participants complete the program and are not convicted of another crime within a year of graduation. In 2016, 78 percent of participants successfully completed Treatment Court. Recidivism is low for all crimes (about 32 percent three years after last contact), but particularly for drug-related charges (18 percent three years after last contact).³⁴ Treatment courts have shown reduced recidivism when compared to traditional adjudication for drug offenders, reducing rates of re-arrest and re-conviction by approximately 6 percent to 26 percent.³⁵ However, Treatment Court cannot currently serve all of the people who could benefit from the program due to limited resources.

ACTIONS TAKEN BY DBHIDS IN RESPONSE TO THE OPIOID EPIDEMIC

- ✓ Required all halfway houses to accept individuals on all forms of medication-assisted treatment and psychiatric medications to decrease discrimination and increase access to this important treatment (effective June 1, 2017)
- ✓ Expanded the use of recovery houses and extended hours of some residential programs to take individuals after 5 p.m. and during weekends
- ✓ Started work on a web-based portal documenting treatment capacity. All residential providers are required to enter their availability daily and DBHIDS staff is assisting individuals directly with placement to improve timely access to treatment services when residential treatment is required

- ✓ Authorized higher levels of care in cases where there is significant or potential medical co-morbidity requiring residential treatment, decreasing delays in access for individuals in need
- ✓ Increased the availability of buprenorphine from approximately 100 slots to over 1,000 at the present time
- ✓ Mandated all opioid treatment programs to offer all forms of medication-assisted treatment, including methadone, buprenorphine and naltrexone in 2017. Three residential sites currently offer buprenorphine inductions and Naltrexone is now available in fourteen outpatient treatment sites and four residential sites.
- ✓ Initiated planning for the development of a 24/7 walk-in center where individuals can receive immediate stabilization in the outpatient setting and get access to further treatment. This center should be operational by the 3rd quarter in 2017.

TREATMENT SERVICES

In Philadelphia, Community Behavioral Health (CBH) manages publicly funded treatment for mental health and addiction services.

CBH is a non-profit organization that is contracted by the City of Philadelphia and the Department of Behavioral Health and Intellectual disAbility Services (DBHIDS) to manage the behavioral health services for Philadelphia Medicaid beneficiaries. The Office of Behavioral Health manages care for uninsured Philadelphia residents.

CBH maintains a network of treatment providers to provide the continuum of care. These treatment providers include 13 opioid treatment programs, 36 residential treatment facilities, six halfway houses, 10 hospitals, five Crisis Resource Centers, one Behavioral Assessment Center, 59 outpatient facilities, 34 intensive outpatient programs, 14 prevention providers, and three drug and alcohol case management providers.

Approximately 25,000 individuals participated in care in Philadelphia's publicly funded drug and alcohol treatment system in 2016, 14,000 of whom received treatment for opioid use disorder. Eighty-four percent of these individuals received treatment not only for their addiction, but also for a co-occurring mental health diagnosis.³⁶

Among uninsured Philadelphians, 27% reported heroin to be their preferred drug when being admitted to a treatment program in 2015, an increase from 17.6% in 2011. Consistent with the overall burden of opioid use disorder in Philadelphia, uninsured adults admitted to treatment programs for opioid use disorder are predominantly non-Hispanic whites, men and ages 26–44 years.

Across the public and private health care systems, thousands of Philadelphia residents receive medication-assisted treatment for opioid use disorder. Medication-assisted treatment, in which patients participate in counseling in addition to Federal Drug Administration (FDA) approved medications for opioid use disorder, has been shown to be effective in reducing illicit opioid use. Medication-assisted treatments (including methadone, buprenorphine and extended-release naltrexone) for opioid use disorder are considered evidenced based, and are supported as essential to treatment by multiple professional agencies, including the National Institute on Drug Abuse, Substance Abuse and Mental Health Services Administration, the National Institute on Alcohol Abuse and Alcoholism, Centers for Disease Control and Prevention, the American Academy of Addiction Psychiatry, the American Medical Association and the National Council. Multiple studies have proven that medication-assisted treatments in combination with psychosocial treatment are effective in reducing mortality, lessening illicit opioid use, increasing retention in treatment, lowering criminal justice consequences of substance use and diminishing overall health care and societal costs. While MAT for substance use disorders has been available for many years, SAMHSA reports that numerous studies have shown that MAT is grossly underused and access to MAT remains limited.³⁷

In Philadelphia, increasing the availability and use of all forms of medication-assisted treatments (including methadone, buprenorphine and extended-release naltrexone), in conjunction with other forms of treatment is paramount. Across the public and private health care systems, thousands of Philadelphia residents participate in medication-assisted treatment for opioid use disorder. Nonetheless, despite the strong evidence to support the use of medication-assisted treatments in helping individuals with opioid use disorder, these are significantly underutilized due to stigmatization, regulatory barriers, as well as a lack of knowledge about them among treatment professions, prescribers and the community. Methadone remains an important medication-assisted treatment for opioid use disorder, with 13 clinics receiving city funding. In 2016, almost 6,000 individuals received methadone in conjunction with other treatments for their opioid use disorder. Treatment availability of other important forms of medication-assisted treatments, including buprenorphine and extended-release naltrexone, was also increased in 2015 and 2016.

While challenges exist, there is potential for the use of medication-assisted treatments to greatly expand in Philadelphia throughout the public and private behavioral health treatment system and in all medical settings where individuals present. Unlike methadone, which must be dispensed from licensed facilities when treating opioid use disorder, extended-release naltrexone and buprenorphine can be prescribed in primary care clinics and other medical settings. For these settings to be successful, however, policies, programs, and education to support and promote the use of medication-assisted treatments are needed at all levels of the health care system. Individuals with opioid use disorder may find themselves dissuaded from engaging in medication-assisted treatment by stigma, misinformation, and policies in their selected treatment settings, and these types of barriers need to be addressed to better serve the public.

CBH NETWORK OF TREATMENT PROVIDERS



RECOMMENDATIONS

Strategy 1: PREVENTION AND EDUCATION



Despite the magnitude of the opioid epidemic in Philadelphia, public awareness is low about the dangers of opioids and the need to recognize, intervene, and support people who may be opioid dependent. In addition, doctors and other prescribers still prescribe too many opioids. This strategy area focuses on developing recommendations to change behaviors around use of prescription opioids, including through mass media campaigns, education for doctors and other prescribers and insurance policies, as well as recommendations to increase public awareness about how to help people with opioid use disorder. Addressing stigma will be a core part of making prevention and education efforts successful, but also will ease the entire task of combatting the city's opioid epidemic.

1 Conduct a consumer-directed media campaign about opioid risks.

The City should implement a comprehensive, consumer-directed media campaign about the dangers of opioids, which addresses specific populations along the developmental life course (adolescents, young adults, adults, parents) and reflects the diversity of Philadelphia. The campaign should educate consumers about other ways to treat pain. It should also be available in multiple languages.

Prescription opioid pain medication continue to be prescribed at high rates, both nationally and in Philadelphia. However, the risks associated with these medications are poorly understood by the general public. Because these medications are prescribed by physicians and other health care providers, people who use them—both medically and recreationally—often perceive prescription opioids as safe or at least less dangerous than illicit drugs, such as heroin. In addition, a national survey indicated that more people blame prescription opioid misuse on individual behavior (such as lack of self-discipline) than on external factors such as physician prescribing.³⁸

Large national studies have shown that nonmedical use of prescription opioid pain medication can begin as early as middle school.³⁹ However, many people also begin use of opioid pain medication when they are older and have been prescribed it by a health care provider for acute pain. Media campaigns have been effective in changing behaviors around other substances, including in preventing initiation of tobacco use among young people and increasing cessation of tobacco use among people of all ages.⁴⁰ A broad consumer-directed media campaign is needed to ensure the diverse adult population in Philadelphia is aware of the inherent risks of opioids.

2 Conduct a public education campaign about naloxone.

The City should launch a citywide public education campaign to increase knowledge, use, and access to naloxone, including awareness of legal protections (Good Samaritan law), awareness of statewide medical standing order, and availability of naloxone through various venues. The campaign should also be available in multiple languages.

Naloxone is a potentially life-saving medication that reverses opioid overdoses, including those from heroin and fentanyl. It can easily be given by people who are not medical professionals, and due to a statewide “standing order” issued by Pennsylvania’s physician general, it can be obtained by any Pennsylvanian without the need for an individual prescription. However, many people are not aware of what naloxone is or how to access it. Evidence from Massachusetts shows that community-based overdose education and naloxone distribution programs are effective at reducing fatal overdoses.⁴¹

Community-based overdose education and naloxone distribution programs are effective at reducing fatal overdoses.

3 Destigmatize opioid use disorder and its treatment.

The City should conduct public education to raise awareness about opioid use disorder as a chronic medical condition and to reduce the stigma of treatment for opioid use disorder. This effort should recognize it as affecting everyone in Philadelphia, and use existing programs and people with lived experiences to conduct individual and family education in multiple languages and targeted at specific populations. Because stigma is a major barrier to siting new services, the City should also partner with City Council, civic groups, and neighborhoods to plan for new treatment programs and recovery support services in key areas.

The stigma surrounding both drug use and treatment often prevents individuals and families from seeking help. Demeaning words such as “addict” and “junkie” and other depictions of drug users perpetuate the belief that a substance use disorder is a moral failing. Public education is needed to reframe the discussion such that a substance use disorder is seen as a chronic medical condition for which effective treatments are available.

The City should partner with existing organizations across Philadelphia who engage different populations and communities and who can help disseminate this message. Educational programs should employ peers and people with lived experiences, and should be able to connect people to treatment resources.

The stigma surrounding both drug use and treatment often prevents individuals and families from seeking help.

4 Improve health care professional education.

Health care professional schools and provider organizations should require and have standards for broad, interdisciplinary competency-based training for all levels of health care professionals on pain, pain management and substance use disorder, and support evidence-based approaches that change behavior of doctors and other prescribers when combined with education, including prescriber detailing, outreach programs, and tailored small group learning. The City should continue to convene professional schools and provider organizations to discuss these efforts and encourage them to share their curricula on pain, pain management, and addiction.

Health care professionals have historically received limited education on substance use disorders. National survey data suggest that about half of primary care physicians are “very” concerned about the risk of substance use disorder or death related to opioid use, but fewer are concerned about other adverse effects, including tolerance, impaired cognition, and sedation.⁴² Most physicians surveyed indicated that they are “moderately” or “very” confident in their clinical skills related to opioid prescribing, though this may reflect cognitive biases. These findings suggest that while physicians may be confident in their prescribing, they may not be fully aware of the range of risks associated with opioid use.

In recent years, education of health care professionals has increased attention to pain and opioid prescribing for pain. While medical schools are expanding curriculums to include pain, pain management, and substance use disorders, such education needs to be expanded to all health care professionals, including dentists, pharmacists, physical therapists, counselors and social workers. Professional schools, training programs, and health systems can adopt standards for such interdisciplinary education.

While education is necessary, alone it is unlikely to change provider prescribing behaviors, particularly among established clinicians. In order to reduce the liberal prescribing of opioid pain medication, the City should support evidence-based approaches to changing prescribing behavior. In 2015, the New York City health department conducted an academic detailing program on judicious opioid prescribing in Staten Island that showed a reduction in the prescribing of high-dose opioids.⁴³

5 Establish insurance policies that support safer opioid prescribing and appropriate treatment.

Public and private insurers should

- 1) require prior authorizations for opioid prescriptions;*
- 2) increase access to alternative pain treatments;*
- 3) make all FDA-approved medications in addiction treatment readily accessible; and*
- 4) improve coordination of care by reducing the separation between physical and mental health services.*

Even as awareness of the opioid use epidemic has risen among health care providers, many continue to prescribe too many opioids, which suggests that provider education will be insufficient to change prescribing behavior. However, prescribing behavior can be altered through health insurer policies. In Massachusetts, when a commercial insurer implemented robust opioid policies that included a prior authorization requirement for new opioid prescription, the prescribing of short-acting opioids decreased by 16 percent.⁴⁴

Additionally, health insurers have the opportunity to expand access to treatment for individuals already affected by opioid use disorder. This may be accomplished through the lowering of insurance barriers to medication-assisted treatment (including buprenorphine and extended-release naltrexone) and alternative pain treatments, and greater coordination of care between physical and mental health providers. Beyond lowering coverage barriers, insurers and managed care entities should develop disease management programs to achieve increases in the rates of identification and engagement of patients with opioid use disorder. The City cannot legally require insurers to make these changes, but can and should convene and urge them to do so.

Strategy 2: TREATMENT



Many barriers impede access to quality treatment for substance use, including a shortage of sites that provide medication-assisted treatment, gaps in services for special populations, restrictive hours of operation, antiquated treatment modalities, requirements of clients for state-issued identification cards, housing issues, workforce limitations, and the separation of behavioral health treatment from physical health care.

6 Increase the provision of medication-assisted treatment.

The City and substance use disorder treatment provider organizations should vigorously continue its efforts to increase the provision of medication-assisted treatment (MAT) in all forms as standard practice, and facilitate referral and/or provision of MAT at multiple sites including emergency departments, halfway houses, outpatient practices, residential treatment facilities, psychiatric facilities, medical facilities, primary care sites and prisons. All consumers should be offered all options of treatment available to them, including all FDA-approved versions of MAT. Treatment programs should introduce these agents and offer both agonist and antagonist medications, within the treatment program. Integrating MAT into all treatment settings will ease patients' burden of navigating the complex treatment system. All regulatory barriers to the use of MAT should be identified and reduced.

MAT is considered as a vital evidence-based treatment by numerous national professional organizations, as referenced previously in the Treatment Services section.

All consumers should be offered all options of treatment available to them, including all FDA-approved versions of medication-assisted treatment.

Expand treatment access and capacity.

The City should

- 1) increase the number of sites in the city offering addiction treatment services;*
- 2) expand weekend and evening operations for facilities at multiple levels of care;*
- 3) identify gaps in substance use disorder treatment capacity for special populations and increase capacity of treatment slots and providers to engage these populations at all levels of care;*
- 4) partner with the state to resolve identification issues that are barriers to accessing treatment;*
- 5) create a web-based database for the general public and provider access to identify available treatment slots in real time;*
- 6) integrate information on how to access treatment into public education campaigns;*
- 7) expand the capacity of crisis centers and emergency departments in Philadelphia to assess and treat individuals with opioid use disorder;*
- 8) improve the quality of assessments for individuals entering treatment by adopting ASAM Criteria; and*
- 9) increase the use of peer recovery specialists to support individuals in their recovery throughout behavioral health and medical settings.*

An increase in sites offering addiction treatment services should include providers within the behavioral health treatment system as well as medical providers, early intervention programs, and important recovery support programs. Public education campaigns should emphasize all levels of care where individuals can access treatment, including outpatient and other nontraditional settings.

A requirement for determining treatment need is a multidimensional assessment. The adoption of the state of Pennsylvania of the American Society of Addiction Medicine Criteria and its requirement for utilization review purposes by the U.S. Centers for Medicare and Medicaid Services is an opportunity for the system to upgrade and standardize the assessment of patients' needs and outcomes.

It has been known for many years that the “treatment gap” is massive—that is, among those who need treatment for a substance use disorder, few participate in it.⁴⁵ The Drug Enforcement Agency and National Survey on Drug Use and Health estimated that there are between 122,000 and 150,000 Philadelphians in need of substance use disorder treatment.

The Drug Enforcement Agency and National Survey on Drug Use and Health estimated that there are between 122,000 and 150,000 Philadelphians in need of substance use disorder treatment.

8 Embed withdrawal management into all levels of care, with an emphasis on recovery initiation.

The City should require all substance use disorder treatment providers at every level of care to begin offering withdrawal management and place greater emphasis on developing comprehensive treatment approaches to increase the likelihood of continued engagement in treatment. Individuals who enter programs for withdrawal management should receive a comprehensive evaluation of potential psychiatric, medical and psychosocial complications, and informed consent around the evidence base for medication-assisted treatments (MAT). All individuals should be evaluated for the appropriateness of MAT, and programs should offer all forms of MAT or be able to link individuals to them. Integrated services within programs should include treatment of psychiatric disorders since the majority of individuals seeking treatment for substance use disorders have a co-occurring psychiatric diagnosis. Treatment facilities will also need to be able to address other substance use disorders that may be co-morbid with opioid use disorder. Psychosocial treatment and engagement of peer supports should be provided as early as possible to combine other evidenced based practices with MAT.

The current practice of detoxification programs as isolated levels of care and siloed programs, as well as being considered the major treatment entry point for individuals with opioid use disorder, is inconsistent with current evidenced based practice. Multiple individuals are entering detoxification alone without any continued engagement in treatments and other recovery support services. Individuals who receive detoxification alone without other treatments including evidenced-based MAT (agonist or antagonist) are at greater risk of relapse and death from overdose. According to ASAM criteria, withdrawal management is a medical intervention which can be offered in every level of care ranging from outpatient to hospital based services, so that the emphasis is placed on recovery initiation and engagement in sustained treatment. The emphasis on entry into detoxification programs also creates an unnecessary strain on the perceived availability of treatment slots. Expanding access to withdrawal management across the treatment system will reduce perceived unavailability of treatment slots.

9 Implement “warm handoffs” to treatment after overdose.

The City should ensure that people experiencing nonfatal overdoses revived in the field or in emergency departments have unfettered access to services including dedicated centralized coordinators, peers, removal of financial/ insurance barriers until services can be identified, and use of MAT as bridge. Hospitals and behavioral health providers should create systems and protocols for warm handoffs from emergency departments to treatment providers. This “warm handoff” starts with appropriate MAT induction in emergency departments and a take-home supply of medication.

A lack of coordination in response to nonfatal overdoses places those needing help at risk. Individuals who are discharged from emergency medical care following an opioid overdose have an increased risk for repeat overdoses.⁴⁶ MAT induction and care coordination in emergency departments would provide immediate access to treatment and resources.

Emergency departments throughout the city should develop protocols to induct individuals on buprenorphine when clinically appropriate, and should explore the development of hospital based urgent care clinics to provide immediate access to individuals needing stabilization with the goal of linkage to longer term treatments.

Hospitals and behavioral health providers should create systems and protocols for warm handoffs from emergency departments to treatment providers.

10 Provide safe housing, recovery, and vocational supports.

The City should work with other systems and elected officials to increase safe permanent supportive housing, recovery houses, vocational support, and recovery support services for individuals with substance use disorders, eliminate barriers to longer retention at treatment facilities, and eliminate housing discrimination against individuals enrolled in medication-assisted treatment and special populations. This expansion should include support for youth and young adults through recovery high schools and collegiate recovery infrastructure.

There is a shortage of safe housing and vocational supports to facilitate healthy and positive outcomes for individuals with substance use disorders. Without a safe, affordable place to live, it is almost impossible to achieve good health or to achieve one's full potential. Individuals with substance use disorders can be particularly vulnerable to becoming homeless or being precariously housed.⁴⁷

Recovery support services empower individuals with substance use disorders to direct their own recovery. These support services are essential for special populations. NIMBY is a major barrier to siting new treatment programs and engagement of elected officials will be a necessary strategy. DBHIDS' recent policy changes for halfway houses, recovery houses and residential treatment programs support these objectives, but additional action is needed.

Recovery support services empower individuals with substance use disorders to direct their own recovery.

11 Incentivize providers to enhance the quality of substance use disorder screening, treatment, and workforce.

The City should develop strategies to

- 1) increase capacity and competency of non-substance use disorder (SUD) professionals in health care and other social services to identify SUDs and work with them and*
- 2) incentivize qualified staff to work in the SUD workforce using the most current and supported evidence-based practices and requiring continuing education:*
 - a) incentivize a specialization in SUD Treatment,*
 - b) develop a standardized, uniformed, and mandatory training that will increase effectiveness across all SUD treatment providers,*
 - c) incorporate holistic offerings and alternative therapies into the scope of SUD treatment,*
 - d) develop city-wide standard rigorous training for certified recovery specialists and certified peer specialists and incorporate peers across private and public systems.*

The broader health care workforce does not have the capacity for integrated health care and is undertrained to deal with issues related to SUDs. Non-SUD professionals within health care and other social services (such as child welfare and criminal justice) need basic SUD competency so that SUD screening can take place outside of the formal treatment system. The SUD workforce shortage is exacerbated by the scarcity of providers who can provide culturally competent services to minority populations, a very high turnover rate, and recruitment challenges. As of June 2016, more than three-quarters of United States counties had severe shortages of psychiatrists and other types of health care professionals needed to treat mental health and SUDs.⁴⁸

The broader health care workforce is undertrained to deal with issues related to substance use disorders.

Strategy 3: OVERDOSE PREVENTION



Not all opioid users are able and willing to begin drug treatment. Until those persons do begin treatment, actions can be taken to increase use of health and treatment services and reduce fatalities, non-fatal overdoses, and the infectious complications (HIV, hepatitis B and C, infections) of drug use.

12 Expand naloxone availability.

The City should develop a strategic plan to make naloxone readily available to reverse opioid overdoses. The plan should engage governmental agencies, community-based organizations, health care providers, pharmacies, and private citizens who may know individuals using opioids. The plan should prioritize supporting naloxone programs and activities that have the greatest likelihood of achieving overdose reversals.

Although many health care professionals and emergency services personnel are experienced in administering naloxone, laypeople can also be successfully trained to identify and respond to overdose. Use of naloxone by laypeople has been linked to reductions in overdose death rates. People who use opioids are at greatest risk of overdose, and are also motivated to protect themselves and others around them.

Naloxone should be readily available and/or administered to persons at risk of overdose through four major mechanisms:

- 1) governmental and quasi-governmental agencies, such as Fire, Police and Homeless Outreach;
- 2) harm-reduction programs;
- 3) take-home programs, including from hospital emergency departments, prison discharge, and opioid treatment programs; and
- 4) direct request at pharmacies.

The City should support the purchase of naloxone with public funds for specific distribution in supported programs. Because resources may limit ability to provide all persons and agencies with naloxone, the City should strategically select those who are most likely to encounter overdose victims. Distribution of naloxone has expanded in the city with some government and philanthropic investment, but additional distribution is needed.

All naloxone distribution programs should include specific training on recognition of overdose, administration of naloxone, treatment service availability, and other harm reduction messages.

13 Further explore comprehensive user engagement site(s).

The City and/or partner organizations should further explore the possibility of implementing one or more comprehensive user engagement sites (CUES), on a pilot basis, in which essential services are provided to reduce substance use and fatal overdose (including referral to treatment and social services, wound care, medically supervised drug consumption, and access to sterile injection equipment and naloxone) in a walk-in setting.

Safe consumption facilities (SCF) have a long record of success in reducing the health and social harms of drug use among persons injecting heroin and other opioids. SCFs have been in operation since 1988, beginning in Europe and extending to Australia and Canada. They have been shown to:

- » Reduce overdose death, disease transmission (including HIV, hepatitis C, and hepatitis B), injection-related infections, and other adverse health outcomes associated with drug use.⁴⁹
- » Serve as an access point for drug and alcohol treatment, medical services, social services, and housing services that in turn reduce the burden on the Emergency Departments, Police and Fire.⁵⁰
- » Improve public order and neighborhood safety by reducing public drug consumption and improper disposal of drug use equipment.⁵¹

The continuing rise in opioid overdose, now driven in part by highly dangerous fentanyl products, has brought new salience to safe consumption as a potentially valuable intervention in the U.S. Seattle-King County's overdose task force has recommended the opening of several facilities providing safe consumption and other services, and other U.S. cities hit hard by overdose are also considering the move. Deploying CUES in Philadelphia will require a serious process of planning and community engagement to fully assess the value proposition and secure public acceptance. In addition, there are serious legal impediments that would need to be addressed. The pilot program should be rigorously evaluated for health and community outcomes to guide future decisions on continuation or expansion.

14 Establish a coordinated rapid response to “outbreaks.”

The City should develop a strategy for identifying (in real time) and responding to significant surges in the number of opiate overdoses (“outbreaks”) in a non-coercive manner. The strategy should aim to prevent additional overdoses by increasing situational awareness, improving deployment of resources, and enhanced treatment services.

Illicit opioids often are mixed with harmful adulterants (for example, fentanyl and its analogs blended with or deliberately substituted for heroin or mixed with opioid analgesic combinations). Resultant outbreaks of fatal and nonfatal overdoses may impact opioid experienced or inexperienced individuals. The explosive occurrence of multiple overdoses should trigger a rapid response by public safety and medical communities to identify the substance and its source. Local agencies should respond to gather additional information, alert the public, confine the outbreak, and save lives where possible.

15 Address homelessness among opioid users.

The City should expand outreach and specialized programs to meet the unique needs of individuals with opioid use disorder who are homeless, such as the City's Safe Haven, Journey of Hope, and Housing First programs.

Housing First provides access to housing for homeless individuals without restriction for those suffering from substance use disorder. This strategy has been proven to reduce homelessness, shelter costs, and health care costs through emergency department utilization. In addition, it increases substance use disorder and mental health treatment among its participants.⁵² Housing First has been used successfully in many cities across the United States and Canada, including in Philadelphia.

Strategy 4: INVOLVEMENT OF THE CRIMINAL JUSTICE SYSTEM



Individuals in the justice system continuum, from arrestees to sentenced prisoners, with OUD who are not participating in adequate treatment services constitute a particularly risky population.⁵³ A change to a public health approach within the justice system is urgently needed,⁵⁴ however, members of the Justice System, Law Enforcement, and First Responders subcommittee reported systemic barriers and gaps in programming, resources, and training which must be addressed in Philadelphia to enable implementation of an evidence-based public health strategy.

16 Expand the court's capacity for diversion to treatment.

The City should collaborate with the court system, the District Attorney's office, the Defenders Association, and treatment providers to expand existing court-sanctioned treatment programs to increase capacity, including but not limited to Drug Treatment Court and the Accelerated Misdemeanor Programs.

Drug Treatment Court allows defendants with SUDs who are charged with nonviolent felony offenses an opportunity to participate in treatment and avoid conviction. The Accelerated Misdemeanor Programs (AMP 1 and AMP 2) are diversion programs that expedite the resolution of misdemeanor charges by allowing substance-using offenders to engage in treatment and avoid conviction. Across the United States, integration of court monitoring with clinical OUD care that includes MAT has achieved remarkable success rates, for both public health and public safety. At present, the number of participants is capped due to limited resources.

The judicial intervention of diverting offenders to treatment programs has been extensively studied, and can reduce recidivism, increase abstinence in closely supervised offenders, and improve retention in treatment. Philadelphia's system is cited as a best practice model by the National Association of Criminal Defense Lawyers.

The judicial intervention of diverting offenders to treatment programs... can reduce recidivism, increase abstinence in closely supervised offenders, and improve retention in treatment.

17 Expand enforcement capacity in key areas.

Federal, state and local law enforcement agencies should

- 1) *expand capacity for investigating those who divert prescription opioids, focusing on pharmaceutical companies and opioid prescription abuse by registrants, recognizing that there are DEA regulatory sanctions as well as state and federal criminal penalties that can be levied against registrants involved in the illicit distribution of prescription opioids; and*
- 2) *take action against drug dealers who prey on people trying to recover at clinics and treatment facilities.*

Philadelphia is following recommended best practices with regional coordination through the High-Intensity Drug Trafficking Area program and DEA 360 strategy; however, additional staffing resources are needed for complex investigations.⁵⁵ Federal funding may be available to leverage local funding for high-level investigation and interdiction.

18 Provide substance use disorder assessment and treatment in Philadelphia Department of Prisons.

The Philadelphia Department of Prisons should provide substance use disorder assessment to all inmates upon entry and comprehensive treatment during incarceration, with a continuum of care plan upon release, which includes a plan to obtain an identification card to facilitate treatment.

Treatment during incarceration increases the likelihood of engagement in treatment post-incarceration and correlates with positive outcomes such as reduced recidivism, increased abstinence, and decreased overdose morbidity in the weeks immediately after release.

In a well-designed study,⁵⁶ inmates who participated in medication-assisted treatment (MAT) during incarceration were more than twice as likely to engage in treatment upon re-entry than the control group. A large, multi-site study that included patients in Philadelphia found similar benefit for MAT in patients on parole or probation.⁵⁷ SAMHSA also recommends provision of MAT in jails.⁵⁸

... inmates who participated in medication-assisted treatment during incarceration were more than twice as likely to engage in treatment upon re-entry,

IMPLEMENTATION

This report makes 18 recommendations that together have the potential to turn the tide on the opioid epidemic in Philadelphia. However, the City will succeed only if a large number of organizations and individuals referenced in the recommendations implement these changes. The participating city government agencies that report to the mayor are committed to implementing these recommendations to the extent that resources and legal authority allow. The members of the Task Force strongly encourage all other organizations and individuals referenced in these recommendations do the same.

MONITORING AND EVALUATION

In addition to monitoring progress around implementation, the City should increase its data collection and analysis efforts around key opioid use and overdose trends. The Data Analysis and Sharing subcommittee of the Task Force specifically reviewed city agencies' existing efforts to quantify and track the opioid epidemic, and made the following recommendations for how to improve data collection and analysis.

The City should establish a high-level substance use surveillance program that would:

- a. *Develop an opioid epidemic data report to establish a baseline and monitor the epidemic;*
- b. *Establish use of real-time data to support a rapid response plan;*
- c. *Use data matched across departments to identify barriers and opportunities for optimal system interactions with individuals; and,*
- d. *Develop an evaluation plan that assesses the progress and impact of actions and interventions undertaken as a result of the Mayor's Opioid Task Force Report.*

In developing this data collection and analysis plan, the data subcommittee drew on examples of effective surveillance programs in other locations. Jurisdictions that have made real and measurable success in addressing the opioid epidemic, such as New York City, Baltimore, and Rhode

Island, have established surveillance programs within their local and state health departments. A permanent program with an organizational structure that is modeled on the structure of other "disease"-specific program areas within Philadelphia's health department would help ensure that the city remains accountable for the recommendations it puts forth and remains sustainable over the long term.

In the interim, the Data Analysis and Sharing subcommittee also produced a set of core metrics to monitor progress on the opioid epidemic (see table below). These metrics will be tracked on a quarterly basis. In addition, a draft list of metrics to evaluate Philadelphia's progress in implementing these recommendations is in Appendix IV.

METRIC

Opioid prescription rate per 1,000 population*
Buprenorphine prescription rate per 1,000 population*
Behavioral health treatment rate for patients with a primary diagnosis of opioid use disorder*
Medication-assisted treatment rate for patients with a primary diagnosis of opioid use disorder*
Doses of naloxone distributed
Doses of naloxone administered by first responders
Fatal overdoses
Nonfatal overdoses

* Medicaid-enrolled patients only

APPENDIX I: GLOSSARY OF TERMS

12-Step Program: Group providing mutual support and fellowship for people recovering from addictive behaviors. Alcoholics Anonymous, the first 12-Step program was founded in 1935; an array of 12-step groups following a similar model have since emerged and are the most widely used mutual aid groups for maintaining recovery from substance use disorders. It is not a form of treatment.

Adverse Childhood Experience (ACE): Stressful or traumatic events, including abuse and neglect. They may also include household dysfunction such as witnessing domestic violence or growing up with family members who have substance use disorders. ACEs are strongly related to the development and prevalence of a wide range of health problems throughout a person's lifespan, including those associated with substance misuse.

American Society of Addiction Medicine (ASAM) Criteria: The ASAM treatment criteria provide separate placement criteria for adolescents and adults to create comprehensive and individualized treatment plans. Patients are assessed for treatment needs, obstacles, and liabilities as well as their own strengths, assets, resources, and support structure. Treatment plans are developed to cover five broad levels of treatment that are based on the degree of direct medical management provided, the structure, safety and security provided and the intensity of treatment services provided.

Benzodiazepines: A class of drugs primarily used for treating anxiety; also known as tranquilizers (e.g., Valium, Xanax).

Buprenorphine: Generic name of Suboxone, a treatment medication for opioid use disorder used in medication-assisted treatment.

Cognitive Behavior Therapy (CBT): CBT is a time-sensitive, structured, present-oriented psychotherapy directed toward solving current problems and teaching clients skills to modify dysfunctional thinking and behavior.

Certified Recovery Specialist (CRS): The CRS credential is for drug and alcohol peers in recovery who have been trained to help others move into and through the recovery process. Candidates must attest that he/she has personal, lived recovery experience in a continuous manner for a minimum of 18 months to be eligible.

Certified Peer Specialist (CPS): A person willing to self-identify as having a serious behavioral health condition (mental illness or co-occurring disorder) with lived experience. To be certified, the person must have received specific training in the role, functions, and skills of the CPS position. The purpose of a CPS is to support others in their recovery process.

Diversion: A voluntary, judicial intervention which provides an alternative to criminal-case processing for a defendant charged with a crime related to their substance use disorder (SUD); ideally, upon successful completion of a program /plan, diversion results in a dismissal of the charge(s).

Fentanyl: A synthetic, short-acting opioid analgesic with a potency 50 to 100 times that of morphine. Fentanyl carries a high risk of overdose. These drugs are sold illicitly for their heroin-like effects and may be mixed with heroin and/or cocaine as a combination product, with or without the user's knowledge. The biological effects of fentanyl are indistinguishable from those of heroin. Overdoses involving fentanyl increased six-fold from 2013 through 2015.

Implications: A higher dose or multiple doses of naloxone may be required to revive patients with overdoses involving fentanyl. Patients presenting to emergency departments with symptoms of opioid intoxication may be unaware that they have taken fentanyl. Providers should be mindful that fentanyl is not detected by standard urine toxicology screens.

Heroin: An opioid drug that is synthesized from morphine, a naturally occurring substance extracted from the seed pod of the Asian opium poppy plant. Heroin is a full opioid agonist.

Integration: The systematic coordination of general and behavioral health care. Integrating services for primary care and behavioral health together provides the most effective approach for supporting comprehensive health and wellness.

Intervention: A professionally delivered program, service, or policy designed to prevent substance misuse (prevention intervention) or treat a substance use disorder (treatment intervention).

Medication-Assisted Treatment (MAT): The use of medication in combination with therapy to treat substance use disorders.

Methadone: A medication used in medication-assisted treatment for opioid use disorder.

Naloxone hydrochloride: Generic name for the opioid overdose antidote; known as naloxone.

Naltrexone: Also known as Vivitrol®. A medication used in medication-assisted treatment for opioid-use disorder.

NIMBY: The acronym for “not in my backyard”, which is used to express opposition by local citizens to the locating in their neighborhood of a civic project, such as a treatment program. Although needed by the larger community, it is considered unsightly, dangerous, or likely to lead to decreased property values.

Office of Mental Health and Substance Abuse Services (OMHSAS): The OMHSAS is an agency within Pennsylvania’s Department of Human Services that is responsible for the mental health and substance abuse service system for the entire state of Pennsylvania.

Opioid: A compound or drug that binds to receptors in the brain involved in the control of pain and other functions, for example, morphine, heroin, fentanyl, hydrocodone, and oxycodone.

Opioid Treatment Program (OTP): SAMHSA-certified program, usually comprising a facility, staff, administration, patients, and services, that engages in supervised assessment and treatment, using methadone, buprenorphine, or naltrexone, of individuals who have opioid use disorders. An OTP can exist in a number of settings, including but not limited to intensive outpatient, residential, and hospital settings. Services may include medically supervised withdrawal and/or maintenance treatment, along with various levels of medical, psychiatric, psychosocial, and other types of supportive care.

Opioid Use Disorder (OUD): A medical illness characterized by a problematic pattern of opioid use leading to clinically significant impairment or distress, as manifested by assessing cognitive, behavioral, and psychological symptoms.

Prescription Drug Misuse: Use of a prescribed medication in any way a prescribing health care provider (including doctors, dentists, nurse practitioners, physician assistants, etc.) did not direct an individual to use it.

Recovery: A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential. Individuals with severe and chronic substance use disorders can, with help, overcome their substance use disorder and regain health and social function. “Being in recovery” is when those positive changes and values become part of a voluntarily adopted lifestyle. Although abstinence from all substance misuse is a cardinal feature of a recovery lifestyle, it is not the only healthy, pro-social feature.

Relapse: Breakdown or setback in a person’s attempt to change or modify a particular behavior; an unfolding process in which the resumption of compulsive substance use is the last event in a series of maladaptive responses to internal or external stressors or stimuli.

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

Screening, Brief Intervention, and Referral to Treatment (SBIRT): A method for early intervention to identify, reduce, and prevent problematic use of and dependence on alcohol and illicit drugs.

Special Populations: Groups of individuals with unique circumstances requiring specific needs and alternate considerations for behavioral health treatment, for example, women, pregnant and parenting women, youth, young adults, LGBTQIA, and Spanish-speaking Latinos.

Substance Use Disorders (SUDs): A medical illness caused by repeated misuse of a substance or substances. SUDs are characterized in the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-5) by clinically significant impairments in health, social function, and impaired control over substance use and are diagnosed through assessing cognitive, behavioral, and psychological symptoms. Substance use disorders range from mild to severe and from temporary to chronic. They typically develop gradually over time with repeated misuse, leading to changes in brain circuits and executive functions. Severe substance use disorders are commonly called addictions.

Take Home Programs: Under the supervision of doctors and other prescribers, some forms of medication in addiction treatment can be dispensed to enrolled individuals to “take home” in multiple doses for future use as prescribed.

Tolerance: A condition in which higher doses of a drug are required to produce the same effect achieved during initial use; often associated with physical dependence. Alteration of the body’s responsiveness to alcohol or a drug such that higher doses are required to produce the same effect achieved during initial use.

Withdrawal: Symptoms that occur after chronic use of a drug is reduced abruptly or stopped. A set of symptoms that are experienced when discontinuing use of a substance to which a person has been dependent or addicted, which can include negative emotions such as stress, anxiety, or depression, as well as physical effects such as nausea, vomiting, muscle aches, and cramping, among others. Withdrawal symptoms often lead a person to use the substance again.

APPENDIX II: SUBCOMMITTEE MEMBERS

PUBLIC EDUCATION AND PREVENTION STRATEGIES

Co-Chairs:

Jeffrey Hom, MD MPH
Policy Advisor, Philadelphia
Department of Public Health

Reverend Richard A. Harris
Pastor, Firm Hope Baptist Church

Michael Ashburn, MD MPH
Mark C. Austerberry
Laura Bamford, MD MSCE
Joseph F. Carey, Jr.
Mary K. Doherty
George Downs, PharmD
Zachary F. Meisel, MD MPH MSHP
Jonathan Orens
Vaibhav (Vaib) Penukonda
Jeanmarie Perrone, MD FACMT
Ann Ricksecker, MPH
Kim Rubenstein, CRS
Clayton Ruley, MSS
Elise Schiller, MA
Robert Sharrar, MD MSc
Alex Shirreffs, MPH
Andrew Spiers
Faith Dyson-Washington, PhD
Mel Wells

SERVICE ACCESS, BEST PRACTICES, TREATMENT PROVIDERS

Co-Chairs:

Robert Holmes
Executive Director, Addiction Medicine
and Health Advocates, Inc.

Gloria Maloney
Clinical Management Supervisor,
Behavioral Health Special Initiative,
Philadelphia Department of Behavioral
Health and Intellectual disAbility
Services

Yasser Al Khatib, MSN
Fred Baurer, MD
Sandy Cini, MSW MEd LSW CCS
Winston Collins, DSW
Joseph L. D’Orazio, MD
Oluwatoyin Fadeyibi, PharmD MPH
Art Fastman
Evan Figueroa-Vargas
Angelita Alomar-Gilbert
Rose Julius, DO MPH DABAM
Abigail Kay, MA MD
Roland Lamb
Deanna Lear, LSW
Marvin Levine
Priya E. Mammen, MD MPH
Silvana Mazzella
James R. McKay, PhD
Jim Peightel, MD
Cheryl V. Pope, PhD
Joe Pyle, MA
Christi Rinehart
Arlene Schofield, MEd CAC
Serge-Emile Simpson, MD
Sister Mary Scullion
John White

OVERDOSE PREVENTION AND HARM REDUCTION

Co-Chairs:

Jose Benitez, MSW
Executive Director, Prevention Point
Philadelphia

Caroline Johnson, MD
Deputy Commissioner, Philadelphia
Department of Public Health

Lt. Karyn Baldini
Alyssa Bowers, MSW
Jeanette Bowles, MSW
Mel Brodsky, RPh
Scott Burris, JD
Colette Green, MSS LCSW
David Holloman, MS
Frank A. James III, DPhil PhD
Lee Roy Jordan
Rachel L. Levine, MD
Richard Ost, RPh
C. Crawford Mechem, MD
Carol Rostucher
Alexis Roth, PhD MPH
Matt Tice, LCSW
Evelyn Torres, MBA
Ricardo Tull
Max C. Tuttleman
Michael Vitali
Fred Way, MA
Brian Work, MD MPH
Hannah Zellman, MSW
Jeanmarie Zippo, RN

JUSTICE SYSTEM,
LAW ENFORCEMENT,
AND FIRST RESPONDERS

Co-Chairs:

Jeremiah Laster
Deputy Commissioner,
Emergency Medical Services,
Philadelphia Fire Department

George D. Mosee, Jr. Esq.
Interim Executive Director,
Philadelphia Anti-Drug,
Anti-Violence Network

Hector Ayala
Byron Cotter
Jeremiah Daley
Benjamin H. Field
Sam Harrison, III
Bruce W. Herdman, MBA PhD
William Judge
Christopher McFillin, MS
Officer Linda Muraresku
Thomas J. Nestel, III
Elvis Rosado
Derek Riker
Honorable Sheila Woods-Skipper
Gail Groves Scott, MPH
Cecilia Velasquez
Joan Vieldhouse
Julie Wertheimer
Wilfredo Rodriguez, BHS CRS
Joseph F. Whelan
Glenn Wilson
H. Jean Wright, II, PsyD
Kristin Van Zant, MD

DATA ANALYSIS
AND SHARING

Co-Chairs:

Suet Lim, PhD
Director, Research and Evaluation,
Community Behavioral Health

Kendra Viner, PhD MPH
Viral Hepatitis Program Manager,
Philadelphia Department of
Public Health

Robert Ashford, BSW
Ben Cocchiario, MD MPH
Marsha Zibalese-Crawford, PhD
MSW
Rebecca Drake, MPH
Tara Garvey, PhD
Sara Gefvert
Sam Gulino, MD
Amy B. Jessop, PhD MPH
Danica Kuncio, MPH
Stephen E. Lankenau, PhD
Jose Lojo, MPH
Samantha Matlin, PhD
David Metzger, PhD
Matt Miclette, RN-BC BSN
Lynn S. Mirigian, PhD
Benjamin Mishkin
James Moore
Dan Panusky
Lia Pizzicato, MPH
Diane Schweizer
Jerry Stahler, PhD
Kevin Thomas, MA
Curt Watkins
Catherine Williams, PhD
Sandy Vasko, MA MEd

SUPPORT TEAM FOR
SUBCOMMITTEES

Logistic Coordinators

Ava Ashley
Nadine J. Burton
Natalie Charney
Keena Cravison
Ramos Cruz
Evelyn Finch
Rasmiyyah Gaines
L'Oreal McCollum
Randi McKeon
Andrea Stout
Catherine Williams

Recorders

Kelly Boettcher
Mary Figgatt
Lolita Griffin
Natalie Kotkin
Victoria Prisco

APPENDIX III: DETAILS ON TASK FORCE PROCESS

CHARGE FOR MAYOR'S TASK FORCE TO COMBAT THE OPIOID EPIDEMIC IN PHILADELPHIA

The task force met semi-monthly over three months, for a total of six meetings, kicking off with Mayor Kenney on January 11, 2017 and concluding on March 22, 2017. All Task Force Meetings were open for the public to attend. Fifteen minutes were set aside at the end of every Task Force meeting for public comment.

SUBCOMMITTEE CHARGES

The Task Force worked through five subcommittees:

1. Public Education and Prevention Strategies
2. Service Access, Best Practices, and Treatment Providers
3. Overdose Prevention and Harm Reduction
4. Justice System, Law Enforcement, and First Responders
5. Data Analysis and Sharing

Each subcommittee was led by two co-chairs and met five times for two hours, beginning on January 18, 2017 and concluding on March 20, 2017.

The five subcommittees were given the following overall charges, in addition to their specific topics to address:

- All subcommittee recommendations should take into consideration the general diversity of Philadelphia County, e.g., youth, LGBTQIA, pregnant and parenting women, race, ethnicity, gender, and so on.
- All subcommittees will thoroughly understand and analyze the key issues, needs, and priorities of the opioid epidemic as it impacts and relates to their subcommittee area.
- All subcommittees will submit a written report to the Task Force, summarizing their findings related to their specific subcommittee area and providing justification for their recommendations.

COMMUNITY PERSPECTIVES FROM THE LISTENING SESSIONS

Overview

The Task Force held four Community Listening Sessions over two weeks in January and February 2017. The Community Listening Sessions were held at the following locations on the following dates:

1. Northwest Philadelphia

Monday, January 23, 2017

Resources for Human Development (RHD)

4700 Wissahickon Ave, 19144

2. North Philadelphia

Wednesday, January 25, 2017

Prevention Point Philadelphia (PPP)

2913 Kensington Ave., 19134

3. South and West Philadelphia

Tuesday, January 31, 2017

Greater Philadelphia Health Action, Inc. (GPHA)

1401 S 31st St., 19146

4. Northeast Philadelphia

Thursday, February 2, 2017

Counseling Or Referral Assistance (CORA)

8540 Verree Rd., 19111

ATTENDANCE

The combined total attendance for all four Community Listening Sessions was 463 community members. On average, 116 people attended each session. Attendees came from all over the city, including at least 42 of Philadelphia's 47 populated zip codes. Of those surveyed, 86 percent of participants have been directly impacted themselves or know someone directly impacted by the opioid epidemic. Eighty four percent of surveyed participants felt they were seriously listened to by city officials and Task Force members on possible solutions to the opioid epidemic.



COMMON THEMES

There were several common themes expressed by attendees at the four Community Listening Sessions, including:

Opioid Prescribing

- » Impose harsher restrictions on doctors illegally prescribing opioids
- » Improve monitoring of doctors distributing and prescribing opioids

Public Education

- » Increase early intervention and education opportunities for at-risk children and populations

Increasing Treatment Access and Availability

- » Increase medication-assisted treatment (MAT) for opioid use disorder
- » Increase the length of time that individuals remain engaged in treatment
- » Increase financial investment from the state in substance use disorder treatment
- » Make available innovative alternative treatments for pain management, such as acupuncture and EEG biofeedback

Public Safety

- » Establish drug-free communities so persons in recovery do not have to be tempted by drug dealers while participating in or after returning from treatment

Government Coordination and Communication

- » Facilitate a partnership between the City and its communities in fighting the opioid epidemic (with emphasis on communication)
- » Increase understanding and partnership between the Department of Human Services (DHS) and recovering mothers

APPENDIX IV: COMPILED TASK FORCE METRICS

PREVENTION AND EDUCATION	1	Conduct a consumer-directed media campaign about opioid risks	<ul style="list-style-type: none"> Estimated view of campaign messages People using opioids in previous seven days
	2	Conduct a public education campaign about naloxone	<ul style="list-style-type: none"> Estimated view of campaign messages People trained
	3	Destigmatize opioid use disorder and its treatment	<ul style="list-style-type: none"> People reached through community events
	4	Improve health care professional education	<ul style="list-style-type: none"> Opioid pills sold
	5	Establish insurance policies that support safer opioid prescribing and appropriate treatment	<ul style="list-style-type: none"> Opioid prescriptions Buprenorphine prescriptions People with public insurance or uninsured receiving methadone
TREATMENT	6	Increase the provision of medication-assisted treatment	<ul style="list-style-type: none"> Publicly insured opioid use disorder clients participating in medication-assisted therapy
	7	Expand treatment access and capacity	<ul style="list-style-type: none"> People treated for opioid use disorder in the public behavioral health system
	8	Embed withdrawal management into all levels of care, with an emphasis on recovery initiation	<ul style="list-style-type: none"> Facilities using physical health stabilization protocol
	9	Implement “warm handoffs” to treatment after overdose	<ul style="list-style-type: none"> Successful warm hand-offs
	10	Provide safe housing, recovery, and vocational supports	<ul style="list-style-type: none"> Number of individuals housed that have opioid use disorder
	11	Incentivize providers to enhance the quality of substance abuse disorder screening, treatment, and workforce	<ul style="list-style-type: none"> To be developed
OVERDOSE PREVENTION	12	Expand naloxone availability	<ul style="list-style-type: none"> Doses of naloxone distributed, by agency Doses of naloxone administered, by agency Nonfatal drug overdoses treated in hospital emergency departments Fatal drug overdoses
	13	Further explore comprehensive user engagement sites	<ul style="list-style-type: none"> Community impact assessment
	14	Establish a coordinated rapid response to “outbreaks”	<ul style="list-style-type: none"> Time from recognition of a surge in non-lethal overdoses to coordinated response
	15	Address homelessness among opioid users	<ul style="list-style-type: none"> Individuals with opioid use disorder placed in Safe Havens and Housing First programs
INVOLVEMENT OF THE CRIMINAL JUSTICE SYSTEM	16	Expand the court’s capacity for diversion to treatment	<ul style="list-style-type: none"> People served by Drug Treatment Court People in Accelerated Misdemeanor Program
	17	Expand enforcement capacity in key areas	<ul style="list-style-type: none"> To be developed
	18	Provide substance abuse disorder assessment and treatment in the Philadelphia Department of Prisons	<ul style="list-style-type: none"> Inmates treated for opioid use disorder while incarcerated Inmates with opioid use disorder released with continuum of care plan

APPENDIX V: ADDITIONAL RECOMMENDATIONS FOR INVOLVEMENT OF THE CRIMINAL JUSTICE SYSTEM (STRATEGY #4)

In order to fully address the issues raised by the Justice System, Law Enforcement, and First Responders Subcommittee, this group wished to provide additional recommendations beyond those described in the main body of the report. These additional recommendations, listed below, complement the Subcommittee's three main recommendations and should be considered as expansions upon those recommendations.

SUBRECOMMENDATIONS FOR:

RECOMMENDATION #16

Expand the court's capacity for diversion to treatment

A. Create Access to Medication-assisted Treatment

Federal, state, and local law enforcement should align policies across the criminal justice system to create access to medication-assisted treatment (MAT) within each sector including jail, probation and parole, drug courts and other diversion programs, and housing programs.

B. Recovery Housing

Identify and address factors that hinder or enhance capacity of quality recovery housing (zoning, regulations, funding) for court referrals.

C. Gender Specific Needs

Federal, state, and local law enforcement must ensure that the appropriate resources are readily available for court referred men and women in need.

RECOMMENDATION #17

Expand enforcement capacity in key areas

A. Protocol Support

Federal, state, and local law enforcement should support law enforcement and fire department protocol changes to ensure that all overdose survivors are transported to sites for proper evaluation as a prelude to entering a continuum of care.

B. Pharmaceutical Representative Licensing

Federal, state, and local law enforcement should enact new laws requiring the licensing of pharmaceutical representatives to ensure practices adhere to ethical and professional standards.⁵⁹

RECOMMENDATION #18

Provide substance use disorder assessment and treatment in the Philadelphia Department of Prisons

A. Cognitive Behavioral Therapy

Federal, state, and local law enforcement should specifically make cognitive behavioral therapy (CBT) available to all inmates.

B. Medication-Assisted Treatment

Federal, state, and local law enforcement should initiate medication-assisted treatment (MAT) in conjunction with community treatment programs during incarceration.

C. Mutual Aid Groups

Federal, state, and local law enforcement should create additional Mutual Aid Groups, such as Narcotics Anonymous, Alcoholics Anonymous, SMART Recovery, etc. for cell blocks and vastly increase the number of meetings.

D. Good Time/Earned Time

Federal, state, and local law enforcement should increase the “Good Time/Earned Time” credit for cognitive behavioral therapy (CBT) and general education development (GED) completion as an incentive for inmates to participate in these programs.

E. Assure Medical Assistance (Medicaid)

The City should work with state officials at the Office of Mental Health and Substance Abuse Services (OMHSAS) to revise Medical Assistance (Medicaid) policies so that coverage is suspended, rather than canceled, during incarceration; jails would then re-enroll detainees just prior to release.

F. Naloxone at Release

Federal, state, and local law enforcement agencies should train inmates and provide naloxone to them at the time of their release to mitigate the risk of fatal overdose, which is 15 to 29 times higher for released prisoners than for the general population in the first two weeks after release.⁶⁰

G. Assure Government Issued Identification

The City should work with state officials at the Department of Motor Vehicles to provide non-driver photo licenses upon release.

APPENDIX VI: HOW TO GET HELP

ACCESS TREATMENT:

The Task Force encourages individuals who are actively using and at-risk for overdose to access treatment. To determine your eligibility for services and find the nearest assessment site, contact:

**Community Behavioral Health (CBH) Member Services:
(888) 545-2600**

CBH Member Services operates a 24/7, 365 days a year hotline that directs people to available behavioral health resources, emergency services, and treatment programs.

ACCESS COMMUNITY SUPPORT:

The Task Force encourages individuals who may not be ready to enter treatment to access support in the community.

**PRO-ACT's Philadelphia Recovery Community Center:
(215) 223-7700**

1701 W. Lehigh Ave., Philadelphia, PA 19132-2123

Hours of Operation:

Monday – Wednesday: 10 a.m. – 6 p.m.

Thursday – Friday: 11:30 a.m. – 7 p.m.

The Philadelphia Recovery Community Center is a resource for education, information, support, and socialization for those in recovery and their family and friends. It is meant to authenticate that recovery from the disease of addiction is possible. The basis of services and programming available through the Recovery Centers are Peer Recovery Support Services. These are non-clinical services focusing on removing barriers and providing invaluable resources to those who are seeking to achieve and maintain long-term recovery.

OTHER SUPPORTS:

The Task Force encourages individuals who may be grieving the loss of loved ones to seek support for themselves by using CBH Member Services; if they are not ready to access services, contact the DBHIDS Crisis Intervention Hotline or the Philadelphia Warmline to talk with someone for confidential support.

**DBHIDS 24-Hour Suicide & Crisis Intervention Hotline:
(215) 686-4420**

DBHIDS operates a 24-hour telephone hotline to assist people and their families dealing with behavioral health emergencies. Compassionate, trained professionals are available 24 hours a day, 7 days a week, and 365 days a year. Callers will receive counseling, guidance and direction for receiving prompt evaluative and treatment services. Interpreter services are available for all languages and TTY services for those who are hearing impaired.

Philadelphia residents can call the DBHIDS Crisis Intervention Hotline if they (or someone they know):

- Are suffering from depression
- Have feelings or thoughts of wanting to harm themselves or others
- Have feelings of hopelessness
- Are having difficulty dealing with life stressors
- Suffer from intense anger or other emotional or substance abuse crises

**The Philadelphia Warmline:
(855) 507-3945**

The Philadelphia Warmline is a non-judgmental “listening ear” operated by trained certified peer specialists to help individuals who may be experiencing anxiety, depression, loss, stress, and other life challenges.

thank you

ACKNOWLEDGMENTS

Co-Chairs Thomas Farley, MD, MPH, and Arthur Evans, PhD, gratefully acknowledge the roles of many people who made the work of the Task Force possible, including the Task Force members, the co-chairs of the Task Force's five subcommittees, and the members of the subcommittees. Each of these individuals have contributed meaningfully to the work of the Task Force, and helped to shape its recommendations. Their names are listed in Appendix II.

In addition, Co-Chairs Farley and Evans are grateful to the staff from DBHIDS and PDPH who supported the operations and logistics of the Task Force, including:

Project Manager:

Pamela D. McClenton, LCSW

Logistics Coordinators:

Mika Dabney Walton

Rasmiyyah Gaines

Report Writers:

Andrea Brooks, LSW

Natalie Kotkin

Recorders:

Natalie Kotkin

Sekaiya Willis

The co-chairs also wish to thank Senior Editors Adam C. Brooks, PhD and David R. Gastfriend, MD for their support with drafting and editing the report.

Finally, Co-Chairs Farley and Evans extend their thanks to the members of the public who attended the Task Force's community listening sessions, Task Force meetings, and subcommittee meetings.

TASK FORCE MEMBERS



CO-CHAIRS

Arthur C. Evans, Jr., PhD

Commissioner, 2004–February 2017
Department of Behavioral Health and
Intellectual disAbility Services (DBHIDS)

Thomas Farley, MD, MPH

Health Commissioner
Philadelphia Department of
Public Health (PDPH)

Reverend James P. Baker, Jr.

Chair, Mayor’s Drug
and Alcohol Executive
Commission; President,
Baker & Company, LLC

Jeremiah Daley

Executive Director,
Philadelphia-Camden
High Intensity Drug
Trafficking Program

Charles P. O’Brien, MD PhD

Kenneth Appel Professor,
Founding Director, University
of Pennsylvania Center for the
Studies of Addiction

Richard Snyder, MD

Senior Vice President and
Chief Medical Officer,
Independence Blue Cross

Jose Benitez, MSW

Executive Director, Prevention
Point Philadelphia

Michael A. DellaVecchia, MD PhD

Past President, Philadelphia
County Medical Society

David Oh

Councilman At-Large/
Minority Whip

Christopher R. Sweeney

Executive Director, Wedge
Recovery Centers

Ex Officio:

Jean Mackey Bennett, PhD MSM MSN RN

Regional Administrator,
Region III, Substance
Abuse and Mental Health
Services Administrator, US
Department of Health and
Human Services

Gene DiGirolamo

State Representative,
Pennsylvania House of
Representatives

Devin A. Reaves, MSW

Clinical Outreach Coordinator,
Life of Purpose Treatment

Adam Thiel

Commissioner, Philadelphia
Fire Department

Blanche Carney

Commissioner, Philadelphia
Department of Prisons

Beverly J. Haberle, MHS

Executive Director, The
Council of Southeast
Pennsylvania, Inc.; Project
Director, Pennsylvania
Recovery Organization/
Achieving Community
Together

Richard Ross

Commissioner, Philadelphia
Police Department

Gary Tuggle

Special Agent in Charge,
Philadelphia Division,
US Drug Enforcement Agency

John T. Cooper III

Program Director, Department
of Corrections; Director,
Inpatient Halfway House,
Self-Help Movement, Inc.

Priya Mammen, MD MPH

Clinical Assistant Professor,
Director of Public Health
Programs, Department of
Emergency Medicine, Sidney
Kimmel Medical College at
Thomas Jefferson University

Joshua Shapiro

Attorney General, State of
Pennsylvania;
Surrogate: Paul Reddel,
Senior Deputy Attorney

Jingduan Yang, MD FAPA

Clinical Professor, Attending
Physician, Department
of Psychiatry and Human
Behavior; Director,
Acupuncture and Chinese
Medicine Program, Jefferson
Myrna Brind Center for
Integrative Medicine

Jennifer Smith

Acting Secretary,
Pennsylvania Department
of Drug and Alcohol
Programs; Surrogate:
Carol Gifford,
Communications Director