

**Joshua Nirella**  
**10-18-16 HR 590 Testimony**

Good morning,

My name is Josh Nirella and I would like to thank you for providing me with the opportunity to testify today to speak about medication-assisted treatment (MAT) and access to care.

I work with Acadia Healthcare as Regional Director for our Western, PA Methadone and Suboxone clinics. I am also VP of PATOD. PATOD represents 43 of the approximately 76 licensed Narcotic Treatment Programs in Pennsylvania (NTPs). Most of the clinics that PATOD represents are located in well-populated areas, which leaves the more rural areas struggling to find treatment for opiate-dependent people. The overall costs associated with regulatory compliance make small-size programs nonviable. NTP/OTP's are outpatient programs which are licensed by the PA Department of Drug & Alcohol Program Licensing and are mainly accredited by CARF. In addition, OTP's receive regulation oversight at the federal level by the DEA and CSAT. Most receive inspection and oversight by their respective County SCA's and Health Choices contractors, as well. Program quality is thus closely scrutinized at multiple levels.

As I am sure you are aware, drug overdoses are now the leading cause of accidental death in America. Opioid pain relievers pose an increasingly dangerous threat to public health and safety, and do so at an epidemic proportion. **The United States represents approximately 5% of the World's population, yet are consuming 80% of the World's supply of pain medication.** Heroin dependence and use, therefore, has more than doubled in just ten years, as more than 80% of Heroin users begin with using pain pills.

Despite this reality, and the horrific toll this epidemic has levied against individuals, families, community based human service agencies, criminal justice agencies, businesses, etc. within all of our communities...a documented, evidence based, and effective medical response and treatment (MAT) to opioid dependence for those who suffer from Substance of Abuse disorder is tragically underutilized.

MAT is the use of medications such as: Methadone(MTD), buprenorphine(Subutex), Buprenorphine/Naloxone(Suboxone) or Naltrexone(Vivitrol). All of which, need to be medically monitored and combined with strict adherence to therapeutic engagement at various levels based on the unique needs presented by the individual. Clearly utilizing Recovery Oriented Systems of Care (ROSC) to afford the most holistic and dynamic treatment and community based coordination of services that may be offered; as comorbidity is a distinct reality amongst this population of community members.

MAT provides this service with individualized therapeutic engagement in concert with physician-prescribed medication to modify maladaptive belief structures, relieve overt withdrawal symptoms, reduce opiate craving and bring about a biochemical balance for the mind and body. Thereby, significantly reducing the overall strain to the aforementioned community partners, not to mention the cognitive relief it affords the individual to focus on the development of a long term and sustainable personal recovery program.

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I wish to offer testimony to each of the medications presented herein, specifically to accessibility to care and the management of said care. Yet, the majority of this testimony will be on MTD. It is my assumption that an education as to the medicinal realities and pharmacological properties of these medications to this group, at this point, may be more than redundant.

Buprenorphine and Buprenorphine/Naloxone have been administered for addiction treatment since the 1980's. Although, Buprenorphine and Buprenorphine/Naloxone may be prescribed by any physician for pain, Buprenorphine and Buprenorphine/Naloxone may only be prescribed for addiction purposes by a physician who has completed specific training and has acquired such DEA approval.

Buprenorphine and Buprenorphine/Naloxone are partial agonists, as such offering partial binding to the opioid receptors within the brain. Buprenorphine and Buprenorphine/Naloxone have proven most beneficial to those who are at a specific level of recovery to opioid dependence. Such as, one who has completed a higher level of care, say with MTD, and/or as a relapse preventative measure with minimal abuse/use history, or for one whom may present medically to more aptly meet this pharmacological regimen of care.

Naltrexone (Vivitrol) is a deep muscle tissue injectable that provides significant relapse and craving relief for one who has already detoxed off of opioids. It is another level of preventative care that, under medical supervision and combined with ongoing clinical engagement, may offer significant benefits to community members working a recovery program.

Naltrexone has also shown significant impact to those who have been confined within the criminal justice system and returning to the community. The most significant is the reduction in overdose and overdose fatalities due to an individual's significant time of abstinence; thereby creating a reduction in ones tolerance to opioids and their initial relapse to a former level of opioid use.

The effectiveness of either of the aforementioned medications to the sustainment of ones' personal recovery program is directly linked to the level of ones' therapeutic engagement in concert with the medically supervised prescribed medication.

Methadone (MTD), administered for addiction treatment, may only be prescribed and administered by a Narcotic Treatment Physician via an Opioid Treatment Program (OTP). Methadone treatment (MMTP) is based on the knowledge and fact that long-term use/abuse of illicit or prescribed opioids, frequently results in significant and permanent damage to ones' internal opioid chemistry within the brain. This makes long-term abstinence impossible; synonymous to any of us choosing not to eat or breathe.

Methadone is a synthetic opioid medication, first used in World War II by Germany for the treatment of pain. Since the 1950's American Physicians were using MTD for the treatment of opioid addiction; yet did not have a clear understanding of how to best to use this medication. It was in the 1960's, following the extensive work of Dr. Vincent Dole, who established the proper

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protocols of single daily dose, that MTD has been effectively integrated into the treatment of SUD's.

As a full agonist, Methadone binds to the to the brain's opioid receptors. At the proper dose, methadone fills these opioid receptors and relieves the need for another opioid drug. At the proper dose MTD frees the individual to truly focus on the development of a personal recovery plan. MTD does not create a euphoric state, and eliminates ones' need to seek out alternate opioids; thereby, allowing the individual to experience a former presence of mind and clarity of vision. MTD has become a popular choice for treating opioid dependence. Aside from the medicinal benefits is the ability for an individual to actively and productively engage therapeutically through their daily presence in the OTP setting. For many, MMTP provides that long 'sought out' opportunity to regain harmony & balance in both lifestyle and priorities.

Methadone IS a Life Sustaining Medication – the evidence to support this statement is profound.... You will see in your materials a pamphlet titled Myths v. Reality Methadone Treatment. This brochure was prepared by PATOD and the Pa. Community Providers Association for the General Assembly to address some of the myths that surround methadone and create barriers for those who need access to this level of care.

Barriers:

Buprenorphine, Buprenorphine/Naloxone Barriers:

- Inadequate coverage from private or public insurers for medication
- Poor therapeutic engagement and protocols for community based prescribers, thereby increased probability of abuse and diversion
- Under-treatment of patient true needs based on minimal screening and minimal to no, clinical assessment and engagement to make a more appropriate determination as to level of care need(s)
- Minimal regulatory oversight to ensure clinical engagement to care
- Due to poor education, regulation of non-OTP providers, and oversight, ignorance and outmoded stereotyping remains

Naltrexone Barrier:

- Inadequate coverage from private or public insurers for medication
- Poor therapeutic engagement and protocols for community based prescribers
- Cost of medication

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- Minimal regulatory oversight to ensure clinical engagement to care
- Due to poor education, regulation of non-OTP providers and oversight, ignorance and outmoded stereotyping

MTD Barriers:

- Inadequate coverage from Private Insurers
- Limited funding offered to SCA's for MMTP offerings
- Limited funding to assist public transportation to rural and other locations
- Extensive Regulatory oversight for established practices on an annual basis
- The lack of exercising 'Deemed Status' Licensure approval following a OTP's successful obtainment of Re-Accreditation; at a minimum
- In-ability for professionals in the field to determine treatment protocol and duration of service needs; e.g. treatment planning timeframes thereby increasing the therapeutic engagement for patients served and reducing redundant paperwork at various stages of recovery
- Some regulatory and bureaucratic hurdles that increase the time it takes to admit a patient into an OTP
- Ignorance and outmoded stereotypes that prevent MAT from becoming available in health care systems and in the criminal justice systems.

Thank you for giving me this opportunity to speak on behalf of PATOD and our providers, but more importantly, our patients. We appreciate all of the attention and action to address this deadly and tragic Epidemic within the Commonwealth of Pennsylvania and the Nation. I hope that we can continue our fight to meet the needs of our community members and restore the balance to their lives and that of our communities.

Respectfully submitted:

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Joshua Nirella, BSW, MSOL  
Regional Director, CTC Division  
Acadia Healthcare