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HOUSE DEMOCRATIC POLICY COMMITTEE

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House of Representatives
COMMONWEALTH OF PENNSYLVANIA

HOUSE DEMOCRATIC POLICY COMMITTEE HEARING
Topic: The Place of Mental Health in Substance Use Disorder Treatment and Recovery
Friends Hospital – Philadelphia, PA
March 6, 2019

AGENDA

2:00 p.m. Welcome and Opening Remarks

2:10 p.m. Panel from State Agencies:
- Lynn Kovich, Deputy Secretary for the Office of Mental Health and Substance Abuse Services, Pennsylvania Department of Human Services
- Ellen DiDomenico, Deputy Secretary, Pennsylvania Department of Drug and Alcohol Programs
- Steven Datlof, Board-Certified Psychiatrist and Distinguished Fellow of the American Psychiatric Association
- Michael Blank, Professor of Psychology in Psychiatry, University of Pennsylvania's Perelman School of Medicine

2:50 p.m. Panel Two:
- David Como, Executive Director, Northeast Community Center for Behavioral Health
- Elvis Rosado, Education and Community Outreach Coordinator, Prevention Point Philadelphia
- Mitali Patnaik, Medical Director, Friends Hospital Crisis Response Center
- Ken Martz, Psychologist, Gaudenzia, Inc.

3:30 p.m. Panel Three:
- Devin Reaves, Executive Director, Pennsylvania Harm Reduction Coalition
- Dawn Holden Woods, CEO, Turning Points for Children
- Rebecca Bonner, Director, The Bridge Way School

4:00 p.m. Closing Remarks

Lynn Kovich, Deputy Secretary
Office of Mental Health and Substance Abuse Services

House Democratic Policy Committee Hearing

MH/SUD Treatment

March 6, 2019

pennsylvania
DEPARTMENT OF HUMAN SERVICES

Good afternoon Representative Hohenstein, members of the House Democratic Policy Committee, and staff. My name is Lynn Kovich, and I am the Deputy Secretary of the Office of Mental Health and Substance Abuse Services (OMHSAS) within the Department of Human Services (DHS). On behalf of Secretary Miller, I would like to thank you for the opportunity to present testimony regarding the role of mental health in substance use disorder (SUD) treatment and recovery.

The issues of mental illness and SUDs are closely intertwined and, as evident by this hearing, cannot be ignored. At least one-quarter of individuals with serious mental illness also experience substance use, a rate four times higher than the general population.[1] Research has shown that almost half of individuals hospitalized for psychiatric illness had co-occurring substance use, and as many as two-thirds of pregnant women in a residential treatment setting for opioid use disorder had co-morbid psychiatric conditions. Often, the use of substances seems to be linked to past trauma. People with Post-Traumatic Stress Disorder (PTSD) are up to seven times as likely to have SUDs and victims of childhood sexual abuse are three to five times as likely than the general popularion.[2,3,4] The association between mental illness and substance use is even seen in adolescents, as those experiencing significant depression are more than twice as likely to use drugs as their peers.[1]

Individuals suffering from both mental illness and substance use tend to face more difficulty compared to those who are battling only mental illness or substance use.[5] Someone with a dual diagnosis is more likely to relapse in both their psychiatric and substance use disorder treatments and experience depression and suicidal thoughts, violence, incarceration, homelessness and frayed family relationships.[1,5,6]

Hospitalization rates, psychiatric symptom severity, and functional impairment are worse for those who are not dually-diagnosed. Additionally, total treatment costs are higher for these individuals as they tend to overutilize more expensive hospital and emergency services.

Traditionally, people with serious mental illness and co-occurring substance use have received treatment for each of the conditions from two different sets of providers in parallel treatment systems.[5] However, in practice, individuals tend to receive services from one system and not the other. As might be expected, this separate mental health and substance use treatment model of care has not been successful in enabling individuals to achieve long-term recovery.

Efforts to simply add drug and alcohol group therapy to outpatient psychiatric treatment has little effect due to the high dropout rate, and brief, intensive programs in hospital settings and residential programs showed little long-term benefit, but significant benefits can be gained from comprehensive, long-term, integrated dual-diagnosis programs.[5,6] These comprehensive, integrated programs combine components like assertive outreach and case management to keep people engaged in treatment. They use stage-wise, motivational interventions, as most individuals early in treatment are not motivated to pursue complete abstinence from substances. These programs often combine group sessions, individual counseling, and family interventions to develop and maintain a strong support network. Comprehensive, integrated programs have been shown in a number of studies to result in high levels of engagement, less severe psychiatric symptoms, reduced hospitalization rates, less substance use, less need for detox admissions, fewer arrests, more stable housing, and better overall quality of life.

Preliminary data also shows that these programs may substantially reduce overall treatment costs.

OMHSAS, in collaboration with other state offices, works to ensure local access to a comprehensive array of quality mental health and substance use services that reflect the needs of citizens across the commonwealth. Our guiding principles are simple and direct:

- Provide quality services and supports that facilitate recovery for adults, including older adults, and resiliency in children;
- Emphasize prevention and early intervention; and
- Encourage collaboration with stakeholders, community agencies, and county service systems.

DHS provides support and guidance for community-based services that build on the natural and communal supports unique to each individual and family.

Overview of the Pennsylvania Mental Health System

The Mental Health and Intellectual Disability (MH/ID) Act of 1966 established a county-based mental health service system. OMHSAS allocates state funds to county governments for the provision of community behavioral health services, and works in close collaboration with the Commonwealth's 48 single-county or multi-county (joinder) MH/ID program offices. Additionally, OMHSAS is responsible for the oversight and management of the behavioral health portion of the HealthChoices Program, the Department's mandatory Medicaid managed care program. In Pennsylvania, the behavioral health services are "carved out" from the physical health managed care system.

OMHSAS is responsible for the program, policy, and oversight of the delivery of community mental health services administered by counties, and manages the Medical

Assistance (MA) portion of drug and alcohol services. In addition, we administer behavioral health services (BHS) funds for mental health and substance use disorder services that are not covered by MA or for individuals no longer eligible for MA, as well as the Act 1988-152 funds to provide non-hospital residential substance use disorder services. Through these multiple service delivery systems, OMHSAS funds a wide range of inpatient, outpatient, and community-based mental health and SUD treatment services.

Centers of Excellence

There are 45 Centers of Excellence (COEs) across the Commonwealth in 29 different counties, representing diversity in terms of both geography and provider type. These centers coordinate care for people with Medicaid. Treatment is team-based and "whole person" focused. The goals of COEs are:

- Integrating and coordinating physical health care with behavioral health care to treat the whole person.
- Engaging individuals across the continuum of care by using community-based care management teams.
- Increasing access to Medication Assisted Treatment (MAT).

Community-based care management teams are the critical element of the COEs, providing enhanced care management services beyond traditional case management. With a focus on the entire individual, these care management teams assist individuals navigating between levels of care. Partnerships are key for COEs, as they allow for a complete array of services to be offered to each client by supplementing what a COE offers in-house. Each COE has referral partners, including community-based providers of drug and alcohol treatment services, recovery support services, and physical and

behavioral health services. This is a prime example of truly integrating services for people with co-occurring mental illness and substance use disorder while also addressing their physical health needs.

Drug and Alcohol Recovery Houses

Drug and alcohol recovery houses provide housing for individuals recovering from drug or alcohol addiction, which affords individuals with a safe and supportive drug and alcohol-free environment that includes peer support and other recovery support services. As part of their efforts to develop a recovery-oriented system of care, the counties have worked with individuals in recovery, stakeholders, and system partners to identify and prioritize the need to increase recovery housing options and opportunities. As a result, many counties have developed recovery houses using HealthChoices reinvestment funding (at least 40 counties have invested at least $7.5 million). Recovery houses have supported many populations, including men, women, and women with children.

Counties are continuously developing plans that make it easier for individuals to access recovery house programs and other services. One example of this is the York/Adams county plan, *Substance Abuse Housing Support*. This plan provides up to three months of funding for an individual to reside in a recovery house that meets specific criteria. This plan provides access to an important service to individuals who otherwise could not afford it.

Certified Community Behavioral Health Clinics

In December 2016, Pennsylvania was awarded a two-year demonstration grant to fund seven Certified Community Behavioral Health Clinics (CCBHCs) across the Commonwealth. These clinics primarily serve adults and children with serious mental

illnesses and substance use disorders. CCBHCs allow individuals to access a wide array of services at one location and remove the barriers that too often exist across physical and behavioral health systems. Enhanced coordinated and individualized care has the potential to greatly improve quality of life. All CCBHCs offer the following nine core services:

- Crisis mental health services;
- Screening, assessment, and diagnosis, including risk assessment;
- Patient-centered treatment planning;
- Outpatient mental health and substance use services;
- Outpatient clinic primary care screening and monitoring of key health indicators and health risk;
- Targeted case management;
- Psychiatric rehabilitation services;
- Peer support and counselor services and family supports; and
- Community-based mental health care for members of the armed forces and veterans.

Outcomes from this demonstration have been promising. All CCBHCs are using evidence-based practices, including MAT, Cognitive-Behavioral Therapy (CBT), and trauma-focused interventions which have increased the quality of services being provided. Access to service has also increased. The average number of days from first contact with a client to the day a risk screen is conducted is 5.1, and 90.3 percent of CCBHC clients have evaluations done within 10 business days. Even more encouraging, data reported by the CCBHCs shows that 90 percent of clients with a positive depression screening have a documented follow-up plan in their record on the same day. CCBHCs have been able to fundamentally change the way outpatient care is

provided. Again, the CCBHC model emphasizes our priority to provide services to people who have co-occurring mental illness and substance use disorder and to integrate care for people and address all their needs in one setting.

Conclusion

It is the goal of OMHSAS to ensure people have access to services and supports when and where needed. While challenges in our service system exist, we are working to develop innovative programs and treatment options to address the complex needs of the individuals we serve. We believe that people with serious mental illness and substance use disorder can and do recover. Thank you for the opportunity to provide this information to you today. I am happy to address any questions you may have at this time.

References

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4 Childhood Sexual Abuse and Adult Psychiatric and Substance Use Disorders in Women: An Epidemiological and Cotwin Control Analysis. Kenneth S. Kendler, MD; Cynthia M. Bulik, PhD; Judy Silberg, PhD; et al John M. Hettema, PhD, MD; John Myers, MS; Carol A. Prescott, PhD, Arch Gen Psychiatry. 2000;57(10):953-959.

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6 Co-occurring substance abuse and mental health problems among homeless persons: Suggestions for research and practice. Douglas L. Polcin, Journal of Social Distress and the Homeless 2016 VOL. 25 NO. 1 1

Testimony of Steven Datlof, M.D.

Hearing of the Policy Committee of the Democratic Caucus of the Pennsylvania General Assembly on the Opioid Crisis, March 6, 2019

My name is Steven Datlof. As a practicing psychiatrist in a mental health clinic in North Philadelphia, I see first-hand the difficulties in successfully treating patients with opioid addictions. My remarks this afternoon will focus on how we can make progress in addressing the opioid crisis. My prescription is two-fold. First, we must make state-of-the-art treatment available to everyone who needs it in Philadelphia and throughout Pennsylvania. Second, we must use every method available, and develop new, innovative methods, to encourage opioid dependent individuals to accept this treatment. I will address each of these issues in turn.

It is important that we understand what is involved in state-of-the-art treatment of opioid use disorder. Keep in mind that like all mental health conditions, opioid use disorder involves both psychological and biochemical factors. Research shows that many individuals with depression or bipolar disorder (also commonly called manic-depressive disorder) do best when treated with both psychotherapy and medication.

Similarly, both psychotherapy and medication are used in the treatment of opioid use disorder. Therapy is used to help the individual make modifications in their lifestyle, to provide a safe environment to promote change, and to help the addicted person develop a supportive peer group of drug-abstinent individuals. Therapy also may be directed towards helping the person gradually come to terms with childhood traumas.

Medication is used to treat opioid withdrawal, and then to help maintain abstinence. This treatment is known as "Medication-Assisted Treatment" or "MAT." Treatment of the withdrawal syndrome, often referred to as detoxification, usually involves the use of either buprenorphine or methadone, often combined with other medications. The medication dose is tapered once the withdrawal symptoms are controlled. Then, the patient must decide about longer term treatment: whether to continue on lower-dose maintenance medication, or to be completely tapered off medication.

While methadone and buprenorphine have been used successfully for both detox and maintenance for many years, these medications are controversial because they stimulate opioid receptors in the brain. Critics claim that using these medications substitutes one addiction for another. Unfortunately, this view is held by some addicted individuals, families, and even treatment facilities. However, it is important to understand that this is not the case. The prescribing of these medications is carefully controlled and only allowed at certain settings. The prescribed medication doses are stable and may be gradually decreased, even to abstinence if desired by the patient. Buprenorphine is often combined with the opioid blocker naloxone, in a combination known as Suboxone, to prevent abuse of this medication. Most importantly, research shows that these medications have helped many patients be able to function constructively in society, and have helped prevent fatal overdoses.

That said, a newer maintenance option, naltrexone, has become available in the last few years. This medication is an opioid blocker: it does not stimulate opioid receptors. Rather, by blocking opioid receptors, the result is that if a person taking this

medication uses an opioid such as heroin, the person will not experience the desired euphoric effect. While previously, when the medication was only available in pill form, the person could stop the medication and the blocking effect would wear off within days, it is now available in an injectable form that lasts for one month.

Just as not every patient responds to the same medication for high blood pressure or for depression, none of these three medications, methadone, Suboxone, or naltrexone, work for everyone. Yet, all of them have been shown to benefit a substantial portion of individuals. Therefore, all of these treatments should be available to opioid users who need them, and the person, in discussion with their health care providers and family, should determine which treatment is best for them.

Furthermore, treatment for co-existing mental health conditions should also be available, including both therapy and medication treatment where indicated for conditions such as depression or bipolar disorder. Ideally, this would be provided at the same location where the patient receives treatment for opioid use disorder.

I would also like to comment on the importance of including 12-step programs such as Narcotics Anonymous in the treatment of opioid use disorder.

As many of you know, Narcotics Anonymous is a program that involves group meetings where people accept that they have lost control of their lives as a result of their addictions. This approach does a great deal to combat a person's denial of their addiction, which is a key factor that prevents people from staying in treatment. It also emphasizes that addiction is a life-long problem. One is not "cured," but in "recovery."

The NA environment allows addicted individuals to develop a social network with people who don't use drugs or alcohol. Usually each person has a "sponsor," someone

who has been clean and sober for a longer period of time and can serve as a mentor and also a support in time of crisis. The availability of NA meetings on a daily basis, including weekends and holidays, provides the possibility of help when the risk of relapse is high.

In my practice, the substance use disorder patients who have the best results almost always have incorporated NA or AA into their lives. Most attend multiple meetings each week; often they attend different meetings at different locations. A recent research study showed that opioid users who attended NA meetings were 3-4 times more likely to be abstinent from heroin than those who did not go to meetings.

Having discussed the elements of state-of-the-art treatment for opioid use disorder, I will spend the last few minutes of my testimony discussing barriers that prevent patients from obtaining the proper treatment and sticking with the treatment.

First, we must work to remove barriers presented by health insurance. We should ensure that both therapy and all medication options are available to every Pennsylvanian who needs it, regardless of insurance status or ability to pay.

Next, we should strive to make all treatments available at the same site. It is hard enough for an addicted individual to muster the motivation and courage to attend one facility. Requiring that the person go to one location for Medication-Assisted Treatment; another place for group or individual therapy focusing on the substance use disorder; and a third place for treatment of a co-existing mental health condition; results in a lower likelihood that the person will obtain all the necessary treatment. Communication among the different providers at the various offices or clinics may be limited or non-existent, thereby further limiting the effectiveness of the care.

Further, we should do everything possible to educate addicted individuals and their families about the available treatments and work to dispel myths about them, such as the myth that medication merely substitutes one addiction for another. We also need to do a better job providing this education to primary care practitioners, in schools, and in the workplace. We should also not forget to emphasize the importance of 12-step programs in the long-term recovery process.

Even with all these approaches, we should acknowledge that it still will be difficult to get opioid users who need it to accept the available treatment. Acceptance itself is a long-term process. The likelihood of breaking down a person's denial is enhanced when the message is delivered on a consistent basis by the same caregivers, in a supportive manner, in a setting that is acceptable to the patient.

We should consider innovative ways to get people in treatment that take these factors into consideration. The establishment of safe injection sites is one such approach that has been proposed. Legal safe injection sites have been in existence in Europe since the 1970's, in Sydney, Australia since 2001, and in Vancouver, British Columbia, since 2003.

Published data from Vancouver show a 35% decrease in fatal overdoses in the area around the safe injection site and that users of the facility are more likely to start detox. Analyses of the Vancouver and Sydney sites have not shown an increase in crime or an influx of drug users in the neighborhoods where they are situated. Here in Philadelphia, efforts are underway to study the use of safe injection sites. We should support these efforts and consider instituting safe injection sites on a trial basis. In this way, at-risk individuals would be under observation to protect them from fatal

overdoses; and, through frequent contact with a consistent team of health care providers, could gradually be encouraged to accept the treatment they need.

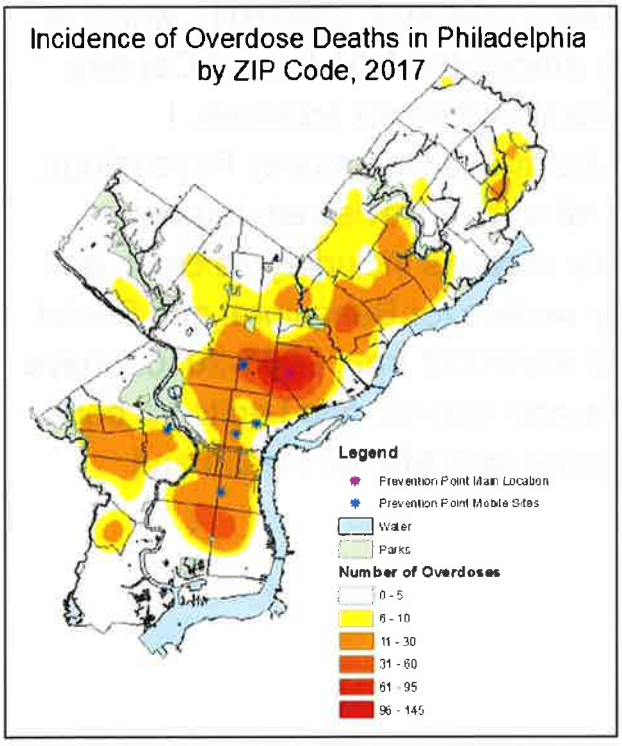
To sum up, treatment for opioid addiction involves a combination of psychotherapy for the addiction, medication for detoxification and potentially for maintenance, as well as treatment for co-existing mental health disorders. We should work to make this treatment available to all who need it, regardless of insurance status or financial means. We should also think outside the box, to find innovative ways to break down denial and resistance to treatment, so that addicted individuals can accept treatment, and have the chance to potentially change their lives.

Thank you for your consideration.

I am Michael B. Blank, Professor of Psychology in Psychiatry at the Perelman School of Medicine at the University of Pennsylvania. My research and writing focus on integration of health and mental health service delivery systems including treatment for co-morbid illness such as HIV/AIDS. Other areas of interest include informal care and impact on consumers and families, rural mental health, ethics in prevention, and applications of technology and computer-assisted care in health service delivery. My primary affiliation is with the HIV Prevention Research Division in the Department of Psychiatry and I also hold a secondary faculty appointment as Professor in the School of Nursing. I am also currently Distinguished Research Fellow at the Annenberg Public Policy Center, and also hold appointments at the Leonard Davis Institute for Health Economics, the Center for Public Health Initiatives, the Center for Health Outcomes Research, and the Comprehensive Neuroscience Center. I currently also serve as co-Director of the Behavioral and Social Sciences Core of the Penn Center for AIDS Research (CFAR) and the Penn Mental Health and AIDS Research Center (PMHARC) where I also direct the Community Engagement Core. I served as a Governing Councilor from the Mental Health Section of the American Public Health Association from 2006-2008. I am also a founder and member of the Executive Committee of the Social and Behavioral Sciences Research Network (SBSRN), which is intended to foster multi-site collaboration among the NIH-funded Centers for AIDS Research (CFAR) in the behavioral and social sciences. I currently serve as Editor-in-Chief of the Journal of Community Psychology, and I serve on the editorial boards of 12 other peer-reviewed Journals. I have served on many NIH and CDC study sections including as chair, and was a standing member of the NIH study section for Behavioral and Social Science Approaches to the Prevention of HIV/AIDS from 2005-2010. I have authored over 150 papers, book chapters and reports, and I edited a book with Marlene Eisenberg, entitled "HIV: Issues with Mental Health and Illness".

Communities across the US are suffering from the devastating effects of the increasing access to opioids including prescription drugs and illicit opioids, including heroin and illicitly manufactured substances such as fentanyl and equivalents. Millions of Americans experience improper use of opioids and opioid use disorder (OUD). The consequences of this epidemic are catastrophic, resulting in increasing overdose fatalities. Further, rates of OUD and injectable drug use, acute hepatitis C infections, localized outbreaks of HIV, and other serious health conditions such as endocarditis and Neonatal Opiate Withdrawl Syndrome (NOWS) continue to rise.

The nation faces an ongoing and worsening crisis in the incidence of substance use disorders (SUD). The consequences of the opioid crisis are measured on the bleakest of scales: overdose deaths, new clusters of infectious disease, babies born with NOWS, with these children often needing foster care. These trends weaken the fabric of our communities and they threaten the economic vitality of the nation. Sadly, the epidemic of opioid misuse and opioid overdose deaths shows no signs of slowing. The most recent CDC report shows that the age-adjusted rate of drug overdose deaths in the US was 9.6% higher in 2017 than in 2016, with a total of 70,237 lives lost in 2017, and opioids were involved in 66.4% of these cases (42,249 overdose deaths) (Seth, Scholl et al. 2018). Further, the rate of drug overdose deaths involving synthetic opioids other than methadone was 45% higher in 2017 than in 2016.



Philadelphia is an urban epicenter of the opioid epidemic in the United States. In Philadelphia in 2017 there were 1,217 drug overdose deaths. Medical examiner reports indicate that 88% involved opioids, including prescription opioids, heroin, and fentanyl (City of Philadelphia, 2018). The increasing presence of fentanyl

is directly associated with the escalating numbers of fatalities and in 2017, fentanyl was found in over 80% of the opioid fatalities. The 2017 the age-adjusted opioid-related death rate (59.8 per 100,000) was more than twice that found in New York City and greater than any of the other largest cities in the country. Conservative estimates suggest that there are 70,000 individuals using heroin in Philadelphia and approximately 50,000 who misuse opioid prescription medications. According to the DEA, the heroin sold in Philadelphia has the highest purity and the lowest price in the country. A bag of heroin in Philadelphia can be cheaper than a pack of cigarettes. There is no demographic that remains unaffected by the opioid crisis in Philadelphia (City of Philadelphia, 2018: https://www.phila.gov/programs/combating-the-opioid-epidemic/reports-and-data/). The age adjusted mortality rates have increased for all categories of age, race and gender. The highest rates of increase over the past two years have occurred for women (49% increase) and 15 to 24 year olds (62% increase). Using the City of Philadelphia Department of Health and Human Services' integrated data system (CARES), analyses of fatal overdoses during the past 5 years indicated that 70% were males, 63% white, and 27% were ages 25 to 34. Importantly, 41.4% of these individuals had contact with at least one service of the Philadelphia Behavioral Health System within the 6 months prior to their death and 26.4% within 1 month of their death.

According to a recent paper in the New England Journal of Medicine by Maria Oquendo, who is the Chair of my department at Penn, and Nora Volcow, who is Director of the National Institute on Drug Abuse (NIDA), there is an unrecognized epidemic of suicide within fatal opiate overdoses (Oquendo, M, and Volcow, N., 2018). Data from the 2014 National Survey of Drug Use and Health showed that an OUD involving prescription opioids was associated with an increase of 40 to 60% in the risk of suicidal ideation, after controlling for overall health and psychiatric conditions. People using opioids regularly were at greatest risk: about 75% more likely to make suicide plans and twice as likely to attempt suicide as people who did not report any opioid use. Though suicidal ideation and attempts are not

the same as suicide deaths, they are important predictors of eventual suicide.

Data also document a steady annual increase in opiate-overdose visits to emergency departments. Data from the Nationwide Emergency Department Sample from 2006–2011 on more than 250,000 emergency department visits for opiate overdose show that 54% of the overdoses were classified as unintentional, 26.5% were deemed intentional, and 20.0% were "undetermined." Together, these data suggest that the true proportion of suicides among opioid-overdose deaths is somewhere between 20% and 30%, but it could be even higher.

The Penn Mental Health AIDS Research Center (PMHARC) is Directed by Dwight L. Evans, MD, and co-directed by myself and David S. Metzger, PhD. PMHARC has been continuously funded by NIMH since 2012, and is the only NIMH AIDS Research Center around the US with an exclusive focus on the complex and recursive interactions between HIV and mental illnesses including substance abuse.

PMHARC conducted the "Prevalence of HIV infection and Depression among PWID with Opioid Use Disorder" in December, 2018 and January, 2019 to get initial prevalence estimates. This was a pilot conducted in a single venue using our Mobile Clinical Trials Unit (MCTU), a diesel powered vehicle containing a waiting area and two examination rooms.

We parked the MCTU at the intersection of Kensington Ave and Somerset Ave, an area of North Philadelphia commonly referred to as the "badlands", where injection

drug users tend to congregate and use. The venue-based sampling was highly successful as word got around the area that people who injected drugs (PWID) would be paid for an interview lasting a half an hour or so and provide blood and urine samples. In fact, the rate limiting factor was the number of hours the MCTU was available and people were literally lining up for a time to participate. We were able to enroll 143 people into the pilot study in those two months.

There were many more men than women, and somewhat surprisingly the sample was majority European American. The majority had never been married, and more than 80% reported a high school education or less. More than 60% reported being unemployed and the average annual income was reported to be $14,378 from all sources. Overwhelmingly these participants reported relying on public assistance services for food and health care services, and the majority reported being currently homeless. Complete demographics are provided in the following table.

Table 1 - Demographics

Age – mean (SD)	40.3 (10.4) – range (20-69)
Gender	
Male	101 (70.6)
Female	41 (28.7)
Transgender	1 (0.7)
Race	
AA	32 (22.4)
EA	91 (63.6)
Native American	2 (1.4)
More than one race	16 (11.2)
Hispanic – Yes n (%)	26 (18.2)
Marital status	
Married/ Living w/ partner	30 (21.0)
Divorced/ Separated	23 (16.1)
Widowed	6 (4.2)
Never married	77 (53.8)
Sexual orientation	
Heterosexual	132 (92.3)
Homosexual	2 (1.4)
Bisexual	9 (6.3)
Education	
Less than High School	42 (29.4)
High School diploma	75 (52.4)
Some college	20 (14.0)
College graduate	3 (2.1)
Tech/Vocational school	2 (1.4)

College +	1 (0.7)
Work status	
Employed	32 (22.4)
Unemployed	86 (60.1)
Retired	2 (1.4)
Disabled	13 (9.1)
Student	1 (0.7)
Income – Mean (SD)	$14,378 (18,473) Range ($0 - $100,000)
Less than $5,000	62 (44.6)
$5,000 - $20,000	38 (27.4)
$20,001 – 45,000	31 (22.3)
More than $45,000	8 (5.8)
Running out of money for necessities – n (%)	105 (73.4)
Public assistance sources	
Medical card	111 (77.6)
Food Stamps	109 (76.2)
SSI	10 (7.0)
Health Insurance – Yes n (%)	133 (93.0)
Homeless n (%)	80 (57.6)
Living condition	
Own/ rent apt/home n (%)	29 (20.3)
Home family/ friends n (%)	46 (32.2)
Shelter n (%)	34 (23.8)
Street n (%)	58 (40.6)

All participants received a rapid test for HIV and 12 people (8.4%) were seropositive, 4 of whom claimed that they had never before been diagnosed. Of the 8 who had been previously diagnosed, 7 had detectable viral loads. Our experience phlebotomists were unable to collect samples from several participants because of problems with collapsed veins among PWID. We collected self-reports regarding Hepatitis C infections, and just over half reported being currently infected, less than 30% reported they had tested negative, 18% claimed to have been cured or that they were currently in treatment, and just under 8% claimed they had never been tested.

Table 2 – Medical Status

HIV status	
Positive n (%)	12 (8.4)
Newly diagnosed – n (%)	4 (33.3)
ART – n (%)	8 (66.7)
Detectable VL – n (%)	7 (87.5)
Hepatitis C (self-reported) – n (%)	
Positive	72 (50.4)
Negative	42 (29.4)
Cured	18 (12.6)
Unknown	11 (7.7)
In treatment	4 (5.6)

*Other Chronic disease (at least one) Yes – n (%)	94 (66.2)
In Tx for – n (%)	65 (69.1)
**Hospitalization for medical condition – Yes n (%)	
Past 6 months	50 (35.0)
Past 30 days	15 (10.5)
**ER (excluding OD)	
Past 6 months	73 (51.0)
Past 30 days	32 (22.4)
** Outpatient visit for medical issue	
Past 6 months	76 (53.1)
Past 30 days	32 (22.4)

Notes: * Included cardiovascular, respiratory, neurological, digestive, metabolic, cancer, chronic physical conditions, physical disability – could break down by type if needed

** Excluded hospitalization for drug and/or alcohol and psychiatric-related issues

With regard to drug and alcohol use, over 97% met criteria for OUD, with almost 93% meeting criteria for severe OUD. Almost 70% reported having ever had an overdose with about a third having had one within the past six months. Almost 75% reported having received detoxification in the past, but just one third reported receiving detoxification within the last 6 months and just 8 participants reported having received detoxification in the past 30 days. Just over 40% of these participants reported have received residential treatment in the past, with just 14 people reporting that they received residential treatment in the last six months and just 7 reporting receiving residential treatment in the last month. More than three quarters of these participants reported having received medication assisted treatment (MAT) in the past, with over half reporting MAT in the last 6 months, and over a third reporting MAT in the last month. Polysubstance abuse was the norm in these participants, with large numbers reporting concurrent alcohol, cannabis, and tobacco use.

Table 3 – Drug and alcohol variables

Opiate Use Disorder (DSM5) – Yes n (%)	137 (97.2)
Severity	
Mild (2-3 criteria)	4 (2.8)
Moderate (4-5 criteria)	2 (1.4)
Severe (6+)	130 (92.8)
Overdose – Yes (%)	
Lifetime	99 (69.7)
Mean (SD)	5.7 (6.9) - Range (1 – 50)
Past 6 months	41 (32.3)
Mean (SD)	2.5 (2.5) – Range (1-10)
Treatment for Opiate Use Disorder – Yes n (%)	
Detoxification	
Lifetime	106 (74.6)

		Past 6 months	41 (32.0)		
		Past 30 days	8 (6.5)		
	Residential				
		Lifetime	57 (40.1)		
		Past 6 months	14 (12.8)		
		Past 30 days	7 (6.5)		
	Medication Assisted Treatment				
		Lifetime	109 (77.3)		
		Past 6 months	68 (53.1)		
		Past 30 days	46 (36.5)		
Substance use					
Substance	Lifetime		Past 30 days		Main route
	n (%)	Years – mean (SD)*	n (%)	Days – mean (SD)*	
Heroin	141 (98.6)	12.3 (9.9)	139 (97.2)	26.3 (7.8)	IV: 135 (95.7) Sniff: 6 (4.3)
Other opiates	114 (80.9)	3.3 (4.5)	106 (74.1)	18.4 (13.5)	IV: 77 (69.4) Oral: 25 (22.5) Sniff: 7 (6.3)
Methadone	86 (61.4)	2.8 (2.8)	71 (49.7)	20.2 (11.5)	Oral: 82 (97.6)
Buprenorphine	90 (63.8)	2.0 (2.1)	81 (56.6)	10 (9.6)	Oral: 82 (94.3) Smoke: 1 (1.1) IV: 4 (4.6)
Alcohol	111 (78.2)	8.7 (11.9)	41 (28.7)	8.8 (10.7)	Oral: 111 (100)
Alcohol (+5/day)	43 (31.6)	14.1 (14.4)	12 (8.4)	14.5 (12.8)	Oral: 43 (100)
Cannabis	125 (88.0)	12.6 (10.6)	110 (76.9)	11.9 (10.5)	Smoke: 114 (94.2) Oral: 5 (4.1)
Cocaine	127 (88.8)	9.6 (9.4)	99 (69.2)	18.8 (10.9)	Smoke: 57 (46.3) IV: 48 (39.0) Sniff: 18 (14.6)
Benzodiazepines	78 (55.3)	9.4 (10.2)	72 (50.3)	8.8 (9.8)	Oral: 74 (97.4) Sniff: 2 (2.6)
Amphet/ Methamphet.	29 (20.3)	7.8 (7.4)	28 (19.6)	7.1 (9.6)	IV: 28 (50.0) Oral: 18 (32.1) Sniff: 4 (7.1)
Hallucinogens	22 (16.1)	6.1 (6.5)	5 (3.5)	15.2 (13.9)	Oral: 33 (80.5) Smoke: 8 (19.5)
Inhalants	2 (2.2)	1.0 (-)	0 (-)	-	
Tobacco	139 (97.2)	23.3 (11.9)	135 (94.4)	27.8 (7.3)	Smoke: 139 (100)

Notes: * mean and SD are calculated among users only

With regard to legal status, over 90% reported having ever been incarcerated. On average these participants reported be incarcerated more than seven times for an average of a total of 56 months.

Table 4 – Legal Status

Incarceration – Yes n (%)	127 (90.1)
No. times – mean (SD)*	7.5 (8.1)
Total months of incarceration – Mean (SD)*	56.2 (68.2)

Notes: * Means and SD are calculated among individuals who reported an history of incarceration

With regard to psychiatric disorders, a standard psychiatric examination was administered using a structured interview. A majority reported having

History of psychiatric disease	
Lifetime – Yes n (%)	**78 (55.3)**
Mood disorder	
Lifetime	**71 (49.7)**
Past 6 months	**30 (21.0)**
Past 30 days	**22 (15.4)**
Anxiety disorder	
Lifetime	**60 (42.0)**
Past 6 months	**26 (18.2)**
Past 30 days	**20 (14.0)**
Psychotic disorder	
Lifetime	**19 (13.3)**
Past 6 months	**7 (4.9)**
Past 30 days	**6 (4.2)**
Medication for any psychiatric disorder	
Past 30 days – Yes n (%)	**25 (18.7)**
QIDS Score	
Mean (SD)	**12.5 (6.1)**
Median, quartiles	**13, q1 = 7, q3= 17**
BASIS-24 - Score	
Total	**1.73 (0.70)**
Depression/ Functioning	**2.03 (0.98)**
Substance Misuse	**2.71 (0.71)**
Psychosis	**0.75 (0.93)**
Interpersonal relationships	**1.76 (0.92)**
Emotional lability	**1.88 (1.11)**
Self-harm	**0.37 (0.65)**

received a diagnosis of a mental illness in the past. About half of these participants met criteria for a current psychiatric disorder with just under half meeting criteria for a current mood disorder, most commonly depression.

While these data come from a small convenience sample in a single venue in Philadelphia, the results are compelling. These people have significant problems in every life domain and treatment is not being provided. What is needed is integrated health and mental health treatment for persons with

OUD. I would venture to guess that this treatment will work better by providing it in the same venues where these people live, and that while it is likely very expensive, it will almost certainly be more cost effective than the current costs of the opioid crisis, both in dollars and in quality of life.

In early February, 2019, Gostin et al. published a review of the literature on innovative harm-reduction solutions and concluded that Supervised Injection Facilities (SIFs) are imperative. SIFs create safe places for drug injection by trained personnel, including overdose prevention, immediate counseling, as well as treatment referral services as needed. Supervised injection facilities do not provide illicit drugs nor do their personnel actually inject users. The extant research concludes overwhelmingly that SIFs are effective in reducing drug-related mortality, morbidity, as well as needle-borne infections, however their lawfulness remains uncertain. Philadelphia has been in the forefront of cities embracing SIFs as a proactive solution to preventing opioid-related morbidity and mortality. The Department of Justice (DOJ) has recently threatened criminal prosecution for SIF operators, medical personnel, and patrons. This is a prototypical example of US criminal justice policy that stands in direct opposition to well established science and public health practice throughout the world. Gostin et al. speculated that if the DOJ persists in threatening prosecution of SIFs, individual states could seek a research exemption under CSA §823(f), which allows government-funded public health studies where registered health professionals may allow research participants to use heroin or other schedule 1 drugs in the public's interest.

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NORTHEAST COMMUNITY CENTER FOR BEHAVIORAL HEALTH

3/6/19 PRESENTATION AT FRIENDS HOSPITAL

Good afternoon, my name is David Como. I am the Executive Director of the Northeast Community Center for Behavioral Health. I have been at the Northeast Community Center for Behavioral Health since 1986 in many different capacities.

Our community is again confronted with an opiate crisis. There are many reasons why people use alcohol or substances and struggle with mental health challenges. In my administrative and clinical capacities, both of these issues usually occur concurrently. Our community struggles with crushing poverty, generational trauma, not enough access to opportunities or jobs and too much access to guns. The Northeast Community Center for Behavioral Health is a multiservice agency, however our primary mission is to provide behavioral healthcare services. These behavioral health services include, outpatient treatment, medication management, residential placement, community integrated recovery centers and case management. Most of the individuals that we serve have multiple issues which include mental health, drug or alcohol and medical problems.

Comprehensive treatment is difficult to find. There are many reasons for failures in our system. The Northeast Community Center for Behavioral Health has taken the approach to offer concomitant services to adults with co-occurring issues, that is substance use disorders and mental health disorders. Many adults who have co-occurring disorders come to our Center and receive treatment either through our outpatient or day programs. We also work with IOP's, methadone clinics and physicians who prescribe Suboxone to offer outpatient mental health treatment in conjunction with these programs. This is problematic, due to privacy regulations that make coordinating care difficult.

Currently in Pennsylvania, mental health treatment is licensed by the Department of Human Services, while substance use treatment is licensed by the Health Department. Thus, on a State level, the approach can be disjointed. This division limits a truly coordinated approach to service. For example, the current outpatient drug and alcohol regulations were last revised in the 1970s. The approach to addiction recovery was based on a short-term model. As we all know today, substance use disorders and mental health problems are chronic

conditions. Therefore, I recommend that our current approach to providing outpatient substance and mental health treatment be reviewed, so treatment encourages better access and coordination for those adults with co-occurring disorders.

March 6, 2019

Re: House Democratic Policy Committee Hearing
Executive Summary

GAUDENZIA
50th ANNIVERSARY
Helping People Help Themselves since 1968

Background

- History of mistaking medication as "safe" and effective.
- Personal history of adolescent substance use with alcohol, tobacco and marijuana.

SUD/MH

- Similarities and Differences
  - Myth #1 Everyone with SUD is Mentally Ill
  - Myth #2 Trauma Causes SUD and so Trauma Treatment is the Solution
- Prevention (e.g. School based skills training)
- Intervention (e.g. Naloxone)
- Treatment (e.g. Evidence based length of stay, intensity and continuum of care)
- Recovery (e.g. Recovery schools, Long term abstinence from mood altering substances)

Goals

- Harm Reduction vs Recovery
- Cheap vs. Cost Benefit

Recommendations

- Oppose elimination of the carve-out for MH/SUD
- Support DiGirolamo bill on Pennsylvania specialized treatment service placement
- Take steps to fund licensed SUD treatment in a way that permits programs to expand services
- Improve efforts to increase engagement in the proper level of care, length of stay, such as publishing a study of length of stay and levels of care from funders with plans to remediate deficiencies, as recommended in Kinsey's HR 590 of 2015 report.
- Remember the central role of relationships in the protective recovery process
- Use opioid medications and opioid based treatment medications with appropriate caution.
- Maintain focused goal believing in our brothers and sisters, knowing that recovery is the expectation, and the only long term path to safety
- In the context of many valuable paths and interventions, target spending in areas with solid basis for long term recovery. This may not be cheaper but will be more cost saving to the government system, our communities and our families.

March 6, 2019

Ken Martz, Psy.D., MBA
Special Assistant to the CEO/President
Gaudenzia Inc.
106 W. Main Street
Norristown, PA 19403

Representative Mike Sturla, Chairman
Representative Joe Hohenstein

Re: House Democratic Policy Committee Hearing on Mental Health and SUD

We appreciate the opportunity to provide testimony regarding the substance use disorder treatment to the House Democratic Party Committee Hearing on Mental Health and Substance Use Disorder (SUD). In the context of this epidemic it is critical to examine funds to address the opioid epidemic since funding is one of the top reasons why individuals are unable to access care. In the context of limited funds it is critical to focus spending on the most effective elements of care.

Gaudenzia Inc, is a non-profit treatment provider specializing in SUD, with programs spanning outpatient, intensive outpatient, and residential treatment programs. Celebrating 50 years in operation, in Pennsylvania, Gaudenzia has over 70 programs in Pennsylvania across a wide range of levels of care and specialties including young adult, criminal justice, dual diagnosis, HIV, and women with children's treatment. Last year, 8,000 individuals were admitted into treatment across our system.

I am a licensed psychologist and have worked across three states treating SUD in a range of settings including outpatient, intensive outpatient, residential, hospital and prison settings. In these 25 years of experience in the field, providing therapy, program management, and state-level policy oversight, there are some consistent concerns as I will outline below that are specifically related to mental health (MH) and SUD.

Context

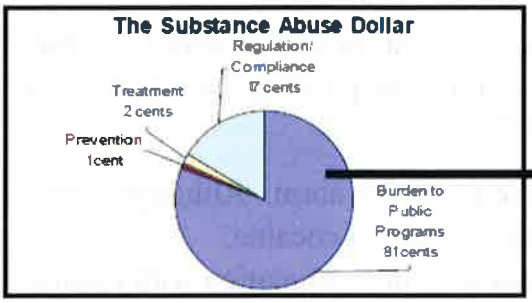
Substance Use Disorder is estimated to exist in one out of four families, and the loss of life associated with opioid overdoses has been on a sharp rise in the recent years, as reported by the National Institute of Health (2017).

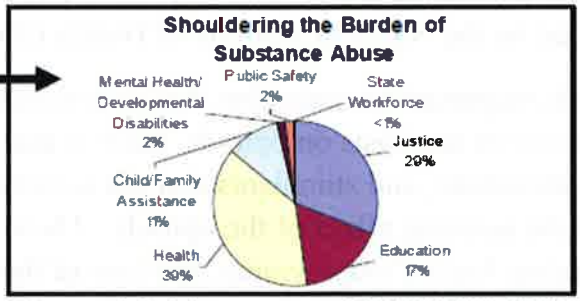
It is important to remember that polysubstance use is the norm. Although there has been recent emphasis on opioids, there is also an increase in cocaine, methamphetamine, and stimulants that are sometimes used in combination with opioids to offset the sedating effect of the opioids. Those who did not die often face incarceration, loss of employment, and loss of their children. This includes costs associated with death, and other costs such as criminal justice system costs, work productivity, and other related costs. It is also important to remember that although opioids have received recent focus, there are approximately 14 million Americans with alcohol use disorder (followed by tobacco, another legal drug) compared with approximately 7 million Americans other drug use disorders (SAMHSA, 2017).

Research indicates that opioid use disorder typically follows a complex path involving other substances. While approximately 80% of heroin users previously used prescription opioids the picture is often more complicated. Kocian (2017) found that the average age of onset for marijuana and alcohol use was 14 and that 84 percent of participants who used other drugs at 14 or younger went on to heroin use later in life. This is similar to research by DuPont (2019) reports significant relationships between adolescent use of alcohol, tobacco and marijuana with the use of other substance use such as opioids. Thus, these substances have been known as "gateway drugs" in that their use reduce the perception of risk, and increase the likelihood that individuals may experiment with other substances.

The Council of Economic Advisors (2017) estimated the cost of opioid use disorder at $504 billion. **Pennyslvania's share of this, based on population would be an estimated $19.7 billion dollars.** This includes costs associated with death, and other costs such as criminal justice system costs, work productivity, and other related costs. The University of Columbia (2009) examined a wide range of costs including health, child welfare, income assistance, homeless assistance, public safety, adult corrections, juvenile justice, education costs, mental health complications, and workforce costs. They found that in Pennsylvania, only 2 cents per dollar was spent on treatment of SUD, while compared with expenditures on the costs of substance use such as criminal justice, health and child welfare.

Pennsylvania Expenditure on SUD Related Costs





Total State Budget	$33.589 M
• Elementary and Secondary Education	$7.694 M
• Substance Abuse and Addiction	$6.635 M
• Medicaid	$7.518 M
• Higher Education	$1.913 M
• Transportation	$3.221 M
Population	12.4 M

Tobacco and alcohol tax revenue total $1,267,917,000; $101.92 per capita.
Liquor store revenue total $1,171,179,000; $94.14 per capita.

* Numbers may not add due to rounding.

These cost drivers make it clear that failure to adequately fund treatment causes substantial costs both fiscally and in societal impact to our neighbors and families. Chronic funding deficits have limited the ability of programs to fully respond. With low Medicaid rates, programs are often contracted for lower than the cost of services, causing cuts in needed ancillary services, as well as low salaries, which limit the development and engagement of an effective workforce. A 2015 review by SAMHSA finds that Pennsylvania's SUD counselors have some of the lowest salaries among allied disciplines and across other states in our region.

Funding Gap

The Substance Abuse and Mental Health Services Association (SAMHSA) completes the annual National Survey of Drug Use and Health (NSDUH) that surveys over 90,000 Americans (the most recent was published September, 2017). The NSDUH study continues to find that one of the top reasons why individuals do not seek treatment is lack of funding. They also find that among those who need treatment, approximately 90% do not receive it.

How Did We Get Here?

In the late nineteenth and early twentieth century, instead of Bayer aspirin, there was Bayer Heroin. It was most often a cough syrup in children (Edwards, 2011). Cocaine was used as an anesthetic and was found in Coca-Cola. We learned the lesson from these past mistakes.

In the 1990's and early 2000's, there was a belief that the use of prescription opioids, such as OxyContin, did not carry a risk of addiction. There was also a concern that it was inhumane to allow individuals to be in pain while a safe opioid was available to provide relief. For these reasons, pain became identified as the "fifth

vital sign" so that all assessments would include a patient rating of their pain, which lead to a rapid increase in opioid prescribing. Unfortunately, the thinking of the day was wrong as we now know that prescription opioids carry the risk of addiction.

In an effort to correct this issue, in 2013, the Federal Drug Administration (FDA) added a new warning to the label of all long-lasting opioids stating:

> "Because of the risks of addiction, abuse and misuse with opioids, even at recommended doses, and because of the greater risks of overdose and death with extended-release opioid formulations, reserve [Trade name] for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain." (2013)

Today, as opioid deaths continue to rise, we need to learn the lessons from our past. We need to increase funding to match the rapid increase in opioid use disorder in this epidemic, just as we did for other emergency situations such as Ebola. Further it should be directed in a way that creates a system that is capable of diverse impacts rather than solely opioid focused (given the growing concerns of a stimulants epidemic on the rise).

The Mental Health Myth

There are a number of similarities and differences between SUD and MH, but the differences are critically important. SUD is a diagnosis within the Diagnostic and Statistical Manual Fifth Edition, the manual used to identify mental health conditions, however, there are separate training, experience and delivery systems for SUD and MH. Similarly, cancer and heart disease are medical conditions, but are effectively treated with specialists in separate but coordinated treatment systems.

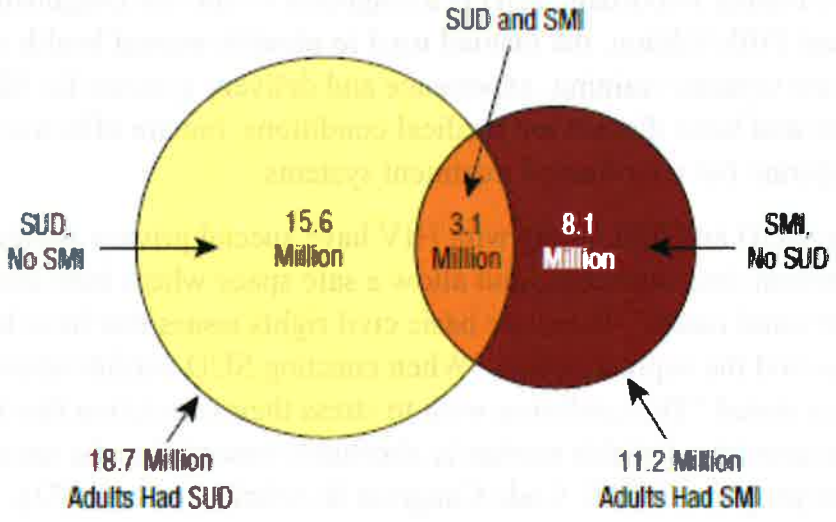
Similarly, SUD and MH, along with HIV have special privacy protections, which are critical to prevent discrimination, and allow a safe space where individuals are able to explore these personal issues. These are basic civil rights issues that have been supported by both congress and the supreme court. When enacting SUD confidentiality regulations in 1972 Congress stated "The conferees wish to stress their conviction that the strictest adherence to the provisions of this section is absolutely essential to the success of all drug abuse prevention programs" (U.S. Code Congress & Admin. News, 1972).

Myth #1: Everyone with SUD is mentally ill: Despite these similarities there are significant differences between MH and SUD. When an individual wakes up in a licensed inpatient non-hospital detox program (called level 3.5 or 3.7 withdrawal management in ASAM criteria), they feel physically ill, shame, guilt and lack of energy, with damaged

relationships and potential legal or employment impacts. In this situation, a depressed mood is a natural reaction to a life situation. However, this is not the same as clinical depression. Since post acute withdrawal from substance use can last for several months after abstinence from that substance, one must only diagnose mental health conditions with extreme caution, since the proper diagnosis is more accurately "Other Substance Induced Mood Disorder". Failure to properly understand this can lead to lifelong inaccurate labeling and medicating for schizophrenia, bipolar disorder or other serious chronic conditions which may or may not be present in the individual.

While there is overlap in co-occurring conditions, the overlap is often overestimated. The federal Substance Abuse and Mental Health Administration (SAMHSA) in annual national research finds a low but consistent overlap between these conditions as seen below, only about 16% of those with SUD were identified as having a co-occurring serious mental illness. Since this is common, SUD programs routinely manage clients with mental illness, however, only a small percentage of programs specialize in co-occurring *serious* mental illness, since issues such as severe schizophrenia and other thought disorders can benefit from specialized programming components. This is complicated by the funding and workforce issues noted above. Specifically, private SUD treatment programs with higher rates than Medicaid, can afford to hire a more diverse (higher salaried) clinical team including psychologists, social workers, family therapists etc.

Figure 55. Past Year Substance Use Disorder (SUD) and Serious Mental Illness (SMI) among Adults Aged 18 or Older: Numbers in Millions, 2017



(*Key Substance Use and Mental Health Indicators in the United States,* SAMHSA, 2018)

Myth #2 Trauma Causes SUD and so Trauma Treatment is the Solution: Recent studies such as the Adverse Childhood Experiences studies have found that higher exposure to traumatic experiences is associated with higher rates of SUD. While it is true that these issues are often related, again, they are more accurately concentric circles with many people experiencing trauma who never develop SUD. Further often individuals with SUD never experienced trauma until after the development of the SUD (i.e. being assaulted/robbed on the streets while unconscious from drugs/alcohol).

While it is important for programs to be trauma informed, meaning they are sensitive to assessing the role of trauma, trauma treatment is often not appropriate in the context of early recovery from SUD as the exposure to the traumatic memories can lead to relapse. One of the leading experts in this area, Lisa Nijavits, developed a program which does not directly address trauma until an individual has many months of recovery. Instead, the evidence based "Seeking Safety" program focuses on teaching the coping skills, and SUD stabilization as necessary precursors to addressing trauma.

Goals

Harm Reduction vs. Recovery: Treatment goals have varied through the years, and across the MH/SUD treatment system. Individuals rise or fall to the expectations we set for them. If we expect that individuals will relapse and remain "addicted" we will likely get that outcome, since we as providers will be less likely to reach for a higher goal. In contrast, by expecting the goal of recovery, while relapse may occur, stable recovery is more likely to be achieved. Consider that when entering treatment, individuals often do not have hope for their future, or believe that recovery is possible. This is a key role of treatment: to develop the hope and tools to achieve this possibility.

Historically, abstinence has been the standard goal of treatment. Recently, due to the high rates of overdose death, often the goal has shifted to harm reduction, with a goal of keeping one alive, for example naloxone. While these types of tools have value, they should not be confused with an expectation that individuals cannot recover.

An example of this can be seen in focused definitions of recovery. The Pennsylvania definition of recovery is:

> Recovery: A highly individualized journey that requires abstinence from all mood and mind-altering substances that may be supported through the use of medication that is appropriately prescribed and taken. This journey is a voluntarily maintained lifestyle that includes the pursuit of spiritual, emotional, mental and physical well-being that is often supported by others. (DDAP, PCPC, p. 128)

This is consistent with the Betty Ford definition: "Recovery from substance dependence is a voluntarily maintained lifestyle characterized by sobriety, personal health, and citizenship." (Betty Ford Institute Consensus Panel, What is Recovery? p. 222)

In sharp contrast, SAMHSA which combines recovery from both MH and SUD writes:

> Recovery is a process of change through which people improve their health and wellness, live self-directed lives, and strive to reach their full potential. There are four major dimensions that support recovery:
>
> Health—overcoming or managing one's disease(s) or symptoms and making informed, healthy choices that support physical and emotional well-being.
>
> Home—having a stable and safe place to live.
>
> Purpose—conducting meaningful daily activities and having the independence, income, and resources to participate in society.
>
> Community—having relationships and social networks that provide support, friendship, love, and hope. (SAMHSA, 2019)

This definition highlights the significant differences between the disciplines, including the possibility that one could claim to be in SUD recovery while still using illicit substances, committing crimes, and other issues related to active substance use.

Cheap versus Effective: While business interests (insurance) are focused on saving money, often through under-treatment, effective treatments offer much more robust benefits such as improved health, reductions in crime, family connections, and related cost savings.

To be effective, a treatment system must offer a full continuum of care, so that a range of intensities of treatment are available when the client experiences the narrow window of readiness to enter treatment, as well as stepping down when more intensive modalities are no longer necessary.

A model of this can be seen in the Impaired Physician's Program. Described as the standard for treatment, the impaired physician's program provided in 16 states provided 60 to 90 days of abstinence based residential treatment followed by ongoing 12-step oriented outpatient counseling and supportive drug testing. At 5-year follow-up, among 904 physicians, only 22% ever had a positive drug test, and 72% continued to practice medicine. Conclusions found that addicted physicians receive an intensity, duration, and quality of care that is rarely available in most standard addiction treatments:

> (a) Intensive and prolonged residential and outpatient treatment,
> (b) Five years of extended support and monitoring with significant consequences, and

(c) Involvement of family, colleagues, and employers in support and monitoring.

These principles are central to effective treatment. In particular, length of stay is consistently one of the best predictors of outcome for treatment, with a direct linear relationship that begins at 90 days of treatment, and continues to increase through nine months of treatment as found in multiple studies (Greenfield et al., 2004)

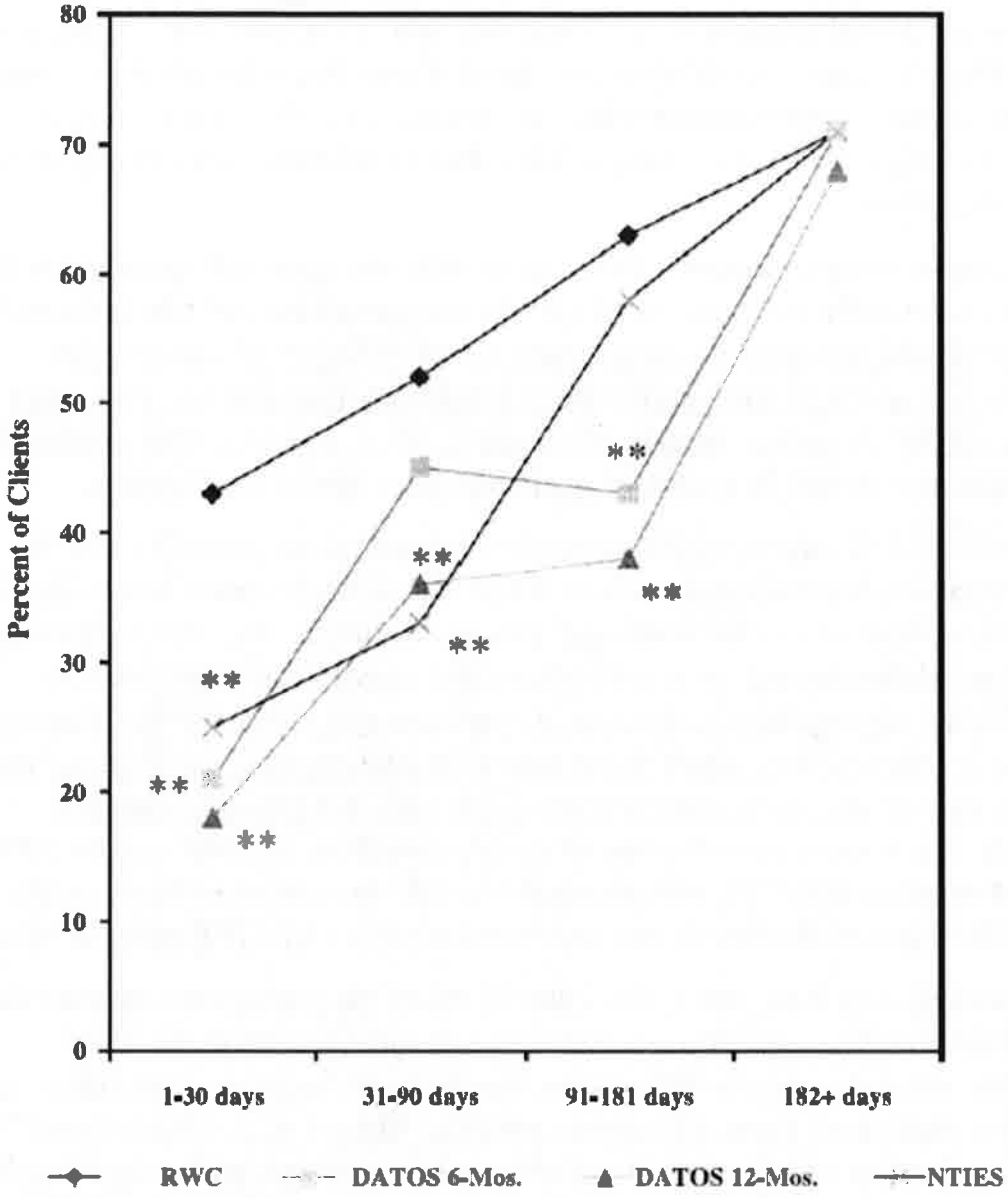


Figure 1. Percentage of abstinent post-discharge by LOS and study. Note: **Difference from RWC is statistically significant at $p < .01$.

Source: Greenfield et al, (2004). *Effectiveness of Long Term Residential Treatment for Women: Findings from 3 National Studies*

The National Institute of Drug Abuse (2013) states: "research has shown unequivocally that good outcomes are contingent on adequate treatment length. Generally, for residential or outpatient treatment, participation for less than 90 days is of limited effectiveness, and treatment lasting significantly longer is recommended for maintaining positive outcomes."(p. 14)

While a continuum of care is necessary, often there is a gap in detoxification programs and residential programming. While they may seem to be more costly, severe Opioid Use Disorder cannot be stabilized in a level of care that is lower than the intensity needed by the client. Undertreatment while cost saving in the short term, leads to increased costs long term, just like using a half a dose of antibiotic, we can expect to see a relapse of symptoms.

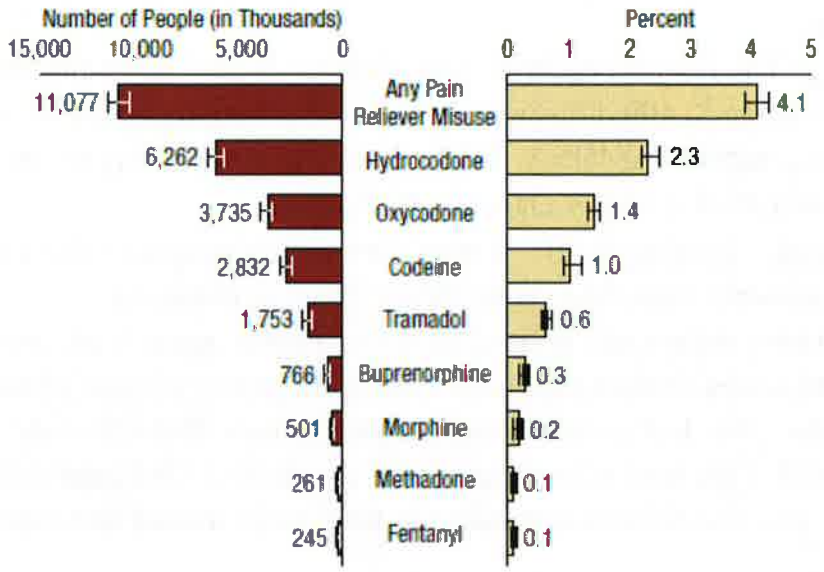
Fortunately, research supports this as a cost-effective approach, particularly for opioids. The recent study by Stahler et. al. (2016), examined over 300,000 cases and found that residential treatment was particularly effective for opioid use disorder compared to other levels of care. Furthermore, residential treatment was even more effective for opioids than other primary drugs of use. They concluded that greater use of residential treatment should be examined, particularly for opioid use disorders.

Recently, "MAT advocates have propelled buprenorphine treatment into the limelight, identifying buprenorphine as both the safest treatment option and easily self-administrated medication assisted treatment" (Mund & Stith, 2018). This heavy focus on buprenorphine, while ignoring the system of care and other effective pathways to recovery. While buprenorphine is valuable, it is important to remember the lessons of our past, and use appropriate caution to the risks associated with an opioid partial agonist, including the risks of diversion, addiction and death when not properly managed. Unfortunately, this is more often the case in the buprenorphine provider system (Office based opioid treatment [OBOT]) with minimal oversight in contrast to the oversight on the licensed SUD and methadone (narcotics treatment program [NTP]) provider systems.

Research (Kenny et al., 2017) finds that 50.5% of the participants reported they had shared buprenorphine and 28% reported they had sold buprenorphine. They concluded that although considered diversion, sharing buprenorphine is normative among buprenorphine medication assisted treatment patients. Moratti et al., (2010) found "In total, 23.12% of patients admitted an IV misuse of buprenorphine, with a significantly greater prevalence among patients currently receiving buprenorphine (35.48%) than those receiving methadone (17.75%; p,001)." (p. 3) Lastly, the FDA reports 19,963 buprenorphine related deaths, as compared with only 6,002 methadone related deaths and 637 naltrexone related deaths (FDA, 2019). Similarly, SAMHSA (2018) reports that methadone and buprenorphine are more widely used than fentanyl, although fentanyl is a more well-known cause of death. Proper management of any medication is a critical

component to success and must be in the context of comprehensive treatment rather than medication only, in order to be evidence based.

Figure 24. Past Year Misuse of Prescription Pain Reliever Subtypes among People Aged 12 or Older: 2017



(*Key Substance Use and Mental Health Indicators in the United States,* SAMHSA, 2018)

Lastly, there are research sources that suggest the cost benefit of various approaches that can guide the balance of funding emphasis within a system of many pathways to recovery. Research (Ettner et al., 2010) finds an average cost benefit of $6:1 for residential treatment for SUD, $11:1 savings for outpatient drug free treatment, with the highest cost savings for the residential treatment services (which typically addresses the most ill individuals). Similarly, a comprehensive review by the Washington State Institute for Public Policy finds that the most well-known components remain the most effective for outcomes including approaches such as 12 step, cognitive therapy, motivational enhancement therapy, and residential therapeutic communities (see summary in Appendix).

Gaudenzia has completed a cost benefit study on one program, including a continuum of care as described here with the right length of stay, continuum and therapeutic interventions. The cost benefit analysis demonstrates **that over a 5-year period the state saved $8,479,450** and this was achieved via two levels of savings. This includes savings by avoiding state costs such as incarceration, as well as through increased engagement in employment creating tax revenue, and related savings.

Challenges to the Treatment System

There are three key challenges to the treatment system: underfunding, workforce and administrative burden. Together these limit the effectiveness of the existing system that could better manage those already in our care.

- Underfunding: Limited resources cause programs to limit services, preventing existing programs from fully funding components such as couples/family services, aftercare coordination, and complementary treatment alternatives (for pain management etc.). These limitations also cap staff salaries and prevent the growth and maintenance of an effective workforce.
- Workforce: The Pennsylvania SUD workforce is paid substantially lower than the average of allied disciplines within the state as well as in our neighboring states (SAMHSA, 2015). This limits the ability to attract, maintain and grow a highly effective workforce.
- Administrative Burden: Sadly, within the existing programs there are ongoing concerns regarding payment for services rendered. Administrative delays and related burdens, lengthy appeals procedures and related issues distract programs from their primary focus of treating our citizens. This further compromises programs with are already underfunded. This is also limits access to the federal Medicaid dollars available, that would have been used to fund these denied services.

Recommendations:

- Support DiGirolamo HB 386 providing for SUD treatment placement with specialized criteria for Pennsylvania and the publicly funded client as supported by the consensus of the Joint State Government review of the issue (Addiction Treatment Services report, 2018).
- Oppose elimination of the carve-out for MH/SUD, along with major MH and SUD related organizations from around the state.
- Improve efforts to increase engagement in the proper level of care, length of stay, such as publishing a study of length of stay and levels of care from funders with plans to remediate deficiencies, as recommended in Kinsey's HR 590 of 2015 report.
- Take steps to fund licensed SUD treatment in a way that permits programs to expand services.
- Remember the central role of relationships in the recovery process.
- Use opioid medications and opioid based treatment medications with appropriate caution.
- Maintain focused goal believing in our brothers and sisters, knowing that recovery is the expectation, and the only long term path to safety.
- In the context of many valuable paths and interventions, target spending in areas with solid basis for long term recovery. This may not be cheaper but will be more cost saving to the government system, our communities and our families.

Conclusions:

Thank you for thoughtfully considering the role of mental health in combatting SUD. Expenditure on key elements of prevention, intervention and treatment that are research supported as highly effective tools to manage this epidemic and help our loved ones reach lasting recovery from opioid use disorder. By using targeting our efforts to research proven approaches that have stood the test of time, we can succeed, one family member at a time. It is important to remember that recovery is a reality, as there are an estimated 23.5 million Americans in recovery from SUD.

We appreciate the opportunity offer testimony. If there is any additional information that would be useful please feel free to contact me at the below address. Again, thank you for your interest and support in this life saving issue in the context of the current epidemic.

Sincerely,

Ken Martz, Psy.D.

Ken Martz, Psy.D., MBA, CAS
Special Assistant to the CEO/President
Licensed Psychologist

Gaudenzia Inc.
106 W. Main Street
Norristown, PA 19401
Mobile: (484) 704-0003

Referenced Source Materials
(Supplemental)

Centers for Disease Control and Prevention
CDC 24/7: Saving Lives, Protecting People™

Overdose Deaths Involving Opioids, Cocaine, and Psychostimulants — United States, 2015-2016

Weekly / March 30, 2018 / 67(12);349-358

Puja Seth, PhD[1]; Lawrence Scholl, PhD[1,2]; Rose A. Rudd, MSPH[1]; Sarah Bacon, PhD[1] (View author affiliations)

Summary

What is already known about this topic?

From 1999 to 2015, the drug overdose epidemic resulted in approximately 568,699 deaths. In 2015, 52,404 drug overdose deaths occurred; 63.1% (33,091) involved an opioid. From 2014 to 2015, the age-adjusted opioid-involved death rate increased by 15.6%; the rapid increase in deaths was driven in large part by synthetic opioids other than methadone (e.g., fentanyl).

What is added by this report?

In 2016, there were 63,632 drug overdose deaths in the United States. Opioids accounted for 66.4% (42,249) of deaths, with increases across age groups, racial/ethnic groups, urbanization levels, and multiple states. Age-adjusted death rates for overdoses involving synthetic opioids other than methadone doubled from 2015 to 2016, and death rates from prescription opioids, heroin, cocaine, and psychostimulants also increased.

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Substance Abuse Prevention and Treatment (SAPT) Block Grant

SAPT Block Grant Funding

- FY 2016*: $1.820 billion (requested by the President)
- FY 2015: $1.820 billion
- FY 2014: $1.820 billion
- FY 2013: $1.710 billion (after 5% sequestration cut)
- FY 2012: $1.779 billion (Congress appropriated $1.8 billion, but HHS redirected $21.5 million to other programs)
- FY 2011: $1.783 billion
- FY 2010: $1.799 billion
- FY 2009: $1.779 billion

Overview

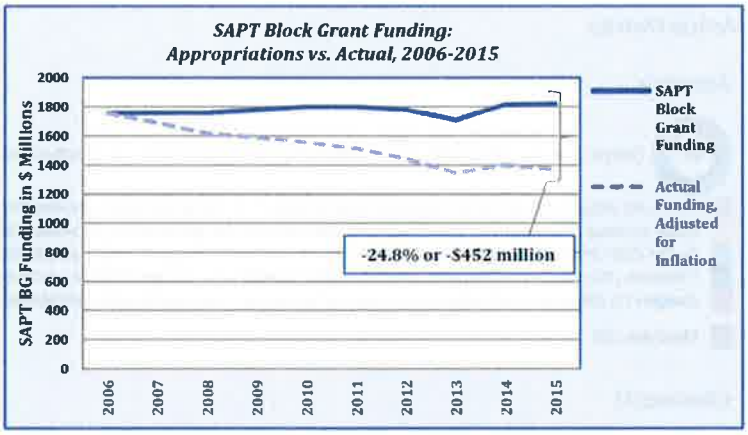
The Substance Abuse Prevention and Treatment (SAPT) Block Grant is distributed by formula to all States and Territories. **It is the cornerstone of States' substance abuse prevention, treatment, and recovery systems.** The SAPT Block Grant is administered by the Substance Abuse and Mental Health Services Administration (SAMHSA), within the Department of Health and Human Services (HHS).

SAPT Block Grant Outcomes

In FY 2014 the **SAPT Block Grant funds provided treatment services for 1.6 million Americans.** During the same year, of clients discharge from treatment, 92.9% had stable housing, 93.9% had no arrests, 81.5% were abstinent from alcohol, and 72.1% were abstinent from illicit drugs.

Funding Decreasing over Time

The SAPT Block Grant is a critical safety net program. **Over the last 10 years, SAPT Block Grant funding has not kept up with health care inflation, resulting in a staggering 25% decrease in actual funding by FY 2015.** As inflation increases, the actual purchasing power of the same funding decreases. In order to restore the SAPT Block Grant's 2006 purchasing power, Congress would need to allocate an additional $450 million for FY 2016. As States work to maintain their systems with fewer resources, the demand for services continues to rise. According to NSDUH, past month use of illicit drugs has been on the rise, increasing from 8.3% of individuals aged 12 or older in 2006 to 9.4% in 2013, a 13% increase.



Financial Burden of Substance Use Disorders

According to the National Survey on Drug Use and Health (NSDUH), 21.6 million people aged 12 or older needed treatment for an alcohol or illicit drug use problem in 2013 (met criteria for abuse or dependence). During the same year, more than 4 million received treatment for such a problem at a specialty facility. As a result, 17.6 million Americans needed but did not receive services for a substance use problem in 2013. The economic impact of substance use disorders is staggering. The **National Institute on Drug Abuse (NIDA) estimates that illegal drugs, alcohol, and tobacco cost society roughly $559 billion every year** or $181 billion for illegal drugs, $185 billion for alcohol, and $193 billion for tobacco (Surgeon General 2004, ONDCP 2004, Harwood 2000).

Substance Use Disorders Represent Tiny Fraction of Overall Health Expenditures

According to SAMHSA's 2013 report, *National Expenditures for Mental Health Services and Substance Abuse Treatment, 1986-2009*, **expenditures for substance use disorder services represented only 1% of all health expenditures** in 2009. That translates to approximately $24 billion for substance use disorders vs. $2.3 trillion for all health expenditures. In contrast, an estimated 14% of Americans had a substance use problem in 2013. Spending for substance use disorder services also grew at a slower rate than general health spending from 1986-2009. Using inflation adjusted terms, the growth rate for health spending was 7.5%, while the rate for substance use disorder spending during the same period was 4.4%.

Investments in Substance Abuse Save Money

In 2006, the National Institute on Drug Abuse (NIDA) noted that for every dollar spent on substance use disorder treatment programs, there is an estimated $4 to $7 reduction in the cost of drug related crimes. With outpatient programs, total savings can exceed costs by 12 to 1. Substance abuse prevention is also a cost-effective way to reduce the financial burden of substance abuse and substance use disorders. According to cost benefit analyses conducted by SAMHSA and other researchers, every $1 spent on effective school-based prevention programs saves roughly $18.

SAPT Block Grant Produces Results

An independent study of the SAPT Block Grant, released in June 2009, found that the program was effective in:

1) Producing positive outcomes as measured by increased abstinence from alcohol and other drugs, increased employment, decreased criminal justice involvement, and other indicators;
2) Improving States' infrastructure and capacity;
3) Fostering the development and maintenance of State agency collaboration; and
4) Promoting effective planning, monitoring, and oversight.

The Underestimated Cost of the Opioid Crisis

The Council of Economic Advisers
November 2017

Executive Summary

November 2017

The opioid drug problem has reached crisis levels in the United States—in 2015, over 33,000 Americans died of a drug overdose involving opioids. CEA finds that previous estimates of the economic cost of the opioid crisis greatly understate it by undervaluing the most important component of the loss—fatalities resulting from overdoses. This paper estimates the economic cost of these deaths using conventional economic estimates for valuing life routinely used by U.S. Federal agencies. It also adjusts for underreporting of opioids in overdose deaths, includes heroin-related fatalities, and incorporates nonfatal costs of opioid misuse. CEA estimates that in 2015, the economic cost of the opioid crisis was $504.0 billion, or 2.8 percent of GDP that year. This is over six times larger than the most recently estimated economic cost of the epidemic.

The National Center on
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at Columbia University

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New York, NY 10017-6706

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fax 212 956 8020
www.casacolumbia.org

Shoveling Up II:
The Impact of Substance Abuse on Federal, State and Local Budgets

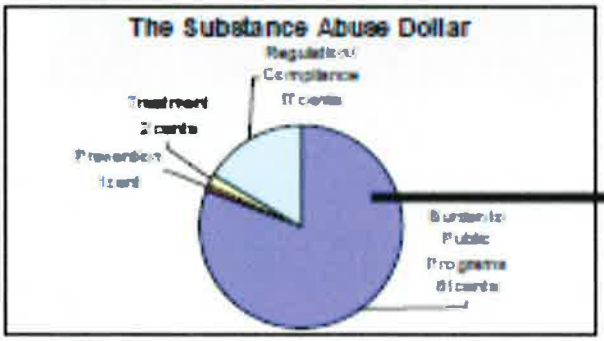
May 2009

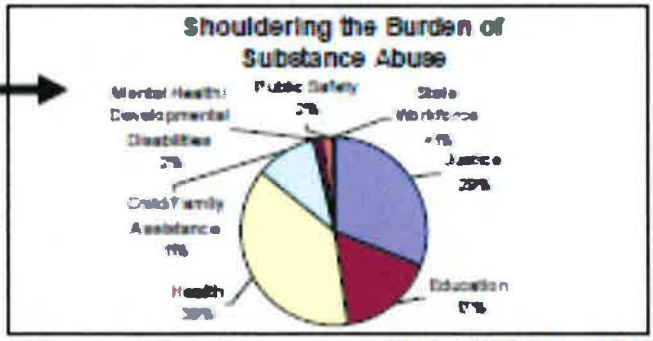
*The National Center on Addiction and Substance Abuse at Columbia University is neither affiliated with, nor sponsored by, the National Court Appointed Special Advocate Association (also known as "CASA") or any of its member organizations, or any other organizations with the name of "CASA".

Pennsylvania

Summary of State Spending on Substance Abuse and Addiction (2005)*

	State Spending by Category ($000)	Spending Related to Substance Abuse			
		Amount ($000)	Percent	As Percent of State Budget	Per Capita
Burden Spending		***$5,344,357.7***		***15.9***	***$429.59***
Justice	**1,955,408.9**	**1,572,366.4**		**4.7**	**126.39**
Adult Corrections	1,409,585.4	1,141,889.6	81.0		
Juvenile Justice	94,188.9	74,915.1	79.5		
Judiciary	451,634.5	355,561.7	78.7		
Education (Elementary/Secondary)	**7,694,150.0**	**921,353.7**	**12.0**	**2.7**	**74.06**
Health	**6,955,317.1**	**2,086,122.9**	**30.0**	**6.2**	**167.69**
Child/Family Assistance	**1,222,291.8**	**566,571.3**		**1.7**	**45.54**
Child Welfare	624,449.3	462,540.1	74.1		
Income Assistance	597,842.5	104,031.3	17.4		
Mental Health/Developmental Disabilities	**776,519.2**	**85,655.7**		**0.3**	**6.89**
Mental Health	9,958.0	5,569.7	55.9		
Developmental Disabilities	766,561.2	80,086.0	10.4		
Public Safety	**328,297.0**	**94,025.0**	**28.6**	**0.3**	**7.56**
State Workforce	**4,975,462.6**	**18,262.6**	**0.4**	**0.1**	**1.47**
Regulation/Compliance	***1,102,435.6***	***1,102,435.6***	***100.0***	***3.3***	***88.62***
Licensing and Control	1,044.6	1,044.6			
Collection of Taxes	19,884.0	19,884.0			
Liquor Store Expenses	1,081,507.0	1,081,507.0			
Prevention, Treatment and Research	***188,216.1***	***188,216.1***	***100.0***	***0.6***	***15.13***
Prevention	51,727.3	51,727.3			
Treatment	87,582.3	87,582.3			
Research	NA	NA			
Unspecified	48,906.5	48,906.5			
Total		***$6,635,009.3***		***19.8***	***$533.33***





Total State Budget	$33,589 M
• Elementary and Secondary Education	$7,694 M
• Substance Abuse and Addiction	$6,635 M
• Medicaid	$7,518 M
• Higher Education	$1,913 M
• Transportation	$3,221 M
Population	12.4 M

Tobacco and alcohol tax revenue total $1,267,917,000; $101.92 per capita.
Liquor store revenue total $1,171,179,000; $94.14 per capita.

* Numbers may not add due to rounding.

Yes, Bayer Promoted Heroin for Children -- Here Are The Ads That Prove It

Jim Edwards *Business Insider* Nov. 17, 2011, 10:58 AM

FDA NEWS RELEASE

For Immediate Release: Sept. 10, 2013
Media Inquiries: Morgan Liscinsky, 301-796-0397, morgan.liscinsky@fda.hhs.gov (mailto:morgan.liscinsky@fda.hhs.gov)
Consumer Inquiries: 888-INFO-FDA

En Español (/7993/20170112130229/http://www.fda.gov/NewsEvents/Newsroom/ComunicadosdePrensa/ucm367724.htm)

FDA announces safety labeling changes and postmarket study requirements for extended-release and long-acting opioid analgesics
New boxed warning to include neonatal opioid withdrawal syndrome

The U.S. Food and Drug Administration today announced class-wide safety labeling changes and new postmarket study requirements for all extended-release and long-acting (ER/LA) opioid analgesics intended to treat pain.

"The FDA is invoking its authority to require safety labeling changes and postmarket studies to combat the crisis of misuse, abuse, addiction, overdose, and death from these potent drugs that have harmed too many patients and devastated too many families and communities," said FDA Commissioner Margaret A. Hamburg, M.D. "Today's action demonstrates the FDA's resolve to reduce the serious risks of long-acting and extended release opioids while still seeking to preserve appropriate access for those patients who rely on these medications to manage their pain."

Given the serious risks of using ER/LA opioids, the class-wide labeling changes, when final, will include important new language to help health care professionals tailor their prescribing decisions based on a patient's individual needs.

The updated indication states that ER/LA opioids are indicated for the management of pain severe enough to require daily, around-the-clock, long-term opioid treatment and for which alternative treatment options are inadequate.

The updated indication further clarifies that, because of the risks of addiction, abuse, and misuse, even at recommended doses, and because of the greater risks of overdose and death, these drugs should be reserved for use in patients for whom alternative treatment options (e.g., non-opioid analgesics or immediate-release opioids) are ineffective, not tolerated, or would be otherwise inadequate to provide sufficient management of pain; ER/LA opioid analgesics are not indicated for as-needed pain relief.

"The FDA's primary tool for informing prescribers about the approved uses of medications is the product labeling," said Douglas Throckmorton, M.D., deputy director for regulatory programs in the FDA's Center for Drug Evaluation and Research. "These labeling changes describe more clearly the risks and safety concerns associated with ER/LA opioids and will encourage better, more appropriate, prescribing, monitoring and patient counseling practices involving these drugs."

Recognizing that more information is needed to assess the serious risks associated with long-term use of ER/LA opioids, the FDA is requiring the drug companies that make these products to conduct further studies and clinical trials. The goals of these postmarket requirements are to further assess the known serious risks of misuse, abuse, increased sensitivity to pain (hyperalgesia), addiction, overdose, and death.

Region 3
Behavioral Health Workforce

	Pop	Psychiatrists		psychologists		Social Workers		SA Counselors		MH Counselors		MFTs	
		#	Avg Salary	#	Avg Salary	#	Avg Salary	#	Avg Salary	#	Avg Salary	#	Avg Salary
DE	897,934	90	$180,630	330	$89,780	340	$48,250	190	$41,050	500	$37,550	240	$51,430
DC	601,723	340	$139,290	440	$82,590	480	$54,310	190	$46,770	1360	$43,630	NA	NA
MD	5.8M	470	$204,110	2330	$70,680	2100	$43,680	2040	$42,380	2100	$39,720	1470	$46,500
PA	12.7M	1150	$191,810	5620	$73,670	9800	$39,240	9350	$39,450	12260	$43,110	1110	$48,770
VA	8M	540	$167,740	2500	$69,620	3430	$46,220	1960	$46,650	7890	$44,950	1600	$46,730
WV	1.9M	80	$153,370	630	$50,770	450	$30,030	530	$29,750	590	$34,280	340	$35,950

SAMHSA

Slide 3

SAMHSA Behavioral Health Workforce Overview (2015)

ELSEVIER

Journal of Substance Abuse Treatment 36 (2009) 159–171

Journal of Substance Abuse Treatment

Special article

Setting the standard for recovery: Physicians' Health Programs

Robert L. DuPont, (M.D.)[a], A. Thomas McLellan, (Ph.D.)[b,*], William L. White, (M.A.)[c], Lisa J. Merlo, (Ph.D.)[d], Mark S. Gold, (M.D.)[d]

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Received 22 October 2007; received in revised form 4 January 2008; accepted 8 January 2008

Abstract

A sample of 904 physicians consecutively admitted to 16 state Physicians' Health Programs (PHPs) was studied for 5 years or longer to characterize the outcomes of this episode of care and to explore the elements of these programs that could improve the care of other addicted populations. The study consisted of two phases: the first characterized the PHPs and their system of care management, while the second described the outcomes of the study sample as revealed in the PHP records. The programs were abstinence-based, requiring physicians to abstain from any use of alcohol or other drugs of abuse as assessed by frequent random tests typically lasting for 5 years. Tests rapidly identified any return to substance use, leading to swift and significant consequences. Remarkably, 78% of participants had no positive test for either alcohol or drugs over the 5-year period of intensive monitoring. At post-treatment follow-up 72% of the physicians were continuing to practice medicine. The unique PHP care management included close linkages to the 12-step programs of Alcoholics Anonymous and Narcotics Anonymous and the use of residential and outpatient treatment programs that were selected for their excellence.

Keywords: Addiction treatment; Substance use disorders; Physicians health programs

THE AMERICAN JOURNAL OF DRUG AND ALCOHOL ABUSE
Vol. 30, No. 3, pp. 537–550, 2004

Effectiveness of Long-Term Residential Substance Abuse Treatment for Women: Findings from Three National Studies[#]

Lawrence Greenfield, Ph.D.,[1,*] Kenneth Burgdorf,[1] Xiaowu Chen,[1] Allan Porowski,[1] Tracy Roberts,[1] and James Herrell[2]

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ABSTRACT

The effectiveness of residential substance abuse treatment for women was examined using data from the Center for Substance Abuse Treatment's Residential Women and Children/Pregnant and Postpartum Women (RWC/PPW) Cross-Site Study and two other recent national

[#]This study was supported under contract 270-97-7030 from the Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), and the U.S. Department of Health and Human Services (DHHS). Views and opinions are those of the authors and do not necessarily reflect those of CSAT, SAMHSA, or DHHS.
[*]Correspondence: Lawrence Greenfield, Ph.D., 11123 Midvale Rd., Kensington, MD 20895, USA; E-mail: lg439@aol.com.

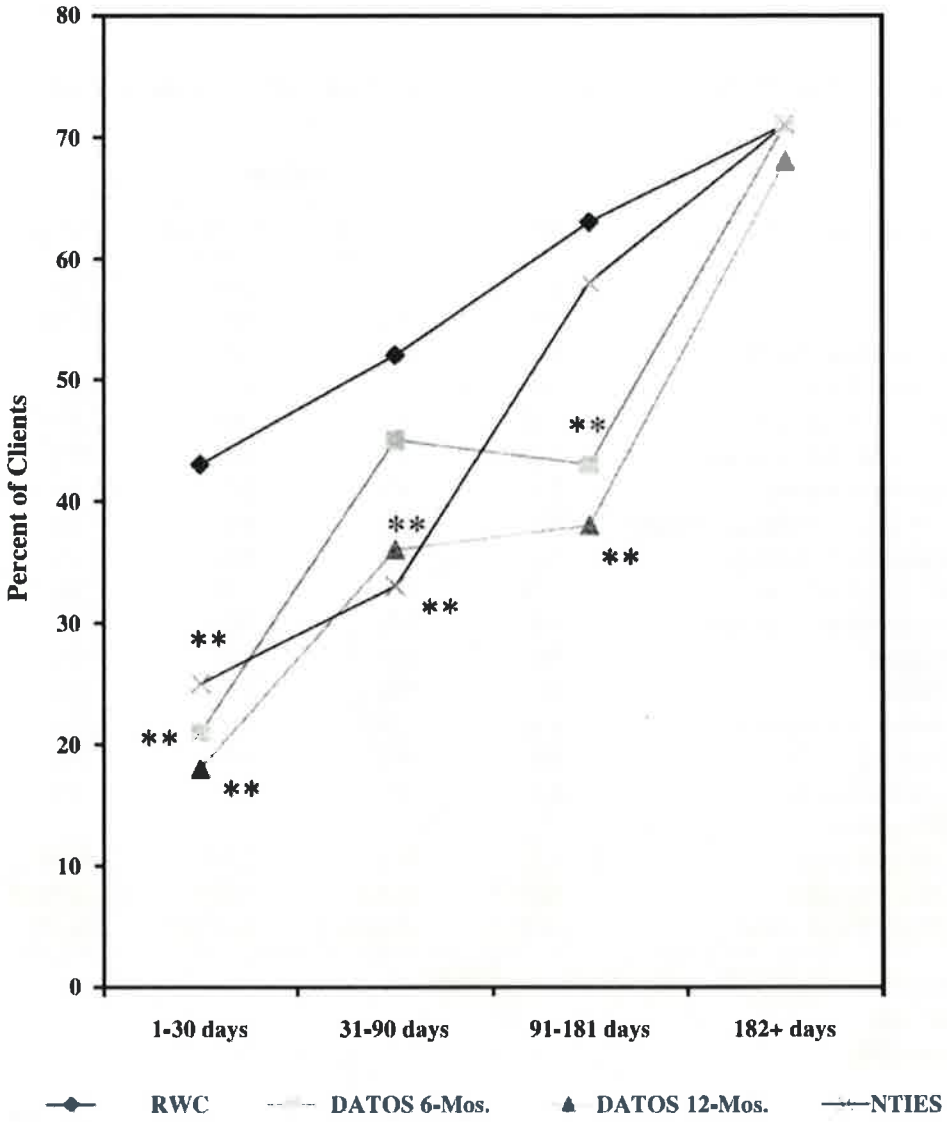


Figure 1. Percentage of abstinent post-discharge by LOS and study. Note: **Difference from RWC is statistically significant at $p < .01$.

A client's LOS in treatment is partly influenced by the practices and policies of the treatment facility, which may limit how long clients are allowed to remain in a program. Insurance coverage may also be a limiting factor in some cases. Beyond such external constraints, self-selection may also be important. If clients with certain characteristics systematically remain longer in treatment than do other clients, it may be these other

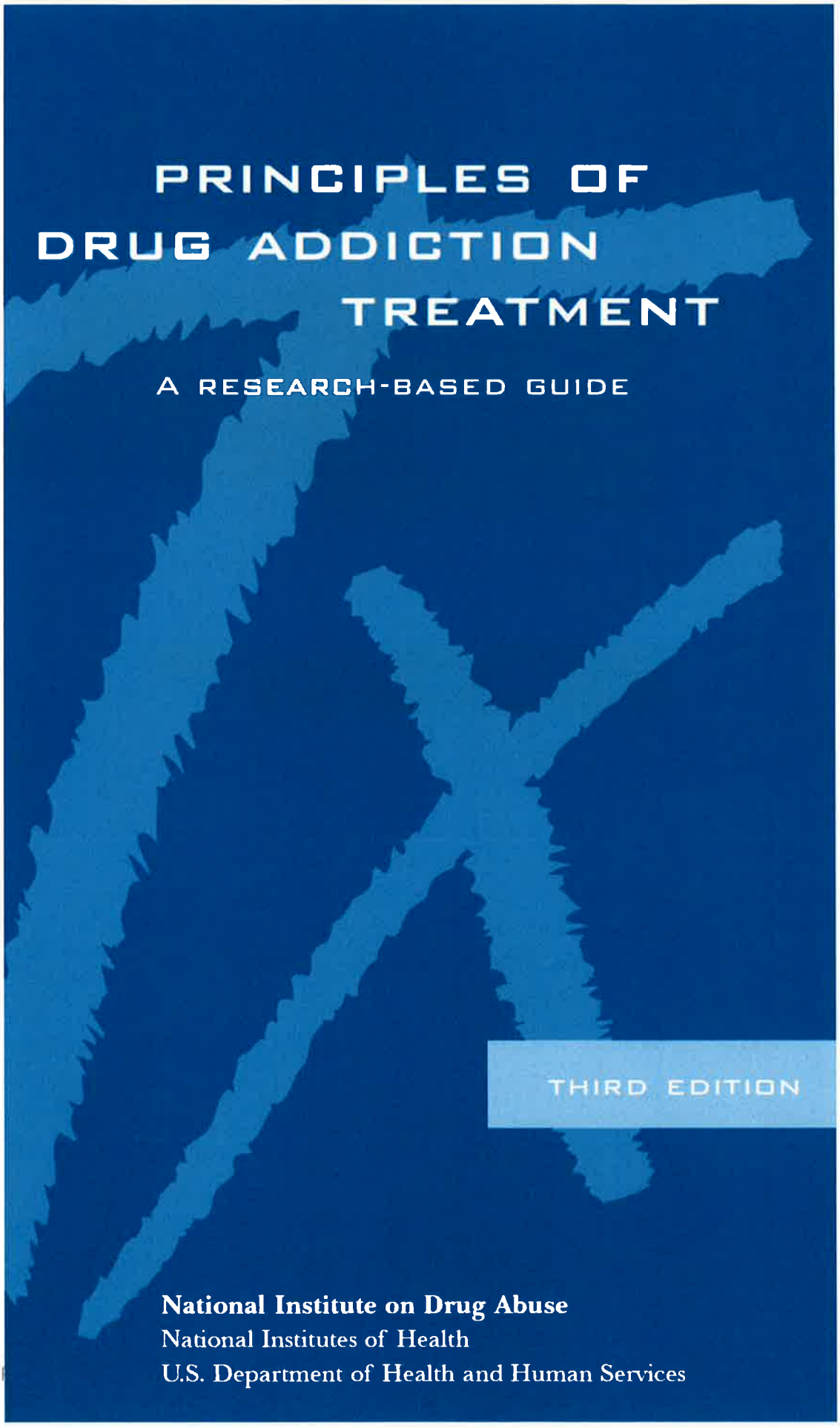
Table 4. Logistic regression odds ratios (OR) obtained in predicting abstinence, by study.

		DATOS		
Variables in model	RWC	6-Month	12-Month	NTIES
n	1154	219	219	424
Age	1.03*	NS	NS	1.04*
H.S. diploma/GED	NS	NS	NS	NS
Employed FT/PT	NS	NS	NS	NS
Prior SA treatment	0.64*	NS	.42**	.58*
Cocaine/crack is primary	0.02*	NS	NS	NS
Heroin is primary	NS	NS	NS	NS
Methamphetamine is primary	NS	NS	NS	NS
Marijuana is primary	NS	NS	NS	NS
Alcohol is primary	0.58**	NS	.24*	NS
Another drug is primary	NS	NS	NS	NS
Hispanic	NS	NS	NS	NS
White	NS	NS	NS	NS
African American	1.42*	2.04*	2.24*	NS
Court supervised	NS	NS	NS	NS
Parent/pregnant	NA	NS	NS	NS
LOS groups				
31–90 days	1.3	3.55*	2.90	1.44
91–181 days	2.06**	3.36*	4.07*	4.29**
182 days or more	3.06**	10.0**	12.89**	6.44**

Notes: NA = Not applicable; NS = Not selected.
*$p < .05$.
**$p < .01$.

characteristics—rather than LOS—that are causally responsible for a statistical association between LOS and treatment outcome. To examine this possibility, we conducted a series of logistic regression analyses. We examined the association between treatment LOS and post-discharge abstinence, separately for each of the four data sets, controlling for a common series of client characteristics that were available in all of the data sets. Results of these analyses are summarized in Table 4.

Table 4 shows that LOS was the only predictor variable that was significantly associated with treatment outcome (post-discharge abstinence) in all four data sets, and it was the single strongest predictor in each one. In all four data sets, controlling for other salient client characteristics, the odds of remaining drug-abstinent throughout the follow-up period were significantly greater for clients who received 91–181 days of treatment


PRINCIPLES OF
DRUG ADDICTION
TREATMENT
A RESEARCH-BASED GUIDE
THIRD EDITION
National Institute on Drug Abuse
National Institutes of Health
U.S. Department of Health and Human Services

5. How long does drug addiction treatment usually last?

Individuals progress through drug addiction treatment at various rates, so there is no predetermined length of treatment. However, research has shown unequivocally that good outcomes are contingent on adequate treatment length. Generally, for residential or outpatient treatment, participation for less than 90 days is of limited effectiveness, and treatment lasting significantly longer is recommended for maintaining positive outcomes. For methadone maintenance, 12 months is considered the minimum, and some opioid-addicted individuals continue to benefit from methadone maintenance for many years.

Good outcomes are contingent on adequate treatment length.

Treatment dropout is one of the major problems encountered by treatment programs; therefore, motivational techniques that can keep patients engaged will also improve outcomes. By viewing addiction as a chronic disease and offering continuing care and monitoring, programs can succeed, but this will often require multiple episodes of treatment and readily readmitting patients that have relapsed.

6. What helps people stay in treatment?

Because successful outcomes often depend on a person's staying in treatment long enough to reap its full benefits, strategies for keeping people in treatment are critical. Whether a patient stays in treatment depends on factors associated with both the individual and the program. Individual factors related to engagement and retention typically include motivation to change drug-using behavior; degree of support from family and friends; and, frequently,

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Addictive Behaviors

journal homepage: www.elsevier.com/locate/addictbeh

Residential and outpatient treatment completion for substance use disorders in the U.S.: Moderation analysis by demographics and drug of choice

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HIGHLIGHTS

- Clients in residential treatment (vs. outpatient) were 3 times more likely to complete treatment.
- Treatment completion was particularly moderated by age, race and ethnicity, and drug of choice.
- Opioid users were more likely to benefit from residential treatment than users of other substances.
- Marijuana users were less likely to benefit from residential treatment than users of other substances.

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Dropout

ABSTRACT

Background: This study investigates the impact of residential versus outpatient treatment setting on treatment completion, and how this impact might vary by demographic characteristics and drug of choice, using a national sample of publicly funded substance abuse programs in the United States.
Methods: This is a retrospective analysis using data extracted from the 2011 Substance Abuse and Mental Health Services Administration (SAMHSA) Treatment Episode Data Set (TEDS-D). A total of 318,924 cases were analyzed using logistic regression, fixed-effects logistic regression, and moderated fixed-effects logistic regression.
Results: Residential programs reported a 65% completion rate compared to 52% for outpatient settings. After controlling for other confounding factors, clients in residential treatment were nearly three times as likely as clients in outpatient treatment to complete treatment. The effect of residential treatment on treatment completion was not significantly moderated by gender, but it was for age, drug of choice, and race/ethnicity. Residential compared to outpatient treatment increased the likelihood of completion to a greater degree for older clients, Whites, and opioid abusers, as compared to younger clients, non-Whites, and alcohol and other substance users, respectively.
Conclusion: We speculate that for opioid abusers, as compared to abusers of other drugs, residential treatment settings provide greater protection from environmental and social triggers that may lead to relapse and non-completion of treatment. Greater use of residential treatment should be explored for opioid users in particular.

Benefit–Cost in the California Treatment Outcome Project: Does Substance Abuse Treatment "Pay for Itself"?

Susan L. Ettner, David Huang, Elizabeth Evans, Danielle Rose Ash, Mary Hardy, Mickel Jourabchi, and Yih-Ing Hser

Objective. To examine costs and monetary benefits associated with substance abuse treatment.

Data Sources. Primary and administrative data on client outcomes and agency costs from 43 substance abuse treatment providers in 13 counties in California during 2000–2001.

Study Design. Using a social planner perspective, the estimated direct cost of treatment was compared with the associated monetary benefits, including the client's costs of medical care, mental health services, criminal activity, earnings, and (from the government's perspective) transfer program payments. The cost of the client's substance abuse treatment episode was estimated by multiplying the number of days that the client spent in each treatment modality by the estimated average per diem cost of that modality. Monetary benefits associated with treatment were estimated using a pre–posttreatment admission study design, i.e., each client served as his or her own control.

Data Collection. Treatment cost data were collected from providers using the Drug Abuse Treatment Cost Analysis Program instrument. For the main sample of 2,567 clients, information on medical hospitalizations, emergency room visits, earnings, and transfer payments was obtained from baseline and 9-month follow-up interviews, and linked to information on inpatient and outpatient mental health services use and criminal activity from administrative databases. Sensitivity analyses examined administrative data outcomes for a larger cohort ($N = 6,545$) and longer time period (1 year).

Principal Findings. On average, substance abuse treatment costs $1,583 and is associated with a monetary benefit to society of $11,487, representing a greater than 7:1 ratio of benefits to costs. These benefits were primarily because of reduced costs of crime and increased employment earnings.

Conclusions. Even without considering the direct value to clients of improved health and quality of life, allocating taxpayer dollars to substance abuse treatment may be a wise investment.

Table 1: Summary of Costs and Benefits Associated with Substance Abuse Treatment (Based on the Social Planner Perspective)

	All Treatment Modalities (N = 2,567)	*Methadone Maintenance (N = 115)*	*Outpatient Treatment (N = 1,585)*	*Residential Treatment (N = 867)*
Average cost per substance abuse treatment episode (based on weighted per diem prices)	$1,583 ($1,506, $1,660)	$2,737 ($2,469, $3,004)	$838 ($806, $871)	$2,791 ($2,600, $2,984)
Average cost per substance abuse treatment episode (based on unweighted per diem prices)	$3,336 ($3,150, $3,524)	$2,867 ($2,440, $3,290)	$1,505 ($1,443, $1,567)	$6,745 ($6,282, $7,215)
Average benefits	$11,487 ($9,784, $13,180)	$5,313 (−$2,418, $8,265)	$9,049 ($6,864, $11,225)	$16,257 ($13,482, $19,078)
Net benefits (benefits minus cost of treatment, based on weighted per diem prices)	$9,903 ($8,205, $11,592)	$2,575 (−$321, $5,529)	$8,211 ($6,028, $10,385)	$13,467 ($10,706, $16,269)
Cost–benefit ratio (based on weighted per diem cost estimates)	7:1	No statistically significant benefits	11:1	6:1

Note: The follow up period is 9 months. Ninety-five percent confidence intervals (shown in parentheses) were bootstrapped using normal-based methods and 10,000 replicate samples.

Washington State Institute for Public Policy

Program name	Total benefits	Costs	Benefits minus costs (net present value)	Benefit to cost ratio
12-Step Facilitation Therapy	$4,097	$320	$5,016	n/a
Relapse Prevention Therapy	$3,982	$0	$3,982	n/a
Cognitive-Behavioral Coping Skills Therapy	$35,594	($263)	$35,331	$135.56
Motivational Interviewing to enhance treatment engagement	$6,890	($263)	$6,627	$26.17
Seeking Safety: A Psychotherapy for Trauma/PTSD and Substance Abuse	$9,509	($391)	$9,118	$24.29
Motivational Enhancement Therapy (MET) (problem drinkers)	$5,615	($338)	$5,277	$16.63
Contingency management (lower-cost) for substance abuse	$2,359	($248)	$2,112	$9.53
Therapeutic communities for chemically dependent offenders (community)	$11,503	($1,562)	$9,941	$7.37
Holistic Harm Reduction Program (HHRP+)	$3,754	($803)	$2,951	$4.68
Methadone maintenance treatment	$8,531	($3,722)	$4,809	$2.29
Therapeutic communities for chemically dependent offenders (incarceration)	$9,892	($5,004)	$4,888	$1.98
Matrix Intensive Outpatient Model for the Treatment of Stimulant Abuse	$2,425	($1,265)	$1,160	$1.92
Individual Drug Counseling Approach for the Treatment of Cocaine Addiction	$4,217	($2,352)	$1,865	$1.79
Buprenorphine/Buprenorphine-Naloxone (Suboxone and Subutex) treatment	$6,201	($4,556)	$1,646	$1.36
Peer support for substance abuse	$3,493	($2,783)	$709	$1.25
Contingency management (lower-cost) for marijuana use	$310	($248)	$62	$1.25
Supportive-Expressive Psychotherapy for substance abuse	($1,587)	($2,015)	($3,602)	($0.79)
Behavioral Self-Control Training (BSCT)	($12,642)	($156)	($12,798)	($81.03)

Source: http://www.wsipp.wa.gov/BenefitCost?programSearch=

Good Afternoon Members of the Policy Committee:

My name is Devin Reaves and I have worked with people who struggle with substance use disorders since 2008. I have had many jobs within the field. My 1st job in the field in 2008 was assistant half way house manager. After I got my master's in social work from the University of Pennsylvania, I operated a recovery residence in Philadelphia for 4 years. I have worked as a therapist to adults and teens. And my last job in the field offering direct services I was the executive director of a treatment center. Over the years I became frustrated with the poor outcomes my clients were experiencing in our current system. I decided that I needed to advocate for sweeping changes at the state level.

In 2017 I founded the Pennsylvania Harm Reduction Coalition. The mission of PAHRC is to promote the health, dignity, and human rights of individuals who use drugs and communities impacted by drug use. Recognizing that social inequity, criminalization, and stigma silence those affected most, we advocate for policies that improve the quality of life for people who use drugs, people in recovery, and their communities. My testimony is informed by my experiences as a recipient of substance use services as well as a provider of direct services and an administrator.

The National Institute on Drug Abuse describes Comorbidity as two or more disorders or illnesses occurring in the same person. They can occur at the same time or one after the other. Comorbidity also implies interactions between the illnesses that can worsen the course of both.

- Comorbid substance use disorder and mental illnesses are common, with about half of people who have one condition also having the other[i].

And while this hearing is about the place of mental health in substance use disorder treatment and recovery, the two must go hand in all discussions. Prior to my testimony today you have heard from extremely qualified and experienced people in this field. I hope to offer you a slightly different perspective.

I am here to discuss harm reduction. Harm reduction is widely known in Pennsylvania yet still tragically underutilized. In fact, all substance use prevention and treatment is Harm Reduction, in that Harm Reduction is a continuum of intervention for an individual using drugs that can range from safer drug use i.e. never using alone, always using a sterile syringe, testing drugs, having Naloxone on hand when you use drugs, to total abstinence from drugs. Harm Reduction embraces "meeting a person where they are but not leaving them there" attitude. Harm Reduction is also a social movement looking to evolve society's response from one of punitive criminal justice to one centered in compassionate care for people who use drugs, acknowledging that many of our systems must change to fix our failed drug policy.

When I say harm reduction is widely known in Pennsylvania I am referring to our robust Naloxone distribution efforts which was first made possible by the passing of ACT 139

also known as David's Law which allowed for the expanded access to Naloxone to 1st responders, family members, as well as those who are using drugs. I was the co-founder of the Pennsylvania Overdose Prevention Action network, which advocated tirelessly to help pass this law including collecting thousands of signatures and many legislative education visits. Secretary of Health Dr. Levine later wrote a standing order allowing anyone to get access to Naloxone (if they can afford it) making this life saving medication even more accessible. At the end of last year, many communities statewide took part in Naloxone Day, during which 6000 doses of this life saving medication were distributed. These harm reduction efforts have led to thousands of saved lives. We have made so much progress since 2014. The 1st program to ever give naloxone to people who use drugs was a Syringe Service Program and that was over 20 years ago in Chicago. The Chicago Recovery Alliance.

We must center the health and wellness of people who have substance use disorders and approach the substance use epidemic from a compassionate, practical public health perspective. that is why many experts agree that syringe service programs are the next step for Pennsylvania. Syringe Service Programs increase the chance of someone entering treatment, save money, and decrease overdose deaths. Pennsylvania is the only state the Northeast that has not passed compressive syringe access legislation.[ii] While it is true, we have Syringe Service Programs her in Philadelphia and in Pittsburgh we still need them in many more communities. Some people think that syringe service programs only give out sterile syringes, but they do so much more. Syringe Service programs offer referral to needed social services including mental health services, testing and treatment for communicable disease and tools to stop the spread of disease such as Hepatitis C and HIV. Hepatitis C kills more American then any other infectious disease.[iii] And Pennsylvania has a rate of Hepatitis C twice is almost twice that of the national average.[iv] It is the overdose epidemic that drives this. We must address this public health crisis with good public health. We must dispel bias and embrace science. Legislation to solve this problem was introduced the previous two sessions by Representative Ed Gainey. I know he plans to introduce it again this session I encourage you all to consider this co-sponsoring and supporting that legislation this session

Before I end, I have on more issue I would like to discuss regarding harm reduction

The Pennsylvania Harm Reduction Coalition seeks to advocate for those most at risk over overdose. No population is more at risk than those leaving correctional facilities. According to research from American Public Health Association [v] In the first two weeks after being released from prison, returning citizens are 40 times more likely to die of an opioid overdose than someone in the general population. Correctional facilities in Allegheny [vi] and Philadelphia[vii] counties are already taking the needed step to address this issue by distributing Naloxone the overdose reversal medication to those returning citizens, but we must expand this effort to every county.

Naloxone distribution while vital is not enough to protect our returning citizens. We must also ensure that individuals in correctional facilities have access medication assisted

recovery. According to the Substance Abuse and Mental Health Service Administration "Medication-Assisted Recovery" is a practical, accurate, and non-stigmatizing way to describe a pathway to recovery made possible by physician-prescribed and monitored medications, along with other recovery supports, e.g., counseling and peer support. Although no medications cure dependence on drugs or alcohol, some can play a significant and lifesaving role in helping people begin and sustain recovery. The Pennsylvania Harm Reduction Coalition supports the use of and access to all three FDA approved medications for treating Substance Use Disorder.

I say all of this to you not only as a master's level clinician but as a person in recovery for over 11 years who is devoted to ending the overdose epidemic and all of the tragedies that come along with it. I urge you to lead the local and state service systems in Pennsylvania to the forefront of substance use care and help to end the public health crisis we are currently facing.

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[i] https://www.drugabuse.gov/publications/drugfacts/comorbidity-substance-use-disorders-other-mental-illnesses

[ii] https://www.vox.com/science-and-health/2018/6/22/17493030/needle-exchanges-ban-state-map

[iii] https://www.cdc.gov/media/releases/2016/p0504-hepc-mortality.html

[iv] https://www.cdc.gov/hepatitis/statistics/2016surveillance/pdfs/2016HepSurveillanceRpt.pdf

[v] https://ajph.aphapublications.org/doi/abs/10.2105/AJPH.2018.304514?journalCode=ajph&

[vi] https://www.alleghenycountyanalytics.us/index.php/2019/02/28/naloxone-distribution-in-the-allegheny-county-jail-to-prevent-overdose/

[vii] https://whyy.org/articles/to-prevent-od-deaths-in-vulnerable-population-philly-will-give-people-exiting-jail-naloxone/

Thank you Representative Hohenstein and the rest of the Policy Committee for convening today's public hearing. This concerted effort to come together to better understand the scope of this issue and the needs of our community is a critical step for us to influence and enact change.

My name is Dawn Holden Woods and I am the Chief Executive Officer for Turning Points for Children, a subsidiary of Public Health Management Corporation (PHMC), and the Managing Director of Child and Family Services for PHMC. Turning Points is the largest provider of child welfare services in Philadelphia County, offering a variety of prevention and intervention services to more than 5,000 children.

We are responsible for four Community Umbrella Agencies, including CUA Region 3, which represents 525 families in this district. In addition to these services, we operate the only long- and short-term residential and outpatient substance use treatment program for adolescents through our subsidiary, The Bridge, located in Representative Hohenstein's district.

We are here because we know that Philadelphia struggles with systemic challenges relating to substance use, including poor access to treatment and under-identification of problematic substance use – particularly among youth. Research has now clearly shown that there is a distinct 'at risk' period for developing the disease of addiction – adolescence.

It's important that today's conversation include adolescents.

More than 90% of those suffering from addiction meet diagnostic criteria before the age of 22 years, yet despite this fact, the state of substance abuse prevention for adolescents and young adults is woefully inadequate and underfunded. There are significant systemic barriers to improving the quality of adolescent opioid use disorder prevention, including awareness and education of adolescents, parents, caretakers and treatment providers.

Despite what we know about the potential of prevention during adolescence, the youth treatment continuum has fewer levels of care than the adult continuum, and youth-specific treatment is rare: only 23% of all treatment facilities in Pennsylvania offer specialty programming for adolescents.

Youth substance use in Philadelphia remains prevalent, with serious implications for health, educational and job success, justice system involvement, and cost burden to public systems. The most recent Youth Risk Behavioral Surveillance data indicate that:

- more than 1 in 4 high school students in Philadelphia currently use tobacco
- 1 in 5 currently smoke marijuana
- 1 in 10 engaged in binge drinking over the past 30 days
- And more than 1 in 10 had taken a prescription drug without a prescription in their lifetime.

An estimated 472,000 individuals 12 years or older in the Greater Philadelphia metropolitan area have a Substance Use Disorder, yet only 12.5% of those diagnosed in Pennsylvania received treatment in the past year.

Options for youth are limited: Philadelphia has one youth-specific residential program, no youth-specific intensive outpatient (IOP) or partial hospitalization programs, and only a few youth-specific outpatient (OP) treatment programs. The systems serving Philadelphia's highest-risk youth, such as the child welfare system, have no systematic processes in place to identify and address problematic substance use.

With recent funding from SAMHSA, we are looking to expand the number of youth in Philadelphia with substance use disorder who are identified and referred to treatment by implementing universal evidence-based screening for substance use at our four child welfare service agencies.

We are also enhancing current services for youth with substance use disorder and co-occurring disorders in Philadelphia. We have implemented the city's first youth-specific intensive outpatient program at The Bridge and are incorporating evidence-based practices (EBPs) that provide support for family members and engage family in youth's treatment, provide peer recovery supports to youth, address trauma exposure, and connect youth to comprehensive wraparound services during and after treatment.

The Bridge offers a host of comprehensive services accredited by the Joint Commission for adolescents and their families and offers *the only residential substance use treatment program for adolescent males and females in Philadelphia*.

Through a coordinated effort between Turning Points for Children, PHMC and Health Promotion Council, also a PHMC subsidiary, we are providing case management services for all youth and their families. This is a significant enhancement to existing care practices. Youth are connected to a comprehensive network of health and social services provided by PHMC and its network of Federally Qualified Health Centers.

This lends itself to also ensuring youth are able to transition into the appropriate after-care that they may need to maintain their recovery and progress made during treatment. It's critical that resources and supports are available for youth to return to their homes and schools and adhere to the positive, healthy behaviors that were established during treatment.

Another area that we are paying close attention to is the impact of substance use on youth within the foster care system. National research suggests that nearly a third of children entering foster care in 2015 were placed there due at least in part due to a parent's illicit drug use. Through the City of Philadelphia, we have established the "Philadelphia Coalition on Children and Opioids" to develop a realistic roadmap for addressing the needs of these children and look to offer recommendations targeted at reducing the impact of the opioid crisis on children in Philadelphia.

We are working to strengthen the assessment of substance use in the homes of families that are involved with the child welfare system and developing strategies for child welfare workers to use to access supports and services for the children and their parents/caregivers.

Case managers across this city – regardless of which provider employs them – should have the right tools and resources available to them to walk into a home where there is active substance use and identify that issue. We want all case managers to know how to respond and know how to follow up in a way that provides the right support to the children and the adults in the home.

We hope to extend this knowledge base beyond the child welfare workers and equip other systems and individuals who interact with children with the same knowledge and access to resources.

As we look to expand and improve treatment for those most in need at this very moment, parallel work and efforts should focus on delivery and expansion of services for youth, including prevention.

I'm hopeful that some of you have seen the new billboard on xxx or social media ads that call out an opportunity to help prevent substance use, including opioid use, among our youth. PHMC recently launched a campaign called the Pennsylvania Opioid Prevention Project where youth played an intricate role in the advisement and development of messages to help inform youth and parents about the dangers of substance use. Through this grant work from the Pennsylvania Commission on Crime and Delinquency, there is new movement to empower teens and parents with education, knowledge and resources to make healthy choices.

As we battle the opioid epidemic here in Philadelphia and across the country we are faced with loss of life that is unprecedented. We are forced to both look at how we manage the everyday needs related to this crisis while also considering how we can use the epidemic as a springboard for creating meaningful change in the way we prevent, identify, intervene early and treat addiction. While many people across the city, state and country are devoting their time and expertise to this thinking, I would like to offer that too few are thinking about the needs of children and youth impacted by addiction. Long-term change can only happen with our young people as the starting point for prevention.

Thank you again Representative Hohenstein for challenging all of us to address the tough questions. I look forward to continuing to work with you and your colleagues to develop sustainable solutions that will make a difference in the lives of the individuals, families and communities we both serve.

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Thank you Representative Hohenstein and the Democratic Caucus for convening this hearing on the opioid crisis, and giving me this opportunity to talk about the impact of substance use and co-occurring mental health disorders in adolescents and how this relates to the plague of opioid deaths we are seeing. Today, I want to share about recovery high schools, an intervention that is shown to work to prevent substance use disorder from developing into full-blown addiction.

All of us in this room know the terrible devastation of the current opioid epidemic. If the current rate of deaths from the opioid misuse continues, over a half million people will die in the next decade. In Pennsylvania, the most recent numbers indicate that we had 5,456 deaths from overdoses -- a 400% increase from the prior year.[1]

What I'm about to say is very important to understanding how we can make policy to address this bleak news.

We know that the kids who are now dying from opioid overdoses in their 20s did not first pick up in their 20s. 1 in 4 Americans who smoked, drank, or used other drugs before the age of 18 has a substance problem. One in four. 90% of those adults with a substance problem, developed it between the ages of 12 - 18[2]

This is why it is critical that we look for innovative measures to intervene before full-blown addiction occurs. Intervening with adolescents and their families -- often a neglected and underserved population with respect to the prevention, treatment , and provision of recovery supports -- is one of the most important efforts we can make to reduce the massively high and unacceptable rates of overdose deaths due to heroin, fentanyl, and other opioids. Recovery high schools are uniquely set up to provide such interventions.

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[1]Substance Use + Mental Health in Teens and Young Adults: Your Guide to Recognizing and Addressing Co-Occurring Disorders. Center on Addiction. February 12, 2019. https://www.centeronaddiction.org/newsroom/press-releases/national-study-reveals-teen-substance-use-america. (Accessed 3/4/19)
[2]Ibid.

The Bridge Way School is Pennsylvania's first recovery high school designed to serve adolescents in grades 9 - 12 who have substance use disorders and co-occurring mental health disorders. Bridge Way is part of the national Association of Recovery Schools, and is one of about 50 such schools across the country.

Recovery high schools started almost 40 years ago for the express purpose of providing recovery supports to adolescents who had received treatment for substance use disorder. We know that treatment works (though only about 1 in 10 who need it receive it[3]), but treatment alone seldom works. A full continuum of care includes recovery supports for adults, adolescents, and their families. Recovery high schools are designed to provide supports that help the adolescent and their families learn how to sustain life-long recovery by addressing underlying mental health illnesses and helping teens and their families develop coping skills and resiliency.

To qualify as a recovery high school, the school must be accessible to all who want it, be licensed by its state as a credit-granting institution, and be able to confer diplomas.

Why recovery high schools? We know that 8 out of 10 students who return to their prior high schools will have a recurrence within 6 months[4] and if there is any kind of co-occurring disorder -- anxiety, depression, trauma, even ADHD -- the median time to relapse is 19 days.[5] Recovery high schools effectively work to prevent this.

Recent research by Andrew Finch, Emily Tanner-Smith, Emily Hennessy & D. Paul Moberg looked at two samples of students who had received treatment for substance use disorder. One group attended recovery high schools post-treatment, while the other group did not. Finch, et al found that adolescents attending recovery high schools were significantly more likely than non-recovery high school students to report complete abstinence from alcohol, marijuana, and other drugs, significantly lower levels of marijuana use, and less absenteeism from school at the 6-month follow-up.[6]

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[3] Lipari, Rachel N., Eunice Park-Lee, and Struther Van Horn. America's need for Receipt of Substance Use Treatment in 2015. SANHSA. The CBHSQ Report. September, 29, 2016. https://www.samhsa.gov/data/sites/default/files/report_2716/ShortReport-2716.html. (Accessed 3/4/19)

[4] Winters, *et al*. 2000. The effectiveness of the Minnesota Model approach in the treatment of adolescent drug abusers. *Addiction* 95 (4): 601-12.

[5] Meyers, K. and Mundela, C. (2012, September). The Case for Continuing Care and Recovery Supports for Adolescent Substance Abusers. Lecture conducted from Adolescent Symposium at The Bridge Way School, Philadelphia, PA.

[6] Andrew J. Finch, Emily Tanner-Smith, Emily Hennessy & D. Paul Moberg (2018)Recovery high schools: Effect of schools supporting recovery from substance use disorders, The American Journal of Drug and Alcohol Abuse, 44:2, 175-184, DOI: 10.1080/00952990.2017.1354378

In fact, recognizing the benefits of a recovery high school, our state legislature created a recovery high school pilot program that allows students to attend a recovery high school at no cost to the family. In 2017, Bridge Way was selected as the school for this program.

Recovery high schools like Bridge Way provide a meaningful intervention for students with co-occurring substance use and mental health disorders. Although there are fewer studies on comorbidity among youth, research suggests that adolescents with substance use disorders also have high rates of co-occurring mental illness. Over 60 percent of adolescents in community-based substance use disorder treatment programs also meet diagnostic criteria for another mental illness.[7]

At Bridge Way and other recovery high schools, we see a very high correlation of substance use and mental health disorders. About five years ago, the Association of Recovery Schools did an informal survey of our schools to determine the number of students enrolled at our high schools who experienced mental illness. We discovered that over 90% of students at recovery high schools across the country had co-occurring mental health disorders including anxiety, depression, bipolar disorder, and childhood trauma.

Multiple national population surveys have found that about half of those who experience a mental illness during their lives will also experience a substance use disorder and vice versa.[8] And while substance use disorder can happen at any time during a person's life, drug and alcohol misuse typically starts in adolescence. This is also a period when the first signs of mental illness commonly appear.

On a day to day basis, we face this chicken and the egg question -- which came first? The substance use disorder or the mental illness? While there is frequently no way to determine whether the SUD provoked the mental illness, or vice-versa, addressing both is essential to sustain recovery. As a result, Bridge Way has a Director of Intervention Services, two peer specialists, and we have partnered with CORA Services to provide individual and group counseling to our students as necessary. Providing an integrated approach to substance use

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[7]National Institute on Drug Abuse. Common Comorbidities with Substance Use. February 2018. https://www.drugabuse.gov/publications/research-reports/common-comorbidities-substance-use-disorders/references. (Accessed 3/4/19)

[8]Ross S, Peselow E. Co-occurring psychotic and addictive disorders: neurobiology and diagnosis.Clinical Neuropharmacology, 2012; 35 (5): 235 - 243. Kelly ™, Daley DC. Integrated Treatment of Substance Use and Psychiatric Disorders. Social Work Public Health, doi: 10.1097/WND.-b-1318261e193;doi: 1080/197371918.2013.774673.

disorder and mental health has become best practice in all schools recognized by the Association of Recovery Schools.

Curiously, what we are seeing is that it is much easier for our students to access mental health care than to get treatment for their substance use. Since we opened our doors in 2011, five adolescent treatment facilities have closed. Many local intensive outpatient programs have shifted away from providing drug and alcohol counseling to focus on treating mental health disorders exclusively.

I think often about a student I will call Cara. Cara enrolled in Bridge Way in 2016 as a high school sophomore addicted to heroin. Cara received treatment at a residential facility and had attended a wilderness camp. She came in sober and maintained this for almost a year. Last winter, she acknowledged that she had a recurrence. She had picked up weed. She knew where this had led for her in the past, and she came to us to ask us to help her get the help she needed. I was so proud of her.

We helped Cara schedule an assessment at a local intensive outpatient provider. Cara went, and she and her mom were told that she did not meet criteria for drug and alcohol treatment. Regardless of the fact that her use of marijuana in the past, in her view, had led to her heroin addiction. She was able to get mental health counseling, and I'm happy to say that she got back on track and graduated last June. But this shouldn't happen. Drug and alcohol counseling should be as accessible as mental health care. And ideally, for our population, the two should be concurrent.

Thank you for your time today. I leave with four requests:

***Examine how we spend our budgeted monies for drug and alcohol programs in PA.**

In Pennsylvania, dealing with substance use disorder accounts for 19.8% of our state budget. Of every dollar spent, 3 cents goes to treatment and prevention; 85 cents goes towards dealing with the managing the consequences of our failure to prevent, treat, and provide recovery supports.[9]

One example of this is how much it costs the state to send a kid into juvenile incarceration v. how much it costs to divert a student into Bridge Way. (Copy this from our promo material.)

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[9] State Spending on Addiction and Substance Use. Center on Addiction. .https://www.centeronaddiction.org/addiction/state-spending-addiction-risk-use. (Accessed 3/4/2019)

***Establish more community-based drug and alcohol treatment options for adolescents and their parents across the state.**

Philadelphia, the largest city in the state, has 4 IOPs that will take teens without private insurance. I'm sure that adolescents living in more rural parts of the state may be even less served.

***Explore if regulatory relief would increase access to adolescent drug and alcohol programs, thereby establishing parity with access to adolescent mental health treatment.**

***Open up the pilot program to additional schools across the state.**

There are groups working to start recovery high schools in the Lehigh Valley, Lancaster, and western Pennsylvania. Recovery schools often intervene with adolescents before they pick up heroin or other opiods We need to shine a light on -- and provide funding to -- interventions with adolescents that we know work. And that are cost effective. The pilot program currently costs the state $240,000. Even if three more schools were funded through the pilot program, the total annual cost would be under $1 million.

Thank you for your time today.