

House Resolution No. 590 Testimony

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As the addiction epidemic continues to grow, barriers to quality and effective treatment have increased proportionately. While many of these barriers pose significant threats to the delivery of timely treatment services, I believe it is the lack of treatment beds throughout the Commonwealth of Pennsylvania which have created the greatest complications. I began working as an assessment specialist in Northampton County at Lehigh Valley Drug and Alcohol Intake Unit (LVDAIU). Agencies such as LVDAIU are an invaluable community resource as they provide an impartial assessment with the sole purpose of matching an individual to the appropriate level of care. I would often encounter individuals at their most desperate of times. They would arrive at LVDAIU ready to begin the process that would hopefully end up initiating a sustainable recovery in their lives. Individuals often endure a lengthy assessment and funding authorization process that lasts up to 3 hours, and usually involves the onset of disruptive acute withdrawal symptoms. Each moment feels like an eternity, and increases the possibility that the individual will remove themselves from the process prior to placement being completed. It is all too common for there to be a significant wait period between the authorization being completed and a bed being located. Depending on the level of care (i.e. medically managed or monitored detox), individuals sometimes are asked to wait weeks for a bed. We know that the minute an addicted individual walks out the door of our offices with the instructions of "do your best to hold on," the likelihood that they make it to that bed is significantly reduced. Depending on the nature of the abused substance (i.e. opiates, benzodiazepines, or alcohol), it becomes a physical necessity to resume using. The challenges to get an addicted individual to the intervention process are enormous; re-engaging them once they have attempted and perceived their efforts to be fruitless usually sets the stage for more dire consequences. An individual's acceptance process of treating their addiction is monumental; the re-acceptance is far more complicated, and too often ends in incarceration or loss of life. I can recall a young lady who I assessed at the intake unit one Friday morning. She was relieved to be authorized for detox that would certainly be followed by residential treatment. Her bags were packed and she waited patiently for a bed to be located. I checked on her at one point, and she referred to an almost uncomfortable peace of mind that she was experiencing knowing she had finally surrendered. A bed search proved unsuccessful, and at 4:30pm, I had to go back out and notify her that she would have to wait until Monday for the bed search process to begin again. She begged me to not send her back out there. I told her that there was nothing more I could do on that day, and provided her with 12 Step meeting lists, instructions to go to the ER if her symptoms became too severe, and keep herself surrounded with family and friends who would look after her. I asked her to return to our office 8:30am Monday morning. She never did. I called a few times over the next couple weeks, but got no response. Several months later, I received a call from her dad saying that she overdosed in Philadelphia and had died. He conveyed his appreciation for my efforts, but also talked about his frustration that she had to

leave our facility that afternoon without a bed. He couldn't understand how a bed wasn't readily available for his sick daughter who was suffering from a medically recognized disease. A person who needed hospitalization for kidney issues would go to the ER and be admitted into a room. Why was his daughter's medical issues any different? There are countless more stories I could relay of individuals who got sent back out to their addiction, and ended up committing crimes, causing harm to others, and/or had brushes with near death.

Another layer to the bed issue is the actual bed search process. The majority of individuals that the intake unit serve are either covered through medical assistance or require county funding. Through medical assistance, the authorization is usually completed and the reviewer will then pass the case on to the bed search team. The hope is that this will be a thorough process with consistent status updates occurring. This is not how the bed search is actually executed. More times than not individuals slip through the cracks. My guess is that the medical assistance personnel are just as overtaxed as every other human services agency. Staffing and time deficiencies cannot be an acceptable excuse for the life and death matter that locating a treatment bed is. I recall a case in particular where I reached out to the bed search team member from one particular BHMCO. She looked up the individual and chuckled a bit when informing me that she received the request from their interviewer, but never did anything with it. "I guess it fell through the cracks like the others," she responded. After questioning what she meant by "like the others," she told me about how it is really difficult to get to or stay on top of all the requests they receive. She even told me that if I really cared about the client, I would do the bed search myself. I did, and after several hours of relentless phone calling, I located a bed. The concept of the assessor doing the bed search sounds logical as they are the ones who are most invested in the individual. The problem is that a thorough assessment can and should realistically take up to 2 hours. That does not include the notes, miscellaneous paperwork, authorization, and bed search process. Based on how BHMCO's and County SCA's reimburse for assessments, it is almost always fiscally impossible for agencies to provide that type of follow through. The agencies that provide assessment services are accustomed to having waiting rooms full of individuals who need to be assessed, appointments booked out for weeks, and waiting lists that are quite extensive.

I could go on and on in great detail about many more barriers that prevent or dangerously delay individuals from receiving the life-saving treatment they require. These issues include a lack of acceptable identification. We understand that the nature of this disease creates dysfunction on a level where basic responsibilities such as having identification become an afterthought, yet we turn them away for presenting this specific symptomology. Another issue is the type of information required by the funder in order to get the necessary information. The problem is that all too often the assessor is being pressured to provide information that blatantly violates confidentiality. As a result of the assessor ethically adhering to confidentiality laws, individuals are sometimes being denied authorizations for medically necessary treatment. There is also the issue of not funding a sufficient amount of treatment. In many cases, we are expecting to treat a sustained addiction which spanned over the course of years with 2 to 4 weeks of treatment. I am confident you will hear about much of what I have touched on and more by the other representatives who are providing testimony. It is important that all

testimony be regarded as a systemic issue rather than isolated barriers. Thank you for your consideration of my testimony.