

**September 7, 2016**

**Testimony Regarding HR 590**

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Good morning. My name is Diane Rosati, Executive Director, Bucks County Drug & Alcohol Commission, Inc. On behalf of my Single County Authority colleagues and our Board of Directors, thank you very much for the opportunity to testify today about HR 590 with the primary focus on resolving the many barriers to accessing treatment services.

As is the case throughout most of Pennsylvania, in Bucks County, heroin is reported as the primary drug of use for those seeking treatment, and heroin surpassed alcohol five years ago as the primary drug of use. Faced with a perfect storm, we border Philadelphia, who has among the highest purity of heroin, coupled with among the lowest cost, and this makes for a deadly mix. Heroin addiction is, most often, the result of an unwitting addiction to prescription medications that leads to heroin use. Our rate of fatal overdose continues to rise. Significant prevention and intervention efforts are being made to combat overdose, and we are saving lives. However, one overdose is too many. Our business as usual is not working. There are just too many barriers.

As a County we are committed to ensuring that none of us receive that dreaded news that a loved one, neighbor, client or stranger has lost a life to addiction. There is no denying that we are embroiled in an opiate and overdose epidemic. That said – we are also challenged to still address the overall issue of substance use disorders, including underage drinking, alcoholism and other drug use, as well as co-occurring disorders. Our resources are limited and we are doing our level best to continue to focus on addiction as a whole. We have important work to do – but we can't do it alone, it requires all hands on deck.

Our areas of challenge are the following:

**Funding**

The commonly held belief, as supported by research and scientific evidence, is that the longer a person remains in treatment, the better their chance at establishing long term recovery. Currently abused opiates and prescription medications dictate new and expensive treatments. SCAs simply do not have the funding to meet these

needs. Secretary Gary Tennis has been a leader in advocating for the right length of stay, with treatment that is provided with clinical integrity. DDAP has upped the ante on the populations for whom we are to prioritize – including individuals who have survived an overdose, pregnant women, veterans, injecting drug users, etc. They are at the top of our list, as we triage not only clinical approval – but fiscal approval as well. Our care managers, who are Masters level clinicians, are forced almost daily to make Solomon-like decisions on who we can fund and who we cannot fund. Expansion of our priority populations is the right thing to do – but it further stresses our system. Last year, we funded ten Veterans for residential treatment. With the loosened guidelines, we have funded seven in just July and August of this year. These individuals dictate specialized and extensive treatment. For non- priority populations, those that are not immediately funded are offered special outreach and services until they can enter treatment – but that can be a roll of the dice. People deserve treatment when they, themselves, determine they are ready.

In addition, a population that we are challenged to assist are those who are enrolled in Medicare. There are so few facilities who are participating providers, and the requirements are so stringent, that the wait for treatment for someone enrolled in Medicare can easily stretch from weeks to months. This is a further push on the SCA system. We are closely reviewing each individual's situation – we are funding their assessment, and sometimes their treatment. It is a life and death decision for some and we choose to help someone in their first step toward recovery. But we just cannot continue to subsidize a federal program that has too many barriers. An essential component of HR 590 should review access for individuals who are covered by Medicare.

We are putting our best minds together to come up with unique and customized treatments – including wraparound services in residential treatment, mobile engagement services to reach out to people who traditionally would not have sought treatment, and an increasing number of medications within medication assisted programs. We are pushing our providers to offer specialty programming, including trauma informed care, co-occurring treatment, gender specific programming and a multitude of evidence based programs. These are costly investments – training, supervision, oversight and evaluation impact the provider's bottom line.

Only through a special grant from our county, have we been able to provide services without a financial wait over this past year – the only year in my recent memory. But a special grant means that another system does not receive their needed allocation. Drug and alcohol treatment funding should not be a stop gap, afterthought or means of placating a group. It must be top priority – it must be increased – and it must be done immediately. In the year prior to this exceptional funding shift – there were over 100 county residents for whom we could not provide access to detox or rehab levels of care.

### **Treatment Capacity**

Nothing is more frustrating for an individual seeking treatment, than to be told that they qualify for treatment, they have been approved for treatment, they agree to enter treatment, and there is not an available bed placement. In addressing access to treatment, this is a cornerstone. Capacity logjams occur at both the detox and rehab levels of care, as well as outpatient. We have created an Open Access assessment process, in conjunction with the NiaTx process – so the vast majority of our residents are reported to be seen same day. However, following the assessment, there is a gap of 1, or 2, or 3 days, for residential or detox treatment.

I previously mentioned that we are saving lives – with our treatment, and with the help of the rescue medication Narcan. Our Bucks Co. police departments have saved over 150 lives in the last 16 months, using Narcan. Countless others, including six people living in our registered Recovery Houses, have been saved. For every life saved, we need access to care. Last year, eight percent of those whom we funded for residential treatment, reported an overdose in the last 365 days. This year, in just July and August, that percentage has more than doubled, to 19%. The good news is that people are surviving overdose, but we need a system that can accommodate these individuals, as the next overdose may well be the fatal one.

We need additional facilities who are skilled in evidence based drug and alcohol programming. Only through approved Reinvestment funds do we have hope of opening new facilities. And I stress that we hope for these facilities to open. We are encountering community push back and stigma that is a significant barrier. Virtually every community is experiencing an increase in overdose. Virtually every community where we intend to expand has pushed back. Before we can expand our capacity, we must address community stigma and present with one voice, that treatment works and recovery is possible.

## **Regulations**

A significant barrier to access is a regulatory system that does not allow for a seamless integrated system. There are varying regulations for Departments, which are not in the best interest of the resident seeking treatment. Examples of this are co-occurring treatment and certified recovery specialist versus certified peer specialist. We are seeking not only parity within our Departments, including HealthChoices and County funded, but an understanding of the value of each of our programs. Accessing, for example, a Certified Recovery Specialist or CRS (with lived experience in the substance use disorder field), should not come with the barriers that are presented for Certified Peer Specialists (with lived experience in the mental health/co-occurring field). An example of a barrier is the requirement of sign off by a practitioner of the healing arts, in order to qualify for the service, if this is seen as an in plan service via HealthChoices. A simpler solution would be to maintain CRS as a supplemental service, which would allow recovery needs to be met as there are many paths to recovery. Recovery comes in all forms – including for those who are not seeking traditional treatments.

As an SCA, we are bound and committed to improving access to treatment for our residents. HR 590 requires a frank review of current barriers, which will only be worthwhile in identifying if we have a bold, results oriented response. This public health crisis dictates nothing less than the best solutions. Thanks to each of you for your time and consideration, and for your commitment to this most important issue. I look forward to responding to any questions that you may have.