

**Testimony of John White Jr.
Department of Drug and Alcohol Hearings**

Good afternoon/morning Secretary Tennis,

I'm pleased to offer testimony today on how best to empower your task force to establish the improvements needed on existing laws, treatment methods and procedures, to genuinely help consumers accessing treatment for drug and alcohol addiction, dependency and attendant health problems.

In my decades of service from Pennsylvania Secretary of Welfare, years in the state house, running a federal housing agency with all its attendant social problems, service city council and now my 16 years with a community based behavioral health agency, I believe I bring a uniquely broad horizon of expertise to the discussion today. I understand the frustration and anxiety that a counselor feels, when he or she knows what a patient needs and their inability to access needed services. I have felt the pain of losing a loved one to addiction and the horrors of losing someone when they sought help but were refused. I understand the desires of the elected officials to try and solve their neighborhood problems when the politics gets in the way. And I understand the gut-wrenching decisions that government executive has to make within the constraints of balancing a budget.

We have a problem not only with the patient's pre-existing condition, but leaders have to work within 'the system's pre-existing conditions, that do not allow progressive use of resources, but rely instead on the silo of business as usual.

Within the context of drug and alcohol dependency, one of the most important areas for improvement needed right now, are in linkages throughout the system. The links between the health care institution, hospital emergency rooms, police stations and providers are paramount and in need of review. We know that people in need show up in an emergency room – but we have to find out what happens to them all along the system trail. Where are patients referred? Where do they go when they are discharged?

At the Consortium we have hospitals that are right in our neighborhood but we get very few of their patient referrals. Is this going on across the state? Because if it is, the family-neighborhood component so crucial to healing and recovery is being compromised and

the patient is not getting the best care with best utilization of an area's resources and medical treatment.

Equally important is the lack of uniform availability of 'best treatments' and practises. Best practices and best methods of treatment are not available in every neighborhood uniformly across the City of Philadelphia or the Commonwealth of Pennsylvania. New drugs which greatly improve outcomes are **serboxin and naloxone** are only available in a very few treatment facilities. There are only 3 treatment facilities that offer this in the entire city which means over of treatments being performed are not up to new standards of success.

Law enforcement is another vital link. They are often the first point of contact and their referrals of people with drug and alcohol related problems are crucial.

There needs to be a clear pathway linking hospital emergency rooms to community based treatment of individuals presenting with life threatening drug problems. We have to review all the services for all who are being discharged after overdose treatment, where the Courts and law enforcement fit in, service providers vs incarceration, and how are the new opiate centers connected to providers and is funding available for treatment options other than methadone. I might add, to their great credit, the drug courts in Philadelphia are working well in keeping and treating health-based problems in the medical community and not in the prisons.

As clinicians, we view addiction as a disease that transcends the identified individuals. The disease adversely affects the patient and their caregivers, family members and loved ones. While good treatment might work for certain individuals; the rate of recidivism is high. Treatment for addicted individuals tends to focus mainly on identified individuals without the inclusion of the environment to which they will return (i.e. parents, spouses, loved ones, friends, etc.). Focus should shift to treating the identified individuals with their environment simultaneously. I do not mean through collateral services only, but individual and group services. Family or related members of individuals living with addictions deal with anger, shame, blame, guilt, hopelessness and helplessness. Treating the environment simultaneously will lessen the "rejection" received by the addicted individuals from family members after undergoing treatment. Both parties will learn together and understand that everyone feels same emotional, financial, lack of trust frustration, shame, guilt, etc. issues.

Dealing with how to manage all these issues together may promote good result and reduce recidivism.

Here are some frightening facts of today - this is a picture of what is going on out there, right now:

Deaths by overdose of all drugs in Philadelphia grew by 50 percent, from 459 in 2013 to 701 in 2015, according to Dr. Evans and Dr. Thomas Farley, the city's health commissioner, and Jeremiah Laster, deputy fire commissioner for emergency medical services, who spoke at City Hall in August (Source: DBHIDS website)

297,000 Pennsylvanians are dependent or abusing illicit drugs. That's 2.7 % of all Pennsylvanians.

In Pennsylvania, about 297,000 individuals aged 12 or older (2.7% of all individuals in this age group) per year in 2013–2014 were dependent on or abused illicit drugs within the year prior to being surveyed. The percentage did not change significantly from 2010–2011 to 2013–2014. (Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010–2011 to 2013–2014).

But only 17.5% of those who need treatment get it.

In Pennsylvania, among individuals aged 12 or older with illicit drug dependence or abuse, about 54,000 individuals (17.5%) per year from 2010 to 2014 received treatment for their illicit drug use within the year prior to being surveyed. (Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Surveys on Drug Use and Health, 2010–2011 to 2013–2014).

Rate ratios for accidental poisoning (“overdose”) mortality in Pennsylvania increased more than 14-fold from 1979 to 2014. The largest rate ratios were among 35–44 year olds, females, and White adults. (Source Citation: Balmert LC, Buchanich JM, Pringle JL, Williams KE, Burke DS, Marsh GM (2016) Patterns and Trends in Accidental Poisoning Deaths: Pennsylvania's Experience 1979-2014. PLoS ONE 11(3): e0151655. doi:10.1371/journal.pone.0151655)

The **highest** accidental poisoning (“overdose”) mortality rates were found in the **counties of Southwestern Pennsylvania, those surrounding Philadelphia, and those in Northeast Pennsylvania near Scranton.** (Source Citation: Balmert LC, Buchanich JM, Pringle JL, Williams KE, Burke DS, Marsh GM (2016) Patterns and Trends in Accidental Poisoning Deaths: Pennsylvania's Experience 1979-2014. PLoS ONE 11(3): e0151655. doi:10.1371/journal.pone.0151655)

Another area of concern is -

We need to increase community based services: Addictions programs have traditionally been "clinic" services. The idea of providing services "in the home" or in the community needs to be explored. Many persons have difficulty with transportation to and from the program. Additionally, treating persons in "their environment" can really give the clinician a better understanding of how that environment (family, housing, support system), affects the person's ability to recover and also provides the clinician with additional strategies to assist the member by treating the whole person.

We need provision of technical assistance training: Staff require increased training in multiple areas to keep abreast of the trends in DA treatment. Staff need to be skilled in providing evidence based training, and ensure consistency of the treatment being delivered despite which clinician is providing the treatment. Training specific to Trauma, Cultural Competency, LGBTQI, etc, would assist in ensuring our programs are capable to work with these very diverse populations and also may ensure retention of those who are receiving services. The goal is to be equipped with tools that will move persons along the treatment continuum and into recovery.

. Thank you for your time and effort and I hope this testimony is helpful.