

JOINT STATE GOVERNMENT COMMISSION

General Assembly of the Commonwealth of Pennsylvania

ADDICTION TREATMENT SERVICES

REPORT OF THE ADVISORY COMMITTEE
ON ADDICTION TREATMENT SERVICES

February 2018



*Serving the General Assembly of the
Commonwealth of Pennsylvania Since 1937*

REPORT

Advisory Committee Report on Addiction Treatment Services

Project Staff:

Glenn Pasewicz, Executive Director

Kahla Lukens, Administrative Assistant

The report is also available at <http://jsg.legis.state.pa.us/publications.cfm>

JOINT STATE GOVERNMENT COMMISSION

Room 108 Finance Building
613 North Street
Harrisburg, PA 17120-0018

Telephone: 717-787-4397
Fax: 717-783-9380
E-mail: jntst02@legis.state.pa.us
Website: <http://jsg.legis.state.pa.us>

The Joint State Government Commission was created in 1937 as the primary and central non-partisan, bicameral research and policy development agency for the General Assembly of Pennsylvania.¹

A fourteen-member Executive Committee comprised of the leadership of both the House of Representatives and the Senate oversees the Commission. The seven Executive Committee members from the House of Representatives are the Speaker, the Majority and Minority Leaders, the Majority and Minority Whips, and the Majority and Minority Caucus Chairs. The seven Executive Committee members from the Senate are the President Pro Tempore, the Majority and Minority Leaders, the Majority and Minority Whips, and the Majority and Minority Caucus Chairs. By statute, the Executive Committee selects a chairman of the Commission from among the members of the General Assembly. Historically, the Executive Committee has also selected a Vice-Chair or Treasurer, or both, for the Commission.

The studies conducted by the Commission are authorized by statute or by a simple or joint resolution. In general, the Commission has the power to conduct investigations, study issues, and gather information as directed by the General Assembly. The Commission provides in-depth research on a variety of topics, crafts recommendations to improve public policy and statutory law, and works closely with legislators and their staff.

A Commission study may involve the appointment of a legislative task force, composed of a specified number of legislators from the House of Representatives or the Senate, or both, as set forth in the enabling statute or resolution. In addition to following the progress of a particular study, the principal role of a task force is to determine whether to authorize the publication of any report resulting from the study and the introduction of any proposed legislation contained in the report. However, task force authorization does not necessarily reflect endorsement of all the findings and recommendations contained in a report.

Some studies involve an appointed advisory committee of professionals or interested parties from across the Commonwealth with expertise in a particular topic; others are managed exclusively by Commission staff with the informal involvement of representatives of those entities that can provide insight and information regarding the particular topic. When a study involves an advisory committee, the Commission seeks consensus among the members.² Although an advisory committee member may represent a particular department, agency, association, or group, such representation does not necessarily reflect the endorsement of the department, agency, association, or group of all the findings and recommendations contained in a study report.

¹ Act of July 1, 1937 (P.L.2460, No.459) (46 P.S. § 65), amended by the act of June 26, 1939 (P.L.1084, No.380); the act of March 8, 1943 (P.L.13, No.4); the act of May 15, 1956 (1955 P.L.1605, No.535); the act of December 8, 1959 (P.L.1740, No.646); and the act of November 20, 1969 (P.L.301, No.128).

² Consensus does not necessarily reflect unanimity among the advisory committee members on each individual policy or legislative recommendation. However, it does, at a minimum, reflect the views of a substantial majority of the advisory committee, gained after lengthy review and discussion.

Over the years, nearly one thousand individuals from across the Commonwealth have served as members of the Commission's numerous advisory committees or have assisted the Commission with its studies. Members of advisory committees bring a wide range of knowledge and experience to deliberations involving a particular study. Individuals from countless backgrounds have contributed to the work of the Commission, such as attorneys, judges, professors and other educators, state and local officials, physicians and other health care professionals, business and community leaders, service providers, administrators and other professionals, law enforcement personnel, and concerned citizens. In addition, members of advisory committees donate their time to serve the public good; they are not compensated for their service as members. Consequently, the Commonwealth of Pennsylvania receives the financial benefit of such volunteerism, along with the expertise in developing statutory language and public policy recommendations to improve the law in Pennsylvania.

The Commission periodically reports its findings and recommendations, along with any proposed legislation, to the General Assembly. Certain studies have specific timelines for the publication of a report, as in the case of a discrete or timely topic; other studies, given their complex or considerable nature, are ongoing and involve the publication of periodic reports. Completion of a study, or a particular aspect of an ongoing study, generally results in the publication of a report setting forth background material, policy recommendations, and proposed legislation. However, the release of a report by the Commission does not necessarily reflect the endorsement by the members of the Executive Committee, or the Chair or Vice-Chair of the Commission, of all the findings, recommendations, or conclusions contained in the report. A report containing proposed legislation may also contain official comments, which may be used in determining the intent of the General Assembly.³

Since its inception, the Commission has published more than 350 reports on a sweeping range of topics, including administrative law and procedure; agriculture; athletics and sports; banks and banking; commerce and trade; the commercial code; crimes and offenses; decedents, estates, and fiduciaries; detectives and private police; domestic relations; education; elections; eminent domain; environmental resources; escheats; fish; forests, waters, and state parks; game; health and safety; historical sites and museums; insolvency and assignments; insurance; the judiciary and judicial procedure; labor; law and justice; the legislature; liquor; mechanics' liens; mental health; military affairs; mines and mining; municipalities; prisons and parole; procurement; state-licensed professions and occupations; public utilities; public welfare; real and personal property; state government; taxation and fiscal affairs; transportation; vehicles; and workers' compensation.

Following the completion of a report, subsequent action on the part of the Commission may be required, and, as necessary, the Commission will draft legislation and statutory amendments, update research, track legislation through the legislative process, attend hearings, and answer questions from legislators, legislative staff, interest groups, and constituents.

³ 1 Pa.C.S. § 1939 ("The comments or report of the commission . . . which drafted a statute may be consulted in the construction or application of the original provisions of the statute if such comments or report were published or otherwise generally available prior to the consideration of the statute by the General Assembly").



In Memory of

Sandra Wummer

Wernersville, Pennsylvania

Jan 17, 1956 - Sep 27, 2017

In sadness, we note the passing of Sandy Wummer, who had been a member of the (SR267) Advisory Committee on Addiction Treatment Services when she died unexpectedly prior to the completion of this report.

Sandy dedicated her career with understanding and compassion to provide for those suffering from substance use disorders. Her wisdom helped guide her friends and colleagues on the Advisory Committee, and we remain forever grateful for having known her.



Advisory Committee on Addiction Treatment Services

(Senate Resolution 267 of 2015)

Dale Adair, MD
Chief Medical Officer
Office of Mental Health
and Substance Abuse Services
Pa Department of Human Services

Jessica Altman, Chief of Staff
Pa Department of Insurance
(9/2016-11/2017)

Alison Beam, Esq.
Chief of Staff, Pa Department
of Insurance
(11/2017-conclusion)

Michael Ashburn, MD, MPH
Professor of Anesthesiology
and Critical Care Director
Penn Pain Medicine Center

Hon. Michael Barrassé
President, Judge Lackawanna
County Court of Common Pleas

Chuck Beasley
Treatment Trends, Inc.

Deb Beck, President
Drug and Alcohol Service Providers
Organization of Pennsylvania

P. Karen Blackburn
Program Administrator
Problem Solving Courts Program
Administrative Office of the Pa Courts
Supreme Court of Pennsylvania

Hon. Sherriff Philip Bueki
Pike County Sherriff's Office

Laura Conrad, Legislative Director
Pa Department of Drugs and Alcohol Programs

Erich Curnow, Director of Clinical
and Case Management Services
One Day at a Time Washington
Drug and Alcohol Commission, Inc.

Christopher Erthal
Kutztown University

Matthew Fogal, District Attorney
Franklin County Courthouse

Douglas J. Furness
Insurance Federation of Pennsylvania

Lou Parrott, MD, PhD
Vice President/Medical Director
Magellan Healthcare

Kristen Houser, MPA
Chief Public Affairs Officer
Pennsylvania Coalition Against Rape

Fern Gilkerson, M.A.
Health Education Specialist
Pennsylvania Coalition Against
Domestic Violence

Angela J. Grannas
Manager, Drug & Alcohol Program
Pa Department of Corrections
(11/2017-conclusion)

Kathleen Jansen, Pys.D
Wellspan Behavioral Health

Kimberly Kockler
Vice President Government Affairs
Independence Blue Cross

Advisory Committee, continued.

Kira Lopresto, Outreach Specialist
Greenbriar Treatment Center

Kenneth J. Martz, Pys.D
Special Assistant to the Secretary
Pa Department of Drugs
and Alcohol Programs

BK McDonough, MBA
Government Affairs Specialist
Caron Treatment Centers

Florence Paige, MHS
Division Director, Central Region
Women & Children's Programs
Gaudenzia, Inc.

Cathleen Palm, Founder
The Center for Children's Justice

Ashley Potts, Team Leader
Crisis Diversion Unit
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Pa Board of Probation and Parole

Judy Rosser, Executive Director
Blair County Drug and Alcohol
Program, Inc.

William Santoro, M.D.
Chief, Section of Addiction Medicine
Tower Health System

Deborah Ann Shoemaker
Executive Director
Pennsylvania Psychiatric Society

Cheryl Scott
Pa Department of Corrections
(9/2016-11/2017)

Nicholas Slotterback
Health & Physical Education Advisor
Pa Department of Education

Jennifer S. Smith, Acting Secretary
Pa Department of Drugs and Alcohol Programs

E. Renea Snyder, MS
Founder and CEO, Migliore Treatment

William Stauffer LSW, CADC
Executive Director, Pennsylvania
Recovery Organizations Alliance

Hon. Gary Tennis, Esq.
Pa Department of Drugs and Alcohol
(9/2016-1/2017)

Robert Tomassini, Deputy Director
Juvenile Court Judges' Commission

Arvind Venkat, M.D.
Vice Chair for Research and Faculty
Academic Affairs Department of Emergency
Medicine Allegheny Health Network Physicians

Sandra Wummer, LPN, CPHQ
Corporate Director of Compliance
Caron Treatment Centers

Michael Yantis, Vice President
State Government Affairs
Highmark Inc.



General Assembly of the Commonwealth of Pennsylvania
JOINT STATE GOVERNMENT COMMISSION
Room 108 Finance Building - 613 North Street
Harrisburg, PA 17120
717-787-4397

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February 2018

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Administrative Staff:

GLENN J. PASEWICZ
Executive Director

YVONNE M. HURSH
Counsel

To the Members of the General Assembly of Pennsylvania:

The Joint State Government Commission is pleased to announce the release of the report, *Advisory Committee Report on Addiction Treatment Services*, written in response to Senate Resolution 267 of 2015.

SR267 directed the Commission to establish an advisory committee to review the current services and programs available to Pennsylvania residents who are suffering from substance abuse disorders. The report presents information on substance use disorders, the costs borne by individuals and society, and Pennsylvania's treatment and rehabilitation systems. The report contains recommendations for the General Assembly's consideration.

Respectfully submitted,

Glenn J. Pasewicz
Executive Director

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EXECUTIVE SUMMARY

Senate Resolution 267 of 2015 directed the Joint State Government Commission to establish an advisory committee to study issues relating to the need for, availability of, and access to effective substance use disorder treatment in this Commonwealth. Substance use disorder presents an enormously complicated health problem for those afflicted because it affects nearly every part of an individual's life. The problem grows in its enormity when SUD rates climb to a point where it is a public health problem; its damaging effects are felt statewide.

Pennsylvania has been one of the states most affected by the rapid increase in SUD. The commonwealth's drug treatment and rehabilitation system has reacted by developing programs, innovating treatments, and redoubling its efforts to serve those residents of Pennsylvania who have been harmed by SUD. From the state government level to local service providers, cross-system collaborations have grown together by necessity and by design to help as many people as possible as quickly as possible.

Just as successful outcomes for traditional chronic diseases require inputs from varieties of plans, treatments, and services, so too does SUD. Pennsylvania, as a whole, is capable of providing leading edge services that consolidate resources to the point of ultimate need—the individual—as is shown throughout this report. However, in the absence of streamlined cooperation, resources, funding, and expertise, treatments and supports may not reliably find their ways to everyone at their time of need.

This report provides background data and information on the scope of drug overdoses, opioids in particular, in Pennsylvania and the U.S. It examines the costs associated with SUD, and provides a comprehensive review of the many types of treatments currently in use by withdrawal management, treatment, and rehabilitation programs. The report includes an overview of the numerous federal, state, and county agencies that regulate SUD programs, and also presents the roles of private sector insurers and accreditation bodies.

The SR267 Advisory Committee deliberated at length over appropriate recommendations to make to the General Assembly. Everyone agrees that the problem of statewide SUD must be solved. Not everyone agrees on which recommendations would be most beneficial. The recommendations included herein reflect the consensus of the Advisory Committee; not all were unanimously approved—some were, and will continue to be, hotly debated. Nonetheless, it is hoped that the report provides the General Assembly with information that adds value to its own deliberations.

INTRODUCTION

The opioid class of drugs, that is, substances that are derived from or are pharmacologically similar to opiates, comprise a powerful family of analgesics that carry with them a significant risk of addiction. The wide availability of opioid analgesics has been both a blessing, in that many Pennsylvanians have been able to manage debilitating pain and consequently return to productive lives, and a curse, in that tragic numbers of lives have been destroyed as a consequence of opioid addiction.

Too many people are familiar with stories about family members, friends, or neighbors who have been trapped by substance use disorder (SUD). “I knew I was addicted when the first prescription ran out,” one high school athlete told her drug addiction counselor. Anecdotally, opioids are widely available in the construction and roofing industries. “It’s such a physically demanding job, they rely on the pills to work through the day,” according to another drug addiction counselor.

Until recently, most people, whether health professionals or laymen, regarded the opioids as one of the most powerful tools in pain management. They were considered effective and inexpensive, and their wide availability made the opioids the easy solution for pain. The fine line between using opioid analgesics as a means of controlling one’s pain and having one’s life controlled by opioid addiction has been underscored by the addiction epidemic. Not only is the push to find effective opioid alternatives urgent, but medical science is reevaluating commonly held notions about the drugs’ usefulness.

Research over the past few years has exposed rifts in what has been accepted about opioid effectiveness and the reality of pain management. The National Safety Council cited several studies that show NSAIDs (nonsteroidal anti-inflammatory drugs), both prescription and over-the-counter, are in many cases more effective than opioids at relieving acute dental, back, and renal colic pain.⁴ Further, evidence supporting the long-term use of opioids for chronic pain is either limited or lacking.⁵

The U.S. contains less than 5% of the world’s population and consumes 99% of the world’s hydrocodone.

⁴ Donald Teater, MD, Medical Advisor, National Safety Council, *Evidence for the Efficacy of Pain Medications*, nsc.org, n.d., accessed May 16, 2017, <http://www.nsc.org/RxDrugOverdoseDocuments/Evidence-Efficacy-Pain-Medications.pdf>. “[R]enal colic pain...happens when a kidney stone gets stuck in the ureter leading from the kidney to the bladder, obstructing the flow of urine. Many consider renal colic to be one of the most severe pains humans experience. The Cochrane Collaboration concluded that NSAIDs and opioids are both effective. The review does mention that “(10 out of 13) studies reported lower pain scores in patients receiving NSAIDs.” NSAIDs also had fewer side effects and required fewer rescue medications, or additional pain medication.

⁵ Ibid.

A cultural shift away from opioids as the first line of defense against acute and chronic pain would be seismic. The United States, despite containing less than 5 percent of the world's population, consumes approximately 80 percent of the global opioid supply, including 99 percent of the hydrocodone supply.⁶ Though this widespread and growing use of opioids over the past two decades has been able to help some of the estimated 100 million Americans suffering from chronic pain, it has also had tragic side effects.⁷ As rates of prescribing opioid analgesics have dramatically risen, so have admissions for opioid addiction treatment and opioid overdose deaths.

It is important to note that there are differences between substance abuse and SUD and one must keep in mind a significant distinction between the two: An abuser uses by choice. SUD is diagnosed along a spectrum that spans mild to moderate to severe. In light of such distinctions, a most critical consideration of any treatment program is the determination of the level of care needed for each individual patient.

Any treatment program or curriculum will be ineffective, despite the research and evidence that might support it, if it is not applied at the appropriate level of care for the appropriate duration of treatment. In general, Advisory Committee members consider the obstacles to diagnosis and treatment to be limited resources, stigma, and a treatment system that is not fully equipped to simultaneously and comprehensively treat SUD and co-occurring disorders and trauma. With these obstacles to overcome, recovering and maintaining sobriety is extremely difficult. The broad spectrum of challenges cluster at three succinctly-stated areas: 1. point of entry; 2. assessment and diagnosis; 3. treatment itself.

The drug and alcohol addiction treatment and rehabilitation system involves federal, state, and county authorities in the form of funding, oversight, and dissemination of best practices for providers, and health benefits coverage for individual patients. Pennsylvania's state government entities include the Departments of Drug and Alcohol Programs (DDAP), the Department of Health (DOH), and the Department of Human Services (DHS).

⁶ Laxmaiah Manchikanti and Angelie Singh, "Therapeutic Opioids: A Ten-Year Perspective on the Complexities and Complications of the Escalating Use, Abuse, and Nonmedical Use of Opioids," *Pain Physician Journal*, 2008, accessed March 18, 2015, <http://www.painphysicianjournal.com/2008/march/2008;11;S63-S88.pdf>.

⁷ "Relieving Pain in America: A Blueprint for Transforming Prevention, Care, Education, and Research," *Institute of Medicine of the National Academies* (June 29, 2011), <https://www.iom.edu/Reports/2011/Relieving-Pain-in-America-A-Blueprint-for-Transforming-Prevention-Care-Education-Research.aspx>.

Pennsylvania's county governments coordinate their efforts with the state through Single County Authorities (SCAs). More recently, the state initiated a plan to establish Centers for Excellence, which coordinate drug and alcohol addiction treatment and rehabilitation services at the local level in a manner similar to the function of SCAs. Private health systems and service providers provide drug and alcohol addiction treatment and rehabilitation through collaboration with public health authorities and through arrangements with health insurance providers.

The numbers continue to soar—whether measured as overdoses, crime statistics, broken families, or ruined lives. The readily apparent solutions, from a public health and policy perspective, are being implemented and are making progress. The strategy needs to include what is needed next to turn momentum against the problem and preparation for increases in illicit drug availability as prescription drugs are curtailed.

The Epidemic by the Numbers

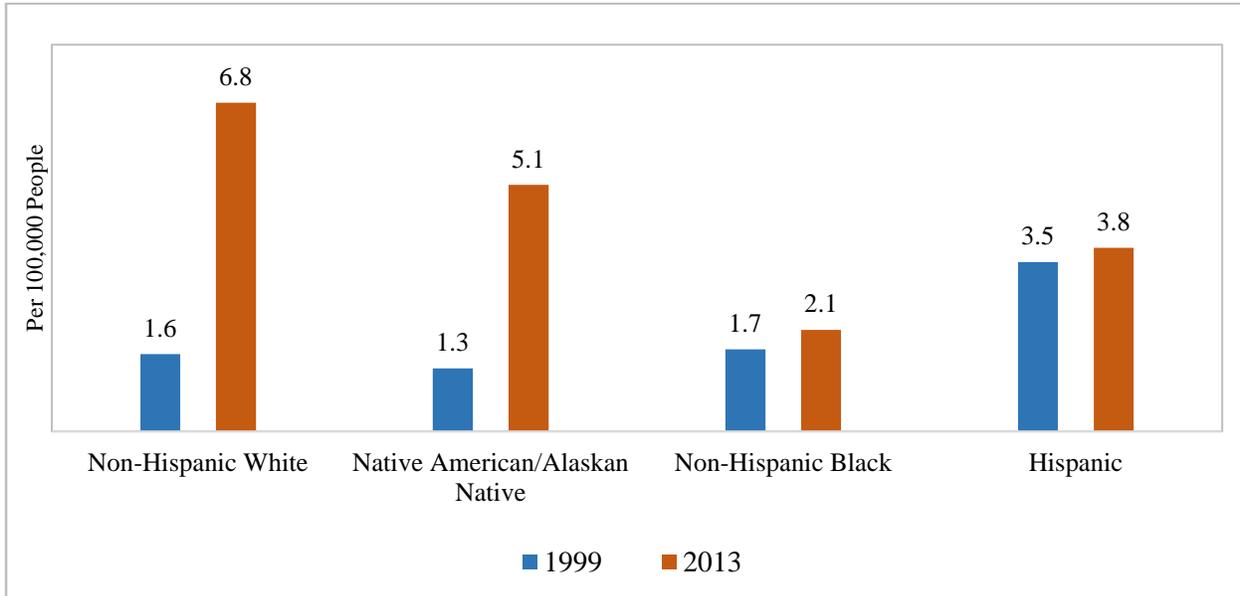
Those with the highest risk of an opioid overdose death are between the ages of 25 and 54. However, adults aged 55 to 64 saw a more than seven-fold increase from 1999 to 2013. Fifty-six percent of overdoses are among men, and men are 59 percent more likely than women to die of an overdose. However, the gender gap is closing at an astonishing rate. Between 1999 and 2010, overdose deaths from prescription pain medications among women increased more than 400 percent. The incidence of overdose death for men continued to grow as well, by an alarming 265 percent.

The majority of those overdosing on prescription painkillers are non-Hispanic whites. From 1999 to 2013, this population saw an increase from 1.6 to 6.8 deaths per 100,000 people. Native Americans (including Alaska Natives) have higher rates of overdose than people identifying as other races or ethnicities; their rates increased from 1.3 to 5.1. Non-Hispanic Black people saw a significant increase, from 0.9 to 2.5. The Hispanic population saw minor increases from 1.7 to 2.1 per 100,000. It is estimated that 10 percent of Native Americans, 5 percent of whites, and 3 percent of blacks were using prescription pain medication for nonmedical uses in 2013.⁸ See Figure 1.

⁸ "Prescription Drug Overdose Data," Centers for Disease Control and Prevention, last updated April 3, 2015, accessed April 6, 2015, <http://www.cdc.gov/drugoverdose/data/overdose.html>.

Figure 1.

**U.S. Overdoses per 100,000 Persons
By Race
1999 and 2013**



Source: <https://www.cdc.gov/drugoverdose/data/overdose.html/>

Additionally, people residing in rural counties were twice as likely as those residing in urban areas to suffer an overdose, and some of the nation’s most rural states have the highest death by overdose rates.⁹

Pennsylvania Youth

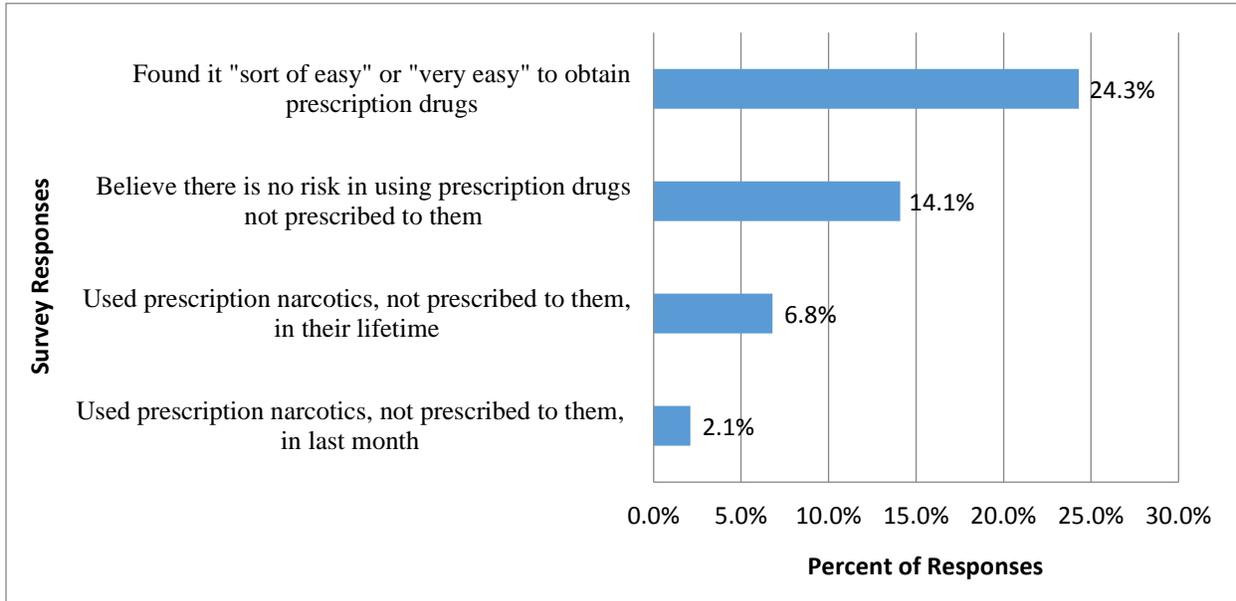
Illicit prescription opioids have a significant impact on Pennsylvania’s youth. According to the most recent Pennsylvania Youth Survey, which surveyed students in grades 6, 8, 10 and 12 across the state, 2.1 percent of students had used prescription narcotics that were not prescribed to them in the past month. Use increased for each grade level. Further, 6.8 percent of students said that in their lifetime they had used prescription narcotics that were not prescribed to them. These numbers were relatively stable from the previous survey in 2011. Not surprisingly, the percent of youth using grew with age; while 2.1 percent of 6th graders admitted to taking pills not prescribed to them, the number grew to 12.1 percent for 12th graders. Another 14.1 percent of students believed there was little to no risk in using prescription drugs not prescribed to them and 24.3 percent said it would be “sort of easy” or “very easy” to obtain prescription drugs.¹⁰ See Figure 2.

⁹ “Prescription Pain Killer Overdoses in the U.S.,” Centers for Disease Control and Prevention, last updated November 1, 2011, accessed June 24, 2014, <http://www.cdc.gov/vitalsigns/PainkillerOverdoses/index.html>.

¹⁰ Pennsylvania Youth Survey (PAYS), fall 2013, <http://www.pccd.pa.gov/Juvenile-Justice/Pages/Pennsylvania-Youth-Survey-%28PAYS%29.aspx#.VWxmYUYjdp8>.

Figure 2.

**Pennsylvania Youth
Illicit Opioid Use
2011**



Source: <http://www.pccd.pa.gov/JuvenileJustice/Documents/2013%20PAYS%20State%20Report%20Final%2006112014.pdf>

Prison Population

The National Association of Drug Court Professionals (NADCP) estimates that 80 percent of offenders abuse drugs or alcohol, and that 50 percent of America’s adult prison population is clinically addicted.¹¹ Further, between 12 and 15 percent have a history of heroin addiction. Those committing more serious offenses have SUD rates closer to 25 percent. Despite this, just 15 percent of inmates who used drugs 30 days prior to their incarceration received proper substance abuse treatment.¹²

¹¹ NADCP, “Drugs and Crime in America: Drug Courts Significantly Reduce Crime,” NADCP website, <https://www.nadcp.org/learn/drug-courts-work/drugs-and-crime-america>, n.d., accessed November 28, 2017.

¹² Anna Pecoraro and George E. Woody, “Medication-assisted treatment for opioid dependence: making a difference in prisons,” *F1000 Medicine Reports*, January 2011, <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3042317>.

In Pennsylvania, estimates are that 70 to 80 percent of criminal offenders have substance abuse problems. The Department of Corrections' reported, in the Governor's Executive Budget for fiscal year 2017-2018, that the inmate population count was 49,671 inmates incarcerated in State Correctional Facilities in fiscal year 2016-2017; and 32,286 had been "assessed as having an alcohol or other drug problem."¹³ The department budgeted to spend \$1.965 million of a federal Substance Abuse Block Grant on drug and alcohol programs in fiscal year 2017-2018.¹⁴

**In Pennsylvania, estimates are that
70 to 80 percent of criminal offenders
have substance abuse problems.**

Often this substance abuse can be directly linked to drug courts criminal behavior. In 2013, the Pennsylvania Office of Attorney General's Bureau of Narcotics Investigations made 522 arrests related to heroin, accounting for 38 percent of drug arrests. In 2014, 748 arrests involving heroin were made, which is almost 50 percent of drug arrests made by the Bureau.¹⁵

U.S. and Pennsylvania Trends

Figure 3 depicts the rates of prescription painkiller sales, deaths, and substance abuse treatment admissions in the U.S. from 1999 to 2010.

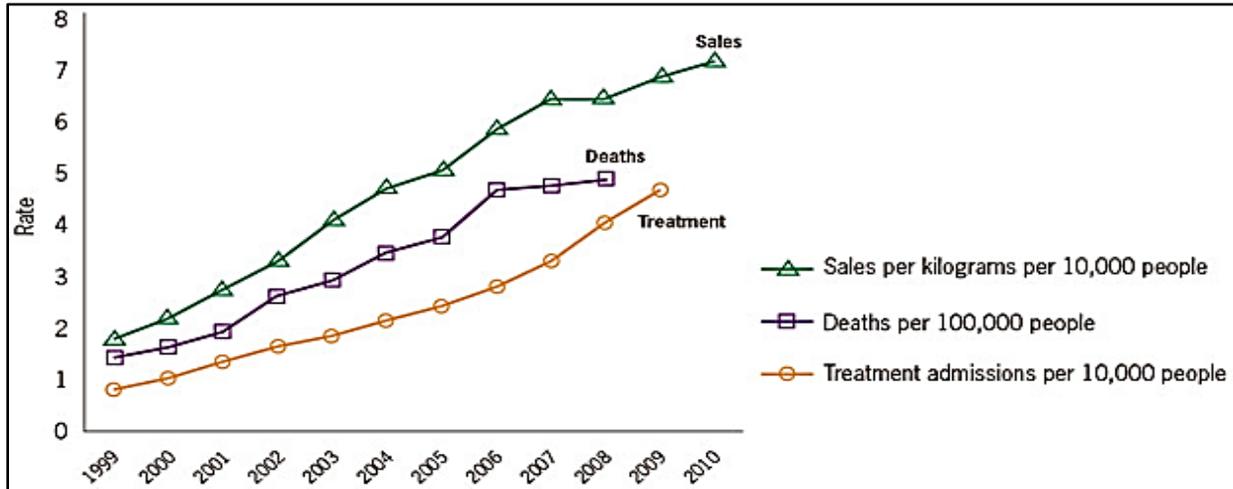
¹³ "Criminal Justice Program Measures" Pennsylvania Governor's Executive Budget 2017-2018, E12-15, <http://www.budget.pa.gov/PublicationsAndReports/CommonwealthBudget/Pages/default.aspx>, (Accessed December 4, 2017).

¹⁴ "Criminal Justice Program Measures" Pennsylvania Governor's Executive Budget 2017-2018, E12-3, <http://www.budget.pa.gov/PublicationsAndReports/CommonwealthBudget/Pages/default.aspx>, (Accessed December 4, 2017).

¹⁵ Alyssa Weinhold e-mail message to Commission staff, April 9, 2015.

Figure 3.

**Rates of Prescription Painkiller Sales, Deaths, and
Substance Abuse Treatment Admissions
U.S.
1999 to 2010**



Sources: National Vital Statistics System, 1999-2008; Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 1999-2010; Treatment Episode Data Set, 1999-2009 <http://www.cdc.gov/vitalsigns/painkilleroverdoses/infographic.html>

2015 640 MME per person, which equals 5 mg of hydrocodone every four hours for three weeks. 46 deaths per day, 91 Americans die every day from an opioid overdose. In 2015, health care providers in the U.S. wrote enough prescriptions for opioids to medicate every American every four hours for three weeks. At the same time, 91 people died each day from an overdose of prescription painkillers.¹⁶ This amounted to 16,007 deaths, accounting for nearly 40 percent of all drug-poisoning deaths. Furthermore, deaths from opioid analgesics have more than tripled since 1999, from 1.4 deaths per 100,000 to 5.1 deaths in 2012. There was a decline of 5 percent from 2011 to 2012, the first decrease seen in over a decade.¹⁷ The death rate climbed yet higher in 2013; the data show that 16,235 deaths involved opioid analgesics in the U.S., an increase of 1 percent from 2012.¹⁸

The CDC's WONDER database allows comparisons of the states' death rates due to overdoses from all drugs. As of 2012, the death rate in Pennsylvania due to drug overdose was 19.6 per 100,000 persons. Map 1 shows the 2012 overdose drug rates by state.

¹⁶ "Opioid Painkiller Prescribing," Centers for Disease Control and Prevention. Last updated July 1, 2014, accessed January 30, 2015. <http://www.cdc.gov/vitalsigns/opioid-prescribing/>.

¹⁷ Margaret Warner, Holly Hedegaard, and Li-Hui Chen, "Trends in Drug-Poisoning Deaths Involving Opioid Analgesics and Heroin: United States, 1999-2012," Centers for Disease Control and Prevention, December 2014, accessed March 18, 2015. http://www.cdc.gov/nchs/data/hestat/drug_poisoning/drug_poisoning_deaths_1999-2012.pdf.

¹⁸ "Prescription Drug Overdose in the United States: Fact Sheet," Centers for Disease Control and Prevention, last updated March 2, 2015, accessed March 30, 2015.

Map 2 depicts the states' overdose death rates in 2015. A glance at the map confirms the common perceptions of the U.S. drug epidemic. The dark red states, having death rates between 23 and 43 per 100,000 people, stretch from Pennsylvania to the southwest through most of Appalachia and west and north through Ohio and Michigan. This concentration comprises the nation's largest area of high drug overdose rates, and is composed of large urban centers, large rural populations, and six state government jurisdictions.

According to a recent report, 20 to 30 percent of opioids prescribed for chronic pain are being misused.¹⁹ The rate of addiction was found to be roughly 10 percent among chronic pain patients.²⁰ Moreover, there are approximately 5 million Americans misusing prescription opioid pain relievers, an estimated 2.1 million of whom are suffering from substance use disorders related to these drugs.^{21,22} Among Pennsylvanians, slightly fewer than 8 percent of residents reported that they had taken illicit prescription pain medication in the previous month; the national average was 8.82 percent.²³

Figure 4 shows the overdose death rates associated with four types of opioids.²⁴ Methadone-associated deaths hovered between one and two deaths per 100,000 people from 2000 to 2015, a stable rate relative to the other types of opioids. Death rates for the categories Heroin, Natural and Semi-synthetic Opioids, and Other Synthetic Opioids were similar to Methadone's in 2000. Natural and Semi-synthetic Opioids had a death rate of approximately 1 per 100,000. Heroin is shown at about 0.6 per 100,000, and Other Synthetic Opioids is shown at about 0.5 per 100,000.

¹⁹ Opioid misuse is defined as use contrary to the directed or prescribed pattern of use, regardless of the presence or absence of harm or adverse effects.

²⁰ C.J. Arlotta, "Opioid Misuse In Chronic Pain Patients Is Around 25%, New Study Shows," *Forbes*, (April 1, 2015), <http://www.forbes.com/sites/cjarlotta/2015/04/01/opioid-misuse-in-chronic-pain-patients-is-around-25-new-study-shows/>.

²¹ "Topics in Brief: Prescription Drug Abuse," National Institute on Drug Abuse, December 2011, www.drugabuse.gov/publications/topics-in-brief/prescription-drug-abuse.

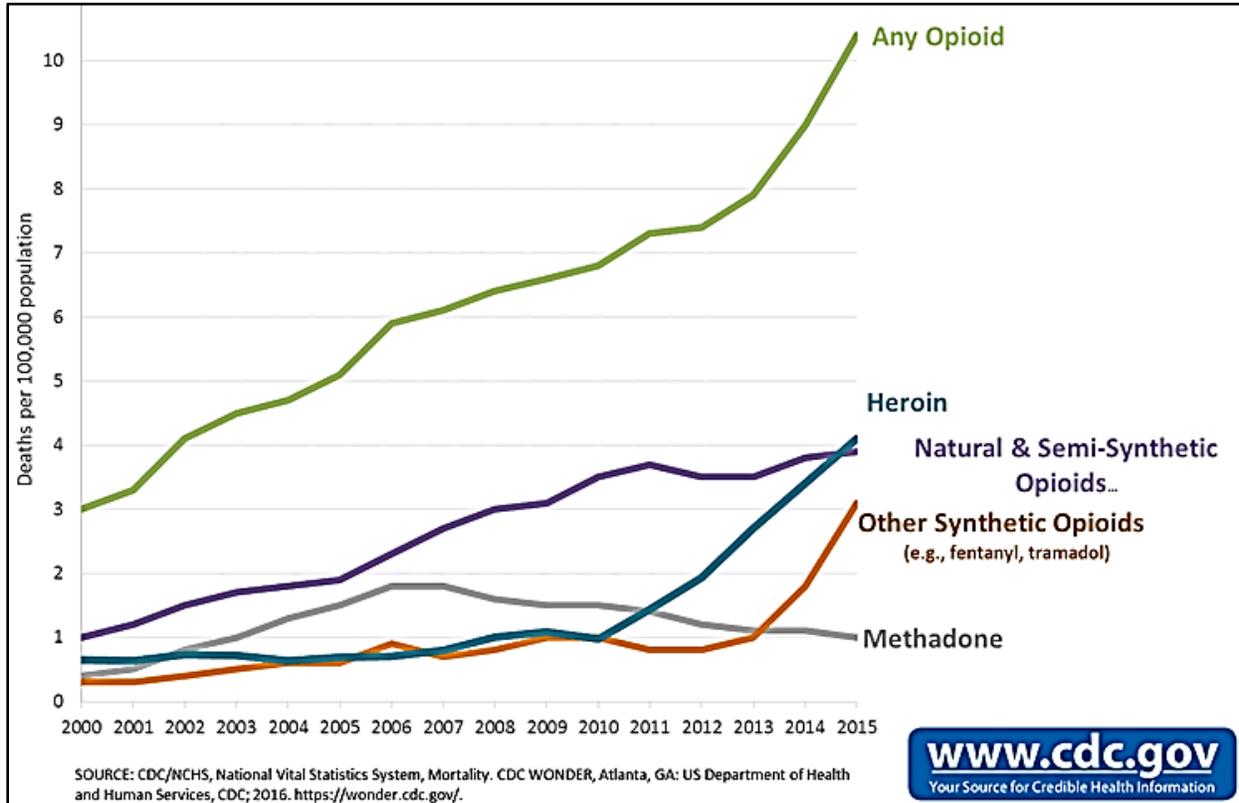
²² "Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings," Substance Abuse and Mental Health Services Administration, NSDUH Series H-46, HHS Publication No. (SMA) 13-4795 (Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013).

²³ "National Survey on Drug Use and Health," (NSDUH 2009-2010), <http://www.samhsa.gov/data/NSDUH/2k10State/NSDUHsae2010/Index.aspx>.

²⁴ CDC/NCHS, National Vital Statistics System, Mortality, CDC WONDER, Atlanta, GA: U.S. Department of Health and Human Services, CDC: 2016, <https://wonder.cdc.gov>.

Figure 4.

Overdose Deaths Involving Opioids, by Type of Opioid
United States, 2000-2015



Taken together, the full extent of the opioids death rate has grown from 3 to 10 people per 100,000 over the 15 year period. In other words, the death rate has more than tripled.

In contrast to the stable death rate associated with Methadone, the other three categories markedly diverge from their starting point. The Natural and Semi-Synthetic Opioids category shows a steady increase in its association with overdoses over the 15 years reported, and ended 2015 at quadruple its starting rate by nearly reaching 4 deaths per 100,000. Despite hovering at or below Methadone for most of the 15 years reported, the Heroin category grew quickly beginning in 2010 and ended at a rate just above 4 in 2015. Beginning in 2013, Other Synthetic Opioids' rate shot upward rapidly and finished at a rate of nearly 3 deaths per 100,000 people. Over that two year period, the alarming increase in deaths associated with Other Synthetic Opioids went from fewer than 1 to slightly more than 3 per 100,000 people.

Map 3 shows the rate of drug-related overdose rates per 100,000 people in Pennsylvania counties for 2015. A visual examination shows the extent of the devastating effects on the death rate: the dark red counties in the western part of the state reported a death rate in excess of 40 people per 100,000. Montour County has a rate of 67.4 deaths per 100,000 people, making its death rate the highest of all counties and substantially worse than those next on the list, including Philadelphia at a rate of 44.8, Armstrong and Cambria with 41.8, and Indiana with 41.4 overdoses per 100,000 people. Table 1 lists the counties in alphabetical order.

Table 1.

**Pennsylvania Counties
Overdose Rates per 100,000 People
2015**

County	Rate	County	Rate
Adams	9.8	Lackawanna	34.9
Allegheny	33.6	Lancaster	14.9
Armstrong	41.8	Lawrence	34.1
Beaver	20.7	Lebanon	14.6
Bedford	26.1	Lehigh	31.9
Berks	16.6	Luzerne	30.1
Blair	30.3	Lycoming	21.5
Bradford	26.1	McKean	18.9
Bucks	19.6	Mercer	16.6
Butler	25.2	Mifflin	10.8
Cambria	41.8	Monroe	27.6
Cameron	21.1	Montgomery	21.2
Carbon	28.1	Montour	64.7
Centre	10.6	Northampton	23.6
Chester	25.4	Northumberland	17.2
Clarion	10.1	Perry	6.6
Clearfield	17.3	Philadelphia	44.8
Clinton	10.1	Pike	12.5
Columbia	24	Potter	5.9
Crawford	32.4	Schuylkill	16.6
Cumberland	16.6	Snyder	2.5
Dauphin	30	Somerset	21.2
Delaware	36.9	Sullivan	0
Elk	9.7	Susquehanna	14.4
Erie	24.5	Tioga	7.2
Fayette	29.9	Union	6.7
Forest	27	Venango	20.7
Franklin	13.7	Warren	0
Fulton	20.5	Washington	35.1
Greene	37.3	Wayne	35.2
Huntingdon	21.9	Westmoreland	35.2
Indiana	41.4	Wyoming	25.2
Jefferson	18	York	22.4
Juniata	8.1		

Source: Pennsylvania State Coroners Association, *Report on Overdose Death Statistics 2015*, <http://www.pacoroners.org>.

The CDC’s clinical comments present the numbers without emotion:

In 2015, 3,383 drug-related overdose deaths were reported in Pennsylvania, an increase of 23.4 percent from the total number of overdose deaths (2,742) reported in 2014[.]

and

The 2015 statewide drug overdose death rate in Pennsylvania was 26 per 100,000 people, an increase from the reported 2014 rate of 21 per 100,000 people.

Table 2 ranks the 15 states with the largest percent increases from 2013 to 2014 and from 2014 to 2015. Pennsylvania’s 2013 to 2014 increase of 12.9 percent grew worse for 2014 to 2015, as the rate accelerated to a 20.1 percent increase in overdose deaths.

Table 2.
Drug Overdose Death Data
Percent Change
2013 - 2014 and 2014 – 2015

2013 - 2014				2014 - 2015			
<u>Rank</u>	<u>State</u>	<u>Significant Increase¹</u>	<u>Change</u>	<u>Rank</u>	<u>State</u>	<u>Significant Increase¹</u>	<u>Change</u>
1	North Dakota	Yes	125.0%	1	North Dakota	No	36.5%
2	New Hampshire	Yes	73.5	2	Massachusetts	Yes	35.3
3	Maine	Yes	27.3	3	Washington, D.C.	No	31.0
4	New Mexico	Yes	20.8	4	New Hampshire	Yes	30.9
5	Alabama	Yes	19.7	5	Maine	Yes	26.2
6	Maryland	Yes	19.2	6	Connecticut	Yes	25.6
7	Massachusetts	Yes	18.8	7	Florida	Yes	22.7
8	Ohio	Yes	18.3	8	Ohio	Yes	21.5
9	Alaska	No	16.7	9	Kentucky	Yes	21.1
10	Virginia	Yes	14.7	10	Rhode Island	Yes	20.5
11	Arkansas	No	13.5	11	New York	Yes	20.4
12	Oregon	No	13.3	12	Maryland	Yes	20.1
13	Michigan	Yes	13.2	13	Pennsylvania	Yes	20.1
14	South Dakota	No	13.0	14	Vermont	No	20.1
15	Pennsylvania	Yes	12.9	15	Iowa	No	17.0

Source: Injury Prevention & Control: Opioid Overdose "Drug Overdose Data." Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Unintentional Injury Prevention December 16, 2016. <https://www.cdc.gov/drugoverdose/data/statedeaths.html>.

¹. “Significant increase” identifies those states whose increase was statistically significant, meaning that the data can be interpreted as reliably indicative of a true increase that cannot be attributed to random effects in the data.

Table 3 shows the frequency at which different drugs were reported in overdose deaths. The presence of at least one opiate (heroin, acetyl fentanyl, fentanyl, hydrocodone, methadone, oxycodone, tramadol) was reported in 81 percent of decedents. Although heroin is the leading drug of death, the presence of fentanyl increased by 93 percent over a single year. The only increase remotely close to that of fentanyl was found with methamphetamine's increase of 95 percent. Yet, despite methamphetamine's devastating effects, it accounted for only 3.1 percent of drug-related deaths while fentanyl was implicated in nine times as many.

Table 3.

**Ranking of Frequency of Drugs of Interest Present and Percent Change
In Drug-Related Overdose Decedents
Pennsylvania
2014-2015**

Drug	Frequency¹	Change 2014 - 2015
Heroin	54.6%	5.4%
Fentanyl	27.0	92.9
Cocaine	23.9	40.6
Alprazolam	20.5	5.7
Oxycodone	18.6	3.9
Clonazepam	9.9	3.1
Diazepam	7.5	9.6
Marijuana	7.1	7.6
Methadone	6.7	11.8
Hydrocodone	5.8	7.4
Tramadol	3.8	17.4
Acetyl Fentanyl	3.6	a
Methamphetamine	3.1	95.0
PCP	1.7	16.5

^a No Acetyl Fentanyl Reported in 2014

¹ Frequencies sum to more than 100 percent because multiple drugs may be present in many decedents.

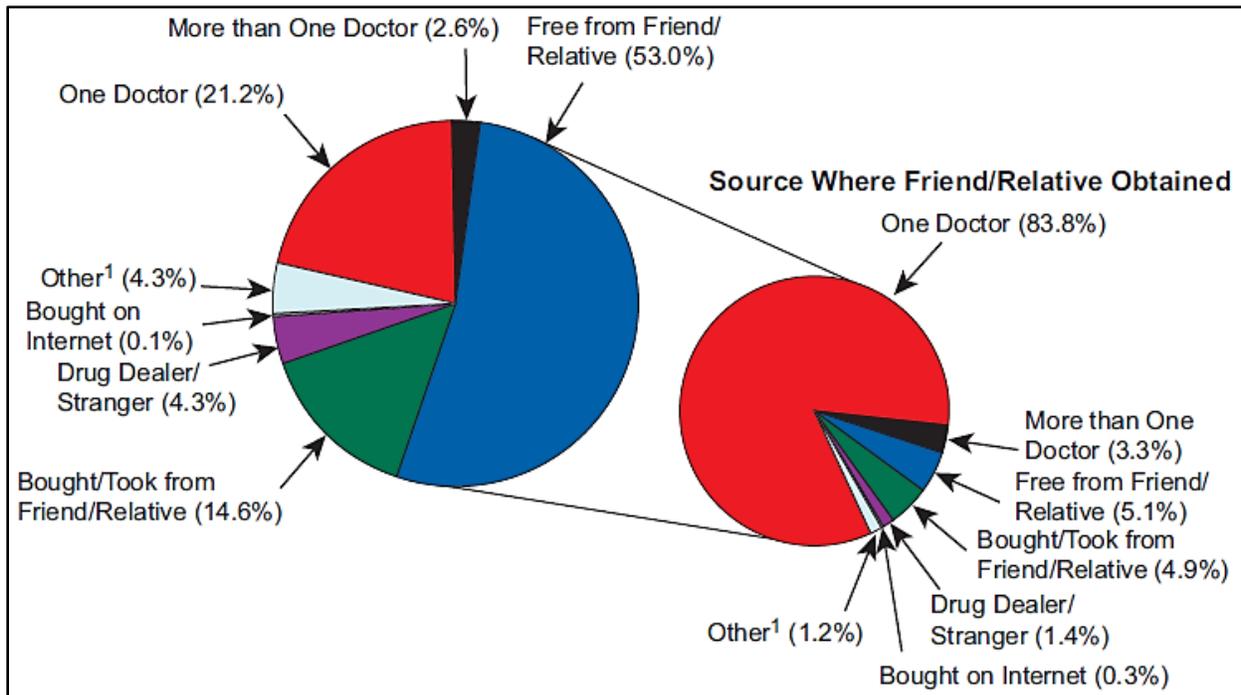
Source: Pennsylvania State Coroners Association, *Report on Overdose Death Statistics 2015*, <http://www.pacoroners.org>.

Source of Opioids

According to the U.S. Substance Abuse and Mental Health Services Administration’s (SAMHSA) National Survey on Drug Use and Health, 53 percent of people aged 12 or older who used pain relievers nonmedically in the past year obtained them from a friend or relative for free. Those receiving them through a prescription from a single provider accounted for 21.2 percent, up from 18.1 percent from the 2010-2011 survey.²⁵ Figure 5 depicts the sources from which pain relievers were obtained for their most recent nonmedical use among past-year users aged 12 or older from 2012-2013.

Figure 5.

**Sources of Pain Relievers for
Most Recent Nonmedical Use
Among Users Aged 12 or Older
U.S.
2012 to 2013**



¹ The Other category includes the sources, “Wrote Fake Prescription,” “Stole from Doctor’s Office/Clinic/Hospital/Pharmacy,” and “Some Other Way.”

Note: The percentages do not add to 100 percent due to rounding.

Source: “Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings,” Substance Abuse and Mental Health Services Administration, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014. 32.

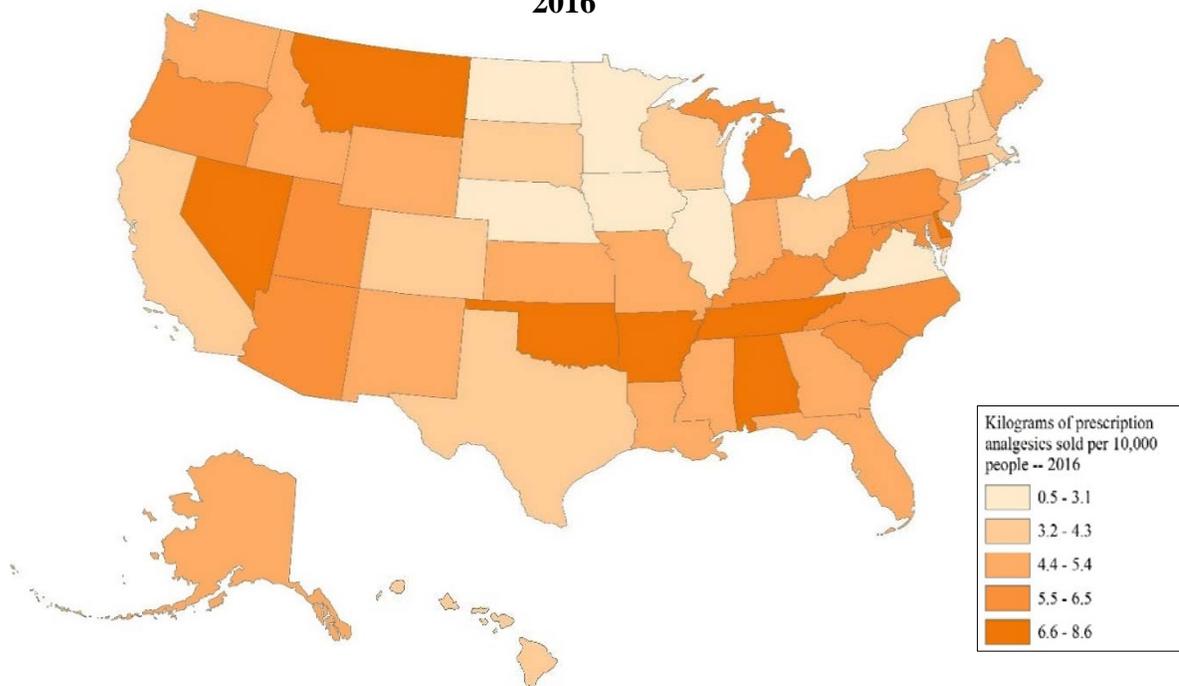
²⁵ “Results from the 2013 National Survey on Drug Use and Health: Summary of National Findings,” Substance Abuse and Mental Health Services Administration, NSDUH Series H-48, HHS Publication No. (SMA) 14-4863. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2014. 32.

Though most abusers of opioids receive pills for free from family and friends, startlingly, those with the highest risk of overdose often get prescriptions directly from a doctor.²⁶ Some data suggest that patients who had no history of substance abuse and who were under the care of only one practitioner account for up to 60 percent of prescription opioid.²⁷

From 1998 to 2010 the quantity of prescription pain medications sold to pharmacies, hospitals, and doctor’s offices quadrupled.²⁸ Specifically, Pennsylvania ranks 21st in the U.S. with a prescribing rate of 88.2 opioid pain relievers per 100 people. In comparison, California, ranking 50th, has a prescribing rate of 57.0.²⁹ Map 6 depicts the amount of prescription painkillers sold by state per 10,000 people as of 2010.

Map 6.

**Prescription Painkillers Sold
Per 10,000 People
2010**



Source: “Prescription Painkiller Overdoses in the U.S.,” CDC Vital Signs, (November 2011), <http://www.cdc.gov/vitalsigns/painkilleroverdoses/>. Accessed August 6, 2014

²⁶ “Automation of Reports and Consolidated Orders System (ARCOS) of the Drug Enforcement Administration (DEA), 2010,” (November 1, 2011), accessed August 8, 2014, <http://www.dea.gov/arcos/>.

²⁷ Edwards, E. & Read, E., “Prescription Opioid Overdose: Providing a Safeguard for At-Risk Patients,” *Pharmacy Times* (June 26, 2014), <http://www.pharmacytimes.com/publications/issue/2014/June2014/Prescription-Opioid-Overdose-Providing-a-Safeguard-for-At-Risk-Patients#>.

²⁸ Ibid.

²⁹ J. Leonard Paulozzi, Karin A. Mack, and Jason M. Hockenberry, “Vital Signs: Variation Among States in Prescribing of Opioid Pain Relievers and Benzodiazepines — United States, 2012,” Centers for Disease Control and Prevention, July 4, 2014, accessed March 17, 2015, http://www.cdc.gov/mmwrhttp://www.cdc.gov/mmwr/preview/mmwrhtml/mm6326a2.htm?s_cid=mm6326a2_w#Tab.

A separate study found that a small number of patients accounted for a relatively large number of prescriptions obtained via “doctor shopping.”³⁰ This small number of purchasers, representing 0.7 percent of all purchasers, were presumed to be doctor shoppers, in that they each obtained, on average, 32 opioid prescriptions from 10 different prescribers. Their purchases accounted for 1.9 percent of all opioid prescriptions. In other words, extreme doctor shoppers, as individuals, account for nearly three times as many prescriptions as do other purchasers. The authors did not conclude, however, that doctor shoppers are necessarily making purchases for illicit purposes. More important, to connect doctor shopping exclusively to illicit use would be to ignore potential problems associated with complex healthcare delivery systems.³¹ Simply put, some doctor shoppers may be attempting to manage pain that is not being managed by their regular doctor visits.

The American Journal of Preventive Medicine published an article in August 2017 that found substantial differences between reported and recalculated deaths attributed to prescription opioids and heroin in a number of states. Pennsylvania, in particular, was highlighted in the findings because of the wide separation between deaths reported as attributed to opioid drugs and the results of the study.

The researchers’ hypothesis was that, because unspecified drugs are given as a cause of death on as many as one half of death certificates for overdose fatalities, and as many one quarter of cases list unspecified drugs as the *only* cause of death, a statistical analysis could produce more accurate counts of overdose deaths attributable to opioids and heroin. The results of the analysis showed that mortality rates for opioids and heroin were underestimated by between 22 percent and 24 percent nationally. Both opioids and heroin were substantially underestimated in Pennsylvania.

The researchers created a statistical model of known overdose cases, i.e. those for which opioids or heroin were listed on death certificates, and included a number of variables associated with each case, such as sex, age, race, marital status, education, and poverty. Those cases were then used to estimate probabilities that opioids and heroin were causes of death for cases where the substance causing the overdose death was unspecified.

The results are startling. Pennsylvania’s “corrected” overdose rate from opioids increased by 108 percent, and the corrected heroin overdose rate increased by 107 percent. In comparative terms, Pennsylvania moved from having the 32nd highest opioid mortality rate to having the 20th highest. Similarly, the Commonwealth’s heroin overdose rate climbed from 7th worst to 4th worst nationally.

It is critical to understand that, despite the enormous swing in the figures, the overall overdose death rate in Pennsylvania is essentially the same as has been previously reported. In other words, the drug overdose epidemic in Pennsylvania, as awful as it is known to be, is not shown to be worse by recalculating the numbers.

³⁰ Doctor shopping is defined as ‘seeing multiple treatment providers, either during a single illness episode or to procure prescription medications illicitly.’ Randy A. Sansone, MD, and Lori A. Sansone, MD, “Doctor Shopping: A Phenomenon of Many Themes,” *Innovations in Clinical Neuroscience* 9.11-12 (2012): 42–46, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3552465/>.

³¹ Douglas C. McDonald, Kenneth E. Carlson. “Estimating the Prevalence of Opioid Diversion by “Doctor Shoppers” in the United States.” *PLoS ONE*, vol. 8, no. 7, July 17, 2013, accessed September 5, 2014, doi: 10.1371/journal.pone.0069241.

Nonetheless, the corrected figures for opioid and heroin mortality point to public policy strategies that decision makers should take into consideration. Federal policies, grants, and support tend to flow toward those states having the worst overdose severities. Therefore, improved accuracy in accounting for opioid and heroin deaths can be leveraged for more federal assistance.

That inaccuracies in overdose reporting exist in Pennsylvania has been known for years. The Commonwealth took action with the establishment the Methadone Death and Incident Review Team with enactment of the Methadone Death and Incident Review Act, Act of Oct. 24, 2012, P.L. 1198, No. 148. The statute directed, among other duties, that methadone deaths be recorded uniformly and that coroners and medical examiners collaborate to the fullest extent possible to share data and to ensure complete collection of information regarding deaths related to methadone.

Presently, DDAP provides online forms for coroners, medical examiners, and the general public to report critical information related to fatalities where drugs are suspected as a cause. The efforts appear to be meeting with success. Dr. Ruhn's research also shows that Pennsylvania's percentage of fatal overdoses where no drug was specified decreased from 58.4 percent in 2008 to 49.9 percent in 2014, a drop of approximately 9 percent.

HEALTH CARE AND SOCIETAL COSTS

The mishandling of prescription opioids has led to a dramatic rise in the number of emergency department (ED) visits related to the misuse or abuse of pharmaceuticals, as shown in Table 4. From the years 2004 through 2011, the count of visits grew from 626,470 to 1,428,145, a rate of growth of over 100,000 visits per year, which equates to an increase of 16 percent per year. Anti-anxiety and insomnia medications were cited in 501,207 visits, while opioid analgesics accounted for 420,040 visits.³²

SUD treatment providers, physicians, and public health authorities are alarmed at the growth in recent years by the misuse and abuse of buprenorphine. Data show that from 2006 to 2011, the number of emergency department visits related to buprenorphine increased by 255 percent.³³ Anecdotally, there is every indication that this is a threat that will continue to grow in enormity unless rapid intervention curtails it.

Table 4.

**Drug-Related Emergency Department Visits
for Misuse or Abuse of Opioid Analgesics
Percent Change from 2004 to 2011**

Drug	Percent Change
Opioid Analgesics	153%
Buprenorphine ¹	255%
Oxycodone products	220%
Hydrocodone products	96%
Methadone	74%
Morphine products	144%

1. Percent for buprenorphine is for the period 2006 to 2011.

Source: Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. The DAWN Report: Highlights of the 2011 Drug Abuse Warning Network (DAWN) Findings on Drug-Related Emergency Department Visits. Rockville, MD. February 22, 2013. www.samhsa.gov

³² “The DAWN Report: Highlights of the 2011 Drug Abuse Warning Network (DAWN) Findings on Drug-Related Emergency Department Visits.” (Rockville, MD: SAMHSA, 2011), <http://www.samhsa.gov/data/2k13/DAWN127/sr127-DAWN-highlights.htm>.

³³ CESAR U.S. ED Visits <http://www.cesar.umd.edu/cesar/cesarfax/vol22/22-05.pdf>.

Emergency Department–Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence Gail D’Onofrio, MD, MS, Patrick G. O’Connor, MD, MPH, et al, JAMA. 2015 April 28; 313(16): 1636–1644. doi:10.1001/jama.2015.3474.

The costs to the economy, not to mention the social costs, of this abuse and addiction is staggering. Though estimates vary, the costs of illicit use of opioid analgesics has created an enormous drain on the U.S. economy. In 2007 *Pain Medicine* published a study putting societal costs at \$55.7 billion annually. Annual costs shared by employers and workers, including premature death, reduced compensation, and lost employment, were estimated at \$25.6 billion. Criminal justice costs, which included corrections and law enforcement, were close to \$5.1 billion. Health care costs consisted primarily of excess medical treatment and prescription costs of about \$23.7 billion.³⁴ The Coalition Against Insurance Fraud estimated in 2007 that public and private insurers' costs related to opioid theft and abuse totaled \$72.5 billion annually.³⁵

A report published by Matrix Global Advisors, LLC., in April 2015, presented estimates for states' health care costs based on cost figures derived in H.G. Birnbaum's 2011 research, *Societal Costs of Prescription Opioid Abuse, Dependence, and Misuse in the United States*, and on findings of White in 2011 that the bulk of state spending is in the area of inpatient care.³⁶ The Matrix report used hospital-adjusted expenses per inpatient day that were identified in a 2014 report by the Kaiser Family Foundation.

Matrix reported that Pennsylvania ranked tenth in total state expenditures with \$874 million spent on health care costs for opioid abuse in 2015. The U.S. state average was \$490 million, 56 percent of the Pennsylvania expenditure. Pennsylvania ranked 30th among states in terms of per capital spending. See Table 5 and Figure 6. Birnbaum's 2011 paper concluded that 95 percent of the expense is attributable to excess medical and drug costs, stating that "Substance abuse treatment, prevention, and research account for the remaining 5 percent of the total health care burden."³⁷ A detailed table of Birnbaum's findings is presented in Appendix A.

The U.S. Surgeon General 2016 report gave a detailed analysis of the economic effects of the overall substance abuse problem. *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*, shows that alcohol misuse, illicit drug use, misuse of medications, and SUD are estimated to cost the United States more than \$400 billion in lost workplace productivity (in part, due to premature mortality), health care expenses, law enforcement and other criminal justice costs, and losses from motor vehicle crashes.³⁸

³⁴ H.G. Birnbaum, et al, "Societal Costs of Prescription Opioid Abuse, Dependence, and Misuse in the United States," *Pain Medicine*, vol. 12, issue 4, (April 2011), <http://www.ncbi.nlm.nih.gov/pubmed/21392250>.

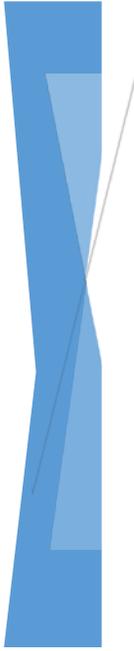
³⁵ "Prescription for Peril: How Insurance Fraud Finances Theft and Abuse of Addictive Prescription Drugs," Coalition Against Insurance Fraud, (December 2007), www.insurancefraud.org/downloads/drugDiversion.pdf.

³⁶ Matrix Global Advisors, LLC. "Health Care Costs from Opioid Abuse: A State-by-State Analysis. (April 2015). www.matrixglobaladvisors.com. Accessed November 4, 2016.

³⁷ Matrix Global Advisors, LLC. "Health Care Costs from Opioid Abuse: A State-by-State Analysis. (April 2015). www.matrixglobaladvisors.com. Accessed November 4, 2016. 4.

³⁸ Vivek H. Murthy, M.D., M.B.A., Surgeon General, Vice Admiral, U.S. Public Health Service, *Facing Addiction in America: The Surgeon General's Report on Alcohol, Drugs, and Health*, U.S. Department of Health and Human Services, (Washington, D.C.:2016), <https://addiction.surgeongeneral.gov/>, (accessed December 4, 2017).

In its 2015-2016 annual report, DDAP presented estimates of how much untreated SUD costs Pennsylvania taxpayers.³⁹ The estimate was that approximately \$430 per capita paid for problems associated with alcohol, tobacco, and other SUD, which amounted to 16 percent of the state budget. At that time, only \$15 of the \$430 was spent on prevention, treatment, and research. In other words, the per capital amount spent on SUD programs was barely 3.5 percent of what the epidemic cost Pennsylvania. The balance, over 96.5 percent, went to pay for crime and punishment, health care, lost wages, and lost economic productivity. As a proportion of the estimated \$428 billion costs of untreated alcohol and drug problems in the U.S. in 2016, Pennsylvania’s share was estimated as being between \$17 billion and \$21 billion.⁴⁰



In 2013, SUD cost Pennsylvania \$430 per capita—about \$15 of it went to treatment, prevention, and research.

Table 5.

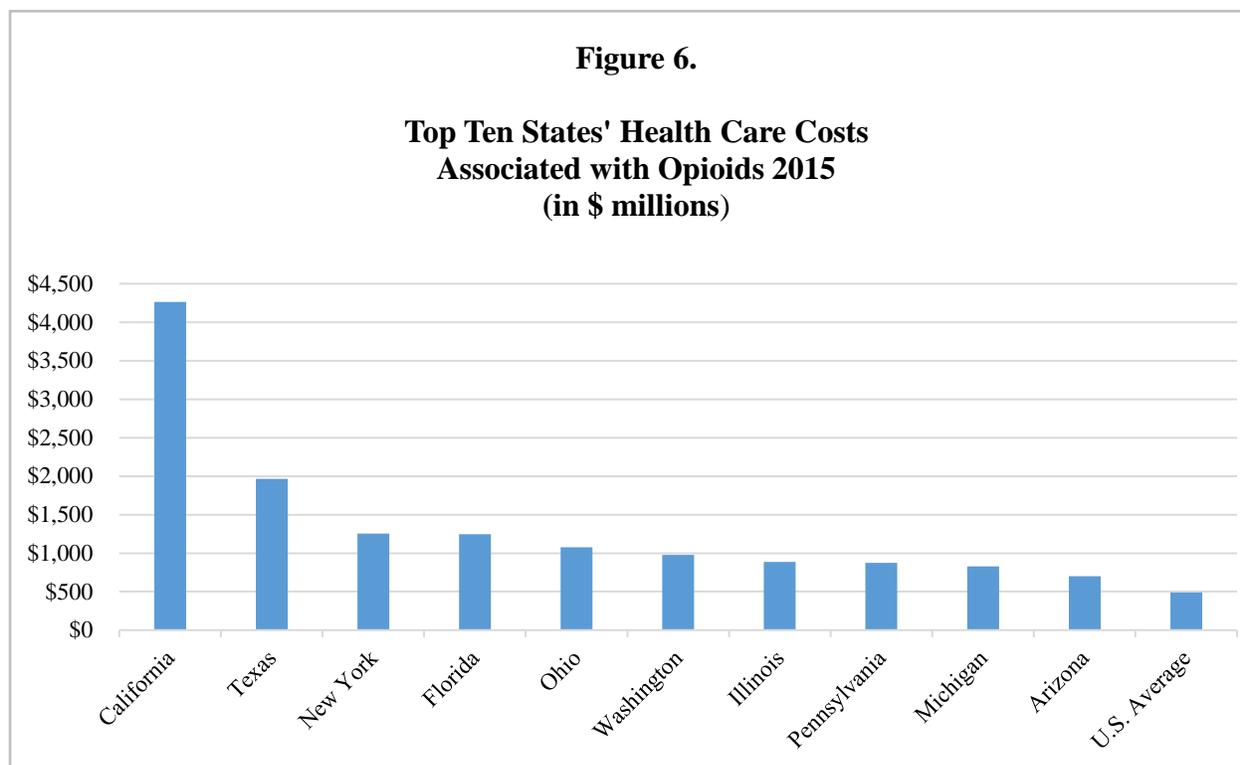
**Top 10 States’ Health Care Costs for Opioid Abuse
Total and Per Capita
2015**

Rank	State	Total cost (\$ millions)	Rank	State	Per capita (\$ dollars)
1	California	\$4,263	1	Oregon	\$155
2	Texas	1,964	2	Washington	138
3	New York	1,256	3	Delaware	117
4	Florida	1,247	4	Colorado	111
5	Ohio	1,076	5	California	110
6	Washington	977	6	Arizona	104
7	Illinois	887	7	Rhode Island	103
8	Pennsylvania	874	8	Indiana	99
9	Michigan	830	9	Idaho	96
10	Arizona	699	10	D.C.	95
	U.S. Average	490		U.S. Average	75

Source: Matrix Global Advisors, LLC. “Health Care Costs from Opioid Abuse: A State-by-State Analysis. (April 2015). www.matrixglobaladvisors.com. Accessed November 4, 2016. 4.

³⁹ DDAP, *Pennsylvania Drug and Alcohol Annual Plan and Report: Drug and Alcohol Abuse Prevention and Treatment 2015-2016*, DDAP, accessed March 27, 2017, <http://www.ddap.pa.gov/Reports/State%20Plan%20and%20Annual%20Reports/2015-2016%20DDAP%20State%20Plan%20and%202013-2014%20Report.pdf>.

⁴⁰ Drug & Alcohol Service Providers of Pennsylvania, “Annual Costs of Untreated Alcohol and Drug Problems Loss to U.S. Economy,” via email to Commission staff, November 17, 2017.



Source: Matrix Global Advisors, LLC. “Health Care Costs from Opioid Abuse: A State-by-State Analysis.” (April 2015). www.matrixglobaladvisors.com. Accessed November 4, 2016. 4.

Since Birnbaum’s oft-cited research of 2007 and 2011, however, the epidemic has continued to grow and consume people’s lives and society’s resources. In 2011, the CDC reported 43,544 drug overdose deaths.⁴¹ By 2013, the death toll had increased by 2,927 to 46,471.⁴² By 2015, the death toll had increased by another 5,933 to 52,404, with an estimated 33,091 (63.1 percent) drug deaths attributed to opioids.⁴³ In a 2013 paper published in the journal *Medical Care*, the researchers sought,

⁴¹ Centers for Disease Control and Prevention, National Center for Health Statistics. Multiple Cause of Death 1999-2015 on CDC WONDER Online Database, released December, 2016. Data are from the Multiple Cause of Death Files, 1999-2015, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Accessed at <http://wonder.cdc.gov/mcd-icd10.html> on Feb 24, 2017 9:54:00 AM

⁴² Ibid.

⁴³ Rose A. Rudd, MSPH. Noah Aleshire, JD. Jon E. Zibbell, PhD. R. Matthew Gladden, PhD. “Increases in Drug and Opioid Overdose Deaths — United States, 2000–2014.” *Morbidity and Mortality Weekly Report*. January 1, 2016/64(50).1378-82. <https://www.cdc.gov/mmwr/preview/mmwrhtml/mm6450a3.htm>. Accessed February 24, 2016.

To estimate the economic burden of prescription opioid overdose, abuse, and dependence from a societal perspective.⁴⁴ The study aggregated 2013 data from various sources to estimate costs associated with health care, criminal justice, and lost productivity due to opioid use disorder. The authors concluded that a large portion of the cost burden is borne by the public, including the loss of taxable earnings. The health care sector was shown to bear approximately one-third of the costs.⁴⁵

Public health researchers have asked the questions: “1) Are total health system costs different for persons treated with buprenorphine plus counseling, compared with those who are treated with counseling only and those receiving little or no addiction treatment? 2) Are patterns of addiction treatment and other medical care services different for persons treated with buprenorphine plus counseling, compared with those who are treated with counseling only or those with little or no addiction treatment?”⁴⁶

To answer these questions, researchers analyzed data from two large non-profit healthcare systems, and divided the patient data into three treatment groups: those who received buprenorphine (a medication used for opioid treatment) and counseling; those who received only counseling; and those who received no treatment. The researchers’ review of previous studies revealed that methadone maintenance may have slight advantages over buprenorphine maintenance in terms of effectiveness. An advantage of buprenorphine, identified by the researchers, is that it can be managed in primary care settings and shows some indication that it may reduce mortality to a slightly greater extent.⁴⁷ Methadone maintenance cannot be managed in primary care settings; it must be dispensed and administered to patients through specially licensed methadone clinics.

Further, the researchers identified improved quality of care for opioid-dependent patients because of the patients’ improved access to primary care, and because co-occurring health consequences can be managed along with buprenorphine therapy. The patients in buprenorphine maintenance tended to experience fewer emergency department visits, increased contact with primary care, and increased diagnoses and treatment for comorbid conditions. The researchers found that health system costs were about the same for patients receiving both buprenorphine and counseling and those receiving counseling only, and approximately \$17,000 per year less than health system costs for those patients receiving no treatment.



TREATMENT FOR
OPIOID DEPENDENCE
ULTIMATELY SAVED
\$17,000 PER PERSON,
PER YEAR IN
HEALTH CARE COSTS

⁴⁴ Curtis S. Florence, PhD. Chao Zhou, PhD. Feijun Luo, PhD. Likang Xu, MD. “The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013.” *Medical Care*. 54, no. 10 (October 2016): 901-06. doi: 10.1097/MLR.000000000000062.

⁴⁵ Ibid.

⁴⁶ Frances L. Lynch, et al. “Costs of care for persons with opioid dependence in commercial integrated health systems.” *Addiction Science and Clinical Practice* (September 2016). doi: 10.1186/1940-0640-9-16.

⁴⁷ Ibid.

They concluded:

“Buprenorphine is a viable alternative to other treatment approaches for opioid dependence in commercial integrated health systems, with total costs of health care similar to abstinence-based counseling. Patients with buprenorphine plus counseling had reduced use of general medical services compared to the alternatives.”⁴⁸

There is evidence that as the availability of buprenorphine increased so did the number of ED visits related to the nonmedical use of it. A study published in 2013 showed a 255 percent increase in ED visits, from 4,440 to 15,778 during the years 2006 to 2010. The authors concluded:

Findings in this report show significant growth in the number of ED visits involving buprenorphine at the same time that there was an increase in its availability for treatment of opioid dependence. These data show that buprenorphine is sometimes used nonmedically, resulting in health events that require acute treatment in the ED. Buprenorphine use can be risky for individuals who are not opioid dependent because its effects are similar to other opioids (although usually more mild), leading to injuries and other health consequences. Additionally, dangerous effects can occur if buprenorphine is combined with certain other drugs, including benzodiazepines.⁴⁹

Table 6 presents estimated aggregate costs by category for prescription drug dependence, abuse, and overdose in 2013.⁵⁰ Costs for health care, substance abuse treatment, criminal justice, and lost productivity were calculated as annual costs. Costs attributed to fatalities were lifetime costs associated with lost productivity and were calculated based on a person’s sex, age, and expected lifespan.⁵¹ Out of the total \$75.5 billion, the smallest expenditure is in the area of federal, state, local, and private funding of substance abuse treatment, which accounts for only \$2.8 billion, or 3.4 percent, of the full cost.

⁴⁸ Ibid.

⁴⁹ Elizabeth H. Crane, Ph.D., M.P.H., “Emergency Department Visits Involving Buprenorphine,” *The CBHSQ Report*, SAHMSA, January 29, 2013, <https://www.ncbi.nlm.nih.gov/books/NBK384655/>. Accessed November 13, 2017.

⁵⁰ Curtis S. Florence, PhD. Chao Zhou, PhD. Feijun Luo, PhD. Likang Xu, MD. “The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013.” *Medical Care*. 54, no. 10 (October 2016): 901-06. doi: 10.1097/MLR.000000000000062.

⁵¹ Curtis S. Florence, PhD. Chao Zhou, PhD. Feijun Luo, PhD. Likang Xu, MD. “The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013.” *Medical Care*. 54, no. 10 (October 2016): 901-06. doi: 10.1097/MLR.000000000000062.

Table 6.
Aggregate Societal Costs of Prescription Opioid Abuse, Dependence, and Fatal Overdose
United States
2013
(Millions of 2013 Dollars)

Nonfatal Costs	Aggregate Costs	Percent of Aggregate Costs
Health care		
Private insurance	\$14,041	17.9%
Medicare	2,593	3.3
Medicaid	5,490	7.0
CHAMPUS/VA ¹	428	0.5
Other	1,003	1.3
Uninsured	2,519	3.2
Total	26,075	33.2
Substance abuse treatment		
Federal	721	0.9
State and local	1,823	2.3
Private	276	0.4
Total	2,820	3.6
Criminal justice		
Police protection	2,812	3.6
Legal and adjudication	1,288	1.6
Correctional facilities	3,218	4.1
Property lost due to crime	335	0.4
Total criminal justice costs	7,654	9.7
Lost productivity		
Reduced productive time/increased disability	16,262	20.7
Production lost for incarcerated individuals	4,180	5.3
Total	20,441	26.0
Total nonfatal costs	56,990	72.6
Fatal costs		
Lost productivity	21,429	27.3
Health care	84	0.1
Total fatal costs	21,513	27.4
Total of nonfatal and fatal	\$78,503	100.0

Source: Florence, Curtis S., PhD. Chao Zhou, PhD. Feijun Luo, PhD. Likang Xu, MD. “The Economic Burden of Prescription Opioid Overdose, Abuse, and Dependence in the United States, 2013.” *Medical Care* 54, no. 10 (October 2016): 901-06. doi: 10.1097/MLR.0000000000000625

1. CHAMPUS responsibilities are now under the Defense Health Agency.

Figure 7.

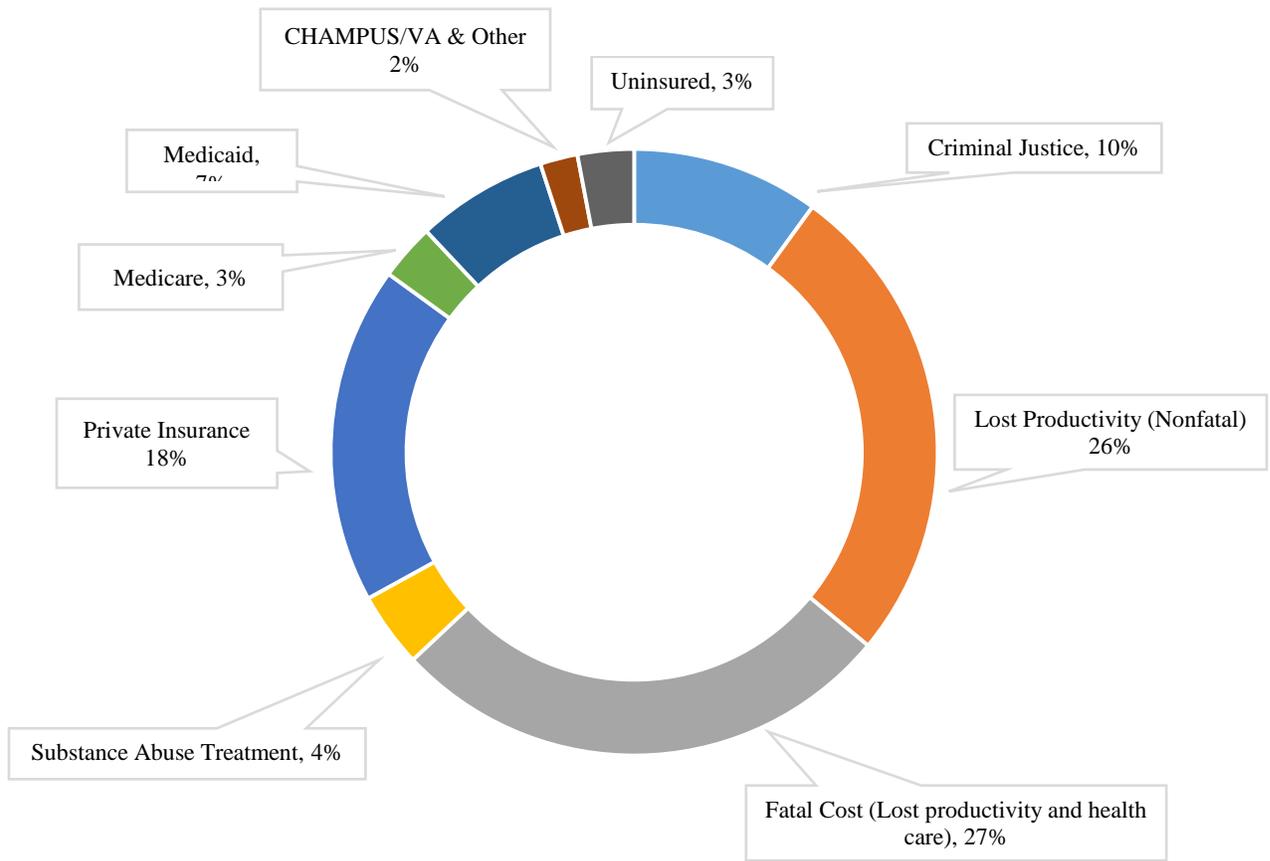


Figure 7 shows the breakdown of expenditures in a way that is visually more accessible than columns of numbers. It is easy to see how the costs borne by society due to fatalities and lost production outweigh the other categories. Presumably, increased spending for treatment, health insurances, and appropriate criminal justice programs could reduce the fatal costs and lost productivity costs.



**Since 2009,
SUD treatment
spending
outpaced overall health
spending
by 44 percent.**

SAMHSA reported a number of significant findings in its 2016 report, *Behavioral Health Spending & Use Accounts, 1986 - 2014*, related to spending trends for substance abuse disorder (SUD) treatment.⁵² From 1986 to 2009, the increase in SUD treatment spending was two-thirds that of overall health spending. After 2009, however, the growth in SUD spending was greater than overall health spending, outpacing it by 44 percent. Nevertheless, over the entire period, the overall share of SUD treatment financed by Medicaid, Medicare, and private insurance remained steady at 45 percent. Within that block of funding, however, there have been several changes.

Decades of underfunding and cuts have decimated the system's capacity. Medicaid expansion has allowed more patients to be moved much more quickly into care, and allowed them to receive levels of care previously unavailable. However, providers often are left unable to accommodate patients' needs because the types of programs needed are not available in that area. Without placements and services, patients have nowhere to go.

The IMD Exclusion

In order to cut costs while maintaining quality standards, providers are sometimes forced to reduce levels of care and lengths of stay. Exacerbating the problem of coordinating insurance coverage with patients' needs, Medicaid rules prohibit federal matching funds for treatment for patients cared for in institutions for mental disease (IMD). An IMD is a licensed non-hospital facility with more than 16 beds that provides diagnosis and treatment that often includes SUD patients. Among those facilities considered IMDs and therefore excluded from Medicaid are community-based residential treatment programs with more than 16 beds. The IMD exclusion has been, since the establishment of Medicaid in 1965, the source of significant obstacles in providing care for people suffering from SUDs. In the opinion of Advisory Committee members, the 16-or-fewer beds limitation imposed by the IMD exclusion makes economic survival impossible while complying with state requirements for addiction treatment licensure including numbers and types of staff and coverage hours. In 2017, CMS issued new rules on the IMD exclusion. The new rules permit federal Medicaid matching for patients who are in an IMD provided they are there for 15 or fewer days per month.

Both the decades old IMD exclusion and the new CMS rules present major obstacles to the continuum of care that is critical for comprehensive treatment and good outcomes. The new rules state that a person remaining in an IMD for more than the maximum 15 days loses Medicare/Medicaid coverage for all health problems, not limited to those related to SUD. Further,

⁵² "Behavioral Health Spending & Use Accounts, 1986 - 2014," U.S. HHS Publication No. SMA-16-4975, Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016, accessed April 12, 2017, <http://www.store.samhsa.gov/product/Substance-Abuse-and-Mental-Health-Services-Administration-Behavioral-Health-Spending-and-Use-Accounts-1986-2014/SMA16-4975>.

CMS can recoup any federal matching funds that were disbursed during the first 15 days. A review of treatments that was conducted by David Loveland, titled *Addiction Treatment Dosage: Determining an Effective Length of Treatment*, presented the following conclusion:

Clients in all levels of care beyond detoxification showed significant reductions in substance use, though the reduction was substantially larger for those who remained in treatment for 90 or more days in any level of care; conversely, there were no differences in outcomes for those who left any level of care before 90 days. In other words, MMT, residential, or OP had the same outcomes at 10, 20, 30, or any other length of stay (LOS) that fell below 90 days.⁵³

Not only does the 15 day limitation contravene accepted clinical research that correlates length of stay with good outcomes for SUD patients, the consequential refund of matching funds borders on being punitive.

Limitations of capacity include more than the availability of tangibles like beds, equipment, and floor space. The low salary, approximately \$15/hour, paid to counselor's places great strains on providers to attract and retain qualified employees.⁵⁴ SAMHSA found that Pennsylvania drug and alcohol treatment providers are paid less than in any other state in the region except for West Virginia.

PENNSYLVANIA DRUG AND ALCOHOL
TREATMENT COUNSELORS
ARE PAID LESS THAN IN ANY OTHER STATE
IN THE REGION, EXCEPT FOR WEST VIRGINIA

The expense of medications used for SUD treatment has been growing at a nearly incomprehensible rate. In 1986, \$3 million was spent on prescriptions for medication-assisted treatment. By 2014, the cost was \$1.818 billion. Despite the shocking increase and a price tag measured in billions of dollars, prescription drugs account for a mere 5 percent of total SUD spending.⁵⁵

Researchers have shown that the future benefits for each dollar spent today on SUD treatment are as follows:

- Outpatient ranged from \$1.33 to \$6.50
- Residential treatment ranged from \$1.68 to \$5.19
- Drug court treatment programs ranged from \$1.74 to \$6.32.

⁵³ David Loveland, PhD, *Addiction Treatment Dosage: Determining an Effective Length of Treatment*, Community Care Behavioral Health Organization, August 23, 2016. 3.

⁵⁴ Comparatively, warehouse workers who fulfill online orders are paid upwards of \$13.50/hour with minimal training.

⁵⁵ "Behavioral Health Spending & Use Accounts, 1986 - 2014," U.S. HHS Publication No. SMA-16-4975, Rockville, MD: Substance Abuse and Mental Health Services Administration, 2016, accessed April 12, 2017, <http://www.store.samhsa.gov/product/Substance-Abuse-and-Mental-Health-Services-Administration-Behavioral-Health-Spending-and-Use-Accounts-1986-2014/SMA16-4975>.

In other words, one dollar spent on outpatient programs could result in a savings of between \$1.33 and \$6.50. The savings are mostly realized in terms of reduced future crime (criminal justice expenditures and victimization), although the net savings attributed to reduced crime varies for methadone maintenance treatment (MMT).^{56,57}

David Loveland, in *Addiction Treatment Dosage: Determining an Effective Length of Treatment*, stated:

Overall, treatment was cost-effective in all levels of care if future costs for criminal justice, health care, and lost earnings were considered (estimated, not actual dollars). However, the ratio of savings decreased from nearly ten dollars for every one dollar spent on treatment in a continuum of care (e.g., residential treatment followed by outpatient treatment) to nearly two dollars for every one dollar spent in multiple disconnected treatment episodes (mostly residential services).⁵⁸

A dollar spent on outpatient programs can save up to \$6.50 in criminal justice expenditures and victimization.

It must be emphasized that, despite the positive net return of future savings based on current spending on treatment, the dollar benefit declines by 80 percent, from \$10 to \$2, when treatment is provided in “episodes,” rather than through a continuum of care. Treatment is known to be less effective when patients are limited to 14 or 28 days of residential services; the patients enter a revolving door: inadequate time in treatment followed by relapse followed by inadequate treatment. It is when patients receive comprehensive, continuing care for the necessary length of time that they achieve their optimal recoveries and the public dollar is best spent.

A 2010 report showed the average annual overall Medicaid cost for individuals with SUD:

- Methadone maintenance treatment (MMT) \$7,163;
- Other psychosocial services \$14,157; and
- No addiction treatment services \$18,695.⁵⁹

Tables 7 and 8 show the expenditures by Pennsylvania’s Single County Authorities (SCAs) for fiscal year 2013-2014.⁶⁰ On average, DDAP funds made up 56 percent of SCA expenditures. Individually, the SCAs received anywhere from 86 percent of their funding through DDAP, in the case of the Bradford/Sullivan SCA, to 35 percent, in the case of the Chester SCA. Most of the SCA funding from DDAP clusters within 10 percent of the average funding. Philadelphia had the highest total expenditure at \$43.3 million; Allegheny County was second at \$17.3 million. The average SCA total fund expenditure was \$3.8 million. The SCA with the lowest expenditure was Potter, at approximately \$276,000. The median expenditure was slightly more than \$2 million.

⁵⁶ David Loveland, PhD, *Addiction Treatment Dosage: Determining an Effective Length of Treatment*, Community Care Behavioral Health Organization, August 23, 2016. 14.

⁵⁷ Ibid.

⁵⁸ David Loveland, PhD, *Addiction Treatment Dosage: Determining an Effective Length of Treatment*, Community Care Behavioral Health Organization, August 23, 2016. 5.

⁵⁹ Ibid.

⁶⁰ Single County Authorities are largely responsible for SUD programs at the county level. They are discussed in detail in the chapter Standards of Care.

Table 7.

**Single County Authority Expenditures
by Fund Source
State Fiscal Year 2013- 2014**

Single County Authority	Total DDAP Funds	Total County Funds	Total Other Funds	Total Funds
Allegheny	\$11,360,257	\$142,604	\$5,836,087	\$17,338,948
Armstrong/Indiana/ Clarion	1,396,197	-	2,165,268	3,561,465
Beaver	1,220,946	80,000	65,695	2,066,641
Bedford	394,587	-	320,589	715,176
Berks	3,076,758	1,845,841	3,475,659	8,398,258
Blair	1,146,799	-	307,572	1,454,371
Bradford/Sullivan	497,925	22,847	59,585	580,357
Bucks	3,475,387	380,942	1,626,603	5,482,932
Butler	1,116,896	25,316	977,437	2,119,649
Cambria	1,030,090	24,790	483,137	1,538,017
Cameron/Elk/ McKean	830,488	81,393	1,046,182	1,958,063
Carbon/Monroe/ Pike	1,026,595	55,147	1,490,808	2,572,550
Centre	766,871	30,085	602,083	1,399,039
Chester	2,414,610	597,062	3,920,866	6,932,538
Clearfield/Jefferson	1,019,684	-	807,436	1,827,120
Columbia/Montour/ Snyder/Union	821,530	14,785	730,672	1,566,987
Crawford	731,367	16,620	1,045,438	1,793,425
Cumberland/Perry	1,644,491	212,300	1,037,883	2,894,674
Dauphin	2,402,752	207,870	1,279,158	3,889,780
Delaware	3,526,398	122,471	2,786,126	6,434,995
Erie	3,535,022	281,864	2,016,787	5,833,673
Fayette	1,053,255	-	1,588,813	2,642,068
Forest/Warren	302,454	7,228	230,582	540,264
Franklin/Fulton	601,927	51,661	567,870	1,221,458
Greene	290,477	10,281	143,787	444,545
Huntingdon/Mifflin/ Juniata	652,722	-	346,386	999,108
Lackawanna/ Susquehanna	1,687,775	82,500	1,018,196	2,788,471
Lancaster	2,472,225	63,579	2,278,211	4,814,015
Lawrence	779,145	-	690,009	1,469,154
Lebanon	641,120	195,347	426,868	1,263,335
Lehigh	2,214,651	94,184	1,648,007	3,956,842
Luzerne/Wyoming	2,180,588	184,096	1,423,089	3,787,773
Lycoming/Clinton	953,358	79,545	1,355,149	2,388,052
Mercer	990,336	45,000	832,215	1,867,551
Montgomery	3,849,412	172,463	2,324,419	6,346,294
Northampton	1,664,716	63,278	1,652,234	3,380,228
Northumberland	527,196	21,472	353,011	901,679
Philadelphia	25,830,722	1,558,218	15,956,618	43,345,558
Potter	171,105	18,717	86,735	276,557
Schuylkill	1,110,539	58,800	755,169	1,924,508
Somerset	538,869	17,415	166,389	722,673

Table 7.

**Single County Authority Expenditures
by Fund Source
State Fiscal Year 2013- 2014**

Single County Authority	Total DDAP Funds	Total County Funds	Total Other Funds	Total Funds
Wayne	302,242	226,453	216,380	745,075
Tioga	330,337	41,748	157,953	530,038
Venango	455,278	16,665	516,642	988,585
Washington	1,398,301	-	1,308,571	2,706,872
Westmoreland	2,525,945	38,302	836,547	3,400,794
York/Adams	1,775,245	100,000	932,882	2,808,127
TOTAL	\$98,735,590	\$7,288,889	\$70,593,803	\$176,618,282

Source: Pennsylvania Drug and Alcohol Annual Plan and Report: Drug and Alcohol Abuse Prevention and Treatment 2015-2016, DDAP, accessed March 27, 2017, <http://www.ddap.pa.gov/Reports/State%20Plan%20and%20Annual%20Reports/2015-2016%20DDAP%20State%20Plan%20and%202013-2014%20Report.pdf>. 126.

Table 8 shows the amounts spent by each SCA in each of four activities: Administration, Prevention, Intervention, and Treatment. On average, they spent nearly two-thirds of their expenditures on treatment services, which, for all SCAs, totaled \$115 million. Of the remainder, 15 percent was spent on Prevention (\$26 million), 14 percent on Administration (\$25 million), and 6 percent on Intervention (\$10 million).

Table 8.

**Single County Authority Expenditures
by Major Activity
State Fiscal Year 2013-2014
(all sources)**

Single County Authority	Total Administration	Total Prevention	Total Intervention	Total Treatment	Total Amount
Allegheny	\$1,836,969	\$2,626,164	\$2,621,094	\$10,254,721	\$17,338,948
Armstrong/Indiana/Clarion	480,709	736,946	208,600	2,135,210	3,561,465
Beaver	421,471	319,290	5,058	1,320,822	2,066,641
Bedford	118,809	358,171	29,615	208,581	715,176
Berks	824,733	1,200,392	292,473	6,080,660	8,398,258
Blair	928	75,304	584,272	793,867	1,454,371
Bradford/Sullivan	100,978	145,496	55,940	277,943	580,357
Bucks	1,052,795	771,508	780,718	2,877,911	5,482,932
Butler	225,680	328,901	163,398	1,401,670	2,119,649
Cambria	201,884	200,941	48,330	1,086,862	1,538,017
Cameron/Elk/McKean	193,389	237,806	2,116	1,524,752	1,958,063
Carbon/Monroe/Pike	337,855	338,780	120,042	1,775,873	2,572,550

Table 8.

**Single County Authority Expenditures
by Major Activity
State Fiscal Year 2013-2014
(all sources)**

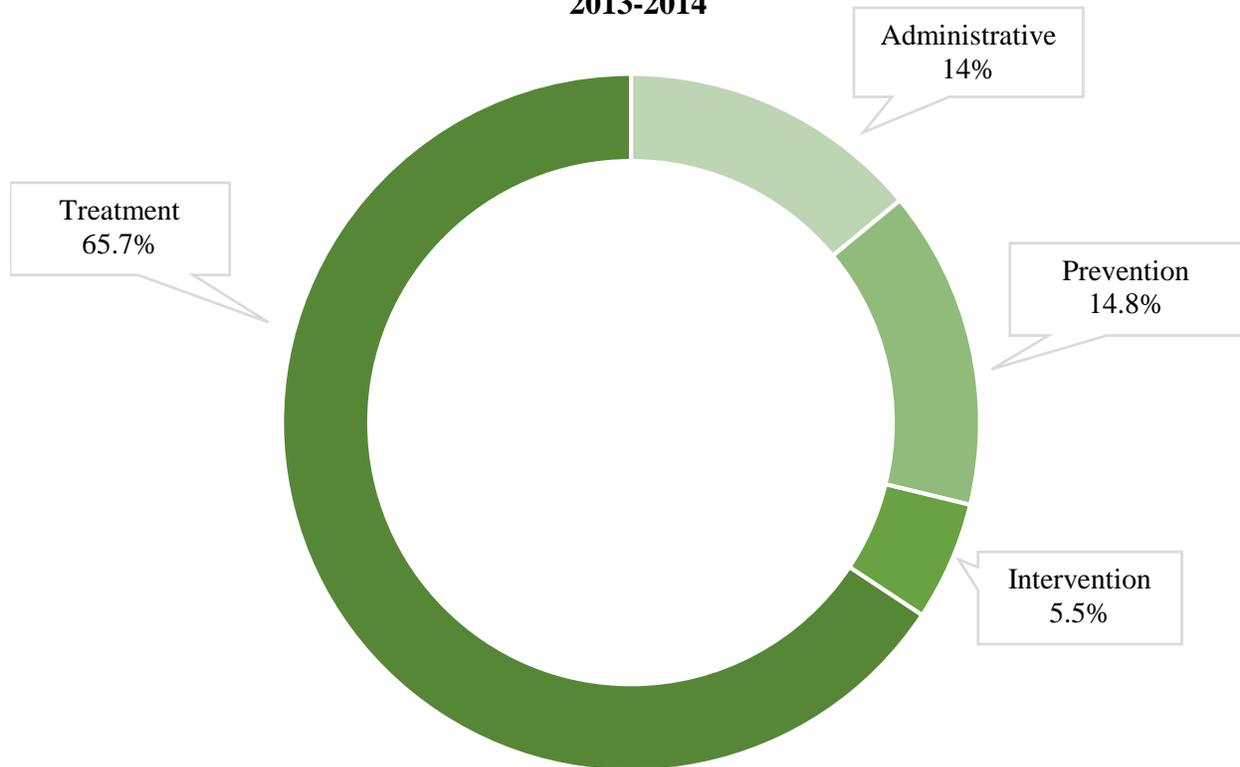
Single County Authority	Total Administration	Total Prevention	Total Intervention	Total Treatment	Total Amount
Centre	180,131	300,091	41,993	876,824	1,399,039
Chester	1,045,460	536,199	10,948	5,339,931	6,932,538
Clearfield/Jefferson	119,024	558,472	112,409	1,037,215	1,827,120
Columbia/Montour/ Snyder/Union	212,369	155,401	139,452	1,059,765	1,566,987
Crawford	115,372	257,618	70,481	1,349,954	1,793,425
Cumberland/Perry	299,057	794,501	41,968	1,759,148	2,894,674
Dauphin	711,837	804,746	148,152	2,225,045	3,889,780
Delaware	719,129	697,262	-	5,018,604	6,434,995
Erie	317,377	1,310,905	548,876	3,656,515	5,833,673
Fayette	224,819	351,043	244,265	1,821,941	2,642,068
Forest/Warren	132,530	68,618	1,926	337,190	540,264
Franklin/Fulton	211,380	137,361	22,070	850,647	1,221,458
Greene	83,217	104,288	-	257,040	444,545
Huntingdon/Mifflin/Juniata	220,504	147,384	34,989	596,231	999,108
Lackawanna/Susquehanna	153,848	516,821	193,407	1,924,395	2,788,471
Lancaster	500,102	1,553,825	49,304	2,710,784	4,814,015
Lawrence	231,310	269,380	6,045	962,419	1,469,154
Lebanon	212,046	180,243	100,808	770,238	1,263,335
Lehigh	388,929	715,099	271,842	2,580,972	3,956,842
Luzerne/Wyoming	271,465	593,744	95,308	2,827,256	3,787,773
Lycoming/Clinton	320,371	269,155	11,376	1,787,150	2,388,052
Mercer	262,905	437,412	15,459	1,151,775	1,867,551
Montgomery	848,420	444,192	260,343	4,793,339	6,346,294
Northampton	449,494	436,642	138,254	2,355,838	3,380,228
Northumberland	169,072	83,890	90,977	557,740	901,679
Philadelphia	8,371,542	4,203,069	2,008,448	28,762,499	43,345,558
Potter	70,563	60,671	-	145,323	276,557
Schuylkill	245,440	434,318	43,649	1,201,101	1,924,508
Somerset	93,148	140,022	27,307	462,196	722,673
Wayne	\$144,719	\$113,043	\$70,518	\$416,795	\$745,075
Tioga	124,124	67,249	-	338,665	530,038
Venango	184,740	147,256	7,453	649,136	988,585
Washington	387,397	478,121	6,771	1,834,583	2,706,872
Westmoreland	536,317	950,495	-	1,913,982	3,400,794
York/Adams	343,887	432,783	14,877	2,016,580	2,808,127
TOTAL	\$24,698,245	\$26,091,018	\$9,741,331	\$115,907,688	\$176,618,282

Source: Pennsylvania Drug and Alcohol Annual Plan and Report: Drug and Alcohol Abuse Prevention and Treatment 2015-2016, DDAP, accessed March 27, 2017,

<http://www.ddap.pa.gov/Reports/State%20Plan%20and%20Annual%20Reports/2015-2016%20DDAP%20State%20Plan%20and%202013-2014%20Report.pdf>. 127.

Figure 8.

**Single County Authorities
Expenditures by Type of Activity
Pennsylvania
2013-2014**



Coverage for Substance Abuse Treatment Services

The Advisory Committee discussed insurance parity at length. Each insurer has a different method of accessing benefits for all coverages, not just drug and alcohol addiction benefits. Whether or not a patient is ultimately eligible for coverage, a quick denial may mean that the provider can move the patient to another funding source, such as through the SCAs. A system that can make quick determinations about eligibility would be beneficial.

The federal Centers for Medicare and Medicaid Services has done a tremendously good job working with DDAP with enrolling people for coverage, and at the time of this report, “everyone in Pennsylvania,” aside from perhaps one-half of one percent, has insurance coverage.⁶¹ Patients who are in need of behavioral health care (without needing SUD care) have presumptive eligibility: they are presumed to have coverage, and services can commence without waiting for payment approvals. This presumption of coverage is similar to that afforded a patient who presents with a heart attack: he or she is presumed to have coverage before treatment is rendered. Advisory Committee members enthusiastically embraced the idea that presumptive eligibility should be afforded overdose patients.

⁶¹ SR267 Advisory Committee meeting, September 15, 2016.

At present, the insurance companies' information systems work well in the hospital setting when a patient has been admitted because there is time in the in-patient setting to process information. In the past, it was more common than it is now for people who went to the hospital to be admitted for two to three days, which gives enough time to process paperwork and plan for services. Over time, however, low rate-setting has made it unaffordable for hospitals to admit overdose patients. The situation is considerably, if not tragically, different for heroin overdose patients. Patients taken into the emergency department are given medical treatment, and once stabilized they are anxious to leave, and there is no time to process the insurance information and certainly no time to do anything beyond trying to get them directly into treatment. In the words of one Advisory Committee member, "You've revived the patient and put him exactly where he least wants to be – in withdrawal." Advisory Committee members who are familiar with EDs know that

"You've revived the patient and put him exactly where he least wants to be – in withdrawal."

"If I have an OD survivor in the hospital and he has Blue Cross/Blue Shield, he's getting a bed tomorrow. If he has county funding or Medicaid, he might have to wait five or six days."

a half-hour is about the maximum amount of time to process insurance information and refer a patient for further services before the patient gets up and walks out. Generally, it takes approximately six to eight hours to process insurance information and refer to further services.

Further, this particular problem may be extrapolated to reflect broader problems with network adequacy. For example, an insurer may not include coverage for the Screening, Brief Intervention, and Referral to Treatment (SBIRT) evidence-based model available consistently across its plans. According to members of the Advisory Committee, at least one existing SBIRT program is grant-funded through DHS, and includes a built-in EHR process for screening, brief intervention, and, optimally, a referral to treatment. An analysis of payments made in this system showed that Medicare paid nothing, Medicaid paid for 3 percent, and, private insurance providers covered 10 to 15 percent of expenses. The private insurance payments are motivation for EDs to develop systems and train staff in a relatively basic counseling process, which may eventually develop the infrastructure for partnerships to provide for "warm hand-offs." (A warm hand off is an approach where a physical health provider does a face-to-face introduction between an SUD patient and a substance abuse specialist and makes a direct referral into substance abuse treatment.⁶²) Ideally, the Commonwealth could mandate a process for payers to fund some type of ED-based counseling, which would encourage hospitals to train staff.

⁶² "The Department's Focus On Addressing Overdose, Letter of Explanation," DDAP website, <http://www.ddap.pa.gov/overdose/Pages/Department%20Focus%20on%20Addressing%20Overdose.aspx>, accessed October 24, 2017.

An example of a warm hand-off system has been implemented by the Washington County SCA. The SCA has met considerable success in helping patients by locating an office in a hospital ED. It also operates a 24-hour crisis line that connects to the hospital in order to triage clients and make connections from the ED to a treatment bed.

Network adequacy is a demonstration of the capacity to provide whatever services are needed by subscribers. Credentialing and network adequacy together form the backbone across all the work that insurers do. Insurers must affirm that a given network adequately covers its subscribers; further, they must ensure that providers meet standards that may exceed those required by DDAP. Insurers are themselves non-compliant with laws and regulations if they cannot provide all of their subscriber's equal access to any particular service. Not all service providers are of optimal quality, unfortunately, which presents serious challenges to insurers, as they are committed to ensuring the best care is available in each benefits package. There is a range of providers who are willing and able to serve at existing reimbursement rates and those providers whose financial position constrains their ability to serve as well as they should. Insurers are balancing their portfolios of coverages with the available providers, while taking into consideration each provider's ability to deliver positive outcomes for patients.

The Advisory Committee discussed the new Centers for Excellence that are mandated to provide care, mostly MAT, for people with SUD. Members expressed concern that the Centers for Excellence would not be able to handle the expected overwhelming increase in new clients entering the system, particularly because Medicaid beneficiaries are the intended population to be served. With respect to the Advisory Committee members' experiences with the sometimes onerous process of receiving coverage for Medicaid clients, an Advisory Committee member stated, "If I have an OD survivor in the hospital and he has Blue Cross/Blue Shield, he's getting a bed tomorrow. If he has county funding or Medicaid, he might have to wait five or six days."⁶³

Types of Insurance

Parity rules govern several areas of coverage.

- Number of outpatient visits covered
 - Out-of-pocket costs (co-pays, co-insurance, and deductible)
 - Prior authorization requirements
 - Provider network and payment for out-of-network services
 - Criteria used to determine medical necessity
-

⁶³ SR267 Advisory Committee meeting September 15, 2016.

There are basically three ways in which a person receives health insurance coverage: through an employer, through the individual market, or through a government program. All three avenues include certain provisions that guarantee coverage for substance abuse services, although they differ in what is required of the insurer. Federal and state statutes and regulations cover all insurance plans in Pennsylvania, and ensure parity for SUD services. Of the multitude of federal and state statutes and regulations related to health insurance coverage and substance abuse treatment, few are as important as the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 and Pennsylvania's Act 106 of 1989, which mandates minimum coverage for alcohol and substance abuse treatment.⁶⁴ MHPAEA itself does not require insurance plans to offer SUD treatment benefits. However, under the Affordable Care Act (ACA), individual and small group plans must offer SUD benefits. Large group plans or self-funded entities are not required to offer SUD benefits, but if one of these does offer such coverage, the SUD benefits must parallel the plan's medical and surgical coverage. Act 106 mandates certain minimum benefits that may exceed the medical and surgical benefits even if the insurer is in compliance with MHPAEA:

For example, Act 106 mandates coverage of 30 outpatient sessions for MH/SUD services. If your plan covers 60 days of outpatient sessions for M/S services, the parity law would require that plan to also cover 60 outpatient sessions for MH/SUD services. . . . If the person's group plan limited outpatient treatment for medical/surgical reasons to 20 sessions per year, then under the parity law that plan could have an equivalent 20 session limit on substance use disorder outpatient treatment. However, because of, Act 106, that person would be covered for 30 sessions of outpatient treatment per year.⁶⁵

Essentially, behavioral health and substance abuse treatments must be provided at the same level of benefit as medical health benefits if the insurance plan includes coverage of behavioral health and substance abuse treatments.

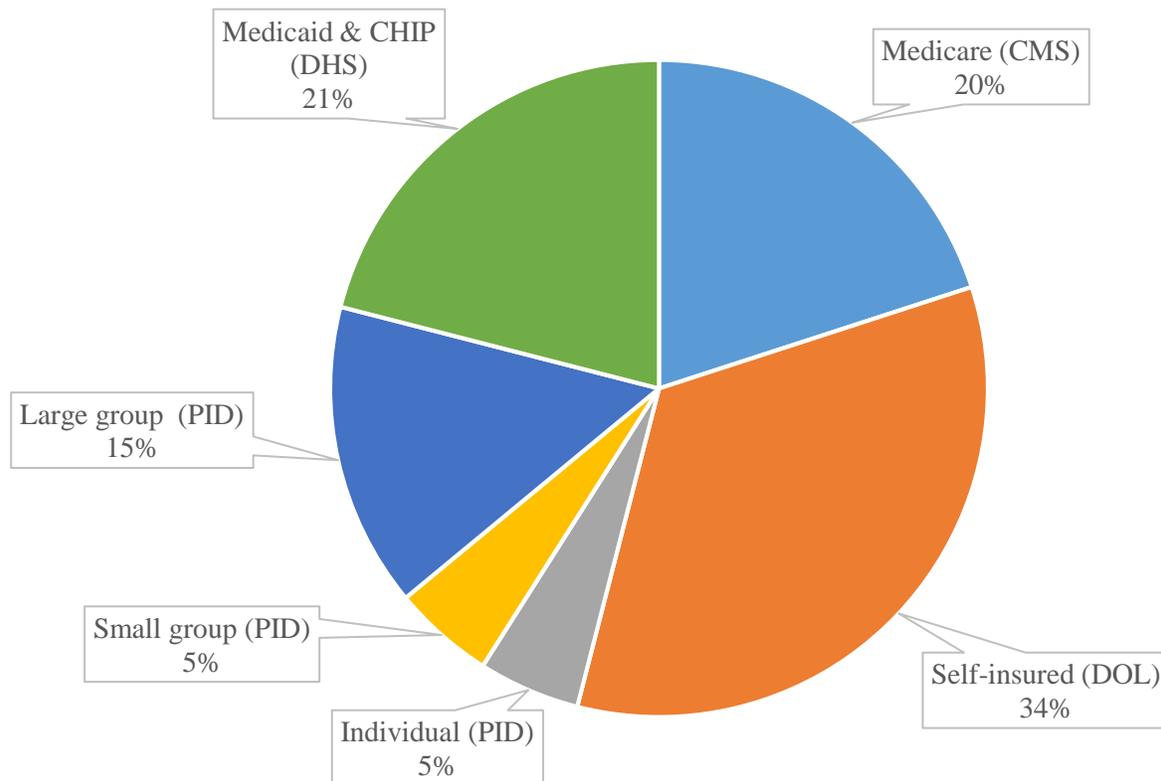
There is disagreement among Advisory Committee members over the practical application of MHPAEA. Some hold a firm position that neither insurers' compliance nor regulators' enforcement is sufficient and patients are going without services despite MHPAEA. Others, in contrast, dispute that blame lies with the insurers and regulators.

Enforcement of health insurance laws and regulations is divided among federal and state government entities. CMS enforces compliance with Medicare. Pennsylvania's DHS enforces Medicaid and the Children's Health Insurance Program (CHIP). Compliance for self-insureds is enforced by the federal Department of Labor (DOL). Large group, small group, and individual plans' compliance is enforced by the Pennsylvania Insurance Department (PID). Figure 9 shows the portion of coverage by source of insurance and the government entity responsible for each sector's oversight.

⁶⁴ Mental Health Parity and Addiction Equity Act of 2008, Pub. L. 110-343, 122 Stat. 3881 (2008) (MHPAEA) and Act of May 17, 1989 (P.L.755, No.106) as discussed during SR267 Advisory Committee meeting September 15, 2016.

⁶⁵ PID, "What is the "Mental Health Parity and Addiction Equity Act" and how does it affect me?" website, <http://www.insurance.pa.gov/Consumers/Pages/Consumer%20Alerts/Mental-Health-Parity-FAQs.aspx>, accessed December 14, 2017.

Figure 9.
Insurance Coverage By Proportion of Insured
Population and Enforcement Agency
Pennsylvania
2016



Source: Jessica Altman, Chief of Staff, Pennsylvania Insurance Department, presentation to SR267 Advisory Committee, September 18, 2016.

The Insurance Department has extensive authority to monitor compliance with MHPAEA and to take enforcement action if violations occur. Enforcement follows a three-pronged approach of monitoring and resolving consumer complaints, reviewing insurance policy forms for accuracy and that benefits comply with state and federal laws, and examining market conduct. Penalties vary according to severity of infraction.

PID is working on market conduct examinations on all major health insurers for compliance with state laws and ACA provisions. MHPAEA and Act 106 are areas of focus.

The department’s plan is to focus on consumer outreach and education, and to increase sophistication in enforcement by partnering with other entities. PID is working toward better understanding of MHPAEA compliance so as to improve compliance. Further, the department applied for a CMS grant for assistance in implementing ACA market reforms, which includes funding dedicated for MHPAEA activities.

Employer Coverage

Employers frequently offer health insurance coverage that falls into two broad categories, fully insured employer coverage and self-insured employer coverage. There are three types of employer insurance plans: self-insurances, small employer plans, and large employer plans. Each is governed by slightly different regulations.

Self-Insureds. Self-insured employers are not required to provide substance abuse treatment benefits. If they do, however, they are required to comply with federal and state parity laws and regulations. The U.S. Department of Labor regulates these entities.

Small Employer. Small employer plans refer to those of employers with 50 or fewer employees. Most plans are required to cover substance abuse services. Those that are not required were grandfathered if they existed prior to January 1, 2017. Those that are required to provide substance abuse services must do so according to benchmark categories established by the Commonwealth, which include parity. The Pennsylvania Insurance Department regulates these entities.

Large Employer. Large employers, those with 51 or more employees, are classified as having large group insurance. Pennsylvania law requires them to cover certain minimum levels for substance abuse treatment, although the plans may voluntarily cover above those minimums. Insurance companies can only use the minimum limits if those same limits are applied to medical health. The Pennsylvania Insurance Department regulates these entities.

Individual Market

The individual market refers to the insurance market through which people purchase insurance directly from an insurance company or through the federal health insurance marketplace. ACA rules require that all insurance companies in Pennsylvania cover behavioral health services, including substance abuse treatment. The level of coverage varies, and not all insurance plans are required to cover the same types of treatments or to the same level. However, all benefits that are provided are subject to parity rules. The Pennsylvania Insurance Department regulates these plans, unless beneficiaries are enrolled in medical assistance. The Department of Health and Human Services regulates plans that cover Pennsylvanians receiving medical assistance.

The Affordable Care Act (ACA) Marketplace plans cover mental health and substance abuse services as essential health benefits. Pre-existing conditions are covered, and there are no lifetime dollar amount limits for services. Further, Marketplace plans must comply with parity protections, meaning that coverage for substance abuse services cannot be more restrictive than coverage for medical services. For example, parity protections include deductibles, copays, coinsurance and out-of-pocket limits; number of days or visits covered; and care management restrictions, such as requiring pre-authorizations for substance abuse treatments when pre-authorizations are not required for medical treatments.⁶⁶ Nonetheless, it can be difficult or impossible for patients to receive adequate care because some copays are cost-prohibitive. For example, under ACA policies some patients are responsible for \$75/day copays for three days a

⁶⁶ Healthcare.gov, “Mental health & substance abuse coverage,” website, <http://pa.milesplit.com/videos/230526>, accessed September 25, 2107.

week treatment. Under these conditions, the length of treatment many patients can afford is far shorter than what they need.

Private insurance's dollar share of SUD coverage decreased from 32 percent to 13 percent from 1986 to 2014, while Medicaid increased its share from 9 percent to 21 percent. State and local funding was variable. From 1986 to 1998, state and local support increased from 27 percent to 35 percent. It decreased after 1998 and settled to 29 percent by 2014.⁶⁷

Patients are best served when they receive the services they need; otherwise, they may find themselves caught up in a loop of ineffective treatments. Treatments and services, whether effective or not, cost money and resources that are perennially in short supply.

Insurance regulations do not necessarily translate to the practice of medicine. A significant issue is the availability of resources to match insurance coverage. More than just a rapidity of assessment, there may be nowhere for SUD patients to go that aligns with their insurance coverage. If a patient presents with a heart attack, he is treated with all necessary medical services and kept under observation. If a person is revived after having ingested heroin, he will be released as soon as he is medically stable.⁶⁸ An option might be to require SUD treatment centers to accept patients with or without determinations about their insurance coverages and afterward address billing. Of course, such a system would place enormous financial risk on the treatment centers if they are accepting patients for whom there is inadequate coverage or no coverage at all.

There are very high mortality rates at the stage when a person is revived from an overdose and leaves the hospital. Those who show up in EDs are usually in dire conditions. Oftentimes, the people who do not have coverage are those who are most sick, too sick to be able to enroll and get help. An expedited process that connects a patient's insurance coverage to SUD treatment would probably save money. For example, substance abuse treatment for Medicaid patients reduced total medical costs

It costs approximately \$40,000 to incarcerate someone for a year, while six months of treatment might cost around \$6,000.

30 percent in a comprehensive health maintenance organization (from \$5,402 per treated member in the year prior to treatment to \$3,627 in the year following treatment). Similarly, it costs the Commonwealth approximately \$47,000 in state funds to incarcerate someone for a year.⁶⁹ Six months of treatment might cost around \$6,000.

Public policy makers, health agency administrators, insurers, and others have expressed growing concerns about workers compensation programs and reported misuse of opioid analgesic prescriptions by beneficiaries.

⁶⁷ SAHMSA, *Behavioral Health Spending and Use Accounts, 1986-2014*, SAHMSA, U.S. Department of Health and Human Services, <https://store.samhsa.gov/shin/content/SMA16-4975/SMA16-4975.pdf>, 7, accessed December 14, 2017.

⁶⁸ Advisory Committee meeting of December 16, 2016.

⁶⁹ "Criminal Justice Program Measures" Pennsylvania Governor's Executive Budget 2017-2018, E12-15, <http://www.budget.pa.gov/PublicationsAndReports/CommonwealthBudget/Pages/default.aspx>, (Accessed December 4, 2017).

RECOMMENDATIONS

This is an epidemic that cannot be eliminated with a vaccine. This is an epidemic that cannot be eliminated with a pharmaceutical vaccine, but together we can administer social inoculation. Standing alone, none of the vast array of preventions, guidelines, or treatments is likely to cure a person of an intractable SUD; neither is any single approach likely to reverse its statewide onslaught. Each of these solutions, however, is an integral and necessary part of the system of care that forms a safety net to catch and support—and save—the people who have fallen. This safety net relies not only on the strength of each component but on the strength of the connections between them.

A successful theory of change will necessarily include treatment and rehabilitation programs that address particular facets of the complexity of SUD. As programs develop and evolve, their strength is not only in how they are each applied but in how they work together. When operating as a coherent network, as repeatedly demonstrated through scientific research, as is known through clinical experience, and as evidenced by survivors' good outcomes, the whole is altogether greater than the sum of the parts.

The coordination of this network of services has long been known as the keystone for population-wide success. Collaboration among providers, insurers, and patients has long been known as crucial for patients' survival. Each discipline knows itself, its capabilities and its strengths, and knows when a “hand-off” draws on the power of its colleagues. The Advisory Committee's discussions, demonstrating the wisdom of decades' worth of experience in caring for people with SUD, led to recommendations that rely on coordination and collaboration as the bulwarks of a strong SUD care network. Therefore, the Advisory Committee makes the following recommendations with the emphasis on collaboration and coordination.

Findings

- Substance use disorders should be considered to be a chronic relapsing disease of the brain, and should be treated using best-evidence care methods, as is advocated when treating other health conditions.
- Stigma related to substance use disorders is historically, and continues to be, a major barrier to individuals seeking care. Moreover, cultural prejudices have caused significant underfunding of SUD treatment and rehabilitation.
- Opioid use disorder is now a major public health crises in Pennsylvania, and is deserving of the attention of everyone to do everything possible to decrease its impact on the residents of the Commonwealth.
- Addressing opioid use disorder will require attention from virtually everyone involved in funding or providing health care.

Recommendations

1. **Prevention.** The Advisory Committee recommends that public health authorities should leverage their existing partnerships with educators to include education, especially for young people, that trauma victims are at increased vulnerability for SUD. Similarly, populations that are known to be at high risk of trauma, such as military personnel and first responders, must be informed of the strong correlations between trauma and SUD. Information on supports and services must be included when educating anyone, whether young people or first responders, about trauma and its link to SUD.

Domestic violence and sexual violence prevention and treatment programs should encourage partnerships with drug and alcohol treatment providers to ensure that victims and their loved ones know the risks of SUD and how to get help.

Health care providers must think carefully about how they diagnose and treat painful conditions, and what role, if any, opioids play in the treatment of acute and chronic pain. Providers must focus on being good stewards of opioids, so that opioids are properly administered, and so that unused prescribed opioids do not remain in the community.

2. **Use of Opioids to Treat Chronic Pain.** The Advisory Committee recommends that physicians, prescribers, care providers, and public health authorities, and others continue to advocate for reductions in the prescribing of opioids to treat noncancer pain. Opioids are prescribed far too often, and far too often they are prescribed at doses too high for treatment of chronic noncancer pain. Providers must follow best evidence guidelines when using opioids to treat noncancer pain to lower patients' risk of developing of opioid use disorder.
3. **Screening, Referral for Treatment, and Availability of Best Evidence Care.** The Advisory Committee recommends that policy makers, health care institutions, and individual providers make changes to the health care system to develop and implement universal screening for substance use disorders, both in the inpatient and outpatient medical settings. Further, a process must be established for brief intervention and immediate referral (SBIRT) for addiction specialty care of patients identified as engaged in risky behavior or who likely have a substance use disorder. These efforts should include the use of a "warm handoff" and expedited decisions on insurance coverage.
4. **Expand the Availability of High Quality, Integrated, Interdisciplinary Addiction Specialty Care.** The Advisory Committee recommends that access to high quality, integrated, interdisciplinary addiction specialty care be expanded. The treatment and rehabilitation system needs to provide more care and services. Not only is an increase in dollars absolutely necessary, but the workforce of care providers must grow to keep pace with the SUD epidemic. The need for residential care for pregnant women and women with young children is particularly acute. To this end, state and local agencies should leverage information technology analyses and data driven evidence to help decision makers direct resources to areas of greatest need.

5. **Emergency Departments and SUD Services.** The Advisory Committee recommends that more resources be invested in offering initiation of MAT in ED and hospital inpatient care to patients with urgent needs. Furthermore, the Advisory Committee adjures the community of emergency care physicians to continue studying the matter. Care initiated in these settings must be linked, through proper transitions, to ongoing outpatient care, ready availability of MAT in the community, and increased availability of intensive outpatient and residential addiction care.

The Advisory Committee recommends increasing the number of arrangements between hospital emergency departments and SUD services to include more hospitals and local providers. In arrangements where a provider is located within the hospital, as currently exists where some hospitals host SCA offices, a person can be referred directly from emergency medical care into SUD care. Without a direct connection, too many people leave the hospital once they are ambulatory, and do not access SUD care.

6. **Navigators.** The Advisory Committee recommends that insurers, care providers, and those in a position of first contact are able to communicate clearly, knowledgeably, and effectively with those in need of help for SUD. Oftentimes, a brief window of opportunity exists for good outcomes to occur, and just as often the critical need for help arises with little warning. It is critical that services be readily available, that access be easily achieved, and that payment be quickly made. However, the layers of oversight and quality control, the array of public funding and private insurance, and the many services combine into an often confusing network that can confound even the most astute as they seek help for themselves or loved ones.

Navigators guide the public through the process of accessing SUD resources and insurance coverage. Some navigators function through websites, as in the case of DDAP's online public resources. Navigators at the SCAs, insurance providers, and SUD care providers have direct contact with the public. The Advisory Committee recommends that all agencies, care providers, and insurers have navigator resources available to help people during their critical times of need.

7. **Defeating Regulatory Barriers.** The Advisory Committee recommends that state and federal agencies continue with regulatory reform. State and federal regulations, while intended to provide care and protect patients, can lead to unintended consequences such as reducing access to addiction treatment and stopping and slowing innovation. The state should partner with providers to develop and implement necessary changes in the process of care, with a focus of increasing access to best practices addiction care.

8. **Advocacy for Best Evidenced Care.** The Advisory Committee recommends that all stakeholders advocate for, and practice the use of, best evidenced care. The Commonwealth, providers, and insurers should strive to support high quality, integrated, interdisciplinary care teams, and continue to explore opportunities to improve patient outcomes. Clinical decisions must be based on evidence. Treatment and rehabilitation programs should be required, whenever possible, to collect and make public their patients' outcome data, including the benefits and harms of treatment, so that policy makers can effectively allocate limited resources.

In conjunction with the Governor's declaration of disaster status for the opioid epidemic, the General Assembly should facilitate use of best practices by requiring that DHS and PID report to it outcome data, including insurance coverage information from the contracted BHMCOs. Comprehensive information on coverage will add value to legislative decisions on regulatory reform and appropriations.

9. **Case Managers.** The Advisory Committee recommends that case managers be funded and considered as necessary staff for care providers. The Commonwealth's system of providing services for people with SUDs must include case managers to help coordinate care across different disciplines. The therapeutic model paradigm requires services and supports that provide for each patient's needs across disciplines, including those such as child care, social supports, education and job training, life skills, and, of course, rehabilitation and treatment for medical and behavioral conditions.

In the current treatment and rehabilitation environments, direct care counselors are overburdened with the tasks associated with coordination of care, recordkeeping, data collection, accreditation requirements, and other administrative mandates. Case managers who have the training, resources, and time to coordinate cross-systems care have become a necessity. Funding, whether from federal, state, or health insurance sources, must be available to pay for these positions.

10. **Efficiency and Streamlining.** The Advisory Committee recommends that state and county authorities set regulations that preclude competition between the SCAs, PacMATs, and OUDs. Government oversight must eliminate redundancies that could lead to inefficient or ineffective use of limited resources. Federal funds typically carry with them regulations that govern their expenditure; these regulations, in turn, create "silos" that feed resources into eligible programs. At the state, and particularly the local, levels scarce resources are further filtered to provide for the spectrum of mandated care. The patients, further still along the network of care, ultimately benefit only when those resources are applied in a sufficient manner.

11. **DDAP Cross-System Events.** The Advisory Committee recommends that DDAP considers sponsoring cross-systems education events. Cooperative events could link trauma services and SUD services, for example, given that SUD is a common outcome for those afflicted by trauma. Connections already exist between county social services offices and organizations such as PCADV and PCAR; it may take only a step forward by DDAP to develop wider and ongoing linkages.

12. **PCPC and ASAM PPC.** *Advisory Committee members did not reach unanimity on a recommendation regarding the PCPC and ASAM PPC for patient evaluation in Pennsylvania. Nonetheless, consensus indicated a preference for the continued use of both the PCPC and the ASAM PPC.*

The PCPC and ASAM PPC are widely accepted, well established, well proven, and robust tools that are utilized every time a patient is evaluated for treatment. The PCPC were created and exist for use with particular populations (destitute persons) that had not been originally covered by the ASAM criteria. In short, the PCPC fill gaps in ASAM coverage. To the extent that counselors need to communicate clearly with insurers, the PCPC are a common language that crosswalks discussing patient care with coverages.

During the final stages of writing this report, Governor Wolf's Administration announced policy actions to utilize solely the ASAM PPC.

13. **Close Coordination of Health Insurance Coverages.** The Advisory Committee recommends that PID, insurance providers, and care providers work together closely to ensure compliance with federal and state insurance parity laws and regulations so that patients receive the services they are eligible for. PID has initiated analyses of Pennsylvania's insurance market so as to develop clear and comprehensive oversight of insurance coverages, including for SUD. The Advisory Committee supports PID in these endeavors and recommends that they continue to be treated as essential functions of the department.
14. **Length of Stay.** The Advisory Committee recommends that the Commonwealth ensure that insurance coverage for residential treatment extends to cover the time period prescribed for the patient.
15. **IMD Exclusion.** The Advisory Committee urges CMS to end the IMD exclusion. The federal IMD exclusion places restrictions on which patients can receive SUD coverage and for how long they are covered.
16. **Physicians Health Plans.** The Advisory Committee recommends that stakeholders continue to explore evidence-based practices from a variety of treatment and rehabilitation plans. For example, research demonstrates that treatment and rehabilitation methods available through physician health plans work. Public health authorities need to develop ways to implement the components of these and similar plans, where feasible. Simple, low cost methods, such as connecting patients to auxiliary supports prior to release from residential treatment, have been successfully used in PHPs, (e.g., clinical research provides scientific evidence that inexpensive twelve-step programs that leverage existing community resources can lead to good patient outcomes in PHPs.).

17. **Workforce.** The Advisory Committee recognizes that staff salaries, not only of drug and alcohol counselors but for other social service disciplines such as trauma counseling, need to be competitive to attract and keep qualified staff. Patient outcomes depend on experienced direct care counselors to provide the necessary continuity of care. Members of the Advisory Committee noted that a typical counselor needs about seven years' experience to be fully effective—a tenure similar to other job fields such as the practice of law. In other words, to maintain a high quality workforce providers need to compensate direct care counselors to encourage them to remain rather than leave for employment that offers more viable expected salary growth.

Being mindful that MAT is not opioid replacement, the Advisory Committee urges decision makers to make it a priority to increase the treatment and rehabilitation workforce to keep pace with the availability of medications. In the experience of some physicians who use MAT to treat patients, only about 20 percent of MAT-eligible patients are able to attain placement in appropriate treatment and rehabilitation programs.

18. **Leave a Card.** The Advisory Committee recognizes that first responders' use of naloxone saves lives. But these lives remain critically endangered unless they get help fast from the “second” responders, like counselors and caseworkers. Help could be as simple as having the first responders leave a card with phone numbers and information on where victims can get the help they need. Having the information on where to reach out for help when one has the strength to reach could mean the difference between a life lost and a life regained. The practice of “Leave a card” is regular protocol for law enforcement officers responding to overdoses in areas of widespread and desperate need of SUD services.
19. **Follow-up.** The Advisory Committee recognizes that first responders could connect those whom they helped initially with counselors and social workers. Follow-up contact from a “second” responder, such as a drug and alcohol treatment counselor or a caseworker, could help guide the person into the SUD care system. The practice, as with “Leave a card,” is regular protocol in areas where law enforcement officers respond to more overdoses than crime scenes.

“I didn’t wake up one morning and decide to become an addict.”

The American Society of Addiction Medicine describes addiction as “a primary, chronic disease of brain reward, motivation, memory, and related circuitry.”⁷⁰ This definition, developed through decades of experience from clinicians and counselors, medical researchers, and the application of contemporary medical technology, is far removed from old definitions that primarily addressed SUD as a flawed character or a failure of moral fortitude in affected individuals.

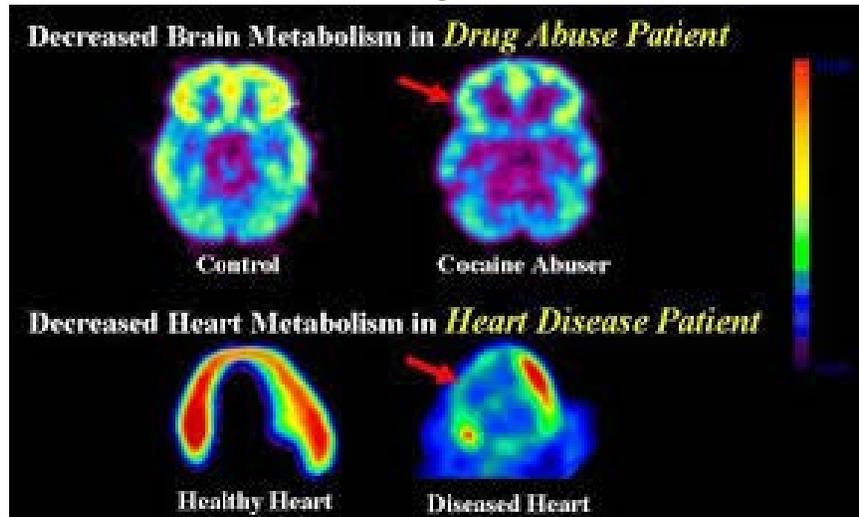
A person suffering from SUD may show no outward signs of the disease. In many respects, an incipient SUD may remain hidden even from close loved ones and friends. Surely, however, healthful self-care behaviors are eventually supplanted by addictive behaviors. An individual’s normal motivations are replaced by the insatiable motivation for the addicting substances. Anti-social behaviors, high-risk behaviors, impaired cognition, and criminal behaviors are rationalized. Fortunately, this is no longer seen as the outgrowth of a flawed character or the justified wages of sin.

Most people recognize that a SUD has negative effects on a person’s behavior, learning, and memory. It is a gross over-simplification to characterize these deficits as rooted in a person’s willful behavior or lack of self-discipline. What many people may not recognize is that substance abuse demonstrably physically alters the brain’s regions that control that individual’s behavior, motivation, learning, and memory. Medical science provides evidence that undercuts the foundation levying such moral judgments. The scans in Image 1 compare metabolic processes of the brains and hearts of healthy people with those with illnesses. The brain of a cocaine user has a substantially larger area of low metabolic function when compared to that of a healthy person. A healthy heart displays a very high metabolic function compared to one afflicted with heart disease. SUD and heart disease are both diseases that are preventable and treatable, and both result in life long deterioration if left untreated. As SUD grows and takes hold deeper and deeper in a person’s physical and spiritual being, it manifests itself in identifiable, empirically evidenced ways. The so-called “brain reward structures,” are affected “such that the memory of previous exposures to rewards (such as food, sex, alcohol and other drugs) leads to a biological and behavioral response to external cues, in turn triggering craving and/or engagement in addictive behaviors.”⁷¹

⁷⁰ ASAM, “Definition of Addiction: Public Policy Statement,” April 19, 2011, accessed March 8, 2017, <http://www.asam.org/quality-practice/definition-of-addiction>.

⁷¹ Ibid. 2.

Image 1.

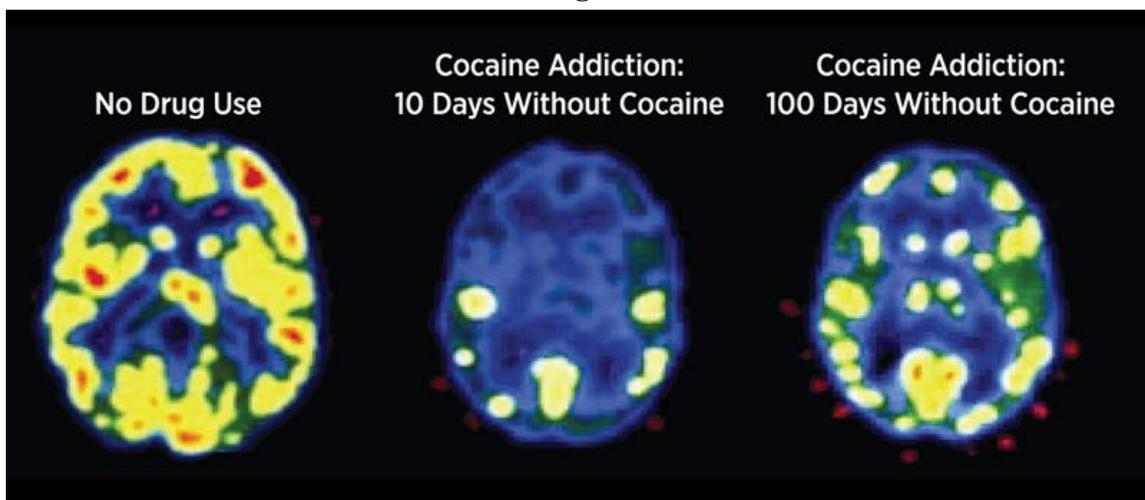


Source: Nora Volkow, MD. "Drugs, Brains, and Behavior: The Science of Addiction," NIDA, NIH Pub. No. 145605. April 2007. Revised July 2014.
<https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/preface>.

It is possible for the brain to heal over time.

Importantly, Image 2 shows scans comparing a healthy person's brain with two individuals' brains that have been damaged by cocaine abuse. They reveal a promising truth: it is possible for the brain to heal over time. Note how higher levels of brain metabolism begin to return as length of abstinence increases.

Image 2.



Source: Nora Volkow, MD. "Drugs, Brains, and Behavior: The Science of Addiction," NIDA, NIH Pub. No. 145605. April 2007. Revised July 2014.
<https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/preface>.

The National Institute on Drug Abuse published “Treatment Approaches for Drug Addiction” in July 2016. The authors concluded that SUD has three characteristics:⁷²

1. Chronic disease characterized by compulsive or uncontrollable drug seeking and use despite harmful consequences and changes in the brain.
2. These changes in the brain can lead to harmful behaviors.
3. Drug addiction is a relapsing disease.

ASAM goes on to give a slightly more technical description of what happens in the brain of a person with an SUD:

The frontal cortex of the brain and underlying white matter connections between the frontal cortex and circuits of reward, motivation and memory are fundamental in the manifestations of altered impulse control, altered judgment, and the dysfunctional pursuit of rewards (which is often experienced by the affected person as a desire to “be normal”) seen in addiction—despite cumulative adverse consequences experienced from engagement in substance use and other addictive behaviors.⁷³

Indeed, it is the primal drive for normalcy that often marks a full-blown SUD. The patient now seeks the drug to stave off debilitating withdrawal symptoms. The drug becomes a vital component of everyday living, taking primacy over food and sleep. It becomes sustenance, morphing from a reason for living to a requirement for life. The National Institute on Drug Abuse stated it succinctly:

Our brains are wired to ensure that we will repeat life-sustaining activities by associating those activities with pleasure or reward. Whenever this circuit is activated, the brain notes that something important is happening that needs to be remembered, and teaches us to do it again and again without thinking about it. Because drugs of abuse stimulate the same circuit, we learn to abuse drugs in the same way.⁷⁴

⁷² National Institute on Drug Abuse. “Treatment Approaches for Drug Addiction.” National Institute on Drug Abuse (July 2016), 1, accessed October 31, 2016.

<https://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction>.

⁷³ ASAM, “Definition of Addiction: Public Policy Statement,” April 19, 2011, accessed March 8, 2017, <http://www.asam.org/quality-practice/definition-of-addiction>. 2.

⁷⁴ “Drugs, Brains, and Behavior: The Science of Addiction,” NIDA, NIH Pub. No. 145605, April 2007, revised July 2014, accessed March 9, 2017,

<https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/preface>.

Health researchers estimated that enough opioid analgesics had been prescribed in 2015 for every person in the U.S. to be dosed with 5 mg of hydrocodone every four hours for three weeks. At the same time, 46 people died each day from an overdose of prescription painkillers.⁷⁵ This amounted to 16,007 deaths, accounting for nearly 40 percent of all drug-poisoning deaths. Furthermore, deaths from opioid analgesics have more than tripled since 1999, from 1.4 deaths per 100,000 to 5.1 deaths in 2012. There was a decline of 5 percent from 2011 to 2012, the first decrease seen in over a decade.⁷⁶ The death rate climbed yet higher in 2013; the data show that 16,235 deaths involved opioid analgesics in the U.S., an increase of 1 percent from 2012.⁷⁷



**ENOUGH OPIOID ANALGESICS
HAD BEEN PRESCRIBED IN 2015
FOR EVERY PERSON IN THE U.S.
TO BE DOSED WITH 5 MG OF
HYDROCODONE EVERY FOUR HOURS
FOR THREE WEEKS.**

Tragically, one's sobriety may not rest entirely in one's own hands. According to ASAM, genetic, environmental, and cultural factors also play a role:

Genetic factors account for about half of the likelihood that an individual will develop addiction. Environmental factors interact with the person's biology and affect the extent to which genetic factors exert their influence. Resiliencies the individual acquires (through parenting or later life experiences) can affect the extent to which genetic predispositions lead to the behavioral and other manifestations of addiction. Culture also plays a role in how addiction becomes actualized in persons with biological vulnerabilities to the development of addiction.⁷⁸

Health risk factors such as obesity, stress level, and inactivity, which are products of familial, cultural, and personal factors, are significant contributors to morbidity and mortality. Even among those with demonstrated genetic risk, a significant part of the total risk for developing hypertension can be traced to individual behaviors.⁷⁹ The choice to take the drug may have been ill-informed or influenced by exogenous manipulation, peer pressures, or other contextual pressures; however, the effects of peer pressure, in particular, are not always as strong as often assumed.⁸⁰ Further, a person faced with physical pain from injuries or medical problems may see no alternative for relief but for that promised by prescription opioid analgesics.

⁷⁵ Understanding the Epidemic: Drug Overdose Deaths in the United States Continue to Increase in 2015," <https://www.cdc.gov/drugoverdose/epidemic/index.html>.

⁷⁶ Margaret Warner, Holly Hedegaard, and Li-Hui Chen, "Trends in Drug-Poisoning Deaths Involving Opioid Analgesics and Heroin: United States, 1999-2012," Centers for Disease Control and Prevention, December 2014, accessed March 18, 2015. http://www.cdc.gov/nchs/data/hestat/drug_poisoning/drug_poisoning_deaths_1999-2012.pdf.

⁷⁷ "Prescription Drug Overdose in the United States: Fact Sheet," Centers for Disease Control and Prevention, last updated March 2, 2015, accessed March 30, 2015.

⁷⁸ ASAM, "Definition of Addiction: Public Policy Statement," April 19, 2011, accessed March 8, 2017, <http://www.asam.org/quality-practice/definition-of-addiction>. 3.

⁷⁹ A. Thomas McLellan, PhD, David C. Lewis, MD, Charles P. O'Brien, MD, PhD, Herbert D. Kleber, MD, "Drug Dependence, a Chronic Medical Illness Implications for Treatment, Insurance, and Outcomes Evaluation," *Journal of the American Medical Association* Vol 284, No. 13, October 4, 2000, accessed March 8, 2017, <https://www.ncbi.nlm.nih.gov/pubmed/11015800>. 1690.

⁸⁰ Daniel Eisenberg, "Peer Effects for Adolescent Substance Use: Do They Really Exist?" UC-Berkeley School of Public Health, March 2004, accessed, March 9, 2017, <http://www-personal.umich.edu/~daneis/papers/peereffects.pdf>.

Trauma

Trauma—physical, psychological, sexual—frequently leads victims onto a ruinous path of substance abuse. Post-traumatic stress disorder (PTSD) is an anxiety disorder brought on by exposure to unexpected extreme traumatic stressors.⁸¹ It can be experienced at any age, although is more prevalent among young adult, and nearly twice as common among women as among men (. Typical triggers include war, violent personal assault (e.g., rape), being taken hostage or kidnapping, confinement as a prisoner of war, torture, terrorist attack, severe automobile accidents. PTSD among children may be caused by sexual abuse, witnessing serious injuries to others, or unexpected deaths of loved ones.⁸²

Any person suffering from PTSD is at high risk for suffering a number of co-morbid conditions, and about 84 percent do.⁸³

- major depressive disorder (48 percent)
- alcohol abuse/dependency (40 percent)
- drug misuse/dependency (31 percent)
- conduct disorder (29 percent)
- social phobia (28 percent)
- panic disorder (9.5 percent)
- mania (9 percent)

Victims of Sexual Violence

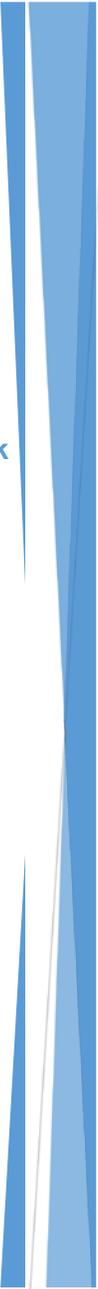
In their paper, “The Unique Associations of Sexual Assault and Intimate Partner Violence With PTSD Symptom Clusters in a Traumatized Substance-Abusing Sample,” Emily Dworkin and Natalie Mota, et al, refer to the incidence of sexual violence and intimate partner violence among women with SUD as being “staggeringly common”: nearly 22 percent of women will be victims of intimate partner violence and 18 percent will be victims of rape; slightly more than 7 percent of men will be victims of intimate partner violence and 3 percent will be raped during their lives.⁸⁴

⁸¹ H. Javidi, M. Yadollahie, “Post Traumatic Stress Disorder,” *The International Journal of Occupational and Environmental Medicine*, Vol. 3 No. 1, pp. 2-9, January, 2012, <https://www.ncbi.nlm.nih.gov/pubmed/23022845>, (Accessed December 4, 2017).

⁸² Ibid.

⁸³ H. Javidi, M. Yadollahie, “Post Traumatic Stress Disorder,” *The International Journal of Occupational and Environmental Medicine*, Vol. 3 No. 1, pp. 2-9, January, 2012, <https://www.ncbi.nlm.nih.gov/pubmed/23022845>, accessed December 4, 2017.

⁸⁴ Emily R. Dworkin, Natalie P. Mota, et al, “The Unique Associations of Sexual Assault and Intimate Partner Violence with PTSD Symptom Clusters in a Traumatized Substance-Abusing Sample,” *Psychological Trauma: Theory, Research, Practice, and Policy*, Vol. 9 No. 4, pp 500-508, American Psychological Association, doi: 10.1037/tra0000212, accessed December 4, 2017.



The National Child Traumatic Stress Network estimates that nearly 60 percent of young people with PTSD subsequently develop substance abuse problems.

Sexual assault is a powerful predictor of SUD. Dworkin, Mota, et al reported that 69 percent of women and 17 percent of men in inpatient SUD treatment had a history of being victims of sexual assault. In terms of intimate partner violence, the rate among people receiving treatment for alcohol use disorder is four to six times higher than in the general population. The paper concludes with two pertinent recommendations:⁸⁵

First, providers offering substance use and PTSD services should consistently screen for SA history, as these patients are likely to be experiencing particularly severe symptoms of PTSD . . . Second, is important for settings that are focused on serving survivors of [sexual assault] (e.g., rape crisis centers) to ensure that they have resources available to meet the unique needs of their population.

Pennsylvania has resources that are working to help people with SUD that results from PTSD induced by sexual violence. Across the state there are 50 rape crisis centers and 60 domestic violence programs located in county offices and that take referrals from SUD treatment and rehabilitation counselors. The Pennsylvania Coalition Against Rape and the Pennsylvania Coalition Against Domestic Violence are two organizations that provide training to SUD treatment and rehabilitation staff. Optimally, interactions across disciplines will build the community of practice to redouble efforts to ensure that appropriate treatments are provided according to each patient's needs.

Adolescents and Young Adults

Young people are particularly at risk, and there appears to be a two-way connection between teens' substance abuse and PTSD. PTSD is highly correlated with illicit use of drugs and alcohol among teenagers. The National Child Traumatic Stress Network estimates that nearly 60 percent of young people with PTSD subsequently develop substance abuse problems.⁸⁶ The reverse relationship also appears to correlate: teens who abuse drugs and alcohol are more likely than their peers to suffer trauma that leads to PTSD. Further, "youth who are already abusing substances may be less able to cope with a traumatic event."⁸⁷ Many patients suffer from co-occurring conditions, like severe mental health problems, along with SUD. Patients cannot be adequately treated unless the co-occurring problems are treated along with the addiction; the risk of relapse is otherwise too high.

⁸⁵ Ibid.

⁸⁶ The National Child Traumatic Stress Network, "Making the Connection: Trauma and Substance Abuse," website, http://www.nctsn.org/sites/default/files/assets/pdfs/SAToolkit_1.pdf, June 2008, accessed September 26, 2017.

⁸⁷ The National Child Traumatic Stress Network, "Making the Connection: Trauma and Substance Abuse," website, http://www.nctsn.org/sites/default/files/assets/pdfs/SAToolkit_1.pdf, June 2008, accessed September 26, 2017.

Evidence of these correlations has been shown through research into PTSD:⁸⁸

- The amygdala (the brain's threat detection center) can become overactive, engaging in a constant program of looking for, seeing and assessing threat, leading to intense feelings of anxiety, vulnerability, and fear.
- The hippocampus (the brain's center for processing memories) can become underactive. Rather than consolidating and then placing memories in the outer layer of the brain for long-term storage, memories get hung up in a present-day loop. The result is that a person will experience and re-experience intrusive, disturbing, and uncomfortable recollections.
- The cortex (the brain's center for executive control) becomes interrupted by survival-oriented instincts from deep inside the inner brain. These instincts overrule logical thinking, diminish cognitive processing, and decrease ability to inhibit behavior. Even when one tries to refrain from addictive behavior, the urge to engage in it may be unstoppable.

There appear to be a number of reasons why the incidence of PTSD correlated with SUD is high among teenagers. Illicit use and misuse of intoxicating substances can help a person feel safe, "out of it," and escape bad memories. The drugs can give the illusion of creating an alternative reality where the person is in control and make intolerable surroundings appear tolerable. The drugs can entice a person to redefine who he or she is, and to find belonging in a community of others who seek an escape from their suffering.⁸⁹

Occupational Risks

First responders and veterans with PTSD also exhibit high correlations between their PTSD and substance abuse. Observations of different demographic groups' rates of PTSD were reported in *The International Journal of Occupational and Environmental Medicine* in 2012. Among occupations that are more likely to experience PTSD are those that endure conditions that are likely to precipitate it. For example, a study of police, fire, and rescue workers showed PTSD rates going

⁸⁸ Michele Rosenthal, "Trauma and Addiction: 7 Reasons Your Habit Makes Perfect Sense," *Behavioral Health, Living in Recovery, Living with Addiction*, March 30, 2017, <https://www.recovery.org/pro/articles/trauma-and-addiction-7-reasons-your-habit-makes-perfect-sense/>, accessed September 26, 2017.

⁸⁹ Michele Rosenthal, "Trauma and Addiction: 7 Reasons Your Habit Makes Perfect Sense," *Behavioral Health, Living in Recovery, Living with Addiction*, March 30, 2017, <https://www.recovery.org/pro/articles/trauma-and-addiction-7-reasons-your-habit-makes-perfect-sense/>, accessed September 26, 2017.

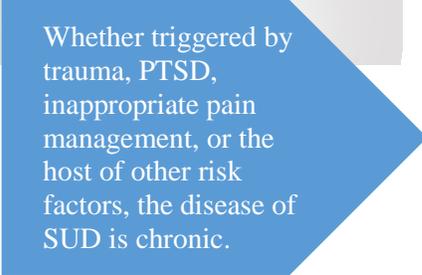
as high as 32 percent. In other words, as many as one-third of first responders may suffer from PTSD. Also at high risk are people working in construction and sanitation, particularly among those who performed tasks not normally encountered during their daily work routines. Generally, risky and dangerous occupations have been traditionally held by men; men are more likely than women (60.7 percent to 51.2 percent) to experience at least one event in their lives that puts them at risk for PTSD.⁹⁰

However, work-related PTSD is not necessarily confined to those people who work in occupations that are generally recognized as dangerous and risky. Several other factors are known to contribute to PTSD that has its root in the workplace, including female gender, previous psychiatric problems, degree and nature of exposure to traumatic events, and lack of social support.⁹¹ Among women, work-related factors are attributed sexual harassment and discrimination. Among forms of discrimination, “mobbing syndrome” is experienced by as many as 65 percent of women between 34 and 45 years of age.⁹²

The U.S. Department of Veterans Affairs found that:⁹³

Treatments include cognitive behavioral treatments, psychological treatments specific to PTSD, and MAT.⁹⁴ The SCAs and private insurers know which of their programs can handle specific co-occurring problems. The primary obstacle in these cases is the struggle to accommodate all of the patient’s needs.

Chronic Complications



Whether triggered by trauma, PTSD, inappropriate pain management, or the host of other risk factors, the disease of SUD is chronic.

Whether triggered by trauma, PTSD, inappropriate pain management, or the host of other risk factors, the disease of SUD is chronic. As with people with SUD, those who relapse with other chronic health disease like Type I diabetes, hypertension, and asthma, are beset with problems of low socioeconomic status, comorbid psychiatric conditions, and lack of family and social supports—among the most important predictors of

⁹⁰ Ibid.

⁹¹ Ibid.

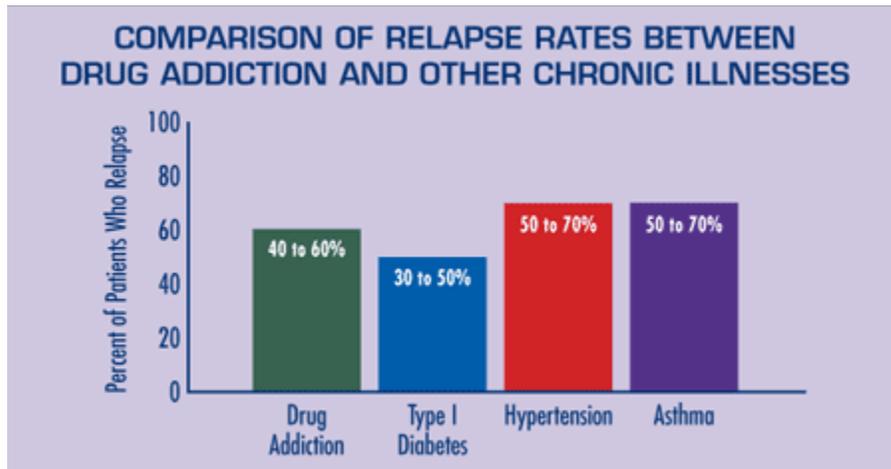
⁹² Ibid. Mobbing syndrome is defined as “a form of organizational pathology in which co-workers essentially “ganged up” and engaged in an ongoing rituals of humiliation, exclusion, unjustified accusations, emotional abuse and general harassment in their malicious attempt to force a targeted worker out of the workplace.” Noa Davenport, Ruth Distler Schwartz, and Gail Pursell Elliott, *Mobbing: Emotional Abuse in the American Workplace*, 2002 Revised Edition ISBN 0967180309 Published January 1st 1999 by Book Masters Distribution Center

⁹³ U.S. Department of Veterans Affairs, “PTSD: National Center for PTSD,” website, https://www.ptsd.va.gov/public/problems/ptsd_substance_abuse_veterans.asp, August 13, 2015, accessed September 27, 2017.

⁹⁴ U.S. Department of Veterans Affairs, “PTSD: National Center for PTSD,” website, https://www.ptsd.va.gov/public/problems/ptsd_substance_abuse_veterans.asp, August 13, 2015, accessed September 27, 2017.

adherence to health regimens.⁹⁵ Relapse rates for SUD are similar to those for other chronic diseases, such as Type I diabetes, hypertension, and asthma.⁹⁶ See Figure 10.

Figure 10.



Source: “Drugs, Brains, and Behavior: The Science of Addiction,” NIDA, NIH Pub. No. 145605, April 2007, revised July 2014, accessed March 9, 2017, <https://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/preface>.

“We don’t kick a diabetic out of treatment and say the treatment failed when he has a relapse, but people do take that attitude with drug addicts.”

Further, people suffering from these three chronic diseases have been shown to require additional medical intervention when they fail to comply with health programs. Approximately 50 percent to 70 percent of adults with hypertension or asthma require additional medical care each year.⁹⁷ Sufferers of these (and similar) chronic diseases get adequate treatment, a suboptimal amount and then chastised for still being ill. To put this in perspective rather bluntly, in the words of an Advisory Committee member, “We don’t kick a diabetic out of treatment and say the treatment failed when he has a relapse, but people do take that attitude with drug addicts.”

⁹⁵ A. Thomas McLellan, PhD, David C. Lewis, MD, Charles P. O’Brien, MD, PhD, Herbert D. Kleber, MD, “Drug Dependence, a Chronic Medical Illness Implications for Treatment, Insurance, and Outcomes Evaluation,” *Journal of the American Medical Association* Vol 284, No. 13, October 4, 2000, accessed March 8, 2017, <https://www.ncbi.nlm.nih.gov/pubmed/11015800>. 1693.

⁹⁶ In a 2010 paper published in the *Irish Medical Journal*, 91 percent of patients suffered a relapse, with 59 percent returning to daily opioid use within a week of discharge from a residential detoxification center.⁹⁶ B.P. Smyth, E. Keenan, K. Ducray, “Lapse and Relapse Following Inpatient Treatment of Opiate Dependence,” *Irish Medical Journal* 103(6), June 2010 : 176-9, accessed March 8, 2017, <https://www.ncbi.nlm.nih.gov/pubmed/20669601>.

⁹⁷ A. Thomas McLellan, PhD, David C. Lewis, MD, Charles P. O’Brien, MD, PhD, Herbert D. Kleber, MD, “Drug Dependence, a Chronic Medical Illness Implications for Treatment, Insurance, and Outcomes Evaluation,” *Journal of the American Medical Association* Vol 284, No. 13, October 4, 2000, accessed March 8, 2017, <https://www.ncbi.nlm.nih.gov/pubmed/11015800>. 1693.

However, the pernicious grasp that suffocates both body and soul grows stronger and stronger toward an end that few avoid without professional help. With extraordinary efforts lent by any number of people, from the patients themselves to counselors, physicians, family, and friends, there is hope that a person will survive the disease. Most do, in fact, overcome their addictions and resume normal lives, albeit continuously vigilant lest the chronic disease take hold once again.

DIAGNOSIS AND TREATMENT

**“When I was an addict,
I never said to myself, ‘I love my life.’”**

The overall focus of the fight against substance abuse, and the efforts to provide effective rehabilitation and treatment, must maintain an organizational discipline to marshal resources in a top-down approach so as not to dilute available resources. Inefficient and ineffective initiatives, despite their understandable intentions, will consequently increase administrative burdens and redirect resources without providing good outcomes. Certainly, this is not a call to allow an inertial state to take root; new treatments and programming should and must be investigated, reviewed, and applied as they are developed at all levels of care. The application of funding, certification and licensing, and oversight of quality, must nevertheless remain organized, coherent, unified, and directed from the top. Policy makers have to step back from visualizing the micro, i.e., the boots on the ground level, and use their expertise to ensure that at the macro level the system is delivering adequate resources through appropriate treatment streams to achieve optimal outcomes for patients. In short, the members of the Advisory Committee emphatically underscore the need to be vigilant in not losing sight of the forest for the trees.

Any treatment program or curriculum will be ineffective, despite the research and evidence that might support it, if it is not applied at the appropriate level of care for the appropriate duration of treatment. In general, Advisory Committee members consider the obstacles to diagnosis and treatment to be limited resources, stigma, and a treatment system that is not fully equipped to simultaneously and comprehensively treat SUD and co-occurring disorders and trauma. With these obstacles to overcome, recovering and maintaining sobriety is extremely difficult. The broad spectrum of challenges cluster at three succinctly-stated areas: 1. point of entry; 2. assessment and diagnosis; 3. treatment itself.

Several Advisory Committee members pointed out that recovery and rehabilitation are particularly problematic for vulnerable populations. Racial and ethnic minorities, veterans, and people with disabilities have challenges where treatment facilities lack resources to appropriately address their needs. An increasing number of infants are born experiencing withdrawal from opioids also known as Neonatal Abstinence Syndrome (NAS). NAS is not fatal, but may be an indicator of the infant's risk for complicating medical conditions or abuse or neglect in the critical first year of life. Infants are affected by the substance use disorders of not only their mothers but also their fathers or other caregivers. PA has recorded too many fatalities and near fatalities of very young children, many under the age of one, from situations where the parent's substance use disorder places the child at risk (e.g., an infant sleeping with an adult who is under the influence of drugs).⁹⁸ Moreover, increasing numbers of children are exposed to overdose trauma and are

⁹⁸ Cathy Palm, Founder of Center for Children's Justice in email to Commission Staff, January 30, 2018.

living in multiple out-of-home placements because of family members' SUD and overdoses and are experiencing drug ingestions themselves. The mother-baby dyad is critical—all babies come with a mother, and mothers need their babies. The federal Mother and Child Health Services Block Grant program is the impetus for addressing maternal SUD, rather than in the Child Abuse Prevention and Treatment Act.⁹⁹



TRANSPORTATION, HOUSING, LIFE SKILLS, AND JOB/EMPLOYMENT MAY ALL NEED TO BE PART OF A PATIENT'S SUCCESSFUL TREATMENT.

Although substance abuse often first presents itself as an acute illness, it must be treated as a chronic health illness and the infrastructure needs to be in place to treat it as such. There are many secondary issues that not only contribute to SUD, but impede recovery and rehabilitation. People who are chronically homeless and those who have chronic mental health conditions that go beyond depression and anxiety (schizophrenia, for example) frequently number substance abuse among their problems. Patients get trapped in a revolving door of jails, hospitals, and homeless shelters. Transportation, housing, life skills, and job/employment may all need to be part of a patient's successful treatment. Further exacerbating the issue is Pennsylvania's geography, which includes nearly isolated rural areas.

Certainly people with SUD face the worst of the obstacles, but treatment providers are often frustrated by systemic and bureaucratic obstacles in their efforts to deliver critical services. The Department of Health had a project investigating barriers faced by professionals working in mental health and substance abuse treatment, and concluded that most of the barriers appeared to be unintended consequences of regulations.¹⁰⁰ The Department of Human Services was awarded a three year federal grant to study access to treatment, MAT, and develop metrics of treatment.

Detection and diagnosis

Diabetes can be diagnosed by analyzing tangible markers such as A1c and blood glucose levels. Hypertension can be diagnosed from evaluating a series of blood pressure readings. Asthma can be diagnosed through evaluation of a patient's lung capacity under different breathing conditions. SUD is diagnosed by a composite of physical and behavioral conditions collected through observation and assessments. It is true that drug use can be detected quite cheaply and easily through urine and blood tests. These tests, however, offer a point-in-time snapshot of the person's system. The tests cannot determine whether a person is suffering from a SUD or measure the severity of an addiction. In diagnosing SUD, health professionals rely on a toolbox of techniques to conduct the necessary analyses, which include observing and interacting with the patient.

⁹⁹ Mother and Child Health Services Block Grant, 42 U.S.C. §§701-710; Child Abuse Prevention and Treatment Act, 42 U.S.C. §5101 et seq; 42 U.S.C. §5116 et seq.

¹⁰⁰ SR267 Advisory Committee meeting July 12, 2016.

The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5), describes the diagnosis of substance use disorder as, “based on evidence of impaired control, social impairment, risky use, and pharmacological criteria.”¹⁰¹ An SUD is indicated if at least two of 11 criteria are met over a one-year period.¹⁰²

1. A person takes larger amounts of the drug over a longer period of time than intended.
2. A person’s attempts to reduce use or abstain have not been successful.
3. A person spends a good deal of time getting the drug, using the drug, or recovering from the effects of the drug.
4. A person has intense urges for the drug that block out any other thoughts.
5. A person is not meeting obligations and responsibilities because of substance use.
6. A person continues to use the drug, even though it is causing life problems.
7. A person reduces or avoids important social, occupational, or recreational activities because of his substance use.
8. A person uses the substance in situations that may be unsafe, such as when driving or operating machinery.
9. A person continues to use the substance even though it causes physical or psychological harm.
10. A person develops tolerance, which means that the drug has less and less effect and more of the drug is needed to get the same effect.
11. A person has physical or psychological withdrawal symptoms when he stops taking the drug, or he takes the drug (or a similar drug) to avoid withdrawal symptoms.

Each clinician’s observations, interactions, and interpretations are pivotal contributors to diagnosis. The clinician synthesizes all available information to determine whether a person suffers from a SUD and what appropriate actions should start treatment and rehabilitation.

¹⁰¹ Diagnostic And Statistical Manual of Mental Disorders: DSM-5. Arlington, VA: American Psychiatric Publishing, 2013.

¹⁰² Mayo Clinic Staff, “Diseases and Conditions, Drug Addiction,” Mayo Clinic, accessed February 14, 2017, <http://www.mayoclinic.org/diseases-conditions/drug-addiction/basics/tests-diagnosis/con-20020970>.

Treatment works. The National Institute on Drug Abuse (NIDA) provides a graphic (Figure 11, below) that encapsulates the components of comprehensive drug abuse treatment. As is apparent from the image, drug abuse treatment is complex, multi-faceted, and perhaps overwhelming. Treatment includes care and services that range beyond what could reasonably be

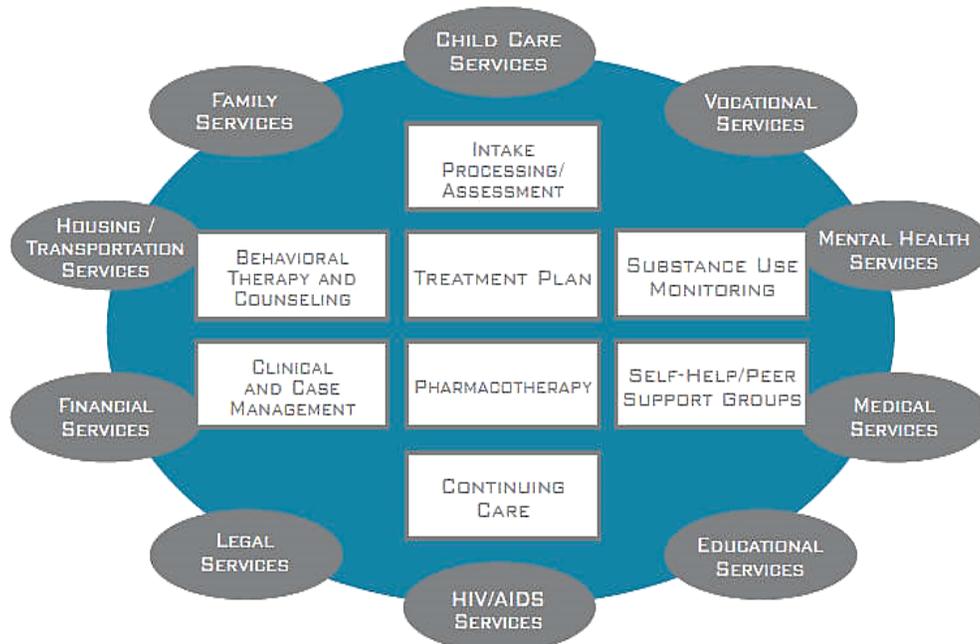
Holistic treatment, including pharmacotherapy, counseling, and ancillary services, is necessary for successful treatment of substance abuse disorder.

considered as sufficient care for a person suffering from SUD. Three significant considerations must be made at this point. First, many of these types of care and services are commonly necessary for successful treatment of chronic diseases in general, not just for those that are SUD-related. Second, both clinicians' experiences and scientific research prove that holistic treatment, the so-called therapeutic model that includes pharmacotherapy, counseling, and all the ancillary services shown, is indeed necessary for successful SUD treatment outcomes. The

risk that a patient in treatment will succumb to relapse and possibly death increases substantially when needed services are absent from the treatment plan or when the services are not engaged for a sufficient period. Of course, not all patients require all services—which is why the creation of an individualized treatment plan is among the very first steps toward recovery and wellness. Recovery is the expectation, and the expectation is realized when treatment and rehabilitation systems have the resources to meet their patients' needs.

Figure 11.

Components of Comprehensive Drug Abuse Treatment



Source: “Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition),” NIDA website, December 2012, accessed April 4, 2017, <https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/frequently-asked-questions/what-drug-addiction-treatment>.

Since the 1970s, scientific research has led researchers, clinicians, and policy makers to the following conclusions about effective treatment of SUD:¹⁰³

1. Addiction is a complex but treatable disease that affects brain function and behavior. Drugs of abuse alter the brain's structure and function, resulting in changes that persist long after drug use has ceased. This may explain why drug abusers are at risk for relapse even after long periods of abstinence and despite the potentially devastating consequences.
2. No single treatment is appropriate for everyone. Treatment varies depending on the type of drug and the characteristics of the patients. Matching treatment settings, interventions, and services to an individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.
3. Effective treatment attends to multiple needs of the individual, not just his or her drug abuse. To be effective, treatment must address the individual's drug abuse and any associated medical, psychological, social, vocational, and legal problems. It is also important that treatment be appropriate to the individual's age, gender, ethnicity, and culture.
4. Treatment programs should test patients for the presence of HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases as well as providing targeted risk-reduction counseling, linking patients to treatment if necessary. Typically, drug abuse treatment addresses some of the drug-related behaviors that put people at risk of infectious diseases. Targeted counseling focused on reducing infectious disease risk can help patients further reduce or avoid substance-related and other high-risk behaviors. Counseling can also help those who are already infected to manage their illness. Moreover, engaging in substance abuse treatment can facilitate adherence to other medical treatments. Substance abuse treatment facilities should provide onsite, rapid HIV testing rather than referrals to offsite testing—research shows that doing so increases the likelihood that patients will be tested and receive their test results. Treatment providers should also inform patients that highly active antiretroviral therapy (HAART) has proven effective in combating HIV, including among drug-abusing populations, and help link them to HIV treatment if they test positive.
5. Many individuals suffering from SUD also have other mental disorders. Because drug abuse and addiction—both of which are mental disorders—often co-occur with other mental illnesses, patients presenting with one condition should be assessed for the other(s). And when these problems co-occur, treatment should address both (or all), including the use of medications as appropriate.

¹⁰³ "Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition)," *NIDA* website, December 2012, accessed April 4, 2017, <https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/principles-effective-treatment>.

6. An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs. A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient may require medication, medical services, family therapy, parenting instruction, vocational rehabilitation, and/or social and legal services. For many patients, a continuing care approach provides the best results, with the treatment intensity varying according to their changing needs.
7. Drug use during treatment must be monitored continuously, as lapses during treatment often do occur. Knowing their drug use is being monitored can be a powerful incentive for patients and can help them withstand urges to use drugs. Monitoring also provides an early indication of a return to drug use, signaling a possible need to adjust an individual's treatment plan to better meet his or her needs.
8. Behavioral therapies—including individual, family, or group counseling—are the most commonly used forms of drug abuse treatment. Behavioral therapies vary in their focus and may involve addressing a patient's motivation to change, providing incentives for abstinence, building skills to resist drug use, replacing drug-using activities with constructive and rewarding activities, improving problem-solving skills, and facilitating better interpersonal relationships. Also, participation in group therapy and other peer support programs during and following treatment can help maintain abstinence.
9. Treatment needs to be readily available. Because individuals with SUD may be uncertain about entering treatment, taking advantage of available services the moment people are ready for treatment is critical. Potential patients can be lost if treatment is not immediately available or readily accessible. As with other chronic diseases, the earlier treatment is offered in the disease process, the greater the likelihood of positive outcomes.
10. Remaining in treatment for an adequate period of time is critical. The appropriate duration for an individual depends on the type and degree of the patient's problems and needs. Research indicates that most with SUD need at least 3 months in treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment. Recovery from SUD is a long-term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses into drug abuse can occur and should signal a need for treatment to be reinstated or adjusted. Because individuals often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.

11. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies. For example, methadone, buprenorphine, and naltrexone (including a new long-acting formulation) are effective in helping individuals stabilize their lives and reduce their illicit drug use. Acamprosate, disulfiram, and naltrexone are medications approved for treating alcohol dependence. For persons addicted to nicotine, a nicotine replacement product (available as patches, gum, lozenges, or nasal spray) or an oral medication (such as bupropion or varenicline) can be an effective component of treatment when part of a comprehensive behavioral treatment program.
12. Medically assisted withdrawal management is only the first stage of SUD treatment and by itself does little to change long-term drug abuse. Although medically assisted withdrawal management can safely manage the acute physical symptoms of withdrawal and can, for some, pave the way for effective long-term SUD treatment, withdrawal management alone is rarely sufficient to help individuals achieve long-term abstinence. Thus, patients should be encouraged to continue drug treatment following withdrawal management. Motivational enhancement and incentive strategies, begun at initial patient intake, can improve treatment engagement.
13. Treatment does not need to be voluntary to be effective. Sanctions or enticements from family, employment settings, and/or the criminal justice system can significantly increase treatment entry, retention rates, and the ultimate success of drug treatment interventions.

Three prevailing characteristics of SUD are that:¹⁰⁴

1. It is a chronic disease characterized by compulsive or uncontrollable drug seeking and use despite harmful consequences and changes in the brain;
2. These changes in the brain can lead to harmful behaviors; and
3. Drug addiction being a relapsing disease, there can be little surprise that “addiction affects parts of the brain involved in reward and motivation, learning and memory, and control over behavior.”

¹⁰⁴ “Treatment Approaches for Drug Addiction,” *National Institute on Drug Abuse*, July 2016, accessed October 31, 2016, <https://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction>. 1.

The steps that are widely recognized among clinical providers as being key parts of successful treatment plans include:

1. Withdrawal management (the process by which the body rids itself of a drug)
2. Behavioral counseling
3. Medication (for opioid, tobacco, or alcohol SUD)
4. Evaluation and treatment for co-occurring mental health issues such as depression and anxiety.
5. Long-term follow-up to prevent relapse. It is important to note that medication is an integral part of SUD treatment, whether for opioids, tobacco, or alcohol.¹⁰⁵ Despite SAMHSA's finding that nearly 80 percent of withdrawal management included the use of medications, this often-critical first step is not, in and of itself, constitute treatment.¹⁰⁶ Nonetheless, outcomes measurements exist, and are compiled by different means. Levels of healthcare utilization provide something of a proxy measure—clinicians and patients tend to utilize those modalities that tend to predict favorable outcomes. There are empirical studies that present conclusions about different treatments.

Despite the existence of empirical findings based on clinically measured outcomes and experience and observations of counselors and clinicians working with patients, there nonetheless exist some treatment programs that function suboptimally. Several Advisory Committee members were personally aware of treatment programs that provided insufficient therapeutic interaction with counselors, for example. Insufficient interaction is, unfortunately, often attributable to patients who fail to show up at therapy and counseling sessions.

People who get treatment: SAMHSA National Survey on Drug Use and Health: 22.5 million people (8.5 percent of the U.S. population) aged 12 or older needed treatment for an illicit drug or alcohol use problem in 2014. Only 4.2 million (18.5 percent of those who needed treatment) received any substance use treatment in the same year. Of these, about 2.6 million people received treatment at specialty treatment programs.¹⁰⁷

¹⁰⁵ Ibid.

¹⁰⁶ 2014 National Survey on Drug Use and Health: Detailed Tables, Center for Behavioral Health Statistics and Quality (CBHQ), website, 2015, accessed March 30, 2017, <https://www.samhsa.gov/data/sites/default/files/...DetTabs2014/NSDUH-DetTabs2014.pdf>.

¹⁰⁷ "Treatment Approaches for Drug Addiction," National Institute on Drug Abuse, July 2016, accessed October 31, 2016, <https://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction>. 6.

Types of Treatment Programs

The current system of care varies across the commonwealth. There are many different curricula, many different providers, different insurance providers, different treatment capacities and competencies, and different resource mixes.

“Just as not every person needs counseling, not every person needs detox in a rehab. The system need not create a bed for every person with a SUD...”

An Advisory Committee member cautioned, “Just as not every person needs counseling, not every person needs detox in a rehab. The system need not create a bed for every person with a SUD. Instead, the system needs to develop a reimbursement mechanism that can provide SBIRT to triage patients and get them into the appropriate services.”¹⁰⁸

There are many types of approaches and programs that generally cluster into several treatment modalities. Withdrawal management is often considered the first stage of treatment and is a medically monitored process that clears the body of the dangerous substances. Withdrawal management does not include treatment for psychological, social, or behavioral problems and can be carried out in either inpatient or outpatient programs, and may include administration of medications under physician supervision. “Medically managed withdrawal” is withdrawal management that includes treatment with medications. In outpatient behavioral treatment, motivational incentives/contingency management use positive reinforcement to encourage abstinence from drugs.

Other treatment modalities include:

- Therapeutic Communities (TCs)
- Short-term residential treatment
- Outpatient treatment programs
- Individualized drug counseling
- Group counseling
- Pharmacotherapy

¹⁰⁸ SR267 Advisory Committee meeting September 15, 2016.

Therapeutic Communities (TCs) are residential treatment facilities that provide 24 hour per day care that lasts from six to 12 months. The overall objective of TC is the resocialization of the patient. Components of treatment include other residents, staff, and the social context. The patient's social and psychological deficits are considered the context that frames the SUD, and treatment includes developing personal accountability, responsibility, and social productivity. Patients are guided through confronting their damaging beliefs, self-concepts, and destructive patterns to replace them with socially productive, constructive, and harmonious relationships with themselves and others.

Short-term residential treatment is relatively brief but intensive treatment that consists of three to six week treatment based on modified 12-step approaches originally developed to treat alcohol SUD. Inpatient treatment is hospital based; upon discharge patients receive continued care through outpatient programs. Patients are largely responsible for maintaining their engagement with recovery.

Outpatient treatment programs include a wide range of types of treatment that vary in intensity and services. This is often a suitable alternative to TC or short term residential treatment for people with job and family obligations. Some models include intensive day treatment, group counseling, or other treatments that are tailored to individuals' needs. The caveat is that some programs amount to little more than drug education.

Individualized drug counseling focuses on short-term individualized behavioral goals that are intended not only to reduce or eliminate illicit drug use but also to address impaired functioning in terms of job, family, and other obligations. The objectives are to provide a framework of coping strategies to abstain and maintain abstinence.

Group counseling capitalizes on social reinforcement characteristic of group settings of peer discussions. Positive outcomes are achieved when group counseling is used in conjunction with individualized counseling, cognitive behavioral therapy, or contingency management.

Pharmacotherapy may include administration of different medications to assist with withdrawal management and maintenance.

Evidence-based approaches include a number of different variants, including:

- Behavioral Therapies
- Cognitive Behavioral Therapy
- Contingency Management Interventions (CM)/Motivational Incentives
- Community Reinforcement Approach (CRA) Plus Vouchers
- Matrix Model
- 12-Step Facilitation Therapy
- Family Behavioral Therapy (FBT)

Behavioral Therapies, which help engage people in drug misuse treatment, provide incentives for them to remain abstinent, modify their attitudes and behaviors related to drug misuse, and increase their life skills to handle stressful circumstances and environmental cues that may trigger intense craving for drugs and prompt another cycle of compulsive misuse.

Cognitive Behavioral Therapy is based on the theory that addictive behaviors are learned, and that learning and applying different sets of skills can help the individual stop misusing drugs.

Contingency Management Interventions (CM)/Motivational Incentives have been shown effective by research. In these, patients are given tangible rewards to reinforce positive behaviors. *Voucher based reinforcement (VBR)* rewards patients with vouchers with monetary value, which can be exchanged for goods or services consistent with drug-free living. The voucher values increase as the patient's time of abstinence increases.

Community Reinforcement Approach (CRA) Plus Vouchers is an intensive 24 week outpatient treatment program that uses tangible incentives along with recreational, familial, social, and vocational reinforcement to make drug-free living more desirable. A computer-based CRA Plus Vouchers, Therapeutic Education System (TES) has been shown to be as effective as CRA Plus Vouchers therapy administered by a therapist.

Matrix Model is used as therapy for individuals to counter stimulants such as cocaine and methamphetamines. The therapist, acting as both coach and partner, encourages the patient to learn coping strategies to reinforce positive behavioral changes.

12-Step Facilitation Therapy is “an active engagement strategy designed to increase the likelihood of a substance misuser becoming affiliated with and actively involved in 12-step self-help groups.”

Family Behavioral Therapy (FBT) works to eliminate substance misuse problems as well as co-occurring problems that exist in the patient's family, such as child maltreatment, family conflict, unemployment, and depression.

Therapies for adolescents are intended to meet the unique needs and circumstances that characterize adolescents with SUD. Research has shown that, to be most effective, treatment therapies for adults must be modified when applied to teenagers.

- Multisystemic Therapy (MST)
- Multidimensional Family Therapy (MDFT)
- Brief Strategic Family Therapy (BSFT)
- Adolescent Community Reinforcement Approach (A-CRA)

Multisystemic Therapy (MST) addresses serious antisocial behaviors exhibited by children and teens who misuse alcohol and illicit drugs. Child, peer, and family behaviors are addressed in “natural environments” such as home, school, and neighborhood settings.

Multidimensional Family Therapy (MDFT) is very similar to MST.

Brief Strategic Family Therapy (BSFT) targets family interactions under the assumptions that family behaviors are interdependent, and seeks to identify and remediate specific behaviors that are causing the errant behaviors, such as drug abuse.

Adolescent Community Reinforcement Approach (A-CRA) is a comprehensive substance misuse therapy that focuses on family, social, and educational/vocational interactions to reinforce positive behaviors. The therapist chooses from among 17 A-CRA procedures to address such areas as problem solving, coping, and communications skills.

Medically Assisted Treatment (MAT)

In discussions with Commission staff, experts emphatically stated that, of the evidence-based and evidence-informed treatments currently in use, there is no single modality that is better than another. Just as not every heart patient requires the same treatment, so do people with SUD require individualized treatment plans to help them recover and survive. There may be considerable debate over whether MAT is appropriate or not; some people insist that MAT is little more than a substitution of licit use for illicit use; others, perhaps the majority of clinicians, regard MAT as another medical tool to be used with the same consideration

**PEOPLE WITH
SUBSTANCE ABUSE
DISORDER REQUIRE
INDIVIDUALIZED
TREATMENT PLANS.**

“Individuals with an opioid dependence diagnosis tend to benefit the least from abstinence-based programs and have the poorest outcomes compared to individuals with other alcohol or drug addictions.”

as any other medical intervention. “Detoxification is not in itself “treatment” . . . medications were used in almost 80 percent of detoxifications.”¹⁰⁹ In *Addiction Treatment Dosage: Determining an Effective Length of Treatment*, the author observed, “Individuals with an opioid dependence diagnosis tend to benefit the least from abstinence-based programs and have the poorest outcomes compared to individuals with other alcohol or drug addictions.”¹¹⁰ Further, research shows that:

. . . taking these medications as prescribed allows patients to hold jobs, avoid street crime and violence, and reduce their exposure to HIV by stopping or decreasing injection drug use and drug-related high-risk sexual behavior. Patients stabilized on these medications can also engage more readily in counseling and other behavioral interventions essential to recovery.¹¹¹

¹⁰⁹ “Treatment Approaches for Drug Addiction,” National Institute on Drug Abuse, July 2016, accessed April 3, 2017, <https://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction>.

¹¹⁰ David Loveland, PhD, *Addiction Treatment Dosage: Determining an Effective Length of Treatment*, Community Care Behavioral Health Organization, August 23, 2016. 13.

¹¹¹ “Treatment Approaches for Drug Addiction,” *National Institute on Drug Abuse*, July 2016, accessed April 3, 2017, <https://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction>.

MAT typically refers to a process in which a patient who has been assessed and thoroughly examined is prescribed medications that reduce cravings for the addicting drug or may block uptake of the addicting drug. Three medications, methadone, buprenorphine, and naltrexone, are approved by the FDA for MAT for the treatment of opioid use disorder (OUD), and are categorized as agonists, partial agonists, and antagonists. In MAT, the medications are used in combination with counseling and behavioral therapies.

Medications can reduce the cravings and other symptoms associated with withdrawal from a substance by occupying receptors in the brain associated with using that drug (agonists or partial agonists), block the rewarding sensation that comes with using a substance (antagonists), or induce negative feelings when a substance is taken. MAT has been primarily used for the treatment of opioid use disorder but is also used for alcohol use disorder and the treatment of some other substance use disorders.¹¹²

MAT is used in different settings and by different means. Methadone and buprenorphine ease withdrawal symptoms and reduce cravings for the opioids. Naltrexone blocks the effects of opioids at the receptors in the brain; it is used after withdrawal management. The most widely known MAT is the traditional methadone clinic, where clients appear daily to receive their doses as prescribed by the clinic's medical staff. Methadone clinics often use the prospect of allowing patients to have take-home doses as a reward for adhering to their individualized treatment programs. Take-home doses allow the patient to take the daily dose without having to travel to the clinic. Further, achieving permission for take-homes is recognized in the rehabilitation community as a laudable accomplishment on the part of the client.

Buprenorphine is another medication used as part of MAT. Whereas methadone can only be dispensed through a methadone clinic, buprenorphine can be prescribed and dispensed by a family doctor in his or her private practice. Buprenorphine prescribers are required by the DEA to hold a special license, whereas a special license is not required for prescribing methadone. Buprenorphine prescribers, however, do not have to be licensed for addiction treatment.

Methadone is an agonist—it occupies receptors in the brain and suppresses cravings for illicit opioids. Research shows there are a number of benefits derived from methadone use in MAT. Methadone is most effective when patients participate in individual or group counseling and receive other medical, psychiatric, and social services where necessary.¹¹³ Studies have shown that the death rate of people suffering from untreated heroin addiction may be seven-and-a-half times greater than that of those individuals who are treated with methadone.¹¹⁴

¹¹² “Treatments for Substance Use Disorders,” *SAMHSA*, website August 9, 2016, accessed March 30, 2017, <https://www.samhsa.gov/treatment/substance-use-disorders>.

¹¹³ “Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition),” *NIDA*,

¹¹⁴ Adrienne C. Lindsey, Medication-Assisted Treatment 101: Medication Overview and a Review of the Evidence, MAT Symposium, Center for Applied Behavioral Health Policy, Arizona State University, August 2014, accessed March 31, 2017, <https://cabhp.asu.edu/sites/default/files/mat-101.pdf>.

Patients in methadone MAT exhibit:

- increased treatment retention
- decreased illicit opioid use
- eight-fold to ten-fold decrease in drug related deaths
- increase in employment rates
- decrease in criminal activities¹¹⁵

Buprenorphine works because it has a much stronger affinity at the brain's receptors than other opioids do. Buprenorphine fills the receptors, thereby preventing others from binding. In some sense, buprenorphine is "stickier." Importantly, as compared to other opioids, buprenorphine lasts longer and produces less euphoric sensations. In MAT, buprenorphine's results are similar to those from methadone:

- increased treatment retention
- decreased illicit opioid use
- decrease in self-reported cravings¹¹⁶

Naltrexone is an antagonist—it blocks the effects of opioids at the receptors in the brain; it is used after withdrawal management.¹¹⁷ Naltrexone is somewhat different from methadone and buprenorphine, as it:

- prevents euphoric effects of opioids
- is non-addictive
- is available in an extended release formulation¹¹⁸

A person will not perceive any particular drug effect while taking naltrexone. Methadone, unlike naltrexone, can result in intoxication or even unintentional overdose if the dosage is not closely monitored by prescribers. Methadone, however, is affordable, is covered through government health assistance programs, and has demonstrated safety for pregnant women. Buprenorphine is easier to taper than methadone, has a lower risk of overdose than methadone, and, when formulated with naloxone, discourages opioid use because the client will experience severe withdrawal symptoms should he or she attempt to use opioids. The disadvantage of buprenorphine and buprenorphine/naloxone is that they are costly. Naltrexone's disadvantage is that of non-compliance.¹¹⁹

¹¹⁵ Ibid.

¹¹⁶ Ibid.

¹¹⁷ "Treatment Approaches for Drug Addiction," *National Institute on Drug Abuse*, website, July 2016, accessed October 31, 2016, <https://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction>. 3.

¹¹⁸ Adrienne C. Lindsey, Medication-Assisted Treatment 101: Medication Overview and a Review of the Evidence, MAT Symposium, Center for Applied Behavioral Health Policy, Arizona State University, August 2014, accessed March 31, 2017, <https://cabhp.asu.edu/sites/default/files/mat-101.pdf>.

¹¹⁹ Ibid.

In Pennsylvania, virtually all programs work with medications. There is considerable variability in two broad contexts.

1. Whether the medications are provided by the program itself or through referral agreement with another agency. It is important to remember the context that since most individuals are not dependent on opioids and do not require specialized services, it is common for programs to coordinate with specialty narcotics treatment programs (NTP). For example, it is common for a drug-free program to send an individual to a nearby NTP provider to manage the specialty regulations of medication management of the controlled substance.
2. What medications are used (narcotic, non-narcotic, etc.). Often, programs offer only one or the other of these medications. However, there is a variety of medications offered for alcohol use disorder, nicotine use disorder, and mental health conditions in the broad category of substance use disorder treatment programs. Program providers cannot address issues that exist beyond the scope of their licensed programs.

As of June 2016, there were 738 total drug and alcohol addiction treatment facilities in Pennsylvania. This number changes daily as program licenses are approved or other programs close. The state has experienced a rapid expansion of NTPs recently, with 13 opened since July 2012. This brings the total number of specialty NTPs to 76, with a capacity for serving 26,088 individuals. Most of these patients are being treated with methadone. Pennsylvania has 107 programs offering methadone and 28 programs offering Vivitrol (naltrexone). It is not known how many additional programs provide which medications through referral agreements, as described points 1 and 2 above.

Buprenorphine requires certification from the federal Drug Enforcement Agency; there are over 1,900 individuals in Pennsylvania who have received certification to treat with buprenorphine products. It is not known how many are actively prescribing, or the number of individuals in their caseloads. As discussed, the map of buprenorphine providers therefore does not mean that an individual provider is active, although the maps below can be considered for planning purposes.

Federal certification is not required for prescribers of Vivitrol, which makes it difficult to track the number of prescribers. Put another way, to determine the number of doctors prescribing Vivitrol would be similar to trying to determine the number of physicians prescribing Prozac.

The Pennsylvania emergency medical community is split over whether or not emergency physicians want to assume the function of administering buprenorphine in the ER. Any process that requires patients to remain in the ED even a minute longer than necessary is not feasible for a number of operational reasons. ED physicians would likely accept an SBIRT program if there were reimbursements for hospitals to keep patients for a day or two under observation while SBIRT is facilitated. Currently, it is highly unlikely that any hospital in the Commonwealth will institute an ED-based SBIRT program without appropriate reimbursements. Additionally, most

hospitals are not willing to, or cannot, admit patients for a two-day stay to initiate MAT under the current regulatory guidelines.¹²⁰

Among opioid-dependent patients presenting for emergency care, ED-initiated buprenorphine, compared with brief intervention and referral, significantly increased engagement in formal addiction treatment, reduced self-reported illicit opioid use, and decreased use of inpatient addiction treatment services but did not significantly decrease the rates of positive urine testing for opioids or HIV risk. Although this single-site study supports this ED-initiated treatment strategy, these findings require replication in other centers before widespread adoption.¹²¹

In other areas such as mental health, if a doctor has a psychotic patient in his ER who does not meet criteria for the BHU (behavioral health unit), the patient can instead be placed in a stabilization unit while awaiting services. Advisory Committee members suggested that the same structure could be established for SUD patients, where a patient could be transferred from the ED to a stabilization unit.

Buprenorphine is widely recognized as an efficacious, helpful, and possibly lifesaving component of SUD treatment and rehabilitation. Buprenorphine is also showing a strong propensity for diversion, and ED visits involving buprenorphine are increasing alarmingly. One doctor specializing in SUD treatment and rehabilitation noted, “By the time I see a patient who is a candidate for buprenorphine, I find he’s already been exposed to it.” In other words, an increasing number of people with SUD are turning to buprenorphine in attempts to self-treat their opioid dependence.¹²² Data show an increase in ED visits involving buprenorphine went from 3,000 in 2005 to 30,000 in 2010.¹²³

Twelve-Step Programs

Twelve-step programs are not treatment programs. Twelve-step programs are widely known for their use in helping people overcome alcohol misuse. Indeed, Alcoholics Anonymous has been nearly synonymous with 12-step recovery since its inception in the 1930s. Over the decades, 12-step programs have become widely available and provide no-cost support for SUD rehabilitation and healthful lifestyle maintenance. They are evidence-based practices and help prepare patients to use the 12-step support network throughout the treatment experience. NIDA defines 12-step therapy as “an active engagement strategy designed to increase the likelihood of a substance misuser becoming affiliated with and actively involved in 12-step self-help groups, thereby promoting abstinence.”¹²⁴

¹²⁰ SR267 Advisory Committee meeting September 15, 2016.

¹²¹ Gail D’Onofrio, MD, MS, et al, “Emergency Department–Initiated Buprenorphine/Naloxone Treatment for Opioid Dependence,” *JAMA*, 2015 Apr 28; 313(16): 1636–1644, doi: 10.1001/jama.2015.3474, accessed November 13, 2017.

¹²² Center for Substance Abuse Research, “Number of U.S. Emergency Department Visits Involving Buprenorphine Increases Nearly Ten-Fold from 2005 to 2010,” *CESAR FAX*, Vol 22, Issue 5, Center for Substance Abuse Research, University of Maryland, (College Park, MD:February 4, 2013).

¹²³ *Ibid.*

¹²⁴ “Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition),” *NIDA* website, 2012, accessed April 3, 2017, <https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition>.

Three principles form a core value system among the 12 steps:

- 1. Acceptance, which includes the realization that drug addiction is a chronic, progressive disease over which one has no control, that life has become unmanageable because of drugs, that willpower alone is insufficient to overcome the problem, and that abstinence is the only alternative.**
- 2. Surrender, which involves giving oneself over to a higher power, accepting the fellowship and support structure of other recovering addicted individuals, and following the recovery activities laid out by the 12-step program.**
- 3. Active involvement in 12-step meetings and related activities.**

NIDA concludes that, “While the efficacy of 12-step programs (and 12-step facilitation) in treating alcohol dependence has been established, the research on its usefulness for other forms of substance misuse is more preliminary, but the treatment appears promising for helping drug misusers sustain recovery.”¹²⁵ Not long after NIDA published its conclusion, researchers observed some promising evidence for accepting the efficacy of 12-step programs for SUD rehabilitation. In a research paper published in 2013, *12-Step Interventions and Mutual Support Programs for Substance Use Disorders: An Overview*, the authors studied the active involvement of people representing several demographics who were suffering SUD and the effectiveness of 12-step programs. They found a positive correlation between active involvement in 12-step programs and good outcomes for patients. Further, the authors were able to infer that successful outcomes were not attributable to variables (motivation, severity of SUD, comorbid psychopathology, prognosis) other than the intervention of 12-step. Thus, they concluded that the evidence does support, albeit does not prove, that there is a “causal pathway between 12-step attendance and abstinence.”¹²⁶

Counselors’ experiences reinforce the empirical research supporting the efficacy of 12-step programs. Nearly all those with experience in the field would concur with what one researcher concluded: “Because [12-step programs] are free, available 24/7, and provide social support for abstinence that is otherwise unavailable, they may play a role in some people’s recovery that is not easily filled by anything else.”¹²⁷

¹²⁵ Ibid.

¹²⁶ Dennis M. Donovan, et al, *12-Step Interventions and Mutual Support Programs for Substance Use Disorders: An Overview*, Social Work Public Health. 2013; 28(0): 313–332, accessed April 3, 2017, doi: 10.1080/19371918.2013.774663.

¹²⁷ Maia Szalavitz, “What I’ve Finally Concluded About 12-Step Programs After 25 Years Writing About Drugs and Addiction,” Pacific Standard website, September 24, 2014, accessed April 3, 2017, <https://psmag.com/what-i-ve-finally-concluded-about-12-step-programs-after-25-years-writing-about-drugs-and-addiction-d0ec78253cb>.

Trauma

From each patient's moment of entry, programs and providers need to assume each has a background of trauma, and necessary support systems must be available for the counselor to engage those resources. Moreover, the scope of resources cannot lump all traumatized patients together; trauma is not the same for every patient. A person who experienced sexual violence will not likely suffer the same type of trauma that a combat veteran would. The identification of trauma-related therapy as part of treatment modalities is far from being a new concept. Rather, consideration and treatment of patients' traumas have been part of SUD counseling for many years (although perhaps trauma had been more commonly addressed for patients who were treated in publicly funded programs).

Despite wide recognition that trauma counseling is crucial to most SUD patients, there is similarly widespread recognition that counselors must move cautiously when opening up a patient's trauma. To uncover trauma too quickly is to risk losing focus on sobriety. To uncover trauma too late is to risk resumption of SUD behaviors, and possibly exacerbate the problems. One clinician present at the Advisory Committee meeting stated that "sometimes a risky treatment environment is better than the risk of not being in treatment." A clinician's consideration of trauma should perhaps start with mitigation before attempting cures. Significantly, if the patient is in a program, the program's work should begin with risk assessment.

SAMHSA released TIP 57, *Trauma-Informed Care in Behavioral Health Services*, to inform providers of "Six Key Principles of a Trauma-Informed Approach," which are designed to integrate policies, procedures, and practices such that they are integrated with knowledge and understanding about trauma and effective treatments. Importantly, the principles are intended to actively resist re-traumatization.^{128, 129}

There are specific trauma-informed interventions and treatments that are known to be effective.

SAHMSA'S SIX KEY PRINCIPLES

1. Safety
2. Trustworthiness and transparency
3. Peer support
4. Collaboration and mutuality
5. Empowerment, voice, and choice
6. Cultural, historical, and gender issues

It is critical that each care provider be trained to recognize trauma in patients and, if not specifically trained in how to provide trauma-informed care, be able to refer those patients to providers who work in that capacity.

¹²⁸ SAMHSA, *A Treatment Improvement Protocol: Trauma-Informed Care in Behavioral Health Services*, <http://www.samhsa.gov/nctic/trauma-interventions>, accessed September 27, 2017.

¹²⁹ SAMHSA, *A Treatment Improvement Protocol: Trauma-Informed Care in Behavioral Health Services*, <http://www.samhsa.gov/nctic/trauma-interventions>, accessed September 27, 2017.

Effectiveness

SAMHSA directs that there be no “wrong door”: optimally, providers should be able to meet all patients’ needs, whether they be for MAT, emotional and psychological trauma care, or to accommodate criminal justice requirements. A key improvement to Pennsylvania’s SUD treatment and rehabilitation system would be to ensure that standard definitions of effective treatment be understood by all stakeholders.

National accreditation is not required in Pennsylvania. A downside to accreditation is the cost borne by the facility, which can be very burdensome for a small organization. Accrediting costs around \$1,700 per surveyor per day, or approximately \$6,000 for a triennial accreditation. Joint Commission¹³⁰ accreditation is about two-thirds more expensive than Commission on Accreditation of Rehabilitation Facilities (CARF). However, it was noted that accreditation could become more widespread if third party payers got involved in monitoring quality of outcomes and determined funding according to benchmarks: those not meeting accepted standards pose a risk as a misdirection of funding and, most significantly, the well-being of patients.

Accreditation, according to Advisory Committee members, is a process of improvement for each organization. Accreditation is not proscribed; it is intended to reflect how each provider is working to improve its outcomes. Increasingly, standards set by CARF are showing providers how to monitor “fidelity of model” for evidence-based practices (EBP): if a provider says it uses EBP, CARF will hold it to its own practices.¹³¹

Advisory committee members stressed that however important meeting accreditation standards are, fidelity of model is necessarily bounded by each provider’s individualized attention and treatment of each patient. Holding too closely to the parameters of evidence based practices risks losing the individualized care needed for successful treatment. Further, members remarked that evidence based practices are primarily applied in group therapy, whereas individualized modalities work best in one-on-one sessions. In the words of an Advisory Committee member, “The purpose of evidence-based practices is not to do the model, it’s to get the best outcome.”¹³² In other words, it is important for clinicians and policy makers to consider not only evidence-based practices, but also *practice-based evidence*. In “Practice-Based Evidence,” Anne Swisher wrote,

“The purpose of evidence-based practices is not to do the model, it’s to get the best outcome.”

¹³⁰ The Joint Commission, formerly named the Joint Commission on HealthCare Accrediting Organizations, is not to be confused with the Joint State Government Commission, often stylized “the Commission”, which was established in 1937—14 years prior to establishment of The Joint Commission.

¹³¹ Fidelity of model is a phrase used to refer to, “[T]he extent to which the delivery of an intervention adheres to the program model originally developed.” Sarah Kaye, PhD, Todd Holder, MSW, “Fidelity 101:How to Develop, Validate and Use Fidelity Measures to Inform Implementation in Child Welfare,” presentation at National Child Welfare Evaluation Summit, Washington, D.C., August 29, 2011, https://www.acf.hhs.gov/sites/default/files/cb/es2011_session_108.pdf, accessed September 29, 2017.

¹³² SR267 Advisory Committee meeting of July 12, 2016.

In the concept of Practice-Based Evidence, the real, messy, complicated world is not controlled. Instead, real world practice is documented and measured, just as it occurs, “warts” and all. It is the process of measurement and tracking that matters, not controlling how practice is delivered. This allows us to answer a different, but no less important, question than “does X cause Y?” This question is “how does adding X . . . intervention alter the complex personalized system of patient Y before me?”¹³³

Reconciling the two approaches in developing novel treatment modalities leads to debate among clinicians. Nevertheless, there is broad agreement that both evidence-based practice (the evidence having been empirically derived, documented, and peer reviewed via randomized controlled trials) and practice-based evidence (the evidence having been experienced, learned, and shared via “the real, messy complicated world” of counseling clients as they arrive at the clinic) have a role in developing and delivering the best possible treatments to patients.

Treatment is tailored to each client’s needs. For many people, initial treatment is intensive, with clients attending multiple outpatient sessions each week. As clients complete each step of their treatment plans, they can transition to less-intensive care. Clients transitioned to regular outpatient treatment meet with counselors less often and for fewer hours per week as they sustain their recovery.

Behavioral Therapies. In *Behavioral Therapies for Drug Abuse*, researchers Kathleen Carroll and Lisa Onken identified a trend that developed in the early 1990s indicating that “when behavioral therapies, therapist training, study populations, and objective outcome measures were carefully specified,” and held to the strict rigors of empirical research, the outcomes might not reach their full potentials.¹³⁴ Indeed, the empirical model, preeminent as it is for ensuring validity and repeatability, is the generally accepted standard for conducting scientific research in many disciplines, including public policy and health domains. The rigorous use of the model supports policy makers’ evidence-based and evidence-informed decisions. Yet strict adherence to empirical research, which Carroll and Onken refer to as the “technology model,” can, and did, create bottlenecks in the development of new treatments and outcomes. In their findings, “...no articulated research strategy was available to determine how those [novel] treatments might best be transferred to and administered effectively in clinical settings.”¹³⁵

¹³³ Anne K. Swisher, PT, PhD, CCS, Editor-in-Chief, “Practice-Based Evidence,” *Cardiopulmonary Physical Therapy Journal* 21.2, June 21, 2010, accessed April 4, 2017, <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2879420/>.

¹³⁴ Kathleen M, Carroll, Ph.D., Lisa S. Onken, Ph.D., “Behavioral Therapies for Drug Abuse,” *American Journal of Psychiatry* 162 (August 2005): 1452-1460. doi:10.1176/appi.ajp.162.8.1452.

¹³⁵ Kathleen M, Carroll, Ph.D., Lisa S. Onken, Ph.D., “Behavioral Therapies for Drug Abuse,” *American Journal of Psychiatry* 162 (August 2005): 1452-1460. doi:10.1176/appi.ajp.162.8.1452. 2.

From the National Institute on Drug Abuse:

Outpatient behavioral treatment includes a wide variety of programs for patients who visit a behavioral health counselor on a regular schedule. Most of the programs involve individual or group drug counseling, or both. These programs typically offer forms of behavioral therapy, such as:

- *cognitive-behavioral therapy*, which helps patients recognize, avoid, and cope with the situations in which they are most likely to use drugs;
- *multidimensional family therapy*, which was developed to help adolescents with drug abuse problems, as well as their families, addresses a range of influences on their drug abuse patterns and is designed to improve overall family functioning;
- *motivational interviewing*, which makes the most of people's readiness to change their behavior and enter treatment; and
- *motivational incentives*, including contingency management, (mentioned previously in this report), which use positive reinforcement to encourage abstinence from drugs.¹³⁶

Contingency management is the technique of providing rewards to clients who meet particular goals in their treatment plans. Rewards may include take-home doses for methadone patients. Other types of contingency management are divided into Voucher-Based Reinforcement (VBR) and Prize Incentives.

In VBR, for example, a patient may receive a voucher for every drug-free urine sample provided. The voucher has monetary value that can be exchanged for food items, movie passes, or other goods or services that are consistent with a drug-free lifestyle.¹³⁷ Voucher-based incentives demonstrate outcomes that are positively associated with successful SUD outcomes for patients: such as:

- Improved retention in treatment programs
- Reduced illicit use among sufferers of SUD with opioid addiction in MMT
- Reduced marijuana use
- Improved compliance with naltrexone maintenance¹³⁸

In an example system of Prize Incentives, participants supplying drug-negative urine or breath tests draw from a bowl for the chance to win a prize worth between \$1 and \$100. Participants may also receive draws for attending counseling sessions and completing weekly goal-related activities. The number of draws starts at one and increases with consecutive negative drug

¹³⁶ "Treatment Approaches for Drug Addiction," National Institute on Drug Abuse, website, July 2016, accessed October 31, 2016, <https://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction>. 4.

¹³⁷ "Contingency Management Interventions/Motivational Incentives (Alcohol, Stimulants, Opioids, Marijuana, Nicotine)," *Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition)*, NIDA website, December 2012, accessed March 31, 2017, <https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-0>.

¹³⁸ Kathleen M, Carroll, Ph.D., Lisa S. Onken, Ph.D., "Behavioral Therapies for Drug Abuse," *American Journal of Psychiatry* 162 (August 2005): 1452-1460. doi:10.1176/appi.ajp.162.8.1452. 3.

tests and/or counseling sessions attended but resets to one with any drug-positive sample or unexcused absence.¹³⁹

Greater reductions were found in those patients who had tasks outlined in individualized treatment programs other than drug-negative urine specimens. VBR contingency management reduces opioid use in the context of methadone maintenance. “Access to the therapeutic workplace, which provided job training and a salary, was linked to abstinence and was contingent on the participants’ producing drug-free urine specimens.”¹⁴⁰

The contingency management technique is generally successful and is considered highly effective. Practical limitations exist, however. Local treatment and rehabilitation clinics are often strapped for resources and cannot afford to sustain contingency management programs. Carroll and Onken identified four salient problems associated with CM:

1. Cost of vouchers and the need for frequent urine monitoring.
2. Effects weaken after contingencies are terminated.
3. Lower cost and non-monetary vouchers are promising but “without cost-effectiveness data,” which means policy makers and insurers are less likely to support the approach.
4. A contingency management approach does not work for a “substantial proportion” of abusers.¹⁴¹

Despite these drawbacks, Carroll and Onken concluded that “Efficacious behavioral treatments exist, and conditions for which efficacious medications exist can be treated with combinations of behavioral and pharmacological treatments that have even greater potency than either type of treatment alone.”¹⁴²

Their conclusion is consistent with that of the majority of researchers and clinicians. The most effective approaches are those that utilize various modalities, including appropriate behavioral treatments combined with MAT, depending on each individual client’s needs.

Inpatient or residential treatment can also be very effective, especially for those with more severe problems (including co-occurring disorders). Licensed residential treatment facilities offer 24-hour structured and intensive care, including safe housing and medical attention. Residential treatment facilities may use a variety of therapeutic approaches, and they are generally aimed at helping the patient progress to a drug-free, crime-free lifestyle after treatment. Three categories of residential treatment settings include:¹⁴³

¹³⁹ “Contingency Management Interventions/Motivational Incentives (Alcohol, Stimulants, Opioids, Marijuana, Nicotine),” Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition), NIDA website, December 2012, accessed March 31, 2017, <https://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/behavioral-0>.

¹⁴⁰ Kathleen M, Carroll, Ph.D., Lisa S. Onken, Ph.D., “Behavioral Therapies for Drug Abuse,” American Journal of Psychiatry 162 (August 2005): 1452-1460. doi:10.1176/appi.ajp.162.8.1452. 4.

¹⁴¹ Ibid. 4.

¹⁴² Ibid.

¹⁴³ “Treatment Approaches for Drug Addiction,” National Institute on Drug Abuse, website, July 2016, accessed October 31, 2016, <https://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction>. 5.

- Therapeutic communities are highly structured programs in which patients usually remain at a residence for six to 12 months. The entire community, including treatment staff and those in recovery, play a role in each client's recovery by influencing his or her attitudes, understanding, and behaviors associated with drug use.
- Shorter-term residential treatment typically focuses on detoxification and provides initial intensive counseling with the goal of transitioning the patient to a community-based setting.
- Recovery housing provides supervised short-term housing for patients, often following more intensive types of inpatient or residential treatment. Recovery housing can help people transition to independent life. For example, recovery housing can help them learn how to manage finances, seek employment, and connect them to support services in their communities.

Treatment Effectiveness, Cost-Effectiveness, and Cost-Benefits of Treatment

Measurement of outcomes is, first and foremost, a vital function of clinical programs in their determination of which models work best for which patients. Another important reason for assiduous measurement of outcomes is so payors can effectively direct funding, whether public, private, or self-funded, to the best treatment modalities. Despite the importance of accurate outcome measures, the answer to the underlying question of how one defines failure, relapse, and success is nearly as individualized as the presentation of each patient's SUD.

In *Effectiveness and Cost-effectiveness of Four Treatment Modalities for Substance Disorders: A Propensity Score Analysis*, the four modalities studied were inpatient programs, which are modeled on hospital care and include intensive medication and counseling for relatively short durations; residential programs, which are less reliant on medical and nonmedical professional staff and instead utilize peer counselors and a communal living experience; outpatient withdrawal management and MAT programs, which feature somewhat fewer contact hours with medical and nonmedical professional staff; and outpatient drug-free programs, which emphasize counseling rather than MAT.¹⁴⁴ Among the authors' principal findings were "only minor differences between various modalities with regard to effectiveness. Outpatient drug-free programs were the most cost-effective."¹⁴⁵

¹⁴⁴ R. Mojtabai, J. Graff Zivin, "Effectiveness and Cost-effectiveness of Four Treatment Modalities for Substance Disorders: A Propensity Score Analysis. Health Services Research," *Health Services Research*, February, 2003: 38 (1 Pt 1):233-259, accessed April 12, 2017, doi:10.1111/1475-6773.00114.

¹⁴⁵ Ibid.

David Loveland, PhD, authored *Addiction Treatment Dosage: Determining an Effective Length of Treatment*, for Community Care Behavioral Health Organization, which is one of the Behavioral Health Managed Care Organizations contracted by OMHSAS to provide health benefits coverage to Pennsylvania’s Medical Assistance beneficiaries.¹⁴⁶ Dr. Loveland reviewed longitudinal studies of opioid dependence treatments to evaluate their effectiveness. One meta-analysis of 28

Mortality rates are highest for opioid addiction when compared to other types of SUD.

studies, which covered 60 years’ worth of data, revealed that the average rate of 10 to 30 years of abstinence for opioid dependent individuals was 30 percent, while abstinence rates for alcohol, marijuana, and nicotine addictions ranged from 50 percent up to 90 percent. The indication is that opioid dependence does not disappear over time; it remains a chronic, lifelong condition. Whereas most individuals age out of other addictions, heroin dependence persists until death. Further, mortality rates are highest for opioid addiction when compared to other types of SUD.

Length of treatment is strongly correlated with successful outcomes. Loveland reported that individuals who were retained in TCs [therapeutic communities] and other long-term residential programs beyond 90 days showed significant reductions in opioid use over extended periods of time, with substantial reductions achieved at 12 months for those who remained in the TCs. . . .Published accounts found that all three levels of care, including MMT, OP, and TCs, were equally effective for men with opioid dependence with no statistical differences for those who remained in treatment beyond 90 days. . . MMT had the highest retention rates, and TCs (or other forms of LTRs) had the lowest retention rates (OP was always in the middle) across all three waves; on the other hand, TCs and other forms of long-term residential [treatment] had the best outcomes if clients remained in treatment beyond 90 days.¹⁴⁷ Most people in residential treatment are certainly among the sickest, and it may be the case that their motivation to get better is strong enough to be a contributor to their healing.

The reader is advised yet again to note the significance of 90 days of continual treatment.

The relationship between the therapist and patient accounts for at least one third of the quality of the outcome of rehabilitation.

Advisory Committee members commented that clinical research shows that the relationship between the therapist and patient accounts for at least one third of the quality of the outcome of rehabilitation, which is double the effect of any particular evidence-based practice being employed. It is difficult to imagine that quality of outcomes can be improved without providers being able to pay salaries that attract and keep good therapists who are capable of building beneficial relationships with patients.

¹⁴⁶ David Loveland, PhD, *Addiction Treatment Dosage: Determining an Effective Length of Treatment*, Community Care Behavioral Health Organization, August 23, 2016. 13.

¹⁴⁷ David Loveland, PhD, *Addiction Treatment Dosage: Determining an Effective Length of Treatment*, Community Care Behavioral Health Organization, August 23, 2016. 4-5.

The length of stay, the rapport with the therapist, and the management of extra-therapeutic needs, when combined, account for 70 percent of the quality of outcomes. These three factors are essentially affected by reimbursements. Without competitive salaries, providers cannot attract and keep therapists who develop beneficial rapport with patients. Without adequate reimbursements, patients cannot remain in a program long enough to ensure positive outcomes. Without proper case management, which often falls by the wayside because providers cannot afford to provide it, patients are unlikely to remain in a program long enough to benefit from it. Evidence-based practices are far less effective when they are applied in an environment that does not treat the patient in a comprehensive manner that includes managing extra-therapeutic needs. The end result is that the low reimbursement rate poses a barrier to the quality of treatment.

The Advisory Committee discussed an example of a particular clinic and the implementation of a therapeutic alliance model. At one point, the clinic worked toward providing the necessary services stipulated by the therapeutic alliance model. The clinic was recognized by a number of experts as being at the forefront of this approach because it comprehensively met clients' needs. However, the resources to sustain this model were not forthcoming, and the clinic was put in a position of having to curtail or eliminate some of its services.

Recognizing that all services are necessary, the clinic eventually chose to eliminate the services whose absence would cause the least amount of long-term harm to clients. Further, the administrative burden posed by behavioral health managed care organizations (BHMCO) and other oversight organizations could take between one and eight hours for a single patient, depending on the levels of care being provided. Significantly, clinic staff time spent on administrative matters is not reimbursed. More important, counselors are unable to spend time with clients when they are fulfilling administrative requirements.

Physician Health Programs

Physicians exhibit a prevalence of SUD that is closely parallel to the general population rate of 10 to 12 percent.¹⁴⁸ Studies have shown that, "Physicians with substance use disorders receive care that is qualitatively different from and reputedly more effective than that offered to the general population . . ."¹⁴⁹ The data appear to support the theory that treatments for physicians' care are indeed more effective than that received by other demographic groups.

Physicians care begins with the authority of state statutes, licensing boards, and contractual agreements that guide them toward early detection, assessment and evaluation if a substance use problem is identified, and ultimately a referral to an abstinence-based residential treatment program for 60 to 90 days. After they have completed their residential treatment, physician-patients participate in 12-step outpatient treatment. Over the course of the ensuing five years or more, status reports, including results of random drug tests, are shared with employers, insurers, and state licensing boards. Statistics show that 22 percent of physicians test positive for alcohol or drug use at any point during the five year period, and 71 percent are still employed and licensed at the end of the five year period.¹⁵⁰

¹⁴⁸ Robert L. DuPont, et al, "How Are Addicted Physicians Treated? A National Survey of Physician Health Programs," *Journal of Substance Abuse Treatment*, 37, March 2009, 1-7, doi:10.1016/j.sat.2009.03.010

¹⁴⁹ Ibid.

¹⁵⁰ Ibid.

There are five “essential ingredients” that were shown to make SUD treatment for physicians successful.¹⁵¹

1. Contingency Management. Significant positive reinforcements and significant negative consequences are demonstrate robust effects on patient outcomes. In the case of physician-patients, they keep their licenses to practice medicine so long as they remain in treatment. Further, they risk losing their licenses and risk professional disgrace if they fail to comply with treatment programs. Contingency management plans have shown similar success in other domains as well, notably in drug courts, where offenders are offered reduced sentences, alternatives to traditional incarceration, and other incentives provided that they comply with treatment programs. In contrast, the individuals face immediate incarceration and other sanctions if they fail to comply.¹⁵²
2. Frequent Random Drug Testing. Drug testing is infrequently conducted in general population treatments and not often linked to meaningful consequences. Knowing that stringent consequences will occur for failed drug tests, physician-patients acknowledge that the drug tests are powerful incentives to maintain compliance; the drug tests function, in part, as behavioral interventions.¹⁵³
3. Tight linkage between 12-Step Programs and the Abstinence Standard. The abstinence-based protocols of physician health programs include abstinence from *all* mood-altering substances. The efficacy of the linkage has been demonstrated in a number of studies.¹⁵⁴
4. Active Management of Relapses: Intensified Treatment and Monitoring. Physician-patient relapses do not typically lead to discharge from the treatment system. Rather, the patients are reevaluated and entered into different or more intensive services as indicated.¹⁵⁵
5. Continuing Care Approach. The research paper, “Setting the Standard for Recovery: Physicians’ Health Programs,” clearly identifies the need for significantly longer treatment than is provided to the general public, and further includes family members and significant others.

Treatment, support, and monitoring in traditional addiction programs lasts 30 to 90 days. This is rarely accompanied by involvement of family or significant others. The formal treatment is typically followed by passive referral to AA meetings but no continued aftercare, support, or monitoring. It is significant in this regard that although 1-year post-treatment relapse rates are typically 50% to 60%, more than 80% of those who relapse within a year do so within the first 2 to 3 months following discharge from formal treatment. Our data support the conclusion that SUDs are chronic illnesses that are best managed with ongoing care just as are other serious, chronic

¹⁵¹ Robert L. DuPont, et al, “Setting the Standard for Recovery: Physicians’ Health Programs,” *Journal of Substance Abuse Treatment*, 36, March 2009, 151-171, doi:10.1016/j.jsat.2008.01.004.

¹⁵² Ibid. 167.

¹⁵³ Ibid. 167.

¹⁵⁴ Ibid. 168.

¹⁵⁵ Ibid. 168.

illnesses. Specifically, acute care-oriented, short-term approaches have little evidence of long-term success in the treatment of SUDs. There are many novel ways of extending formal care with telephone-based or Internet-based monitoring and support and regular home visits that have been shown to reduce relapse rates and enhance long-term recovery rates. The [physician health programs] have formalized this element of sustained continuity of care and focused much of their professional resources on sustaining therapeutic contact over 5 years or longer.¹⁵⁶

The extraordinary impact of length of stay in residential treatment has been repeatedly demonstrated as one of the most beneficial components of SUD treatment and recovery. One is led to believe that to curtail a length of stay to a period shorter than what is optimal for the SUD patient is akin to stopping short a round of chemotherapy for a cancer patient in hopes that the disease had been cured by less than the necessary dose of medicine.

6. Focus on Lifelong Recovery. Support and encouragement to improve quality of lifestyle in both personal life and practice of medicine is a requisite focus of physician-patient SUD care. The authors of, “Setting the Standard for Recovery: Physicians’ Health Programs,” stated, “Mere abstinence from the use of alcohol and drugs of abuse is seldom sufficient for [physician health program] care.”¹⁵⁷

It is well-recognized that the treatment provided to physician-patients is optimal. It is state-of-the-art. It has been developed, is monitored, is improved, and has resources to help a specific population of people suffering from SUD. Further, staffing and community support are valuable assets utilized through physician health programs but are difficult to leverage for the general population. Widespread application of these best-practices to the general population is a daunting task for public health officials and treatment providers alike. The resources available to Pennsylvania state agencies, counties, and providers are no more sufficient than to ensure existing programs, let alone to develop such comprehensive and intense treatment programs as those available through physician health programs like those studied in the papers discussed above.

Yet, those same state agencies, county agencies, and providers are nonetheless capable of and deliver services that result in the best outcomes possible for each individual SUD patient. Regrettably, the epidemic outpaces the Commonwealth’s existing treatment and recovery system too often. Too many outcomes, rather than achieving the optimal, or even the good, are recorded as lost lives, victims of unrelenting disaster.

Far from portraying a dim comparison between physician health programs and services available for the general population, however, the physician health programs demonstrate which components work and why they work. These and other studies illuminate not only a path forward but a roadmap.

¹⁵⁶ Ibid. 168.

¹⁵⁷ Ibid. 168.

STANDARDS OF CARE

All opioid treatment and rehabilitation providers in Pennsylvania must comply with very detailed and specific standards of care that are promulgated by a number of entities at different levels of authority. These entities include the federal government, state government, private insurers, and accreditation agencies. While some of the following are not specific to standards of care, they do represent an overview of the rules and regulations that are applied to treatment and rehabilitation facilities, and include:

- zoning
- other local regulations
- DDAP licensing applications
- Medicaid/insurance network applications
- facility licensing
- private insurance credentialing
- SCA contracting
- license renewals
- contract monitoring

A number of entities inspect, regulate, certify, and license treatment and rehabilitation facilities. As a general example, Table 9 shows that a substance use and psychiatric hospital that provides in-patient residential and outpatient care is overseen by a number of organizations. These organizations include all three levels of government as well as national accrediting bodies and each of the insurers that provide health coverage private plans or those contracted with federal and state as managed care organizations (MCO), for example those that are contractors for HealthChoices, which is Pennsylvania's medical assistance program:

Table 9.
Typical Oversight of Addiction and Behavioral Health Hospital

FEDERAL	Department of Health and Human Services, Centers for Medicare and Medicaid Services	-
STATE	Department of Health	Division of Acute and Ambulatory Care
	Department of Drug and Alcohol Programs	Drug and Alcohol Program Licensing
	Department of Human Services	Office of Mental Health and Substance Abuse Services
COUNTY	Single County Authorities	-
THE JOINT COMMISSION	-	-
PRIVATE HEALTH INSURERS	Each health insurer that provides coverage at the hospital	-

Department of Drug and Alcohol Programs (DDAP)

The DDAP annual report for 2016-2017 highlights six goals of the department.¹⁵⁸

Goal 1 - Develop State Plan for substance use disorders and problem gambling.

Goal 1 has five components that address data and information collection and analyses. Cost benefit analyses and evidence based planning are significant aspects in the development of the state plan, and fulfill the requirements of Act 50. This goal includes both gathering input from SCAs to identify promising approaches to SUD and establishing guidelines to assist SCAs in developing their own plans, which further illustrates the synergistic relationship between DDAP and SCAs.

Goal 2 - Gather and analyze trending data in order to maximize the effectiveness of efforts in prevention, intervention, treatment and recovery.

Goal 2 focuses on data gathering processes that have capacity to provide routine updates for optimal monitoring, analyses, and evaluation. As with Goal 1, the collaboration between DDAP and SCAs is sustained and strengthened by effective and efficient sharing of information. This goal focuses on maintaining the most effective mechanisms for DDAP to serve as an information clearinghouse and expert advisor not only to SCAs but also to prevention providers, state agencies, and the public. This is of significant importance with regard to oversight of treatment modalities and the sharing of best practices and evidence-based and evidence-informed treatments.

Goal 3 - Identify and promote best practices and policies to ensure full access to high quality and cost effective prevention, intervention, treatment and recovery support services.

Goal 3 is focused on across-the-board access to information for everyone connected to SUD. To meet this goal, DDAP develops and provides prevention resources and outreach materials to the public. The Department develops resources and materials that are focused on different populations, such as pregnant women and women with children; older adults; and veterans. DDAP collaborates with the respective state agencies—PDE, DHS, PDA, and DMVA—to best provide for these demographic groups. DDAP also maintains close relationships with the medical community along the same lines.

Policy makers are frequently concerned with the quality and effectiveness of SUD services, particularly with regard to the delivery of MAT and alternatives. DDAP's annual report explicitly details its goals to develop clinical standards and evidence-based curricula, and its commitment to the implementation of standards in local drug and alcohol addiction planning, in treatment facilities, and in grants and contracts to providers. Further, Goal 3 includes development and dissemination of improved interventions and drug detection methods.

¹⁵⁸ *Pennsylvania Drug and Alcohol Annual Plan and Report: Drug and Alcohol Abuse Prevention and Treatment 2016-2017*, DDAP, accessed March 27, 2017, <http://www.ddap.pa.gov/Reports/State%20Plan%20and%20Annual%20Reports/2015-2016%20DDAP%20State%20Plan%20and%202013-2014%20Report.pdf>. 14.

Goal 4 - Increase effectiveness of Pennsylvania's drug, alcohol and gambling prevention and treatment efforts by promoting and establishing federal, state and local collaboration.

Goal 4 is met when DDAP works productively with other agencies. Of course, the close partnership with SCAs continues under this goal. Also included in Goal 4 is DDAP's work with those agencies concerning specific demographic populations, such as Pennsylvania Commission on Crime and Delinquency (PCCD), Department of Corrections (DOC), and DHS. This goal also covers DDAP's cooperation with a number of Pennsylvania's provider associations. Significantly, the Department maintains open lines of communication with people who are in recovery from SUD and works closely with organizations that support and advocate for the individuals who are the principal clients, the *raison d'être* for the existence of the entire drug and alcohol addiction system.

Goal 5 - Develop, and expand, a highly competent, dedicated and efficient workforce and infrastructure to ensure the Department accomplishes its mission and achieves its goals.

Goal 5 includes DDAP's efforts to assess current training and development of its staff, partners, and collaborating organizations. The Department provides training courses and materials for stakeholders in the criminal justice system, as well.

Goal 6 - Ensure a system of continuous quality improvement (CQI).

Finally, Goal 6 covers the Department's efforts to ensure that the entire system of substance abuse prevention and treatment is continually monitored, evaluated, and modified to improve the effectiveness, efficiency, and quality of the services that are provided to individuals who suffer from SUD. This includes routine examination of existing regulations, from which DDAP initiates regulatory modifications when necessary. As with each of the previous five goals, Goal 6 similarly features close collaboration with the SCAs, other state agencies, providers, and community partners to incentivize compliance, maintenance of high quality standards, and utilization of best practices. Of significant importance to SR267, the Department ensures many aspects of meeting Goal 6 through its licensing of providers.

PA Open Beds. One notable program in particular is PA Open Beds, which was piloted in 2016 between DDAP and the Pennsylvania Association of County Drug and Alcohol Administrators. PA Open Beds is an information sharing platform that connects the department, the SCA, and licensed non-hospital detoxification and inpatient residential treatment providers so that they can share information about available beds. Making such information available allows navigators to quickly and efficiently direct patients to appropriate providers who have bed space to accept them. Because of the pilot program's success, PA Open Beds was able to launch statewide.

Navigators

A person with a medical health problem can usually find help simply by calling a doctor's office, visiting a clinic, or at worst going to a hospital emergency room. For those with behavioral health problems, however, particularly substance use disorders, navigating the professional care system can prove insurmountable for both privately insured individuals and beneficiaries of medical assistance programs.

For those with SUD, navigating the professional care system can prove insurmountable.

Private insurers continually work to improve the way they provide information to subscribers and at least some of them fill the role of navigator for their subscribers. As navigators, their purpose is to provide information on covered services and direct customers to appropriate resources within the system. The state's current system has been able to build connections between services but sometimes patients are passed from one provider to another too quickly, meaning without appropriate communication, care, and follow-up by the providers. The SCAs are moving into a navigator role for Pennsylvania residents who are beneficiaries of medical assistance as Medicaid expansion opens more doors for people who need coverage. The new Opioid Use Disorder-Centers of Excellence and the still-newer Pennsylvania Coordinated Medication-Assisted Treatment (PacMAT) programs may prove to be models that can divert patients from potentially fatal overdose to allow them to stabilize and then connect them with the right resources at the moment of crisis.

Department of Health (DOH)

The DOH website defines the differences between licensure and certification in Pennsylvania:

Licensure permits the facility to operate in Pennsylvania. Certification permits the facility to claim and receive payment for services rendered from the Medicare and Medicaid programs. The Department of Health, as state licensing agency and State Survey Agency for the U.S. Centers for Medicare and Medicaid Services (CMS), conducts both routine and special inspections of health care facilities to determine ongoing compliance with regulatory requirements which is a condition of licensure and certification. If, during an inspection, the Department determines a facility does not meet regulatory requirements for licensure and certification, the Department notifies the facility in a Statement of Deficiencies. Health care facilities are required to submit a Plan of Correction in response to the Statement of Deficiencies. The Plan of Correction is mandatory, regardless of whether the facility agrees with Department findings or not, and is the means by which the Department monitors and ensures correction of deficiencies. As long as the facility submits a Plan of Correction, the facility may continue to operate and receive Medicare and Medicaid payment, while deficiencies are being corrected. A

Plan of Correction, for purposes of licensure and certification, is not an admission of wrongdoing on the part of the facility.¹⁵⁹

The Division of Drug and Alcohol Program Licensure's main mission is to ensure that the citizens of the Commonwealth are afforded the appropriate treatment for their drug and/or alcohol misuse or addiction within a safe environment. As such, the Division is the regulatory agency responsible for the licensure of drug and alcohol addiction facilities operating in the Commonwealth. All persons, partnerships, corporations, or other legal entities intending to provide drug and alcohol addiction treatment services are required to be licensed for the specific drug and alcohol addiction activity or activities being provided. A drug and alcohol addiction setting may be either free-standing or under the administration of a health care facility. Drug and alcohol addiction treatment and rehabilitation settings for which licensure is required include:

Freestanding treatment facility - a setting in which drug and alcohol addiction treatment services take place that is not located in a health care facility. The majority of drug and alcohol addiction services are delivered in a freestanding treatment facility.

Inpatient hospital - the provision of withdrawal management or treatment and rehabilitation services, or both, 24 hours a day, in a hospital. The hospital shall be licensed by the Department (of Health) as an acute care or general hospital.

Inpatient non-hospital - a non-hospital, residential facility, providing one or both of the following services: treatment and rehabilitation or withdrawal management. The client resides at the facility.

Inpatient non-hospital transitional living - the provision of supportive services in a semi-protected home-like environment to assist a client in his gradual reentry into the community. No formal treatment (counseling/psychotherapy) takes place at the facility. This is a live-in/work-out situation.

Intake, evaluation and referral - the provision of intake and referral by a facility designated by the Single County Authority to perform those services centrally for two or more facilities within that Single County Authority. A Single County Authority (SCA) is the county level of government or its designee responsible for planning, funding and administering drug and alcohol addiction activities in a specific county or joinder of counties.¹⁶⁰

Outpatient - the provision of counseling or psychotherapeutic services on a regular and predetermined schedule. The client resides outside the facility.

¹⁵⁹ "D&A Facility Locator Page," *Pennsylvania Department of Health*, accessed April 12, 2017, <http://sais.health.pa.gov/commonpoc/Content/PublicWeb/DAFind.aspx>.

¹⁶⁰ A joinder is defined as two or more counties acting in concert to establish a county program.

Partial hospitalization - the provision of psychiatric, psychological, social and other therapies on a planned and regularly scheduled basis. Partial hospitalization is designed for those clients who would benefit from more intensive services than are offered in outpatient treatment projects, but who do not require 24 hour inpatient care.

Psychiatric hospital - the provision of withdrawal management or treatment and rehabilitation services, or both, 24 hours a day, in a psychiatric hospital. The psychiatric hospital shall be approved as such by the Department of Public Welfare.

The following is excerpted from the Pennsylvania Department of Health's website:

Licensing Specialists for the Division of Drug and Alcohol Program Licensure inspect drug and alcohol addiction treatment facilities in the Commonwealth to determine compliance with state licensure regulations. Minimally, an annual inspection is conducted for licensure renewal. Inspections may also be conducted for other reasons including plan of correction follow up, investigation of a complaint or unusual incident, follow-up on an intent to show cause order, and monitoring for the facility's compliance with state and Federal narcotic treatment regulations.

Should the Department determine that there are violations of a regulation, a Statement of Deficiencies (2567 report) is issued to that facility. The Statement of Deficiencies includes the regulation violated and the Department's findings relative to the violation as well as an explanation of what is needed for compliance. The drug and alcohol addiction facility is required to prepare a written plan of correction detailing how the violation will be corrected, when the violation will be corrected, and who is responsible for ensuring the violation is corrected.

Information about a specific site inspection becomes available to the public approximately 45 days following the completion of the licensure inspection. The DDAP website is updated daily.

Based on the findings during an on-site renewal inspection, each facility is granted a new or renewal licensure. Full licensure is issued for up to a one year period when it has been determined that licensure requirements have been met. Provisional licensure is issued for up to a six-month period when the requirements have been substantially, but not completely, met. Provisional licensure may be renewed no more than three times (four consecutive) or exceed a two-year period.¹⁶¹

The responsibilities and authority of DDAP to regulate and ensure appropriate treatment of people with SUD are listed in Chapters 704, 705709, 710, 711, and 715 of Title 28 "Health and Safety" and are shown in Table 10.

¹⁶¹ Pennsylvania Department of Health Drug and Alcohol Facility Drug and Alcohol Facilities Inspection Results, http://sais.health.pa.gov/commonpoc/Content/PublicWeb/DADefinitionsInspect.aspx?exit_date=03/15/2016.

Table 10.

Regulation of Substance Abuse Disorder Treatment

Chapter	Regulation
704	Staffing Requirements for Drug and Alcohol Treatment Activities
705	Physical Plant Standards
709	Standards for Licensure of Freestanding Treatment Facilities
710	Drug and Alcohol Services
711	Standards for Certification of Treatment Activities Which are a Part of a Health Care Facility
715	Standards for Approval of Narcotic Treatment Program

Aside from the regulations applied to the facilities, their management, and the administration of SUD programs, the regulations related to direct care are most pertinent to SR267.

Section 704.7 addresses the required qualifications for the position of counselor, which include:¹⁶²

- (a) Drug and alcohol treatment projects shall be staffed by counselors proportionate to the staff/client and counselor/client ratios listed in §704.12 (relating to full-time equivalent (FTE) maximum client/staff and client/counselor ratios).
- (b) Each counselor shall meet at least one of the following groups of qualifications:
 1. Current licensure in this Commonwealth as a physician.
 2. A master's degree or above from an accredited college with a major in chemical dependency, psychology, social work, counseling, nursing (with a clinical specialty in the human services) or other related field which includes a practicum in a health or human service agency, preferably in a drug and alcohol setting. If the practicum did not take place in a drug and alcohol setting, the individual's written training plan shall specifically address a plan to achieve counseling competency in chemical dependency issues.
 3. A bachelor's degree from an accredited college with a major in chemical dependency, psychology, social work, counseling, nursing (with a clinical specialty in the human services) or other related field and one year of clinical experience (a minimum of 1,820 hours) in a health or human service agency, preferably in a drug and alcohol setting. If a person's experience did not take place in a drug and alcohol setting, the individual's written training plan shall specifically address a plan to achieve counseling competency in chemical dependency issues.

¹⁶² 28 Pa. Code § 704.7.

4. An associate degree from an accredited college with a major in chemical dependency, psychology, social work, counseling, nursing (with a clinical specialty in the human services) or other related field and two years of clinical experience (a minimum of 3,640 hours) in a health or human service agency, preferably in a drug and alcohol setting. If a person's experience was not in a drug and alcohol setting, the individual's written training plan shall specifically address a plan to achieve counseling competency in chemical dependency issues.
5. Current licensure in this Commonwealth as a registered nurse and a degree from an accredited school of nursing and one year of counseling experience (a minimum of 1,820 hours) in a health or human service agency, preferably in a drug and alcohol setting. If a person's experience was not in a drug and alcohol setting, the individual's written training plan shall specifically address a plan to achieve counseling competency in chemical dependency issues.
6. Full certification as an addictions counselor by a statewide certification body which is a member of a national certification body or certification by another state government's substance abuse counseling certification board.

Department of Corrections

The Department of Corrections provides treatment for an enormous number of offenders who are suffering from SUD, many of whom are in prison as a result of their substance abuse. SUD treatment is provided as a means of supporting healthy prison populations, as a means of complying with inmate's sentences if the sentences include completion of treatment programs as specified by drug court decisions, and, importantly, to prepare reentrants as they return to their communities.

In Pennsylvania, of the 50,756 total offenders in state corrections, well over half (65 percent were male and 68 percent were female) required some type of alcohol and other drug (AOD) treatment in 2014.

Males

41.6 percent need intensive AOD treatment
 23.5 percent need outpatient treatment
 34.9 percent do not need AOD treatment

Females

55.8 percent need intensive AOD treatment
 12.3 percent need outpatient treatment
 32.0 percent do not need AOD treatment

Since 2014, Vivitrol treatment has been provided to female inmates in state correctional institutions (SCIs). As of June 2017, it has been made available to male inmates at a number of SCIs. The DOC's goal is to provide Vivitrol for those inmates for whom it is appropriate at all of the departments SCIs.¹⁶³

A major obstacle in the way of successful outcomes for people with SUD is that the continuum of care is often interrupted or halted entirely prior to their reaching their goals. Such obstacles are all the more significant when faced by those who are reentering their communities after having been incarcerated. In order to sustain whatever progress inmates make while in prison, DOC and DHS have collaborated to create a process ensuring that Medical Assistance (MA) benefits are in place for reentrants on the date of their release. The SCI completes the DHS COMPASS application for the reentrant prior to the scheduled release date. Upon receipt, the County Assistance Office (CAO) processes the application. If the individual is eligible, MA is authorized no sooner than seven days prior to the individual's release date from the SCI, using the release date as the MA begin date. According to DOC, this partnership has resulted in the development of a more effective and expedited continuum of care.¹⁶⁴

Pennsylvania Courts

Nationally,

- 80 percent of criminal offenders abuse alcohol or other drugs;
- 50 percent of jail and prison inmates are clinically addicted; and
- 60 percent of individuals arrested for most types of crimes test positive for illicit drugs at arrest.¹⁶⁵

Drug courts, along with Veterans courts, mental health courts, and others are types of specialty courts that have been developed over the past two to three decades for the purposes of diverting certain offenders from the traditional criminal justice system. It had been demonstrated that some demographic groups exhibit behaviors and live in circumstances that put them at risk for engaging in criminal activities that they would not engage in if their circumstances could be improved. Thus, the intent of specialty courts is to provide court-directed treatments and supports to help the people improve their lives and reduce or avoid incarceration, and to substantially reduce the governmental and societal expenses. Treatment is less expensive than incarceration; people are more likely to be contributing members of society if they are not in prison.

¹⁶³ DOC, "Medication Assisted Treatment," website, June 15, 2017, <http://www.cor.pa.gov/General%20Information/Pages/Medication-Assisted-Treatment.aspx>, accessed September 20, 2017.

¹⁶⁴ DOC, "Medication Assisted Treatment," website, June 15, 2017, <http://www.cor.pa.gov/General%20Information/Pages/Medication-Assisted-Treatment.aspx>, accessed September 20, 2017.

¹⁶⁵ NADCP, "Drugs and Crime in America: Drug Courts Significantly Reduce Crime," <https://www.nadcp.org/learn/drug-courts-work/drugs-and-crime-america>, accessed December 5, 2017.

Specialty courts function on an agreement of trust between the court and the person found guilty: the criminal justice system will structure the sentence in such a way as to allow the person reduced prison time if he or she fulfills an obligation to successfully complete a curriculum of treatment.

The NADCP describes drug courts in particular as

Judicially-supervised court dockets that strike the proper balance between the need to protect community safety and the need to improve public health and well-being; between the need for treatment and the need to hold people accountable for their actions; between hope and redemption on the one hand and good citizenship on the other.

Drug Courts keep nonviolent drug-addicted individuals in treatment for long periods of time, supervise them closely. Clients receive the treatment and other services they require to stay clean and to lead productive lives, but they are also held accountable by a judge for meeting their own obligations to society, themselves and their families. They are regularly and randomly tested for drug use, required to appear in court for the judge to review their progress, and receive rewards for doing well and sanctions for not living up to their obligations.¹⁶⁶

Offenders who successfully complete the program have a recidivism rate of 25 percent, as compared to a recidivism rate of approximately 60 percent to 80 percent for those who do not go through problem-solving courts. Moreover, without treatment services while they are incarcerated, approximately 95 percent of former inmates return to drug abuse after release from prison. The Pennsylvania court system has, in some counties, problem-solving courts that divert offenders to specialized programs designed to avoid or mitigate sentences. (Not all counties in PA have the resources to establish problem-solving courts at this point.) Offenders who are suffering from mental health or SUD in a county with problem-solving courts are diverted from traditional sentencing and into recovery and rehabilitation programs. Offenders who successfully complete a drug treatment program as an alternative to the criminal justice system may earn the possibility of parole and reduced charges. The problem-solving courts' success, however, is a consequence of the quality and availability of treatment. Further, there is not a standard mode of treatment at the county jails.

Pennsylvania's Juvenile Court Judges' Commission, the Pennsylvania Council of Chief Juvenile Probation Officers, and the Pennsylvania Commission on Crime and Delinquency work with each county to provide addiction services to young people with SUD in the juvenile justice system through the Juvenile Justice System Enhancement Strategy. Assessments and identifications are improving, and stakeholders are ensuring that juvenile offenders are receiving treatments for the duration of their sentences.¹⁶⁷

¹⁶⁶ NADCP, "Drugs and Crime in America: Drug Courts Significantly Reduce Crime," <https://www.nadcp.org/learn/drug-courts-work/drugs-and-crime-america>, accessed December 5, 2017.

¹⁶⁷ Advisory Committee meeting

Drug courts have proven themselves to be cost-effective means of accomplishing a number of objectives. First and foremost, they are fully integrated with the criminal justice system and carry out their role and associated obligations as such. Where the drug courts differ from traditional criminal courts is in how they meet their special obligations to reduce crime, reduce drug abuse, and save money. The National Association of Drug Court Professionals (NADCP) reports that drug courts reduce crime by up to 45 percent more than other sentencing options. Translated into dollars, it is estimated that every \$1 spent in drug courts offsets up to \$27 in costs associated with victimization, healthcare utilization, and other expenses.¹⁶⁸ For fiscal year 2017-2018, the Pennsylvania Commission on Crime and Delinquency (PCCD) was appropriated \$3.4 million to support and expand drug courts. According to the Governor’s Budget Request, the appropriation will also be used for

Communities that are seeking state accreditation to root their practices in evidence-based strategies or communities looking to expand treatment strategies to divert offenders into more meaningful treatment and recovery. Funding will also be available for counties that are looking to implement drug courts for the first time. In addition, a portion of these funds will be allocated to the Administrative Office of Pennsylvania’s Courts to provide assistance to communities with existing drug courts.¹⁶⁹

With respect to the interests of the SR267 Advisory Committee, the most important facets of drug courts are their abilities to keep patients in compliance with treatment programs. According to NADCP, 70 percent of offenders drop out of treatment unless held accountable by a judge, and drug courts are six times more likely to keep offenders in treatment long enough to reach successful outcomes.¹⁷⁰

Drug courts are six times more likely to keep offenders in treatment long enough to reach successful outcomes.

Drug courts reduce crime by up to 45 percent more than other sentencing options.

Pennsylvania first established drug courts in 1997, in the counties of Chester, Philadelphia, and York. Currently, 46 counties have drug court programs that specialize in particular cases, such as of families, juveniles, and veterans. Table 11 shows the counties with drug courts and the year they were established.

¹⁶⁸ NADCP, “The Verdict Is In,” website, <http://www.nadcp.org/learn/facts-and-figures>, accessed September 20, 2107.

¹⁶⁹ Pennsylvania Governor’s Executive Budget 2017-2018, E2-14, <http://www.budget.pa.gov/PublicationsAndReports/CommonwealthBudget/Pages/default.aspx>, (Accessed December 4, 2017).

¹⁷⁰ NADCP, “The Verdict Is In,” website, <http://www.nadcp.org/learn/facts-and-figures>, accessed September 20, 2107.

Table 11.
County Drug Courts and Year Established Pennsylvania
2017

<u>County</u>	<u>Year</u>
<u>Adult Drug Courts</u>	
Allegheny	1998
Berks	2005
Blair	2005
Bucks	2010
Butler	2011
Chester	1997
Columbia/Montour	2010
Delaware	2008
Erie	2000
<u>Adult Drug Courts continued</u>	
Franklin	2017
Indiana	2007
Lackawanna	2000
Lancaster	2005
Lawrence	2012
Luzerne	2006
Lycoming	1998
Montgomery	2006
Northampton	2015
Northumberland	2005
Philadelphia	1997
Potter	2015
Schuylkill	2017
Snyder/Union	2008
Tioga	2017
Venango	2016
Warren	2010
Washington (Co-occurring)	2005
Westmoreland	2015
York	1997
<u>Regional Drug Court</u>	
RDC – Elk, Forest, Jefferson	2017
<u>Re-entry Drug Court</u>	
Blair	2001
<u>Recovery Drug Court</u>	
Blair	2000
Chester	2007

Table 11.
County Drug Courts and Year Established Pennsylvania
2017

County	Year
<u>Adult Drug/DUI Hybrid Courts</u>	
Bradford	2006
Clarion	2007
Clinton	2014
Cumberland	2006
Dauphin	2008
Mifflin	2011
Wayne	2017
Wyoming/Sullivan	2007
<u>Family Drug Courts</u>	
Blair	2007
Erie	2011
Lackawanna	2003
<u>Juvenile Drug Courts</u>	
Blair	2009
Lackawanna	2002
Lycoming	2004
Mifflin	2006
Northumberland (co-occurring)	2011
Philadelphia	2004
York	2001
<u>Veterans Courts</u>	
Allegheny	2009
Beaver	2013
Berks	2010
Butler	2012
Cambria	2013
Carbon	2017
Chester	2011
Clinton	2016
Dauphin	2011
Delaware	2012
Erie	2015
Fayette	2012
Lackawanna	2009
Lancaster	2012
Mercer	2014
Montgomery	2011
Northumberland	2011
Philadelphia	2010
Washington	2011
York	2012

Single County Authorities

Single County Authorities (SCAs) are the Commonwealth's local administrators of publicly funded drug and alcohol addiction programs. Pennsylvania established the Single County Authorities (SCAs) in 1979 through regulations promulgated under the authority of Act 63 of 1972, Pennsylvania Drug and Alcohol Abuse Control Act.¹⁷¹ Act 63 requires that DDAP develop annual plans for drug and alcohol addiction abuse prevention and treatment, and SCAs are charged with carrying out the annual plans at the local level.¹⁷² There are currently 47 SCAs that are located throughout the Commonwealth, as listed below.¹⁷³ Several thinly-populated counties have formed jointures to combine staff, funding, and resources.

1. Allegheny County Department of Human Services/Office of Behavioral Health/Bureau of Drug and Alcohol Services
2. Armstrong-Indiana-Clarion Drug and Alcohol Commission, Inc.
3. Beaver County Behavioral Health Drug and Alcohol Program
4. (Bedford) Personal Solutions, Inc.
5. Berks County Council on Chemical Abuse
6. Blair County Drug and Alcohol Program, Inc.
7. Bradford/Sullivan Drug and Alcohol Programs
8. Bucks County Drug & Alcohol Commission, Inc.
9. Butler County MH/MR Drug and Alcohol
10. Cambria County MH/MR Drug and Alcohol Program
11. Cameron Elk McKean Counties Alcohol and Drug Abuse Services Inc.
12. Carbon Monroe Pike Drug and Alcohol Commission
13. Centre County Office MH/MR Drug and Alcohol
14. Chester County Department of D&A Services
15. Clearfield Jefferson Drug and Alcohol Commission
16. Columbia Montour Snyder Union Drug and Alcohol Program
17. Crawford County D&A Executive Commission, Inc.
18. Cumberland Perry Drug and Alcohol Commission
19. Dauphin County Department of Drug and Alcohol Services
20. Delaware County Office of Behavioral Health
21. Erie County Office of Drug and Alcohol Abuse
22. Fayette County Drug and Alcohol Commission Inc.
23. Forest -Warren Human Services D&A Program
24. Franklin Fulton County Drug and Alcohol Program
25. Greene County Human Services Program
26. Juniata Valley Tri-County Drug and Alcohol Abuse Commission
27. Lackawanna/Susquehanna Office of Drug and Alcohol Programs
28. Lancaster County Drug and Alcohol Commission
29. Lawrence County Drug and Alcohol Commission Inc.
30. Lebanon County Commission on Drug and Alcohol Abuse
31. Lehigh County Drug & Alcohol Services
32. Luzerne Wyoming Counties Drug and Alcohol Program
33. Lycoming Clinton West Branch Drug and Alcohol Abuse Commission
34. Mercer County Behavioral Health Commission Inc.

¹⁷¹ Act of April 14, 1972 (P.L.221, No.63). These regulations were adopted June 15, 1979 and were published in 9 Pa.B. 1862, Dec. 31, 1979.

¹⁷² "Membership Directory," PACDAA website, revised February 9, 2017, accessed march 23, 2017, <http://www.pacdaa.org/Pages/About-Us.aspx>

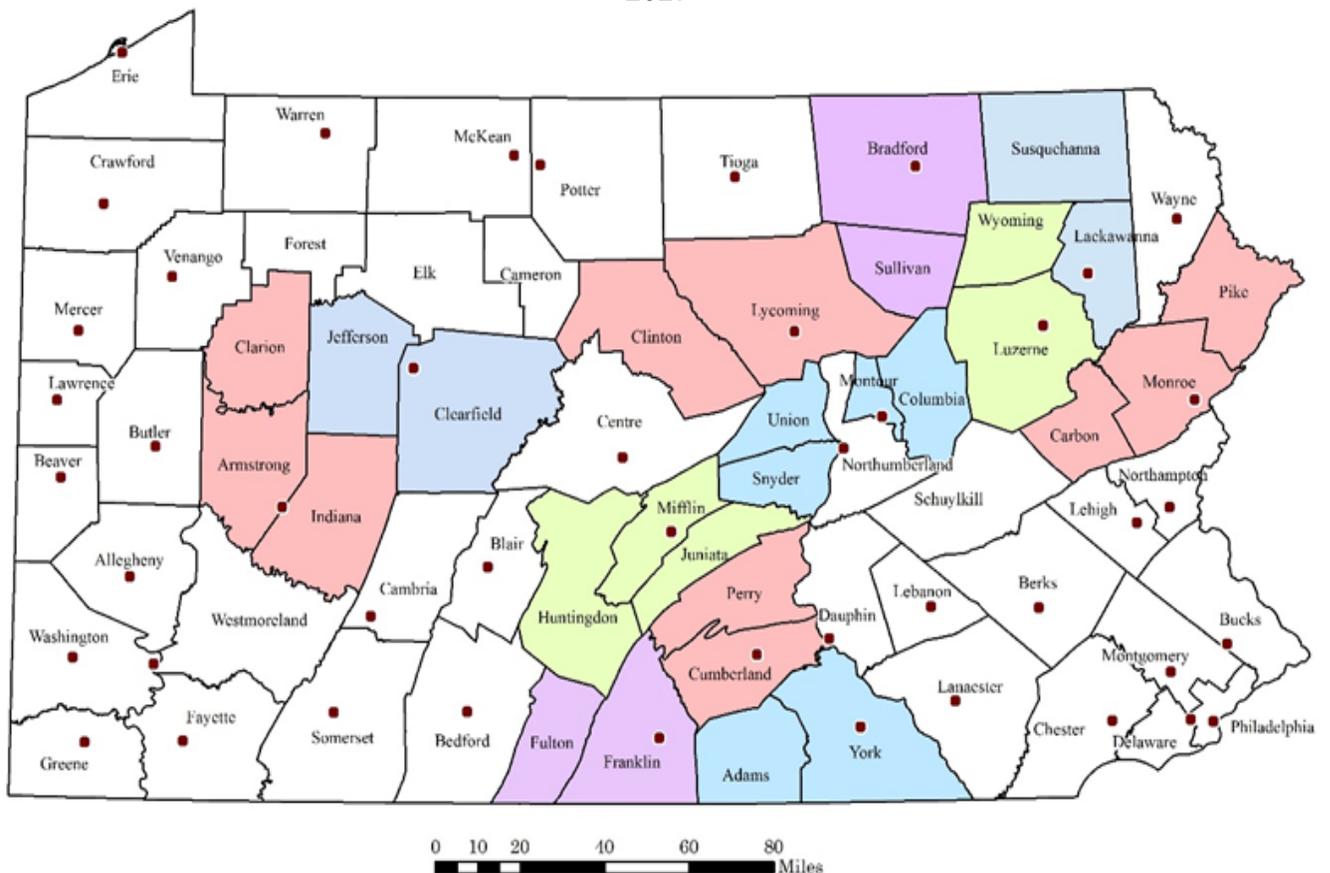
¹⁷³ Ibid.

- 35. Montgomery County Department of Behavioral Health and Developmental Disabilities
- 36. Northampton County D&A Division
- 37. Northumberland County BH/IDS
- 38. Philadelphia Office of Addiction Services
- 39. Potter County Drug and Alcohol
- 40. Schuylkill County Drug and Alcohol
- 41. Somerset County Drug and Alcohol Commission
- 42. Tioga County Department of Human Services
- 43. Venango County Substance Abuse Program
- 44. Washington D&A Commission, Inc.
- 45. Wayne County Drug and Alcohol Commission
- 46. Westmoreland Drug and Alcohol Commission, Inc.
- 47. York Adams Drug and Alcohol Commission

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Map 7.

Pennsylvania Single County Authorities 2017



¹⁷⁴ “Get Help Now | County Services,” DDAP website, accessed March 23, 2017, <https://apps.ddap.pa.gov/gethelpnow/CountyServices.aspx>

The SCAs' powers and duties are found in Section 254.4 "Powers and duties of the SCA," of Title 4 of the Pennsylvania Code:

1. To review and evaluate drug and alcohol addiction services, projects and special problems in relation to the incidence and prevalence of drug and alcohol abuse.
2. To prepare the annual Comprehensive Drug and Alcohol Treatment and Prevention Plan.
3. To review and amend, on an annual basis, the Comprehensive Drug and Alcohol Treatment and Prevention Plan.
4. To recommend approval of projects and any other matters related to drug and alcohol addiction services in the county.
5. To assist the Council in the evaluation of drug and alcohol treatment, intervention and prevention projects through the implementation of the UDCS in all projects in the county.
6. To conduct unique evaluation of SCA funded projects in accordance with guidelines approved by the Council.
7. To prescribe, amend, and repeal bylaws governing the manner in which business is conducted and the manner in which the powers granted to it are exercised.
8. To submit the Annual Plan to the county commissioners for approval.
9. To monitor compliance/performance of service providers relative to uniform policies, regulations, contractual obligations, and goals/objectives.¹⁷⁵

Members of the Advisory Committee are staunch proponents of the SCAs, and discussed the SCAs benefits at length during the course of their tenure. The SCAs are able to meet and accommodate extra-therapeutic needs better than any other entity in the Commonwealth.

The Single County Authorities are able to meet and accommodate extra-therapeutic needs better than any other entity in the Commonwealth.

Moreover, SCAs have an established infrastructure with the independence to make unbiased referrals for services. The SCAs appropriately assess and triage patients because of the comprehensive array of services available through their network of providers. Every patient who enters treatment through an SCA is assigned to a case manager, and SCA staff is able to meet people wherever they are needed, whether in hospitals, jails, shelters, or Children & Youth facilities.

¹⁷⁵ Title 4 Administration, Chapter 254. Single County Authorities, § 254.4, "Powers and duties of the SCA."

Critically, SCAs connect patients with recovery mentors, those individuals who have experienced addiction and achieved successful outcomes. Without meeting the extra-therapeutic needs, patients are left in a vacuum. In a nutshell, SCAs shepherd patient through clinically appropriate services in an environment of limited resources. To meet these responsibilities, SCAs contract with the Department of Drug and Alcohol Programs (DDAP) to receive state and federal funding to “plan, coordinate, programmatically and fiscally manage and implement the delivery of drug and alcohol prevention, intervention, and treatment services at the local level.”¹⁷⁶

Critically, SCAs connect patients with recovery mentors, those individuals who have experienced addiction and achieved successful outcomes.

To qualify for DDAP funding, the SCAs are required to use SAMSHA’s Strategic Planning Framework (SPF)¹⁷⁷

1. **Data driven:** The SPF uses data to help providers identify existing and emerging SUD problems in their communities, to help identify the best ways to address the problems, and to evaluate the effectiveness of the interventions.
2. **Dynamic:** The SPF is iterative. It allows providers to evaluate the validity and effectiveness of their plans, inputs, outputs, and interventions so as to make as-needed modifications to improve outcomes in their communities.
3. **Focused on population-level change:** The entire community population must be considered when prevention and treatment interventions are implemented. Multiple strategies must be employed at their respective population points to address risk and protective factors that exist across the entire community.
4. **Intended to guide prevention efforts for people of all ages:** Traditional prevention strategies focused on adolescents. Experience shows that often-overlooked age groups, e.g. 18-25 and aged 65 and older, are also in need of prevention education.
5. **Reliant on team approach:** Each SPF step requires participation from diverse community.

¹⁷⁶ “Welcome to the PACDAA,” Pennsylvania Association of County Drug and Alcohol Administrators website, accessed march 23, 2017, <http://www.pacdaa.org/Pages/PACDAAHome.aspx>.

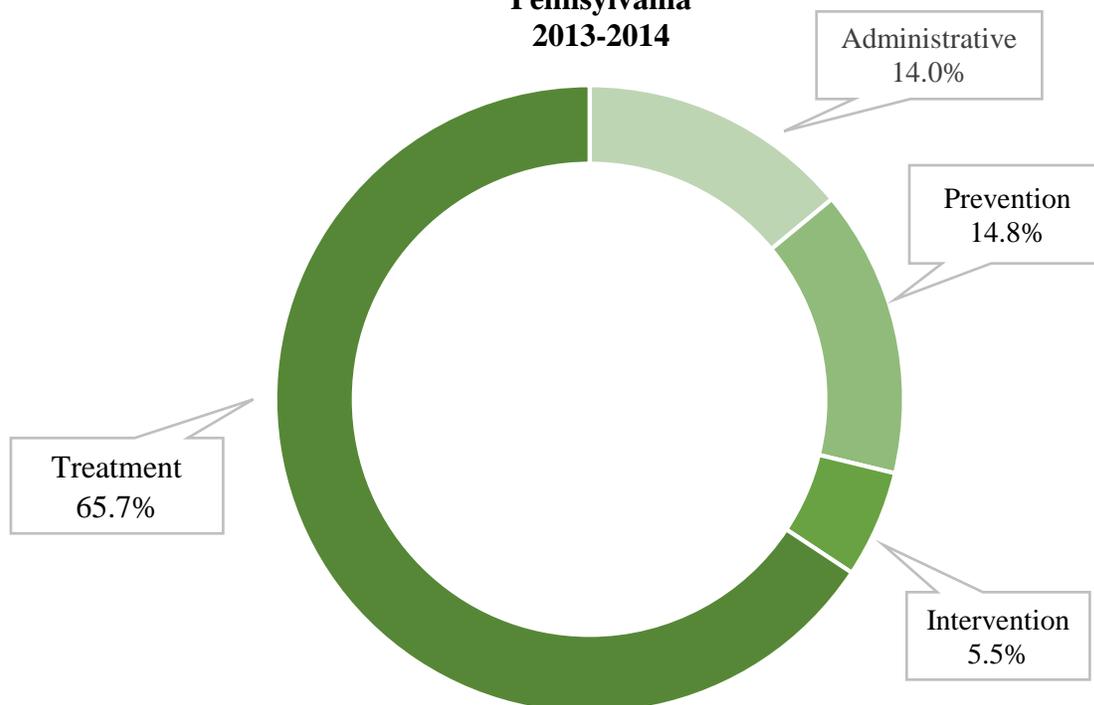
¹⁷⁷ “Applying Strategic Prevention Framework,” SAMHSA website, accessed March 28, 2017, <https://www.samhsa.gov/capt/applying-strategic-prevention-framework>.

Beyond the requirement to develop SPF plans that adhere to SAMHSA’s guidelines, DDAP encourages SCAs to deliver at least 25 percent of their services as a combination of evidence-based and evidence-informed prevention programs and strategies. The Department provides detailed definitions of evidence-based and evidence-informed prevention, which are shown in Appendix B. In short, such prevention programs and strategies are defined as follows:

- Evidence-based—Shown through research and evaluation to be effective in the prevention and/or delay of substance use/abuse. These programs also must be listed among those included in various federal registries.
- Evidence-informed—Based on a theory of change that is documented in a clear logic or conceptual model, or is based on an established theory that has been tested and supported in multiple studies.¹⁷⁸

SCAs are also funded through DHS OMHSAS to provide services for individuals who are eligible for Medical Assistance (MA) in non-hospital residential care and a continuum of care for those no longer eligible for MA as a consequence of welfare policy reforms. Figure 12 displays the breakdown of how SCAs’ funding is used.

Figure 12.
Single County Authorities
Expenditures by Type of Activity
Pennsylvania
2013-2014



¹⁷⁸ Pennsylvania Drug and Alcohol Annual Plan and Report: Drug and Alcohol Abuse Prevention and Treatment 2015-2016, DDAP, accessed March 27, 2017, <http://www.ddap.pa.gov/Reports/State%20Plan%20and%20Annual%20Reports/2015-2016%20DDAP%20State%20Plan%20and%202013-2014%20Report.pdf>. 35.

SCAs are required to develop needs assessments, implement contracts for the continuum of care, and maintain reporting requirements. DDAP and the SCAs share an emphasis on a recovery oriented systems of care, trauma-informed care, motivational enhancement, and evidence-based practices.

In turn, the SCAs contract with drug and alcohol addiction service providers to deliver treatment and rehabilitation services.

The Pennsylvania Association of County Drug and Alcohol Administrators (PACDAA) serves as the coordinating body for the SCAs and establishes their objectives:

- Ensure that client needs determine cost and appropriateness of care
- Ensure that taxpayer dollars are used effectively and efficiently
- Promote community-based support for clients' continued recovery so they may become productive citizens
- Provide treatment, along with the use of environmental and social service supports, as the best way to enhance clients' continued recovery
- Support comprehensive community-based prevention programs that empower and mobilize citizens to assume active roles in reducing substance abuse in their own communities.¹⁷⁹

SCAs provide public information on the services they provide for people who seek help with SUD. Generally, when a person first contacts the SCA, the office schedules an assessment with a contracted provider organization or conducts the assessment through its own staff. Next, the office makes a recommendation for appropriate level of care utilizing the Pennsylvania Client Placement Criteria or the ASAM Client Placement Criteria. Following those beginning stages, the SCA refers the client to a treatment provider based on the level of care recommendation.

In their roles as the local administrative and oversight agencies, SCAs handle case management and coordination of services. The SCA office authorizes funding for each client's treatment and rehabilitation, after which the client begins his or her treatment. The SCA monitors each client's progress and coordinates with the client and treatment provider at each level of care, such as through halfway house treatment or MAT. When clients progress from one level of care to the next, the SCA again authorizes funding for each consequential level. Further, the SCA monitors client progress as they follow through with continuing care until discharge from treatment.¹⁸⁰

SCA clients who have insurance through an HMO, Medical Assistance, or veterans benefits are referred to their insurance providers to determine what is covered and how to properly access SUD benefits. In some cases, pre-authorization from an HMO is required. Some SUD providers will assist clients in working with insurance providers. Most military veterans are eligible for SUD treatment services. Clients who have the ability to pay for SUD treatment may choose any facility they can afford.

¹⁷⁹ "Membership Directory," PACDAA website, revised February 9, 2017, accessed march 23, 2017, <http://www.pacdaa.org/Pages/About-Us.aspx>.

¹⁸⁰ "Pennsylvania Drug And Alcohol Treatment Services And Funding Information,"

Clients who are not covered under a health insurance plan may be referred to SUD providers contracted by the SCA for a short phone assessment. If it is determined that the client is appropriate for in-patient withdrawal management, the SUD provider will begin a bed search to locate treatment accommodations. The provider will also help the client determine if he or she is eligible for county funding, or help make other payment arrangements. Those clients who need in-patient rehabilitation rather than withdrawal management are directed to make an appointment with an outpatient clinic for an evaluation and a financial liability review.”¹⁸¹ Appendix C presents a flow chart from the York County SCA that explains how a person would access SUD services.

SCAs often work with local schools’ Student Assistance Programs, meeting with SAP teams to provide consultation and technical assistance. The staff also conducts assessments of children and adolescents who are at risk of drug abuse and coordinates referrals to treatment and other services.

SCAs plan and coordinate speaking events, educational activities, and disseminate informational materials aimed at reducing the impact and incidence of SUD in its service area.

Recognizing that SUD is not a separate part of a client’s life, as part of their responsibility the SCAs assist clients in coping with specific crises or situations that impact each client’s progress to healthful lifestyles. The SCAs will assess, assist, and refer clients to necessary and appropriate intervention services.¹⁸²

Opioid Use Disorder-Centers of Excellence (COE)

Given that many SUD patients are underserved because their care is not properly coordinated across their spectrum of needs and co-occurring health problems, the COE were initiated in Pennsylvania in 2015 to provide coordinated care that includes coverage of both substance abuse treatment and co-occurring medical health problems to those individuals who are enrolled in medical assistance. Each patient is supported by a team that includes substance abuse counselors, physicians, and family members.¹⁸³

Each COE patient is supported by a team.

¹⁸¹ “2017 Service Guide: Getting Help,” Lancaster County Drug & Alcohol Commission, accessed March 24, 2017, <http://web.co.lancaster.pa.us/DocumentCenter/View/7444>.

¹⁸² “York/Adams Drug & Alcohol Commission,” York County, Pennsylvania website, accessed March 28, 2107, <https://yorkcountypa.gov/health-human-services/drug-alcohol-services.html>.

¹⁸³ Centers of Excellence, Pennsylvania DHS, “What Is a Center of Excellence?” infographic, <http://www.dhs.pa.gov/citizens/substanceabuseservices/centersofexcellence/index.htm>, accessed September 18, 2017.

COE are care providers that are funded through DHS. They are administered through the Office of Mental Health Substance Abuse Services (OMHSAS), and are required to

- deploy a community-based care management team;
- track and report aggregate outcomes;
- meet defined referral standards for drug and alcohol addiction as well as mental health counseling;
- report on standard quality outcomes; and
- participate in a learning network¹⁸⁴

Further, the COE must deploy a community based care management (CBCM) team that consists of licensed and unlicensed professionals. The CBCM team’s activities must not overlap or be redundant to already existing reimbursed care management services. The care management team is expected to work within its local community to accept warm hand-offs of individuals with OUD from local emergency departments, state and county corrections facilities, and from primary care providers. The CBCM also works with inpatient and outpatient residential drug and alcohol addiction providers to assure individuals living with OUD transition from that level of care to the COE for ongoing engagement in treatment. The CBCM team is expected to motivate and encourage individuals with OUD to stay engaged in both physical health and mental health treatments. Team members will facilitate recovery by helping individuals find stable housing and employment, and helping them reestablish family/community relationships.¹⁸⁵

The Wolf Administration budgeted \$34.2 million for operation of the COE in fiscal year 2016-2017.¹⁸⁶

Pennsylvania Coordinated Medication-Assisted Treatment (PacMAT)

Pennsylvania began developing the PacMAT program in early 2017 by combining resources of DDAP, DHS, and DOH. PacMAT is a “hub and spoke” model based on models developed in Vermont and Rhode Island that are designed to provide comprehensive services from a coordinating central location. PacMAT is not envisioned to be a state funded program; rather, money will be derived from a flexible array of funders including grants, fee-for-service, and capitated coverages. The ideal scenario has PacMAT financially self-sustaining, driven by insurance.¹⁸⁷ A “hub” in the PacMAT model could simultaneously serve as one of the new COEs,

¹⁸⁴ Letter from Dr. Dale Adair, MD, Medical Director of OHMSAS and Dr. David Kelly, MD, Chief Medical Officer of OMAP, to OUD-COE funding applicants, undated,

http://www.secretsafe.org/cs/groups/webcontent/documents/document/c_225625.pdf. accessed September 18, 2017.

¹⁸⁵ Letter from Dr. Dale Adair, MD, Medical Director of OHMSAS and Dr. David Kelly, MD, Chief Medical Officer of OMAP, to OUD-COE funding applicants, undated,

http://www.secretsafe.org/cs/groups/webcontent/documents/document/c_225625.pdf. accessed September 18, 2017.

¹⁸⁶ Centers of Excellence, Pennsylvania DHS, “What Is a Center of Excellence?” infographic, <http://www.dhs.pa.gov/citizens/substanceabuseservices/centersofexcellence/index.htm>, accessed September 18, 2017.

¹⁸⁷ Presentation by Dr. Rachel Levine, Pennsylvania Physician General, to SR267 Advisory Committee, February 2, 2017.

although PacMAT is not intended to be a system that parallels the COE. COE are likely to be established by existing organizations that will function as navigational hubs to coordinate a range of services (substance abuse, mental health, physical health) for Medicaid patients. Dr. Levine added that approximately 70,000 people have accessed treatment through COE since the Commonwealth's Medicaid expansion. In August 2017, Governor Wolf's administration announced that four \$1 million grants, available as part of a \$26.5 million federal "21st Century Cures" grant awarded to the Commonwealth, would be awarded to organizations and medical institutions to increase access to treatment, reduce unmet needs, and reduce opioid-related deaths.¹⁸⁸

The Advisory Committee noted the PacMAT design introduced to them at the February 2, 2017 meeting lacked trauma specialists assigned to the hub. Given that SUD is often characteristic of trauma victims, the absence of trauma specialists, particularly those who provide services to victims of rape and sexual assault, is especially a problem in rural areas of Pennsylvania.¹⁸⁹

Medication-Assisted Treatment:

As required by DDAP and DHS, each SCA, COE, and PacMAT will refer individuals to medication-assisted treatment if their treatment plans require it.

The quality of the programs is of utmost importance; the administrative burden, however, must be recognized when driving programs toward continuous quality improvement. A balance must be struck between quality outcomes and administrative burden. One of the most crucial jobs of the therapist is to provide the programs to the client that will lead to the best possible outcomes, which does not necessarily mean that the therapist holds to a particular curriculum manual. The therapist must work within his or her competency and choose from the best programs that will work for each particular client.

Any particular treatment program or curriculum will be ineffective, despite the research and evidence that might support it, if it is not applied at the appropriate level of care for the appropriate duration of treatment. Moreover, there is a demonstrated relationship between the number of days in treatment and the quality of observed outcomes. The SCAs are organized to have the infrastructure and responsibility to monitor the quality of outcomes because they serve as distribution points for state and federal funding.

A person suffering from an SUD or addiction needs to get professional help before the drug use wrecks his or her life, relationship, family, friends, and employment. And, unfortunately, the downward spiral increases in velocity and inertia, accelerating faster toward an ultimate, irreversible end that becomes harder and harder to avoid as time goes on. There are several avenues by which the person can enter the treatment system. It may be of his or her own volition by walking into a health or drug treatment clinic, by seeing a family practitioner, by being coerced by family or friends, or an employer, or compelled by the criminal justice system through arrest, incarceration, and court sentencing.

¹⁸⁸ "Wolf Administration to Use 21st Century Cures Grant to Expand Access to MAT," Pennsylvania Governor Tom Wolf press release dated August 15, 2017, <https://www.governor.pa.gov/wolf-administration-use-21st-century-cures-grant-funding-expand-access-medication-assisted-treatment-mat/>, accessed September 18, 2017.

¹⁸⁹ SR267 Advisory Committee meeting, February 2, 2017.

Disjointed Transitions and Communications

Despite improved bridges between providers, points of contact in the system appear disjointed to both patients and clinicians. DDAP is working to open communication with providers regarding levels of care recommendations, so as to identify, track, and solve problems in the system. Advisory committee members commented that people presenting for acute addiction problems at hospital emergency departments are typically released without plans for sustained care. These releases are symptomatic of a treatment environment wherein most doctors, whether in the emergency department or in primary care, do not have adequate training or knowledge on how to ensure that SUD patients are effectively connected to appropriate services. It must be noted, however, that medical professionals are making improvements. Similarly, the criminal justice system recognizes the evidence that comprehensive treatment reduces criminal recidivism, yet struggles with a shortage of comprehensive addiction treatment services and wrap-around services, particularly when people are paroled or released from institutions where they had services to places where they have none. Despite whatever bridges and wrap-around services might be in place, having authorization for treatment does not necessarily mean that a patient will receive insurance coverage to pay for treatment.

There are gaps in information and education between doctors and treatment clinics. Doctors often do not understand the behavioral health treatment system, which makes referrals from medical to behavioral care problematic. The level of care recommendation cannot be changed to match the treatment available. Thus, the level of care recommendation stays the same, the available treatment is provided, and the patient's history is noted that the appropriate level of treatment was not available. There are currently no data on how often recommended levels of care or lengths of stay are thwarted by funding limits or unavailability of the appropriate treatment, however.

SCAs might run into difficulties in managing the Pennsylvania Client Placement Criteria (PCPC), which guide the development of each patient's treatment plan. A number of Advisory Committee members expressed the opinion that the PCPC are valuable tools, provided that staff receives appropriate training and oversight. Moreover, it has been offered that replacing PCPC in their entirety with ASAM may lead to further expenses that would be better utilized on other system needs, particularly salaries and length of stay.

In some cases providers are not following or are unable to follow risk assessments for people who are leaving incarceration. People with low, moderate, and high risk of re-offending are sometimes placed together in the same treatment groups. Low risk people are at much higher risk of re-offending when they are grouped with high risk offenders. Also, criminogenic needs are not being identified and met within the criminal justice population. When jails and prisons contract for services, it is crucial that providers can adhere to the risk principles and evidence-based curricula that are specific to the criminal justice population.

A key improvement would be to ensure that standard definitions of effective treatment be understood by all stakeholders.

SAMHSA lists four phases of treatment for people with SUD:

1. Engagement
2. Stabilization
3. Primary treatment
4. Continuing care¹⁹⁰

Using a multi-modal approach to these four phases that tailors them to each client's needs, the APA stated in 2007:

Additionally, the purpose of treatment should help the patient reduce use of the substance or achieve complete abstinence, reduce the frequency and severity of substance use episodes, and improve psychological and social functioning.¹⁹¹

The National Institute on Drug Abuse (NIDA) lists five steps of successful treatment:¹⁹²

NIDA'S FIVE STEPS OF SUCCESSFUL TREATMENT

1. Detoxification
2. Behavioral counseling
3. Medication
4. Evaluation and treatment for co-occurring mental health issues such as depression and anxiety
5. Long-term follow-up to prevent relapse

In Pennsylvania, a person's first step toward treatment and rehabilitation, commonly referred to as "intake," begins when he or she enters a treatment facility. The person is assessed by a trained counselor who meets qualifications specified in regulations contained in Chapter 704, Title 28 "Health and Safety." The counselor may use one of two assessment tools, client placement criteria, utilized in Pennsylvania.

¹⁹⁰ "Evidence-Based Practices in Drug and Alcohol Treatment and Recovery," Magellan Health, Inc., June 2016.

¹⁹¹ Ibid.

¹⁹² "Treatment Approaches for Drug Addiction," *Drug Facts*, National Institute on Drug Abuse, revised July 2016, accessed March 20, 2017, <https://www.drugabuse.gov/publications/drugfacts/treatment-approaches-drug-addiction>.

Client Placement Criteria: ASAM and PCPC

In 1991, the American Society of Addiction Medicine (ASAM), established its patient placement criteria (PPC), which have since expanded to include placement, continued stay, and transfer/discharge criteria for adolescent and adult patients suffering from SUD. ASAM continues to revise the criteria in an iterative process.

DDAP's precursor, the Office of Drug and Alcohol Programs in the Department of Public Welfare, began developing placement criteria upon enactment of Act 152 of 1988 with respect to "... governing the type, level and length of care or treatment, including hospital withdrawal management, as a basis for the development of standards for services ...".¹⁹³ Prior to Act 152, Medicaid funding was available for the continuum of care except for residential services in non-hospital facilities. The resultant Pennsylvania Client Placement Criteria (PCPC) were released in 1999. They were adapted from ASAM PPC, and were developed with the explicit permission of ASAM; ASAM, in recognition of the value and validity of what had been created in Pennsylvania, asked for no remuneration. From inception, the PCPC were intended to serve Medicaid populations because ASAM PPC were geared toward patients who had commercial insurance. Prior to advancements in treatments and recovery wrought by Act 152, the PCPC, and others, the predominant recovery environment was not substantial enough to provide for those patients whose lives hit rock bottom. Both ASAM PPC and PCPC are required by statute for use in Medicaid coverage, as detailed in Title 55 Chapter 1223 (Public Welfare Code (62 P. S. § 443.3(1))).

The primary conceptual difference between PCPC and ASAM PPC is that ASAM PPC are applied as a means of workforce protection, and PCPC are applied to those patients who have deteriorated beyond the point that life maintenance is feasible without professional intervention. ASAM PPC may be applicable to many SUD patients, provided they are helped in time; PCPC are designed and used for the worst of the worst SUD cases. Further, PCPC are designed as a built-out continuation of services available through Pennsylvania providers. The PCPC link together the steps between levels of the treatment and rehabilitation systems.

In short, the ASAM PPC and PCPC are both used in Pennsylvania, albeit for different populations: the two systems are not competing with one another. They are both tools in a provider's tool box, each with its particular use, depending on each particular patient's needs. A good clinician knows when to go off-script. ASAM PPC is organized as a grid, with levels of care; they identify MAT as a separate element in an outpatient level only, excluding the use of MAT in other areas of the continuum. PCPC also includes MAT, and in contrast, specifies that MAT should be available across the entire continuum of care.

The Advisory Committee discussed how the system can measure the effectiveness of ASAM PPC and PCPC. Both PCPC and ASAM have their own supporting research and measure outcomes based on their own particular criteria. It is understandable that policy makers and the public want to see national standards (such as ASAM PPC) used so that inputs and outcomes can be compared across treatment systems. From the care providers' perspective, however, such comparisons would not lead to accurate information about system performance. Problems associated with resources and outcomes are not consequences of the particular criteria employed,

¹⁹³ Act December 15, 1988 (P.L. 1239, No. 152) § 2.

but rather are consequences of criteria being applied incorrectly or being thwarted by lack of funding for the treatment recommended.

A nuanced experience with SUD treatment and rehabilitation will conclude that the effectiveness of the criteria is mostly based on the skill set of the intake interviewer rather than on the criteria being used.

At the next step in the treatment and rehabilitation process, beyond the criteria, the interviewer's skill set, and having already accounted for the patient's needs, is the step where the criteria interface with the treatment system itself.

Patients' needs are met with services, insofar as those services are available. Balancing resource allocations is, regrettably, a necessary exercise. It had been noted during the discussion that providers will, sometimes, be in a position of having to match patients' needs with available resources, rather than matching resources to patients' needs—an inversion that increases the likelihood that the system will fail its clients. Thus, the “problem” is no longer one of criteria, but of treatment availability.

Effective treatments exist. Researchers continue to refine the empirical evidence that corroborates clinicians' experiences. Multi-modal approaches to treating SUD, those that combine pharmacotherapies with behavioral therapies, are effective. To reframe the situation from a similar perspective, for someone suffering from diabetes, “diet and exercise don't end with insulin”: the multi-modal treatments continue along with insulin. Despite experts' agreement across the field of SUD treatment about the validity and effectiveness of the multi-modal treatment paradigm, reaching effective treatments is frequently, if not usually, blocked by obstacles of insufficient resources, insufficient funding, hesitancy on the part of some clinicians and patients to move in new directions, and even some talk of discrimination toward MAT patients on the part of providers.

SAMHSA's 2014 *National Survey on Drug Use and Health* revealed that approximately 7.9 million adults had co-occurring disorders.¹⁹⁴ Also, the National Survey of Substance Abuse Treatment Services (N-SSATS) found that about 45 percent of people seeking SUD treatment have been diagnosed as having a co-occurring mental and substance use disorder. In 2016, rates of co-occurring disorders were highest among adults ages 26 to 49, wherein 42.7 percent suffered from both SUD and some form of mental illness. In 2014, the highest rate of COD, 35.3 percent, was found among those ages 18 to 25. One frightening statistic reveals that 55 percent of people with co-occurring disorders receive no treatment at all.

¹⁹⁴ Sarra L. Hedden, et al, *Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health*, Center for Behavioral Health Statistics and Quality, SAMHSA, 2015, accessed April 11, 2017, <https://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf>.

To address these patients' needs, SAMHSA:

Supports an integrated treatment approach to treating co-occurring mental and substance use disorders. Integrated treatment requires collaboration across disciplines. Integrated treatment planning addresses both mental health and substance abuse, each in the context of the other disorder. Treatment planning should be client-centered, addressing clients' goals and using treatment strategies that are acceptable to them.¹⁹⁵

SAMHSA maintains that integrated treatment, i.e., treatment modalities that simultaneously address co-occurring disorders, such as mental disorders and SUDs, is associated with lower costs and better outcomes, such as

- reduced substance use;
- improved psychiatric symptoms and functioning;
- decreased hospitalization;
- increased housing stability;
- fewer arrests; and
- improved quality of life.¹⁹⁶

Fostering Emerging, Promising Forms of Treatment and Best Practices in Pennsylvania

As discussed previously in this report, the Commonwealth recently initiated two new programs to provide SUD services. Centers of Excellence are mandated to serve SUD patients by integrating behavioral health and primary care for those enrolled in medical assistance. The PacMAT design is a hub and spoke network that coordinates access for SUD treatment.

DDAP began implementing a warm hand-off process in 2015 to help transfer overdose survivors directly from an ED to a drug treatment facility. DDAP issued a formal directive for SCAs to partner with local hospital EDs to establish protocols for warm hand-offs. The department also held warm hand-off training in 2015 with the PA Chapter of the American College of Emergency Physicians, which was followed by a 2016 training session at the PA Medical Society. DDAP's 2015-2020 contract with the SCAs requires them to create a process for direct referral from the ED. To this end, DDAP and DOH released guidelines and protocols for doctors to implement ED warm handoffs.¹⁹⁷

Direct Care Staff and Workforce Development

At the Advisory Committee meeting held December 1, 2016, members discussed the number of staffing problems facing providers. There are often shortages among direct care staff. A number of recommendations could help increase the number and retention of counselors. These include loan forgiveness and opening up opportunities for waiving employment requirements for

¹⁹⁵ "Behavioral Health Treatments and Services: Treatment for Co-occurring Mental and Substance Use Disorders," SAMHSA, October 19, 2015, accessed April 11, 2017, <https://www.samhsa.gov/treatment#co-occurring>.

¹⁹⁶ Ibid.

¹⁹⁷ "The Department's Focus on Addressing Overdose," DDAP website, <http://www.ddap.pa.gov/overdose/Pages/Department%20Focus%20on%20Addressing%20Overdose.aspx/>

those who can perform as counselors but do not have college degrees. A “huge pool” of potential counselors are, themselves, in recovery. In fact, formal education can be insufficient preparation for a counselor, and practical experience may be better preparation for the job. It was recommended that educators develop a curriculum in rehabilitation and recovery as a means to graduate counselors who are better prepared. Another recommendation is that training hours and college credits be linked through action of the Pennsylvania Certification Board, which may improve the preparation of direct care staff and help providers acquire trained staff more quickly.

In 2014 the SAMHSA-HRSA Center for Integrated Health Solutions (CIHS) released a guidebook of core competencies for behavioral health and primary care providers, which include a wide range of front-line workers in both disciplines.¹⁹⁸

The stakeholders’ purpose in writing the guidebook was to establish a home for these and future initiatives in workforce development so that care providers would have integrated competencies to effectively manage the emerging models of integrated care:

The core competencies developed through this project are intended to serve as a resource for provider organizations as they shape job descriptions, orientation programs, supervision, and performance reviews for workers delivering integrated care. Similarly, the competencies are to be a resource for educators as they shape curricula and training programs on integrated care. The charge was to develop a “core” or “common” set of competencies broadly relevant to working in diverse settings with diverse populations. The competency sets are not intended to be setting or population specific. Their principal relevance is to the integration of behavioral health with primary care as opposed to the integration of behavioral health with specialty medical care.¹⁹⁹

For its part, DDAP is working to maintain a high-quality SUD workforce. The effort includes finding ways to employ those who have themselves successfully gone through SUD treatment and recovery. It is also evident that jobs for care providers will be more attractive when there has been created a career ladder for growth in the field. A SAMHSA regional report on workforce salaries showed that “SUD treatment providers are the lowest paid of all allied disciplines, and the average salaries in Pennsylvania are lower than all other states in our region except West Virginia.”²⁰⁰

¹⁹⁸ SAMHSA notes that the guidelines are for behavioral health professionals in the following areas: psychiatrists, psychologists, social workers, advanced practice psychiatric nurses, marriage and family therapists, addiction counselors, mental health counselors, psychiatric rehabilitation specialists, psychiatric aides and technicians, and peer support specialists and recovery coaches. The primary care providers include, but are not limited to: physicians, physician assistants, advanced practice nurses, registered nurses, and a range of allied health professionals. SAMHSA-HRSA Center for Integrated Health Solutions, *Core Competencies For Integrated Behavioral Health And Primary Care*, January 2014, www.integration.samhsa.gov/workforce/Integration_Competencies_Final.pdf, accessed September 20, 2017.

¹⁹⁹ SAMHSA-HRSA Center for Integrated Health Solutions, *Core Competencies for Integrated Behavioral Health and Primary Care*, January 2014, www.integration.samhsa.gov/workforce/Integration_Competencies_Final.pdf, accessed September 20, 2017.

²⁰⁰ DDAP, *Pennsylvania Drug and Alcohol 2016-2017 Annual Plan and Report Drug and Alcohol Abuse Prevention and Treatment*, <http://www.ddap.pa.gov/Reports/State%20Plan%20and%20Annual%20Reports/2016-017%20DDAP%20State%20Plan.pdf>, accessed September 20, 2017. 13.

DDAP has several efforts underway that it believes will further develop the drug and alcohol addiction workforce:

- development of continuing medical education courses required to maintain licensure status
- development of drug and alcohol addiction specific curriculum in Medical Schools
- refinement of training curriculum offered to the current drug and alcohol addiction workforce
- collaboration with minority populations and Harrisburg Area Community College to bring a greater diversity to the drug and alcohol addiction treatment field
- participation in regional and national committees/workgroups
- collaboration with the PA Certification Board
- reengineering of its own internal training section²⁰¹

The Pennsylvania Certification Board, a private, not-for-profit organization, oversees the competency based certification and credentialing of behavioral health professionals. The PCB's voluntary certification programs help ensure that drug and alcohol addiction counselors are prepared to achieve optimal outcomes for each patient. For example, to receive credentialing by PCB as a Certified Alcohol and Drug Counselor (CADC) a person must meet a long list of requirements.²⁰²

*“Too many good people
don’t enter the field
or don’t stay
[because of low salaries].
All the other science,
data, statistics, and strategy
will not matter if we don’t
address this.”*

*—SR267 Advisory
Committee member*

Employment

- Two years (4,000 hours) of employment as an alcohol and drug counselor or supervisor of same. Three years (6,000 hours) of employment is required if degree is not in a behavioral science field.
- Employment must have been gained within the last seven years. Applicant must be currently employed in a counseling position at the time application is submitted.
- Acceptable employment is based on applicant providing direct, primary alcohol and drug counseling to persons whose primary diagnosis is that of alcohol and/or drug addiction or that applicant is providing supervision of addiction counseling.
- Applicant must have primary responsibility for providing counseling in an individual and/or group setting, preparing treatment plans, documenting client progress and is clinically supervised.
- Current job description dated and signed by supervisor and applicant.

²⁰¹ P, Pennsylvania Drug and Alcohol 2016-2017 Annual Plan and Report Drug and Alcohol Abuse Prevention and Treatment, <http://www.ddap.pa.gov/Reports/State%20Plan%20and%20Annual%20Reports/2016-2017%20DDAP%20State%20Plan.pdf>, accessed September 20, 2017. 13.

²⁰² Pennsylvania Certification Board, website <https://www.pacertboard.org>, accessed November 13, 2017.

Supervision

- 200 hours with a minimum of ten hours in each domain.
- Supervision is a formal or informal process that is administrative, evaluative, clinical, and supportive. It can be provided by more than one person, it ensures quality of clinical care, and extends over time.
- Supervision includes observation, mentoring, coaching, evaluating, inspiring, and creating an atmosphere that promotes self-motivation, learning, and professional development.
- In all aspects of the supervision process, ethical and diversity issues must be in the forefront.

Education

- Bachelor's degree from an accredited college or university that is recognized by the US Department of Education or the Council on Higher Education Accreditation.
- An official transcript sent directly from college/university is required.
- 300 hours of education relevant to the field of addiction, of which 100 are alcohol and drug specific, including six in professional ethics and responsibilities.

Examination

- Pass the IC&RC Examination for Alcohol and Drug Counselors, which includes several topic areas:
 - Domains Screening, Assessment, and Engagement
 - Treatment Planning, Collaboration, and Referral
 - Counseling
 - Professional & Ethical Responsibilities

Medical Education

Medical practitioners, particularly physicians, have long recognized that medical education is lagging the drug epidemic. According to a leading doctor specializing in addiction medicine, in years past, medical school coursework in addiction medicine amounted to little more than a single, voluntary Saturday class. Since SUD had reached epidemic proportions in the late 1990s and early 2000s, efforts have been made to strengthen medical schools' treatment of addiction medicine through coursework and other requirements. It was clear, however, that legislative and governmental initiatives would be less welcome by the medical profession than would be initiatives growing from the profession itself, complete with the profession's imprimatur.

Physician Education

Physician education is of the utmost importance to maintaining safe patient treatment where opioids, particularly methadone, are employed for pain management. Joseph Merrell, M.D., wrote in the Journal of General Internal Medicine about physician education with regard to addiction and methadone:

The separation of opiate addiction treatment from the medical care system has resulted in a lack of education and experience among physicians in methadone treatment and addiction medicine more generally. While physicians regularly treat the medical complications of addiction, physicians lack skills in the screening, assessment, treatment, and referral of patients with substance abuse problems. Current curricula within medical school, residency, and continuing education programs for generalist physicians devote little time to addiction medicine topics.²⁰³

Curricula for generalist physicians devote too little time to addiction medicine.

Members of the Advisory Committee reflected similar experiences and attitudes to Dr. Merrill's. In their experience, addiction education is almost relegated to voluntarily attending seminars.

Only 30 percent of physicians felt they could identify misuse of prescription drugs.

The National Center on Addiction and Substance Abuse at Columbia University (CASA) surveyed primary care physicians on their opinions regarding their ability to diagnose substance abuse in 2000. Whether the efforts to improve the nation's health through high-profile campaigns to reduce chronic ill health associated with such maladies as hypertension and diabetes, or because chronic disease is widespread, over 80 percent of primary care physicians reported that they are "Very Prepared" to diagnose or identify patients with hypertension and diabetes. Fewer than half, 44 percent, felt the same way about depression. Physicians' confidence to diagnose or identify patients with substance abuse problems was even lower. Only 30 percent felt they could diagnose or identify misuse of prescription drugs, 20 percent felt the same about alcoholism, and 17 percent were confident they could identify or diagnose abuse of illegal drugs.²⁰⁴

The Association of Medical Education and Research in Substance Abuse (AMERSA), after more than a decade of developing drug-abuse education for medical professionals, recognized as early as 1985 that general practitioners, psychiatrists, and pediatricians needed to be proficient in the following areas:

1. Epidemiology, including knowledge of the natural history of substance abuse and risk factors;
2. Physiology and biochemistry of dependency and addictions;
3. Pharmacology, including knowledge of the effects of commonly abused drugs and drug-drug interactions;

²⁰³ <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1495048/>

²⁰⁴ "Primary Care Physicians: More Training Needed to Diagnose Substance Abuse," *CSAT by Fax*, Vol. 5, Issue 18, U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Abuse Treatment, November 8, 2000.

4. Diagnosis, intervention and referral;
5. Case management, including short and long-term consequences of abuse and dependency; and
6. Prevention through health promotion, early identification and patient education.²⁰⁵
 - a. The President’s Commission on Model State Drug Laws was formed in 1993. At the time, its members estimated that up to 50 percent of all general hospital admissions were alcohol and drug related, and 50 to 60 percent of emergency room admissions were alcohol-related.²⁰⁶ The President’s Commission further estimated that many patients left the hospital with their substance abuse problem undiagnosed. Of the 15 percent of doctor office visits that were alcohol-related, approximately two to three percent were diagnosed as such. In its final report, the President’s Commission concluded that “drug abuse, less familiar to most doctors, is probably diagnosed even less often.”²⁰⁷

The President’s Commission formulated a Model Health Professionals Training Act to improve health professionals’ education in the areas of alcohol and drug abuse. The Model Act addressed accreditation and curriculum statutes for medical schools, nursing schools, paramedic schools, and health professional training schools. Primarily, the Model Act specified that 30 hours be spent in the study of drug and alcohol abuse and addiction, and that the curriculum in each state be developed in consultation with the American Society of Addiction Medicine and the state’s medical society. The Model Act also stipulated that each practitioner complete at least ten hours of continuing medical education in abuse and addiction.²⁰⁸

The President’s Commission became the National Alliance for Model State Drug Laws (NAMSDL), which continues to work across the wide spectrum of drug and alcohol addiction laws and to help local, state, and federal stakeholders with legislative and policy assistance.²⁰⁹

Another model policy for health professional education was developed by the Federation of State Medical Boards. Known as the “Model Policy for the Use of Controlled Substances for the Treatment of Pain,” the model policy is endorsed by the American Academy of Pain Medicine, the Drug Enforcement Administration, the American Pain Society, and the National Association of State Controlled Substance Authorities.²¹⁰ The model is designed to communicate a number of important observations that address the gravity of opioid prescribing from the standpoints of

²⁰⁵ “Model Health Professionals Training Act Policy Statement,” President’s Commission on Model State Drug Laws, The White House, 1993 F-123.

²⁰⁶ “Model Health Professionals Training Act Policy Statement,” President’s Commission on Model State Drug Laws, The White House, 1993. F-121.

²⁰⁷ “Model Health Professionals Training Act Policy Statement,” President’s Commission on Model State Drug Laws, The White House, 1993. F-122.

²⁰⁸ See Appendix for full text of the Model Health Professionals Training Act.

²⁰⁹ NAMSDL, “NAMSDL’s Legislative and Policy Services,” website, <http://www.namsdl.org/legislative-and-policy-services.cfm>, accessed September 19, 2107.

²¹⁰ Scott M. Fishman, MD, “Responsible Opioid Prescribing,” Waterford Life Sciences, Washington, D.C.:2007. pp. 131-133.

society, the physicians, and the patients. First and foremost, the model recognizes that pain management is “important and integral” to the practice of medicine. Second, opioids may be necessary for the relief of pain. Third, when used for other than the relief of pain, opioid analgesics pose a threat to the individual and society. Fourth, doctors have a responsibility to reduce the potential for diversion and abuse of opioid analgesics. Finally, doctors will not be “sanctioned” solely for prescribing opioid analgesics for “legitimate medical purposes.”

There are seven guidelines that are recommended that state medical boards adopt as criteria for physicians who are prescribing opioids for the treatment of pain.²¹¹

1. Evaluation of the patient: A complete history and evaluation of the patient should be conducted, including any history of substance abuse.
2. Treatment Plan: A treatment plan, including objectives, should be written and evaluated or adjusted depending on the etiology of the pain and the success of the plan.
3. Informed Consent: The patient or the patient’s surrogate (or guardian) should be informed and aware of the risks and benefits of opioid treatment for pain.
4. Periodic Review: The physician should periodically review the course of pain treatment, including new information about the patient’s health and the etiology of the pain. Information from family members and caregivers should be taken into consideration as well.
5. Consultation: The physician should be willing to consult with other experts, paying special attention to patients who are at risk for medication misuse, abuse, or diversion.
6. Medical Records: The physician should keep accurate, complete, and current records.
7. Compliance with Controlled Substances Laws and Regulations: The physician should remain in compliance with all state and federal laws and regulations regarding controlled substances.

Recently, Dr. Michael A. Ashburn and Pennsylvania’s Physician General Dr. Rachel Levine published *Pennsylvania State Core Competencies for Education on Opioids and Addiction*, which addresses the establishment of core competencies in addiction education in Pennsylvania medical schools.²¹² Dr. Levine established a task force of representatives of all medical schools in Pennsylvania, along with representatives of state and federal agencies, to address improvement to medical education in the face of the opioid epidemic. The task force found that:

²¹¹ Scott M. Fishman, MD, “Responsible Opioid Prescribing,” Waterford Life Sciences, Washington, D.C.:2007. 131-133.

²¹² Michael A. Ashburn, MD, Rachel L. Levine, MD, “Pennsylvania State Core Competencies for Education on Opioids and Addiction,” *Pain Medicine* 2017, 0:1-5, American Academy of Pain Medicine, 2017, doi:10.1093/pm/pnw348, accessed September 12, 2017.

Physicians and other health care providers have limited knowledge regarding the diagnosis and treatment of chronic pain conditions. Additionally, physicians and other health care providers have limited knowledge regarding the proper use of opioids for the treatment of noncancer pain. It has been reported that US medical schools provide on average 11.1 hours of education on pain management Similar or more significant knowledge gaps exist regarding the screening of patients for possible substance use disorder, as well as how to properly refer patients suspected of having substance use disorder for specialty evaluation and treatment. Most medical schools provide little to no education on these topics, and these knowledge gaps do not appear to be effectively addressed during residency.

The task force's output was the development of statewide core competencies to guide medical education in the commonwealth. The intent was to encourage voluntary compliance by medical schools. Prior to publication of the paper, the General Assembly and Governor took action and passed Act 124 of 2016, which requires dispensers or prescribers to have completed at least two hours of education in either pain management or in identification of addiction, and at least two hours of education in prescribing opioids.²¹³

More specifically, Act 124 amends the act that created Pennsylvania's current prescription drug monitoring program, known as the Achieving Better Care by Monitoring All Prescriptions Program (ABC-MAP). The act states that the Department of State's licensing boards must require individuals who apply for or wish to renew prescribing licenses to show documentation that they have completed "education in pain management, addiction and prescribing and dispensing practices for opioids."

Drs. Ashburn and Levine and the task force see the implementation of Act 124 as an endorsement of their efforts to improve medical education regarding addiction in general, and opioids in particular. It is their hope that the core competencies promulgated by the task force will guide medical education in its compliance with Act 124.

Other Pennsylvania Agencies' Initiatives

There are numerous initiatives and established programs underway in the Commonwealth, most of which are jointly coordinated across different agencies. Ten cabinet level departments, DDAP, Aging, DHS, DOC, DOH, General Services, Insurance, Military and Veterans Affairs, PDE, Transportation, along with the Commission on Crime and Delinquency, the Board of Probation and Parole, Juvenile Court Judges Commission, and the Office of Attorney General are working together in different combinations to leverage their resources on specific objectives. Non-governmental organizations, such as the Pennsylvania Medical Society and the Pennsylvania Pharmacists Association, are collaborating with the efforts as well. Taken together, there are nearly 50 different statewide programs, projects, and initiatives that are being applied to substance abuse in the Commonwealth.

²¹³ Section 9.1 of the act of October 27, 2014 (P.L. 2911, No. 191), known as the Achieving Better Care by Monitoring All Prescriptions Program (ABC-MAP) Act; 35 P.S. Section 872.9a.

Of significant importance is the development of a process that informs and educates the residents of Pennsylvania not only about the available resources and how they are accessed and paid for, but also the pitfalls of profiteers and others who are skimming public benefits at the expense of patients and their families. To these ends, every SCA is appropriated funds for prevention activities, which include the provision of evidence-based curricula for classroom use. Student Assistance Programs are available and utilized in schools as first-stop information and prevention assistance for young people. The Pennsylvania Medical Society is supporting initiatives in the areas of public education on prevention and care. The Commonwealth Prevention Alliance is largely supported by the Pennsylvania Commission on Crime and Delinquency and uses funding to provide information, training, conferences, and advocacy. Among free and low cost options to distribute information are those outlets frequently utilized by organizations such as Pennsylvania Coalition Against Rape; these outlets include websites, social media, and news media outlets.

Taken together, there are nearly 50 different statewide programs, projects, and initiatives that are being applied to substance abuse in the Commonwealth.

Projects include everything from the implementation of new data and information systems to provider training to funding initiatives to site acquisition to medical assistance. Nearly every aspect of the overall substance abuse epidemic is being approached. Appendix D lists them in detail.

Private Insurance Provider Initiatives

Private insurance companies are researching and developing programs that their network providers can access to improve the health of subscribers. For example, Highmark Health is introducing a quality improvement program that crosswalks claims data to opioids prescribed for pain management. The program output includes decision support tools, information on best practices, and produces reports to benchmark providers against their peers. Further, it allows practitioners to access network pharmacists in-person and via telephone. Other Highmark initiatives include education programs for behavioral health specialists with the goal of improving coordination between therapists and primary care physicians.

Allegheny Health Network, a Highmark affiliate, is home to one of the Commonwealth's COE supported through a grant from DHS, and has also implemented an all-inclusive program for treating maternal addiction that includes obstetrical care, drug and alcohol misuse and abuse therapy, and MAT. AHN operates a residential facility in Erie, Pennsylvania that can accommodate 16 women with SUD, each of whom may be accompanied by up to two children under the age of 12.

Regulatory Burden

It is true that policy makers and researchers must have whatever information they need to maintain and improve quality of care. The extraordinary IT systems now widely available make it theoretically possible for comprehensive information to be gathered, analyzed, and put to use informing both broad-based reforms and localized refinements. New treatment modalities can be developed and implemented more quickly and effectively than in years past. Individual patients' needs can be simultaneously monitored by treatment team members who can evaluate treatment plans on a regular basis.

The capabilities of the IT infrastructure are enormous and growing; the demands to feed it the digital bits and bytes that sustain it are growing commensurately. And the data that inform all these decisions are still fed into the system by frontline caregivers, whose time with patients is being constrained by filling out required forms, processing forms, filing forms, and data entry.

The increasing burden of paperwork and administrative work that is burdening all fields in healthcare has not left drug and alcohol addiction staff untouched. Counselors and direct-care staff find themselves increasingly responsible for recordkeeping, paperwork, and administrative tasks that curtail their contact with patients. The daily grind of paperwork has been characterized as a situation where dates on papers become more important than patient outcomes, when, above all, the quality of programming should not be a victim of administrative paperwork.

Some argue that state and federal regulations have not kept pace with the field as technological advancements and treatment modalities evolve. DDAP may be able to alleviate the hiring burden by reconfiguring state regulations to open more pathways to employment. Many of the constraints, however, are imposed through federal regulations and are outside the reach of state policy makers.

What's your policy on gender neutrality? In this case, we could go plural ... "the patients themselves" ...

The daily grind of paperwork has been characterized as

a situation where dates on papers become more important than patient outcomes,

when, above all, the quality of programming should not be a victim of administrative paperwork.

PENNSYLVANIA AND OTHER STATES TREATMENT FACILITIES

SERVICES LICENSED IN PA INCLUDE:

- Intake, evaluation, and referral
- Inpatient
- Outpatient
- Partial Hospitalization
- Psychiatric Hospital

There are 634 licensed entities providing SUD services in Pennsylvania. Of these, 271 are for-profit operations and 363 are non-profit operations.²¹⁴ It is important to note that DDAP's database holds a count of licenses categorized by type. Any particular entity may provide more than one type of service and therefore hold multiple licenses. Outpatient maintenance programs, for example, provide counseling in addition to dispensing medications. Conversely, most of the "drug free" providers coordinate with others to provide referrals for medications, even if the medications are not provided on site.

Woman and Children

SUD treatment needs of pregnant women and women with young children differ from the needs of others. An initial barrier to treatment is created by the intense stigma associated with maternal SUD, fear of criminal prosecution, fear of losing their children to the care system, and the practicalities of childcare and family life, which prevent many women from seeking desperately needed treatment. The consequences of delaying treatment threaten the mother's health and wellbeing as well as her infant's. The problem is particularly acute among pregnant women because their misuse of substances like opioids pose significant life or death risks to their unborn babies. Further, infants who survive pregnancy can be born in withdrawal or experience serious physical and cognitive deficiencies that require specialized NICU care. Without clinically appropriate treatment, these women (and their children) face lives of continual deterioration.²¹⁵

MAT is available as a potential component of a treatment plan for a pregnant woman or one with young children. DDAP and DOH facilitated the creation of MAT prescribing guidelines for pregnant women.²¹⁶

²¹⁴ Email dated April 21, 2017 from Dr. Ken Martz, Special Assistant to the Secretary, DDAP.

²¹⁵ House Children & Youth Committee Hearing, September 28, 2016.

²¹⁶ Commonwealth of Pennsylvania, "Use of Addiction Treatment Medications in the Treatment of Pregnant Patients with Opioid Use Disorder," 2016, <http://www.health.pa.gov/my%20health/diseases%20and%20conditions/m-p/opioids/pages/prescribing-guidelines.aspx#.WnIpgnxG3RY>, accessed January 31, 2108.

Act 65 of 1993 authorizes the DDAP to establish and fund residential drug and alcohol addiction treatment programs for pregnant women and women with dependent children. To fulfill its responsibilities under Act 65, the DDAP contracts with SCAs to administer federal Substance Abuse Prevention and Treatment (SAPT) Block Grants allocation for Women with Children and Pregnant Women to include all levels of care that offer specific services to this population.²¹⁷

In addition to SUD treatment, the SAPT programs offer participants training in parenting, social and life skills development, family therapy or family reunification, and other activities related to their rehabilitation. Children are given age appropriate education regarding substance abuse, and, if school age, they are enrolled in a nearby school. Women and children programs across the Commonwealth have worked diligently to establish a positive working relationship with staff from the local school districts so that the children are served in the best possible way.

Other, non-SAPT programs across the continuum of care have been developed within individual SCAs by providers that offer services similar to SAPT and at a level of intensity appropriate to individual types of service. The programs are designed to achieve a number of outcomes for women and children who participate, including

- development of knowledge and skills to maintain self-directed recovery and abstinence from alcohol and other drugs;
- education and life skills to become productive members of society;
- prevention and education for accompanying children;
- reduction in:
 - perinatal addictive disorders;
 - acute health care costs;
 - legal system involvement and criminal behavior;
 - unemployment;
 - homelessness;
- development of parenting skills for mothers; and
- improved communication skills for mothers and children.²¹⁸

For the 2015-2016 fiscal year, DDAP reported the statewide SUD service capacity for women and women with children was as follows.²¹⁹

20 halfway houses

- There is capacity to serve 354 women and 66 children.
 - Three houses serve both women and men, with the capacity to serve 20 women.
 - Five provide services for pregnant women.
 - Three of these five can accommodate children with children and have the capacity to serve 36 women and 66 children.
- Seventeen houses are women-specific, with the capacity to serve 298 women.

²¹⁷ DDAP, "Women And Children's Annual Report, State Fiscal Year 2015-2016," DDAP, www.ddap.pa.gov/Reports/2016-17%20Women%20and%20Children's%20Report.pdf, accessed October 30, 2017.

²¹⁸ DDAP, "Women And Children's Annual Report, State Fiscal Year 2015-2016," DDAP, www.ddap.pa.gov/Reports/2016-17%20Women%20and%20Children's%20Report.pdf, accessed October 30, 2017.

²¹⁹ DDAP, "Women And Children's Annual Report, State Fiscal Year 2015-2016," DDAP, www.ddap.pa.gov/Reports/2016-17%20Women%20and%20Children's%20Report.pdf, accessed October 30, 2017.

Inpatient residential

- Fourteen serve women with children and have the capacity to serve 245 women and 512 children.
- Eighteen either serve only women, or have specifically identified women's service tracks and have the capacity to serve 500 women

SCAs are contractually required to provide access to a full continuum of care and provide preferential services for the SUD population of women and women with children. As a result, a number of treatment providers have developed gender-specific components to existing programs that serve the needs of this population either on-site or by referral to appropriate agencies. Age-appropriate prevention programs for the children of women in treatment are provided as well through agreements with prevention providers or specially trained child development staff.²²⁰

The federal Drug Addiction Treatment Act of 2000 (DATA 2000), part of the Children's Health Act of 2000, created a waiver program for physicians who meet certain qualifications to treat opioid dependency with FDA-approved narcotic medications on Schedules III, IV, and V.²²¹ Under the program, physicians may obtain waivers from the separate registration requirements of the Narcotic Addiction Treatment Act in order to prescribe buprenorphine, for example, outside of a licensed opioid treatment program.²²²

Data acquired from SAMHSA show the number of buprenorphine waivers granted to Pennsylvania prescribers each year since 2002. The number of new DATA-certified physicians in Pennsylvania for years 2002 to date through 2017 sums to 2,179 with waivers for 30 patients and 841 with waivers for 100. Presumably those with waivers for 100 are double counted from the list of those with existing waivers for 30 since a grantee must first be awarded a waiver for 30 before applying for 100. Current federal law allows for physicians to obtain waivers for up to 275 patients. As of May, 2017 there were approximately 2,100 physicians in Pennsylvania certified in the following categories:

- 1,300 certified with capacity of 30 patients
- 600 certified with capacity of 100 patients
- 200 certified with capacity of 275 patients²²³

²²⁰ DDAP, "Women And Children's Annual Report, State Fiscal Year 2015-2016," DDAP, www.ddap.pa.gov/Reports/2016-17%20Women%20and%20Children's%20Report.pdf, accessed October 30, 2017.

²²¹ October 17, 2000, Congress passed the Drug Addiction Treatment Act (DATA)

²²² Narcotic Addict Treatment Act of 1974 (P.L. 93-281), amended the Controlled Substances Act, recognized the use of an opioid drug to treat opioid addiction as critical and, for the first time in Federal law, defined "maintenance treatment." *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*, Center for Substance Abuse Treatment, Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2005 (Treatment Improvement Protocol (TIP) Series, No. 43.) Chapter 2. History of Medication-Assisted Treatment for Opioid Addiction, 2005, accessed May 4, 2017, <https://www.ncbi.nlm.nih.gov/books/NBK64157/>.

²²³ Email to Commission staff dated May 16, 2017 from Dr. Kenneth J. Martz, PsyD, MBA, and Special Assistant to the Secretary, Pennsylvania Department of Drug and Alcohol Programs.

The federal Comprehensive Addiction and Recovery Act of 2016 (CARA)²²⁴ allows Nurse Practitioners (NPs) and Physician Assistants (PAs) to prescribe buprenorphine for opioid use disorder provided that the NPs and PAs meet several conditions:

1. The provider is licensed under state law to prescribe Schedule III, IV, or V medications for the treatment of pain.
2. The provider has completed 24 hours of initial training or has such other training or experience as the Secretary of the U.S. Department of Health and Human Services requires.
3. The provider is supervised by, or works in collaboration with, a qualifying physician, if the provider is required by state law to prescribe medications for the treatment of opioid use disorder (OUD) in collaboration with or under the supervision of a qualifying physician.

CARA defines a qualifying physician as one who is permitted to prescribe buprenorphine for treatment of OUD.²²⁵

Buprenorphine Prescribing Limits for Non-Physician Medical Practitioners in Pennsylvania

In Pennsylvania, physician's assistants "shall not independently prescribe or dispense drugs." In other words, physician's assistants are permitted to prescribe or dispense prescription medication so long as they are operating under the control and supervision of a physician. The physician under whom the physician assistant works determines the scope of the physician assistant's prescribing authority. Because physician's assistants are not prohibited by state law from prescribing Schedule III, IV, or V medications, it would appear that physician's assistants meet the first requirement of CARA mentioned above.

The second requirement is that the physician's assistant (PA) work under the supervision of a qualifying physician, if that is what the state law requires. This provision's use of the conjunction "if" recognizes that some states are less restrictive than others in the degree of autonomy they grant to non-physician medical practitioners. However, because physician's assistants in Pennsylvania must be supervised by a physician, this requirement of CARA would apply and a physician's assistant would only be in compliance with this portion of CARA if he or she was practicing (and prescribing) within the supervision and oversight of a physician.

²²⁴ Comprehensive Addiction and Recovery Act (P.L. 114-198).

²²⁵ The Network for Public Health Law, "Buprenorphine Prescribing Limitations for Nurse Practitioners and Physician Assistants," *The Network for Public Health Law* website, March 29, 2017, accessed March 30, 2017, https://www.networkforphl.org/resources_collection/2017/03/29/877/buprenorphine_prescribing_limitations_for_nurse_practitioners_and_physician_assistants/?utm_source=Network+Report+3-30-17&utm_campaign=Network+Report+3-30-17&utm_medium=email&utm_content=294.

Nurse practitioners, statutorily known in Pennsylvania as certified registered nurse practitioners, (CRNPs) are also permitted to prescribe and dispense “medical therapeutic or corrective measures,” which includes drugs. The state board of nursing has further promulgated regulations delimiting when a certified registered nurse practitioner may prescribe medication. Importantly, the regulation requires that the certified registered nurse practitioner act “in collaboration with a physician” when prescribing medications. Just as with physician’s assistants, the scope of the certified nurse practitioner’s prescribing authority is in the hands of the supervising physician.

The section of CARA under discussion here gives latitude to the states. As long as the state gives nurse practitioners and physician’s assistants prescribing authority, CARA permits them to prescribe buprenorphine. If the state also requires that the non-physician practitioner do so under the supervision of a physician, CARA requires that the non-physician practitioner be in compliance with that requirement in order also to be in compliance with CARA.

Here in the Commonwealth, neither statutes nor regulations governing PAs and CRNPs prohibit a physician from permitting those under his or her supervision from prescribing Schedule III, IV, or V medications, and the physician determines the scope of their prescribing authority. Therefore, a CRNP or PA properly operating under the supervision of a qualified physician can prescribe buprenorphine in Pennsylvania under authority of CARA.

Table 13 shows the number of licenses held by treatment and rehabilitation providers in Pennsylvania. Some of the 634 providers are licensed to provide more than one type of service.

Table 13.

**Pennsylvania Department of Drug and Alcohol Programs
Number of Licenses Held
By Licensee and Type of Service
2017**

Licensee	Type of service	No. of licenses
Inpatient	Hospital Detoxification	13
	Hospital Drug-Free	9
	Hospital Other Chemotherapy	0
	Non-Hospital Detoxification	52
	Non-Hospital Drug-Free	184
	Non-Hospital Drug-Free Transitional Living Facility	5
	Non-Hospital Other Chemotherapy	30
Intake, Evaluation, and Referral		56
Outpatient	Detoxification	18
	Drug Free	562
	Maintenance	73
	Other Chemotherapy	157
Partial Hospitalization	Drug Free	142
	Other Chemotherapy	11
Psychiatric Hospital	Hospital Detoxification	6
	Residential Drug-Free	3

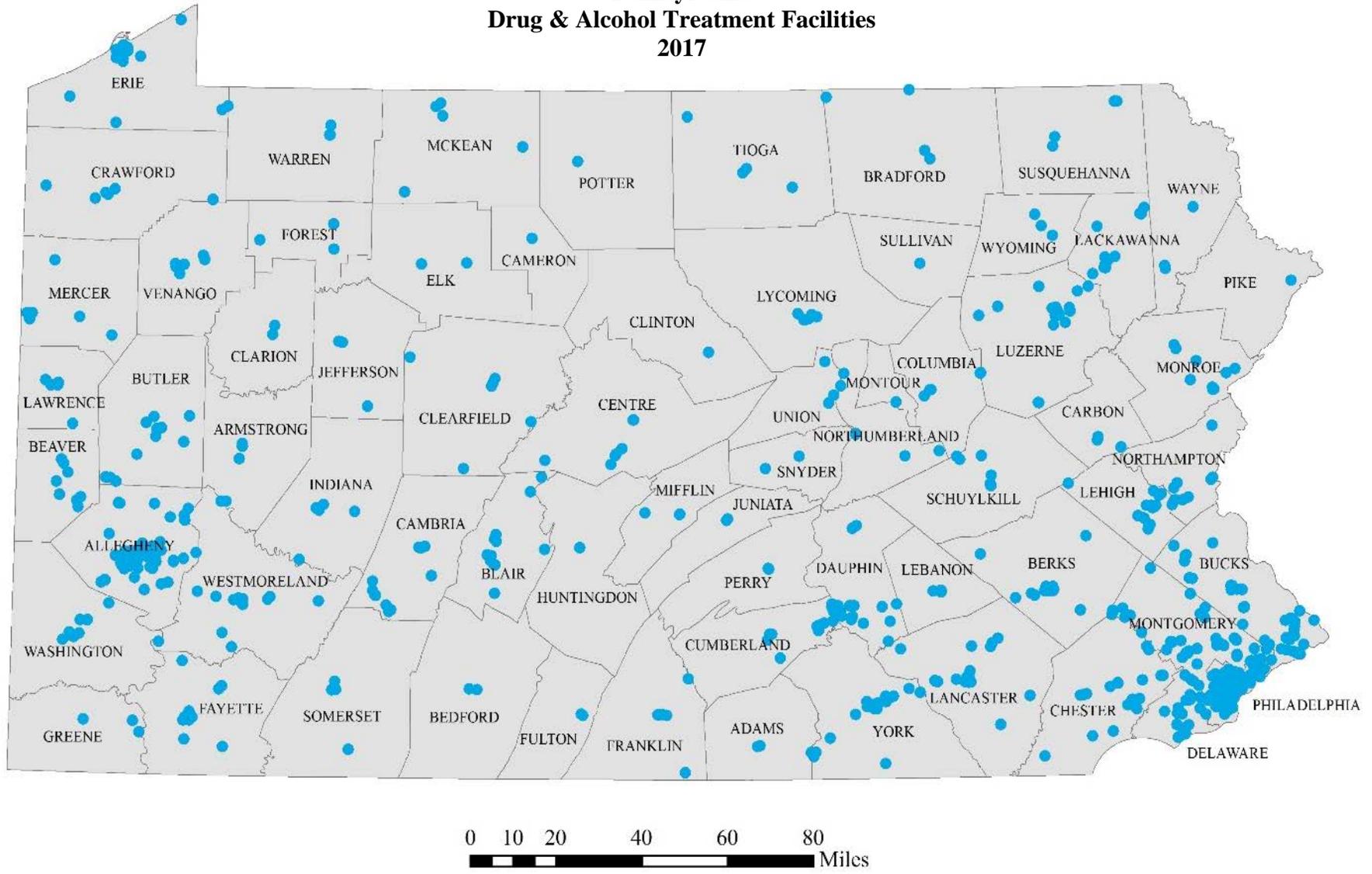
Source: DDAP, April 21, 2017.

Maps 8, 9, and 10 display locations of different types of treatment providers in the Commonwealth and were created by Commission staff. Maps 8 and 9 were created from information available on the DDAP website.²²⁶ Map 10 was created using a SAMHSA online database that records the locations of licensed buprenorphine prescribers in all 50 states. Because inclusion in the database is voluntary, it is likely that there are more practicing prescribers than are listed in the database.

²²⁶ Data found at the DDAP website at: <http://sais.health.pa.gov/commonpoc/Content/PublicWeb/DAFind.aspx>

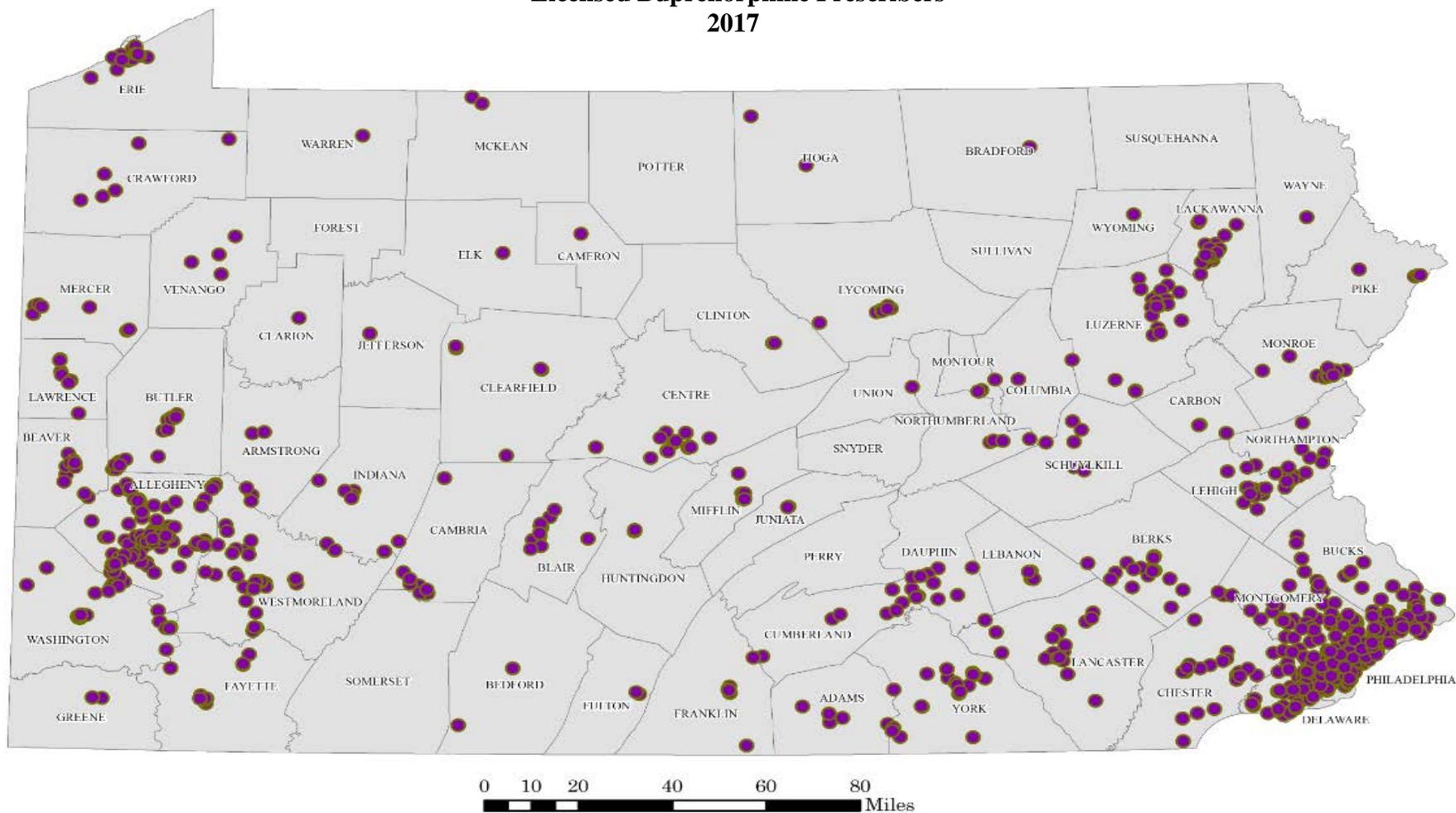
Map 8.

**Pennsylvania
Drug & Alcohol Treatment Facilities
2017**



Map 10.

Pennsylvania
Licensed Buprenorphine Prescribers
2017



Buprenorphine Treatment Practitioner Locator, SAMHSA https://www.samhsa.gov/medication-assisted-treatment/physician-program-data/treatment-physician-Locator?field_bup_physician_us_state_value=PA

DDAP is the recipient of a number of federal grants that provide funding for certain programs. Table 14 shows the grants awarded by federal agencies.

Table 14.
CDC Grants Awarded
PA Department of Drug and Alcohol Programs

Grantor	Name of Grant	Dates	Amount	Description
CDC	Prescription Drug Overdose Prevention (PDOP)	9/2015-8/2019	\$940,000/yr	Prevention and intervention strategies related to PDMP and education
	PDOP Supplemental	9/2016-8/2019	\$1 million/yr	EHR Integration
	Opioid non-fatal and fatal surveillance	9/2016-8/2019	\$490,000/yr	Improve timeliness of nonfatal opioid overdose reporting, fatal opioid overdose and risk factor reporting, and disseminate surveillance findings
Department of Justice/Bureau of Justice Assistance	Harold Rogers–PDMP Grant	Ended September 2017	\$409,000	PDMP system enhancement
SAMHSA	Substance Abuse Prevention and Treatment Block Grant (SABG)	October through September	\$59 million/yr	Prevention, intervention, treatment, and recovery services for uninsured individuals with substance use disorder
	State Targeted Response to the Opioid Crisis	5/2017–4/2019	\$26.5 million/yr	Prevention, intervention, treatment and recovery services
	Strategic Prevention Framework Partnerships for Success	10/2013-9/2018	\$1.815 million/yr	Underage drinking, prescription drug misuse

Other States

The U.S. Centers for Disease Prevention and Control (CDC), recognizing that the following strategies are within states' authority, recommends that states take steps to:²²⁷

- Consider ways to increase use of prescription drug monitoring programs, which are state-run databases that track prescriptions for controlled substances and can help improve opioid pain reliever prescribing, inform clinical practice, and protect patients at risk.
- Consider policy options relating to pain clinics to reduce prescribing practices that are risky to patients.
- Evaluate state data and programs and consider ways to assess Medicaid, workers' compensation programs, and state-run health plans to detect and address inappropriate prescribing of opioid pain relievers, such as through use of prior authorization, drug utilization review, and patient review and restriction programs.
- Increase access to substance abuse treatment services, including Medication-Assisted Treatment (MAT), for opioid addiction.
- Identify opportunities to expand first responder access to naloxone, a drug used to reverse overdose.
- Promote and support the use of the CDC Guideline for Prescribing Opioids for Chronic Pain.
- Help local jurisdictions to put these effective practices to work in communities where drug addiction is common.

Florida

2010 Action: Regulated pain clinics and stopped health care providers from dispensing prescription opioid pain relievers from their offices, in combination with establishing a prescription drug monitoring program (PDMP).²²⁸

2012 Result: Saw more than 50 percent decrease in oxycodone overdose deaths.

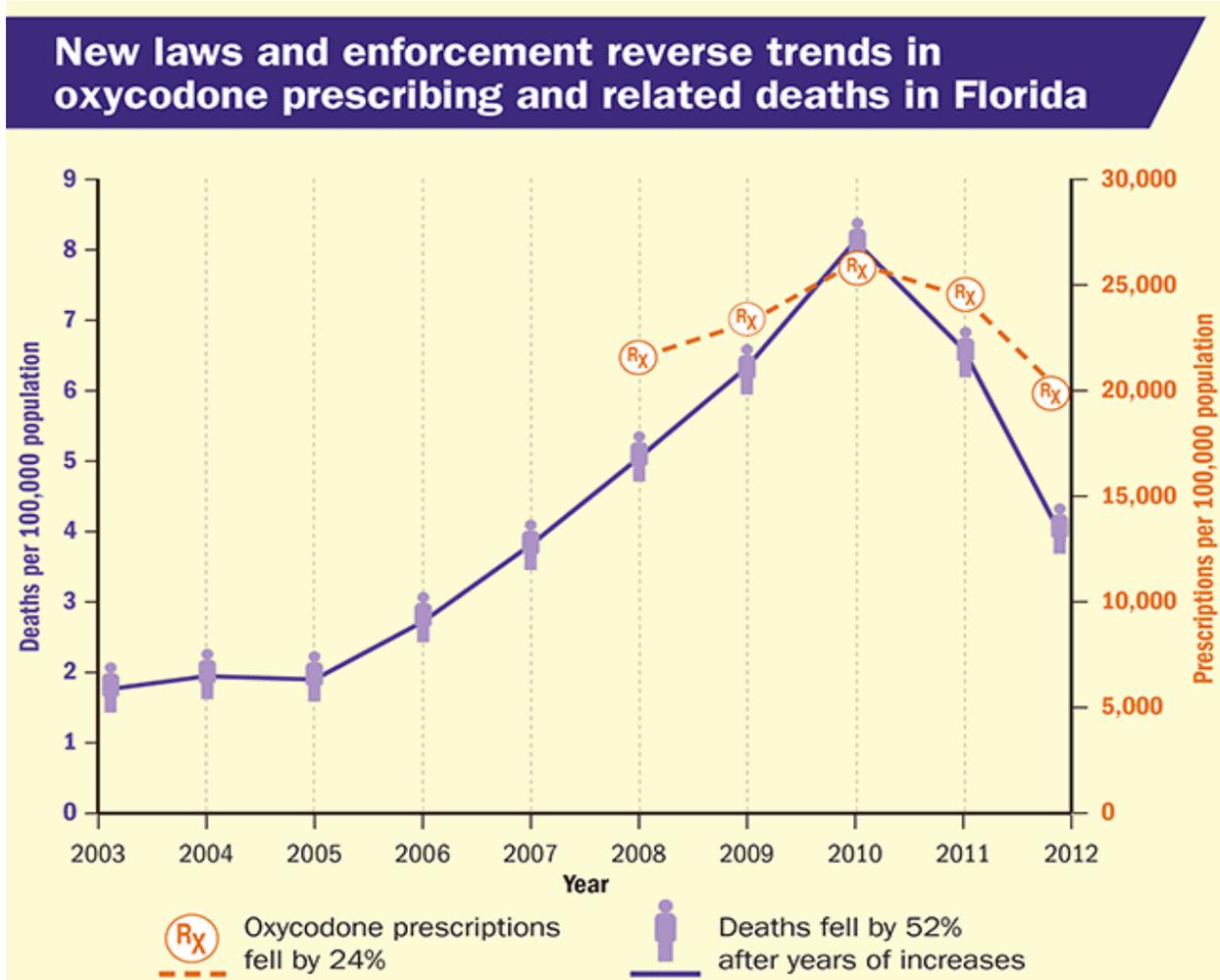
These changes might represent the first documented substantial decline in drug overdose mortality in any state during the previous ten years. See Figure 13.

²²⁷ "Opioid Overdoses: Promising State Strategies," CDC website, June 30, 2016, accessed April 25, 2017 <https://www.cdc.gov/drugoverdose/policy/index.html>.

²²⁸ A PDMP is a statewide database of patients' controlled substance prescriptions that alerts prescribers and dispensers of potential dangers when making treatment decisions and aids law enforcement agencies in detection of fraud, drug abuse, and diversion of controlled substances. Forty-nine states, including Pennsylvania, are networked together.

Figure 13.

Results in Florida from Opioid Programs



Source: Decline in Drug Overdose Deaths After State Policy Changes – Florida, 2010-2012. Morbidity and Mortality Weekly Report, July 1, 2014.

New York

2012 Action: Required prescribers to check the state’s PDMP before prescribing opioids.
2013 Result: Saw a 75 percent drop in patients seeing multiple prescribers for the same drugs.

Tennessee

2012 Action: Required prescribers to check the state’s PDMP before prescribing painkillers.
2013 Result: Saw a 36 percent decline in patients seeing multiple prescribers for the same drugs.

Oregon

As a Core Violence and Injury Prevention Program funded grantee, the Oregon Health Authority (OHA) reports the rate of poisoning due to prescription opioid overdose in Oregon declined 38 percent between 2006 and 2013 (from 6.6 to 4.5 per 100,000 residents). Oregon's rate of death associated with methadone poisoning decreased 58 percent in the same time period.

Key initiatives to address the problem include:

- establishment of a PDMP to track prescriptions of controlled substances;
- implementation of prior authorization for Methadone doses > 100 mg/day under Medicaid;
- education and access of lay persons to provide naloxone to persons suspected of overdose; and
- physician and allied health care trainings about safe and effective pain care.

Oregon's OHA continues to promote adoption of their PDMP, and works with health systems, insurers and other partners to increase access to medication assisted treatment and non-pharmaceutical pain care for chronic non-cancer pain.

Enhanced Surveillance Funding will assist states and key stakeholders in improving prevention and response efforts by providing more timely data on fatal and nonfatal opioid overdoses and in-depth information on risk factors. \$12.8 million is being awarded to 12 states to better track opioid-involved overdoses over a three-year project period that began in the fall of 2016.²²⁹

Through a competitive application process, CDC selected the following states to receive program funds: Kentucky, Maine, Massachusetts, Missouri, New Hampshire, New Mexico, Ohio, Oklahoma, Pennsylvania, Rhode Island, West Virginia, and Wisconsin. States will use the funding to:

- increase the timeliness of reporting nonfatal and fatal opioid overdose and associated risk factors;
- disseminate surveillance findings to key stakeholders working to prevent opioid-involved overdoses; and
- share data with CDC to support improved multi-state surveillance of and response to opioid-involved overdoses.

²²⁹ "Opioid Overdose: Enhanced State Surveillance of Opioid-Involved Morbidity and Mortality," CDC website, October 20, 2016, accessed April 25, 2017, <https://www.cdc.gov/drugoverdose/foa/state-opioid-mm.html>.

Data Driven Prevention Initiative. The newly created Prescription Drug Overdose: Data-Driven Prevention Initiative (DDPI) is planned to award \$18 million over a three-year project period to 13 states and the District of Columbia beginning in federal fiscal year 2016 to support efforts to end the opioid overdose epidemic in the United States.²³⁰ The program is intended to help states advance and evaluate their actions to address opioid misuse, abuse, and overdose. The states are expected to:

- improve data collection and analysis around opioid misuse, abuse, and overdose;
- develop strategies that impact behaviors driving prescription opioid dependence and abuse; and
- work with communities to develop more comprehensive opioid overdose prevention programs.

The 13 states selected to receive the funds through the competitive application process were Alabama, Alaska, Arkansas, Georgia, Hawaii, Idaho, Kansas, Louisiana, Michigan, Minnesota, Montana, New Jersey, and South Dakota, and Washington, D.C.

Funding was available through a \$70 million appropriation to the CDC in fiscal year 2016. Overall, in fiscal year 2016, the CDC provided over \$50 million to state health departments in support of the agency's overarching initiative Overdose Prevention in States. The CDC plans to continue to provide scientific expertise, enhance surveillance activities, and tailor resources to address states' growing and changing needs.

²³⁰ "Opioid Overdose: Data-Driven Prevention Initiative (DDPI)," CDC website, October 20, 2016, accessed April 25, 2017, <https://www.cdc.gov/drugoverdose/foa/ddpi.html>.

PENNSYLVANIA STATE AND COUNTY ENTITIES

DDAP – Department of Drug and Alcohol Programs

DHS – Department of Human Services

DOC – Department of Corrections

DOH – Department of Health

OMHSAS – Office of Mental Health and Substance Abuse Services

COE – Opioid Use Disorder Centers for Excellence

PA Open Beds – A data platform that connects DDAP, SCAs, and licensed non-hospital detoxification and inpatient residential treatment providers so that they can share information about available beds for SUD treatment.

PACDAA – PA Association of County Drug and Alcohol Administrators

PacMAT – PA Coordinated Medication-Assisted Treatment program

SCA – In each county, the Single County Authority serves as the state’s local administrator of publicly funded drug and alcohol programs

FEDERAL/NATIONAL ENTITIES

ASAM – American Society of Addiction Medicine

CMS – Centers for Medicare

FEDERAL/NATIONAL ENTITIES

CDC – Centers for Disease Control and Prevention

CARF – Commission on Accreditation of Rehabilitation Facilities

NIDA – National Institute on Drug Abuse

SAMHSA – Substance Abuse and Mental Health Services Administration

Addiction – A chronic, relapsing brain disease, in this context characterized by compulsive drug seeking and drug use.

AOD – Alcohol and other drug (including opioids)

Behavioral therapies – Treatment approaches that target modification of dysfunctional behaviors. Sometimes used in conjunction with medication-assisted treatment.

BHMCO – Behavioral health managed care organization

BHU – Behavioral health unit, typically of a hospital

Buprenorphine – An opioid that is FDA-approved for treating OUD because it provides a more controlled effect than other opiates

CARA – The federal Comprehensive Addiction and Recovery Act of 2016

CBCM – Community based care management

D&A – Drug and alcohol

EBP – Evidence-based practices. In this context, SUD treatment approaches that have been validated by research and evaluation. Evidence-informed practices have not been validated directly, but are based on a clearly-documented or established theory of change.

ED – Emergency department

EHR – Electronic health record(s)

FEDERAL/NATIONAL ENTITIES

Fentanyl – See opioid. Fentanyl can be up to 50 times as strong as heroin.

Hydrocodone – See opioid

IMD – Institution for mental disease

MA – Medical assistance (“Medicaid”)

MAT – Medication-assisted treatment

Methadone – An opioid that is FDA-approved for treating opioid use disorder because it provides a more controlled effect than other opiates

MMT – Methadone maintenance treatment

Naloxone – Opioid-overdose antidote, often carried by first responders. It is an opioid that counteracts the pain-relieving effects of other opiates.

Naltrexone – An opioid that is FDA-approved for treating opioid use disorder because it counteracts the pain-relieving effects of other opiates. (Brand name: Vivitrol)

NTP – Narcotics treatment program

OD – Drug overdose, whether fatal or survived

Opiate/Opioid – A drug that acts on the opioid receptors. Opiates are used medically for pain relief and anesthesia. Natural opiates include morphine, heroin, codeine, and opium. Synthetic or partially-synthetic opiates (also referred to as “opioids”) include buprenorphine, Fentanyl, methadone, oxycodone, and hydrocodone. Certain synthetics, such as naloxone and naltrexone, are opioid antagonists which counteract the pain-relieving effects of other opiates. In this report, “opioid” refers to the entire class of opiates.

OUD – Opioid use disorder

Oxycodone – See opioid

PCPC – Pennsylvania Client Placement Criteria, the Commonwealth’s version of the Patient Placement Criteria (see next entry)

FEDERAL/NATIONAL ENTITIES

PPC – Patient Placement Criteria (developed by ASAM, see above) for treatment-facility placement, continued stay, and transfer/discharge criteria for adolescent and adult patients suffering from SUD

PTSD – Post-traumatic stress disorder

SBIRT – Screening, brief intervention, and referral to treatment: An evidence-based practice used to identify, reduce, and prevent problematic use, abuse, and dependence on alcohol and illicit drugs

SUD – Substance use disorder

Vivitrol – Brand name of naltrexone

Warm handoff – Transfer of individuals with OUD from local emergency departments, state and county corrections facilities, and from primary care providers to treatment programs within their community

Wrap-around services – Individualized mental health services provided in the home, school, or community to enable that individual to live at home. Also known as behavioral health rehabilitation services.

Table 1 presents the cost data analyzed in 2011 by H.G. Birnbaum in the seminal article, “Societal Costs of Prescription Opioid Abuse, Dependence, and Misuse in the United States.”²³¹

Table 1.

**Societal Costs of Prescription Opioid Abuse
Annual societal costs of opioid abuse, dependence, and misuse
United States 2011**

Cost category	Estimated cost (in millions) ¹	Percent of total societal costs
Health care		
<u>Excess medical and drug (excluding substance abuse treatment)²</u>		
Privately insured opioid abuse patients	\$6,736	12.1
Medicaid opioid abuse patients	7,336	13.2
Medicare opioid abuse patients	1,010	1.8
Uninsured opioid abuse patients	6,861	12.3
Privately insured caregivers ³	547	1.0
Medicaid caregivers ³	596	1.1
Medicare caregivers ³	82	0.1
Uninsured caregivers ³	557	1.0
All excess medical and drug costs	23,725	42.6
<u>Substance abuse treatment</u>		
Federal	326	0.6
State and local	558	1.0
Private	235	0.4
All treatment costs	1,119	2.0
<u>Prevention</u>		
Federal	52	0.1
State and local	14	0.0
Private	19	0.0
All prevention costs	85	0.2
<u>Research</u>		
Federal	52	0.1
State and local	2	0.0
Private	16	0.0
All research costs	69	0.1
Total health care costs	24,998	44.9

²³¹ H.G. Birnbaum, et al, “Societal Costs of Prescription Opioid Abuse, Dependence, and Misuse in the United States,” Pain Medicine, vol. 12, issue 4, (April 2011), <http://www.ncbi.nlm.nih.gov/pubmed/21392250>.

Table 1.

**Societal Costs of Prescription Opioid Abuse
Annual societal costs of opioid abuse, dependence, and misuse
United States 2011**

Cost category	Estimated cost (in millions)¹	Percent of total societal costs
Criminal justice		
Police protection	1,526	2.7
Legal and adjudication	\$726	1.3
<u>Correctional facilities</u>		
Federal	212	0.4
State	1,430	2.6
Local	623	1.1
All correctional facility costs	2,265	4.1
Property lost due to crime	625	1.1
Total criminal justice costs	5,142	9.2
Lost workplace productivity		
Premature death	11,218	20.1
Lost wages/employment	7,931	14.2
<u>Incarceration (lost wages)</u>		
Federal	143	0.3
State	1,097	2.0
Local	528	0.9
All incarceration costs	1,768	3.2
<u>Excess medically related absenteeism</u>		
Employees with abuse/dependence	1,171	2.1
Employed caregivers	643	1.2
All excess medically related absenteeism costs	1,814	3.3
<u>Excess disability</u>		
Employees with abuse/dependence	727	1.3
Employed caregivers	80	0.1
All excess disability costs	807	1.4
<u>Presenteeism</u>		
Employees with abuse/dependence	1,576	2.8
Employed caregivers	468	0.8
All presenteeism costs	2,044	3.7
Total workplace costs	25,582	45.9
Total societal costs (in millions)	55,721	100.0

¹. All costs are reported in 2009 USD.

². Estimates of excess health care costs include patients exhibiting clinical abuse/dependence and do not include patients engaging only in nonmedical use.

³. Caregivers are defined as dependents or spouses of patients with abuse or dependence, but who do not meet criteria for abuse or dependence themselves.

The following information about the use of evidence-based SUD treatment programs in the state was excerpted from the Pennsylvania Department of Drug and Alcohol's *The Pennsylvania Drug and Alcohol Annual Plan and Report 2015-2016*.

PROGRAMS AND STRATEGIES

The Department encourages SCAs and prevention providers throughout the Commonwealth to utilize Evidence-Based and Evidence-Informed programs as a part of their comprehensive approach within their counties. Each SCA is required to deliver at least 25% of services through a combination of Evidence-Based and Evidence-Informed programs.

Using a combination of Evidence-based and Evidence-Informed programs and strategies, based on local community needs, have proven to be a highly successful and effective way of reducing risk factors associated with substance use/abuse. SCAs plan and deliver program services by considering and addressing underage drinking risk and protective factors, youth attitudes towards use, youth-perceived risk concerning consumption and by tracking social indicator data.

Evidence-Based, Evidenced-Informed and Supplemental Programs are defined as follows:

Evidence-Based Programs: Characteristics of evidenced-based prevention programs and strategies include:

- Shown through research and evaluation to be effective in the prevention and/or delay of substance use/abuse;
- Grounded in a clear theoretical foundation and care-fully implemented;
- Evaluation findings have been subjected to critical review by other researchers;

- Reported (with positive effects on the primary targeted outcome) in peer-reviewed journals;
- Replicated and produced desired results in a variety of settings; and,
- Included in Federal registries of evidence-based programs (note: inclusion in a Federal registry is necessary, but not a sufficient characteristic to merit inclusion on DDAP's list of evidence-based programs). Examples of federal registries include:
 - The Substance Abuse and Mental Health Services Administration (SAMHSA) National Registry of Evidence-Based Programs and Practices (NREPP) <http://www.nrepp.samhsa.gov>
 - U.S Office of Juvenile Justice And Delinquency Prevention (OJJDP) Model Programs Guide <http://www.ojjdp.gov/mpg>
 - Exemplary and Promising State, Disciplined and Drug-Free Schools Programs sponsored by the U.S. Department of Education <http://www2.ed.gov/admins/lead/safety/exemplary01/exemplary01.pdf>
 - Center for the Study and Prevention of Violence Blueprints for Healthy Youth Development <http://www.blueprintsprograms.com>

Evidence-Informed Programs: Characteristics of Evidence-Informed prevention programs and strategies must include the following four characteristics:

- Based on a theory of change that is documented in a clear logic or conceptual model, or is based on an established theory that has been tested and supported in multiple studies;
- Based on published principles of prevention, e.g., NIDA's Prevention Principles;
- Supported by documentation that it has been effectively implemented in the past, and multiple times, in a manner attentive to scientific standards of evidence and with results that show a pattern of credible and positive effects; and,
- Must have an evaluation that includes, but is not limited to, a pre/post-test and/or survey.

Other characteristics of evidence-informed prevention programs and strategies may include:

- May be similar in content and structure to interventions that appear in registries and/or the peer-reviewed literature;
- May have appeared in a non-refereed professional publication or journal; and,
- May have been identified or recognized publicly and may have received awards, honors or mentions.

Supplemental Programs: Characteristics of Supplemental programming must include:

- Capture activities that utilize methods of best practice
- Provide basic alcohol, tobacco and other drug awareness/education, as well as everyday alternative prevention activities
- Captures strategies that address population-level change
- Captures activities necessary to implement or enhance evidence-based and evidence-informed programs

In order for a new program or strategy to be added to DDAP's program and strategy listing, it must be submitted to DDAP for review and approval. DDAP has a formal process for reviewing programs and strategies to determine the appropriate program classification.

Each of the three program categories listed above must be delivered through single services and/or recurring services types and be recorded as such in the prevention data system. SCAs are required to provide 20% of services through recurring events. Single and Recurring Services are defined as follows:

Single Service Type – Single prevention services are one-time activities intended to inform general and specific populations about substance use or abuse (examples: Health Fairs, Speaking Engagements).

Recurring Service Type – Recurring prevention services are a pre-planned series of structured program lessons and/or activities. These types of services are intended to inform, educate, develop skills and identify/refer individuals who may be at risk for substance use or abuse. A recurring prevention activity needs to have an anticipated measurable outcome, including, but not limited to, Pre/Post Test and/or survey. (examples: Classroom Education, Peer Leadership/Mentoring, and ATOD Free Activities Recurring). Recurring services also cover certain, limited types of meetings and activities that are not structured lessons and may not have measurable outcomes. (Examples: coalition meetings, technical assistance meetings, Core Team recurring meetings)

There are approximately 43 Evidence-Based and 42 Evidenced-Informed programs that are currently being delivered throughout the Commonwealth that address drug use. Some of these programs include, but are not limited to:

Too Good For Drugs – a school-based prevention program designed to reduce the intention to use alcohol, tobacco and illegal drugs in middle and high school students;

Big Brothers Big Sisters – a mentoring program in which participating youth reach their potential through supported matches with adult volunteer mentors;

Girls Circle – a structured support group for girls that is designed to increase positive connection, personal and collective strengths and competencies;

Life Skills Training – a school-based program that works with elementary to high school students to assist them in developing the necessary skills to resist social pressures to use alcohol, tobacco and other drugs;

Strengthening Families Program – For Parents & Youth 10 to 14 year-olds is a family skills training program designed to enhance school success and reduce youth substance use and aggression;

Communities Mobilizing for Change on Alcohol (CMCA) – a community-organizing program designed to reduce adolescent access to alcohol by changing community policies and practices;

Student Assistance Program (SAP) – a mandatory intervention program provided within the school setting intended to identify and address problems negatively impacting student academic and social growth; and,

Project Lead and Seed – a structured leadership program in which adults, such as parents, youth pastors, youth-serving civic organization facilitators or teachers are trained to return to their schools or communities to provide training to their own youth leaders (in middle or high school); and whom implement action plans to reduce and prevent underage drinking, tobacco and other drugs.

The Department also collaborates with and supports other state agencies and organizations in their efforts to reduce substance use/abuse and promote health and rehabilitation efforts.

Department of Human Services, Office of Mental Health and Substance Abuse Services (OMHSAS)

Pennsylvania Youth Suicide Prevention Monitoring Committee

- The Pennsylvania Youth Suicide Prevention initiative is a multi-system collaboration to reduce youth suicide.

Substance Abuse and Mental Health Services Administration (SAMHSA)

- Support SAMHSA prevention initiatives such as the National Town Hall Meetings

Pennsylvania Liquor Control Board (PLCB)

- Contribute to the mandated Act 85 Legislative Report coordinated by the Pennsylvania Liquor Control Board.

Pennsylvania Commission on Crime and Delinquency (PCCD)

- Disproportionate Minority Contact Committee –Provides technical assistance and information to ensure that individual communities are providing the necessary drug and alcohol prevention supports to disproportionately burdened minorities.
- Balanced and Restorative Justice in Pennsylvania Committee – The committee supports the juvenile justice system in working with children that have committed delinquent acts and supports their care and rehabilitation to include, but not limited to, substance abuse issues.

Department of Health

- Statewide Injury Prevention & Control Plan Injury Community Planning Group (ICPG) – Falls Prevention in Older Adults Workgroup – Mission is to develop a comprehensive and coordinated plan that focuses on preventing injuries and violence across the lifespan by empowering state and local partners through the collection and analysis of data and the leveraging of resources for injury prevention programs to recapture lost human potential. Workgroups have been formed for three main injury topics: motor vehicle crashes, unintentional falls and unintentional poisonings.
- Sexual Violence Primary Prevention Planning Committee – Addresses sexual violence prevention through-out the commonwealth.
- Pennsylvania Coalition Against Domestic Violence – Assist in the development of a statewide prevention plan to support communities throughout Pennsylvania to prevent domestic violence before it occurs.

Department of Education

- Pennsylvania School Wide Positive Behavior Support State Leadership Team - Through training and technical assistance, supports schools and their family and community partners to create and sustain comprehensive school based behavioral health support systems in order to promote the academic, social and emotional well-being of all Pennsylvania's students.
- Youth and Family Training Institute Advisory Board - To achieve quality family and youth driven outcomes by advancing the philosophy, practices and principles of High Fidelity Wraparound through training, coaching, credentialing and ensuring fidelity to the process.
- Safe and Supportive Schools (SAS) Student Interpersonal Skills Development Committee - To develop social and emotional standards that educators and teachers will utilize for instructions with students Pre-K to 12th grade.

- Student Assistance Program Commonwealth Inter-agency Committee – Provides leadership for developing a safe and drug-free environment and mental health wellness in schools and communities across the Commonwealth.

Department of Transportation

- Multi Agency Safety Team (MAST) – Assist in the development and implementation of the Comprehensive Strategic Highway Safety Improvement Plan.

Commonwealth Prevention Alliance (CPA)

- Representative to the Board of Directors
- Conference Planning Committee – Provide trainers and staff support for the annual conference.

Pennsylvania Association of County Drug and Alcohol Administrators (PACDAA)

- Provides information and support for grantees (SCAs) related to adherence to requirements and implementing best practices.

Pennsylvania Prevention Director's Association (PPDA)

- Provides informational updates regarding the Department's prevention relevant matters to PPDA members as well as provides meeting space for their quarterly meetings.

For the Substance User

- Alcoholics Anonymous/Narcotics Anonymous
- York AA Helpline 717-854-4617 www.york-pa-aa.org
- York NA Helpline 717-848-9988 www.na.org
- Hanover AA Helpline 717-451-3991 www.hanoverintergroup.org
- School Aged Children- Contact your School's "Student Assistance Program" (SAP)

For the Family

- Al-Anon/Nar-Anon
 - www.pa-al-anon.org 1-888-425-2666
 - www.nar-anon.org 1-800-477-6291
- Become trained to use and stock Naloxone, the opioid reversal drug.
 - http://www.ddap.pa.gov/overdose/Pages/Naloxone_Reversal.aspx
- York Recovery Alliance 717 340-6100

Community Resources

- Not One More www.notonemoreyorkpa.org - Find us on Facebook
- RASE Project www.raseproject.org - Find us on Facebook
- York Opioid Collaborative, www.herointaskforce.com - Find us on Facebook
- Adams County Heroin Awareness Task Force - Find us on Facebook or go to <https://www.facebook.com/adamscountyheroinawareness/>
- Mason Dixon Anti Drug Task Force cindyseibel47@gmail.com

Things You Can Do to Help

- Check the YADAC website for Current Events www.yorkcountypa.gov
- Count & Lock up all medications/Dispose of old medications at Med Take Back Locations:
 - <http://www.cfygettysburg.com/partnership-events/take-back-medication-disposal>
 - <http://ycswa.org/disposal-of-household-waste/medical/>
- Be supportive of families battling substance use disorder, reach out to them.

How to Seek Help for Drug/Alcohol Treatment

If you do not need crisis or detox follow below for help.

If you are in crisis.

Experiencing suicidal or homicidal thoughts.

True North Mobile Crisis Unit (24/7)
Hanover 717-637-7633
Gettysburg 717-334-0468
1-866-325-0339

Wellspan York Hospital Crisis Unit (24/7)
717-851-5320
1-800-673-2496

If you need detox.

Experiencing withdrawal symptoms.

White Deer Run (24/7)
1-866-769-6822

If you do not have insurance.

For Central York Area
White Deer Run (24/7)
717-668-8035

Surrounding York Area
PA Counseling
Gettysburg 717-337-0026
True North
Gettysburg 717-334-9111
Hanover 717-632-4900
Shrewsbury 717-235-0199
Cornerstone
Hanover 717-632-6555
Gaudenzia
Harrisburg 717-233-3424
West Shore 717-766-8517

If you have insurance.

Call the number on the back of your insurance card to find out locations covered by your insurance.

Or call White Deer Run (24/7)
1-866-769-6822

Locations in **RED** offer adolescent and adult services.

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100 West Market St. Suite B04 York, Pa 17401. 717-771-9222 www.yorkcountypa.gov

Senate Resolution 267 of 2015

THE GENERAL ASSEMBLY OF PENNSYLVANIA

SENATE RESOLUTION

No. 267 Session of 2015

INTRODUCED BY SCHWANK, SABATINA, TEPLITZ, VULAKOVICH, GREENLEAF, FARNESE, COSTA, FONTANA, BREWSTER, RESCHENTHALER, STEFANO, DINNIMAN, BARTOLOTTA, RAFFERTY, YUDICHAK, BAKER, YAW, LEACH, BROOKS, WHITE, EICHELBERGER, McGARRIGLE, WILEY, AUMENT, GORDNER, MENSCH, HAYWOOD, WAGNER, HUGHES AND WARD, JANUARY 28, 2016

SENATOR VANCE, PUBLIC HEALTH AND WELFARE, AS AMENDED, MARCH 16, 2016

A RESOLUTION

1 Directing the Joint State Government Commission to establish an
2 advisory committee to study issues relating to the need for,
3 availability of and access to effective drug addiction
4 treatment in this Commonwealth.

5 WHEREAS, Abuse and illegal use of drugs directly affects
6 thousands of residents of this Commonwealth every day, placing
7 severe financial, emotional and other strains on families,
8 businesses and communities; and

9 WHEREAS, More than 925,000 residents of this Commonwealth are
10 estimated to have drug or alcohol disorders; and

11 WHEREAS, National studies project that one in four people
12 with a substance addiction will die as a result of the
13 addiction; and

14 WHEREAS, The cost of addiction is estimated to be more than
15 \$700 billion a year nationally from the related crime, lost work
16 productivity and health care; and

1 WHEREAS, Decreased funding of inpatient treatment has made
2 programs longer than 28 days increasingly rare despite research
3 showing longer care is commonly required for addiction such as
4 heroin and opioids; and

5 WHEREAS, More than 2,400 people in this Commonwealth died
6 from drug overdoses in 2014, more than twice the number of
7 deaths by automobile accidents and more than four times the
8 number of murders from all means; and

9 WHEREAS, Studies indicate that as many as 80% of criminal
10 offenders nationally have substance abuse issues; and

11 WHEREAS, Every dollar spent on treatment is estimated to
12 result in up to \$11 in savings to the public and in medical
13 costs; and

14 WHEREAS, There is a reported shortfall of more than 70,000
15 treatment spaces in this Commonwealth; and

16 WHEREAS, Only about one out of every eight residents of this
17 Commonwealth who are in need of addiction treatment is able to
18 access it; and

19 WHEREAS, Access, infrastructure and funding affect the
20 ability of a system to provide needed treatment; and

21 WHEREAS, A variety of procedures and formats are used to
22 treat addiction, including medication-assisted treatment and
23 cognitive behavioral therapy; therefore be it

24 RESOLVED, That the Senate direct the Joint State Government
25 Commission to establish an advisory committee suitable to the
26 goals and purposes of this resolution; and be it further

27 RESOLVED, That the advisory committee include representatives
28 of the Pennsylvania Board of Probation and Parole, Department of
29 Corrections, Department of Drug and Alcohol Programs, Department
30 of Education, Department of Health, Department of Human

1 Services, Insurance Department, Administrative Office of
2 Pennsylvania Courts, Juvenile Court Judges' Commission, private
3 organizations that represent general medical hospitals in this
4 Commonwealth, ~~addiction treatment programs in this Commonwealth~~ <--
5 ~~and~~ insurers who market health care policies in this
6 Commonwealth, addiction treatment organizations and programs,
7 including medical specialists in addiction treatment, recovering
8 addicts and family members of addicts, the Pennsylvania
9 Association of County Drug and Alcohol Administrators, the
10 Pennsylvania Chiefs of Police Association, the Pennsylvania
11 Coalition Against Domestic Violence, the Pennsylvania Coalition
12 Against Rape, the Pennsylvania District Attorneys Association
13 and others whose expertise or experience would facilitate the
14 work of the Joint State Government Commission and advisory
15 committee; and be it further

16 RESOLVED, That the Joint State Government Commission, working
17 with the advisory committee, conduct a thorough and
18 comprehensive study of issues relating to the need for,
19 availability of and access to effective drug addiction treatment
20 in this Commonwealth; and be it further

21 RESOLVED, That the study review all of the following:

22 (1) Locations and types of treatment programs, including
23 length of inpatient programs and outpatient follow-up.

24 (2) The need for additional treatment resources,
25 including additional public funding.

26 (3) The opportunity for residents of this Commonwealth
27 to access effective treatment.

28 (4) The prevalence and practical impact of using private
29 or public funding for treatment.

30 (5) The identification of particular forms of treatment

1 and whether it is possible to compare the effectiveness of
2 particular forms of treatment.

3 (6) How to assist consumers in locating and determining
4 the effectiveness and value of different types of treatment
5 and programs.

6 (7) How to encourage and foster emerging, promising
7 forms of treatment and best practices in this Commonwealth.

8 (8) Any other relevant issues the Joint State Government
9 Commission and advisory committee identify as helpful to
10 improving the availability of effective treatment in this
11 Commonwealth;

12 and be it further

13 RESOLVED, That the Joint State Government Commission study
14 include a process providing for reasonable public comment and
15 input on issues of treatment access, availability and
16 effectiveness; and be it further

17 RESOLVED, That the final report include any recommendations
18 for changes to statutes, practices, policies, programs and
19 procedures relating to drug addiction treatment; and be it
20 further

21 RESOLVED, That the Joint State Government Commission issue a
22 report to the Senate with its findings and recommendations not
23 later than 18 months from the adoption of this resolution.