Written Testimony Submitted:

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DEPARTMENT OF DRUG AND ALCOHOL PROGRAMS

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Public Hearing

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Testimony of

Gary Tennis, Secretary

PA Department of Drug and Alcohol Programs

Thank you Chairman DiGirolamo, Chairman Cruz and members of the committee for the opportunity to provide comments on House Bill 1692, legislation to provide for involuntary treatment for individuals suffering from alcohol and drug abuse.

Many people refer to our current substance use treatment system as broken. I think it's fair to say it faces multiple challenges, especially in light of the current opioid use and heroin abuse epidemic that is affecting every community in Pennsylvania and across the nation. By suggesting there are challenges, rather than a broken system, we can denote a sense of hope and positivity, important factors in the fight against this epidemic. There are treatments that work and people can recover from this horrific disease. While system improvements are critical to ensure people have access to the level of care that is appropriate for them, we are making headway in Pennsylvania and I am confident we can continue to be a leader in addressing this epidemic going forward.

Dependent on a number of factors including the availability of financial resources and the specific area of the commonwealth in which an individual resides, substance use disorder treatment can be difficult to access and challenging to navigate. In addition, a stigma exists around heroin and opioid use, one that we must address head on. Prevention and education efforts need to be expanded to every walk of life, not just those already struggling with an addiction. The capacity for treatment across the continuum of care, including inpatient, outpatient, Medication Assisted Treatment (MAT), or any combination of the three, must be expanded in every community. While families and friends of individuals struggling with substance use disorder (SUD) often grapple with a complex system of care and sometimes, individuals who are unwilling to seek treatment, there are resources available for these individuals that don't require us to unnecessarily coerce someone into treatment when they may not be ready.

House Bill 1692, while noble in its efforts to give families and friends an avenue for getting their loved ones the treatment they need, is not necessary given existing Pennsylvania law.

There are laws across the country that allow for the involuntary commitment of an individual in a psychiatric crisis, including Pennsylvania's Mental Health Procedures Act (MHPA). The MHPA provides the tools for families and others to assist in accessing the appropriate care for their loved ones in situations that are dire and typically involve a psychiatric episode coupled with a substance use disorder. In consultation with a physician, a family member or other concerned individual, can petition the court to involuntarily commit a person that is a danger to themselves or others. The MHPA explicitly states that treatment shall be provided in the least restrictive setting available, which can include inpatient or outpatient treatment in varying degrees of intensity. It is important to recognize that while the MHPA may not allow for widespread involuntary commitment, it is important to safeguard the integrity of laws that assist courts with committing individuals in the greatest need.

In addition, the Department has concerns that involuntarily committing someone to treatment who may not be ready to take that step could have negative and long-lasting effects, including creating an unintended distrust in the very treatment system designed to help them. Creating awareness about the various levels of treatment that are available, in which a person can ease into the individualized treatment that is most appropriate for them, is more likely to have long-term, lasting success and result in better overall health outcomes.

Finally, Section 5 of this bill provides that a petition filed under the proposed legislation must be accompanied by a security deposit that will cover half of the estimated cost of treatment for the respondent and a guarantee signed by the petitioner or another individual authorized to file the petition obligating the guarantor to pay the costs of the examinations of the respondent conducted by the physician, the costs of the respondent that are associated with court hearings and that the court determines to be appropriate, and the costs of any treatment ordered by the court. This provision would create an even bigger divide between those individuals who have the means to pay for treatment, which can be overwhelmingly expensive, and those individuals or family members that do not have the financial resources available to cover the cost of treatment. In a system that is already geared toward greater

access for those who can afford it, in particular those that can pay out of pocket, this creates another unnecessary disparity.

To be clear, the next critical step for improving our state's response to alcohol and other drug addiction is to properly resource our treatment system so that our treatment infrastructure is sufficient to meet the overwhelming demand currently being experienced in all our communities.

These are the most significant of our concerns identified in HB 1692; there are others. As a result, the Department of Drug and Alcohol Programs suggests an alternative action pursuant to passage of this bill as follows:

- As of January 1, 2016, DDAP has issued a contractual requirement [attached] of the SCAs to establish policies and procedures for direct referral from the emergency department (ED) directly to SUD treatment post overdose survival. Efforts are underway to create the infrastructure and hospital collaborations necessary to effectively engage in this process. DDAP anticipates that by the end of the calendar year, all counties will have such strategies in place. Significant success has been noted where such measures have already been implemented.

While the above noted suggestion only addresses the targeted population of overdose survivors and not the general population of substance users, given the current opioid overdose crisis, implementation of this suggestion could significantly impact the loss of life and encourage engagement in appropriate treatment, thus initiating the process of recovery. In the meantime, other strategies for improving infrastructure and increased capacity necessary to serve individuals with drug and alcohol addiction in general will need to be implemented, allowing for overall improved services to the individuals and their family members suffering from these disorders.

We appreciate your partnership and your leadership, and we look forward to working with you to turn the tide on this worst ever drug overdose epidemic that is devastating our communities.

Section 6.04 Overdose Survivors

Overview

DDAP defines an overdose as a situation in which an individual is in a state requiring emergency medical intervention as a result of the use of drugs or alcohol. Specific examples may be seen in the International Classification of Disease (ICD-10) diagnosis codes for substance overdose or poisoning.

Requirements

In order to ensure expedient, appropriate and seamless care for an individual who has overdosed, SCAs must develop, implement, and maintain a plan for screening, assessment, treatment and tracking of individuals who have survived a recent overdose. The policy and procedure must include:

1. The details or process by which an overdose survivor will be offered a 24/7 direct referral from the ED to treatment by one or any combination of models noted below;
2. The parties responsible (including having on file any MOU or LOA that may apply);
3. The timelines for the processes involved; and
4. The mechanism for tracking such referrals or refusals for treatment.

This may be accomplished through a timely exchange of referral information from the referring party to the SCA. Such a tracking mechanism may be between the hospital and SCA and/or between the treatment provider network and the SCA. This should include those individuals who are publicly funded, and wherever possible, those individuals who are otherwise funded, even if by basic, unidentified referral statistics.

Regardless of the models chosen by the SCA, all of the elements noted in the preceding paragraph must be present to receive approval of the policy.

As indicated, the policy and procedure established must include one or a combination of the following identified models:

1. **SCA Agency Model:** The SCA, through case management staff or, in the case of a functional unit, through treatment staff, provide assessment services to local healthcare facilities/EDs. In such instances, the SCA would need to assure that procedures for referral to treatment during after hours, weekends and holidays are established for their county, rather than the provision of a number to call during non-business hours.
2. **Contracted Provider Model:** The SCA contracts with a provider(s) i.e., case management units, treatment providers, crisis intervention, etcetera to conduct screening, assessment, and referral services to area hospital EDs. Such an arrangement would be noted in the SCA's contractual agreement with the applicable provider agencies, and would include a work statement and cost of completing such assessments. The SCA facilitates discussions with the agencies and hospital to develop a process to conduct assessments in the hospital setting.

An MOU between *that* agency and the healthcare facilities/EDs (rather than the SCA) may be developed to include protocols for completion of assessments.

3. **Certified Recovery Specialist Model**: Where Certified Recovery Specialist (CRS) services are available to or through an SCA, such staff would be utilized to provide either assessments/referral from healthcare facilities/EDs to treatment OR to provide screening, and/or referral to a professional/provider qualified to clinically assess and refer to treatment. Appropriate training commensurate with the service would need to be completed.

4. **Treatment Provider Model**: The SCAs can assure that *through* the business practices of a local treatment/service provider(s), provider staff is serving the area's Hospital EDs. This may already be occurring as a courtesy/referral source by treatment providers to local healthcare facilities/EDs. (In some instances, the treatment provider may actually be hospital owned/affiliated.)

5. **Direct Referral to Treatment by Hospital Staff**: The hospital Social Worker, detox personnel, or other hospital staff assists a patient with referral directly to SUD treatment. This may occur through a special arrangement that the SCA has with the hospital or by the hospital staff, independent of the SCA; however, it is the expectation that the SCA would be engaged in some level of relationship/arrangement with the hospital or receiving treatment provider as it relates to authorization for funding when necessary and statistically reporting.

6. **Recovery Community Model**: Where the SCA has a strong relationship with the recovery community, be it through a recovery organization or a strong presence of a 12-Step Fellowship, the SCA can arrange for identified/designated individuals who are willing to volunteer with assisting an overdose survivor getting to a treatment facility. This would more likely include client engagement, information and referral to clinical assessment and potential transportation to treatment, rather than assessment and referral. The SCA would be responsible for entering into the necessary agreements with the organization/individuals and for providing basic information on how to access the treatment system within that county.

7. **DDAP Approved Model**: The SCA can present another viable alternative not otherwise mentioned in this policy for DDAP approval or a combination of any of the above. Possible examples might be where an SCA has a strong relationship with the ED hospital staff whose social work department, nursing staff or other identified staff utilize resources made available by the SCA to make a referral directly from the ED; or the SCA might serve as a single point-of-contact with the ED to facilitate referral to treatment with a plan in place for after-hours, weekend and holiday access to treatment.

It should be noted that in those instances in which an entity other than the SCA is responsible for the actual post overdose referral to treatment activity, the SCA should be engaged insomuch as to have an awareness of the protocol(s) that are occurring within the county and be a partner in the process, especially as it relates to establishing a mechanism for post overdose referrals to treatment of publicly-funded individuals.

SCAs are required to identify which models they will be utilizing and the particular details of the policy and procedure to CPO staff upon DDAP's request.

DDAP is identifying individuals who have overdosed as an additional priority in an effort to better facilitate access to care directly following an overdose event. Admission to treatment for individuals who have overdosed must be considered in conjunction with the requirements delineated in the DDAP Treatment Manual. Further, if the SCA chooses to restrict access to assessment/admission to treatment, such restrictions shall not apply to overdose survivors.

In those instances in which an SCA is unable to actively engage in any of the identified strategies noted within this policy, a waiver request must be submitted to DDAP identifying those specific barriers which prevent implementation as well as action steps and timelines for mitigating the barriers.