COUNTY OF ALLEGHENY

RICH FITZGERALD
COUNTY EXECUTIVE

TESTIMONY BEFORE THE HOUSE AND SENATE POLICY COMMITTEE ON THE OPIOID CRISIS

August 2, 2016

Good afternoon. I'm Dr. Latika Davis-Jones, Administrator of the Allegheny County Department of Human Services (DHS) Office of Behavioral Health (OBH), Bureau of Drug and Alcohol Services (Allegheny County Single County Authority). I am responsible for administering the planning, organization, coordination and evaluation of the bureau which includes the provision of technical assistance and ensuring drug and alcohol providers are in compliance with federal, state and local drug and alcohol regulations and mandates.

Thank you, Representative Gainey, for inviting me to provide comments on the opioid epidemic. Much of my work over the past two years has primarily been focused on addressing this issue. We are currently facing a challenging time in our region, and since 2008, Allegheny County has had more than 1,900 fatal overdose deaths with over 1,300 of those deaths having opioids indicated as a contributing factor. We know that the current opioid epidemic is non-discriminating. We have rich, poor, black, white, old, and young people dying every day. One life lost to this epidemic is one life too many.

As Director Cherna mentioned, I plan to offer a few recommendations on treatment and prevention for the House Policy Committee to consider when it comes to designing and supporting a comprehensive behavioral health response to address this epidemic.

First, it is imperative that we listen to the science. The science tells us that addiction is a chronic disease and we should no longer support the idea of providing episodic care to a disease that should be managed from a chronic care and disease-based approach (NIDA, 2012). We must develop better ways to deliver quality care across the lifespan which includes: pre-treatment, adequate lengths of stay/follow-up/aftercare, and recovery/peer supports. It must also include assistance to providers who seek to deliver evidence-based programming, offer medication assisted treatment, ensure effective clinical relationships, and adopt practices that support overall recovery management (Achara, 2010 & William White, 2006).

The science tells us that treatment works and recovery is possible (NIDA, 2012)! However, currently we do not have enough capacity to treat everyone in a timely fashion should they want help. Therefore, we need to have increased funding to expand access to high quality substance use disorder (SUD) treatment. This means increasing access and capacity across the existing continuum of care which includes out-patient, partial, detox, and short/long-term rehab which ranges from abstinence based programs to full blown harm reduction models (multiple pathways).

MARC CHERNA, DIRECTOR
DEPARTMENT OF HUMAN SERVICES
OFFICE OF BEHAVIORAL HEALTH
BUREAU OF DRUG AND ALCOHOL SERVICES
HUMAN SERVICES BUILDING • ONE SMITHFIELD STREET • THIRD FLOOR • PITTSBURGH, PA 15222
PHONE (412) 350-3328 • TDD (412) 473-2017 • FAX (412) 350-3336

There is a great need for innovative and high quality substance use disorder treatment programs for high risk and vulnerable populations. For example, our overdose death data from 2008-2014 showed that many of the individuals who died of overdoses had a prior history of receiving publicly funded mental health and /or substance use disorder treatment or had been recently released from the county jail. Many of these individuals died within 30-days of their most recent service or within 30 days of being released from jail. The jail and our behavioral health system are uniquely poised to intervene earlier in the progression of this chronic disease. These systems can assess for overdose risk and can provide increased opportunities for overdose prevention education and provide naloxone to all individuals who have been identified as using opiates.

However, we must also expand access of naloxone to family members, youth serving organizations, child welfare, homeless outreach teams, and other key stakeholders who often engage, through the course of their daily work, individuals who use opiates. Please note, not only should these stakeholders have access to naloxone but they should also be prepared to distribute naloxone to individual that use opioids.

Increasing treatment capacity and expanding the use of naloxone are extremely important endeavors but it's also equally as important that we help individuals learn how to access our behavioral health system. My department receives hundreds of calls per month from individuals not knowing how to get help for themselves or for loved ones. We recently launched a short-term (2 months) public awareness campaign that focused on decreasing stigma about addiction and telling individuals where to call to get help. We need public awareness campaigns like this to continue but on a much larger scale if we want to increase the likelihood of individuals seeking help and learning how to access our system of care.

Traditional mental health providers, primary care physicians, and hospitals need to be equipped to include the assessment of opiates and/or other drugs whether prescribed, or illicitly obtained, in order that the over-all needs and related history of the individual are considered and addressed.

Back to discussing the importance of science and doing what we know works. The literature is quite solid on indicating that medication assisted treatment (MAT) is a viable option for those addicted to opioids. For example, methadone maintenance treatment (MMT) is designed to reduce illegal and harmful opioid use along with the many problems (e.g. crime, death, disease) associated with its addiction. The primary goals of MMT are to decrease and/or eliminate opioid use, to reduce criminal behavior, and to prevent individuals from contracting Hepatitis C and/or HIV. For those that use opioids, methadone maintenance treatment can be an important point of contact with service providers, because it provides an opportunity to educate drug users about harm reduction approaches (i.e., condom usage, needle exchange, effective needle/crack pipe cleaning methods) while addressing their opiate use and potentially their mental health needs (SAMHSA, 2005). Drug treatment is HIV and Hepatitis C prevention. It is therefore imperative that we increase the capacity for medicated assisted treatment, and include consideration of not only Methadone, but also Suboxone and Vivitrol. The decision to use a medication as an assist should be a clinical and medical one, made by the attending physician, clinical team, and the person receiving treatment.

In order combat this epidemic we must continue to develop cross system partnerships and align regulatory and administrative structures to enhance our behavioral health system that builds on the strengths and resilience of individuals/persons in recovery, families, and communities. However, our system must be adequately and flexibly financed to provide an array of services that are accessible, integrated, person-

centered, and culturally competent. We must remember that no one system or agency has the resources to meet all of the needs of persons addicted to opioids and/or other substances. An effective cross-system partnership, and integrated approach will require the ability to collaborate across service delivery systems (physical health, mental health, drug and alcohol) and share pertinent medical information in the best interests, and in full transparency, of those being served.

The good news is recovery emerges from hope and recovery is a reality. It can, will, and does happen!

Thank you.