Ohio House Finance Subcommittee on Health and Human Services
Testimony of:
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Hancock County Board of Alcohol, Drug Addiction and Mental Health Services
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Chairman Romanchuk, Ranking Member Sykes, and members of the Health and Human Services Subcommittee, good morning.

Thank you for the opportunity to provide testimony this morning. My name is Precia Stuby. I am the Executive Director of the Hancock County Board of Alcohol, Drug Addiction and Mental Health Services, where I have been employed for 27 years.

Today I would like to draw your attention to two handouts that I have prepared to summarize my remarks and draw your attention to key points.

It is well known that in order to address the opiate epidemic a 360 degree approach is needed. My remarks are limited to the role of the local behavioral health systems.

The first box on your left is related to reducing the number of overdose fatalities. It has been proven that overdose fatalities can be reduced when the following four things are implemented:

1. Access to Narcan; especially with first responders and warm handoffs to treatment.
2. A prescription monitoring program, such as OARRS ;
3. 24/7 access to crisis stabilization with Medication Assisted Treatment followed by treatment;
4. Warm hand-offs. (Outreach following an overdose event.)

Local communities are doing well with two out of the three: access to Narcan and a prescription monitoring program (OARSS). This is a result of changes in legislation and an investment of resources.

24/7 hour access is widely unavailable. Isn't it counterintuitive that the fewest resources are at the front door? With any other disease, this would be the first place of investment. That's why a stint procedure can happen within minutes of a heart attack; or the impact of a stroke can be reduced if treated within hours. In the case of addiction, when an individual expresses a willingness to engage in treatment, services must be immediately available. Imagine your son or daughter coming to you in the middle of the night on a Saturday, sick from withdrawal and wanting treatment. Would you want to say we'll call an agency on Monday morning and get an appointment to try and get you help? Would you take them to the emergency room where you might be given some medication to help with her symptoms and sent home? Or would you want to be able to say you're going to get immediate help, put them in the car and take them to a crisis center? At the center they would be assessed, their symptoms relieved and

treatment initiated. Centers like this increase engagement and reduce emergency room visits, jail admissions and most of all overdose fatalities. So why don't they exist? **The simple answer is stigma and resources. The number one priority in our system is to increase access to 24/7 crisis stabilization and withdrawal management (detox).**

Let's talk about the 4th thing known to work: warm hand-offs. What does it mean? Warm hand-offs are ensuring there is a personal linkage from point A to point B. Many of you are familiar with the DART program in Toledo. This is an example of a warm hand-off. If an individual is seen in the emergency room for an overdose and then discharged, an outreach visit is made by a law enforcement official to try and engage them in treatment. Their success rate is over 70%. Similar programs are producing the same results. Warm hand-offs work. Our system is currently designed to deliver treatment when someone enters an agency. Warm hand-offs are about reaching out to get them there.

The second box has to do with treatment/recovery support services. Many are skeptical about treatment, citing poor outcomes and the continued rise in the number of fatalities. I would ask that you keep the following key points to keep in mind:

a. There are no predictive analytics as to who will do well in treatment.
b. While many do not complete treatment and/or have a reoccurrence, there is a cumulative positive impact from each treatment episode.
c. Treatment outcomes are improved when coupled with recovery supports by a minimum of 15%.
d. The number of individuals in treatment for opiate addiction is growing exponentially; much faster than the number of overdose fatalities. I draw your attention to the attached graph. The graph illustrates the overall increase in the number of individuals who are seeking treatment for substance use in our community. Of those seeking treatment, the number seeking treatment as a result of opiate addiction is now over 50%. Please note the number of overdose fatalities across the bottom. The risk of death is much less in relationship to the number in treatment than in 2009. Treatment works!

   If you look at the continued spike in the number of individuals seeking treatment across our state in relationship to the number of deaths, you will see that the odds of survival are improving.

Resources are needed to sustain the services in place and to increase capacity, especially in recovery support services (peer support; housing; recovery support organizations; support groups, etc.).

The third box has to do with Targeted Intervention. The biggest predictor for addiction is family history. Early Intervention is needed for high risk populations. If we don't do something about all of the children we know to be high risk, we will have another generation of

individuals with substance use disorders right behind those that are currently impacted. This group includes:

a. Siblings of individuals who are addicted
b. Infants born exposed
c. Children involved in change of custody hearings
d. Children removed by Children's services

In addition, we must provide support for the families who are caring for the children who have been orphaned by the epidemic or whose parents are too sick with the disease to care for them.

Finally, we must support parents/families who are struggling because they have a family member who is impacted. They are hurting and in need of help.

The fourth box is prevention and community engagement. Each of these categories described above should inform the prevention and community engagement efforts at the local level. In the same way the "pink" initiative was started and expanded for cancer, the same thing needs to happen to remove the stigma associated with the disease of addiction. If not now, before the epidemic is over we will all know someone who has been impacted. In addition to broad prevention efforts such as Just Start Talking, efforts to remove the blame and shame associated with addiction need to be increased. This must occur in order to increase the numbers of community members to get involved and become part of the solution. As I mentioned at the beginning of my testimony, this epidemic requires a 360 degree approach.

Lessons learned from overdose fatality reviews; input from individuals who are in recovery and their families; and science must guide our efforts to inform and engage local communities, prevent overdose fatalities, and improve outreach and engagement in treatment and recovery supports.

Guidance and answers as to what should be done are widely available; resources are not. It is very challenging to go to bed each night with this knowledge. I know what to do, I know how to do it, but I can't do it because I don't have resources. Hold me and hold our local systems accountable but don't withhold resources. Lives depend on your decision to put resources into our local systems.

Proven Methods to Reduce Overdose Fatalities:

1. Access to Narcan
2. Prescription Monitoring Programs
3. 24/7 Access to Crisis Stabilization/Withdrawal Management (Detox)
4. Warm Hand-offs

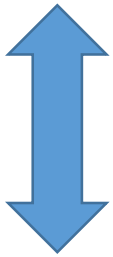
Treatment

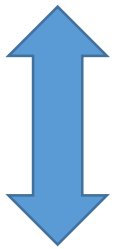
1. There are **No Predictive Analytics** as to who will be success in treatment. Access must be made available to all.
2. There is a **Cumulative Positive Impact** to episodes of treatment. There is no such thing as a "waste of resources".
3. The availability of **Recovery Supports** Improve Treatment Outcomes by a minimum of 15%.
4. **Treatment works.** When compared to the number in treatment, there is an increased likelihood of survival.

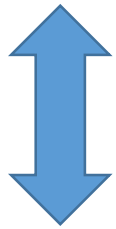
Early Intervention is Critical for High Risk Populations:

1. Siblings of individuals who are suffering with substance use disorders.
2. Infants Exposed to substance use.
3. Children involved in Change of Custody as a result of their parent's illness.
4. Children involved with Child Protective Services as a result of their parent's illness.
5. Family members with a family member who has a substance use disorder.

The Biggest Predictor of a Substance Use Disorder is Family History



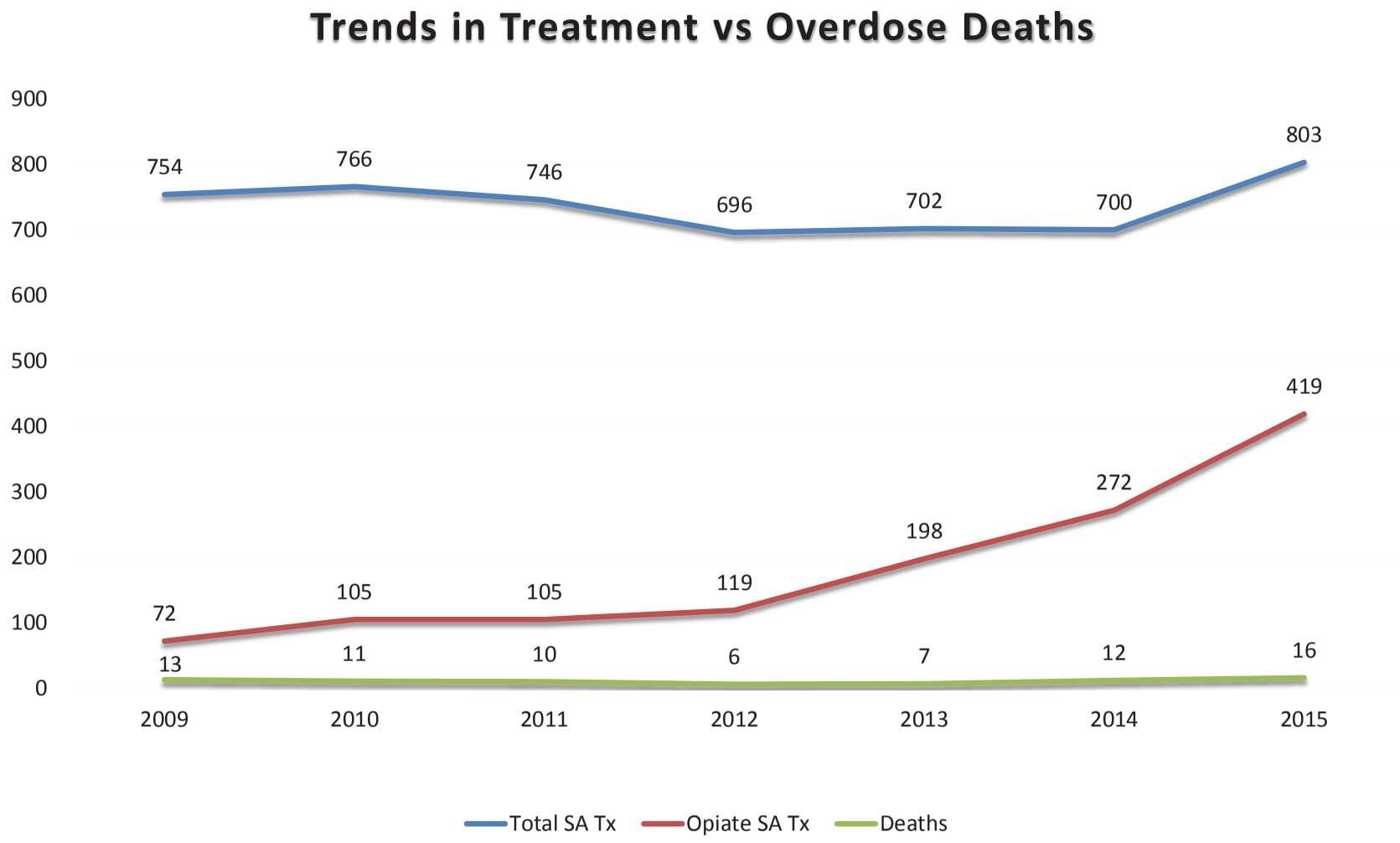




Community Engagement/Prevention

1. There needs to be a focus on reducing the stigma associated with the disease of addiction. **We all know someone.**
2. Efforts need to be informed by our best teachers: overdose fatality reviews; input from individuals and families in recovery; and the science of addiction.

Drafted March 20, 2017



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