COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES

HUMAN SERVICES COMMITTEE
PUBLIC HEARING

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TUESDAY, MARCH 26, 2019
9:00 A.M.

PRESENTATION ON ADOLESCENT SUBSTANCE USE CARE IN PENNSYLVANIA -- CHALLENGES AND OPPORTUNITIES

BEFORE:
HONORABLE GENE DiGIROLAMO, MAJORITY CHAIRMAN
HONORABLE STEPHANIE BOROWICZ
HONORABLE BARBARA GLEIM
HONORABLE JAMES GREGORY
HONORABLE DOYLE HEFFLEY
HONORABLE JOHNATHAN D. HERSHEY
HONORABLE NATALIE MIHALEK
HONORABLE LORI A. MIZGORSKI
HONORABLE THOMAS P. MURT
HONORABLE ERIC R. NELSON
HONORABLE F. TODD POLINCHOCK

* * * * *

Debra B. Miller
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BEFORE (continued):

HONORABLE JAMES B. STRUZZI II
HONORABLE TARAH TOOHIL
HONORABLE JOSEPH C. HOHENSTEIN,
ACTING DEMOCRATIC CHAIR
HONORABLE DANILO BURGOS
HONORABLE ISABELLA V. FITZGERALD
HONORABLE KRISTINE C. HOWARD
HONORABLE STEPHEN KINSEY
HONORABLE MAUREEN E. MADDEN
HONORABLE DAN L. MILLER

I N D E X

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SUBMITTED WRITTEN TESTIMONY

* * *

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P R O C E E D I N G S

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MAJORITY CHAIRMAN DiGIROLAMO: Good morning and welcome, and I'd like to call this meeting of the Human Services Committee to order.

And if I might ask everyone to stand for the Pledge of Allegiance as we start the hearing.

(The Pledge of Allegiance was recited.)

MAJORITY CHAIRMAN DiGIROLAMO: Okay. And again, good morning, and it's a very important hearing we're having today.

And instead of taking the roll call, I'm going to give the Members that are here an opportunity to introduce themselves, and I'll start with Lori.

REPRESENTATIVE MIZGORSKI: Good morning.

I'm Lori Mizgorski from Allegheny County. I represent the 30th District, which includes Shaler, Hampton, and Richland Townships, Fox Chapel Borough, and part of O'Hara Township.

REPRESENTATIVE MIHALEK: Good morning.

Natalie Mihalek, representing the 40th District. I have the southern portion of Allegheny County and parts of Washington County.

1 REPRESENTATIVE GREGORY: My name is Jim Gregory.
2 I represent the 80th District, which is a large portion of
3 Blair County. But thank you for being here today.
4 REPRESENTATIVE POLINCHOCK: Hello, everybody.
5 I'm Todd Polinchock. I represent the
6 144th District, which is entirely in Bucks County, about
7 40 minutes north of Philly.
8 REPRESENTATIVE BOROWICZ: Hi there.
9 My name is Stephanie Borowicz, and I represent
10 the 76th District, which is Clinton County and part of
11 Centre County.
12 REPRESENTATIVE FITZGERALD: Good morning.
13 My name is Isabella Fitzgerald. I represent
14 the 203rd Legislative District in Philadelphia, the
15 northwest.
16 REPRESENTATIVE HOWARD: Hi.
17 Kristine Howard, the 167th District, which is the
18 eastern part of Chester County.
19 REPRESENTATIVE GLEIM: Hello.
20 My name is Barb Gleim. I represent the
21 199th District, which is Cumberland County.
22 REPRESENTATIVE STRUZZI: Good morning.
23 Jim Struzzi, Indiana County.
24 REPRESENTATIVE MURT: Tom Murt. I represent part
25 of Philadelphia and part of Montgomery County.

1 MAJORITY CHAIRMAN DiGIROLAMO: Good morning.
2 Gene DiGirolamo. I represent the 18th District in
3 Bucks County and am Chairman of the Committee.
4 ACTING MINORITY CHAIR HOHENSTEIN:
5 Joe Hohenstein, the 177th in Philadelphia, the lower
6 northeast.
7 MAJORITY CHAIRMAN DiGIROLAMO: Okay. And again,
8 I think this is a really important issue that is in front
9 of us today, and that is adolescent substance use
10 treatment.
11 And I can tell you from personal experience that
12 there is a lot of challenges, not only from my area but
13 around the State, trying to find treatment and placement
14 for our young people. And it is always a challenge, and
15 that's why I think it's important that we're here today.
16 And I want to thank Bill Stauffer, who is the head of
17 Pro•A, for bringing this issue to the attention of our
18 Committee.
19 And just a couple of ground rules before we get
20 started. First, we are being televised. I believe PCN is
21 picking this up, so I would just like everyone to remember
22 that.
23 And also, I think it's better if we hear the
24 testimony from all three of our testifiers today first, and
25 then at the end of the testimony, we will open it up for

1 questions from the Members that are here today.

2 Okay? All right.

3

4 IDENTIFY HISTORICAL PERSPECTIVES

5 AND TRENDS IN CARE

6

7 MAJORITY CHAIRMAN DiGIROLAMO: So with that,

8 we're going to start out with the topic of "Identify

9 Historical Perspectives and Trends in Care" by Patti Anne

10 McAndrews, who is an adolescent and youth advocate.

11 Patti, whenever you're ready, you can begin. And

12 I would also caution everybody to try to speak as closely

13 to the microphones as possible so everyone in attendance

14 will be able to hear.

15 MS. McANDREWS: Hi, everyone.

16 My name is Patti Anne McAndrews, and I am the

17 Director and Founder of Adolescent & Young Adult Advocates.

18 And I also have heavy-duty allergies, so excuse me for my

19 voice.

20 I have been in the business for 40 years, and I

21 have a bio here, with the Montgomery County DUI system in

22 '85. I put it together. I was the Director of Rehab After

23 Work. I wrote and kicked off Rehab After School, which is

24 now owned by Pyramid Health Systems. And I have been in

25 private practice since 1991.

1 I started treatment work at The Bridge when I
2 was 20, working with their adolescents in life-skills
3 development. And in 2005, I started Adolescent Advocates,
4 and I started Adolescent Advocates which put me at this
5 table.
6 Adolescent Advocates is a treatment center --
7 intensive outpatient, partial hospitalization -- for
8 adolescents and young adults. We're located right near
9 Villanova University in Rosemont, Pennsylvania. And I
10 started that program as a result of my husband dying and my
11 son dying.
12 My daughter came to me after her father died of
13 cancer and her brother had had an accident with a brain
14 injury and could not deal with his father's death. She
15 came to me after and she said, what do we do now? And
16 that's why I'm here. What do we do now?
17 So that was 15 years ago, and I walked in and
18 said, okay, let's remember, and she said, do not tell me to
19 remember the good times. And that's what I'm doing here
20 today, too, not to have you remember only that there are
21 adolescents out there that are superheroes, that are doing
22 great, that we pride ourselves in in the State of
23 Pennsylvania. I have plenty of adolescents that I know
24 that are doctors, that became doctors after our program,
25 that became lawyers, that became owners of companies,

1 business executives. But I'm asking you to think about the
2 kids that are out there that aren't doing well.
3 So when my daughter said that, I said, what's the
4 hardest thing you could do, and she said, take the GREs.
5 She had graduated tops cum laude. She went; she took the
6 GREs. And I told her, you take the GREs, I'll start a
7 business. I had no idea that I would be sitting here
8 today, 15 years later.
9 When we speak about adolescent care, if you look
10 at your monitor, you look at the screen, we're talking
11 about an average of 62,000 adolescents who are currently
12 using substances, illicit substances, when the 2017
13 questionnaire was handed out by the -- I'm sorry -- the
14 National Survey on Drug and Health. They did a survey, and
15 they found that 93 percent of the kids were abusing
16 alcohol, and 51 percent were binge drinking.
17 My biggest problem on here is that we had
18 96,000 abusing marijuana, and of that 96,000 abusing
19 marijuana, the THC levels of the marijuana have gone from
20 2 percent to 62 percent. And the difficulty that we have
21 is insurance companies are reluctant to pay for care.
22 Meanwhile, we have kids that are smoking marijuana that
23 gives them psychotic episodes. So we have difficulty with
24 getting treatment provided with insurance, even for the
25 THC.

1 Despite the fact that adolescent use hasn't
2 changed much over the years, it has dropped. It has gone
3 back up, and it has significantly gone back up since 2015.
4 And despite that, we are having overdoses and death rates
5 that are in the 70,000 last year, in '17. In 2017, we had
6 70,000 deaths from opioids. There was a decline only
7 between 2007 and 2014. It increased in 2015 and hasn't
8 stopped.
9 With this chart, I want you to be aware of the
10 fact that the 15-to-24 age has gone up steadily, but what's
11 more important is, they're not getting treatment. And
12 you'll see that the 25- to 35-year-olds have skyrocketed.
13 These are deaths in the State of Pennsylvania. These are
14 our kids. So this isn't a national survey; this is a
15 Pennsylvania overdose issue.
16 And presently, though we are not the number-one
17 State for overdose, per capita we are the number-three
18 State for overdose. And again, the highest numbers are
19 15 to 35, so we are not intervening during adolescent
20 time.
21 During the time that we did this, I picked up the
22 news from CNN, and on the 21st of this month, they printed
23 that opioid fentanyl skyrocketed more than 1,000 deaths
24 between '11 and '16 -- a thousand percent; excuse me. So
25 what's happening in the State is happening nationally, but

1 in our State and many other States, there's nowhere to put
2 an adolescent. Adolescent treatment isn't just poor in the
3 State of Pennsylvania, it's poor in the United States.
4 It's poor across the country. So to think about the fact
5 that we have had a 1,000-percent death rate over the past
6 10 years is ridiculous.
7 The need for adolescent treatment:
8 A million people nationally through the ages
9 12 through 17 had a need for treatment. Ninety-one percent
10 received substance use treatment, and of that 91 percent,
11 they didn't all go to rehab. They went to emergency rooms.
12 They went to mental health facilities. They did not get
13 substance abuse treatment.
14 So one of the reasons why we keep going up in our
15 death rate is we are not getting the true specialized
16 treatment. So if I go to an ER, I don't get sent to a
17 rehab. I get cleaned up, I get some fluid put in my body,
18 and I get sent out.
19 So I have been in the ER plenty of times --
20 they call it the ED now -- and what we're finding is the
21 kids and adults aren't getting treatment. So whether
22 you're arrested or you're in an ER, you do not have to go
23 to treatment. There's hopefully some laws coming into play
24 where we can change some of that.
25 In the State of Pennsylvania, 27,000 people

1 between the ages of 12 and 17 needed substance abuse
2 treatment and didn't get it. So 27,000 people that were
3 adolescents did not get care, and that means those
4 27,000 adolescents are still getting high, if they're
5 alive. So with the death rate that we have, some of those
6 are dead, and these are kids. This is the most important
7 product that we have in the United States, and they keep
8 dying.
9 I put this slide in mainly for you to understand
10 what has been happening. When we have a substance abuse
11 issue, often we have a mental health issue. So with major
12 depressive disorder, this chart shows how many kids from
13 12 to 17 had both a major depressive disorder and substance
14 use, in the red. Those people end up going to mental
15 health facilities. They don't get substance abuse
16 treatment.
17 So I go into a mental health facility and I don't
18 get taken care of for the drug problem. And we can't say
19 whether the drug problem caused the mental health problem
20 or the mental health problem caused the drug problem, but
21 you certainly can't fix it if you don't address the mental
22 health problem.
23 In Adolescent & Young Adult Advocates, we do
24 mental health and we do drug and alcohol. We used to
25 separate them. We would put the drug addicts over here and

1 we'd put the mental health people over there, and we found
2 that the drug addicts were getting better and the mental
3 health kids weren't. So we started doing the same type of
4 treatment, and the drug-addicted kids started taking these
5 mental health kids into AA meetings, took them to NA
6 meetings, and I was getting phone calls in my office, why
7 are your kids at this meeting that don't have a drug or
8 alcohol problem? And I said, is it an open meeting? Yes.
9 Take care; have a great day, and I would just hang up,
10 because they would harass me.
11 So the idea is that the behavior modification
12 program for the mental health piece wasn't working. It
13 wasn't working on our drug and alcohol kids, but they were
14 able to help some of our mental health kids to get better
15 faster. It's not that the mental health kids wouldn't get
16 better in a mental health track, but they were getting
17 better faster because of the leadership of our drug and
18 alcohol kids.
19 And at first, the parents would freak out: Why
20 are you putting my kid with a drug addict; they're going to
21 become a drug addict. You don't catch it. You all aren't
22 going to catch this from anybody. You either have it or
23 you don't have it. And you either have a major depressive
24 episode to lead to it, but you don't catch this. It's not
25 like that.

1 Barriers to treatment:
2 I have a lot of interns from, we have Children's
3 Hospital doctors that do their residency with us, a piece
4 of it for behavioral health and addiction, but we also have
5 interns from Bryn Mawr and UPenn. I happen to be in a
6 highly resourced area, and I actually don't need to sit
7 here today. But I do know that even with major resources,
8 you're in trouble with adolescents, and people need to
9 understand this.
10 So of the two places that we could find, and I
11 want to show you something. I'm going to give you a closer
12 look at this. But these are all the pages that my staff
13 went through to research treatment in the State of
14 Pennsylvania, and you can see it's pretty tedious. Try
15 being a mother with a kid with a drug problem. Think about
16 what it's like to have to go through this.
17 There are two programs that take adolescents for
18 treatment, and one is questionable because it's in
19 Pittsburgh. It's part of the Pyramid Health Systems. So
20 now, I heard you Philadelphia folks. It's 4 ½ hours from
21 your door to this place. So forget the family piece.
22 Not only that, I have to go to Altoona to get
23 detoxed in the adult program, 2 hours away, and drive back
24 to Pittsburgh after I'm detoxed. Meanwhile, my family is
25 back in Philadelphia, and you might as well be in

1 Cleveland. So you're looking at the same distance to get
2 to this treatment center.
3 Caron Treatment Center is the only treatment
4 center in the State of Pennsylvania that will take an
5 adolescent from detox through the completion of an
6 inpatient care and then have them go out to an intensive
7 outpatient, either one of theirs or someone like myself or
8 some of the other intensive outpatients, where they can
9 build themselves to stay strong at home. So they're away,
10 and then they have to come home. Thank God I'm back in.
11 It's not easy talking in front of all you guys, and ladies.
12 So the idea of having these somewhat outdated --
13 so parents are calling and they have this kid that has a
14 drug problem, and they call these places and they have
15 these two options, and only one takes Medicaid. So they
16 have one option, and that is 4 ½ hours away from you. Some
17 of you are a little bit closer, but you still have to go
18 that 2-hour stint if you have to go to detox.
19 So when I put this one in, "No Health Care
20 Coverage and Could Not Afford Cost" is the number-two
21 reason why people don't make it to treatment. With that in
22 mind, Caron Treatment Center, you better get your checkbook
23 out and get that deductible in their pocket before you
24 start treatment. So you're looking at 10 grand upfront
25 before you even can walk through that door.

1 Some people have a lesser deductible, but a lot
2 of people that are middle class, and the average income in
3 the State of Pennsylvania is about $60,000. So you have
4 $60,000, and if you're a two-family, 60,000, still you're
5 at 100,000 a year. You have a family; you have got two or
6 three kids. How are you scraping together the deductible
7 for that kid while you're paying for the other kids?
8 You're in trouble. You're in deep trouble. They are only
9 in network with higher-end Blues, Penn Behavioral Health,
10 Cooper Medical, but there isn't anything average about
11 getting to Caron.
12 I love the program. We get to use it. Again,
13 I'm from a resourced area. If you're not highly resourced,
14 you're not getting in.
15 Adolescent treatment has changed drastically over
16 the years, but adolescent use has not. If you look at this
17 chart, heroin is the same. The only thing that took a dip
18 is alcohol, and that's because the weed is so darn strong,
19 that's where they're going. They're going to the pot.
20 And the synthetic marijuana can be smoked through
21 an E-pen, and when they're smoking this, you can't tell.
22 So I could be in a classroom, take a couple of hits, be
23 high, and you don't know I even did it. My neighbor does
24 because he saw me hitting on that, but you all don't. The
25 teacher doesn't know. And if they did know and you were a

1 millennial -- thank God we're over that; no offense to
2 anybody in the room -- but it didn't happen.
3 So during the millennial time when nothing was
4 really happening and nobody's children were on drugs, we
5 lost a lot of treatment centers. We didn't lose drug use.
6 This is how it used to look in the State of Pennsylvania
7 for treatment. These little blue dots show where all the
8 treatment centers were. I used to shoot kids up to
9 White Deer Run. I could send kids all over the place. Not
10 anymore.
11 See that Scranton area? There's nothing there
12 anymore. See that black dot? That's the only one. That's
13 Caron. That's the one where I have to pay my deductible
14 when I walk through the door.
15 These little gray ones? They're all about
16 criminal justice. The yellow ones are criminal justice
17 referral only.
18 So we're stuck with a couple of blue dots. This
19 one in Lancaster did not work for us. I forget what the
20 issue is. I apologize for that. But you are looking at a
21 situation that is fairly grave, and we have to go back to
22 the fact that we have 27,000 kids that still didn't get
23 treatment. And we don't know what age they were. They
24 could have been 15, so that means they're still 17 and
25 they're in high school and there's nowhere for the general

1 public to send them.

2 The negative outcomes I think everybody is

3 familiar with. I'm not educating you on the fact that

4 people are dying from the use of opioids, but we're also

5 having car accidents where innocent people are getting

6 hurt.

7 I worked in DUI for a while, and I had the repeat

8 offenders' program where I consistently would get yelled at

9 by people with a .4, and I was shocked that you could get

10 that without practice. So some of us have some very wild

11 metabolisms, but that's what's happening. They go out;

12 they have accidents through suicide. There's homicide.

13 In Havertown, Pennsylvania, which is a

14 middle-class Pennsylvania area, a 17-year-old boy shot

15 another kid in the face over an ounce of pot. It was all

16 over the news. This kid that was shot was a football

17 player. He was in the back seat, and the kid in the front

18 seat said that he was going to hurt him and it was

19 self-defense. He leaned over and shot him in the face.

20 So we're talking about a ridiculous amount of

21 need. And I don't know your job. I listen in to the

22 DASPOP things that Gene does, and I try to keep up on

23 going to the Advisory Council. And I know there's these

24 block grants and there's this money that's going here and

25 there's physical health and there's mental health help.

1 And then there's drug and alcohol, and drug and alcohol has
2 always been like the ugly, I don't want to look at it,
3 because we really want to remember all the good things. We
4 don't want to remember the ugly things.
5 And I don't care if you're Betty Ford or you're
6 Downey, Jr.; you're still a drug addict, and it's not posh
7 no matter how much a rapper is talking about getting high
8 and doing drugs. It is not an attractive thing, and
9 there's major stigma. People don't even want to go get
10 help, but here's people knocking at our doors, begging for
11 help, and we don't have money.
12 "James" is a 15-year-old male. His name is not
13 James, but I threw that up there because I'm not allowed to
14 break confidentiality. His grandmother called our office,
15 and I happened to walk into the front office where the
16 phone call was received, and my office manager was really
17 upset. She had just hung up the phone from James's
18 grandmother, who was 80 years old. Her son, the
19 grandmother's son, and her grandson's mother both were drug
20 addicts. They had this child, and she took over.
21 They don't live in Kensington; they live in
22 Malvern. They don't have a lot of money, and her husband
23 is failing. The other grandmother helps out. She's in her
24 mid-60s. She was hysterical on the phone. And my office
25 manager just looked at me, and I said, call her back, and

1 we took James.

2 So our pro bono cases are not easy most of the

3 time. They're pretty darned difficult, but we take them,

4 as many as we can. And the reason that I like taking them

5 is because I have a very privileged group of spoiled kids

6 who never were told no, and I think people think I'm really

7 great at what I do because I'm really well-known, except

8 the only thing I'm really known for is saying no. If you

9 say no, you get a whole lot of growth out of an addict.

10 You have to say no. You have to keep saying no. You can't

11 just say no, you have to say no! Every single day I'm

12 saying no. I have a "NO!" button in my office, the little

13 thing that you get from Staples?

14 James's grandparents tried everything. They went

15 through this list. They called Pyramid. He was not

16 allowed at Pyramid because he had a suicide attempt. Even

17 though it had been a month or two since and he was not

18 suicidal, they wouldn't take him.

19 He was at school. He was coming to us. He

20 really liked our program. He wanted to do everything we

21 said. So he started doing everything we said, except at

22 home, he was sweating, he was throwing up, and we were

23 starting to fear he was going to start having seizures.

24 He called my business partner and said, what do I

25 do; I'm sweating. She said, I don't know; we've got to get

1 you to a hospital. He said, I don't want to go to a
2 hospital. She said, if you stop using, you will have a
3 seizure. So he took another pill. I called the
4 grandmother. I said, take him down to Children's Hospital.
5 And I told you that we have residents at our program, so
6 I'm thinking, okay, they owe me one. Not really.
7 The kid went in with the grandparents, because he
8 was no longer in acute withdrawal. He wasn't sweating; his
9 blood pressure was okay, because he just dropped a Xanax.
10 So he went home and went through the process again, and
11 that's when the teachers and our staff had harassed Pyramid
12 long enough that they took him back.
13 He went to Pyramid, but he had to go to Altoona
14 to an adult program to be detoxed and then a 2-hour ride
15 back to Pyramid. So that's what you're looking at when
16 you're trying to get someone treatment that's on Medicaid.
17 You're looking at this same process, if we go
18 back to the idea of being an average Pennsylvanian with a
19 $60,000 salary, trying to raise kids as a single parent,
20 you won't get treatment. So those 27,000 kids that we did
21 not treat, that wanted treatment, that came for treatment
22 but we could not give them treatment -- I don't know what
23 you do with the money. I sincerely don't. I don't pay
24 full attention when Gene and Deb are talking. It gets
25 pretty intense. But I know that you have these grants, and

1 I do know that in the past when we have put money towards
2 mental health, drug and alcohol was not in that block. It
3 was not acknowledged in that block, and then we didn't get
4 the care we needed. But when that happened, we had more
5 rehabs. We don't even have rehabs. We have nowhere.
6 They highlighted this. Bryn Mawr and Penn
7 students went through this. They are not dummies. They
8 made phone calls. They asked questions like, to a staff
9 member, do you feel safe? I'm not allowed to answer those
10 questions.
11 Do you feel safe? I hope to God my staff feel
12 more than safe. They love coming to work. They enjoy it.
13 We have a great treatment center. But that's what every
14 kid deserves. Every kid in the State of Pennsylvania
15 deserves it.
16 I have spoken with Life of Purpose to try and get
17 them to put in an adolescent unit. I'm in conversation
18 with Brian O'Neill at Recovery Centers of America. He's
19 very open to it. We're looking at starting a treatment
20 center there. I know that I can afford to give them some
21 time, so I told them I'll consult. I don't care. Let's
22 get this thing done.
23 My daughter asked me 15 years ago, what do we do
24 now? That got me in this seat today, and you can tell I
25 was terrified. I'm not a general public speaker. But my

1 question is, what do you do? What are you going to do with
2 that money? Are you going to look at what looks a little
3 bit easier to vote for, or are you going to dive in and
4 say, you know what? I'm going to take care of this dirty
5 mess and I'm going to help these people get the care they
6 need, because they're out there, and they're suffering, and
7 we need your help. So my question is, what are you going
8 to do?
9 God bless you. Thanks so much for listening to
10 me.
11 MAJORITY CHAIRMAN DiGIROLAMO: Thanks, Patti.
12 Pretty eye-opening. Very compelling. Thank you.
13
14 IDENTIFY RECOVERY PERSPECTIVES
15 ON CARE
16
17 MAJORITY CHAIRMAN DiGIROLAMO: Next, we're going
18 to have Samantha Osterlof, who is from Summit Behavioral
19 Health, and her topic is going to be "Identify Recovery
20 Perspectives on Care." Okay?
21 MS. OSTERLOF: Thank you.
22 MAJORITY CHAIRMAN DiGIROLAMO: Samantha, whenever
23 you're ready.
24 MS. OSTERLOF: I want to thank everybody for
25 being here and for Bill for asking me to be here. It's

1 certainly nothing short of a miracle that I'm alive today.
2 And kind of what I want to focus on with my testimony is
3 like Patti Anne said, the trajectory of my life could have
4 been a lot different if there was the access to a greater
5 level of adolescent care, a greater need and emphasis put
6 on prevention, and my intervention could have taken place
7 much sooner than it did, but to also highlight what being
8 supported in recovery has been able to give me and the life
9 that I live today as a result of that recovery.
10 So my name is Samantha Osterlof, and I'm a person
11 in long-term recovery, and what that means for me is that I
12 have not used a mood- or mind-altering substance since
13 December 21st of 2011 after about a little over a decade of
14 active use of various substances, beginning with the
15 drinking, the marijuana, the typical things that we hear
16 when an adolescent is able to tell their story, and
17 eventually moving on -- it's not on? Oh; oopsy. Should
18 I start over? No? Okay -- eventually moving on to a
19 full-blown opiate addiction.
20 As a result of my sustained recovery, I'm able to
21 do a lot of beautiful things today that are a result of
22 recovery. So I am a graduate with a bachelor's degree in
23 criminal justice. I did graduate with honors from
24 Elizabethtown College and was able to do that in active
25 recovery.

1 I have a graduate degree from Saint Joseph's
2 University in Philadelphia where I graduated with honors,
3 with a major in criminal justice and an emphasis in
4 behavior management.
5 I am a member of the Lebanon County Harm
6 Reduction Committee, so I help give back to my local
7 community in that way.
8 I have been able to be a contracted trainer for
9 Pennsylvania Family Recovery Alliance, helping individuals.
10 We start a 7-week training coming up where I will be able
11 to help people in early recovery with children to
12 transition back into their ability to be a parent and work
13 on their recovery.
14 I have done multiple speaking commitments for the
15 Attorney General's Office, speaking to members of the State
16 Police, individuals that are about to graduate med school,
17 and being able to talk to them a little bit about my
18 history and kind of some extra things for them to keep in
19 mind as they go out in the field, whether it be in the
20 hospital system, what you can take a deeper look at, or
21 when you're out there, you know, patrolling or you're
22 arresting somebody, ways in which you can speak to somebody
23 with substance use disorder that helps initiate change, you
24 know, and doesn't perpetuate the stigma attached to the
25 criminal justice system as well as the addict.

1 And regardless of those, you know, monetary
2 things I have been given, you know, in a life of recovery,
3 I have been able to cycle off of a dependency upon my State
4 of Pennsylvania resources and have been able to become
5 fully financially self-sufficient.
6 And really what's most important to me is the
7 beautiful relationships I have been able to build as a
8 result of my recovery, you know, sustained and healthy
9 relationships with my parents, who are here today. If you
10 have any questions for them, they are in the back. I saw
11 them walk in. You know, this beautiful relationship with
12 my family and the ability to be a mother, because something
13 that really touches my heart that is, you know, an ongoing
14 part of the epidemic in general is grandparents raising
15 children, raising their children's children.
16 And I was blessed enough, which I also will
17 stress, you know, like Patti Anne did, is that I was a
18 person of privilege in a sense of, you know, a healthy, a
19 healthy, stable household to help me with those things,
20 help me get into treatment, help me take care of my
21 daughter so she didn't end up in the system, and the access
22 to a private insurance policy under my father to seek
23 treatment options.
24 And when I say all that -- and I talk about,
25 you know, I'm an endocarditis survivor. I had a

1 tricuspid valve repair at the age of 22. As a result, I
2 have continued IV drug use and my inability to enter into
3 recovery. And when I say that, I have to say that I came
4 from a loving household, a two-parent household, where I
5 was given all the opportunities that we think of when we
6 think of a successful child, right? I played piano. I
7 played clarinet. I played violin. I was a cheerleader. I
8 did soccer. I did field hockey. I did all these things
9 that on the outside made me look like Samantha is going to
10 do a really good job in life, right? She's going to do
11 really well. She's an honor student in high school. She
12 sometimes comes to school late but doesn't have a large
13 amount of absences. I was a member of the yearbook, the
14 newspaper. You know, I did all this stuff that on the
15 outside made me look like a thriving adolescent.
16 And when I start talking about my story and we're
17 talking about this topic today of, you know, prevention and
18 treatment and support and lessening the stigma associated
19 with substance use disorder, mental health, and recovery in
20 general, most people's first question to me is, where were
21 your parents? Where were the school administrators? Where
22 were your coaches? Where were these people who were seeing
23 you on a daily basis? And I can tell you 110 percent that
24 they were right there.
25 So when we talk about a couple of these pieces

1 that early on could provide support, where I talk about
2 early on, I can't tell you that if at 16 or 17, if somebody
3 would have came into my life and said, you need treatment,
4 you need prevention, you need to take these classes or be a
5 part of these programs, I can't 100 percent tell you that I
6 would have joined them and got clean before the age of 24.
7 I can't tell you that that would have happened. But what I
8 can tell you is that it might have provided me a resource,
9 a resource to offer and access help, a resource for my
10 family.
11 Because when we talk about the family system, I
12 talk about my story and having a two-parent household. And
13 in the last couple of weeks leading up to today, I have
14 talked to quite a few of the parents of some of my peers,
15 and I can tell you that out of that group of peers, those
16 that have not accessed treatment are either dead as a
17 result of a suicide, dead as a result of a car accident
18 directly related to substance use, have been in and out of
19 the jail systems and treatment. Very few who use the way I
20 did, even early on at the age of 15, 16, 17, 18 and above,
21 are living productive, quality-of-life circumstances today.
22 And I talked to some of those parents of my
23 peers, some of which are not alive, some of which are
24 alive, and I said, what did you guys think? Like, what did
25 you think of what we were doing? And specifically my one

1 friend's mother said, Samantha, we had an idea of what you
2 guys were doing, but we had no idea what to do. We didn't
3 know how to approach you. We didn't know how negatively
4 the situation was going to play out, and we just didn't
5 know. And I can tell you that story is likely true for my
6 parents as well. They just didn't know. There wasn't a
7 high level of family education.
8 When I think back, and Bill had called me and he
9 said, he asked me a couple of questions to make sure that,
10 you know, I was really ready, really able to be here for
11 this testimony and provide something beneficial to you
12 guys, and he said, did you ever go to high school under the
13 influence? And I chuckled a little bit, because absolutely
14 I came to high school under the influence. And I can tell
15 you that there were very few days that I drank alcohol
16 before school, so there may have not been a smell. I can
17 tell you there's many, many days that I was under the
18 influence of narcotic pain medication and many, many days
19 where I was under the influence of marijuana and going to
20 school.
21 I can remember certain days where I may have
22 looked a lot more under the influence than other days, and
23 I cannot tell you that I remember a day when a teacher, a
24 principal, an administrator pulled me aside or looked at me
25 the wrong way. And when I think back to that, I try to

1 think of why. Well, I can tell you that most likely I did
2 not exhibit any warning signs like some of my peers.
3 My peers that may have been deemed druggies, they
4 were coming to school late. They weren't in honors
5 classes. They weren't participating in extracurricular
6 activities. They weren't on the newspaper. They weren't
7 on the yearbook. They weren't in sports or playing
8 varsity. They were individuals who maybe acted out in
9 class. Maybe they were delinquent. Maybe they had a whole
10 bunch of unexcused absences. Those are the people that in
11 my grade were deemed as individuals that may need
12 additional support and may potentially be using drugs. I
13 was not one of those people.
14 And I think back to high school of the stigma
15 attached to the individuals that were deemed troubled. I
16 was not deemed troubled. I was a young female with a
17 two-parent household who wore nice clothing to school, who
18 got good grades, and was kind of left alone. And as I
19 continued to go on, you know, I would go to college. I
20 certainly didn't finish in college. And in my active
21 recovery is really when I finished school.
22 And so we think about now, I work in the field,
23 but I help place adults in treatment, those with both
24 Medicaid and private insurance within the facilities I work
25 for and the other facilities that I work with. And I can

1 tell you that I cringe when I get a call from a mother and
2 her child is not 18, because I don't know where to send
3 them. It's the same issues that Patti brought up. If they
4 have private insurance, awesome, we're a little bit closer.
5 But do you have private insurance and financial means or do
6 you have Medicaid? Okay; cool. Does your family want to
7 be involved in your treatment? Absolutely they do.
8 If I'm a mother -- you know, my daughter is 7,
9 and I can tell you that there's even a stigma attached to
10 her being bad in school -- not my daughter; not my daughter
11 -- and that's what I see with a lot of parents. It's not
12 that my parents didn't care. They cared a lot, sometimes
13 too much. It's not that my parents didn't see there might
14 be an issue, but my parents weren't aware of any resources.
15 I'm only aware of resources because I'm in recovery and I
16 work in the field. So you think about a scared-to-death
17 mother who has no idea what the disease of addiction looks
18 like, no idea, or she'd be scared to death if she knew the
19 progression of the disease and the lack of access to
20 treatment if her child happens to be under the age of 18.
21 We talk about, you know, recovery high schools,
22 and when we think about a recovery high school, it's a
23 person that is able to attend, continue to attend high
24 school, be active in recovery treatment, clinical care, and
25 not fall back in school. One thing that I thought was so

1 brilliant about recovery high schools and collegiate
2 recovery, which I'll talk about soon, is that it's
3 destigmatized.
4 When I was in high school, it wasn't cool to be a
5 part of the group of individuals who weren't taking honors
6 classes and who were falling behind and who were at risk of
7 not graduating high school. That wasn't cool, okay? So
8 there was a stigma attached to, that person might be crazy.
9 They might have mental health issues. They might have a
10 drug addiction. There's a stigma attached to that that we
11 see that starts long before someone becomes an adult and
12 the age of 18, and that keeps people sick. And I stick
13 very close to the fact that when we are quiet, we die, and
14 that's what's happening in the State of Pennsylvania.
15 We're being quiet, and people are dying.
16 I didn't realize how cool it was to be in
17 recovery until I entered recovery and became immersed and
18 associated with other people who were living the same
19 lifestyle in recovery or were advocates of change or
20 advocates and allies in recovery.
21 And I can tell you that when I went to school as
22 an adult for my bachelor's degree, I sat in criminal
23 justice classes with other adult learners and I took a
24 substance use class, and I'm sitting there, and I'm excited
25 because I know I might not have to read the book. This is

1 great. This is a class that I can, like, not really try
2 in, because I should be in the book, you know?
3 And I sat in these classes, and I had this really
4 awesome professor, and I started hearing the other adult
5 learners open their mouth, and I immediately was concerned.
6 I had not made the decision yet in that part of my
7 education as an adult to self-disclose about my story of
8 recovery. I was being quiet. And when these other adult
9 learners opened their mouth, like I said, I was very
10 disturbed, and I raised my hand and I self-disclosed,
11 because I was not going to be quiet and allow these people
12 to enter the criminal justice field having this idea of a
13 substance abuse user.
14 And I remember going up to my professor after
15 class, because I was really scared that I had upset him by
16 self-disclosing, and it was the first time in my education
17 ever, and I had done 3 years at college as a traditional
18 student and somehow got 90 credits, actively using. And
19 again what I'll talk about a little more in detail in a
20 minute is the fact that I received narcotic medication from
21 that university's nursing department, from their little,
22 just a little like urgent care, I guess, on campus. I went
23 to class actively nodding off after beginning to become an
24 IV drug user. And again, even in human services classes, I
25 was never approached by a professor.

1 But thank God for second chances, and this
2 professor, after I self-disclosed at Elizabethtown College
3 and I went up and I said, I'm really sorry that I
4 self-disclosed; I hope I didn't upset you, and he said,
5 absolutely not. He said, my nephew is a heroin addict, and
6 he just can't stay in recovery, and thank you so much for
7 letting the other adult learners know that people that use
8 drugs and alcohol do recover and are not bad people.
9 And what will begin for me is this beautiful
10 opportunity with this professor where I got to speak at the
11 Sheriffs' Association Conference. He hooked me up with
12 people at the Attorney General's Office, and I'm able to go
13 and self-disclose and share my story for the greater good.
14 And when I finished my bachelor's degree and I
15 was so supported by that professor and by that university,
16 I wanted to go to grad school. So I entered grad school at
17 Saint Joseph's University, and I remember attending a
18 conference there that was associated with collegiate
19 recovery and the movement all across the United States
20 about collegiate recovery.
21 So Bill told me to come with a definition, so I
22 did, and I'll read that: A collegiate recovery program is
23 a supportive environment within a campus culture. It
24 reinforces the decision to disengage from addictive
25 behavior. It's designed to provide an educational

1 opportunity alongside and with recovery support. It
2 ensures that students, which is the most important part to
3 me, is that students don't have to sacrifice their
4 education because of their desire and need to be in
5 recovery.
6 And I remember I went to this conference, and I
7 heard about this woman named Katie Bean, and I heard that
8 Saint Joseph's had a collegiate recovery program. They're
9 called The Flock. And I went up to her and I said, I'm so
10 excited; I'm a Saint Joseph's student and I'm in recovery.
11 And I can tell you that I was blown away, because I had
12 never seen somebody be so excited of the fact that I was in
13 recovery and that I was a student at their university and
14 how proud she was and how I immediately became a member of
15 this collegiate recovery organization at Saint Joe's called
16 The Flock.
17 And I started to think back to my old experience
18 as a traditional student, and there wasn't an active
19 support system put into place at that university. I did
20 reach out to them for comment, but I'm not sure if they
21 have one yet. But there wasn't that supportive part, and
22 what we need in recovery, regardless of our age, is peer
23 support, allies, and like-minded individuals. Because I
24 immediately upon meeting this woman became even more
25 excited to be a student at that university, to offer peer

1 support to other students, to be eligible and able to apply
2 for scholarships based upon the fact that I was in active
3 recovery and changing my life and helping in my community.
4 That’s mind-blowing, you know, to be able to take a look at
5 the statistics.
6 I can tell you that when I was in school as a
7 traditional student, my first year I did pretty well. I
8 did all right. I didn’t fail anything. My second year, I
9 got all B’s. I think I got one C. My third year at school
10 as a traditional student, I got all C’s and a D. It was in
11 statistics. I’m still not good at math, even in recovery.
12 And my fourth year, I failed out. I failed out of school.
13 I failed out. I failed out as an intern at a jail,
14 actively using. I became pregnant, and I ended up moving
15 home.
16 In my bachelor’s degree at Elizabethtown College,
17 I graduated with honors. I did not receive any B’s. I got
18 all A’s as a person in long-term recovery going to school.
19 At Saint Joe’s, I got one B. It was in a math
20 class. I, like, barely got a B, and I was devastated, but
21 I’m a part of the National Criminal Justice Honor Society
22 at that university. People in recovery can do wonderful,
23 brilliant, beautiful things, but we need the access to the
24 support and care. We need the access early on. We need
25 prevention.

1 And I'm not talking about a D.A.R.E. program in
2 school. I won the D.A.R.E. essay. I got a T-shirt that
3 said "HUGS NOT DRUGS." I still have my D.A.R.E. shirt, and
4 I'm pretty sure I was mad because I got second place at one
5 point in one year and I didn't win the lion with the
6 D.A.R.E. shirt. I'm not talking about that. I'm talking
7 about getting out there, getting in the schools, and before
8 -- the thing I want to talk about, too, and I really
9 thought about when Patti Anne was speaking is, we can get
10 out there and provide prevention. We can get out there and
11 educate families. We can get out there and provide at-risk
12 students the need for them and their families to be
13 provided prevention, education, and access to services at
14 an early age. But if we don't start doing that now and
15 everybody becomes aware, where are they going to go for
16 treatment? What are they going to do?
17 You know, I wish that -- I know that I was
18 privileged. I was privileged to have access to a great
19 insurance policy with a low deductible. I was privileged
20 to have two parents who, once they realized the severity of
21 my disease, after almost dying didn't get me clean, after
22 having a beautiful little baby didn't get me clean, after
23 two arrests didn't get me clean -- well, the second one
24 did, and I give a lot of credit to my arresting officer,
25 because he helped save my life. He said, Merry Christmas,

1 you can go to treatment and not jail, and I'll never forget
2 that, because that's one of the reasons I'm alive today.
3 And my parents were provided that access and their own
4 ability to seek out education and services on their own so
5 that they could get well, you know, and so that's how
6 everything comes together.
7 And as a result of my recovery, I have to talk,
8 too, about, you know, some of that money that is saved as a
9 State. I'm not getting arrested anymore. I was able to
10 cycle out of the system in terms of financial support from
11 my county and the State. There is no more legal fees.
12 Regardless of the fact that my medical bills were upwards
13 to a million dollars, what if I wouldn't have had
14 insurance? And a lot of people don't, or they have, you
15 know, county-funded and State insurance. What if?
16 My daughter gets to live in a healthy two-parent
17 household today, and she will never, hopefully, God willing
18 -- and I have a son that I was able to have in recovery as
19 well. They will never have to be part of the system, you
20 know. They will never have to have that financial burden,
21 and that's a result of my recovery.
22 So if you take anything away from what I had to
23 share of my story of recovery, it's that people do recover.
24 We do beautiful things. I'm able to give back to the State
25 of Pennsylvania. I get to help be a very small part of

1 some families being able to sleep at night, and that's
2 really what I take a look at. The ripple effect of me
3 remaining clean is endless, and for you to take a look at
4 how much greater that ripple effect could possibly be for
5 the next, the next chunk of adolescents who are eventually
6 going to be the people that are in levels of leadership,
7 who are supporting the State of Pennsylvania, but they have
8 to be alive. They have to get recovery. They have to get
9 a better quality of life or we will have an entire
10 generation that continues to be wiped out.
11 So I thank you from the bottom of my heart for
12 being here and for the opportunity that someone like me,
13 who almost 7 ½ years ago was sticking a needle in my arm,
14 is now, you know, able to sit here. And it truly is a
15 pleasure and a gift and a miracle to be alive today, and I
16 will cherish this memory of being able to be here to speak
17 with you and also that I am open and available.
18 Something I think oftentimes we lack and don't
19 think of is what people in recovery are willing to do for
20 you to help, free of charge. I'm here to take phone calls.
21 I'm here to help in any way I can. I'm here to selflessly
22 give back for all the gifts that I have been given in my
23 recovery. So thank you for letting me share.
24 MAJORITY CHAIRMAN DiGIROLAMO: Samantha, that was
25 pretty good. You know what I'm going to do? I'm going to

1 stand up and ask the Members to give you a round of
2 applause for that.
3 (Applause.)
4 MAJORITY CHAIRMAN DiGIROLAMO: That was pretty
5 good, and we needed to hear that, and we did.
6 MS. OSTERLOF: Thank you for listening.
7 MAJORITY CHAIRMAN DiGIROLAMO: Yeah.
8
9 IDENTIFY LONG-RANGE GOALS TO
10 BETTER POSITION US FOR THE FUTURE
11
12 MAJORITY CHAIRMAN DiGIROLAMO: Okay. Next, we
13 have Bill Stauffer, who I have known for a long time and I
14 consider a good friend, and he’s from the Pennsylvania
15 Recovery Organizations Alliance, the State association.
16 And Bill is going to talk about “Identify Long-Range Goals
17 To Better Position Us For The Future.”
18 Bill.
19 MR. STAUFFER: Thank you very much, and it is an
20 honor to be here today.
21 I am grateful for the opportunity to address this
22 Committee on this very important issue, perhaps the most
23 important issue as you grapple with how to address human
24 services needs in the State of Pennsylvania. Nothing
25 should be at the forefront as much as our young people.

1 To introduce myself, I am the Executive Director
2 of the Pennsylvania Recovery Organizations Alliance. We
3 are the statewide recovery organization for the State of
4 Pennsylvania.
5 I have been involved in this work for over
6 30 years. I have run -- I live in Allentown. I live in
7 the 132nd District. I have been involved in this work my
8 entire adult life. I have run outpatient programs. I ran
9 an outpatient program for a decade. I ran a residential
10 drug and alcohol treatment program for 14 years. Both of
11 these were generally publicly funded programs. I have
12 worked with a whole lot of people that do not look a whole
13 lot like me and have a good sense of what our needs are in
14 diverse communities.
15 I have been involved in policy work for the
16 better part of 20 years. I have had the opportunity to do
17 things, like I ran a task force on recovery housing that
18 informed the State law that was passed related to licensing
19 and certifying recovery houses. I have been involved in
20 numerous committees. And I had the opportunity last fall,
21 or last spring, to address the United States Senate on
22 opioid use in older adults.
23 I have been a reluctant champion of privacy
24 rights for people with substance use disorders, both
25 nationally and here in the State of Pennsylvania, as we

1 have a perennial, it seems like there's a perennial effort
2 to degrade privacy rights for people with substance use
3 disorders. And I would note that they are extremely
4 important, because without confidentiality rights, people
5 like me -- and I am a person in long-term recovery -- do
6 not enter treatment. Currently, actually on that, I am
7 working on a case where somebody is being denied life
8 insurance because they obtained Narcan, so we could talk
9 about that at some point.
10 But more important than any of those things, I am
11 a person in long-term recovery, and what that means to me
12 is I have not had the use of drink or drug since I was
13 21 years old -- 32 years ago. That makes me 53. I also
14 refer to myself as a formally young person still in
15 recovery.
16 So I did similar to what Samantha said. In early
17 recovery, I got involved in service work. I helped start
18 the Habitat for Humanity in my area. I donate blood
19 regularly. I'm up around 26 gallons now. I do all kinds
20 of things to help people in my community, including with
21 drug and alcohol problems, whether it's on the clock, off
22 the clock. Seven days a week, I'm helping people out. And
23 you know what the most remarkable thing about that is?
24 That there is absolutely nothing remarkable about it. This
25 is the normal thing that people in our community do, is

1 service to others.
2 I'm also a college graduate. I barely graduated
3 from high school. The statute of limitations is over on
4 that, but I barely graduated high school. I graduated with
5 honors from Cedar Crest College in Allentown. I have a
6 master's from Kutztown University. I also currently teach
7 social work at Misericordia University. So for a person
8 who barely graduated high school, I am now a college
9 professor in addition to some of the other things that I
10 do.
11 A curse of being in long-term recovery is seeing
12 the train wreck of lost lives and lost opportunities of
13 people who have not had the good fortune of getting help
14 and getting the recovery like me. I have lost immediate
15 family members, more than one, to this condition. I have
16 lost many, many friends. I have watched more loss in our
17 communities to substance use disorder than every other
18 single issue combined. I have devoted my life to this, and
19 I'm convinced that it is our number-one issue. It impacts
20 our productivity. It impacts our criminal justice system.
21 It drives all human service costs. It devastates families.
22 It's the thing that we need to focus on.
23 And I will lapse into college professor briefly
24 here for a minute. I think it's important to understand
25 what substance use disorders are.

1 There is a genetic component. It tends to run in
2 families. That doesn't mean that it runs in every family.
3 You know, I'm a short guy. I got a tall brother. You
4 know, I use that as an example. Not all genetics means
5 that everybody in the family gets it, but it can run in
6 families.
7 Another factor with substance use disorder is
8 trauma, things like physical trauma, sexual trauma,
9 emotional trauma. There's something about trauma that
10 wires the brain for substance use disorder.
11 And the third factor is age of onset. The
12 younger a human brain is that is exposed to substances, the
13 higher the likelihood that they will end up with a
14 substance use disorder.
15 These are really important things to understand.
16 It's not about what kind of family you came from. My dad
17 worked at the Bethlehem Steel Corporation Law Department
18 for 40 years. My mom was a church secretary. I also came
19 from a good home. I ended up actually getting my treatment
20 from the public system, though, a little bit later in life
21 when I didn't have insurance. But the point, as Samantha
22 made, is that this is not something that affects just bad
23 families, it affects all families. It affects one in three
24 or one in four families, depending on who you talk to.
25 This is our greatest problem.

1 Bring this to young people. Substance use
2 disorders are progressive, and there's something that
3 actually sort of, I see them as communicable. They spread
4 among young people. I started using drugs at age 11.
5 People could say, well, where were your parents and where
6 was your family. Well, I was hanging out with older kids,
7 and the best way to keep a kid from telling on you is to
8 also have him smoke pot, so I started with pot.
9 It's also more expensive to treat. The longer
10 you take to treat this, the more expensive it gets. So
11 focusing on young people makes a lot of sense.
12 Now, in your packets you're going to find a
13 handout, and I'm going to briefly refer to things in this
14 handout, but it could be taken along and read. Now, we put
15 a lot of stats in there.
16 We are referring fewer kids to substance use
17 disorder treatment in the State of Pennsylvania. One of
18 the things is that there was a federally funded program,
19 Drug and Alcohol Free Schools, that funding from that was
20 lost in 2010. And there's a graph in your handout that
21 talks about over a thousand referrals a year. Our mental
22 health referrals stayed about the same. We have lost about
23 a thousand or more referrals a year to substance use
24 treatment. That's 5,000 or 6,000 kids right there, and
25 that's just from schools.

1 I mean, I think we should, this issue should be
2 something that our doctors, who generally don't get
3 training on substance use disorders either, would be able
4 to refer people to. But we're not referring kids to
5 treatment because we're not identifying them, and we're not
6 identifying them because of stigma, and that's something
7 that we'll talk about.
8 We have also lost programs. When I talk to
9 Single County Authorities, I'm also told the same things
10 that you heard here today, that we're down to essentially a
11 single program in the State of Pennsylvania that you could
12 refer someone to for a substance use disorder if you're
13 using an SCA or Medicaid funding.
14 I wonder about this thing called network
15 adequacy. I mean, how could one treatment center be
16 network adequacy? We have lost -- I got to read from my
17 notes -- we have lost residential treatment programs in
18 Allegheny, Berks, Bucks, Bradford, Dauphin, Erie, Forest,
19 Lackawanna, Luzerne and Wyoming, Philadelphia, and Warren
20 Counties. Several counties actually lost more than one
21 program in them.
22 What is happening? Well, for one, also if you
23 look in your notes, you'll see that our Federal funding on
24 the Substance Abuse and Prevention Treatment Block Grant
25 has stayed relatively level, and over the years, that means

1 that it funds less. So if it never goes up and inflation
2 and all the other costs go up, the buying power of that
3 Federal money goes down to about a third, by roughly a
4 third.
5 Now, you are all probably aware that there has
6 been some money flowing in more recently for the opioid,
7 you know, targeted towards the opioid use epidemic. It's
8 generally short-term funding. It hasn't developed on the
9 infrastructure of our system. It hasn't translated to
10 funding programs. And we know about warm handoffs, you
11 know, that there's an emphasis on warm handoffs. I think
12 warm handoffs are great. We need to get people help, but
13 we haven't developed an infrastructure in our treatment
14 system. We have actually watched some of it die on the
15 vine.
16 So what it means is that we sort of have like a
17 high-speed entrance ramp to a two-lane road. And I'm a
18 person, I know where the treatment beds are in the State of
19 Pennsylvania. I also shudder when a kid needs help and a
20 family needs help with a kid, but there's not a lot of
21 treatment beds, and you heard that 2 weeks ago at your
22 warm-handoff hearings. You know, we cannot turn back the
23 clock. We can't change what got us here, but we're going
24 to have to take a look at what we need to do to get us out
25 of this, you know.

1 And going back to young people, we need to start
2 learning how to talk about this, all right? You know, I
3 was opposed to trials for drug use when I was in high
4 school. I had long hair. I had a grunge look before there
5 actually was a look. You know, I suspect that the teachers
6 knew that I was using drugs. But I also came from a good
7 family, and people didn't talk about it, because you know
8 what? We don't talk about drug and alcohol use. We don't
9 address it like other issues, and when we do, we can kind
10 of take it in the wrong direction.
11 I was probably actually lucky that they didn't
12 address it, because we also had these things called
13 zero-tolerance policies, and sometimes what happens is, if
14 I would have been identified, I would have been expelled.
15 If I would have been expelled from high school or arrested,
16 that would have changed my whole direction in life.
17 Like I said, I have worked a whole lot of my life
18 with people who don't look like me, you know? And frankly,
19 I think I got a pass for being a White kid, and we need to
20 treat all kids. We need to make sure all kids get help,
21 because they really are our future.
22 You know, talking about stigma, you know, this is
23 something that happens in the family. Like, nobody wants
24 their kid to be a drug addict, you know? Nobody wants
25 that. But the reality is, we all have to take a look and

1 realize, this really does affect all of our families.
2 I suspect that it affects people here. It
3 affects families of your staff. It affects the people you
4 work with. And one of the things that we have to do is
5 start identifying, this is just a condition. It's a brain
6 condition. And because it's a brain condition, you know,
7 we need to make sure that we adequately treat people.
8 Now, the National Institute on Drug Abuse -- it's
9 called NIDA -- they put out a thing, and the minimum dose
10 of effective care for a substance use disorder -- this is
11 an average -- is 90 days. Let me translate that. That
12 means that you have to provide 90 days of care to have any
13 effect at all. We don't provide that, even for adults
14 oftentimes. We may provide a short stint in a rehab. And
15 for an adolescent, I mean, we're not giving that, and we're
16 sending them back into schools in an environment that are
17 drug-using environments, which is why, you know, Samantha
18 talks about recovery high schools and collegiate recovery
19 programs.
20 You know, to get into recovery, at 21, I had to
21 avoid everybody in my own age group. That's how I got into
22 recovery. I hung out with old people, like me now, because
23 I got recovery by looking at what they were doing. And
24 when they were talking about, you know, drug and alcohol
25 use affecting their marriage, I had to be honest and say,

1 well, I wasn't really having much in the relationship front
2 because I was high. But the reality is, it's affecting all
3 of us, and the reality is that we need to create
4 environments where people can recover, and there's really
5 no better place to start than that, than our young people.
6 So talking about this, we know a number of things
7 about substance use that are really not baked into our
8 systems. So there has been long-term research on recovery,
9 and starting with physicians.
10 You know, when a physician gets treatment in the
11 United States -- a physician, a pharmacist, an airline
12 pilot, a nurse, a pharmacist -- they don't get the
13 treatment that is provided in private health insurance
14 plans or in our public system. They get long-term care --
15 urine testing, case management -- and if something happens,
16 they get more structured care. That's what happens for
17 those professions.
18 And the professions have an 80-percent recovery
19 rate. We're talking about the gold standard? There's an
20 80-percent recovery rate as evidenced by 3-year urine
21 testing when we put up models of care that provide
22 structured care. What are we currently doing? Well, we
23 did a workforce study in Pennsylvania. I asked all the
24 counselors, and counselors told me, in the State of
25 Pennsylvania, we provide, generally speaking, a lower

1 structure of care for less time than they would see that
2 the client needs, and I'm talking both adult and adolescent
3 here. So it's kind of like you go to the doctor and the
4 doctor knows you have a bacterial infection and knows that
5 you need a 10-day supply of antibiotics but gives you
6 2 days. He doesn't tell you that that's probably not going
7 to do it. And if you have a substance use disorder and the
8 kind of shame and guilt and remorse that comes with that,
9 you think it's you that didn't get better because you
10 didn't do something right, not that you didn't get the
11 proper care. Think about adolescents. We're taking
12 adolescents, we're not sending them to rehab oftentimes
13 because it doesn't exist in the way that it used to. We
14 may send them to outpatient.
15 And I have got to tell you, as a kid -- I think
16 my dad is watching somewhere -- if I wanted to use drugs,
17 there was no keeping me from using drugs in the home
18 environment. You know, sometimes a kid needs to go away.
19 You know, the idea of least restrictive care, although it
20 may apply to mental health settings, it doesn't necessarily
21 apply to substance use disorders. We need structured care
22 for adolescents, and we also need to follow it up with
23 other things like recovery high schools, alternative peer
24 groups or places where kids or young people can go and have
25 fun, and collegiate recovery programs.

1 So this model, also we know from studying people
2 in long-term recovery, when you go and ask people who have
3 a number of years in recovery, if we can get someone to
4 5 years of recovery, their chance of staying in recovery
5 for the rest of their lives is about 85 percent. Think
6 about that.
7 So we know that if we start setting up systems of
8 care that get people into long-term recovery, they're
9 likely to stay here and they're likely to go to college.
10 They're likely to take care of their families. They're
11 likely to do all the things that we want them to do, and
12 you're not likely to have to spend money on criminal
13 justice costs, on human service costs. We end up with more
14 productive people, healthier communities. A lot of your
15 headaches go away when people get into long-term recovery.
16 And, you know, frankly, people with substance use disorders
17 are everywhere, so why don't we do that? Why don't we
18 focus on getting people into long-term recovery, and what
19 better place to start than young people.
20 Think about what would happen. Think about, I
21 mean, you come to these committees, you listen, you got
22 budgets to deal with and everybody wants more resources,
23 but think what would happen if all these kids who needed
24 help got into recovery at age 16 or 17. They didn't end up
25 in the criminal justice system. They went on to get

1 college educations or get into a trade, and they had normal
2 lives. We have had normal lives. Think about having
3 normal lives and what that means.
4 So what we're hearing, now, the other thing
5 that's in your packet is a handout, it's the ask: What
6 should we do? Well, for people who have been around for a
7 while, there's something called the HR 590 report. That
8 came out about 2 years ago. I brought a number of copies
9 with me, and it talks about things like people not getting
10 the kind of care that they needed, and it made a number of
11 recommendations. One of the recommendations -- and I heard
12 Deb Beck laugh somewhere in the room. She's back there.
13 So when I was 24 years old -- and she knows this
14 is coming; I hate to remind us of it -- we passed this
15 thing called Act 106 of 1989, and it was an insurance
16 mandate that made sure that people could get help, and it
17 was amazing. And I thought, hey, this is over; you know,
18 people are going to get help now. We actually had -- or we
19 -- she fought that through to the State Supreme Court with
20 some people to get part of it enforced so that insurance
21 companies would actually do what they were supposed to do
22 and get people the help.
23 I pulled out my wallet, and you're wondering why.
24 This is my insurance card. You know, when somebody calls
25 for help, when a parent calls for help, I don't know -- I

1 mean, I know this field better than a lot of people -- I
2 don't know what kind of plan they have. The HR 590
3 recommendation was to put something on the back of the card
4 so when someone calls for help, that they would know it was
5 an Act 106 case. That means if somebody showed up at the
6 hospital with an overdose, the medical staff could right
7 away say, this person has the proper care to get them into,
8 you know, into care right out of the door. One-third of
9 the Pennsylvania insured have those policies. I can't tell
10 which one. Deb knows, you know. Call her. But that's not
11 a solution for a family that doesn't even know her.
12 But that's only part of it. You know, we have
13 not fully enforced Act 106. I would like that to happen
14 before I retire. What's not in there -- what's in there
15 that's not being enforced also in the HR 590
16 recommendations? Family counseling and intervention
17 benefits. So can we imagine that when some kid overdoses,
18 we got a law in place that their families could get family
19 counseling and that there could be potentially intervention
20 services paid for? Well, why is that not -- it's in our
21 current law. It's not happening in the State of
22 Pennsylvania, folks, and it needs to.
23 The other recommendations that we have is, you
24 know, make this information available. Put it on the back
25 of the cards. Have insurance companies send things out to

1 family members so they know how to spot a substance use
2 disorder; you know, what services are provided, whether
3 it's outpatient, residential, peer support services, all
4 those kinds of things. Make this part of our regular
5 discourse. So the only way we're going to get through the
6 stigma is if we start talking about it and start talking
7 about it in a way that we realize that this is not
8 affecting those people. Those people are our people. We
9 are those people. So do that.
10 Put in oversight, because, you know, frankly
11 speaking, I know good people who work in the insurance
12 industry. Oftentimes they are machineries of denial.
13 There are a lot of barriers that go up, and we need to take
14 a look at getting those barriers down so that people can
15 get help.
16 I am going to suggest -- and this is a big lift,
17 okay? -- why don't we start changing a continuum of care to
18 provide long-term care. Why don't we start with our
19 adolescents, because we're not doing that, okay? I got to
20 tell you, nobody nationally is doing this. You can't look
21 at any other State that has a system of care that's set up
22 that effectively provides the kinds of services that are
23 needed, whether it's the intensive upfront stuff, detox,
24 residential, intensive outpatient, but then followed by
25 things like peer support services, collegiate recovery

1 programs, recovery high schools. Some of those things
2 aren’t really expensive, but we have narrowly focused on
3 this 28-day model that turns into a 14-day model and isn’t
4 really effective.
5 So my tall order here, my big wish, is when we
6 start having the discussions about a continuum of care that
7 actually meets what a kid needs for a year -- you know, I
8 was afraid to ask for 3 and 5, because I think that’s
9 really what we need -- but, you know, a year would be a
10 milestone above where we are. We could do that.
11 You know, we have an Act 55 in place that sets up
12 recovery high schools in Pennsylvania, and we got one right
13 now. We have another one opening. What would it be like
14 if kids could go to school and be safe? I had to hide from
15 my peers to be safe. Recovery high schools are a place
16 where kids could be safe. Collegiate recovery programs --
17 I hid in college, too. I actually, when I graduated
18 college, I wasn’t even sure of the whole campus, because I
19 would run into my classes, you know, and go to work,
20 because I’m one of those nontraditional students. But a
21 collegiate recovery program is a place where some kid could
22 feel safe.
23 What it also does, it changes the environment,
24 because if there’s a collegiate recovery program like a
25 bowling league or whatever other kinds of things that

1 happen, different clubs, it becomes normalized that some
2 kids are in recovery and that some people in our community
3 are allergic to drugs and alcohol, like me, and it's okay,
4 and you can live a normal life.
5 So these are some of the things that I'm
6 suggesting. The full ask is in here. Put a lot of work on
7 that handout that talks about the fact that the funding
8 hasn't kept up. We need to do a whole lot better job at
9 training people who connect to young people to identify
10 them and get them into help, and if we do that, we actually
11 could save you all a whole lot of headaches, because we
12 cost a lot of money untreated, you know. You saved money
13 helping me get into care, believe me. I would like to see
14 that for other kids, too.
15 Thank you.
16 REPRESENTATIVE MURT: Bill, I have a question.
17 We have a couple of Members that have some questions, but I
18 have a question also.
19 Where are the recovery high schools? There's one
20 in Philadelphia, correct?
21 MR. STAUFFER: Yes. The Bridge Program is
22 outside of Philadelphia, and it has been there for a number
23 of years.
24 Do you---
25 MS. McANDREWS: It's---

1 ACTING MINORITY CHAIR HOHENSTEIN: It’s actually
2 in my district.
3 MS. McANDREWS: Yes.
4 ACTING MINORITY CHAIR HOHENSTEIN: Thanks to my
5 predecessor, John Taylor, who was one of the main---
6 REPRESENTATIVE MURT: There was one in
7 Roxborough, wasn’t there?
8 MS. McANDREWS: That is the same one.
9 REPRESENTATIVE MURT: Okay. Because I visited
10 there.
11 MR. STAUFFER: Yeah. And Taylor actually helped
12 get the recovery house bill, Act 55, in place. But we need
13 to, why don’t we make that permanent? Why not make
14 regional recovery high schools so that other kids could go
15 to those kinds of schools?
16 It’s actually a model that is being followed
17 around the nation.
18 REPRESENTATIVE MURT: Also, I haven’t had the
19 chance to read the document. Your legislative agenda is in
20 here, correct?
21 MR. STAUFFER: Yeah. There’s an ask. There is
22 not a specific legislative agenda. We’re introducing this
23 issue. I mean, I would like to see HR 590 followed.
24 REPRESENTATIVE MURT: If you want to draft one
25 and get it to us, that would be really, I think, useful.

1 MR. STAUFFER: I can absolutely do that.

2 REPRESENTATIVE MURT: Okay.

3 MR. STAUFFER: Thank you.

4 REPRESENTATIVE MURT: One last question for me,
5 and then my colleagues have a few.

6 You articulated very well, you and your
7 colleagues, about the lack of adolescent residential detox
8 and substance abuse services. If there's such a great
9 demand, why don't we have more of these facilities in the
10 Commonwealth? Obviously there's enough business for them
11 to be viable.

12 MS. McANDREWS: Do you want to take that?

13 One of the reasons that -- okay. So let me
14 explain the history of our program, and it may help you to
15 understand that.

16 I joked about the millennial generation, and
17 during the millennial generation, I had gone from the end
18 of that, the beginning of the millennial, having three to
19 four high school age groups. As we went into the
20 generation of millennials, I went down to a half of a high
21 school group for a while, then just one, and three to four
22 college groups. And what I joked about was the millennial
23 generation and being kind of overprotected. So we didn't
24 have Vietnam. We didn't have war. We didn't have the
25 draft anymore. Things changed culturally. So we had

1 parents protecting their kids and extending education,
2 extending insurance policies, and extending adolescence.
3 When we talk about the brain not being developed
4 until age 27, let's take some of the brains of the older
5 people here when they were 18, and was it more developed
6 then during the generation where you were pushed harder
7 than it is now? So there's a debate on how the brain
8 develops, and are we slowing down the process of growth as
9 we care-take, and therefore, we're keeping the kids home
10 and we're not getting them the care. We think we can
11 handle it.
12 I smoked marijuana, so when my kid smokes
13 marijuana, it's not that bad. We're not thinking that it's
14 62 percent higher. And it's also in an E-cigarette with a
15 heck of a lot of chemicals, and they're using GMOs and
16 competing to get higher levels of THC, so the idea of now
17 we're in trouble because we have this product. We have
18 Generation Z, which is a bigger generation of millennials,
19 bigger than the baby boomers, and now we have these kids
20 smoking a lot of marijuana. We have more kids in school,
21 so teachers aren't going to tolerate the behavior. So we
22 have a switch in how things are happening.
23 At my place now, we have two adolescent groups.
24 By the end of next week or the week after, we should have
25 three adolescent groups, and we are down to one college

1 group. That's why we're in trouble. So it's already
2 hitting that people are intervening more.
3 And there are stats to prove that if we do
4 preventive education, even on marijuana, that the use
5 drops. We are not educating kids. We aren't doing
6 prevention in high schools. We're not doing prevention in
7 middle schools. We don't talk about this. So the reason
8 for the change is our culture change and our volume change.
9 So now we're in trouble.
10 And 2006 was the biggest baby boom in the
11 United States. That year had more births than any other
12 year, and during that year, we had 49 percent Latino. We
13 have one really Latino program that I know have from being
14 on the Main Line. It's just Gaudenzia. I would never know
15 that if I wasn't in the field for as long as I've been. So
16 we don't have enough coverage for them. We are looking to
17 open one so we can have a bilingual program for kids in our
18 area, because we don't have it.
19 So we're in a lot of trouble with this new
20 generation.
21 REPRESENTATIVE MURT: Thanks, Patti.
22 MR. STAUFFER: Let me, to add to that, you know,
23 I mentioned earlier that we dropped referrals by about a
24 thousand. The loss of Federal funding, we're not
25 identifying kids, even in schools.

1 And one human services director told me that in
2 their area, one school district had a full-time person
3 devoted to this. Now that focus is around, you know,
4 2 hours a week. So, you know, we have lost focus there.
5 It's also, you know, kids are expensive to treat.
6 They're more expensive because there are more moving parts
7 and there are more needs. And because of the block grant
8 and funding being stagnant, you know, it has caused funding
9 problems, so the per diem rates haven't kept pace with the
10 actual costs of running a program.
11 And, you know, I would point out, we're in what's
12 called SAMHSA, the Federal SAMHSA, Region 3. We have the
13 second lowest paid workforce in our system, in our region.
14 And our region -- West Virginia is lower than us. Our
15 region does not include Ohio, New York, or New Jersey, you
16 know.
17 So what happens is, if you have a high demand and
18 you're getting low pay, you tend to shift other things, you
19 know? And if the referrals are down -- a number of the
20 programs that we lost, I can see that they went to adult
21 focus because there were more referrals. And they're
22 actually a little cheaper to treat because, you know,
23 there's less moving parts. Kids can be a pain.
24 MS. McANDREWS: And we lowered, where in the past
25 if I had a Blue Cross contract, they would give me more to

1 treat an adolescent. They don't anymore. And for my adult
2 program for intensive outpatient, I have to do 9 hours, but
3 for my kid program, I get 6. Completely ridiculous. And I
4 have even had lawyers arguing with the insurance companies,
5 and I have gotten nowhere.
6 REPRESENTATIVE MURT: Thank you.
7 Representative Nelson.
8 REPRESENTATIVE NELSON: Thank you, Mr. Chair.
9 And thank you all for your testimony.
10 I can't see you over there, Samantha, but I have
11 to say, one of the most powerful and effective testimonies.
12 As you were sharing your journey, I had requested to get
13 that video clip to be able to share both to our schools,
14 our high school, and our reality tour in our district,
15 because it's not only a story of success but, you know, a
16 very powerful pathway, you know.
17 My question for the panel is twofold. It was
18 very positive to hear your desire for reforms in the
19 program, because there is a personal frustration that I
20 have that Pennsylvania maybe isn't as person centered in
21 their treatment as we could be, and, you know, some of your
22 ideas of reforming that process I think could be very
23 positive moving forward.
24 You mentioned, Ms. McAndrews, that there were
25 roadblocks between mental health treatment and then

1 addiction treatment and trying to be able to work back and
2 forth within, you know---
3 MS. McANDREWS: Well, what has been happening is,
4 as we have been talking, that there aren't treatment
5 centers for drug and alcohol or substance abuse disorder.
6 So that, along with the stigma, parents are mainstreaming
7 these kids into mental health facilities. They don't have
8 a choice. There's no -- we talked about that. We have one
9 Medicaid rehab and we have one insurance-based rehab that
10 can get you through the continuum.
11 So we have had the tendency to make physical
12 health, mental health, and addiction all separate entities,
13 and they don't -- though they are better, they are way
14 better than they were when I started in this field, as far
15 as working together, they don't mesh. They don't mesh
16 well.
17 And so when---
18 REPRESENTATIVE NELSON: If I'm understanding you,
19 what the pathway is is that---
20 MS. McANDREWS: You go in and out.
21 REPRESENTATIVE NELSON: ---because a parent can't
22 get their teen into an addiction program, then they will
23 enter into a mental health-based program---
24 MS. McANDREWS: Correct.
25 REPRESENTATIVE NELSON: ---to try to get

1 something.

2 MS. McANDREWS: That's correct.

3 REPRESENTATIVE NELSON: But the treatment is not
4 as effective.

5 MS. McANDREWS: That's correct.

6 So we have had a few kids that have gone through
7 mental health treatment, but they come back and we're doing
8 the substance treatment, which is fine, but I'm also highly
9 resourced. That's not the typical. And the way we train
10 our staff is very different because we are highly
11 resourced. You don't have that. And I'm not -- we don't
12 really charge differently, but we have kids that are more
13 high functioning, so that gives us the high resource.

14 And I also have kids who are in my center for,
15 they'll come for 3 years. You're talking about 3 years?
16 They will come for 3 years. They'll come for 1, 2, 3.
17 They stay for a long time. They may drop down in their
18 level of treatment, but a good, well-treated kid stays a
19 year.

20 REPRESENTATIVE NELSON: Great. Thank you.

21 Thank you.

22 MR. STAUFFER: You know, our department -- this
23 HR 590 report of 2015 is worth looking at.

24 You know, our Administration recognizes that we
25 need to look more into long-term care. It's just that

1 these systems haven't been designed, you know, and I think
2 we need to move here.
3 And I also would say, you know, the opioid
4 epidemic has narrowed a focus towards opioid use, and it's
5 important to note that, you know, 80 percent of even opioid
6 users are using other drugs, and alcohol still surpasses
7 that. And when you're in a, you know, when you are in a
8 crisis, you tend to focus only on a single thing, and we
9 need to look at our whole infrastructure, so.
10 REPRESENTATIVE NELSON: Thank you.
11 MAJORITY CHAIRMAN DiGIROLAMO: Representative
12 Struzzi.
13 REPRESENTATIVE STRUZZI: Thank you, Mr. Chairman.
14 Thank you all for being here and sharing your
15 stories. I think it takes a lot of courage to appear
16 before us and really reveal yourselves. But I think, like
17 Representative Nelson said, that's what really impacts the
18 young people out there, when they see that you can go
19 through recovery and live a truly productive life that
20 gives back to society. So thank you for being here today.
21 A couple of questions that I have. Well, I have
22 a lot of questions.
23 What prevents -- is it just cost that prevents
24 the adult treatment centers from treating adolescents or
25 are there other restrictions that cause that to not occur?

1 MS. McANDREWS: They aren't -- so the insurance
2 companies have certain restrictions, that if you have an
3 adult license, you can only treat adults.
4 REPRESENTATIVE STRUZZI: Okay.
5 MS. McANDREWS: And unless you have specific
6 reasoning for treating an adolescent, and you have to prove
7 that need. And depending on the person that answers the
8 phone depends on whether you'll get that or not.
9 REPRESENTATIVE STRUZZI: Mm-hmm.
10 MS. McANDREWS: There aren't many licensed
11 adolescent facilities, and like Bill said, for a lot of
12 people it's a very difficult thing to deal with, because
13 I'm not dealing with you, I'm dealing with you, Mom, Dad,
14 school, probation possibly. We have medical issues. With
15 some of our kids, we're dealing with CHOP. So we're
16 dealing with a lot of different entities, and a lot of
17 people don't want to do that.
18 REPRESENTATIVE STRUZZI: Right. But we don't
19 have to reinvent the wheel then, though. I mean, there are
20 treatment facilities in all of our counties that could
21 treat adolescents.
22 MS. McANDREWS: They would have to be licensed.
23 REPRESENTATIVE STRUZZI: Right.
24 MS. McANDREWS: Some of them still kept hold of
25 their license, but they aren't treating. But most of them

1 do not have the license anymore, so they didn't keep up the
2 certifications necessary to treat an adolescent.
3 REPRESENTATIVE STRUZZI: Right. Because when you
4 look at the map that you showed, you know, from 2002 until
5 now, I mean, that's scary the distance that people have to
6 travel for adolescent treatment, and I think if we can find
7 a way to make it easier for adult treatment centers to
8 treat adolescents, that would help at least some of the
9 problem, right?
10 MR. STAUFFER: Yeah.
11 I think we may also want to consider, though,
12 sometimes, you know, somebody who is running a residential
13 program, if I take somebody who is younger---
14 REPRESENTATIVE STRUZZI: Right.
15 MR. STAUFFER: ---even a 19-year-old who is maybe
16 a little naïve about some of the kinds of things that
17 happen when you have been on the streets for a long time, I
18 may not want to mix that young person with somebody who has
19 been doing this for 10 years, because I may end up with
20 somebody who gets better at doing the things that I don't
21 want them to do.
22 REPRESENTATIVE STRUZZI: Right, right, right, and
23 I understand that, too. Sure.
24 MR. STAUFFER: Yeah. We have to be cautious a
25 little bit about that.

1 MS. McANDREWS: We have to separate that, because
2 we have had sexual abuse issues, so you can't have the two
3 populations in the same---
4 REPRESENTATIVE STRUZZI: Right; right. Yeah.
5 MS. McANDREWS: You have to separate the
6 physicality at the facility.
7 REPRESENTATIVE STRUZZI: No, I'm not suggesting
8 that. I'm just suggesting that you have the counselors---
9 MS. McANDREWS: Right.
10 REPRESENTATIVE STRUZZI: ---you have the recovery
11 specialists that could be utilized.
12 Do you have a question in the back there? Yeah.
13 COMMISSIONER ZANELLI: Actually, I do. Hi.
14 REPRESENTATIVE STRUZZI: Yeah.
15 COMMISSIONER ZANELLI: I'm Amy Zanelli. I'm a
16 Lehigh County Commissioner.
17 REPRESENTATIVE STRUZZI: Mm-hmm.
18 COMMISSIONER ZANELLI: I don't need to interject,
19 but I think -- so I'm here because Bill invited me to be
20 here as well. I'm just going to roll up. Pardon me.
21 But I'm also venturing to open a recovery, not so
22 much a -- more like a drop-in center in Lehigh County to
23 service.
24 REPRESENTATIVE STRUZZI: Mm-hmm.
25 COMMISSIONER ZANELLI: But what I can tell you

1 about venturing into adolescents, because I thought the
2 same thing, oh, we could help the children, too. You run
3 into a lot of liability issues. I don't know if you have
4 any children or anyone in here has children. Have you ever
5 tried to volunteer at a school? It's very difficult for a
6 lot of people.
7 I know myself, the burden has increased a lot for
8 my kids at my school with me, so personally, because the
9 other parents can't always meet the background checks. We
10 run into this with recovery very much. If you have a
11 recovery house that operates a lot on peer support, because
12 that's how most of them are run, you know, one or two
13 full-time staffers and the rest are people who are in
14 long-term recovery, certified recovery specialists, but
15 those people would not necessarily be able to meet the
16 clearances required to assist with children.
17 So you would have to have every single person who
18 is in that building have all their FBI checks, their
19 clearances, their background checks, and then that's nearly
20 impossible to blend those communities, because far too
21 often, you run into problems with the law and such things.
22 So we have to work on ways that we can get to the
23 children separately, and most importantly, before they have
24 a run-in with the law. You know, for about every dollar
25 you spend on preventative care for these children, you

1 recover $9 later for criminal justice, and that's something
2 to be considered.
3 I can tell you, if you're wondering why, you
4 know, we don't have more facilities, in Lehigh County, we
5 used to have a juvenile detention center -- right? -- and
6 we moved away from detaining, so we closed it. But now one
7 thing that I'm trying to do is rejuvenate that center to be
8 more than a storage facility, and to do that, possibly
9 reinvigorating that center so that we can provide this kind
10 of residential service, because it does have private
11 entrances, secure facilities, et cetera. So just please do
12 not underestimate the cost of liability that is associated
13 with treating children.
14 Sorry to interrupt. I'm going to go back to the
15 audience now.
16 REPRESENTATIVE STRUZZI: No; thank you for that.
17 MAJORITY CHAIRMAN DiGIROLAMO: Would you mind
18 introducing yourself?
19 COMMISSIONER ZANELLI: Yes.
20 Amy Zanelli, Z as in zebra-a-n-e-l-l-i, Lehigh
21 County Commissioner. Thank you so much.
22 REPRESENTATIVE STRUZZI: Thank you.
23 I don't want to dominate the rest of the time
24 we have, but I do want to ask, you had mentioned,
25 Dr. McAndrews, that marijuana is the prevalent use among

1 teens right now, correct?

2 MS. McANDREWS: I'm not a doctor, just so you

3 know.

4 REPRESENTATIVE STRUZZI: I'm sorry.

5 MS. McANDREWS: I have my master's and a lot of

6 certifications. That's what all those letters are.

7 The question again? I'm sorry.

8 REPRESENTATIVE STRUZZI: Just to clarify, you

9 said that marijuana---

10 MS. McANDREWS: Oh, the marijuana use.

11 REPRESENTATIVE STRUZZI: ---is the prevalent use

12 of drug choices among teens right now, right?

13 MS. McANDREWS: It is right now, but I cannot

14 stress how high the THC contents are---

15 REPRESENTATIVE STRUZZI: Right.

16 MS. McANDREWS: ---and how many psychotic

17 episodes we have experienced with treatment.

18 REPRESENTATIVE STRUZZI: So my question to all

19 of you then would be, you know, as we have this discussion

20 about the legalization of recreational marijuana, what

21 will that do to adolescent use rates? Addictions? I

22 mean---

23 MS. McANDREWS: You have to look at the Colorado

24 changes---

25 REPRESENTATIVE STRUZZI: Mm-hmm.

1 MS. McANDREWS: ---and what happened in the first
2 year and how high the hospitalization rates have been for
3 psychotic episodes.
4 The idea of legalizing marijuana also means that
5 we can have edibles, and oftentimes the teenager brings the
6 edibles into the house and the 4-year-old eats them and
7 ends up in a hospital.
8 So we're talking about a lot of difficulties that
9 we will encounter. But if you read about what happened in
10 Colorado, you'll see what's going on. But with that,
11 realize that Colorado legalized before us, and now this THC
12 war with growers continues to go up.
13 REPRESENTATIVE STRUZZI: Right.
14 MS. McANDREWS: We will be in so much trouble
15 with psychosis. But I don't -- I'm not here to argue with
16 legalization or not, but we have to be aware of what will
17 come down.
18 REPRESENTATIVE STRUZZI: That's my question, with
19 the implications of. Not whether or not we should, but the
20 implications on teenagers.
21 MR. STAUFFER: Yeah. And I think to note,
22 cannabis is a performance degrader.
23 REPRESENTATIVE STRUZZI: Mm-hmm.
24 MR. STAUFFER: So people compare it to alcohol,
25 and it is different than alcohol. You drink. You know, in

1 general, you sober up and you're okay. What happens with
2 cannabis is it degrades performance over time. So, you
3 know, my neighbor is a college professor who smokes pot
4 once a month. That's probably fine. The people who are
5 using it every day end up not being fine at all, and I have
6 treated people like that.
7 So I would say this: You know, the marketing
8 around addictive substances hasn't changed very much, and I
9 see people here that are old enough to remember Joe Camel.
10 You know, the reality is that substances are marketed to
11 young people for a reason, because the younger you can
12 start someone using drugs and alcohol -- vaping,
13 cigarettes, tobacco, alcohol -- the more likely you are to
14 have a good customer. The thing about these substances is
15 that 80 percent of the use is by roughly 20 percent of the
16 people. Those are our people, and so they are also the
17 people that are being marketed to by these entities.
18 I would say this: We need to be really careful
19 if the General Assembly moves towards this that we do
20 whatever we can to control this, you know, in a way that it
21 keeps it out of the hands of young people, and edibles are
22 particularly marketed---
23 REPRESENTATIVE STRUZZI: Mm-hmm.
24 MR. STAUFFER: ---towards young people.
25 MS. McANDREWS: Mm-hmm.

1 MR. STAUFFER: Just like, you know, they have
2 vaping? You know, cotton candy vape is not marketed to the
3 30-year-old; it's marketed to kids, you know. So we have
4 to be cautious about this and think about how we deal with
5 it, and that would be my comment.
6 REPRESENTATIVE STRUZZI: Okay. All right. Thank
7 you.
8 MAJORITY CHAIRMAN DiGIROLAMO: Okay. Thanks,
9 Jim.
10 We have got three more Members for questions. We
11 have got about a little less than 15 minutes, so I would
12 ask the Members to try to keep it under 5 minutes for
13 questions and answers.
14 Representative Gregory first.
15 REPRESENTATIVE GREGORY: Thank you, Mr. Chairman.
16 Thank you very much for being here, and I'll try
17 to keep this as brief as I possibly can.
18 I'm very interested in the recovery high school.
19 But Samantha, my sister in long-term recovery, thanks for
20 sharing your lead, and we share a story. And it was
21 fantastic to see you walk through the fear that we have to
22 walk through every day to be willing to do this, and you
23 lifted me up today. You're my vitamin, so thank you.
24 MS. OSTERLOF: Mm-hmm.
25 REPRESENTATIVE GREGORY: The recovery high

1 school. Is it -- and, Joe, my colleague, you have one.
2 I'm interested to hear, is it something that, and I'm
3 texting with my school superintendent back home, and Patti
4 Anne---
5 MS. McANDREWS: Where are you from?
6 REPRESENTATIVE GREGORY: I'm in Blair County.
7 MS. McANDREWS: Okay.
8 REPRESENTATIVE GREGORY: Altoona is not in my
9 district---
10 MS. McANDREWS: Right.
11 REPRESENTATIVE GREGORY: ---but it's right next
12 door in Hollidaysburg, and I have had a chance to interact
13 many times with Jon Wolf, the President of Pyramid, and I
14 was texting him to ask him why we have children,
15 adolescents, mixing with adults. But additionally, we also
16 have court-ordered folks who are mixing with folks who are
17 going voluntarily---
18 MS. McANDREWS: That's right.
19 REPRESENTATIVE GREGORY: ---for treatment, and
20 those folks don't normally want to be there, so that's
21 another issue for another day.
22 MS. McANDREWS: Right.
23 REPRESENTATIVE GREGORY: The recovery high
24 school, is it necessary that that complex has to be
25 separate, or is there a way to look at whether or not it

1 could be segregated within a current school system, or does
2 anonymity come into play, or I don't think that that's
3 probably the issue.
4 MS. McANDREWS: I'll talk about the recovery
5 schools.
6 REPRESENTATIVE GREGORY: Thank you.
7 MS. McANDREWS: When you look at the college
8 recovery, they are mainstreamed in with other students, and
9 there are kids that actually ask to go into that dorm, and
10 in some of the colleges they're allowed, whether they're
11 sober or not, but they may be able to live in that
12 building.
13 REPRESENTATIVE GREGORY: High school is also what
14 I was interested in.
15 MS. McANDREWS: With high schools, we only have
16 Bethlehem and Philadelphia, and Bethlehem is up and
17 starting now. You might know more about that. But I met
18 the gentleman that is starting that school, actually at a
19 Saint Joe's event. They are the only tool we have. Could
20 we do it in a school? I don't think that confidentially
21 would be an issue, confidentiality.
22 MR. STAUFFER: No. And the model, there's a
23 model, and it's described in your pamphlet. But, you know,
24 I can look nationally. I believe that there are models
25 that involve just simply publicly funded programs.

1 MS. McANDREWS: Yeah.
2 MR. STAUFFER: And I can check around with some
3 colleagues around the nation about it.
4 I mean, I think the recovery high school movement
5 is early. You know, we're early on in that. I don't see a
6 reason why we couldn't have it in a regular school and
7 mainstreamed. I think over time, that's helpful.
8 REPRESENTATIVE GREGORY: I guess I have concerns
9 about anonymity also.
10 MR. STAUFFER: Mm-hmm.
11 REPRESENTATIVE GREGORY: And before I close,
12 Samantha, your mom and dad are here, too, and the applause
13 that you got they deserve also, because we change people,
14 places, and things, and sometimes we have to change our
15 parents, and they're here for you, and I think that's
16 fantastic.
17 Thank you, Chairman.
18 MAJORITY CHAIRMAN DiGIROLAMO: Thank you.
19 Representative Hohenstein.
20 ACTING MINORITY CHAIR HOHENSTEIN: Representative
21 Gregory took my thunder. Thank you, Chairman.
22 I was also going to comment that it's wonderful
23 to have your parents here, and you definitely did bring
24 something beneficial to us guys today.
25 MS. OSTERLOF: Mm-hmm.

1 ACTING MINORITY CHAIR HOHENSTEIN: And, Bill, you
2 as well.
3 I want to also comment and thank you all for
4 recognizing the role of privilege, you know, you
5 referencing your race; you referencing the idea that you
6 had a private insurance program; you talking about the
7 resources that you have available. I come from a district
8 where a lot of times that isn't what happens for any number
9 of different reasons.
10 MS. McANDREWS: Absolutely.
11 ACTING MINORITY CHAIR HOHENSTEIN: So I
12 appreciate you recognizing that, and that's going to be an
13 extra challenge in some of the other areas.
14 The one question I have actually is directly for
15 you, Mr. Stauffer.
16 You referenced talking about and advocating for
17 the degradation of privacy rights within our current
18 crisis, and I have had other providers talk to me about the
19 obstacles that privacy has placed when we are looking to
20 get appropriate levels of treatment and medication and
21 specifically the problem of essentially getting double hits
22 of medication because you don't tell a doctor that you have
23 also got another prescription, you know, that kind of
24 thing. What's the solution to that problem, balancing
25 privacy issues?

1 MR. STAUFFER: The first thing -- and thank you
2 for asking the question.
3 I got to tell you, when I walked into treatment,
4 my first question was, what happens to the information that
5 I share here, because I was going to talk about illegal
6 drug use, you know? And we need to be really careful about
7 that, because there have been some studies shown that if we
8 don't protect people's information, it could be used to
9 discriminate against people in housing, employment,
10 insurance, that we will have a chilling effect on
11 treatment. So we have to remember that.
12 With somebody who has spent time on this, and
13 I train on confidentiality, the number-one issue that I
14 see both here in Pennsylvania and nationally is a lack
15 of understanding of how the confidentiality standards
16 apply.
17 So hospitals who are not what we call federally
18 assisted drug and alcohol treatment programs are not
19 covered under 42 CFR. So if somebody walks into the
20 hospital and tells somebody of their drug and alcohol use,
21 that hospital is not bound by 42 CFR or 255.5 as they are
22 not a licensed treatment facility. So there's a lack of
23 understanding about who it applies to. And also with a
24 signed consent, a clinician can talk to a clinician and
25 share histories.

1 You know, the issue around information on drugs
2 being out in the PDMP, I would suggest that, you know,
3 95 percent of drug users aren't being open about using
4 drugs. And so I think instead of eroding the rights of
5 people in recovery to have their information protected
6 against discrimination is that we need to have more savvy
7 clinicians to understand what addiction looks like.
8 If somebody is taking opioids and they have been
9 using awhile, it should be easy to spot. And you have to
10 assume that that information may not be able to be
11 accessible, because most people don't get drug and alcohol
12 treatment. So if we don't protect those rights, we're not
13 really going to solve the problem of someone coming in and
14 the information not being in front of the clinician.
15 ACTING MINORITY CHAIR HOHENSTEIN: All right.
16 Thank you.
17 MR. STAUFFER: Sure.
18 MAJORITY CHAIRMAN DiGIROLAMO: Okay. And our
19 last question comes from Representative Polinchock.
20 REPRESENTATIVE POLINCHOCK: Thank you,
21 Mr. Chairman.
22 Ms. Osterlof, you said something that was very
23 profound today that will stay with me for a very long time:
24 When we are quiet, we die, and I will promise you, we will
25 not be quiet.

1 We have a cosponsor memo out right now that is
2 going to shortly become a resolution that is going to start
3 a recovery task force, just, you know, taking us from the
4 next step moving forward.
5 I mentioned at the last hearing that we're
6 looking for expertise from folks that want to get on that.
7 I'm asking you again, my fellow Members here, cosponsor
8 that memo for us.
9 And also, we have talked about that part, the
10 recovery part, but not the adolescent part, so I'm reaching
11 out to you, to folks that you may find that should be on
12 that task force as well from the adolescent side, to please
13 reach out to Melanie, get your names on that list or make
14 recommendations on folks that should be on that.
15 And I put together a list already of about
16 20 different fields of expertise. Can you, you know,
17 briefly brainstorm for me and give me a few folks that you
18 think, you know, from anything from the high schools to,
19 you know, the recovery folks that you think might be good
20 fits for that task force.
21 MS. McANDREWS: That was a big question. Could
22 you kind of give us a little more direct, finite?
23 REPRESENTATIVE POLINCHOCK: In 20 words or less.
24 No, just kidding.
25 MS. McANDREWS: Yes; please. Please.

1 REPRESENTATIVE POLINCHOCK: We're trying to---
2 MS. McANDREWS: To find some people.
3 REPRESENTATIVE POLINCHOCK: Yeah. We're trying
4 to reach---
5 MS. McANDREWS: We need education. We need
6 counseling, human services. And we need medical, because
7 the kid from CHOP should have been kept, but he couldn't
8 be---
9 REPRESENTATIVE POLINCHOCK: Okay.
10 MS. McANDREWS: ---because of regulations. So we
11 need some medical people on the end of, we send the kid to
12 a hospital, and because they aren't in acute detox, we kick
13 them out until they're having a seizure, and then we can
14 take them back. So we need somebody in medicine.
15 I would just say some social workers and
16 counselors. I think that you've got some people up here.
17 I'll do it, if it doesn't kill me. I hate driving this
18 far. But yes, I'll do it. And I'll see if my doc will do
19 it. And whenever you have questions, I already gave you my
20 card and told you that my staff will be more than glad to
21 do some research and we'll try and help out. So they could
22 be on the back end.
23 But we're asking for some -- we have a guy, a
24 doctor on the Advisory Council. I can't think of his name,
25 but we do have a doctor on the Pennsylvania Advisory

1 Council. I would hope that he would be involved.

2 MR. STAUFFER: Yeah.

3 I would just, you know, I think substance use

4 disorders affect everything, you know.

5 I would have to note that, you know, in my work,

6 it's an odd situation, because most people have these

7 strong opinions about substance use disorders, whether that

8 information is backed with insight into what really is

9 going on or just "those people don't deserve our help" kind

10 of an opinion. So I would think when you're looking at

11 people and places to serve, that you really want to make

12 sure that you have people who have a deep understanding of

13 substance use disorders.

14 I have to say that social work school wasn't the

15 greatest place for me to learn, just like medical school

16 isn't, but we have recovering social workers, we have

17 recovering physicians and pharmacists, and so I think the

18 greatest untapped resource that we have on this issue is

19 our recovery community. We just don't, we don't think to

20 include them, and they have all those walks. And so it

21 should be made up by professionals with those

22 backgrounds---

23 MS. McANDREWS: Absolutely.

24 MR. STAUFFER: ---because they are seeing it

25 360 degrees.

1 REPRESENTATIVE POLINCHOCK: That's wonderful, and
2 thank you.
3 And again, please get names to Melanie on that.
4 Thank you, Mr. Chairman.
5 MAJORITY CHAIRMAN DiGIROLAMO: Okay. And I'm
6 just going to---
7 REPRESENTATIVE MURT: Just one, what I think is
8 the final comment.
9 The one observation I have is that I think we
10 need to communicate with the greater world that addictions
11 are not -- this is not a personal failing. This is not a
12 character flaw. And many of our colleagues want to embrace
13 programs that work. They want to know what is
14 cost-effective. And I think what is cost-effective is when
15 we treat addictions as a disease, as a medical condition
16 that needs to be treated, just the way anything else is.
17 And I think that is something that I have gleaned
18 from, not just today but from talking to various people and
19 my good friend, Deb Beck, and this is what works. So I
20 just wanted to make that observation.
21 MR. STAUFFER: Sir, you made my day. Thank you.
22 MS. McANDREWS: Thank you all.
23 MAJORITY CHAIRMAN DiGIROLAMO: Well, I thank the
24 three of you for being here today, and I want to thank our
25 County Commissioner for jumping in.

1 The counties are the ones that are the lifeline
2 for people in human services, addiction and mental health.
3 You manage the Medicaid program, you manage the State
4 money, and you are a lifeline out there for people in need.
5 So thank you for your good work.
6 And I'm just going to close with, Samantha, you
7 touched a nerve for me, because I talked about my son being
8 an addict, and he went through his addiction in high
9 school, and it's so difficult for parents to realize what's
10 going on. And I know your parents are here, and you just,
11 you really touched a nerve for me because you mirrored what
12 my son went through. Trying to get a handle on what's
13 going on, knowing something's wrong, so what you went
14 through, my son went through and my family went through,
15 like your mom and dad went through, so.
16 MS. OSTERLOF: Thank you, sir.
17 MAJORITY CHAIRMAN DiGIROLAMO: Yeah. Go ahead.
18 MS. OSTERLOF: I think, too, something that's
19 really important about that is as a person in recovery, a
20 person that works in the field, a person who has a degree,
21 I really do my best, and I know Bill does, I know
22 Patti Anne does. I know a lot of our colleagues and people
23 we work with which will be beneficial with that task force
24 is, I'm available 24/7. I don't do things based upon the
25 facility I work for. I take calls from parents with kids

1 who have no insurance; calls from parents who are just
2 like, what do I do, my son is homeless. He doesn't have a
3 phone. He doesn't have an address. I can't get ahold of
4 him. What do I do?
5 And really, I kind of think back of, what would
6 my parents have done if they had somebody who was an ally
7 in recovery or if they had someone who had already been
8 through it and felt comfortable to say, what do I do? And
9 so that's really something I think as a State we're doing a
10 better job of and just making sure we're putting that hand
11 out there and we're being vocal---
12 MAJORITY CHAIRMAN DiGIROLAMO: Terrific.
13 MS. OSTERLOF: ---and we're opening our mouth.
14 So thank you for realizing that.
15 MAJORITY CHAIRMAN DiGIROLAMO: A great hearing
16 today, and I want to thank the staff on both sides. Thank
17 you for putting this together.
18 And this meeting is now adjourned of the
19 Human Services Committee. Thank you.
20
21 (At 10:57 a.m., the public hearing adjourned.)

1 I hereby certify that the foregoing proceedings
2 are a true and accurate transcription produced from audio
3 on the said proceedings and that this is a correct
4 transcript of the same.
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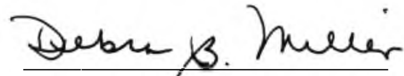
7 
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