**Testimony on Senate Bill 860**
**Criminal Justice and Addiction Treatment Act**
**Drs. Sheryl Ryan, Chief Adolescent Medicine and Leslie Walker-Harding, Chair of the Department of Pediatrics Penn State Health Milton S. Hershey Medical Center**
March 26th, 2018

Good morning, Chairman Greenleaf, Chairman Leach and members of the Senate Judiciary Committee, and thank you for providing us the opportunity to testify on Senate Bill 860 entitled the Criminal Justice and Addiction Treatment Act, specifically as it relates to the need for increased support for education and training of health care providers in the areas of the prevention and treatment of substance use and abuse. Dr. Walker-Harding and I are pediatricians and specialists in adolescent medicine who have devoted out entire careers caring for and advocating for adolescents and young adults and their families and we are here to speak to the fact that substance use and abuse affects people across the entire lifespan and requires a significantly increased workforce of trained and dedicated health professionals if we are to combat this issue successfully.

**The Magnitude of the Problem**

As you all are aware, this country is facing unprecedented medical, economic and social consequences of the use and abuse of both licit and illicit substances by the entire population of the U.S., including children, adolescents, young adults and older adults.

What you hear less about are the numbers of adolescents who are involved in illicit substance use and abuse. Or, the number of infants born to mothers who are using licit or illicit substances, or the number of toddlers and children who are hospitalized with acute ingestions from opioids or other substances such as marijuana that they find in their homes. But Dr. Walker – Harding and I, as pediatricians, are all too familiar with the problem of substance abuse in our younger citizens, and this is why we feel that this Senate Bill is so important. Despite the prevalence of substance use and abuse, the consequences that result from them and the availability of effective solutions, screening and early intervention for substance misuse is rare, and 9 out of 10 people who meet criteria for addiction involving alcohol and drugs other than nicotine receive no treatment.

**Medical Community Response:**

There are a number of important ways that the medical community has responded to the issues of substance use and abuse in the past and now in light of the opioid crisis. We currently have in place a very limited workforce of addiction specialists. These physicians have been trained in medical specialties such as psychiatry, internal medicine, family medicine, emergency medicine and pediatrics – and who have obtained additional clinical expertise in addiction medicine beyond their residencies given their interest in working with this population, and just by virtue of working with patients who have substance use and abuse problems. The medical community also has access to well-developed and evidence-based systems for the screening, brief intervention and referral to treatment that can be readily implemented in clinical settings. We have sound approaches to treating patients with addiction, through the use for example of medication–assistant treatment, behavioral therapy and harm reduction practices. Unfortunately, the medical community has responded in some places by closing residential treatment units, and making it even more difficult for certain populations such as adolescents and pregnant women to access needed services. Until now, there has been a lack of a concerted effort across the nation and across states to address the huge problem of addiction among our population in

detention settings and prisons. The medical community has also not done a great job of reducing the stigma associated with addiction, or bringing this area of medicine from the fringes of the medical system into the mainstream of medical education and practice.

If we look at formal training of addiction specialists, there are a limited number of specialized addiction fellowships, 52 in all across the U.S. and 3 in Canada, which are specifically designed to train physicians in addiction medicine through 1-2 years of training post-residency.

These are one-year, full-time training programs that physicians may apply to after they have completed a residency in a primary specialty such as internal medicine, family medicine or pediatrics. In these fellowship programs, physicians are trained in a wide range of clinical venues in the care of people engaged in unhealthy substance use or who meet medical criteria for a substance use disorder – from hospital wards to outpatient programs and community primary care clinics and practices. Upon completion, physicians will be able to work in these environments as well as engage in teaching, research, advocacy and administrative positions that require in-depth expertise. These addiction fellowship training programs utilize nationally agreed upon benchmarks for training the physicians and they include well-developed sets of competencies.

However, there are too few of these fellowship (55 total), and there is no way that this small number of training programs will be able to provide the workforce that is needed. The Addiction Medicine Foundation is proposing to expand the number of fellowships to more than 100 over the next 5 years, but this will be difficult without support from hospitals and other funding streams to support these programs financially. In addition, education needs to begin earlier during medical training of medical students, nursing students, physician assistant students, as well as for medical residents in all of the subspecialties, especially primary care residencies, and we need support for educational efforts at these early stages of training.

Expanding the workforce of trained physicians through addiction fellowships is important because fellows are specifically trained to:

- Provide the full continuum of care from prevention and early intervention to treatment and disease management in primary care, hospital, and other medical settings;
- Serve as faculty, training the next generation of physicians, influencing medical school and residency curriculum, training other health care providers in prevention and early intervention , and generating new knowledge through scholarship; and
- Become leaders and change agents to influence practice, health system modernization and policy.

Fellowship training drives the knowledge and practice in this field – as these will be the individuals who will not only provide needed specialty care, but more importantly, they will be the workforce that will educate the next generation of generalists and primary care providers who are in the front lines and able to first identify, prevent and treat harmful substance use and addiction in their clinical care practices.

**Addressing Continued Unmet Need in the Medical System**

Senate Bill 860 is an important piece of legislation that can help us make significant strides against addiction in our State. As an Adolescent Medicine Specialist and now as Chair of the Department of

Pediatrics at Penn State Hershey Medical Center, I have spent the last 20 years advocating and caring for children, adolescents and their families to ensure the well-being and health of our communities. Like Dr. Ryan I have specifically focused on the primary prevention of adolescent drug use and the identification and treatment of adolescents and young adults who have substance use disorders. Addiction is a childhood disease that can only be stemmed with a comprehensive approach. We cannot treat ourselves out of the current epidemic or the future epidemics that will occur with other drugs. Primary prevention is an essential evidence-based tool with robust outcomes that must be included by our medical system and our communities.

Dr. Ryan discussed what has already been done in medicine to develop an ACGME accredited addiction medicine specialty in 2015 and the development of training competencies developed in conjunction with the newly accredited addiction medicine fellowship. Along with these important developments evidence-based screening and assessment instruments exist for both adolescents and adults.

**Where do we go from here?**

- **Medical Workforce Development Needed:** Given current medical training is extremely limited and the treatment of those with substance use disorders was historically done by non-medical professionals, there is a dearth of medical educators who have expert knowledge of the disease of addiction. Regardless of how many recommendations we give the medical profession on how and when we would like addiction to be addressed, the current workforce is not prepared to carry it out. This is crucial since most adolescents and adults suffer from co-occurring disorders both behavioral disorders and chronic medical conditions that need to be addressed in tandem with prevention and treatment of substance use disorders. In fact I had an adolescent with a severe substance use disorder who also had diabetes type 1. She had to fly across the country to find a treatment facility who would agree to treat her and manage both conditions. It was fortunate her parents had the funds to do so or else she would have been one of the majority of adolescents in the country and our state who never get treatment for their addiction. More trained addiction medicine specialists who can serve as clinical experts, faculty educators and change agents are desperately needed. The Addiction Medicine Foundation estimates that a minimum of 7,500 addiction medicine physicians will be needed by 2022 to meet population needs.

- **125 Fellowship Programs are needed**: To assure this workforce, The Addiction Medicine Foundation projects that at least 125 addiction medicine fellowship programs are needed for accreditation by 2025. Funding is needed to accelerate the development of the workforce by creating and sustaining fellowship programs across the country that doctors from Pediatrics to Internal Medicine to Psychiatry to Obstetrics and Gynecology and Family Medicine can attend.

- **Comprehensive Systems of Primary Prevention, Identification and Treatment:** Attention to addressing unhealthy substance use and addiction in a comprehensive way is needed, including the fact that we must include ALL addictive substances – nicotine, alcohol, controlled prescription illicit and other addictive drugs in addition to opiates. Use of any substance increases the chance of use of and addiction involving others and cessation of use of one substance, unless addressed in a comprehensive way, is often followed by substitution with another. In particular 9 out of 10 adults who suffer from addiction began using drugs before the

age of 18. The most popular drugs adolescents use first and become dependent and addicted to are marijuana and alcohol.

- **We Cannot Treat our Way Out of This Crisis:** The full continuum of care from primary prevention both universal and targeted and early intervention for unhealthy substance use through treatment and disease management for addiction and co-occurring conditions must be in place in our communities. We will never treat out way out of the addiction crisis otherwise. We must be sure to focus on the front end to prevent unhealthy substance use and intervene early to prevent costly health and social consequences. The evidence supports the need for primary prevention resources, and education on the most effective evidence-based methods need to be in place as well.

**Conclusion:**

Lastly, a few key points for your consideration on the Senate Bill 860 at this time are:

- **Core Clinical Competencies Have Been Developed by the Addiction Medicine Foundation (AMF):** Senate Bill 860 would charge the Department of Drug and Alcohol Programs with responsibility to develop "core clinical competencies that can be incorporated as required components of all medical schools' curricula, residency training programs, licensing examinations and continuing education requirements to address risky substance use and addiction…" The Addiction Medicine Foundation has developed such competencies and has worked with ACGME in their development of core clinical competencies for ACGME accredited addiction medicine training programs.

- **Funding for Fellowship Training Programs Needed:** Given the recent progress with competencies and training program accreditation, one strong recommendation we would make is that the state consider providing funding for the development of new addiction medicine fellowship training programs in PA. As mentioned there are currently two programs that will have to meet the new ACGME accreditation standards if they choose to become ACGME accredited. Also a new program is being developed at Penn State Hershey led by Dr. Ryan and I that will apply directly for ACGME accreditation. This fellowship will be open to all medical specialties and will have an additional year for a total of 2 years, to help develop research skills in the trainees so we can keep moving forward with innovative solutions to the disease in Central Pennsylvania and beyond. These programs are key as specialty training in medicine drives knowledge across healthcare practice – both downstream into residency training and medical school, and upstream into continuing medical education. The largest need for these programs is financial support to develop a program in a medical school or teaching hospital and to support fellows being trained. These trained specialists are key not only to addressing the current opioid epidemic but to preparing the health care system to prevent and respond to the next wave of addictive substances.

---

[1] American Society of Addiction Medicine. *Public policy statement on treatment for alcohol and other drug addiction*. [Online]. Retrieved May 11, 2012 from http://www.asam.org; Hajela, R. & Miller, M. M. (2012). *Addiction is addiction: The development of the new ASAM definition*. Unpublished manuscript; Leshner, A. I. (1997). Addiction is a brain disease, and it matters. *Science, 278*(5335), 45-47; Leshner, A. I. (2001). Addiction is a brain disease. *Issues in Science and Technology, 17*(3), 75-80; Volkow, N. D. (2005). What do we know about drug addiction? *American Journal of Psychiatry, 162*(8), 1401-1402.

[1] Erickson, C. K. (2007). *The science of addiction: From neurobiology to treatment*. New York: W.W. Norton; Hudson, N. L., & Mannino, D. M. (2010). Tobacco use: A chronic illness? *Journal of Community Health, 35*(5), 549-553; Lewis, D. C. (1991). Comparison of alcoholism and other medical diseases: An internist's view. *Psychiatric Annals, 21*(5), 256-265; McLellan, A. T., Lewis, D. C., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *JAMA, 284*(13), 1689-1695; White, W. L. (2008). *Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices*. Philadelphia, PA: Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health/Mental Retardation Services.