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Dear Members of the Delaware Health Care Commission,

My name is Diann Jones. I have lived in Delaware my entire life. My career has been spent in the financial services industry as a licensed insurance agent and financial planner for more than 20 years, and my practice now focuses on special needs planning. I am the mother to three daughters, ages 21, 5 and 3. My oldest daughter, Nicole, has a mental health disability and substance abuse issues. That's a more pleasant way to say my daughter has Bipolar Disorder and is a heroin addict.

Nicole can not live in our family home, as I can't afford to have one of her younger sisters become victim to her addiction if she drops a drug and they put in their mouth. Consequently, Nicole has been homeless for over a year, and her sisters have not seen her since last fall – even though Nicole is in Delaware... somewhere. I know this because I follow her Facebook page and get to send text messages to her back and forth every now and again. Every few months, she'll meet me somewhere for lunch.

Information for consideration by the Delaware Health Care Commission

1. The Office of National Drug Control Policy published a "Fact Sheet: A 21st Century Drug Policy" on April 24, 2013, stating, "Of the 21.6 million Americans aged 12 or older who needed treatment for an illicit drug or alcohol use problem in 2011, only 2.3 million (10.8%) received it. Treatment should be made more available." (Report is attached.)

2. There is a lack of inpatient detoxification and/or substance abuse treatment facilities for minors in Delaware, and too few detoxification centers for adults in our state.

3. States have a limited number of physicians and treatment centers who can be licensed to serve people with opiate addiction who wish to use Suboxone during their recovery. Suboxone is used to treat opiate addiction (Oxycodone, Vicodin, Fentanyl, Heroin). It works by blocking opiate receptors, so the patient can not get "high" from an opiate, but prevents them from becoming deathly ill as they would from otherwise not having an opiate in their system. It appears Delaware has a lower ratio of approved prescribing physicians on a per capita basis than surrounding states. (See attached.)

4. My daughter's introduction to opiates began from pain medication (Oxycodone) prescribed from a physician after an injury. It perpetuated into an addiction when she began using it to self-medicate her mental illness and her body would get ill when she didn't have any in her system. When her physician would no longer prescribe the Oxycodone to her, she would go to pain management doctors, pay cash, and get prescriptions for mass quantities of Oxycodone. From there, she graduated to heroin. I still struggle to understand why we do not limit the number of physicians who can prescribe opiates to the public, yet we limit not only the number of physicians, but also the number of patients to whom they can prescribe Suboxone.

5. After my daughter was released from Kirkwood Detoxification Center after a 3 day stay in August 2012, we searched for a physician who could continue her treatment with Suboxone (Buprenorphine) – which was used successfully during her detox. We called dozens of doctors on the list of approved prescribing physicians in

Delaware. She was put on waiting lists. That was 10 months ago. She has not been moved off of the wait list into treatment by any of them. Although I am still not sure how she will pay for their services, as most of them are "cash only" and require $200-$300 for the first week of visits and will only prescribe a daily dose of Suboxone at a time for the first week. They gradually increase the time between visits and the number of doses of the Suboxone prescription, but it is very expensive. The ones we spoke to did not choose to accept her father's State of Delaware Blue Cross insurance plan. Medicaid seems to be preferred method of payment for substance abuse providers.

6. Due to the personal out-of-pocket expense for lots of people who want to receive Suboxone treatment but only have traditional health insurance plans, they find it much more affordable to purchase their Suboxone off the street – in the same manner in which they obtain their opiates. For $10-20, they can purchase a Suboxone film that will last them a day or two - - or longer. Who do they purchase it from? The people on the roles of the physicians who prescribe it. Lots of these individuals no longer take all of the Suboxone they are prescribed, and can make "good money" selling it on the street to those who need it.

7. Because none of the treatment centers or providers would accept my daughter's State of Delaware Blue Cross plan and only Medicaid is accepted at most providers, we had to get her eligible for Medicaid. Since she does not receive Social Security benefits for her mental health disability or substance abuse issues and is not able to work - the only way she would qualify for Medicaid is if she were uninsured. So we had to cancel her Blue Cross coverage to get her enrolled in Medicaid. She was approved for Medicaid on May 1, 2013. It is therefore, Medicaid, who will now pay what could be tens of thousands of dollars towards her treatment – instead of Blue Cross. As an insurance agent and a taxpaying lifelong Delawarean, this is unsettling to me.

8. On April 9, 2013, I attended an intake meeting with my daughter at Connections treatment facility. She was ready and willing to enter recovery. She was at a new rock bottom, wanting help, and said she was ready to work towards recovery. Thanks to a friend who knows her story, he was able to set up an appointment for her and get her seen right away. The bonus: they would have been able to prescribe Suboxone to her during treatment, since treatment centers are not limited to 100 patients.) At the end of the morning after meeting with various caseworkers, we found she would need to submit a urine sample to make sure she did not have any Suboxone in her system. They didn't care if she had heroin or any other illicit drug in her system. They only wanted to make sure she was not trying to "double dip" into two Suboxone providers which would (1) lessen the chance of someone else receiving treatment; and (2) perpetuate the selling of prescribed Suboxone on the street to those who want to be in recovery, but can not get off a waiting list to receive it. Needless to say, she left Connections feeling even more hopeless. She stopped using the Suboxone with an intent to return in 3 days (which is how long it takes to get out of your system,) started back on heroin, and as of this day is still active in her addiction and dying a slow death.

9. My daughter's opiate addiction has cost more than I care to count. If you added up (1) the jewelry and other items she has stolen to support her habit, the five misdemeanor charges she has acquired in Delaware's Mental Health, Court of Common Pleas and Superior Court; (2) the money I have spent to put her up in a motel room for the night here and there, as she is homeless and can not live in my home; and (3) the cost of treatment that Medicaid will now pay when she chooses to try recovery again - - it is an exorbitant figure. She is only one individual. Multiply that by the number of people who are living with an addiction.

10. Addiction does not discriminate. It does not care what neighborhood you live in, how much money you have, how many people in your family it will alienate or what you look like.

11. Under the direction of Governor Markell, Delaware has taken great strides in gathering information through various task forces and using it wisely to benefit our state via a reduction of spending an increasing capacities. Now that I am speaking out about my daughter's heroin addiction, I am being approached by many people who are facing the same challenges with their loved ones.

12. We have an epidemic on our hands. I would like to see our state create a "Heroin Prevention Task Force," as other states have, to assess this problem. Once someone is addicted to an opiate such as heroin, they face a battle that is not in their favor. For those who do defeat it, it's usually after many failed attempt. For those who are in recovery, they are destined to fight it every single day of their lives – hence the 12-step program slogan of "one day at a time." If we could start to understand this issue, work on prevention instead of limiting treatment – our lives could be changed. From a dollar perspective, a focus on prevention has to cost less than repeated treatment.

13. I pray every day for my daughter's recovery. A few times a week, I will show various photos of Nicole to her younger sisters that I took of her before her addiction started eating her alive, and ask them, "who's that?" I make sure they remember her. Because sadly enough, on any given day, I'm not sure if or when any of us will see her again.

Thank you very much for your time in listening to my family's story and for your consideration in working towards improving prevention and access to treatment for those living a life in addiction.

Sincerely,

Diann Jones

Diann Jones

Licensed Buprenorphine (Suboxone) Doctors and Treatment Centers by State

June 5, 2013

Data Collected by Diann Jones
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State	Maximum Allowable Prescribing Physicians [1][3]	Maximum Total Possible Patients Under Physicians Treatment in State [1][3]	Number of Treatment Programs Authorized to Dispense Suboxone [1][3][4]	2012 Estimated State Population [2]	Maximum Percentage of of Population That Could be Treated by Physician in State
CT	270	27,000	46	3,590,347	0.7520%
DC	54	5,400	8	632,323	0.8540%
DE	56	5,600	8	917,092	0.6106%
MD	453	45,300	97	5,884,563	0.7698%
NJ	609	60,900	57	8,864,590	0.6870%
NY	1,627	162,700	280	19,570,261	0.8314%
PA	767	76,700	55	12,763,536	0.6009%
RI	82	8,200	21	1,050,292	0.7807%

(1) Source: Substance Abuse and Mental Health Services Administration (SAMHSA)
http://buprenorphine.samhsa.gov/bwns_locator/

(2) Source: United States Centus Bureau, 2012 estimate
http://quickfacts.census.gov/qfd/index.html

(3) *"DATA 2000, as amended in December 2006, specifies that an individual physician may have a maximum of 30 patients on opioid therapy at any one time for the first year. One year after the date on which a physician submitted the initial notification, the physician may submit a second notification of the need and intent to treat up to 100 patients."*
Source: CSAT Buprenorphine Information Center
U.S. Department of Health and Human Services
http://buprenorphine.samhsa.gov/bwns_locator/physician_faq.htm#A11

(4) *Treatment programs are authorized under 21 U.S.C. Section 823 (g)(1) to dispense (but not prescribe) opioid treatment medications. Treatment programs registered under 21 U.S.C. Section 823 (g)(1) are not subject to patient limits.*
Source: SAMHSA. http://buprenorphine.samhsa.gov/bwns_locator/

(5) *"Worldwide opium production has doubled since the mid-1980s, resulting in greater heroin availability, rising purity, and lower prices. Universal increases in heroin-related medical emergencies, arrests, and crime indicate that heroin consumption remains a growing problem throughout the world. The UN Drug Control Program estimates that there are some 8 million heroin abusers worldwide. Heroin accounts for a greater percentage of drug-related health problems and criminal activity. There are an estimated 2 million heroin users in the United States, with some 600,000 to 800,000 considered hardcore addicts. While most heroin users in the United States tend to be older, heroin use among younger groups has risen in recent years. Lower prices for heroin make the drug affordable. "*

Source: Central Intelligence Agency of the United States of America. (Posted May 4,2007. Last reviewed and updated on January 3, 2012.) https://www.cia.gov/library/publications/additional-publications/heroin-movement-worldwide/consumption.html

OFFICE OF NATIONAL DRUG CONTROL POLICY
Office of Public Affairs

April 24, 2013

FACT SHEET: A 21st Century Drug Policy

"...this Administration remains committed to a balanced public health and public safety approach to drug policy. This approach is based on science, not ideology—and scientific research suggests that we have made real progress."

- President Barack Obama

President Obama believes in the pursuit of an America built to last – a Nation with an educated, skilled workforce with the knowledge, energy, and expertise to succeed in a highly competitive global marketplace. Yet, for too many Americans, this future is limited by drug use, which inhibits the ability of our citizens to remain healthy, safe, and achieve their full potential.

Today, the Obama Administration is releasing a science-based plan that works to reduce drug use and its consequences while pursuing drug policy reform. The *2013 National Drug Control Strategy* represents a 21st century approach to drug policy that outlines innovative policies and programs and recognizes that substance use disorders are not just a criminal justice issue, but also a major public health concern.

The *Strategy* is informed by Science, Research, and Evidence

Groundbreaking discoveries in neuroscience have revealed that addiction is a chronic disease of the brain that can be prevented and successfully treated. This scientific understanding serves as the foundation for the Obama Administration's drug policy and guides the Administration's decision-making on public health and safety.

The *Strategy* Emphasizes Prevention over Incarceration

Preventing drug use before it begins – particularly among young people – is the most cost-effective way to reduce drug use and its consequences in America. Recent research has concluded that every dollar invested in school-based substance use prevention programs has the potential to save up to $18 in costs related to substance use disorders.[1]

In support of efforts to prevent drug use, the President's plan:

- Promotes national and community-based programs - including the Drug-Free Communities Support Program - that are evidence-based and work to prevent substance use in schools, on college campuses, and in the workplace;

- Provides information on effective prevention strategies to law enforcement agencies, communities, and parents nationwide; and
- Spreads prevention to the workplace through programs that ensure the safety and wellness of employees and their families.

The *Strategy* Empowers Health Care Professionals to Intervene Early, Before a Condition Becomes Chronic

Early detection and treatment of a substance abuse problem by a health care professional is more effective and less costly than dealing with a chronic substance use disorder. To bolster early intervention efforts, the President's *Strategy*:

- Works to expand programs like Screening, Brief Intervention, and Referral to Treatment (SBIRT), which can help reduce adverse health and safety consequences from substance use;
- Supports education and legislation aimed at providing health care professionals with continuing education and training on addiction and safe prescribing practices for painkillers; and
- Seeks to reduce opioid overdose deaths by expanding comprehensive overdose prevention measures, including the use of naloxone by first responders.

The *Strategy* Makes Access to Treatment a Reality for Millions of Americans

Of the 21.6 million Americans aged 12 or older who needed treatment for an illicit drug or alcohol use problem in 2011, only 2.3 million (10.8 percent) received it.[2] Treatment should be made more available. To expand access to treatment, the *Strategy*:

- Details actions to implement the Affordable Care Act, which – for the first time in history – ends discrimination against people with substance use disorders by requiring insurance companies to cover treatment for substance use disorders as they would for any other chronic disease;
- Works to expand treatment and reentry services for those incarcerated; and
- Targets expansion of care for populations with an unmet need for substance abuse treatment, including veterans, college and university students, and Native Americans.

The *Strategy* Gives a Voice to Americans in Recovery

Today, millions of Americans are successfully in recovery from substance use disorders and are healthy, responsible, and engaged members of their communities. The Obama Administration's *Strategy* supports their lifelong process of recovery by:

- Working to lift the stigma associated with addiction by partnering with the recovery community to speak out about their successes and encourage others to seek treatment; and
- Reviewing and reforming laws and regulations that unfairly target those with substance use disorders and impede recovery from addiction, including those laws and regulations that restrict access to housing, employment, and attaining a driver's license or student loan.

The *Strategy* Takes a "Smart on Crime" Approach to Drug Enforcement

Domestic and international law enforcement efforts will always play a vital role in protecting communities from drug-related crime, but the President's *Strategy* acknowledges that the United States cannot arrest or incarcerate its way out of the drug problem. As a result, the *Strategy*:

- Works to implement innovative criminal justice reforms, including specialized Drug Courts, to break the cycle of drug use, crime, arrest, and incarceration by diverting non-violent drug offenders into treatment instead of prison;
- Supports innovative diversion programs that identify offenders with a substance use disorder and refer them to community services while focusing limited law enforcement resources on more serious offenders; and
- Examines innovations, such as Hawaii's Opportunity Probation with Enforcement (HOPE) and the Drug Market Intervention program, that show promise in reducing rates of incarceration while protecting public safety.

The *Strategy* Addresses a Global Problem in the Spirit of Shared Responsibility

Drug issues are a truly global challenge requiring shared solutions. Previous distinctions between "producer" and "consumer" countries are falling away. Today, all countries must view drug policy as a public health and public safety issue that requires a modern, evidence-based response. The President's *Strategy*:

- Expands global drug prevention and treatment initiatives both bilaterally and through cooperation with multilateral organizations;
- Promotes alternative livelihoods for farmers in regions of the world susceptible to drug production and trafficking; and
- Promotes collaboration with international partners to expand and modernize law enforcement and criminal justice institutions.

For more information on Obama Administration efforts to reduce drug use and its consequences while implementing effective drug policy reform, visit www.wh.gov/drugpolicyreform

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[1] Jones, D. E. ; foster, E.M.; and Group, C.P. Service use patterns for adolescents with ADHD and comorbid Conduct disorder, *J. Behavioral Health Service Res*. 366 (4): 436-449, 2008

[2] U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (2012). Results of the 2011 National Survey on Drug Use and Health: Summary of National Findings. HHS Publication No. (SMA) 12-4713. Rockville, MD. P. 84.