

From Pain to Passion:

**How Improving
Public Policy Can
Save Our Kids!**

*The Parent Panel Advisory Council's
Recommendations for Improving Access to
Drug and Alcohol Information and Treatment*

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House of Representatives
COMMONWEALTH OF PENNSYLVANIA
HARRISBURG

Three years ago, I was thrilled to receive unanimous support from my colleagues to enact legislation allowing parents whose children have been affected by alcohol and drug abuse to come together to study accessible treatment services and make recommendations to the House of Representatives to facilitate access to treatment and intervention services in the community.

This legislation was so important to me because there are more than 800,000 people in Pennsylvania with unmet drug and alcohol treatment needs. This is a real problem that needs our immediate attention. We know that addiction cuts across all walks of life, as well as socio-economic and cultural backgrounds. It affects men and women, teens and adults, from the poor to the middle class to the affluent, from the rural towns to the suburbs and the cities.

My resolution required the Bureau of Drug and Alcohol Programs within the Department of Health to establish a parent panel, consisting of parents from across the state whose children have been or continue to be affected by alcohol and drug abuse. The parent panel was directed to convene in Harrisburg at least three times a year and report its findings to the House Health and Human Services Committee and the Bureau of Drug and Alcohol Programs.

There has been an overwhelming concern about the growing number of young people who need treatment in Pennsylvania and the accessibility of available treatment in the Commonwealth. In fact, one in four families in Pennsylvania is affected by untreated alcohol and drug addiction.

Parents with family members in crisis often have difficulty locating alcohol and drug abuse and addiction intervention and treatment services. It was my hope that with the creation of this panel, we can develop strategies that will improve and potentially expand our treatment options and facilities in the Commonwealth.

It is my pleasure to see this idea realized. Within this publication, you will find real ideas from real families who have experienced this traumatic situation first-hand. It is my hope that we take a careful look at these suggestions and implement some or all of them in an appropriate manner. If we continue to look the other way, the ramifications will be endless. Addiction will rise and the cost to Pennsylvania will be enormous.

I would like to thank all of those involved in making this legislation a reality. Your hard work could save lives.

A handwritten signature in black ink that reads "Ronald S. Marsico".

Ronald S. Marsico
State Representative
105th Legislative District

ACKNOWLEDGMENTS

The members of the Pennsylvania Parent Panel Advisory Council (PPAC) wish to thank the Bureau of Drug and Alcohol Programs (BDAP) for understanding the need for this committee and for all of its time, effort, knowledge, and support in guiding us through the intricacies of state government, listening to our stories, and caring about us and our families. Our thanks go out to Robin Rothermel, Director, Bureau of Drug and Alcohol Programs, and her staff: Jeffrey Geibel, Treatment Division Supervisor; William Noonan, Program Analyst; and Kathy Jo Stence, Program Analyst, who also took on the painstaking job of coordinating these meetings, taking and disseminating the minutes, and acting as liaison between us all. Denise S. Schlegel was so instrumental as our facilitator, keeping us on track and in good spirits, all with humor and empathy.

We were privileged to have the opportunity to meet and learn from Deborah Beck, President of the Drug and Alcohol Service Providers Organization of Pennsylvania (DASPOP), Policy Co-Chair of the State Association of Addiction Services, co-founder and board member of the National Alliance for Model State Drug Laws, and a board member of the Pennsylvania Recovery Organizations Alliance (PRO-A). She shared her wisdom gained over more than 30 years working in the alcohol and drug treatment and prevention field. Dr. Thomas McLellan also journeyed from Philadelphia to speak with us on the day after he had learned of his appointment as Deputy Director of the White House Office of National Drug Control Policy. Dr. McLellan is Professor of Psychology and Psychiatry at the University of Pennsylvania and co-founder and Chief Executive Officer of the Treatment Research Institute, a not-for-profit research and development institute in Philadelphia. He has worked to change the way addiction is evaluated and has been instrumental in pioneering new and more effective methods of addiction treatment. Both of these distinguished guests helped to reinforce our own feelings of urgency about the problems of drug abuse and the disease of addiction facing millions of families and parents across Pennsylvania and our country.

We also are grateful to the members of the Committee on Health and Human Services of the General Assembly of Pennsylvania, who proposed House Resolution No. 585, instructing BDAP to establish the Parent Panel.

INTRODUCTION

The Parent Panel Advisory Council (PPAC) was created in 2006 by the Pennsylvania General Assembly's passage of House Resolution 585. This resolution directed the Department of Health, Bureau of Drug and Alcohol Programs (BDAP), to establish a panel of parents whose children have been affected by substance abuse and addiction, to study access to addiction intervention and treatment services and make recommendations to facilitate access. PPAC is comprised of 18 individuals chosen by an application process and appointed by the Deputy Secretary for Health Promotion and Disease Prevention. PPAC meets three times per year in the Harrisburg area. The first meeting was held in September 2007.

Pennsylvanians, especially adolescents, often have difficulty accessing quality prevention, intervention, and treatment programs for substance abuse disorders due to cost, geographic location, social stigmas, public policy, lack of a qualified workforce and other obstacles. The incidence of the disease of addiction is unfortunately, on the rise in our state, as it is throughout our country. Since the 1950s, addiction has been classified as a chronic disease by the American Medical Association. Appropriate treatment has been shown to be highly effective in helping individuals suffering from addiction to maintain abstinence and recovery from this illness.

The panel members had interacted with the systems within Pennsylvania that are concerned with individuals with drug addiction problems—BDAP, local county drug and alcohol agencies, the justice system, private insurance companies, treatment and after-care facilities, and the public welfare system. We agreed to prepare documentation for presentation to all members of the Pennsylvania State Legislature outlining deficiencies in Pennsylvania's addiction treatment services and offering suggestions for improvement. Our information is based on both first-hand experience and additional information gathering.

As our first step, members of PPAC interviewed 17 Single County Authorities (SCAs) across Pennsylvania. The SCAs are the local entities responsible for program planning and assisting individuals in need of public funding for treatment. We conducted these interviews in order to understand the specific challenges in administering and implementing drug and alcohol programs in Pennsylvania. The portion of this document entitled, "Recommended Solutions to Systemic Barriers and Deficiencies in Pennsylvania Addiction Services" (pp 12-19), is based on the information supplied by the SCAs. We have outlined the problems they identified and are offering possible remedies.

In addition to the SCA interviews and our personal experiences, PPAC members examined the *Blueprint for the States*,¹ a 2006 publication presenting recommendations on how all states should organize and deliver drug and alcohol programs. We analyzed how Pennsylvania measures up to the suggestions put forth and what could be done to improve state policies to make alcohol and drug services more available and more effective. Our conclusions and ideas are presented on pages 20 - 28.

¹ "Blueprint for the States" was published in 2006 by Join Together of the Boston University School of Public Health, with support from The Robert Wood Johnson Foundation. A national policy panel of experts made recommendations of how states should organize and deliver drug and alcohol programs.

As a final part of our documentation, members share the story of their struggles to support their children in securing rehabilitation treatment, maintaining recovery, and rebuilding their lives. It is our hope that by adding our voices and the faces of our children, it will show that addiction affects not only individuals but also families. Addiction does not discriminate by age, sex, ethnicity, education-level, profession, economic level, geographic location, or religion. Addiction is an epidemic that affects each and every one of us.

By sharing our experiences and information, we hope to help our state legislators and others to understand the difficulties faced in seeking treatment for addiction, the stigma attached not only to those afflicted with addiction problems, but their families and friends, and most importantly, methods to improve the lives of those suffering from this disease.

MEMBERS OF THE PARENT PANEL ADVISORY COUNCIL

| REGION | NAME |
|----------------------|---|
| South East | L.W. Nelson Christine Loughran Linda Eckman Karen Brown Vellucci |
| South Central | Charlene Sciarretta Lynne Bennetch Lori Mentzer |
| South West | Joan Ward John Clayton Ronald Owen Sheri Hathaway |
| North West | Charles Klenk Frederica J. Hood |
| North East | Patricia Zangardi Carol Hillard Thomas Moreken Jane Holbrook Roseanne Gallagher |

THE GENERAL ASSEMBLY OF PENNSYLVANIA

HOUSE RESOLUTION

No. 585 Session of 2006

INTRODUCED BY MARSICO, ARGALL, BALDWIN, BEBKO-JONES, BOYD, CALTAGIRONE, CAPPELLI, CORNELL, CREIGHTON, DeWEESE, DIGIROLAMO, FRANKEL, GEIST, GINGRICH, GOODMAN, HARPER, HARRIS, HERMAN, HESS, JAMES, M. KELLER, MACKERETH, MARKOSEK, McILHINNEY, PETRONE, PHILLIPS, READSHAW, REICHLEY, RUBLEY, SCHRODER, SIPTROTH, B. SMITH, R. STEVENSON, TANGRETTI, E. Z. TAYLOR, THOMAS, WILT, WOJNAROSKI, YOUNGBLOOD, YUDICHAK, FABRIZIO, BARRAR, BEYER, TURZAI, NAILOR AND TRUE, FEBRUARY 9, 2006

AS REPORTED FROM COMMITTEE ON HEALTH AND HUMAN SERVICES, HOUSE OF REPRESENTATIVES, AS AMENDED, MAY 2, 2006

A RESOLUTION

Directing the Bureau of Drug and Alcohol Programs of the Department of Health to establish a parent panel to study and address family and community access to alcohol and drug abuse and addiction treatment services.

WHEREAS, One in four families in Pennsylvania is affected by untreated alcohol and drug addiction; and

WHEREAS, In this Commonwealth 631,085 persons have been identified as having unmet treatment needs; and

WHEREAS, Untreated alcohol and drug problems contribute to high dropout rates from school, teen suicide, unwanted teen pregnancy, teen alcohol and drug overdoses and juvenile crime; and

WHEREAS, Treatment for alcohol and drug abuse and addiction is highly effective; and

WHEREAS, Parents with children in crisis often have difficulty locating alcohol and drug abuse and addiction intervention and treatment services; and

WHEREAS, Children are the future of our Commonwealth; and

WHEREAS, It shall be the goal of the General Assembly to ensure that parents of children affected by alcohol and drug abuse are able to locate and access intervention and treatment services; therefore be it

RESOLVED, That the House of Representatives direct the Bureau of Drug and Alcohol Programs of the Department of Health to establish a parent panel consisting of parents whose children have been affected by alcohol and drug abuse and addiction; and be it further

RESOLVED, That the panel study access by families to information about alcohol and drug abuse and addiction intervention and treatment services and make recommendations, ON A SCHEDULE TO BE DEVELOPED BY THE PARENT PANEL, to facilitate access to addiction treatment and intervention services in our communities; and be it further

RESOLVED, THAT THE RECOMMENDATIONS DEVELOPED BY THE PARENT PANEL BE DISTRIBUTED TO THE HEALTH AND HUMAN SERVICES COMMITTEE

AND THE BUREAU OF DRUG AND ALCOHOL PROGRAMS ON A SCHEDULE TO BE DEVELOPED BY THE PARENT PANEL; AND BE IT FURTHER

RESOLVED, That the Bureau of Drug and Alcohol Programs of the Department of Health provide staff and other support services to the panel; and be it further

RESOLVED, That travel, lodging and other appropriate expenses be reimbursed by the Department of Health; and be it further

RESOLVED, That panel members represent all regions of this Commonwealth; and be it further

RESOLVED, That the panel convene in Harrisburg three times a year; and be it further

RESOLVED, That a copy of this resolution be transmitted to the Bureau of Drug and Alcohol Programs of the Department of Health.

PARENT PANEL ADVISORY COUNCIL (PPAC) RESPONSE TO HOUSE RESOLUTION 585

EXECUTIVE SUMMARY

In 2006, the Committee on Health and Human Services of the General Assembly of Pennsylvania put forth House Resolution No. 585, directing the Bureau of Drug and Alcohol Programs (BDAP) of the Department of Health to establish a parent panel to study and address family and community access to addiction treatment services. At the time the resolution was published, one in four Pennsylvania families was affected by untreated alcohol and drug addiction, affecting more than 630,000 people in the Commonwealth.

BDAP began the process of fulfilling the challenge of H.R. 585 during the summer of 2006. Every effort was made to recruit volunteer parents who would be selflessly dedicated to the project by virtue of their own stories of frustration and disappointment when they attempted to find addiction information and treatment for their loved ones (several of these stories are included in the full report). By September of 2007, the selections were complete, and the first organizational meeting of parents from all six of the Pennsylvania Health Regions took place in Harrisburg, where the mission was outlined and the real work began.

Fast forward two years to the present. The Council has fulfilled its mission by addressing the gaps and impediments to addiction information and treatment by documenting its first-hand experiences, by empathetically interviewing numerous Single County Authority (SCA) offices throughout Pennsylvania, and by conducting research on the issues through written materials and input from experts in the field.

The council's recommendations from the SCA interviews can be summarized in the following general categories:

- Visibility (Recommendations 1,5,16 and 24)
- Efficiency (#s 2,3,9,15,19,20,23)
- Funding/Resources (#s 4,6,7,8,11,12,13,14)
- Communications/Technology (#s 10,17,18,21,22,25)

Not surprisingly, the issue of funding and lack of resources was the single most recurring theme in our discussions with the SCAs, followed closely by efficiency issues. Communications and technology shortcomings were next cited most frequently, and all agreed that BDAP and allied agencies need higher visibility and priority within our state government.

The next portion of the PPAC report follows the template of *Blueprint For The States*, a 2006 compilation of findings by a national policy panel sponsored by *Join Together* and chaired by Michael Dukakis, former Governor of Massachusetts. Mr. Dukakis and his esteemed panel of public health and government officials heard from experts, clients, providers, community leaders and others, as they examined how state governments could be most effective in preventing and treating substance use disorders and problems.

The following are the major headings and summary of recommendations developed by PPAC specifically for Pennsylvania:

LEADERSHIP AND STRUCTURE

We need the Governor of Pennsylvania to take the lead in coordinating the efforts of all appropriate state agencies to improve delivery and tracking of addiction services. His enthusiastic leadership has the potential to dramatically improve organizing, implementing and tracking improved policies and cooperation among all departments and bureaus that are challenged to “do more with less.”

RESOURCES

Our state agencies are under critically intense pressure to stretch resources to their fullest during this period of economic difficulty. PPAC has recommended numerous action steps that can be taken to eliminate waste, end redundancy, and generally achieve teamwork and efficiency in the delivery of addiction services, including the establishment of “best practices” throughout the state.

MEASUREMENT AND ACCOUNTABILITY

The panel believes that true accountability for improving access to information and treatment services cannot occur until Pennsylvania establishes prevention, treatment, continuum of care, and outcome measures for all state agencies and other funding entities. Several specific recommendations to that end are contained within this report, including one for the creation of a unified data tracking system to monitor compliance of standards behind the measurements.

LEGISLATION

A number of legislative considerations were addressed by PPAC with a recognition that many of our current laws and regulations are in desperate need of updating, as the epidemic of substance abuse has continued to grow in our society. Everything from a review of existing law, to recommended changes, to the creation of new legislation has been considered and recommended in this study.

SUSTAINING STATE FOCUS AND ATTENTION

Once a technologically current, streamlined, efficient and effective framework is created and deployed, the ongoing challenge will be to sustain the improvements. This will require the active participation of numerous coalitions that today operate independently, but whose expertise and effort should be harnessed for the good of the entire Commonwealth. There are several recommendations to achieve this level of teamwork and cooperation.

CONCLUSION

The members of the PPAC appreciate the opportunity to have convened over the past two years to bring attention to family issues surrounding access to information and treatment services for addiction and substance abuse. Our members all have remarkably similar stories to tell—the emotions of shock, fear, grief, and guilt that we felt when we first discovered the problem with our family member; the sense of paralysis that the circumstances had thrust upon us; the feelings of helplessness and despair that set in immediately and lingered for way too long; our total ignorance of addiction and its horribly negative impact on the person affected, his or her family, and, the

community at large; the nightmare of locating and paying for counseling, treatment and longer term rehabilitation; the frustration of relapses and the loss of hope.

Yes, we members of PPAC have been through rough journeys. Some of us have come through it with an affected family member enjoying the fruits of successful recovery; others continue with the struggle of our loved one's active addiction and trying to find the elusive life-changing event or treatment that will begin the recovery process; and others of us, sadly, have lost our family member to overdose and death. It is because of these hardships, and a desire to lessen future burdens on families who find themselves at the front end of this issue, that we have dedicated ourselves to offering suggestions for system improvements and sustainability. We are not experts. We have no formal credentials. We are not counselors, psychologists, clergy, or mentors. We are average, ordinary, hard-working, loving parents who have the benefit of experience and a perspective unique to families who have "been there." This report is offered not in the spirit of criticism of how things currently exist, but in the spirit of encouragement, hope for the future and a belief that our state can and should attack this disease with a systematic, efficient and client-oriented focus.

**PPAC’S RECOMMENDATIONS
FOR IMPROVING ACCESS TO
DRUG AND ALCOHOL
INFORMATION AND TREATMENT
RESULTING FROM SCA INTERVIEWS**

**RECOMMENDED SOLUTIONS TO
SYSTEMIC BARRIERS AND DEFICIENCIES
IN PENNSYLVANIA ADDICTION SERVICES**

In 2008, members of the Parent Panel Advisory Council (PPAC) interviewed Single County Authorities (SCAs) across the state in order to identify impediments to providing citizens with prompt, appropriate, and accessible services in support of addicts and their families. The goal was to understand what additional and/or improved resources would allow the SCAs to better serve their constituencies and to fulfill their mission.

We have identified 25 deficiencies/barriers that appear to be statewide problems and identified feasible actions to solve these problems.

1. The Pennsylvania Bureau of Drug and Alcohol Programs ranks too low on the PA organization chart.

PPAC Recommendations:

- Approve legislation that moves the Bureau of Drug and Alcohol Programs and all of its functions to the Department of Drug and Alcohol Programs. This will enable a direct link to the Governor to coordinate programs and assess the effectiveness of statewide efforts to reduce the consequences of addiction.

2. There is no single point of entry for all clients seeking addiction treatment services.

PPAC Recommendations:

- Establish a single authority to facilitate entry of clients seeking addiction treatment, whether funded by private insurance, private funds, public funding or welfare assistance.
- Provide increased training and education in addiction awareness and services for judicial and correctional personnel.

- Create a statewide standard for interface with the judicial system for addiction treatment services, preferably through a system of “drug courts.” Every defendant with drug-related charges should have an immediate referral to the SCA for drug treatment services.
 - Require mandatory treatment and support services for all incarcerated addicts, including rehabilitation education and Narcotics Anonymous or Alcoholics Anonymous meetings.
- 3. There is no streamlined entry process into the addiction services care system. This is particularly a problem in urban centers of the state.**

PPAC Recommendations:

- Provide a sufficient number of trained staff needed to cope with the influx of addicts seeking care services in urban communities.
 - Establish and maintain an efficient tracking system from initial entry through realized services. BDAP should determine the timing for such tracking to be accomplished and documented. Addiction services programs need to have transparency and accountability.
- 4. SCAs operate with insufficient funding. Mandated funding silos restrict the use of appropriations generating gaps in addiction services.**

PPAC Recommendations:

- Increase the state revenue allocated to BDAP.
 - Provide sufficient and adequately trained staff to administer and efficiently implement programs.
 - Supply additional funding through collaboration with research groups, such as the Institute for Research, Education, and Training in Addictions (IRETA, www.ireta.org). This institute works with national, state, and local partners to improve recognition, prevention, treatment, research and policy related to addiction and recovery.
 - Allow SCAs to use funding as categorically needed within their jurisdiction.
- 5. There is a lack of sufficient emergency care and access to available services.**

PPAC Recommendations:

- Improve visibility of SCAs by implementing the “211” system statewide with information and referral services 24 hours a day, seven days a week. It is a critical statewide problem that addicts and their families do not have information on whom to contact in an emergency to get immediate care and services.

- Increase training for medical professionals about the unique needs of addicts in hospital emergency rooms, in primary care, and in prevention, through education/training/research programs, such as the “Advanced Medical Student Assistantship in Alcohol and Other Drug Dependency” program (www.ireta.org/ireta_main/scaife_program.htm).
- Provide competent and immediate referrals to treatment services while in the emergency room, 24 hours a day, seven days a week. Many social services programs in hospitals operate on a limited basis.

6. There is no existing source of emergency funding independent of other non-emergency sources of funding and their associated restrictions.

PPAC Recommendations:

- Create an “Emergency Fund” category with specific guidelines to implement the use of such monies.
- Increase revenue allocated to BDAP for this funding line.

7. It takes too long for SCAs to request and receive treatment funds.

PPAC Recommendation:

- Expedite the process that SCAs follow to acquire funds from BDAP and the federal government.

8. Private insurance companies often limit or deny coverage for addiction treatment services.

PPAC Recommendations:

- Create laws mandating parity of coverage from private insurance companies and MA Programs throughout the state.
- Enforce Pennsylvania’s Drug and Alcohol Insurance Law, Pennsylvania Act 106 of 1989. Inform physicians, hospital personnel, treatment center employees, social workers and the public about this law.
- Change confidentiality clauses to allow release of treatment records for reimbursement purposes.

9. The processing time to receive MA is too lengthy and complicated.

PPAC Recommendations:

- Establish collaboration between the Office of Medical Assistance Programs (OMAP) and BDAP with the “Memorandum of Understanding” protocol to expedite eligibility, simplify procedures, and efficiently utilize resources without duplication of services.
- Recruit, retain, and appropriately train qualified employees who staff addiction services at the county level.

10. There is a lack of communication and cooperation between entities (would it be better to replace entities with “State and Federal agencies”?) that provide services related to addiction treatment.

PPAC Recommendation:

- Institute a system of consistent communication/collaboration between other state agencies, such as the Department of Public Welfare, the Department of Justice, the Office of Mental Health and Substance Abuse Services, the Department of Corrections, and BDAP, to prevent duplication of services and wasting of valuable resources.

11. The number of service providers and intervention services at the local level is insufficient, especially in the case of adolescents.

PPAC Recommendations:

- Provide increased transportation availability for counties lacking needed services.
- Increase services for all addicts in those counties with the greatest number of addicts needing treatment.
- Provide specialized facilities geared solely for the adolescent population.

12. Both SCA and treatment providers face difficult workforce issues—high number of caseloads, low salaries, lack of appropriate education and training, and employee retention, which create problems in the delivery of quality services.

PPAC Recommendations:

- Evaluate performance of program staff annually.
- Obtain and centralize information, in order to evaluate program effectiveness and allocation of resources.
- Improve staff’s ability to help solve client-related problems.

- Provide culturally competent services.
- Pass and implement legislation which establishes a loan forgiveness program for alcohol and drug addiction counselors. This will help to provide better trained and educated staff for addiction programs throughout the state.

13. Support services, such as transportation and counseling, are not sufficient for the number of clients seeking addiction treatment. This is especially a problem in the non-urban/rural areas of the state.

PPAC Recommendations:

- Improve and expand the services offered by the Medical Assistance Transportation Programs. At present, this transportation service is available for Medical Assistance-eligible clients only. In non-urban areas, clients often travel long distances or to other counties to receive necessary treatment. Intensive Outpatient services and Methadone programs require timely daily attendance. Lack of transportation is one of the causes of recidivism.

14. Addiction clients have a high rate of recidivism or a “revolving-door” approach to services.

PPAC Recommendations:

- Provide and support appropriate levels of care and lengths of stay in rehabilitation facilities, since these are often cited as a reason for the lack of success in achieving abstinence and maintaining recovery.
- Supply ancillary services necessary to support long term recovery, such as outpatient services, follow-up care management, housing, transportation, childcare, and provision of basic living needs.

15. Addicts refuse care/services or do not follow through.

PPAC Recommendations:

- Train healthcare professionals to recognize addiction and initiate appropriate referrals.
- Establish new and expand existing drug courts to mandate treatment services.
- Promote information about available addiction treatment services, especially in high drug traffic areas.
- Refer students and families for immediate addiction treatment services when illegal drug-related activities occur on school property.

- 16. In most areas of the Commonwealth, the SCAs and associated county programs provide little or no services for families of addicts. Family members need help too, and they play a crucial role in supporting the treatment and recovery process for the addict.**

PPAC Recommendations:

- Appoint parents/family members to serve on SCA advisory boards.
- Seek out and train volunteers to serve as advocates for family members to help them navigate the system of finding the proper care for the addict and for themselves.
- Offer family education programs about the disease of addiction, a disease which negatively impacts the entire family.
- Be proactive in providing families with education and contact information about other programs and groups in the county that offer support for families of addicts.
- Encourage all treatment providers to involve the families in the treatment protocols and to offer classes dealing with the family role in recovery.
- Modify the client confidentiality regulations to include parents in all treatment plans for minors.

- 17. SCAs and their staff do not communicate directly with families.**

PPAC Recommendations:

- All SCAs need to have parent programs and family follow-up with increased advocacy, especially from parents. Would it be better... “especially those lead by parents”.
- Addicts should be encouraged to sign consent forms permitting caseworkers and providers to involve family members in discussions of treatment and follow-up services. Caseworkers and providers should include families whenever possible.

- 18. Confidentiality laws restrict information sharing with parents without consent.**

PPAC Recommendations:

- Confidentiality restrictions need to be modified to include parents in treatment plans (whether minor is willing or not).

19. SCAs personnel labor under an unnecessarily excessive administrative burden.

PPAC Recommendations:

- Increase staffing levels where necessary, to provide prompt and effective services.
- Foster heightened collaboration between state and county agencies and BDAP to eliminate redundancy and encourage innovative ideas, which will facilitate evidence-based improvements in treatment and services.

20. There is no coordinated consistent oversight or evaluation process of the effectiveness of the individual SCAs. Although BDAP does indeed monitor grant-related requirements and state-funded programs, there is no overall monitoring of all funds received by SCAs and treatment providers.

PPAC Recommendations:

- Mandate oversight of all SCAs or other administrators of county drug and alcohol programs by BDAP, in conjunction with an appropriate committee, including both specialists in the addiction field, people in recovery and family members of addicts, to evaluate program competency and effectiveness of services. The administration, implementation, and effectiveness of policies and services need to be highly transparent, efficient, cost effective, flexible, and accountable, and to also practice evidence-based outcome protocols to compete for government revenues.
- Establish collaboration between the Office of Medical Assistance Programs and BDAP, with the “Memorandum of Understanding” protocol to provide cooperative oversight of SCAs.

21. The current BDAP computer data system, “Disk Operating System (DOS)” is outdated.

PPAC Recommendations:

- Replace state and county antiquated computer facilities and software programs to streamline reporting and allow for important tracking of services and collating of data. There is a severe backlog of information that has not been organized into a usable framework. Information is therefore sadly lacking, as to the effectiveness of current treatment protocols and service providers, as well as helping to identify where more services are needed.

- Effective tracking of all clients that are assessed within the SCA must be monitored with efficient technology. The current system “loses” clients once they become eligible for MA, private insurances, etc. True numbers are not reported when various state agencies use technology that does not have the ability to interface programs. Statistics reported by BDAP are not inclusive of ALL seeking addiction services, which makes it difficult to establish drug abuse trends. These numbers impact funding.

22. Gaps exist not only in the identification but also in the timely implementation of evidence based outcomes.

PPAC Recommendations:

- Mandate the efficient and timely implementation of evidence-based best practice procedures. Utilize the guidelines provided in IRETA’s “Science to Service” Initiative (www.ireta.org/ireta_main/nida_initiative), which takes evidence-based outcomes from research to the service arena as the model for how to keep our service protocols current.
- Provide means for collaboration between SCAs on best practices and their speedy implementation.

23. There is no standard priority for targeting adolescents with addiction issues.

PPAC Recommendations:

- Re-evaluate and determine high-risk behaviors in adolescents, especially in poor rural areas of the state, in order to eliminate barriers in accessing services for addiction treatment.

24. A major issue is public ignorance of the disease of addiction. Addicts and their families seeking care often have no idea where to turn and are intimidated by the stigma of addiction.

PPAC Recommendations:

- Implement “211” system. “50 Ways 211 Works”. (www.211us.org/documents/50ways.pdf), which was compiled by the United Way of Pennsylvania.
- Educate the general public, government officials, and all personnel involved in the treatment of addicts that addiction is a disease and not a moral issue.

25. Many SCAs do not collaborate with schools and with Student Assistance Programs to provide more intervention and treatment for adolescents.

PPAC Recommendations:

- Improve relations between school administrators and SCAs.
- Conduct the “PA Youth Survey” under the auspices of the Pennsylvania Commission on Crime and Delinquency in all school districts annually. This survey monitors violence,

weapons usage, and the risk factors involved with delinquent behavior and substance abuse. It is a tool to better allocate resources and target addiction treatment efforts.

PPAC'S RESPONSE TO THE "BLUEPRINT FOR THE STATES": THE PENNSYLVANIA ANALYSIS

LEADERSHIP AND STRUCTURE

It is most important that the Governor of Pennsylvania take the lead in declaring the importance of strengthening awareness of addiction problems throughout the state and in organizing, implementing and tracking improved policies and cooperation through all appropriate agencies of the state.

1. **Ensure that state legislators and other state officials understand the nature of the disease of addiction and are made aware of the financial costs and damage to communities caused by drug and alcohol problems. They must also participate in the formation of policies and in the creation/support of services to address the problem. Further, they must provide oversight to the agencies responsible for executing these policies and services.**
 - Only some state officials are engaged in the issues of addiction.
 - The existent central policies or guidelines established for prevention and treatment protocols on a statewide level do not include all, non-BDAP, funding streams.
2. **Educate state legislators and the general public about the stigma attached to addicts and their families which often impedes treatment and prevents addicts in recovery from assuming their rightful place in society. Impress upon them that recovery is more likely when the right combination of resources are easily available to the addict.**
3. **Develop and implement a statewide strategy to encompass all state agencies dealing with drug and alcohol problems.**
 - All state agencies must cooperate in setting joint goals and programs dealing with substance abuse. There must be a system to evaluate effectiveness and track accountability.
4. **Give BDAP status as a cabinet-level department, with direct access to the Governor (also addressed in the "barriers and recommendations" section).**
 - The elevation of BDAP to a cabinet-level position would send a message as to how critical the drug and alcohol epidemic spreading throughout our Commonwealth really is.

- This would facilitate policy approval, budget prioritization considerations and implementation of programs at the highest levels of government.
 - BDAP needs adequate infrastructure and authority to collect, analyze and disseminate regular public reports on trends and outcomes.
 - This agency needs sufficient authority to establish and mandate collaborative efforts with agencies such as child welfare, protective services, Medicaid, housing, employment, and criminal justice.
- 5. Educate judicial personnel, such as judges, lawyers, probation officers and police, by helping them to not only recognize, but also to act effectively on the substance use problems that impact their daily duties and responsibilities.**
- Judges must establish partnerships with the agencies dealing with drug and alcohol problems on the state and county level.
 - Each person released back into the community should be assigned to the proper support system to help them maintain their recovery.
- 6. Encourage and promote statewide drug courts.**
- Pennsylvania prisons are overloaded with addicts who receive little or no treatment while incarcerated.
 - Drug courts would help to assure that addicts receive treatment and be tracked as part of their aftercare.
- 7. Assure that family members are included as members of state, county, and local Advisory Councils on drug and alcohol problems.**
- Addiction is a disease affecting all members of an addict's family.
 - A vital part of any addict's treatment and recovery status depends on educating the family members to understand what their role should be in supporting the addict's recovery.
 - It is important to ensure that family members of addicts have a voice in the decision-making process.
 - Family members provide unique insight into the problems of addicts and their families.

RESOURCES

In this time of economic strain, resources become paramount in attaining the goals of a statewide strategy to address substance abuse and related problems.

- 1. Identify the separate streams of state and federal money available for prevention, treatment, and recovery, which presently flow through multiple agencies.**
 - Having interviewed SCAs across the state, it is apparent that funding is complicated; some counties have financial staff that oversee expenditures, apply for grants, and track the budget. Counties without designated grant writers often miss out on grants and other funding opportunities.
 - Some counties pool their resources with other agencies, and this allows for more flexibility in their budget. All entities that work with youth and adults with addiction problems should be able to work together to meet the goals of a statewide strategy.
- 2. Institute cooperative efforts between the various agencies, such as Criminal Justice Agencies, Office of Mental Health, and the Office of Medical Assistance Programs, with county addiction services, in order to provide more efficient and cost-effective services to addicted clients and their families.**
 - Many families have suffered from the inability of various agencies to communicate and cooperate with each other. This lack of cooperation and communication has created a situation where services may be duplicated by different agencies, while other vital service components are not offered at all.
- 3. Provide consistent statewide and local oversight and accountability, which are essential to making sure that funds are used appropriately (see *Measurement and Accountability*).**
- 4. Design, follow and publicize standard procedures for all clients using best practices.**
 - Often clients, including both the addict and family members, have little or no idea what services are available to help them. They also do not know where to learn about resources or how to access them.
 - County and state Web sites need to be rethought and redesigned to include easily accessible and understandable instructions and details explaining how to get help.
 - Often, those with addiction problems need immediate help in an emergency; both information and assistance must be available 24 hours a day, seven days a week.

5. **Require all public and private health insurance programs to offer the same coverage and access to alcohol and drug treatment as they provide for other chronic diseases. The type of care, length of treatment, and quality of service provided should be appropriate regardless of whether a client has private insurance or public funding.**
 - The provisions of Pennsylvania Act 106 need to be enforced so that private insurance companies comply with mandatory lengths of treatment. The public needs to be made aware of the provisions of this Act.
 - Pennsylvania is requiring private insurance companies to “step up to the plate” and pay for services for children with autism. In the same way, private insurance companies should not be allowed to shirk their responsibility toward providing appropriate services for addiction and alcoholism. It should not be necessary to apply for MA in order to get addiction services, particularly if one is paying an insurance premium each month to be insured. Why should the state carry the burden of treatment alone while the insurance companies are getting paid to provide medical services?
6. **Consider other sources of funding for drug prevention and treatment programs such as an increase of the tax on alcohol and use of a percentage of funds from casinos.**
 - Pennsylvania has the lowest taxes on malt beverages, providing an opportunity to acquire some revenue without excessive taxation.
 - Although these are not popular decisions to make, the urgency of the problem is clear in the cost of alcohol, drug and gambling addictions to families and neighborhoods. These addictions affect all the citizens of Pennsylvania, if not directly, then indirectly in increased violence, public welfare, incarceration and public health costs.
7. **Increase compensation for case managers and others working in state and county addiction services to help retain trained professionals.**
 - Pennsylvania should use its certification and licensing powers to set standards of skills and training for counselors and managers, and set state-controlled salaries and payment rates at levels that will attract and retain qualified providers.
 - All treatment agencies should have the clinical capacity to use medication assisted treatment when appropriate for their clients.
8. **Create loan forgiveness and tuition assistance programs to encourage individuals to choose careers in prevention and treatment. Particular attention should be paid to those who are in recovery.**
 - Colleges and universities should be encouraged to establish programs and curricula to prepare addiction services personnel to make full use of new and emerging behavioral and pharmaceutical treatments. Courses on addiction and treatment should be required as

continuing education for physicians, healthcare professionals, lawyers, judges, court personnel, social workers, and educators.

- Pennsylvania Certified Recovery Specialist position is an example of a program which should be continued and expanded as it allows addicts in recovery to work in the addiction field. Often, they are the best and only professional that can truly reach the addict; they serve as a resource and also a symbol of hope to both the addicts and their families that recovery is possible.

MEASUREMENT & ACCOUNTABILITY

Until Pennsylvania establishes set goals for prevention, treatment, and a continuum of care for all state agencies and other funding entities that deal with individuals and families affected by problems of substance abuse, there can be no measurement and accountability to determine if these objectives have been met.

Pennsylvania should hold agencies and sub-contractors accountable for meeting these set standards. There should be rewards for those meeting or surpassing the requirements and penalties for those who fail to do so. It is important to also keep a check on inter-agency cooperation.

- 1. Change regulations so that all treatment providers, regardless of funding source, are mandated to report into the BDAP data system to allow for comprehensive statistics on care and treatment outcomes.**
 - Pennsylvania does not have statewide guidelines for agencies and providers involved in addressing the problems of addiction. Prevention, treatment, and continuum of care vary from county to county, even with individual cases within the same county.
- 2. Create a unified data tracking system to monitor compliance with standards of prevention, treatment, and outcome measures for individuals and families who may well receive services from a myriad of agencies and subcontractors.**
 - Not only does Pennsylvania have no unified system to monitor agencies and providers, BDAP does not even have a functional software system specific to and dedicated to collection, analysis and dissemination data. This means that there is no accountability and no evidence of success or failure of in-place protocols.
- 3. Provide BDAP and county agencies with appropriate equipment, software, training, and technical support to utilize, maintain, update, and create reports collating information from the various agencies and providers.**
 - This presupposes that there are overall state mandated guidelines of care and also that all agencies and providers involved with addiction issues throughout the state work in a cooperative and collaborative manner.
- 4. Publish and widely disseminate county annual reports to all concerned agencies, the state legislators, providers, and, in an open manner, to the general public. List not only the collected data, but utilize the data to track and analyze the benefits of prevention, treatment and continuum of care, as well as the costs of alcohol and drug addiction.**
- 5. Implement an incentive system for providers by offering higher fees to those who consistently achieve good results and pay less or discontinue contracts with those providers who do not meet the set standards.**

Legislation

The Pennsylvania Parents Advisory Council (PPAC) recommends that Pennsylvania's core legislation addressing addiction prevention, treatment, and recovery be reviewed and updated. As such, we propose that the Pennsylvania legislature consider taking the following measures:

- 1. Conduct a formal review of Pennsylvania's legislation by a committee that includes addiction treatment, prevention, and recovery experts. This review should focus on, but not be limited to and ensuring:**
 - Pennsylvania's laws reflect the understanding that addiction is a disease which is a chronic, recurring condition, and that there are appropriate treatments recommended by addiction specialists.
 - Allowance for the coordination of services between state entities to address the needs of addicted individuals and their families. The interaction between agencies also should be congruent so that any existing can be closed. Loopholes in the system allow addicted individuals to fall through the cracks.
- 2. Review mandatory minimum sentencing laws to ensure fairness and to provide treatment for addiction prior to, during, and just following release from prison. It has been shown that:**
 - Mandatory minimum sentences are used by judges with a great degree of discretion, and usually only for dealers, not individuals who committed crimes due to their addictions.
 - Those re-entering society after receiving inpatient treatment and following up with continuing care after release have a much higher chance for sustained recovery.
- 3. Identify and redress legislation and regulations in the state that act as hindrances to recovery and re-entry into society after drug-related convictions and imprisonment. The legislature should be aware that criminal convictions carry their own stigma. The laws that they enact should not add to the challenges faced by addicted individuals by promoting legislation which encourages bias against them.**
 - The criminal justice system often is the tool of last resort used by parents to get help for their addicted children. At first, parents feel they have saved their child's life by getting him or her off the streets and away from the drugs; unfortunately, the end result is that they have attached a lifetime label of "convict" to their child. We should realize that they are human and that everyone makes mistakes. When restitution has been made for non-violent, drug-related crimes, and when the addict is in recovery, working a program and trying to rebuild his life, there should be a method for expunging or sealing the record after a reasonable period of crime-free time.

- Regulations in the state severely limit where a person with a drug-related criminal record can work and live, and what state benefits and assistance may be available to them on their journey back to becoming a contributing member of society. These regulations, in essence, create a legal basis for discriminating against these individuals.
- Everything is not black and white. Legislation which does not consider the individual circumstances often has counter-productive consequences. An individual with a non-violent, drug-related criminal record should be judged on his or her current behavior, not the past. If it is found that our state's policies impede recovery, unfairly disadvantage recovering addicts both in the community and in the workplace, and generally place roadblocks in the path of successful reintegration into society, then they should be repealed.

4. Legislate continuing education requirements for physicians and other medical professionals. In our research, we have found that:

- Physicians were lowest on the list of those doing referrals for addictions. Since addiction is recognized widely as a disease, the physician should be capable of being one of the first to identify the problem and provide access to prevention, treatment, and recovery services.
- Physicians in the state have little or no training regarding alcohol and drug addiction; neither in recognizing the symptoms of the disease nor in the special requirements for prescribing for and treating patients with addiction issues.
- Today, there are no laws mandating that medical professionals receive education in drug and alcohol prevention and treatment.

SUSTAINING STATE FOCUS AND ATTENTION

*It has been said that the consequences of alcohol misuse and illicit drugs are the single greatest drain on state budgets. In 1998, Pennsylvania spent more than \$3,400,000 of state funding on substance abuse related issues. This represents 14 percent of the annual state budget and \$283.15 to each citizen (National Center on Addiction and Substance Abuse at Columbia University, *Shoveling Up: The Impact of Substance Abuse on State Budgets*, January 2001). Through its leadership, state governments have the power to change this. It has been duly noted that when community leaders and people in recovery work together with elected officials, support is raised and effort, focus and attention is sustained.*

- 1. Strengthen and make highly visible the Drug and Alcohol Advisory Board/Council to keep the issue of addiction in the public view and to assist the Governor in garnering support for policy.**
 - This should include civic leaders, individuals in recovery, family members of individuals with addiction problems, and professionals in the field of addiction. The Governor should be responsible for nominating members for staggered terms to allow for continuity and also for fresh ideas.
 - The board should aim to provide oversight to the entire system of prevention, treatment and recovery, as well as to relate these issues to the social and economic welfare and future of the state and its citizens.
- 2. Involve both state and local governments in supporting and sustaining a strong network of community coalitions and recovery organizations.**
 - This will serve to mobilize local public and private groups to support an alcohol and drug strategy and to help implement policies.
 - Such groups should include individuals in recovery and would be expected to set up a system whereby these individuals can work together.
- 3. Support the creation of recovery organizations.**
 - Recovery groups are vital in working with state agencies and other organizations in helping to combat the discrimination against people in recovery and in changing policies towards individuals with drug and alcohol addiction problems.
 - Such groups will play an important role in sustaining long-term commitment and public involvement in helping to solve these problems.
- 4. Create an interconnected network of health services and treatment providers that work constructively with state agencies to ensure that new clinical developments and research initiatives are incorporated into state standards.**

5. **Ensure that the Pennsylvania Parent Advisory Council for Drug and Alcohol Programs is strengthened and funded to ensure that it continues despite changes in the state government.**

OUR STORIES

We are the parents of individuals suffering with the disease of addiction, and we want to share our stories with you to show you the faces and allow you to hear the voices behind the numbers. We recount our stories of how our once ordinary lives have been changed forever. All our stories are of fear, suffering, and pain. Many are also stories of tremendous courage, perseverance, and an unflinching drive to change things for the better. Some of our stories have happy endings—some don't. Some still are being played out in our homes, on the streets of our communities, and in our state and federal prisons. Some of our children are in prison, some live on the street, some live in our homes, some are in recovery, some have died from their disease. All of our children are addicts.

We share our stories here to help you to understand that we are ordinary people. We are like Pennsylvanians throughout our state. We share our stories, not just as your constituents, but as your teachers, your accountants, your bankers, your realtors, your doctors, your neighbors. As a committee, we not only represent all regions of our state, but all walks of life, all economic backgrounds, and all family structures. It is easy to overlook us at budget time and during periods of economic stress. People look at our children and they see—junkies—dopers—felons. We look at our children and see ballet slippers and cowboy boots, Christmas mornings and birthday parties. We hold forever in our hearts that first moment when we looked into their infant eyes, and knew in that heartbeat that we would give our very lives for them. Unfortunately, that is the last absolute of parenting. It's all guesswork from that point on. Our goal in sharing these stories with you is to help others who must walk in our shoes to know that they are not alone, to help lessen the stigma attached to addiction which adheres to individuals with the disease and to their families, and to help improve the treatment possibilities and recovery support for addicted individuals and their loved ones.

It is very difficult to share these very painful and private stories. We share them with you now and present them as a prayer. A prayer for a brighter future for the children you love, and all children in Pennsylvania. Please read our stories as a cautionary tale: the disease of addiction does not discriminate; it can happen to anyone. Our current system in Pennsylvania does little to assist families in their time of most desperate need. We know, however, that the system can be improved. We have learned so much on our journeys, and we want to share this knowledge with you in the hope that we can help forge an easier path for those who are to follow.

OUR JOURNEY

Joan and Bob W., Pittsburgh Area

For the first 15 years of Rob's life we lived in a small town in rural PA. He was a good student, a dedicated athlete and consistently described by his teachers as quiet and polite. His father and I were both educators and for the most part, Rob attended classes in the school where either his father or I worked. Rob has one sister, Robin, who is also an educator living in Dallas, Texas with her family.

In the winter of 1998 Rob's paternal grandparents, both near 80, began to suffer a series of serious health problems. Frequent trips to their home in the Pittsburgh area (4 hours away) were needed to assist with care-giving and doctors' appointments. I vividly remember the dinner conversation when Rob first began urging us to move back to Pittsburgh to be closer to his grandparents. We shared with him our reservations about uprooting him at this time in his life but he assured us that he would be "just fine." Over time we began to believe his assurances. I accepted a principal's position in the Pittsburgh area. Rob's father took a leave of absence, and eventually an early retirement from his teaching position. Late that summer we moved to Cranberry Township, Pa. While in treatment, Rob described this move as "the turning point" of his life.

At first things seemed to be going well. Rob was doing well in school. He had joined the wrestling team and had made some friends. After about a year things began to change. He began changing friends on a regular basis and his grades began to suffer.

In hindsight I see that the warning signs were there but denial is its own drug. It numbs reality and suppresses the unthinkable, the unspeakable. In February of 2002 a warning came that could be neither minimized nor denied. Rob was caught with a substance at school that was eventually identified as heroin. We left the school and went directly to the closest treatment center. I remembered my friends who specialize in the field of drug and alcohol treatment telling me that a local rehabilitation program was the best around, so we went there. They tested Rob, took our insurance information and sent us home to wait for the results of their test and approval from our insurance carrier.

It took six weeks to get approval from our insurance company and set up an intake appointment. At the time, it felt like the longest six weeks of our life—but as it turned out—we were wrong—there were to be many, many longer days, weeks, and years. At our intake appointment we were told that the substance Rob was abusing was heroin. They were recommending intensive out-patient treatment. I was terrified by the thought of my child using heroin. As a former counselor, I knew how resistant to treatment heroin abuse could be. I specifically asked, "How can you effectively treat heroin addiction with out-patient treatment?" Their reply is still ringing in my ears, "We do it all of the time." Next, they reviewed our insurance coverage with us. Rob would have a LIFE TIME cap of 90 hours outpatient care and 30 days inpatient care. That evening, Rob began attending intensive out-patient therapy—and I began counting backwards from 90.

Once it was verified with the police that the substance Rob had at school was heroin I knew that drug charges would follow. As a school administrator, I also knew that drug charges at school meant certain expulsion. Rather than wait for that to happen, Rob quit school in April of his senior year and got his GED. As a family of educators, this broke our hearts, but we had come to realize that school was a trigger for Rob and staying through the expulsion process would jeopardize his recovery. With a GED he could still pursue post secondary education as he had planned to do all of his life. Rob completed his first round of outpatient treatment. At the end of six weeks, Rob was dismissed from treatment.

The drug charges were still pending at this time. Eventually, Rob was accepted into the Butler County ARD program which mean he had to meet with a probation officer once a month for 18 months. Initially, we saw this as a good thing. Perhaps the additional “supervision” as the court referred to it, would help Rob in his efforts to remain clean. Unfortunately, that did not prove to be the case. All that was required of Rob during his probation was to stop by his PO’s office once a month, any Tuesday of the month, any time of the day, for a meeting and a drug test. Essentially, Rob was being drug tested (supervised) whenever he made an appointment to do so.

By mid-summer 2002 Rob had relapsed and was back in treatment, but this time he was really struggling to maintain sobriety. He asked to be voluntarily committed to the in-patient program. Facilitating this became a battle with the insurance company. Finally, we were able to get an Administrative Override to the insurance company’s initial denial and Rob was approved for a five-day voluntary inpatient commitment. This was eventually extended two more days. Rob spent a total of seven days at the inpatient facility.

After his brief hospitalization, Rob returned home with a new determination to remain clean. Rob continued with outpatient treatment until he was discharged for a second time. He joined the Army National Guard and planned to begin college after completing six months of basic and advanced military training. While he did struggle to maintain sobriety during this time, we naively hoped that if we could hold on until January when Rob was scheduled to leave for boot camp, he would once again be on the right track.

On the morning of Monday, December 23, two days before Christmas, Rob left for work as he always did. I vividly remember kissing him good bye. As it turned out, it would be the last time I would be able to touch him for ten months. A little later that morning, I received a call from his boss, Mark, who was checking to make sure Rob was coming to work that day for he had been ill the Friday before. I was surprised that he didn’t know, because Rob should have already arrived at the job site in Franklinville by the time of Mark’s call. Mark told me that he and the rest of the crew had stopped by another job site first and were just then on their way to Franklinville. A few hours later, the phone rang again. I listened as a police officer told me of Rob’s arrest. Eighteen years of dreaming and planning for our child’s future were about to turn into a nightmare.

We were to learn later that Rob had picked up a young man who he barely knew. The young man had been recently released from prison after serving time for robbery. He was apparently without a job and literally living off the kindness of others. Rob knew they were

short-handed at the job site and had hopes of getting this young man a job. When the two boys arrived to find no one at the Franklinville site, they apparently left. They ended up at a strip mall in Cranberry. The young man Rob was charged with attempted to grab a woman's purse. There was a struggle. The woman fell and hit her head—in that second, an innocent woman was in critical condition, and a purse-snatching had turned into A-1 Robbery. Media frenzy followed, and this became one of the most widely covered cases that year.

Rob admitted from the very beginning that he knew of the purse-snatching plan. He maintains that in the end he couldn't do it and never touched the woman. His co-conspirator verified this. The victim, who thank God, has now recovered, has no memory of the event. The other witnesses present were unable to tell exactly what was happening when the woman fell. Rob was charged with three felonies—aggravated assault, robbery and conspiracy. Rob's attorney told him that under the law, if he was guilty of the conspiracy charge, he was guilty (culpable) of all of the crimes committed. Following his attorney's advice, Rob pleaded guilty, indicating at the time that he was pleading guilty of being culpable for the crimes, not guilty of actually committing the crimes. Our hope was that with Rob's zero prior record score and limited involvement in the crime we would find some mercy in the courts. We did not. In spite of witness testimony in support of Rob's good character, and a total of 25 letters sent to the judge from teachers, counselors, friends and family members the judge elected to run Rob's sentence for the three crimes consecutively instead of concurrently. This essentially doubled the time Rob would spend in prison. He is serving a term of 8 1/2 to 17 years. He has now been in prison for over five years. He has been moved 13 times and he has yet to receive a single hour of treatment.

They may be able to successfully treat heroin addiction through outpatient treatment “all of the time” as I had been told by treatment personnel at Rob's intake interview—but not this time. The next seventeen years of our lives will be witness to that.

MY STORY

Carol Hillard

I am going to start my story from when John (my son) was born June 21, 1978. I didn't know it at the time the trials and tribulations I would have to go through with him being the 5th of 5 children. I came from a dysfunctional family being my father was an alcoholic and we lived in the country. I thought that men were all drinkers and rowdy. So that was the kind of man I was attracted to. I never did drugs or drank.

After John was born I knew something was wrong because all he did was cry and the Dr. said he was allergic to his formula so it was changed a few times. After he started to eat food he would become very nasty and hurt everyone he came in contact with and we found out that he was allergic to a lot of foods and that's why he was acting that way. Moving on in life at the age of 4 he and a friend that was 2 years older than John broke a neighbor's window to get inside to the toys that he wanted to play with. That's when I started taking him to counseling because what kid would break a window to get toys? I also went to counseling and it went into three and a half years for me and I also was in Al-Anon which helped me a great deal. In the meantime, his father and I separated and for years no one knew where he was until I got a call from his sister who told me he was out with her in Illinois. Finally, when John was 11, I got the call that his father was dead at the age of 47 of an apparent overdose. And all the while he was going for counseling he kept saying he wanted to see his father one more time. The counselor and I both talked to him so he would understand what death was all about and when we got to the place where his father was he went running in and right up to the casket and kept asking his father to open his eyes, he said DADDY all I want to know is why you left and why won't you talk to me and my two brothers had to grab a hold of him and take him outside to calm him.

At the age of 13, John got in trouble again in school and came home so defiant that no matter what I said it didn't matter to him. Before this day I was trying to get him into someplace that would evaluate him mentally besides Children Service Center, and they told me they couldn't do anything till he tried to do something to hurt himself so I thought this was the perfect timing to take him there. I told him he was grounded and I wouldn't give him a time of how long so he kept doing things that he thought would make me mad and I totally ignored him till I looked at him at the top of the 5 steps going upstairs and he stood there with a towel around his neck and I said what are you doing and he kept tightening it more so I said you need to come with me and I took him to The First Hospital and told the person that I talked to that he tried to hang himself and he needs help. The outcome of that after 28 day stay was more counseling and was diagnosed with ADHD and put on Ritalin.

At the age of 15, I found out he was smoking pot. He told me he was but wouldn't do it anymore and of course I believed him somewhat but was still on the lookout. With him taking Ritalin it was hard for me to tell if he was doing anything. This went on for a few years and everything seemed to be fine until one day I was counting money that my husband and I got from his Mom's house because she had Alzheimer and she was hiding it and we were going to put it in the bank. When I went to get it, it was gone. I thought, oh my Gosh, I threw it out with the papers so before my husband found out I lost it, I replaced it and it became missing again. Also some checks were missing and when I called the bank John's name was on them. So I started

looking through my son's book bag, clothing, and his room and I found little bags and I asked him what they were and after a long time he admitted to using Heroin. Well we had to have him arrested because that is what I said I would do if anything is missing and he went to jail for a while.

Before John got into the 8th month rehab and among all these treatment centers I was arrested for Contempt of Court but I planned it that way because I would be able to talk to Judge Ciavarella to get John into a long term placement because it has to be court ordered and I wanted to ask him to place John in a long term place. Eventually he got the 8 month stay but not before his best friend died of an overdose.

John has been to many outpatient treatment centers, **15** inpatient centers and one of these for 8 months, 1 Forestry camp, 1 Therapeutic Community where they duck tape their hands together and feet together and put tape over their mouth then put them in a sleeping bag and dance around them reenacting his father's funeral . Then they have to get out the bag and get the tape off. I guess they do that to get them so mad that it is supposed to drive whatever is bothering them out of their bodies. Well let me tell you here and now that it did not work. John also lost a total of 5 of his friends at one time or another while going through all these places.

John stayed out of trouble from 1999 to 2000. He had a baby girl and she was 2 months old when he went to his Dr. that he had since he was a kid and knew all about his Heroin addiction and prescribed oxycontin for him anyway. To make a long story short John landed in Federal Prisons for 7 years for bank robbery. I managed to take his daughter to see him every weekend until they moved him to West Virginia. He was sent to a half way house for his Transitional period but they sent him right in the middle of Philadelphia where he went to get his drugs when he used. So what good did that do? He met a girl that worked there and they went together for about 4 months and she broke off with him and he still went down there to talk to her and he was picked up in a raid and he broke his probation by using and being out of his jurisdiction. Before this happened he had 5 years parole. Now they sent him to New York State for 6 months and took away his parole so when he gets out he will be free. In the meantime our SCA was looking into getting him into a place called Firetree for treatment but he became sick and is not able to work on it. We'll have to see what is going to happen when John gets out on Oct. 28, 2008.

And this is why I want to be on this panel as a PPAC member to make a difference. I would not want anyone else to go through the torture of 15 years I went through and it is not even over yet, but I will keep fighting. I had 2 major cancer operations and survived both of them because I fought for my life and have been cancer free for 5 ½ years. Thank you all for taking the time to read this. I could go on talking about things that happened but I think this is about it for now. This is the first time I have sat down and actually told my story and it was not an easy job as I know it won't be for anyone else to do.

God Bless you all.

OUR STORY—DANNY’S STORY

Wayne & Charlene Sciarretta

On May 13, 2004 my son, Danny, died from an overdose of heroin. Danny was denied the medical help that could have saved his life. We spent two years in and out of court rooms. In May 2006, the young man with Danny that night was sentenced to 2 1/1-5 years in a state prison. Danny left this life at the young age of 26 after battling the darkest gift every given to this world—heroin.

The choices that Danny began to make at 17 and 18 altered his life, and eventually took his life. We were an average, middle-classed family. Both of our children went to private schools, we went to church, Danny played T-ball; he went to home coming at school. But heroin knows no boundaries and didn’t care about where we lived or what school my son attended. Never expecting this unimaginable horror to ever enter our lives, we were not prepared. We never saw it coming and had no concept of the impact it would have on Danny, his family, and everyone who knew and loved him. Danny was using heroin for almost about 8 months before we knew the truth. We had no drug education; we didn’t know the signs. By the time we knew the real demon Danny was facing, he was facing it head on and addicted to heroin.

We never imagined that beer and marijuana would lead to cocaine, ecstasy, eventually heroin. Before I knew the term “gateway drugs,” we were in the middle of it. My unadventurous son took the leap and said yes. The drug world opened its arms to him and he became a member of their club. And we had no clue how deep the waters were.

Danny’s fear of AIDS from needles took us to a meeting with the doctor who knew Danny since birth. The blood test that Danny requested revealed heroin in his system. Thus, began years of trips to emergency rooms, doctors’ offices, out-patient rehab, medication, depression, anger. Danny was a recreational/occasional user, and still he lost his life. We were unaware of the true and tragic truth about heroin – heroin kills.

In 2000, Danny began taking Naltrexone. Over the years, Danny’s dad, his sister and I kept a watchful eye – always waiting for that darkness to surface again. Danny would go 6–8 months without using; he took his medication in front of us every day. He told us that he thought about using heroin. We needed more help than we ever imaged. In May 2003, a young woman entered Danny’s life—to change his life. We were sure this was his ticket. Danny was clean for almost a year. But before that year ended, Danny made the choice to use again. We found his medication in his desk after he was gone. The addiction was too strong.

Had we known the things we know now. If we had known the sources to turn to, other groups of moms and dads fighting the same battle —maybe we could have saved our son. Unfortunately, the resources were not visible enough. We didn’t know where to turn. All we knew was that Danny had to take the Naltrexone every day, and we had to make sure Danny was in an out-patient rehab program. Naively, we thought this would keep him alive.

Live-in rehab centers wanted astronomical amounts of money. Private counseling was paid out-of-pocket—\$250 to \$300 an hour. We did everything and anything to keep Danny alive. I now know that there was more out there; we just didn't know where to go. I now know that no one addicted to heroin can recover on his own, and the treatments are not enough; treatments are not the cure. The stigma of drug addiction keeps us from discussing this nightmare with others; it keeps us from the help we need. Those with the addictions need help like anyone else with any other illness. We need to be heard. The laws need to change. Senators Waugh, Orié and Greenleaf of PA have changed the language in SB353, since changed to SB316, to change the offense against my son from a misdemeanor to a felony. It will be presented to the Judiciary Committee. I tell Danny's Story to schools, probation centers, local TV stations, churches, individual families—anyone who will listen. Schools and doctors need to be trained and mandated to educate and treat those with the addictions. The parents and the children need to know that this tragedy could be waiting just around the corner for them.

AARON'S STORY

The notes scrawled inside the numbered blocks on the desk calendar revealed instant clues to our family's secret: "Call County Agency for Drugs and Alcohol," was written in red on today's date; cell phone and pager numbers for a Bucks County social worker filled up the square before that, and then, right under the month of "December" in heavy, black marker was the number for St. Mary's ICU with Aaron's first name and room number written beneath it.

I felt alone with this crisis. My ex-husband was available to share it with me—as he should have been—but there were no friends or neighbors I could tell. Even my family, if I were to divulge any aspect of the situation to them, would offer platitudes tainted with slivers of superiority and judgment. They couldn't possibly empathize with something they'd never experienced. Despite my hurt feelings, I understood.

Aaron, 18 years old and the eldest of my ex-husband, Mark's and my three children, was a drug addict. After an overdose that had nearly taken his life just 48 hours earlier, Aaron could not be released from the hospital without a recovery plan in place. So, on the day before his expected release from the hospital's ICU, I sat stupefied in front of my calendar, uncertain what I should do and could do for Aaron. The TiVo in my head chirred backwards, and I reviewed the social worker's suggestions.

Betsy had recommended out-patient drug treatment for Aaron. He would visit a local treatment facility to receive regular counseling and possibly referral to a psychiatrist or addiction specialist. Part of his prescribed treatment plan would include regular attendance at Alcoholics Anonymous or Narcotics Anonymous meetings.

Although I thought Betsy's suggestions were reasonable, I did not think out-patient treatment was appropriate for Aaron—not yet, anyway. Still, I had not been able to arrive at a logical, appropriate alternative. It was a confusing tangle of information to sort through at the worst possible time.

In fact, the months and years since Mark had made the decision to leave the marriage and file for divorce had proven to be a very difficult passage for the entire family. For Aaron, though, it signified something deeper and darker. It seemed that each time his father turned a corner in his new life; Aaron did likewise, by destructively acting out. This meant he invariably would suffer a serious injury of some sort on the night his father was out celebrating an anniversary or birthday with the new person in his life. Or it meant that Aaron would crank his drug use up a couple of notches, to a point where the situation practically demanded his father's swift return.

Aaron had been to two adolescent psychologists and a psychiatrist by the time he was 18. They all concluded that he simply was exhibiting the garden-variety symptoms of sadness, anger, and anxiety over the loss of a two-parent family and the security that goes with it. His substance abuse, they said, was secondary to his pain. What they didn't say was that even if Aaron's unfortunate family situation did not exist, Aaron probably would have reacted similarly to some other challenging circumstance in his life. His sensory system seemed to possess no buffer against pain or discomfort.

As I fished for a pen amidst the contents of the desk's bottom drawer, an old prescription pad of Mark's landed in my grasp. Mark was an internist and infectious disease specialist. During our marriage he would sometimes call patients or do paperwork from the den. I marveled as I jammed the pad into a shredder, wondering how it was that Aaron had overlooked this potential treasure during those "dry and desperate" periods when he was withdrawing from drugs.

For the past two years, I mentally had soaked up the signs and symptoms of Aaron's drug experimentation and ultimate drug abuse, and now my head felt as though it were being wrung out to dry. The tears had been coming since I'd received the dreadful news of Aaron's collapse. He had been out after work with an acquaintance or, more aptly, a drug buddy, as were all of Aaron's acquaintances these days. The two began drinking alcohol and using narcotics. An hour and a half after they had started, Aaron lay unconscious, near death.

The blood test administered at the hospital revealed that Aaron also had taken the anti-anxiety drug, Xanax, some Oxycotin, and an illegal opiate, the odious heroin. By the time an ambulance was called, Aaron's life was draining away rapidly. The pink had completely faded from his face, and his lips were turning grey-blue. The emergency medical techs immediately went to work on him, administering CPR and bringing him out of his unconsciousness long enough to get him to the hospital. Once in route, they injected him with Narcan, a drug given to reverse the effects of opiates.

Nothing had prepared us for this: the sight of our firstborn hooked up to lifesaving apparatus in the Critical Care Unit of the hospital. Once Aaron was revived, he was no longer almost comatose, but he was not aware even remotely of his surroundings. He uttered unintelligible gibberish, and when the doctors propped him up so they could listen to his lungs, he drooled and his head flopped forward. We stood at opposite sides of Aaron's hospital bed as the nurses induced vomiting, and then there was nothing to do but wait and numbly watch the unseemly consequences of our son's addiction to drugs.

How had this chemical freefall begun? The nascence of Aaron's drug use came to him in the form of marijuana and cold medicine tablets; he was not quite sixteen. After that, it soared from one predictable drug milestone to the next, much like an infant goes from crawling to standing, then walking and, finally, running. At this stage, Aaron was running the race of his life. Unless we found a solution or, at the very least, a way to delay the inevitable, soon Aaron would be meeting Death at the finish line.

Over the next two days as Aaron recovered from the multiple drug overdoses, his father and I had sat by his bed—stunned, afraid, and ashamed. Doctors' children didn't take illegal drugs, and they certainly didn't inject heroin into their arms, legs, and neck. Suburban mothers take pride in showing off soccer players and honor students, not junkies. We listened as Betsy, the County social worker, explained some of the rehab options available to Aaron once he left the hospital.

Her tone was compassionate as she explained the substance abuse/mental health provisions of our insurance coverage. She told us that Aaron might do best using his 60 allotted

days of out-patient drug treatment; this way he could work, go to school, and even make it to N.A. meetings during the weekdays. His life would be full, but he'd still have those 30 in-patient days per calendar year available, just in case. "And keep in mind," Betsy added, "Aaron's insurance plan provides in-patient substance abuse coverage for a total of up to 90 days, lifetime. Some institutions might request that you use the 90 day (or "lifetime") allotment in one admission."

I considered the meaning and implication of "lifetime." Lifetime wasn't something so clearly defined, I thought, as I looked out at some trees in various stages of shedding their leaves on the other side of Aaron's bedside window. On the branch of the tree closest to the window, a starling sat motionless as though it wanted to be somewhere else. Anywhere but here.

Mark listened and nodded his head nervously, as Betsy spoke, the beeper on his belt loop vibrating manically. An ambulance wailed in the distance and jarred me to a full state of alertness while Mark availed himself of the chance to look at his watch and see who was calling in on his beeper. I glanced quickly toward the window again, past my slumbering son, and for an instant I wanted to be the one in the Land of Nod, away from the sadness of ordinary life. How could I tell this kind woman, who was simply trying to help a dysfunctional family such as ours, that at the rate Aaron was going, he might not *have* a future and might never fulfill the actuarial prediction of "lifetime?" I struggled to harness my grief, and forced my attention back to Betsy and her unintended infomercial on Aaron's insurance coverage for drug addicts.

How wonderful it would be if Aaron were able to actually accomplish the "Touched by An Angel" type of vision Betsy projected for him— life in that all goes according to plan. The sad reality was that Aaron had not demonstrated success in any personal endeavor. Work, school, sports, therapist appointments—these were all attainable duties for the average non-drug abusing kid—the kid Aaron used to be. First, however, Aaron needed intense, minute-to-minute rehabilitation, preferably somewhere out of the local area, maybe out of state. I turned my head to see if Aaron had awoken yet. The reality of his predicament eluded him. Aaron's complexion was the tawny color of wet sand as it reflected the residual toxic drugs still clinging stubbornly to his body.

Betsy excused herself for a minute, and I mentally gathered up what she'd said, words like "relapse," "triggers," "dual diagnosis," and "outpatient."

Now that these terms had come crashing through the gates of our lives, there was nothing to do but make a home for them. From the window, I saw some paisley-colored leaves flutter from their branches and then I watched as the wind swept them up, their destinies unknown.

My thoughts right now were as scattered as the leaves outside. Aaron was still sleeping soundly in a state of infant-like oblivion; a world he seemed to compulsively pursue these days. I looked at him and saw him as a tiny infant, his body wracked with the puzzling newborn affliction known as, "colic." How relatively easy, in hindsight, it had been to help him through his pain. Hour after hour I would gently massage his tiny, distended abdomen and rhythmically rock him all through the night; until finally, mercifully, his soft eyelids snapped shut and he fell

to sleep. Now there was nothing I could do make his pain go away except send him off to an unknown place with unknown people and then hope and pray for his recovery.

It was time for Aaron and me to leave the hospital. Decisions had to be made.

As often happens in life, an accidental meeting between two people sometimes occurs just when it should. That is how the question was resolved of where Aaron would go for help after being discharged from the hospital.

Upon leaving the hospital, Aaron came upon an old acquaintance inside the hospital lobby. The young man was a patient and had just come back inside after going out to smoke a cigarette. After some preliminary small talk, Aaron learned that his old friend recently had gotten help for his drug dependency. He shared with Aaron details of his treatment as well as the name, address, and phone number of the facility. I called the rehab that day, and plans were made for him to leave the next day. It was as though this boy had dropped down from the heavens. To this day, I marvel at the way Aaron and I received the answers we needed so desperately from the unlikely messenger who crossed our path that day. Maybe Aaron was touched by an angel after all.

Epilogue: Aaron has been in two other rehabs since that first one (above), back in 2005. Aaron's experiences in rehab have been valuable to him. Not one minute has been wasted time. He has learned so much about himself, the importance of honesty and forgiveness, the deep-seated reasons for his drug use, how to faithfully execute each of the Twelve Steps, and the most effective ways to respond to stressful situations. Moreover, treatment chooses to focus on the intrinsic goodness in others as opposed to dwelling on negativity.

He has been free of drug use since June 8, 2008, and since then has achieved his objective of attending a meeting a night. Despite his best intentions, though, he always will live with the duality of this disease— an angel on one shoulder, and the foe of addiction perched on the other, always waiting.

LYNNE'S STORY

Six or seven years ago, I received a phone call that changed my life forever. It was a call informing me that my son, Eric, was on heroin.

It has been a nightmare ever since. I have found used syringes on his bedroom floor. He has stolen repeatedly from me. He sold items that I had inherited from my grandmother. They are gone forever. He has stolen my sleep and my peace of mind. He has cost me thousands of dollars that I could have used. He has caused arguments between my husband and me. He has caused me to lose time from my job. He has caused me to shed enough tears to fill an ocean. He has contributed to my high blood pressure, irritable bowel, reflux, insomnia, stress headaches, lines on my face, and gray hair. He has caused me to question my own sanity at times. He has caused my heart to ache when looking at his baby pictures. He has filled my days off and my spare time with me driving him to appointments with doctors, counselors, parole officers, NA and AA meetings, etc. He has soaked my shoulders with his tears as I held him in my arms. I have endured being frisked, having my car searched, passing through metal detectors, and eating lunch from a vending machine after a two hour drive, sometimes in ice and snow, to visit him in state prison.

Why have I tolerated all this? Why do I continue all this? He is my son, and I love him forever. Nothing will ever change that.

OUR STORY

Jane and Scotty

As I write this story, I still find it very hard to think and talk about what happened in my daughter Jenn's life. Because of this story, I am now a member of the Pennsylvania Parents' Advisory Council, hoping to make a difference in changing things to help other kids and their families who are suffering from this horrible disease of addiction.

My daughter Jenn is my life, my one and only child. There isn't a day that goes by that we don't talk on the phone to keep in touch with each other. The thought of other parents going through what my husband and I went through—having that awful feeling in the pit of the stomach every day, watching her destroy her life, knowing there wasn't a blessed thing we could do to stop it—encourages me more and more to write this.

No matter how much love and concern, anger and frustration we showed her, heroin took her into this "New World" of hers.

At the age of 14, she met and fell in love with a high-school boy who was 17 years-old. It was young love at first, and by the time she was 18, it turned into a whirlwind romance, living a dangerous life of drugs. Eventually, she got into legal trouble, which is how she got into rehab treatment centers. When she got arrested for the first time, right away I said, "Thank God it's over. She will stop using drugs and be better!!!!" That's how naïve I was. I did not know a thing about heroin addiction. Family members couldn't help at all due to the lack of education and understanding about drug addiction, so we were really on our own.

Jenn was in and out of treatment centers for the next seven years, thinking that each time she left, she would be better and get back on track with improving her life. Jenn and her boyfriend, by the way, eventually did split up when all the legal problems occurred and to this day have never seen each other again.

No matter how many times she tried to stay in recovery, she kept relapsing. She would get arrested for probation violations for her relapses; she was in and out of half way houses; she had numerous counseling sessions. Nothing seemed to work until someone introduced her to a methadone clinic. She decided to join a clinic and work their program. She has been on methadone for over three years now. I must say that at first I was hesitant about her being on methadone, but it is the only thing that has helped her to start getting her life back and to live a normal decent life again.

She is doing well in her life today. She has learned all over again what values are important in her life, like family, living a productive life and feeling good about herself again. This program that she follows teaches her not only to live without drugs but to learn to be a better person because of it. Today, she speaks to elementary and high-school students about the dangers of drug abuse. Jenn hopes that she can help some of those kids who are using or thinking about using.

I know I should be writing more details about her experience during her “drug life,” but I personally prefer not to at this time in my life. I want to share that she is a recovering heroin addict, struggling to stay in recovery; but there are no guarantees that this will never happen again. Even more so now knowing what I know about what she went through; one day I hope that she will decide to get off methadone.

I am so proud of her for wanting to change her life for the better and having the courage to try and help other kids who might be facing the same problems she had with drug addiction. Listening to her speak to students, she stresses to them the consequences in her life are a struggle due to her choice of using drugs.

In closing, it is important to me to see that changes be made as to how treatment centers should be improved to help stop, and find a way to prevent, the multiple relapsing processes. There must be something we can do to stop addicts from this constant relapsing! If this could be accomplished, then I believe I finally could have that “sigh of relief.”

OUR STORY

John Clayton

I will never forget the shock, fear, grief, and guilt that my wife and I felt the day we discovered our 14-year-old son had a drug problem. We literally were paralyzed by the circumstances into which we had suddenly been thrust. Nothing in our lives had prepared us for the journey we were about to take and no life experience from our past was of any help. This was new and dangerous territory about which we knew absolutely nothing—not surprising since neither my wife nor I had ever even experimented with drugs. We were and are a typical middle-class family: law abiding, tax-paying, hard-working, good citizens with very traditional moral and ethical values. Even though we knew that drugs had seriously invaded our culture, we believed mistakenly that it would never happen in our family. We thought it only happened in dysfunctional families—OTHER families.

Over the past ten years of this ordeal that we never expected to have to endure, we have become educated on the issue of substance abuse and addiction; not the typical institutional type of educated, more “street smart” educated. Contributing to our learning experience were interactions with rehabilitation facilities, psychologists, parent-support groups, other addicts (my son’s “friends”), literature, the internet, and a host of other sources. We have been on a roller coaster ride of ups and downs; achievements and disappointments; drama and tranquility. No part of the journey has been easy, but many aspects of it could have been less difficult.

On day one, we had no idea what to do or who to call. The high school was useless in assisting either our son or helping us in seeking out counseling, treatment, or any other kind of help. We did not know of the existence of state-run programs for substance abuse and addiction, and none of the rehab sources we investigated through trial and error from the Yellow Pages ever mentioned them. After we finally spoke with a local outpatient rehab, we enrolled our son (and ourselves for the parent education nights), and thus began the conflict with our insurance company. We had a very high co-pay and a very short duration of covered treatment. When it became obvious that our son needed in-patient care, the insurance company once again balked at paying our claim for a stay of more 15 days. This despite the recommendation of the therapists that it be extended and that our policy allowed 30 days. We appealed their decision and they finally did pay for the “extra” two weeks. We also had mental health coverage on our policy, but the insurance company denied our psychologist’s claim because our son’s addiction was “just” marijuana. Twenty weeks of counseling sessions were paid 100% out-of-pocket with no help from our insurance company or the state. We never received state help during any phase of our ordeal, mostly because we didn’t know it was available and because our son never had to enter the criminal justice system (for which we are most thankful!).

What have we learned over the past ten years? This epidemic is spreading fast and the number of affected families is growing exponentially. We need to inform families in the Commonwealth how to avail themselves of intervention and access to treatment services in the same way the population knows to call “911” in an emergency. Delays translate into exacerbation of the problem, exacerbation escalates into a public health and safety issue, and the public health and safety issues can lead to death—sometimes the addict’s death and sometimes

his or her victim's death. This is a serious issue and needs serious political and economic attention!

BRYAN'S STORY

As told by his Mother, Linda Eckman

My son Bryan was born on February 27, 1985. Out of my three children, the birth of Bryan challenged me the most. Perhaps because he was the middle child, Bryan also seemed to struggle the most.

My nickname for Bryan was “precious” because of his gentle and kind nature. Although he struggled with ADHD and school work was not something Bryan enjoyed doing, he was a fabulous, gifted athlete and very well liked by his peers.

Perhaps it was the crowd he hung out with, maybe it was because he was “chemically” challenged (in his brain), or perhaps it was because he felt rejection from me or his father, whatever the reason, Bryan slowly began to self-medicate his pain.

At first, when Bryan was 17, (this was after his Dad and I separated, and his Father moved out), I began to smell marijuana on his clothes. When I confronted him about this, Bryan “blew me off,” saying “What was the problem with a little weed? After all, it was harmless and everyone did it.”

As well during this time, there were occasions when I’d smell alcohol on his breath. When I talked to Bryan about my concerns, he’d always say, “It’s okay; the popular kids always party.” Looking back, I wish that I had greater courage to pursue an intervention with Bryan, but I was a complete, emotional mess myself. How could I help Bryan, I hardly could get dressed myself each day?

I suppose it was his senior year that more red flags went up. I had two meetings with his coach (Bryan had decided to not play basketball) and high school principal; both were concerned about the happy-go-lucky kid who now seemed to hang his head low. Was it depression? Was it shame? Was it remorse? Was it self-reproach?

About mid-way through his last year of high school, I had a dream that alarmed me. Nevertheless, with trepidation I followed the path I taken in the dream to Bryan’s bedroom and looked under his bed. To my horror, I found an opened, lock-box containing drug paraphernalia. Only this time, it wasn’t just a pot pipe and a bong or two; it was small baggies and empty pill boxes.

From this point on, I began to require Bryan to give me urine samples to better monitor his drug use. From time to time, I would find, amphetamines (from his Adderall, probably), PCP, and Benzocaine. Other evidence pointed to Xanax and Oxycotin, non-prescribed drugs that he would take to combat his anxiety/depression.

I don’t know how we did it (except by the grace of God, I am sure), but Bryan graduated from high school. My, what a glorious day that was for both of us! What a stupendous goal accomplished; we had a wonderful family celebration. In fact, some of my favorite pictures of Bryan come from that day, such happy memories of a family united!

It was that same summer before Bryan went off to college that he checked himself into a rehab center. Because my insurance only paid for seven days, that is all Bryan stayed. Nevertheless, he was able to stay sober-minded and clean for the next 30 to 40 days!

I reveled in those precious hours! My sweet, happy-go-lucky son was back! What could possibly be better? I was so grateful that God had answered my prayers!

We joked! We laughed! His friends came over for dinner again. His girlfriend and he would snuggle along with his dog Sammy on the couch and watch T.V. into the wee hours of the morning. At times, Bryan's little sister would join them in his room; his big brother would challenge him to a game of basketball out on the driveway. Perhaps most importantly, Bryan and his father were reconciled, and he spent time working for him at his dental office.

Jumping forward a year, after Bryan completed his first year at college and had come home to live with me that summer, I began to notice he had regressed back into the drug use, but I wasn't sure how toxic it was. Later in that month of May, I realized that Bryan was again struggling with addiction because he came high to my Mother's Day celebration. Also he missed my birthday all together; he called but missed the party.

Again, Bryan's imprisoning relationship with drugs/alcohol towered over his precious relationship with me. Oh, how deeply a mother grieves for her child when they get caught up in the snare of addiction. I only could sleep at night knowing he was "kept by the name of Jesus."

Finally, when Bryan would not heed the house rules that I had laid down, he and I decided he should move out. So sometime in June, 2005 he moved in with a buddy he'd known since grade school, just a few miles away from me.

Fortunately for me, Bryan and his friend came to my home every day for 4 to 5 hours to put in new front steps for me. Even though we had chosen to go our separate ways, our hearts were never apart. It was so special for me that I was able to feed Bryan at least two meals a day and talk with him as he diligently worked on cutting railroad ties, removing the old rotten wood, and replacing it with new.

As fate would have it, on August 11, 2005, as my daughter and I were vacationing at the shore in North Carolina to celebrate my parent's 50th anniversary, I got a call from my "husband" telling me that Bryan had died. Oddly enough, during my meditative walk on the beach that morning, it was as if God were preparing my heart that he would be doing something with one of my boys. I can still remember how that favorite hymn bubbled up in my spirit, with the powerful words, "He'll lead many sons to glory!"

Later, from the coroner's report, we would find out that the drugs in Bryan's system were all at very *low* levels, but it was the 'cocktail' or mixture of meds that had killed him. According to the medic on duty, Bryan came back to life twice but then went to be "with the Lord." The guy's words still sting my conscience, "I guess God must have wanted him more!"

So, by God's grace, I spoke at Bryan's funeral in an overflowing room of 300+ people. Every kid from Bryan's high school class was in attendance. I encouraged them to "get out of their coffins" (however 'death' looked to them) while they could—for surely Bryan could not.

Despite that Bryan's life has been taken from this earth, I truly believe, as a woman of faith, that Bryan's human spirit lives on. In my view, Bryan is active and alive in heaven, and he is engaged in a ministry that he only could fulfill from there. In my opinion, drugs/alcohol kept Bry from walking in his God-appointed destiny.

No, I don't believe God ever wanted Bryan to die an early, untimely death. Nevertheless, it is my firm conviction that what Bryan *should* have been doing on this earth (to the glory of God), he is now completing from heaven. From the "great cloud of witness," I believe Bryan Matthew Eckman, intercedes for life and freedom for all young people who struggle with addiction, hurt, rejection, depression, anxiety and inner turmoil.

I am proud to say that on Bryan's grave stone it reads, "Bryan was a special and unique son, his name means precious and powerful one. He will go to war at any hour to set the captive free."

Indeed, my son - who was called by the Almighty to be a "powerful and mighty," is indeed fulfilling his God-given destiny: through his prayers and intercessions many lives shall be saved! Prophecy has been fulfilled and he lives forever more!

Yes, I miss my baby every hour - of every day - and my longing for him just gets stronger. But I know (with every fiber of my being) that he LIVES and I will see him one day.

So, until that time, until I go home to join him in heaven, I shall endeavor to tell Bryan's story.... I shall set out to change the lives of those enslaved by the power of addiction.....to declare what Bryan knows to be true: Yes, we can be over-comers in this world, through the power of our risen Lord Jesus Christ - and nothing, by any means, shall hurt us!

Thank you for letting me share Bryan's story with you!

RYAN'S AND KEITH'S STORY

Lori Mentzer



When you look at this picture, what do you see? Heroin addict? Liar? Thief? Felon? Deadbeat dad? Do you know what I see...two of my three babies – aged 25 and 27 today – and these “tags” pertain either to one, the other or both. I must tell you, though, that they are also loved ones - sons, grandsons, uncles, brothers, friends, one is a father, one is a husband – ashamed of their past – working hard at staying clean (one for 1-1/2 years and one for almost 3) – Hepatitis C sufferers who would probably call a “do-over” if they could. Unfortunately, they can’t, and anyway, that would be their story. I want to tell you our story – my husband’s and mine and our 26 year-old daughter’s.

Ours was an extremely close-knit family. My husband, Keith, was in the military and we lived all over the US and in Germany. Our kids were the center of our lives. Don’t assume that means they were spoiled, though. They didn’t get everything they wanted because we really didn’t have a lot, but they were part of everything we did. We had a lot of adventures together over the years. And most of all...they were loved.

My husband left the Army in 1994, when they kids were nearing their teens, and we returned to my hometown – Hummelstown - to “settle down”. Little did we know that this would be the beginning of the end of our happy home life and the start of a nightmare we’re still trying to wake up from.

Ryan, our youngest, had always been in trouble. Nothing serious, but he just couldn’t follow the rules and was constantly acting out at school. When he was 14 or so, he began smoking cigarettes and soon thereafter, marijuana. We tried everything to get him to stop – working with the school, private counselors, etc. – but nothing worked. We couldn’t be with him 24 hours a day, and just when we felt things were going good – he’d be in trouble again. He created extreme turmoil and tension in our home, which was frustrating for our other two children. Those years were just not good ones.

My mother passed away in January, 2000, and we bought a larger house so that my ailing father could move in with us. Things actually seemed to be going well for a year or so. Our oldest two kids graduated – our daughter going off to college and our son working for Fed-Ex – and Ryan seemed to be settling down. He had a girlfriend that he’d been seeing for a few years

and we thought things might be on the upswing. A few months prior to his graduation in June, 2002, he told his father and me that his girlfriend was pregnant. The night before they were planning to leave for senior week at the beach, my cousin came to us to tell us that Ryan and possible Keith were using heroin. Our world collapsed. Both denied it profusely – we tested them and Ryan tested positive for opiates. We told him he couldn't go to senior week and would stay home so we could get him help. As it was Friday night, and not knowing how to get help, we kept him with us at all times until we contact people on Monday. I initially called Dauphin County Drug and Alcohol. They gave me three places to call for help. All three numbers were useless. I finally spoke to someone at Hershey Medical Center who told me to get him to a counselor and make sure that it was one who had an addictions certification. We found a counselor in Hershey who began seeing him weekly, all the while he was still using. And we naively thought that by keeping him with us and seeing the counselor everything was going to be alright. We had no one to turn to – we couldn't find a support group in this area – and the local agencies that we turned to for help were just not very helpful. We didn't know where to turn. In fact, it took us nearly two years and much searching to find a support group for ourselves.

To make a long story short – Ryan was treated both inpatient and outpatient – at several rehabs. Along the way, we found out that his older brother was using, too, and he too began the long trek toward sobriety. We had to fight for all the services we needed. Our private insurance didn't want to pay for any inpatient – only detox – and the County wouldn't help us because we had private insurance – even though they wouldn't pay. The PA Attorney General's office did help us. Then, we found out both boys had Hepatitis-C. What followed for the next few years were inpatient treatment, relapses, intensive outpatient, suicide attempts, bounced checks, lost jobs, two children, probation and jail, methadone, naltrexone, disappointments, anger, hurt, depression and broken hearts. As I said earlier, both boys are currently clean, and we're all taking it one day at a time.

My hope in writing this is that no family member in the Commonwealth of Pennsylvania, or anywhere in the US for that matter, will have to go through what my family did in obtaining services for our addicted loved ones. My dream is that a system be put in place that will walk the traumatized loved ones through the steps necessary to get help for the addict and themselves.

JEFF'S STORY

Chuck Klenk

I served as a Police Officer for 26 years and have been employed as an Erie County Sheriff for the past seven years. I have been married for 29 years, and my wife and I have one child, our son Jeff, age 24. Currently he is incarcerated and awaiting sentencing.

Our story began long before we found out that Jeff was an addict. He has told us that he began using marijuana around age 12, and then at 15 he began experimenting with cocaine, oxycodone, ecstasy, and heroin.

In the fall of 2002, at age 18, Jeff, was living at home and attending Penn State Behrend in Erie. He was commuting and left each day for “classes” as scheduled. When my wife left work ill one morning and came home to find our son still in bed at the time he was supposed to be taking a final, we knew something was wrong, but he quickly explained everything away— Mom had the wrong day, he had already taken that test, he had enough points to be excused from the test, etc. We believed him because we wanted to believe him.

His report card came right before Christmas, and he had failed all of his classes due to not attending. We made him get a job at the local gas station, and he worked there from January through August 2003. There were many phone calls from his boss about Jeff being late for work or not showing up. He lost the job in August. Again, we knew something was wrong, but we still could not put our finger on the exact problem. So many of his behaviors mirrored typical teenage behaviors—distancing from his parents, wanting his own space in the basement, sleeping late, and staying up late.

When he lost his job August of 2003, my wife asked me to get a drug test kit and to take a urine sample. We told our son that we were going to do a test, but we didn't know when. He was addicted to oxycodone by then. He had tried to get off on his own and was unable to do so. He used every day until we did the test about four days later. He tested positive for opiates and other drugs. I shared the results with my wife after dinner that night, and we were stunned. We had no idea what to do next.

My wife was friends with the school district psychologist, who happens to live nearby, and we went to talk to him. He told us that Jeff needed to get into a rehab, and he explained how to do an intervention. He agreed to do the intervention so we scheduled it for the following evening. Jeff was given the option of rehab, or he would have to leave our home. He chose rehab.

He spent 10 days at a facility in Franklin, PA. At the time, Jeff had insurance through my wife's policy, at a cost of \$400 per month. We thought the stay was short, but what did we know.

After his discharge, Jeff was assigned to an Intensive Out-Patient group in Erie, and we started going to the family group night every Wednesday. We were encouraged to go to Al-Anon as well, and we did. We started educating ourselves about this disease. Jeff agreed to go to AA or NA, get a job, and follow our rules. We bought him a car so he could get to work and meetings.

One week out of rehab, Jeff relapsed. Once again, we didn't see the signs. He did get a job, but we never saw any money on a regular basis. Obviously, it went for drugs. He used the car to go to Pittsburgh and Erie to buy and sell. We continued to take urine samples; most times they were positive. We sat down and talked, and Jeff agreed that he would again go for counseling and AA meetings. He became very good at hiding what he didn't want us to see.

In May of 2005, he moved into an apartment with his girlfriend. Peace returned to our home, and we relaxed and enjoyed the quiet. My wife and I had been involved actively in Al-Anon, and when a Nar-Anon group formed in Erie, we were two of the founding members. We attended meetings three to four times a week, and it gave us the strength to build our own lives, separate from our son's addiction. We learned that we were sicker than our son, and we needed to take care of ourselves.

In July 2005, we went on a vacation trip to Gettysburg. Two days before we were to return home, we received a phone call from our local police department notifying us that our son had been arrested and was currently being arraigned on charges related to a fight in which he was involved earlier that morning. He had stabbed another young man with his fishing knife when that man was beating him up in the parking lot outside of his apartment.

He was in prison for a week. Then he was let out on a \$5000 bond so that he could go to rehab. He spent 2 months at a facility in Ohio, and my wife and I attended family programs there every Sunday from 9 a.m. to 5 p.m. When released from rehab, Jeff returned to live with us. He was clean and sober the entire time. He attended AA, worked closely with his sponsor, and only "hung out" with others in the program. It was a wonderful time until he was sentenced in February 2006.

Following a plea bargain, he was sentenced to 6 to 20 months in the Erie County Prison plus probation for 2 years. He was given immediate work release. He got a job in roofing and had to report back to jail each night after work. He did well for several weeks; then he was offered some cocaine and used it. He was tested the next day and came up positive. His work release was revoked, and he was put back in prison just prior to Memorial Day weekend. He spent 3 more months in prison.

Upon his release, he returned to live with us and kept looking for jobs. On his way to a meeting with his probation officer in the January 2007, he slid on some ice and totaled his car. We promptly got him another one because he told us that he had a job. We justified it because we knew he needed transportation to get to his meetings and to see his PO. More enabling on our part, but we were learning and getting stronger ourselves.

In December 2007, Jeff again tested positive for drugs and his probation was revoked. Since I work at the Court House, I was assigned to that area that particular day and had to handcuff my own son and take him to lockup. He was released after a week, and we took him straight to the rehab facility in Ohio. He spent 15 days there, including Christmas and New Year's. He was released the second week of January 2008 and returned to our home. He went back to meetings and seemed to be doing well. He began spending time with a woman (age 44) who had been in AA for several years. She was currently on disability due to some health issues,

and it gave Jeff a “safe” place to go to hang out. Little did we know that this woman had relapsed awhile back and was currently supplying Jeff and others with oxycodone.

Within a month after getting out of rehab, Jeff had started stealing from us. He stole credit cards, about \$20,000 worth of H.O. trains that I have collected for the past 30 years, DVD’s, and household items. He denied taking anything. I recovered most of the trains, but within a couple of days, my wife noticed that some of her jewelry was missing. My wife left work in the morning and came home to confront our son. He denied taking the jewelry, but when my wife searched “his” car, she discovered some jewelry in the trunk that he was unable to sell. She told him he had to leave, and he called his “friend” and went to stay with her. We found out later that his habit and hers had escalated, and they didn’t have the money to buy the amount of drugs that they both needed. That’s when he began stealing large amounts from us. He believed that we wouldn’t turn him in because we knew that if he was arrested on new charges he would probably get state time.

My wife and I wrestled with this and did a lot of praying. Jeff took the decision out of our hands by committing another crime that did not involve us. He and another friend went to a neighbor’s house and stole her purse. They wrote checks and used her credit cards. He knew he was going to be picked up soon so he checked himself into a local hospital so that he could detox prior to being sent back to jail where you do not receive any help detoxing. I ran into his PO on Easter Monday at the court house; when he asked me where Jeff was, I told him. He went to the hospital and picked Jeff up and took him to Erie County Prison where Jeff has been ever since. He was arraigned on 4 felony counts of forgery plus the revocation of his original charges from 2005. He pled guilty in June and was sentenced on August 6, 2008.

During the past 5 years, our son has lied to us about having a job, used our credit cards and checks, acquired credit cards of his own and didn’t pay for the charges on them, brought people into our home that we would have never wanted to have here, and did whatever it took for him to “protect and continue the use.” That is a phrase that his Intensive Outpatient counselor uses over and over, and it’s so true.

We have learned that the hurts he inflicted on us were not personal, and his remorse is genuine. This is truly a family disease, and our entire family has become educated in regards to addiction, the addict, and the “enablers” in the addict’s life. He has been incarcerated for the past 3 years for his birthday (May 4), Memorial Day, July Fourth, and Mother’s Day and Father’s Day. Each year we hope that he will be home clean and sober for the next birthday, Mother’s Day and Father’s Day.

We are more educated now, but it is still easy to see and believe what the addict wants you to see and believe because you love your addict.

Even with my years in law enforcement and my wife’s background in working with at-risk children for 30 years, we were still at a loss when it came to recognizing and dealing with having an addict in our lives. We wanted to find a way to cure him. When we found out that it wasn’t up to us, we at least wanted to learn how to identify the signs that he was using again. The problem was that as we got smarter so did he. At a Nar-Anon meeting awhile back, a member

described our lives like walking through a mine field: we carefully make our way through, and then we start heading through it again. We know where we removed the mines the first time so we think we can step there safely now, not realizing that the addict has come through the field while we weren't looking and planted new mines. He isn't trying to hurt us; he is just trying to "protect and continue the use".

We love our addict and always will. I am involved in the Pennsylvania Parents' Advisory Council so that I can help others who are going through this same "mine field" for the first time; help them to know where to go to access services that will help them and their addict.

Our story is still being written. I know the ending my wife and I would like; but if our son decides that it is a different ending, then my wife and I will continue to love him, but we will continue to love and take care of ourselves first. We have been put on this journey for a reason, and we hope to make a difference by understanding this disease, and helping addicts and family members to get what they need to recover.

MY STORY

I stood on the steps watching my son trying to focus his eyes on me; fear is gripping my heart. As a nurse, I know that he is under the influence of something powerful, but my mother's heart screams, "No!" I have this sense of unreality—this can't be happening, what do I do, who do I call, who knows what to do? My husband was teaching computer classes at a state correctional facility a couple hours away, and I knew that he did not take his cell phone into the jail for obvious reasons. The protocol for going "behind the wire" requires that he leave virtually everything of value in his car. My friends are good Christian people whose children attend church and Sunday school; they certainly wouldn't know what to do.

I called the local hospital asking to be put through to the rehab floor. I don't give my name; the man on the other end doesn't ask. He kindly offers advice without questions: call the police, take him in to the ER to have him tested. I wrestle with the options, fear in my heart. What if I just let him sleep it off and try to talk to him later? What if I let him fall asleep and he dies under the influence of whatever substance he has taken? I cast out a desperate prayer, my heart strangled with my fears. After a moment, I have the cold calm I need to call the police. I am filled with a deep sense of shame as I answer questions: he was out all night bowling; he came home; he can't finish sentences; he can't focus or walk straight. An officer will be out.

There is something truly intimidating about a police officer. He stands in my hallway, dressed in black. He has a heavy leather belt with a tommy stick, a gun, handcuffs, and mace, tools of the trade for this man. He is holding a pad of paper and a pencil. He is kind and polite, and agrees that my son is definitely under the influence of something. He can't be charged with anything since there is no sign of criminal activity. He recommends that I take him to the ER. He leaves.

I look my son in his unfocused eyes and state that we are going to the ER. He snarls that he is going to bed. He staggers up the stairs and stumbles into bed. I stand in the hallway thinking about my choices. I was involved in a serious car accident in which I broke both legs. Although I am able to walk, I am uncertain of my balance, and too weak to take the chance to wrestle with my teenager and win. I opt for the coward's way out and decide to wait for my husband to get home.

This is the beginning of a journey on which I would not have set out. The valleys are deep and dark; there are moments when the light of day shines down and just barely touches the valley floor. Mostly the pathways are narrow and tricky, strewn with rocks. It is only as I went deeper into the valleys that I discovered that others were traveling through there, too. Each of us was walking a different path, getting lost in darker valleys and getting found in little patches of sunlight. This fellowship of the journey was my lifeline.

Unfortunately, I didn't find that fellowship of travelers for a long time. In fact, for a very long time my husband and I thought we were alone, and we were ashamed and filled with despair.

When our youngest son finished kindergarten, we had decided to home-school our children. We did this for several reasons: to teach our faith, to provide stability, to have the

opportunity to spend time with our children, and to protect them from a family member who had been imprisoned for sexually abusing our oldest child but was now on work release not more than a couple miles from our house. After the shattering experience of the betrayal of sexual abuse, we desperately needed to be with our children, to assure ourselves that they were safe, and that we were together. We had many years of close family times: field trips, bike trips, and camping trips. My husband taught the children to play roller hockey; they spent many hours playing together on the local tennis court together.

We did not realize that there would be long-reaching effects of the abuse that would not be evident for years. We took all three children to a therapist who told us that they were doing well. If we were just supportive of the children, everything should be fine. Looking back, however, I realize that the true damage of the abuse was the mindset of keeping secrets. The children were coached by their abuser to keep everything a secret: don't tell mom and dad. They continue to this day to keep things secret, from themselves and from us.

Our first efforts at research brought us information about rehab facilities we could not afford. The message was simple, if you had the money, you had options. Since my son was involved with the juvenile justice system, he had a probation officer, fines to pay, and community service to perform. In my ignorance of the disease of addiction, I thought that these consequences would be sufficient. In reality, it allowed him the time to get deeper into his addiction as he fulfilled his requirements.

It wasn't until we moved to another county, and police picked up him with my older son in a car getting high together at the end of our driveway that things started to change. His new probation officer started to drug test him on a regular basis. As he continued to fail his drug tests, while still fulfilling his new additional requirements of community service, his new probation officer referred him for a drug evaluation. It was determined that he needed outpatient rehab services, but our insurance did not cover it. He was adjudicated a delinquent, which apparently allowed coverage for rehab services.

Over the years, he has been detained in juvenile centers, sent to inpatient rehab, "302'd" twice, hospitalized, and sent home on house arrest. This last was the most laughable and useless consequence of all: my husband and I both worked, and his friends came to see him and got high on the porch. Over this chaotic time, we learned about support groups for parents and that families of addicts actually need to work on recovery as well. Recovery from emotional abuse, enabling, blaming, and the trauma of life with an addict. As we worked on becoming healthy ourselves, we learned to live this difficult life with two addicts in our family.

Over time, I have become convinced that no rehab program offers a "silver bullet." I believe that recovery is a long and complex process that usually includes relapses, but on the way, the addict can begin to learn things that help him to grow. Each period of addiction and recovery teaches the addict more life skills and abilities that allow him to live free from addiction. When will my two sons learn enough about addiction and recovery to be truly free? I don't know. We wait, and we pray. We believe that one day we will see our children healthy. | Meanwhile, we work on getting healthy ourselves and helping others who walk this road.

OUR STORY

Ron & Judi Owen

November 24 marks a devastating day for my wife, Judi, and me each year. It rekindles a deep sorrow that every other day of the year attempts to ease. On November 24, 2003, we lost our 23-year-old daughter, Sarah, who died after battling drug addiction.

Sarah defied the stereotypical description of a drug addict that many people conceive in their minds. Sarah was respectful and vibrant. She was empathetic to others' needs, especially the elderly.

The stereotype of addicts lying in the gutter, being out of touch, is just not the case. Through all the pain, she still gave us respect, love, and consideration. Many people were not even aware that she was an addict. When we last saw Sarah two days before her death, she was smiling and loving. When Sarah, the single mother of then 5-year-old Taylor, died, Judi and I sunk into despair.

The pain, frustration, and sense of hopelessness that comes with the addiction and loss of a loved one are almost unbearable. It's never over. You don't forget.

Every family handles grief in their own way. Judi and I chose to turn a negative event in our lives into a mission to help other families bounce back from addiction and become what we always envisioned for Sarah to one day be—recovered. We established the Sarah Kristin Owen Memorial Fund to benefit children and young women by improving their lives economically and physically, as well as advancing their education and social well-being.

Judi and I made a decision on what to do with our lives after Sarah's death. Her death put a giant hole in our bodies that doesn't go away—you can only work to make the hole smaller. God gives you what you can handle, but I can't imagine anything harder than this.

The Foundation has surpassed what anyone would have expected from it in the beginning. As of the end of 2008, we have made grants to various organizations in excess of \$150,000.

Sarah, who only needed one more tomorrow, may provide a million more tomorrows for others in her place through her legacy and our efforts.

JONATHAN'S STORY

Roseanne Gallagher

Who knows when it began? It was something that happened slowly, so slowly that I really didn't notice it at first. A glance here and a glance there, knowing something is not quite right but not knowing what. Suddenly, glances become stares. I stare at my son trying to find out what is wrong.

He is in his room all the time, only leaving to go to school, the bathroom, and kitchen. I knock on his door and go in.

“Jonathan, are you okay?”

“Sure Mom, everything is fine.”

“Are you sure? You know we can talk about anything.”

“No! No! Mom, I'm really okay.” (He states this with tears in his eyes).

This goes on for weeks. Finally, one night he says that if he does go out he really could get in trouble. “It is best I stay home”, he says. Jonathan's moods are ever changing. One week manic high and then very low. I think maybe he is having a nervous breakdown. I have never experienced anything like this before.

We decide that he needs to go to the doctor. We make an appointment and go together. They do blood work and prescribe Xanax due to nervousness.

My brother takes him fishing trying to occupy his time. Jonathan comes home, and he can barely walk. My brother has no idea what is wrong with him. No one does. I accuse him of using drugs. He swears that he is not. I get his Xanax bottle from him. They are all gone. He has taken the entire bottle. As far as I know, this is his first overdose.

He is taken directly to the emergency room and then to First Hospital Wyoming Valley, (a psychiatric hospital). Diagnosis: Bipolar Disorder. They prescribed an antidepressant, a mood stabilizer, and an antipsychotic drug. He was in this hospital only two days and then released. I took him to New York for a second opinion because he didn't seem to have made any improvement. This second appointment was with a renowned specialist in bipolar disorder. We traveled 2 ½ hours each way. It cost us \$600, for a 20 minute office visit. Same diagnosis, the only difference was he suggested lithium.

Mood swings, hallucinations, weight gain, and weight loss. What is going on? I expected him to get better. Please God make him better. PLEASE!!!!!!!!!!!!!!!!!!!!!!!!!!!!!!

It's Saturday, I am at work. I get a call from my step daughter. “Something is wrong with Jonathan. He can't stand up, and he makes no sense when he talks.”

“I'll be right home.”

I call my other daughter to go over. She does and calls me on my cell. She is crying; she has called 911. “Mom, I don’t know what is wrong with him, hurry and get home!”

I arrive home to find the ambulance and the paramedics. They want a list of his medications. We are assuming that he overdosed on his prescribed medication. They give him naloxone to counter the effects of the drugs. He can’t walk or talk. He stumbles and falls and falls and falls.

The police arrive. They yell at him to “STAND UP! WALK! WALK! WALK!”

Paramedics put him on the stretcher and carry him out to the ambulance. I ride in the front with the frightening realization that my son may die. He makes it to the ER. He is strapped down. Blood pressure is way up! He is in and out of consciousness. Blood is drawn. They hover over my son never leaving his side. Blood tests come back. Opiates show up. They run them again just to be sure. Yes, they are sure. They transfer him upstairs later that night.

The family physician comes in. He looks at Jonathan’s arms. He then says “Track marks!”

“Oh no,” I say. Those marks were caused because he was strapped down.”

He asks me to come over and look at my son’s arms. Yes, he is right. *My world changed right then.* It would never be the same. I wonder when it changed for Jonathan. When did he abandon his youthful innocence and become a heroin addict? Later that night, I climbed into that hospital bed with my 18-year-old son. He never said a word, but I think we just needed to be near one another.

How could so many professionals miss the signs?—The doctors, the specialists, the counselors, the paramedics, the school personnel. When someone has a disease, you take them to the doctor, and the doctor then gives a diagnosis and further testing is done or medication prescribed. My son was misdiagnosed and misunderstood. Everyone failed him!

All of this and much more took place in 2001. His struggle still continues today.

The reason my son was in his bedroom so much? It was because his drugs were being delivered right to his bedroom window. When his drugs were delivered, he had everything that was important to him within those four walls. He also was using the prescribed medication to keep a handle on his heroin addiction. My son has been in detox, rehab, and a psychiatric hospital. He has had outpatient counseling from drug and alcohol professionals, mental health professionals, case managers, etc. He has relapsed.

It’s interesting how much you learn watching a loved one go through addiction. There is a whole culture out there with its own set of rules, expectations, even vocabulary. Families of addicts know just what I mean.

Did you know you must be actively using before you can be prescribed methadone?

When Jonathan decided to go on methadone, the heroin was out of his system. He was coming unglued and had to wait a day for the first dose of methadone.

So what do you do? You either let him go out and buy, or call up every family member and tell them you have a toothache. “Oh, by the way do you have any pain pills in the house?”

That’s exactly what I did so that he would not go out on the streets. Jonathan was on methadone for 2 1\2 years. He was kicked out of the clinic due to financial reasons. They put him on a 21-day rapid detox, which means he has 21 days to adjust from 100 + mgs of methadone to 40 mgs. Then his assigned doctor told him to go home and immediately start taking the Subutex which sent him into full blown heroin withdrawal. Never have I seen my son suffer more.

He is now on Suboxone. No longer does he have to make his daily trip to the clinic. He does go to see his doctor twice a month. My son still struggles with his addiction. Even though he tells me everything is okay, I know that it is not. I do know that he can someday get to that place, but it really is up to him to keep up the fight. I hope and pray for a cure, but if people can’t get beyond the stigma, I don’t see how we can get beyond substandard treatment for addicts.

I have seen my son knocking on death’s door. *I hope no one answers.*

The loss of appetite, weight loss, grayish cast to his skin, inability to make rational decisions, and mood swings are all symptoms of drug addiction to which I will be hypersensitive forever.

I will never walk away from my son. I walk beside him on this journey. I am grateful and proud to have Jonathan as my son.

CHRISTOPHER'S ADDICTION, OUR FAMILY'S JOURNEY

Sheri Hathaway

I can't say that Chris grew up in a traditional home environment; it was more dysfunctional than not, ending in divorce when Chris was in kindergarten. Statistically, half of all marriages end in divorce, and this is the society and culture into which Chris was born and raised.

I worked many over-time hours as a nurse to support my family, and my kids spent a lot of time on their own after being ineligible for daycare because of age (children still need supervision, especially during adolescence). Chris had a typical childhood: sports, cub scouts and many friends. In Junior High, he started hanging with an older crowd. Being small for his age, he no longer felt confident competing in sports against much larger opponents. He started with the typical vices: smoking cigarettes and then marijuana.

At age 16 during a pediatric visit, I asked to have him drug tested because I suspected but wasn't sure if he was experimenting at this time. It was positive for cannabis. No one was overly concerned, including the healthcare system and me. I had a talk with him, and he promised he wouldn't do it again. I just chalked it up to a rite of passage— boys will be boys. I think this must be a common theme with parents; it's not that we don't know the warning signs. Initially, we choose to ignore them thinking its only teenage angst or a rite of passage. We want so much to believe our children that we are blinded to reality. I think drug education should not only be part of the educational process in schools but also on a community level for parents and community leaders.

Chris started skipping school, and his average grades quickly spiraled to failing. There was no help from the educational community. With state-wide budget cuts, the counselor's position at our high school had been eliminated. We were introduced into the judicial system by the truancy officer. After failing 11th grade and numerous fines, I took my child out of school because I could no longer pay the fines. I enrolled him in GED classes, and he had a diploma before his classmates graduated.

At age 18 and no longer in school, Chris had even more time on his hands. He worked sporadically in minimum wage jobs. Again, I had him drug tested, and this time it was positive for opiates (heroin or narcotics). I tried getting him into a rehab, but because he was no longer a minor legally, I had no recourse. He attended college for a semester but never went to class and again failed. The repeated failures only added to an already fragile ego.

A drug addict's story is never just about him; it encompasses the entire family and community. At this time, Chris was stealing from me, family members, and the community at large to feed his habit. I begged him to get help, but he was in denial. He would break down and cry during periods of abstinence (which were seldom) but still couldn't take the step to ask for help.

I bought my son a car to help improve his chances of getting a better job away from our rural community. This was a big mistake. The car would turn up "missing" for days on end. He

claimed that it had broken down; he had left it at a friend's house. His employer at the time called me and said that at times a man would come to where he worked and take his car. I later found out that this is how Chris paid for his habit. The man was his dealer and would take MY car across state lines to deliver drugs.

I contacted my insurance company because I was petrified what would happen if he were caught dealing with my car. Would I be responsible because the car was in my name? Again I was up against a brick wall; my son would have to say that the car was stolen in order to do anything about it. If he said that it was stolen, he would fear the dealer's repercussions. I called the state police and got pretty much the same answer. Well, two weeks later my worst fears came true. The man was killed while driving my car. This was the turning point when my son willingly went to rehab.

Chris had no insurance at the time, but, by word-of-mouth, he had heard of a drug hotline that might be able to help. This was through Health and Human Services of Greene County. They were very helpful and expedited the process. He had to apply for medical assistance and was approved through a program specifically for residents with substance abuse problems. This was our introduction into the "system" as I refer to it.

Chris left against medical advice after 10 days and was using as soon as he got home. This began the cycle of rehab and being released too soon—either by leaving or because the insurance ran out—then home again only to use the first day. We both gained insight into the disease of addiction but always were up against obstacles and hurdles because of insurance policies that hindered acceptable lengths of treatment.

My son is now in a methadone recovery program, and we have had the most promising results. Methadone is not a cure but promotes and supports harm reduction. Many healthcare professionals do not advocate, and insurances will not cover, methadone treatment. Many obstacles and stigma must be overcome just to initiate the process. Through this entire process, most programs I have found out about have been through my own research or word-of-mouth. He has had many lapses. He has learned what does and doesn't work for him.

He lived on his own for about a year in state subsidized housing but that didn't work. Being eligible for the medical assistance card, he also received food stamps and cash. During his relapses, the money provided by the state was used for drugs. People on methadone don't use narcotics but switch to other non-narcotics to get high, such as benzodiazepines or cocaine. Money received from the medical assistance transportation program also was used to purchase drugs. Personally, I don't think cash payments should be provided to these individuals. Most addicts have underlying personality traits that are very similar, and many have not had to face consequences of their actions because we, as parents, have made the repercussions go away by resolving problems for them. I feel cash payments only continue to enable addicts.

Six months ago, during a period of relapse, he totaled his car, lost his driver's license, and went to a three-quarter house for 3 months. I paid out of pocket for this expense, but later learned that I could have gotten help through the Single County Authority. I always find out after the fact. Programs are out there, but often the populations that most need them are not aware of

them. I think more emphasis should be put into visibility, not just to school students, but to the entire community. Drug addiction touches everyone's lives, whether directly or indirectly.

ERIN'S STORY

Tom and Betty Moreken

Erin was born on January 20, 1974, the first of our three children, and our only daughter. She was the perfect little girl—blue eyes, lots of charm, very outgoing. She was the one that everybody loved. Elementary school was never a problem, but when Erin transitioned to the middle school; her behavior began to be more difficult. We started taking her to see a counselor who made a diagnosis of “Oppositional Defiant Disorder.” Looking back now, a more accurate diagnosis probably would have been that Erin was suffering from depression and anxiety.

We wish we could pinpoint when everything started to go downhill. In high school, Erin was a cheerleader, took dance classes, and made some new friends. It was obvious to us, however, that Erin did not want any kind of rules or boundaries, and she was exhibiting some risk-taking behavior that worried us all the time. By the end of junior year, Erin was dating an older boy, was drinking and smoking, and experimenting with marijuana. During her senior year, Erin was arrested for under-age drinking, and we placed her at a residential treatment facility.

Clear Brook Lodge was an excellent facility. We could see signs that Erin was beginning to understand why she was there and was making some progress....Or so we thought. Erin was so good at manipulating and saying what she thought you wanted to hear. That's what she did at Clear Brook. She knew she would be turning 18 in January, and she also knew that Clear Brook couldn't make her stay there after that. On January 20, her birthday and a few days short of her thirty-day stay, Erin had her boyfriend pick her up. Since she was now 18, she signed herself out of the facility. This would become a pattern for Erin—entering a facility for help but never staying long enough to really be helped.

Erin stayed away from home for a few weeks but finally decided to come home and return to school. The remainder of senior year was manageable. Erin applied to several colleges and graduated in June, 1992, with plans to attend a nearby college.

The rest of Erin's Story consists of recollections, and some information we read in her journals. We have to fill in the blanks sometimes because she didn't share much with us once she went away for college.

After her freshman year, which was spent being stoned on marijuana much of the time, she transferred to Temple University in Philadelphia to be close to her boyfriend. Erin was in and out of school, in and out of Marworth Treatment Facility, and in and out of our lives. We would not always know where she was. She liked it like that. When she was clean and sober, she did well in school. Just like that, she would be dropping out, and we always knew that her demons were at it again.

Erin came home for a while 1995 and worked at a temp agency. She was her old self and appeared to be happy. Then she was off to Pittsburgh to visit her brother who was going to college there. She met a new boyfriend in Pittsburgh, got an apartment, and stayed there for some time. We think she got very involved with cocaine and heroin while she was there, but again we're not sure. In 1997 she traveled from there, to New Orleans to work as a waitress

during the Super Bowl and then on to Florida. Sometimes we would not hear from her for weeks at a time, and then there would be that call in the middle of the night: “Hi, Mom,” as if nothing had happened.

In 2000, Erin began to receive methadone at a clinic in Philadelphia. For about a year she was back at Temple and doing well. We surmise that she used heroin while she was being treated at the methadone clinic, failed a urine test, and, consequently, had to leave the clinic.

There are terrible gaps in the next two years of her life. We were told to use “Tough Love” and to let her hit “bottom”. We received lots of advice but nothing worked. We don’t think much of that advice now. Waiting until someone hit’s “bottom” is probably the most reckless advice that anyone can give.

In February 2002, we went to see Erin to beg her to enter treatment. She was about 90 pounds, had been evicted from the apartment she shared with her boyfriend who had moved to Philadelphia with her from Pittsburgh, and obviously was in need of immediate help. She promised she would seek help. It was June, however, before we got another one of those, “Hi, Mom” calls asking for our help.

Erin entered the Caron Foundation outside Reading on June 5, 2002. We had researched and read great things about this facility, and felt it would be the one that would finally help Erin to get clean for good. We said goodbye on a Wednesday. We knew that we could not speak to her right away, but we felt that she was as safe as she had been for a very long time.

On Sunday, June 9th, the phone rang. On the other end was Erin. We knew this could not be good because she was not allowed to call for at least a week. Erin again had signed herself out of a facility and taken a bus to Philadelphia. We spoke to her for a very long time. She knew she had to go back, and she promised she would take a bus back to the Caron Foundation on Monday.

How we wished that the next phone call would have been one of those “Hi Mom” calls, but instead it was the hysterical voice of Erin’s boyfriend. He had left for work the morning of June 10 with Erin promising that she was taking the bus back to the Caron Foundation. When he returned home, he found Erin. We are surmising that she had to have that last “fix” before she got on the bus, and, in her weakened condition, she died from an overdose. We honestly feel that this was accidental and that Erin really did want to get help.

There is no way to explain what it is like to have a child with the disease of addiction. There is no pity from people who still feel it is a bad choice that was made and that it is the addict’s fault. There is no comprehension that relapse is a real symptom of the disease, and that you must expect that many relapses may occur. People continue to picture the addict as the creepy looking guy on the corner instead of the blue-eyed cheerleader.

Erin was only 28 years-old when she died. She had abused drugs and alcohol for at least ten years. Because of this, she had not achieved anything that she had planned for her life. Trying to find help for Erin was the most frustrating and difficult task we, as parents, had ever faced.

When Erin needed help and made up her mind to seek help, there was never a bed available, or she didn't have the financial resources necessary. We maxed out credit cards and worked extra jobs, but we would do it all again in a heartbeat. Erin was arrested several times, but rehab was never mandated for her, and there was no Drug Court available as there is now.

This was not the life Erin wanted to lead. We along with Erin's younger brothers and extended family still grieve for her life cut short because of the disease of addiction.

In her memory, we established the *Erin Jessica Moreken Drug & Alcohol Treatment Fund, Inc.* Each year we have an event called the *Tour de Scranton*, which is a noncompetitive bike ride through our city and surrounding counties. The money raised is donated to help young people who have completed Drug Treatment Court, and who are trying to lead clean and sober lives. We have raised over \$50,000 thus far. We know Erin would be pleased that we are trying to help others conquer the disease of addiction, something that eluded her throughout her short lifetime. Erin loved to write and wanted to be a journalist. We just wish she could have written this story herself—but with a happier ending.

MY ROUGH ROAD BACK TO NORMAL

Karen V.

The addict in my life is my 26 year-old son, a recovering intravenous heroin user. He has been in recovery for a little more than 5 years. The details are his history to tell, not mine.

It has taken many years, many hours in fellowship meetings, many therapy sessions, and much introspection to realize that I have my own story.

I have a graduate degree, am well traveled, make a comfortable income, speak my mind, have good insurance, and am a single parent. I knew the details of Act 106; learned to overcome the shame and stigma and insist on decent treatment and help for my addict and for me. I say this only because I still was unable to get help for my son from the medical community, law enforcement agencies, legal system, or private and public addiction services.

By the age of 16, my son was out of control, had left school, been arrested, had broken windows and doors and punched holes in my walls. My son was court-mandated to a psychologist more than 20 miles from our home. After a few months of these visits, I was told I needed to get my son away somewhere. Not where, how or why; just away. The therapist would no longer see him and reported that to the court. I could get no information from anyone.

I lived in terror from the time my son was 16. I lived in the insane and frightening roller coaster of life with an out of control, angry, destructive, and strong son. I lost my moral compass; eventually I lost myself. I was terrified and in denial. I was naïve. I had no idea my son's problems stemmed from drugs and neither did any of the professionals involved.

I had my son kidnapped and taken to a wilderness program in Utah. At that point, it was the worst day of my life. He got better therapy and education out in the middle of that isolated dessert than he ever did here at home. Six weeks and he graduated and was ready to come home. I thought having put both of us through this, he would be cured. Many worse days were to come, and many attempts at help were to fail, before I came to realize that each attempt was a small step forward and that the inevitable steps backwards for us both were part of the process.

Professionals diagnosed him as oppositional defiant, but a name and a diagnosis are of little help. He saw a series of therapists; none said he had a drug problem; although he had by that time had one for years. Some said I did not support him or praise him enough; I had given him low self-esteem. They believed everything he told them. I felt like the villain.

I was desperate and barely able to continue myself. After several visits to a therapist of my own, I found the courage to attend my first Nar-Anon meeting. It was awkward and depressing. I heard stories from people who must have been looking in my windows so similar were their accounts to my life. At last, it hit me that my son was an addict. Horrible as that revelation was, finally I knew what his problem was and I was not alone with my terror.

I put my son in many rehabs, sometimes forcing him, sometimes he begged me to take him. The need for a rehab was always an absolute emergency: get me in today or I will keep

using, get me in today or I might die, get me in now this minute or I will take this kitchen knife and go stab and rob the first person I see. My child had become an abusive terrorist in my home; when I looked at him, all I saw was the enveloping specter of heroin, his drug of choice, commanding his every action.

It is difficult and frustrating to get someone into a rehab. Even now when a desperate parent calls me for help, and I am calm and rational and have had years of experience with many rehabs, I still do not know how to help. Take the addict, dump him on the rehab steps, and drive away. Call around to rehabs and see if they have room and go with the addict and wait (you don't understand waiting until you sit in the lobby of a rehab with your addict freaking out, itching, pulling at eyes, jerking their legs, chain smoking and always threatening to go on another run). I would have done anything just to get the rehab to take him. Not because I any longer thought he would be cured; but I thought he would be safe for a while and I could be safe for a while from my son. What a dreadful thing for a mother to have to feel: safe from her son; safe from the incoherent phone calls at 3:00 AM, the crazy drives to emergency rooms or war zones of drug dealers, the pain of looking at my son as he crumbled physically, the anguish at his irrationality.

Once he was out of the house in rehab or on the street meant scouring his room for drugs. Addicts are clever. I would find those dreaded little blue paper holders from the heroin. Hundreds of them, under the bed, under the rug, in the slots of his video games, under the insoles of his shoes; needles chucked behind bureaus; rolled dollar bills, burned spoons, empty water bottles, rubber hoses, rolled up belts, empty plastic Bic pens—the tools of his addiction. Filth all over. I had to remove all the remains of his drug use because inevitably I knew he would be back. I thought of starting a sideline to help pay for rehabs, offering to clean and de-drug rooms of kids in rehab.

We were lucky if, with or without insurance, he got a week in rehab, maybe. That is, if the addict didn't take off before then. Visiting days in rehabs were hard—taking the cigarettes, the blue raspberry milkshakes, losing so many bed pillows to rehabs. The depression of seeing the young children visiting their parents; the older people visiting their middle-aged children, was significant. I saw my future. I kept a rehab kit in my trunk with underwear and socks, comfortable clothes, the pillow, cigarettes, and the assorted toiletries.

Most police treated my son like the lowest scum on earth, and I was the scum's mother; they were nasty, brutal, and uncaring. The rare officers I met who were more gentle and supportive, who offered to drive my son to a detox, asked if I felt safe to have my son in the house or wanted him removed, who treated us both with dignity, seemed like saints.

The justice system was little help; it depended on the judge's experience with addicts. My son was never court-ordered to rehab or outpatient help. Once he was mandated to attend 90 NA meetings in 90 days; he did and had his longest recovery time up to that point, 97 days. I guess he needed to be mandated to a lifetime of meetings. He was sent to jail several times. Those visits were demeaning and pathetic. There were no meetings; no drug therapy; in jail. He learned to play a mean game of spades and make cheddar cheese soup from orange cheese twists, cinnamon lifesavers, and water. I am glad he did not learn worse. Each time he came out, he used within a week. Probation officers were useless.

I got my son into halfway houses when he got out of rehabs. He never lasted more than 2 weeks.

I took him in, but eventually I learned to put him out. I put him out in the middle of blizzards with nowhere to go. I had alarms put on my house. Not to keep burglars out but to keep my son out (and sometimes if he were home, to know when he got out again). I slept for years with a metal baseball bat under my bed in fear of my son and the people he brought into my house at night when I was asleep. I slept with my wallet under my pillow. Still I visited pawn shops to retrieve belongings my son had stolen. My son was an addict; my son knew the secrets of survival.

I always loved my son. I always knew that my son was a decent human being somewhere deep inside. I knew that I was not fighting my son; I was fighting for my son; I was fighting the monster Heroin who controlled my son.

He called on his 21st birthday from what, unbeknownst to us, was to be his final rehab. His buddies in his unit bought him a Krimpet and put 21 match stubs on for candles and sang to him. That was not the 21st birthday I imagined for my son, like so many other rites of passage. I cried and cried for my 21 year-old son and for myself that night, I was grateful to those newly recovering addicts who had cared enough to make him a celebration.

After that rehab, my son relapsed again when his best friend died of an overdose. Sometime after, he learned of a medication that might help him sustain recovery. He began on a program of Suboxone. In the beginning, he took 5 pills a day. No insurance covers this medicine. You could get 30 pills at a time. A six-day supply was \$285. Nor were the weekly doctor visits of \$90 covered by insurance. I was lucky that I could make some sacrifices, take on extra freelance work, but I had the wherewithal to find the money. So many parents cannot.

My son no longer needs the medication. In May of 2008, he graduated from college with honors. He is just beginning as a professional MMA fighter. My son is a wonderful and caring human being. My son has been through hell and fought so hard to make it back. My son has friends, my son just got married, and my son is happy and fulfilled. My son will always be an addict, and I will always love him.

From Zero to One

I am L.W. Nelson, mother who raised 6 children, grandmother of 8.

I am the parent voice of Samuel Nelson,
My 22 year-old son,
Who began using marijuana at 15,
Causing his life to almost be done.

I searched out a faith-based program, "The Bridge,"
With residential treatment allowed him to stay.
They gave him an educational structural program,
With prayer showed him the way.

I plead as other parents for funding to increase,
As some have passed on, for some new life has begun.
Now Samuel has a daughter as well as a son

Samuel will soon graduate from Philadelphia Community College.
Recovery Programs means for many giving positive knowledge.

So hear my voice and please feel my need.
Again, I am here for my son who is recovered and for others in addiction.
Didn't or couldn't, never had a chance for their help to plead.