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SOCIAL DEVELOPMENT COMMISSION

ALCOHOL, DRUGS AND POVERTY

PUBLIC HEARING

OCTOBER 13, 2010

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The above-entitled cause, taken before
KAREN RENEE, Court Reporter and Notary Public in and
for the State of Wisconsin, at Aurora Sinai Medical
Center, Rapkin Auditorium, 950 North 12th Street,
Milwaukee, Wisconsin, on October 13, 2010.

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TRANSCRIPT OF PROCEEDINGS

MR. CASANOVA: First of all, welcome, everyone. I'm Jim Casanova. I am the vice president for medical affairs here at Aurora Sinai. And I want to extend a very warm welcome to all of you. Actually, normally, George Hinton, who is our chief administrative officer, who I know, I know some, probably many of you know, would normally be here to welcome you. And he feels very passionate about this place and about this community and about Milwaukee. We think he probably has an adequate excuse for not being here today: he is on his honeymoon. He didn't actually just get married; he actually got married about a year ago. But apparently, this happens to chief administrative officers. Every time they've gotten together and tried to plan a honeymoon, it didn't work out, had to be rescheduled. And I think this time everybody just said, "George, leave town, go away." And so, otherwise, he would clearly be here.

This is Aurora Sinai Medical Center, and we are very happy to host this today. Just a couple things about us, although this isn't really about us, we're, as you know, I think the last

1 hospital standing, so to speak, in the downtown
2 area. There has been a lot of hospitals in the
3 downtown area. We are sort of the product of many
4 openings and closings and mergers over a long,
5 long time. Probably the very beginning of this
6 was Milwaukee Lutheran Hospital founded back in
7 the Civil War. And then there was Mt. Sinai
8 Hospital for a long period of time eventually, on
9 this physical location, which was founded in 1903.
10 So this has been sort of a long time in coming.

11 We have 380 or so licensed beds. We
12 have 2,000 employees here. And a lot of
13 concern -- and I'm fairly new to Aurora Sinai, but
14 a lot of concern which you feel here about the
15 community, frankly it's a fairly interesting
16 patient mix here also. We have now a lot of young
17 professionals and baby boomers who are buying
18 condos, maybe not so much in the last year or two,
19 but buying condos downtown. And then we also
20 have, living nearby, a large number of people who
21 are economically very disadvantaged who seek their
22 care here also. And it makes for an interesting
23 group of patients or people coming through the
24 facility.

25 We also have the normal services, which

1 I won't go through exactly. We have a very busy
2 emergency department, which is both good and bad
3 depending on who uses it and how it's used,
4 50,000-plus visits a year now in the emergency
5 department.

6 The Milwaukee Clinical Campus of the UW
7 School of Medicine and Public Health is really
8 centered here. Some, if I say so myself, just
9 incredibly good obstetric and women's health
10 services, and a sexual assault treatment center.

11 But we not -- the AODA issues and
12 poverty issues are not unknown to this place. And
13 just a couple of quick references here. We have a
14 case manager in our ED, in our emergency
15 department, and we have about 200 patients now who
16 come fairly frequently to have a plan in place
17 when they come. So we've kind of agreed, they've
18 agreed on various things because they had sort of,
19 apparently, a chronic need to come to us. And we
20 try to remedy that by referring them to other
21 places and getting them services, and so on. And
22 I asked our case manager, Chris, just for her
23 thoughts about this. And she actually looked at
24 the 20 people that use our emergency department
25 the most, there are way more than that, but, I

1 mean, the 20 that use the emergency department
2 here the most. Out of those 20, for 16 of them,
3 AODA and/or, and it's usually "and," behavioral
4 health issues were the primary thing driving their
5 use of this facility. And then she took those 16
6 and added up over the past year the number of ED
7 visits those 16 people had here, and it was 490.
8 So something is clearly wrong. We're trying very
9 hard to address this in multiple ways.

10 So, again, this is something, the topic
11 of your getting together here today, is something
12 very near and dear to this facility too.

13 Another thing that I am proud to say is
14 that we have been in the process of working with
15 Dr. Lisa Berger, who is out there in the audience,
16 from UWM to develop some web-based intervention.
17 Particularly, the one that she is working on now,
18 and then hopefully, we will have NIH funding
19 fairly soon, a web-based technology to expand
20 patient access: prescreening, brief intervention
21 and referral for treatment for drug abuse. So we
22 try to be involved.

23 I'm simply here to welcome you and also
24 to sort of say, you know, best wishes for the hour
25 or two or three, or whatever it is, as far as some

1 success in your discussions of this important
2 topic. Thank you.

3 (Applause.)

4 MR. CELATA: My name is Dave Celata.
5 I'm the policy and research manager of the Social
6 Development Commission. And on behalf of SDC, I
7 would like to thank you for attending this public
8 hearing.

9 Just to take a moment to talk about why
10 AODA and poverty. In June of 2010, SDC released a
11 comprehensive community needs assessment. We
12 asked a number of people through a number of
13 different means, what were the main issues in the
14 community that needed to be addressed. And we had
15 been going door to door and asking people in the
16 inner city, conducting a telephone survey, asking
17 major stakeholders, doing surveys of our staff,
18 which is now a number well over 400, and one
19 complaint in particular really caught our eye, and
20 that was the telephone survey.

21 We surveyed 420 Milwaukee County
22 residents, and there were three main sets of
23 questions, one dealt with trying to cobble the
24 poverty; the second dealing with barriers to
25 getting out of poverty for the individual; and the

1 third dealing with solutions for reducing poverty.

2 The first and the third really looked at
3 a macro approach: what causes poverty, and what
4 we can do to reduce poverty. For those,
5 respondents gave answers that centered around jobs
6 and education, which is no surprise. But when
7 respondents were asked to look at the individual
8 level, what keeps an individual or a family in
9 poverty and what are those barriers? All of a
10 sudden those focused. We didn't go around jobs
11 and education, poor economic conditions, these
12 larger issues that impact poverty, but it switched
13 to AODA and the poor family environment being the
14 main barriers to getting out of poverty. This
15 seemed to be a little bit of a disconnect where
16 there was a recognition that what causes poverty
17 and what can solve poverty, the major thing was
18 jobs and education. But when looking at what
19 keeps an individual in poverty, it changes to more
20 personal issues. And what we wanted to do is just
21 dive a little bit deeper into this. And in
22 keeping with the spirit of the Social Development
23 Commission, we really wanted you to have our
24 policies, our recommendations, our programs not
25 guided from an ivory tower, but instead asking

1 people in the community for their feedback, for
2 their input to then come to a better understanding
3 of the issue, a clearer understanding of what's
4 really going on. We thought well, let's have a
5 public hearing, let's pull people together, let's
6 talk about our experiences, let's talk about our
7 observations, about the ideas we can have to
8 address this, and to better understand the
9 relationship between alcohol and other drug abuse
10 and poverty, and understand in which direction
11 does the causality go: what causes what; does
12 poverty cause AODA, or does AODA really cause
13 poverty?

14 That is why we are here today. And
15 before we get to hear some opening testimony from
16 you all, before, we thought it would be a good
17 idea to have a couple of individuals that are
18 particularly well versed in this issue to talk.
19 The first individual we're going to bring forward
20 is Judge Derek Mosley. He is a municipal court
21 judge here in Milwaukee that will be talking a
22 little about the consequences of substance abuse
23 that he has observed in his years and how that
24 impacts the criminal justice system and how it
25 impacts the individual, also, impacts that he sees

1 for the larger community.

2 (Applause.)

3 JUDGE MOSLEY: Good evening. I'm
4 actually honored to be here today because
5 oftentimes, municipal courts are often overlooked.
6 Many people when I talk about the court system all
7 they think about is circuit court. But why I'm
8 happy that they invited me to be here, and Deborah
9 invited me to be here, is because the beautiful
10 part about municipal court is that it's a court
11 that the vast majority of citizens in Milwaukee
12 have contact with. Just so you know, contrary to
13 watching the news and thinking that everything bad
14 happens in the city -- I'm originally from
15 Chicago, and you want to talk about a city where
16 bad things have been happening, there are some bad
17 things happening there. We are doing okay. As a
18 statistical breakdown, only four percent of the
19 Milwaukee population commit the violent crimes,
20 four percent. Which you would never know that if
21 you read the newspaper and watch the news. It's a
22 pretty small number. But what I like of the
23 municipal court component of this is because
24 municipal court, we are the people's court. We're
25 the court where the most, vast majority of the

1 people come before us.

2 Who here has ever gotten a parking
3 ticket? All right, everybody. So, pretty much
4 everybody. You haven't? You haven't got one?
5 Can I get your name? But pretty much everybody
6 has gotten parking tickets before. So that's one
7 of the things we do. We do traffic cases, and we
8 do municipal ordinance violations. We do building
9 code, health code and zoning code violations. But
10 the vast majority of our cases fall in the group
11 with traffic and municipal ordinance violations,
12 so your retail thefts, your disorderly conducts,
13 your assault and batteries. Any time the City of
14 Milwaukee police officer writes a ticket, that
15 generally comes to us.

16 Why I'm happy about being here is
17 because I did a little research to figure out, you
18 know, the type of cases that we have and the
19 people that come to our court. And I told you
20 that we are the court where the vast majority have
21 contact with. But that being said, anywhere
22 between 35 and 40 percent of our cases involve
23 some type of AODA issue. And that is a huge
24 number, when you think about it, because of the
25 kind of court we told you about, you know, we do

1 parking and traffic. But we do the non-traffic
2 municipal ordinance violations, that is a large
3 number of cases. And so, the initial reaction is,
4 when you think about it, you think, "Well, if
5 you're doing traffic cases, and if you're doing --
6 what kind of cases are you doing that deal with
7 AODA issues?" And basically, everybody knows the
8 standard one: the operating while intoxicated.
9 We get a lot of those cases.

10 For those who don't know, first offense
11 operating while intoxicated is a civil matter in
12 Wisconsin. So if you are pulled over for
13 operating intoxicated and deemed to be guilty of
14 that, you come to municipal court; not the circuit
15 court. We're the only state in the country where
16 you actually, it's handled civilly; every other
17 state in the country handles it criminally. We
18 don't handle it criminally until your second
19 offense. And fortunately, the law has changed
20 dramatically coming up in January 2011 for how we
21 deal with our OWIs. But there is still, the first
22 one, is still with us in municipal court.

23 So you have the operating while
24 intoxicated, your public drinking, your underage
25 drinking, all of those kind of cases are the cases

1 you would expect to see some type of AODA
2 connection. But what people don't understand, of
3 those 30 percent, a vast majority of those cases
4 are your disorderly conducts. It's a very rare
5 situation where I'm doing a case with a disorderly
6 conduct and alcohol or drugs are not involved.

7 And it's actually infuriating to me as a
8 judge, because 90 percent of the things I do with
9 the disorderly conducts shouldn't be in front of
10 me. One, municipal court is ill-equipped to deal
11 with the issues. We do the best we can, but we
12 are a forfeiture-based system, which means if you
13 do something wrong, you get a ticket, the ticket
14 has a fine amount, you have a certain amount of
15 time to pay that fine. If you don't pay that
16 fine, you go to jail, period. And so we may not
17 be the best equipped, but we get the large number
18 of those cases, because -- for a number of
19 reasons. For instance, it's a lot easier for a
20 City of Milwaukee police officer to arrive on the
21 scene, okay, and see a guy laying out in the
22 street, and the other guy over on -- both are
23 drunk, it's easier for that officer to not deal
24 with it, but to write a ticket, hand it to both of
25 them, and then leave the scene. When you do an

1 arrest, you arrest that individual, you bring them
2 down to the station. They are fingerprinted. You
3 do a background check on them. They find out if
4 they are going to do a criminal charge or a civil
5 charge. And it becomes a series of hours that
6 you're with somebody. So we get a lot of those
7 tickets coming to us. And because we get those
8 tickets, we aren't the best equipped for that.

9 The problem that we have is that those
10 disorderly conducts are one thing; the assault and
11 batteries are another thing, but it's the clients
12 that we deal with, the defendants that we deal
13 with. Because we see them as the defendant that
14 committed this offense. But the problem is, they
15 are also fathers, and they are also husbands, and
16 they may be brothers, and what have you. So the
17 issue that we have, because we are that
18 forfeiture-based system, is as soon as you get
19 that ticket, you don't pay it, you go to jail.
20 And no one asks who is taking care of the kids.
21 No one asks who is taking care of the family. We
22 just send you to jail.

23 So I'm very happy that we have been
24 brought to this conversation because we do
25 contract with SDC. Because what a lot of people

1 don't understand outside in the community, when
2 you talk about municipal court, we also do a large
3 number of juvenile cases. I have a pretty -- and
4 Deborah can testify to this, I see juvenile cases
5 every other Tuesday. And every other Tuesday,
6 I'll have as few as 40 juveniles, and I could have
7 as many as 200, every other week. And that is
8 three branches doing that, so I'm not the only
9 branch doing that; all three of us are doing that.
10 So we have a large number of juveniles coming
11 through, and those juveniles have the same issues.

12 And here is the thing that we say all of
13 the time. I go to these conferences across the
14 state with other municipal court judges, and all I
15 hear all of the time is, "Oh, we have these
16 underage drinking parties. And we don't know what
17 to do with these parties and these juveniles -- "
18 and you probably saw on the news, like, Elm Grove
19 and Brookfield having these crazy policies where
20 the police come to the door, no one has to answer
21 the door or let them in. So the kids better not
22 try that in Milwaukee. First of all, that ain't
23 going to happen in Milwaukee. But that is a
24 separate issue. But my point is, that is not our
25 issue. Our underage, our drinking parties happen

1 in two locations basically: Marquette and UWM,
2 when they come into the city. And that's just
3 keeping it real, all right. But what we do have
4 that they don't have in the suburbs is, we have an
5 epidemic when it comes to marijuana. It's an
6 absolute epidemic.

7 I will sit in front of kids in court and
8 say, "Well, why are you smoking marijuana?" And
9 they have no concept of its illegality. They
10 understand they shouldn't do it, but literally say
11 to me, "Well, it's only weed." I mean, "It's only
12 weed, but it's also illegal." You know, and that
13 is our issue, that is our problem.

14 And fortunately, we are able to contract
15 with SDC, which does a lot, probably all of the
16 AODA treatment for the juveniles. Because that is
17 the group that just isn't serviced by us as a
18 municipal court.

19 I remember I started my whole realm into
20 the justice system at a prosecutor. And I'll
21 never forget that there was a time when I was a
22 prosecutor here in Milwaukee where we actually,
23 where we were in a position that we were sending
24 people to prison because that's where they could
25 get their best treatment. And that's -- at that

1 point, I knew I had to stop prosecuting. Because
2 it just came to the point where if I'm sitting
3 down there making a call to somebody and saying,
4 "Well, we got serious drug issues, serious drug
5 issues, and the best opportunity for him to get
6 into treatment now is to have him incarcerated,"
7 there is something seriously wrong.

8 So I want to thank you all for letting a
9 judge come and let you guys know that we on that
10 side of the fence understand the issue. We deal
11 with it on a daily basis. And we are doing the
12 best we can with the tools that we have. We are
13 fortunate to be able to contract with groups like
14 SDC that can handle our juvenile population. But
15 as far as resources are concerned, we don't have a
16 lot of resources. I have defendants in my court
17 that have 30, 40, 50 pending cases. The cases are
18 the same issues: their drug issues; their alcohol
19 issue, they may be homeless. But they all tie in
20 together and they keep getting those tickets.

21 I have a guy, like clockwork, and he
22 should be coming soon, soon as that first freeze
23 comes, he goes to Wisconsin Avenue and throws a
24 brick right through the Dunkin' Donuts window and
25 sits there and waits for the police to come.

1 And so, we have to figure out a better
2 way to handle this issue. And that is why, when I
3 came here, I was happy and excited. But I wanted
4 to speak to you all and let you guys know that we
5 are there, we are in the fight with you. And
6 whatever I can do to help you, whatever services
7 that you have that you might be able to help us,
8 it would be greatly appreciated. Thank you for
9 your time.

10 (Applause.)

11 MR. CELATA: Thank you, Judge Mosley,
12 very insightful.

13 Next, I'd like to invite Pete Carlson.
14 Pete works at Aurora, he runs the psychiatric
15 hospital and Behavioral Health Services. And Pete
16 will be able to give us great insight when it
17 comes to case management, but then also looking at
18 the issue from a practitioner's standpoint.

19 Pete.

20 (Applause.)

21 MR. CARLSON: Thank you. And I want to
22 be the first to say, and I'm not an expert in all
23 of the connections between poverty and AODA, but I
24 certainly have a perspective on it and see it, you
25 know, in the work that I do on a daily basis.

1 Thank you for inviting me, David. I am
2 Pete Carlson. I am the president for Behavioral
3 Health for the Aurora system. So our dealing
4 with, you know, really all of the behavioral
5 health issues all the way from Kenosha up to,
6 really the Upper Peninsula of Michigan.

7 I want to just give you a little bit of
8 an overview about the services that we provide at
9 Aurora related to the addiction medicine aspect of
10 this and give you an idea of sort of the size and
11 the scope. Because I really look at us, and I see
12 us as, you know, we're part of the solution, but
13 we're also part of the problem. There is no
14 question about that.

15 So I want to just give you some
16 information about us, and then I'll just give you
17 some information about some of the recent trends
18 in addiction, the treatments, some of the things
19 that we're seeing, you know, here in Southeastern
20 Wisconsin and the Milwaukee area. And then from
21 there, there are I think some things that we have
22 to be hopeful about, and I want to share some of
23 those with you as well.

24 So I have a few slides that will outline
25 just a couple of the issues related to, you know,

1 what I found through the SAMHSA website just by
2 way of getting some information to make the
3 connection for today's discussion.

4 Regarding the Aurora Behavioral Health
5 Services. We are the division within Aurora that
6 manages all of the behavioral health services for
7 the entire footprint of the area. We employ 450,
8 about 450 caregivers at the freestanding Aurora
9 Psychiatric Hospital. And we've also got two
10 inpatient units in general medical hospitals: one
11 down at St. Luke's South Shore; and one up in
12 Sheboygan. And then we also provide outpatient
13 services.

14 We've got 21 outpatient clinics within
15 the Aurora footprint. And within those clinics in
16 the inpatient units in the various hospitals, last
17 year we provided in excess of 170,000 professional
18 visits to patients. And there were somewhere in
19 the neighborhood of 25,000, or slightly more,
20 individually unique patients that received
21 services from us. So the size of the
22 organization, given sort of the financial standing
23 of how behavioral health generally does, you know,
24 I think is really a testament to the commitment
25 that Aurora has made to helping the community and

1 all of us solve some of these issues.

2 We do offer the only full continuum of
3 substance abuse services within the Southeastern
4 Wisconsin area. So there are other providers, but
5 very few provide the full continuum of care.
6 Generally, for us, most of that is done out at
7 Aurora Psychiatric Hospital, but there are
8 satellite programs related to AODA at some of our
9 outpatient clinics.

10 The services that we provide include:
11 prevention; education; detoxification; inpatient
12 stabilization; residential treatment, which would
13 be a 24-hour type stay but with less nursing care;
14 partial hospitalization programs, or day
15 treatment, people come in during the day and leave
16 in the evening; intensive outpatient programs,
17 much shorter shots of treatment during the week;
18 family therapy as well; and aftercare support
19 groups. We also, on the campus out at Aurora
20 Psych, provide some transitional living quarters,
21 which we rent to patients if they need a place to
22 sort of transition back to -- you know, one of the
23 difficulties, and I'll talk about it in relation
24 to poverty is, if you're in treatment, and you're
25 going back to a setting that has a lot of using

1 going on, and things like that, you know, the
2 likelihood of you being able to stay clean and
3 sober goes down dramatically. So I think that
4 transition is an important piece.

5 We offer some additional specialty
6 programs. One is opiate recovery. Maybe some of
7 you have heard of the medication Suboxone, which
8 is, you know, we've actually heard about it a
9 number of times in several of, you know, the
10 deaths related to overdose recently that were in
11 the paper.

12 And then we also run an adolescent
13 intensive outpatient program. So again, really
14 everything from a child to older adults.

15 The other thing I'm going to just
16 mention, because it actually is something that
17 most of the other providers don't provide, and we
18 see a real value in it, and that is, having the
19 emergency department at all of the medical
20 centers, having either psychiatric nurses or
21 psychiatric social workers working alongside the
22 ER physicians and nurses. And really what they're
23 doing is managing the behavioral health cases.
24 They're working with transferring those patients
25 around, whether it's to a medical floor, to

1 another facility, back to one of our facilities
2 out at the Mental Health Complex, but in general,
3 dealing with sort of the connection points with
4 public mental health systems, which, you know, can
5 be a very complicated, confusing process. And so
6 I think many people get lost through the cracks
7 because of that, you know. There are 14 hospitals
8 in Aurora Healthcare. All of them have this sort
9 of service in their emergency department as well
10 as on their medical floors. So if somebody comes
11 in, you know, maybe they're intoxicated, have some
12 sort of an illness related to that, they end up in
13 a medical bed. We have people that will then go
14 see those folks in the medical bed. It's actually
15 kind of saying something. Because the reality is
16 in healthcare today is that there are few to none
17 psychiatrists that are really interested in doing
18 these inpatient consultations, you know. It has
19 to do with reimbursement, it has to do with
20 convenience, it has to do with their whole other
21 practice. So the fact that Aurora picked that
22 up -- and last year we did in excess on the
23 medical floors or in our emergency department,
24 over 15,000 evaluations. So we're clearly seeing
25 a lot of people, and, you know, recognize that

1 we're just seeing really a sliver of the folks.

2 I'm going to move on to just a few
3 slides that will -- question is, how do I --

4 I had a little research done, and
5 actually, Tracy helped me out with this, and came
6 up with current, just some of the current trends.
7 And I think these are the things. I was looking
8 for things that were, like, within the last year
9 or six months. But there was a 2009 Monitoring
10 the Future survey, which was looking at the use
11 of, the nonmedical use of Vicodin and OxyContin
12 and the increase over the last five years for 10th
13 graders and the usage among 8th and 12th graders,
14 which remained unchanged.

15 So one of the things that we see a lot
16 of today -- and I appreciate the comment about
17 marijuana, and that that is still the most
18 prevalent drug out there, but one of the things
19 that has really been, just seen a tremendous spike
20 in the last year or so, is the use of opiates
21 recreationally, okay, which really led to then
22 that Suboxone program that I mentioned.

23 In the ten years between 1998 and 2008,
24 substance abuse treatment admissions reporting
25 primary pain reliever abuse increased from 18,000

1 in 1998 to approximately 105,000 in 2008. That is
2 a five-fold, six-fold increase in the number of
3 people that are using pain relievers.

4 In 2008, nonmedical use of pain
5 relievers among the population age 12 or older in
6 the United States was the second highest in
7 prevalence after marijuana. And that is exactly
8 what we see as well.

9 2008, National Survey on Drug Use and
10 Health reported that approximately 3.1 million
11 persons age 12 to 25 have used an over-the-counter
12 cough and cold medicine to get high. If you go to
13 Walgreens to get, you know, the decongestant-type
14 medicines, now you have to actually give your
15 driver's license to get the real medicine.
16 Otherwise, you get a scaled-down version of that.
17 And, you know, the reason is because people are
18 using that then and turning it into meth.

19 Some of the statistics related to
20 substance abuse and poverty. Combined
21 2006-to-2008 data indicates that 3.7 million
22 persons age 12 or older living in poverty were in
23 need of substance use treatment in the past year.
24 And of that 3.7 million people, 17.9 actually
25 received treatment at a specific facility for this

1 particular time period.

2 And then the prevalence of that, you
3 know, is really higher in males; almost twice as
4 high than in their female counterparts that have
5 been in need of substance use, yet they get the
6 treatment at about the same rate.

7 Among persons living in poverty, those
8 aged 18 to 25 had the highest rate of past
9 treatment, past year treatment needs, so in the
10 past year, they did need treatment at some point.
11 This age group had the lowest rate of treatment
12 received. So it's the highest group of need; it's
13 the lowest group that actually gets treatment.

14 I posted in the report that I thought
15 really, you know, that said a lot. The
16 difficulties faced by persons living in poverty,
17 however, may be even more formidable as they lack
18 health insurance coverage. Considering that the
19 number of people living in poverty have increased
20 in three consecutive years, reaching a near record
21 high of 39.8 million in 2008. Understanding the
22 gap between service needs and services received
23 help policymakers and program managers ensure the
24 gap does not widen in the future. That is pretty
25 stark stuff.

1 As it relates to employment, substance
2 abuse and employment rates. The substance
3 dependence or abuse or associated with current
4 employment status in 2009, we see a higher
5 percentage of unemployed adults aged 18 and over
6 classified with either chemical dependency or
7 abuse, 16.6 percent. Those that were full-time
8 employed had about a 9.6 percent rate; and those
9 that had part-time employment had an 11.2 percent
10 rate. So more time on their hands, more potential
11 for issues.

12 One of the things that, you know,
13 really, in my opinion, I think plays -- and it's
14 sort of the chicken and the egg, what comes first?
15 You know, is it the substance abuse that brings on
16 the poverty, or is it that poverty brings on the
17 substance abuse? I mean, I can't tell you what
18 the answer to that is.

19 You know, I have some opinions about
20 substance abuse. You know, it's an insidious,
21 chronic condition that really crosses all
22 socioeconomic boundaries without regard. I mean,
23 it doesn't matter if you're a millionaire, you
24 still have as good a shot as anybody of having a
25 problem. Where I see the difference is that when,

1 you know, when we are looking at a group of folks
2 that are in the throes of poverty and that also
3 have the substance abuse problem, it's the cycle
4 that they never get out of. So I'm not just
5 saying that if they didn't have this problem they
6 would immediately get out of that cycle, but
7 clearly, when they have the problem, the cycle is
8 a huge issue.

9 Let's see, resources such as money,
10 education and underemployment opportunities, which
11 could be used for finding out if poverty areas
12 that utilize to chase the next high or are
13 squandered accordingly. So I just feel like, you
14 know, from my point of view, you're not -- if you
15 have means or resources, you're not immune to
16 this. But if you are somebody that is already
17 living in poverty, the likelihood of being able to
18 get out with a substance abuse problem, I think is
19 extremely difficult.

20 Lack of insurance benefits. From my
21 point of view, there is this maze of barriers that
22 people have to work through. Lack of insurance
23 benefits, another barrier frequently faced by
24 people in poverty is the absence of insurance
25 benefits for treatment of substance abuse and

1 mental disorders. I know I said in the beginning,
2 we're part of the problem too. And part of that
3 is because you can't treat everybody that needs
4 treatment. There are -- it's sort of like keeping
5 it real, there are certain aspects to running the
6 program, and things like that, you have to have --
7 you need to be able to keep the lights on and the
8 doors open to keep the program going. So because
9 we have this high proportion of folks that have
10 this need that are uninsured, you see a shortage
11 of programs because you couldn't stay alive if you
12 weren't able to work in a situation where you can
13 pay for what you're doing. The cost of running
14 traditional programs is prohibitive. So we've got
15 to start looking at, are there some other things
16 that we can be doing?

17 Patients who do not have access to
18 insurance have difficulty finding ongoing services
19 and treatment. And, you know, just sort of as an
20 example, if you're in the hospital, and you end up
21 in a general medical hospital, you get detoxed,
22 you know, you're going to get resources to go to
23 follow up. But the likelihood of people actually
24 following up is very low. You know, in relation
25 to if you are in a specialty treatment center,

1 you're connected to a group of people, you follow
2 that continuum of care. The likelihood of
3 sticking is much higher.

4 Gaps in Medicaid coverage restricting
5 availability in programs and services. There are
6 certain Medicaid plans that cover certain things
7 and others that don't. And that is clearly a
8 problem, in my opinion. You know, many times
9 you've got, there are certain Medicaid plans that
10 will provide benefits for a psychiatrist but not
11 for a drug and alcohol abuse counselor. So now,
12 how do we reconcile that? First of all, there are
13 very few psychiatrists that will willingly take a
14 patient if they don't have a therapist that they
15 can send the patient to work with. The same thing
16 with substance abuse. They are not going to take
17 a patient on that they can't refer out to a
18 substance abuse therapist. Similarly, many of the
19 plans don't include benefits for residential or
20 transitional care. I mean, the way it works today
21 in healthcare is that, you come in, if you need to
22 be detoxed, first of all, it's generally alcohol,
23 that's about the only thing you're going to be
24 detoxed from, you know, in the hospital setting.
25 If you're talking cocaine, if you are talking

1 about opiates, you're not going to be detoxed in
2 the hospital. I mean, the medical criteria is not
3 there. Even if you have insurance, they wouldn't
4 pay for it. But one thing the benefit, a typical
5 HMO Medicaid plan doesn't have is something for
6 residential or transitional care. So if you're
7 moving from inpatient, and you have a two-day
8 stay, and now you're being discharged, if you
9 don't have the benefits of the next level of care,
10 where do you go? And you may need a 24-hour
11 setting because you need those supportive
12 services, but the reality is, your insurance isn't
13 going to pay for it. So we set you up with group,
14 we set you up with support groups or AA, and it
15 becomes much more, I think, the patient's
16 responsibility to follow through with the
17 treatment. And you know, not that they should
18 have shouldn't have the responsibility; they
19 should. But we can help facilitate that by
20 keeping them connected in their same group.

21 Similarly, many people don't even
22 realize it, but the HMO and the Medicaid
23 pharmaceutical formularies are different. So, you
24 know, if you're going to get a medication, you may
25 not, if you're on, you know, a specific Medicaid

1 plan, you may not qualify for certain medications.
2 That may not be carried under the formula, and you
3 may have to try something else. That may not be a
4 big deal, or it may. It's just one of those
5 things. There are, you know, I think as the
6 research continues and more and more medications
7 come out, it becomes a bigger deal.

8 Psychosocial barriers to access in your
9 participating and treatment, I think these are
10 significant. And this is certainly not an
11 all-inclusive list, but, you know, one of the
12 areas that we struggle with on the provider's side
13 tremendously is getting patients to come in for
14 their appointments. You know, and typically there
15 are so many psychosocial issues going on that it's
16 not at all uncommon that somebody can't make it to
17 an appointment. You know, the real sort of
18 problem area, in my opinion, is that there are
19 times when the patient is ready for the treatment
20 but we can't find treatment for the patient. And
21 sometimes there is treatment for the patient, but
22 the patient doesn't have the motivation to go. So
23 how do we sort of bridge that gap? It can be a
24 significant issue to maintain the path to
25 recovery.

1 So these barriers, if you don't have a
2 supportive environment to return to, the
3 likelihood of using again certainly goes up. The
4 inability to follow up with aftercare and support
5 group services, you know, to stay connected with
6 the recovery and community, the ability to stay
7 connected to the community.

8 That lack of treatment programs and
9 providers is a national problem, and it is not
10 just unique to Milwaukee. There is a shortage of
11 qualified providers, including addiction
12 psychiatrists in particular, who are extremely
13 difficult to find, as well as masters, prepared
14 therapists that provide substance abuse
15 counseling. You know, you would think that
16 wouldn't be the case, but it is. Shortage of
17 programs and services available in underserved
18 areas. You know, so if we can't bring the patient
19 to the treatment, we bring the treatment to the
20 patient. So what you will find is that many of
21 the services, it's hopping in the car, getting on
22 the bus and going out to Wauwatosa, or someplace
23 like that. I think that's clearly something that
24 needs to be looked at.

25 Implementation of -- so that is all sort

1 of the bad news, now here's kind of what I think
2 is the good news:

3 Implementation of mental health parity.
4 As the implementation of mental health parity
5 statutes continue to move forward, more behavioral
6 health programs and services become available to
7 the public. You know, in the past, if you had an
8 insurance plan, a commercial insurance plan in the
9 state of Wisconsin, you generally had \$5,000 or
10 \$7,000 worth of treatment benefits. That was it.
11 Medicaid plans actually do have a fair amount. I
12 mean, that's essentially unlimited benefits, so it
13 doesn't apply to that. But the issue that, you
14 know, you see is that the patients that have the,
15 actually that carry the insurance run out of
16 insurance, you know, very quickly if they are in a
17 hospital-type setting, or if it's a hospital
18 program. And then, you know, essentially, the
19 hospital in the end is left holding the bag.

20 At the end of, I think it was, 2008, we
21 did a sort of a look at, you know, out at Aurora
22 Psychiatric Hospital, of the patients that are
23 admitted to the hospital when the insurance
24 stopped paying, we literally would collect five
25 cents on the dollar. I mean, that's the reality.

1 And what we've seen, this parity that has
2 partially been in effect this year, and it will
3 only get more enhanced as we move forward over the
4 course of the next couple years. I think what you
5 will see is that, you know, those days that have
6 been written off by the facility will now begin to
7 be paid for. And because there are more dollars
8 there and people can run these programs without
9 losing money, the likelihood of other programs
10 developing and being established is very good, I
11 think.

12 Implementation of healthcare reform
13 legislation. I mean, I think for the substance
14 abuse patients and the behavioral health in
15 general, this is going to increase access to
16 healthcare coverage. So there will be many less
17 uninsured people that will sort of get caught in
18 this, you know, "how do I get into treatment"
19 spiral. It will encourage the integration of
20 medical and behavioral healthcare, which is where
21 we need to get in this country. So that as you
22 are going to see your primary care physician, if
23 you have behavioral health people, you know, he
24 knows what's going on, or she knows what's going
25 on. They're communicating with the substance

1 abuse people and making sure that any of the
2 issues that, you know, they may have physically,
3 if they're being affected by their behavioral
4 health problems, that we're certainly making
5 treatments towards those particular issues. It's
6 going to expand primary care and behavioral health
7 services offered at the community health centers.
8 And I think, you know, that's another area where
9 today they're essentially at capacity.

10 There is, I want to say, somewhere in
11 the neighborhood of \$11 billion out there on the
12 horizon for federally-qualified health centers.
13 And I do believe you will see an improvement or an
14 enhancement in access at some of the community
15 health centers.

16 Right now, behavioral health has the
17 attention of the media and the politicians. You
18 know, all of the issues going on out at the
19 Milwaukee County Mental Health Complex keep
20 behavioral health issues in the, sort of, the
21 limelight. Now, in that particular case, it's not
22 for a good reason, but I can tell you that because
23 of the election and because of the politics going
24 on with that whole thing, you're going to continue
25 to see this behavioral health, all these

1 behavioral health issues in the media for the
2 next, well, at least until the election, before
3 that kind of goes away. It's going to continue to
4 have legs and stay out there.

5 And then the other thing is, there is
6 the Public Policy Forum, which is the thinktank in
7 Milwaukee, had a study chartered by the Milwaukee
8 Healthcare Partnership Group, which is a
9 collection of the CEOs of the large healthcare
10 systems within the Milwaukee area, and the CEOs
11 for the federally qualified health centers. And,
12 you know, essentially, what this study did, they
13 studied the adult mental health delivery system.
14 And they looked at many of the issues that are
15 confronting not only people's substance abuse
16 problems, but people's mental health problems. You
17 know, I think what will come out of that study in
18 the end, and this study went on for about a year,
19 and really they did an excellent job of connecting
20 with all of the appropriate stakeholders, I think
21 what this is going to do is, it's going to push
22 some additional resources to the county for mental
23 health services. The county is, it's going to
24 push for additional resources in their outpatient
25 program, with case management, which, again, I

1 think are all very important to, you know, helping
2 to mitigate this problem. And I think it's also
3 going to push more public/private partnerships.

4 You know, one of the things, in my
5 opinion, is that, you know, we're unique in
6 Wisconsin in having the County Mental Health
7 Complex. In most states, there isn't county
8 mental health facilities; you have state
9 facilities, but not county facilities. And that
10 is a significant difference for us. And I think
11 what needs to happen, in my opinion, is that, you
12 know, the county needs to get out of the
13 providing-care business. And this actually came
14 out in their master plan, I want to say it was 15
15 years ago, to get into this, because it is so
16 expensive to provide the care. You know, they can
17 do it much cheaper by contracting with private
18 outside vendors. Now, there are issues that
19 obviously would have to get worked out for that,
20 but I think that this is really going to sort of
21 push that on down the road. I think that is a
22 hugely important thing to addressing at least some
23 aspects of this problem.

24 Current substance abuse research and
25 studies continue to relate to new medications and

1 approaches to substance abuse treatment. So to my
2 comments earlier about formularies and as new
3 medicines come out that are effective, how do we
4 make sure that not everybody has access to them?

5 And then, hope related to genetics and
6 the potential for new treatment approaches for
7 preventative measures based upon somebody's
8 genetic makeup. So, if because of the genetic
9 work that is being done now, we can identify that,
10 you know, somebody, an individual is prone to have
11 a problem with addiction, are there some things we
12 can do up front to prevent that?

13 At Aurora Psychiatric Hospital last
14 year, we celebrated our 125th anniversary. I was
15 sort of laughing with the medical directors. They
16 had gone back and done some research about, you
17 know, the early days of psychiatric care and what
18 the treatments were like. And, you know, there
19 are some pretty amazing stuff that you would look
20 at now and you would say, "God, how barbaric."
21 And, you know, I mean, people with, you know,
22 malaria, I mean, if you can believe that, I mean,
23 actually, you would inject somebody with malaria,
24 they would run a fever, and that would help to
25 break their psychosis. I mean, it sounds

1 barbaric. You know, but think about 100 years ago
2 when there was nothing. There was no way to treat
3 people. They didn't understand any of this. What
4 are we going to do? And I was saying to Tony
5 Meyer, our medical director, I said, "You know,
6 Tony, 50 years from now, they are going to be
7 talking about us. And they are going to be
8 saying, 'You know, I can't believe the medicines
9 they were putting these people on instead of doing
10 this genetic stuff and preventing the problems
11 from occurring in the first place.'"

12 So I do -- I think that is my last
13 slide -- I do think that, you know, there is hope
14 here. It's been -- and I've been doing this for
15 25 years, and I can tell you that it's hard to see
16 the progress that we've made, but we've made
17 tremendous progress over the years. Not to say
18 there isn't a long way to go, because there is,
19 but we actually have, I think, made some pretty
20 significant steps. And I do feel, even though
21 these problems are real, and, you know, it's going
22 to take some time to drill into this and make a
23 difference, in my opinion, I do see some very
24 positive things down the road.

25 So I will stop there, and I also want to

1 just welcome people, and, you know, I look forward
2 to hearing some of the public testimony, and wish
3 you well. Thank you.

4 (Applause.)

5 MR. CELATA: I'd just like to thank both
6 of our opening speakers for their insight,
7 extremely valuable perspectives. I am not going
8 to discount their comments at all, but I think the
9 interesting things that come out of public
10 hearings is hearing from the public. So with
11 that, I call SDC's chair, Mr. Fred Royal, to begin
12 the public-comment period.

13 (Applause.)

14 MR. ROYAL: As Dave Celata alluded to,
15 this is the most valuable portion of this public
16 hearing, to get your testimony, your input on how
17 we craft the policies that affect our community.

18 We do have one housekeeping item that we
19 have to have Attorney Hall speak to first, and
20 that's our statutory provisions for public
21 housing, or public hearings. So, Attorney Hall.

22 MR. HALL: Thank you. This is a public
23 hearing held by the Community Relations Social
24 Development Commission, pursuant to Wisconsin
25 Statutes Section 66.01253(C)4. The testimony and

1 information gathered may be used by SDC and
2 related parties to assist in efforts to analyze
3 the issues, recommend solutions, develop policy,
4 promote public education, or otherwise, in
5 connection with responding to the concerns
6 addressed at this hearing.

7 By providing oral or written testimony,
8 or appearing at the hearing, you provide
9 authorization and consent to SDC for such use.

10 MR. ROYAL: Thank you.

11 And we'll start the testimony off with
12 the first person who signed up. That would be
13 No. 1.

14 MS. SEGAL: Hello, my name is Suzan
15 Segal. I also work for SDC in youth and family
16 development as an AODA therapist. I'm also a
17 mental health therapist. I've been a parent, I've
18 been a child of the community and a member of the
19 community as well.

20 One of the things I see most importantly
21 that perpetuates poverty is the fact that people
22 forget the connection with family at times and how
23 strongly the family is impacted and how much the
24 family may be a part of the solution as well as a
25 part of the problem.

1 Part of what's important is to
2 re-empower the community and the individuals to be
3 aware of their resources. Also, for us as
4 providers, on whatever level we are, to be able to
5 be more sensitive, to be more capable, to be more
6 culturally competent, to be trauma informed so
7 that at all levels of access, regardless of what
8 level of education or training somebody has, that
9 we make it a welcoming and an open place for
10 people to look for solutions, and to find their
11 wealth and their prosperity as they transform from
12 poverty and create change in their lives.

13 Addiction creates barriers, but recovery
14 creates capacity for growth. Thank you.

15 MR. ROYAL: Thank you.

16 And I'm sure that anyone who knows, who
17 has gone through an addiction, that the whole
18 embarrassment of coming forth and admitting as the
19 first step, is one of the hardest. So, I
20 wholeheartedly agree with the comments, that you
21 have to have the local environment.

22 Our next person is No. 2 on the list.

23 MR. SHIPIN: I would like to actually
24 address the issue that, you know, the lack of
25 something in our community that is actually aiming

1 towards drug abuse, poverty and alcohol. Me,
2 being a former abuser myself, you know, and going
3 through the court system, you know, as a young
4 man, to -- I'm going to actually pass these around
5 -- and to me now, to my today, success is
6 something I involve myself in.

7 (Applause.)

8 And being that, you know, I went through
9 the prison system, and, you know, now I'm on the
10 front cover doing something positive.

11 You know, when I went to court, every
12 time I went to court, they had me on TV. I was
13 this guy. I was that guy. I was disturbed. And
14 in a way, I was. But, you know, now that I'm
15 trying to strive to better myself, I want to be
16 able to spread that to the younger youth. Yes,
17 I've been -- even had to be strapped down to a
18 bed, injected before, because I didn't know how to
19 control myself. I've been through the worst of
20 it.

21 And a lot of these guys just see the
22 hand in front of their face. They don't see what
23 can surpass their hand. They are just looking
24 like this every day. They are not looking to see
25 everything around them. And that's what I want to

1 try and strive for and help these young people and
2 mentor these young people, you know, to stop them
3 from using alcohol and stop them from, you know,
4 not managing their money right.

5 But you can easily teach a child how to,
6 you know, sell drugs, why can't you teach him how
7 to work? Why you can't teach them how to dress
8 right? Some of these guys don't even know how to
9 tie a tie. You know, you can teach them how to
10 sell dope, but you can't teach them how to do
11 anything else? You can teach them how to pick up
12 a gun. You can teach them how to sell dope,
13 marijuana, whatever they sell, because they can
14 sell anything now. They are coming out with a new
15 drug called K2, and that's like marijuana, and
16 that's legal. You know, they're selling that now.
17 You know, so if we want to stop this, we gotta
18 start now and produce better individuals because I
19 want to allow the community -- they are just
20 kicking it. They ain't reading. They ain't
21 trying to do nothing that is supposed to help
22 them. Yeah, it's a safe and sound place, but they
23 are just kicking it. They are just playing cool
24 video games. They can do that at home. Why can't
25 we help them and strive for the better things that

1 they could be doing with their life instead of
2 sitting there playing games? Life ain't games.
3 We all know that, we are adults. It ain't easy.
4 So teach them at a younger age that life ain't fun
5 and games, then when they get older, life won't be
6 fun and games.

7 MR. ROYAL: Thank you.

8 (Applause.)

9 MR. ROYAL: Our third speaker.

10 MR. RICHARDSON: Basically, hit it right
11 on the head. Basically, poverty is related to
12 drug use. So if you just try and think back of
13 how the United States was basically founded, some
14 of the things that's going on here, in the Great
15 Depression, and how you had the white America, now
16 there are soup kitchens. Speed it up to 1975, how
17 they show the face of African Americans to see how
18 the media plays a big important part in
19 privatizing black America.

20 And so in the middle of 1986, 1987, I
21 graduated from high school, so basically, I was
22 faced with the crack epidemic for years. And so,
23 they called it inflation back then. Well, one
24 thing about me coming out of high school that I
25 noticed was A.O. Smith moving out of town, Briggs

1 & Stratton moving, and the next thing you know,
2 it's going to influx crack cocaine coming to the
3 community, the urban community.

4 And so, when the crack epidemic hit the
5 urban community, it hit like a tsunami and
6 devastated families and devastated me because I
7 got caught up in that. So instead of me going to
8 work somewhere, I picked up guns and drugs. And I
9 started getting involved in that type of thing.

10 And one thing about it is, when you are
11 dealing with anger, when you are dealing with
12 hopelessness, when you are dealing with violent
13 mental factors, that plays an important part.

14 When we take programs or cut programs
15 out of the schools, like wood shop or metal shop,
16 for kids to learn different trade skills, so then
17 there you go. I mean, those are the types of
18 barriers that we're faced with. So we have to
19 really have a paradise ship without sinking, to
20 step out of the box and come meet the people where
21 they are at.

22 Okay, so one thing about any addiction,
23 it will affect anyone. It doesn't matter what
24 race you're talking.

25 Some of the goals that we should focus

1 on is helping the people that's in poverty to
2 acquire work. That means training, educating,
3 teach them, like Mr. Shipin said, on how to budget
4 okay, and come out of the comfort zone and not
5 stereotype people, okay.

6 And so, like Mr. Mosley said, a lot of
7 these men, I'm working with them, I've been an
8 alcohol counselor for the last 11 years, and with
9 the prison reentry, and a lot of these men feel
10 less than a man because they don't have
11 employment. One of the barriers that they are
12 faced with is felony convictions, okay. A lot of
13 these men that I've worked with have spent some
14 time in prison, but what happens is, people still
15 look at their past history. A lot of these guys,
16 I mean, write better than you or I can, are very
17 talented in a lot of different areas, but America
18 needs to give these people a chance. Even with
19 the incarceration rate of the black males, in
20 Wisconsin, we're at 50 percent high incarceration
21 rate for nonviolent crimes. These are some of the
22 things I've read, studies from Dr. Devine at UWM.

23 So, I mean, this is not just a poverty
24 problem, it's a United States problem. So we
25 really need to come together and come up with a

1 strategic plan on what we need to do, because
2 poverty is not going to go anywhere. The key
3 thing is we have to get out of our comfort zone
4 and do something about it. Thank you.

5 MR. ROYAL: Could you state your name
6 for the record, please?

7 MR. RICHARDSON: Clint Richardson.

8 MR. ROYAL: Thank you.

9 MR. RICHARDSON: You're welcome, sir.
10 (Applause.)

11 MS. DEVINE: Hi, everyone, my name is
12 Catalyn Devine. And I'm a Jesuit volunteer. I
13 just graduated from Georgetown University in
14 Maine. This is my first time to the Midwest and
15 to Milwaukee. I've been here for two months so
16 far. And my placement agency is as a community
17 organizer element of a nonprofit here in
18 Milwaukee.

19 So what I do is I actually go into the
20 low-income housing areas in Milwaukee and to job
21 resource centers. And right off the bat, I knew
22 something was a little off. Just driving through
23 Milwaukee and noticing all of the alcohol
24 advertising that I have never seen, just the
25 extent of it. And where they were placed, I feel

1 like so many of them are concentrated in the poor
2 neighborhoods of Milwaukee. I really think that
3 is a problem.

4 It's almost like these kids don't have a
5 chance, they have to go out of their way to stay
6 sober. You go into convenience stores and what do
7 you see first? Liquor. You have to go all the
8 way to the back of the store to get the food, like
9 the bananas and real nutrition. So I really just
10 noticed that.

11 And also, something I've never seen
12 before, were these huge cans of beer that I have
13 termed "mutant" cans. We don't have those in
14 Pennsylvania. I've never seen like an unhealthy
15 amount to encourage someone to drink at once. So
16 from my perspective is, just as an outsider and as
17 a recently-graduated college student, a change of
18 thinking needs to occur. Marketing really should
19 be, I think, regulated a little more. And, you
20 know, just really be mindful, and, you know, just
21 -- even the signs for the grocery stores say
22 "liquor" first, and they don't say "food." They
23 say "groceries" at the very bottom, but mostly it
24 says "liquor" I mean, these kids don't have a
25 chance, and I just really wanted you to know the

1 observation that I made, so. Thank you.

2 (Applause.)

3 MR. ROYAL: Thank you.

4 MS. FEINBERG: I'm Dr. Francine
5 Feinberg. I am the executive director of Meta
6 House. I have some prepared notes because I tend
7 to ramble.

8 But I want to say I also came here from
9 New York, and I had the exact same reaction:
10 "What in the world is going on here?" And this
11 was, you know, 30 years ago, 35 years ago, I was
12 quite shocked.

13 To press you a little more, I don't know
14 if people are aware of it, but Milwaukee County
15 has the highest rate of persons with substance
16 abuse facilities of any urban area in the entire
17 country. And to make that worse, we have the
18 second highest treatment gap in the entire
19 country. And I think that says a lot about what's
20 going on here.

21 I'm going to go through the talk that I
22 have, but if I have time, I'd like to talk a
23 little bit about what Mr. Carlson talked about in
24 terms of his perspective on healthcare reform,
25 because I have a totally opposite perspective.

1 What he sees as a bright light, I do not. So if
2 we have time, I'd like to talk about that.

3 Meta House is involved in a pilot right
4 now with child welfare, and they are targeting
5 moms in particular to talk about this, and
6 pregnant women. In the eight months that we have
7 been operating, there are only two hospitals
8 referring. We have had over 150 referrals. So we
9 have a serious problem in Milwaukee, and this
10 problem affects many of the things that we are all
11 concerned about. I'm talking about infant
12 mortality. I'm talking about the incarceration
13 rates that we have, child abuse and neglect, the
14 physical and mental health many people are
15 concerned about, and certainly the perpetuation of
16 poverty.

17 Substance abuse is definitely a factor
18 of poverty, but it is -- the lack of money is
19 really not associated with drug abuse. There have
20 been many studies done on that. Somebody
21 mentioned before that this seems to cross economic
22 classes.

23 What we do know is that that stereotype
24 that drug use is more prevalent among the poor is
25 absolutely wrong. What we do know, however, is

1 that the attitudes, behaviors and conditions that
2 contribute to substance abuse are also the same
3 things that contribute to poverty. And that's why
4 we tend to mix those things up.

5 We like to think about substance abuse
6 as an individual problem, and we like to penalize
7 moral judgment on them. And what we do is
8 incarcerate as a result. These negative attitudes
9 are especially true for women. And when we're
10 talking about women who are mothers, the depth of
11 disapproval is just astounding.

12 Meta House treats women with their
13 children, so I'm going to address this from that
14 point of view.

15 Since 1986, there has been a 400 percent
16 increase in the number of women who have been
17 incarcerated; 800 percent for women of color.
18 Eighty percent of those women that are
19 incarcerated today are for drug-related offenses,
20 and most of those women are mothers. One of the
21 tragedies in all of this is that for women, the
22 path to substance abuse is actually quite
23 predictable. For most women, alcohol and drug
24 abuse has its roots in a child who was sexually
25 abused, physically abused, abandonment, by living

1 a life defined by unrelenting fear and betrayal.
2 And the life their children are living right now
3 is the same thing. It's a life that will predict
4 dysfunction, continuing poverty.

5 So one of the things that I saw in your
6 flyer asked about, what would work? The answer to
7 this problem, as far as I'm concerned, is
8 prevention and treatment. And the family
9 treatment model, like the one that we have at Meta
10 House, integrates fully and has some shelters with
11 an excellent outcome.

12 Nationally, these programs treat women
13 with their children and include the other family
14 members. The data shows significant drops in
15 substance abuse, improved employability, improved
16 reunification, and I could go on and on and on,
17 including better functioning for children as well.

18 At Meta House, in 2009, 81 percent of
19 the women that were in our children, women and
20 children treatment programs, were sober 12 months
21 later; 54 percent were employed, in school, or in
22 the job-training program; and 26 babies were born,
23 none of them were positive for alcohol or illegal
24 drugs.

25 The family treatment programs provide

1 integrated services that address the past history
2 of the woman and how it influences her present.
3 It helps women do their very best to fulfill all
4 of the roles that they have, especially the roles
5 that they play as mothers. We know that just like
6 most mothers, mothers with substance abuse
7 problems view parenting as an essential purpose
8 and a defining goal in their lives. And like
9 other mothers, it's a major source of their
10 identity and self-worth.

11 The family treatment model recognizes
12 the importance of the role that women play as
13 mothers, at the same time that it addresses the
14 impact of substance abuse on their children. They
15 provide services to pregnant women, who, like any
16 other mother, want to have a healthy baby. And
17 there is no better predictor of a mother's
18 successful treatment than her ability to feel
19 confident as a parent. There is also no better
20 way then to break the cycle of poverty and
21 substance abuse than to provide children with a
22 confident mother.

23 Now, while all of this may make sense,
24 and it's been proven to work, the family treatment
25 programs fall victim to the same problems that the

1 traditional programs fall into: a complete and
2 utter lack of adequate funding. In some ways,
3 it's even worse for the family treatment program,
4 because as Mr. Carlson said, residential treatment
5 is not paid for by Medicaid in this state. That
6 is a choice our state makes. But it also doesn't
7 pay for the work we do with the children and with
8 the moms in the relationship to their children.

9 So once the brain is affected by
10 substance abuse, the ability to plan, make
11 decisions, be consistent in your behavior, it's
12 simply a compromise. And so, you're not able to
13 get a job, you're not able to hold a job, you're
14 not able to meet the needs of your children, and
15 they then can develop educational, physical and
16 social skills that they are going to need to work
17 out in the future. So no matter what programs we
18 put in place for workforce development, without
19 funding for treatment, the impact simply can't be
20 felt. So if we don't impact on these adults, then
21 we cannot impact on their children, and then that
22 cycle of poverty continues.

23 Can I talk about what Mr. Carlson said?
24 I know I'm over my time.

25 MR. ROYAL: Briefly.

1 MS. FEINBERG: Briefly, okay.

2 Everything that Mr. Carlson said is
3 correct about healthcare reform. There is
4 definitely positive aspects of it. I think what
5 people don't realize is that it's still an
6 insurance mandate, and insurance is not the kind
7 of model that is extremely helpful to the people
8 that we serve.

9 First of all, they're talking about
10 primary care. Nobody comes to Meta House from
11 primary care; they're coming from the child
12 welfare system, they're coming from the criminal
13 justice system. So they are never walking through
14 that door to get to us in the first place. We're
15 the ones who are then sending them to primary
16 care.

17 The other thing is that the insurance
18 model, and especially managed care models, tend to
19 focus on system management, okay. Treatment is
20 not about system management; it's about changing
21 your life. That is not covered by insurance.
22 They tend to have a prescribed way of paying for
23 things. It's "X" amount of time, "X" number of
24 days for this particular symptom. And, you know,
25 our experience is, whenever we see somebody, we're

1 peeling back pieces of an onion, and there is
2 always something new coming out of them, okay.
3 The reality is that at Meta House probably 90
4 percent of what we do is not traditional substance
5 abuse treatment. It's about everything else
6 that's going on in that person's life. And that's
7 what makes us successful. So while, yes, people
8 will have more insurance, and I'm very happy for
9 that, and maybe we can get a little bit more
10 insurance, I don't see healthcare reform as the
11 answer to this.

12 I'm currently working with the White
13 House Office of National Substance Abuse for
14 policies on this very issue, because they
15 recognize that this is a problem. But it's going
16 to take major, major system changes in policies if
17 we really are going to impact it in a way that is
18 meaningful to people's lives. Thank you.

19 (Applause.)

20 MR. ROYAL: Doctor, just a question
21 because you said you're on the national task force
22 looking at this. We have countries, as in
23 Amsterdam, where drug use is legal, and still the
24 addiction rate isn't as high as in the United
25 States. Is there any data that supports or

1 explains that phenomenon?

2 MS. FEINBERG: You know, I don't know
3 that I can point to -- you're asking me if
4 legalizing drugs is a better thing or --

5 MR. ROYAL: I'm just saying, is there an
6 explanation for the phenomenon?

7 MS. FEINBERG: I think that the woman
8 who spoke before had it right. You cannot turn on
9 your TV, you cannot read a paper, you cannot open
10 a book without being told that you shouldn't feel
11 pain, and that means emotional pain and physical
12 pain, and there is a pill for everything. So that
13 is the culture that we have in Milwaukee, which
14 seems to be --

15 MR. ROYAL: And let me speak on that for
16 a moment, because we have breweries that actually
17 encourage you to drink. Why you have work, just
18 because of that --

19 MS. FEINBERG: I know.

20 MR. ROYAL: Our next speaker. And
21 please state your name for the record.

22 MS. HUGHES: Hello, my name is Shirley
23 Hughes. I'm a graduate from Meta House. I'm here
24 today because I was asked to come here. But this
25 is something that is close to my heart. I'm a

1 recovering addict, as I stated, and that I am so
2 thankful that Meta House has the program that it
3 has today.

4 I came into Meta House in 2006 with my
5 child, and I had two other kids that were being
6 taken care of by my sister. But when I went in
7 there, I only had three months of treatment. And
8 that was due to, that was allowed to me. You
9 know, and I've been out using drugs for 23 years.
10 And three months in treatment, residential
11 treatment, is not enough. But I was determined
12 that I was going to get over this because I was
13 tired. I was very tired. And, you know, some
14 women have a harder time than I had did because I
15 was determined. And I'm not saying that other
16 women are not determined, but it's -- I was so
17 frustrated, I was scared when I had to leave in
18 those three months. But they had the outpatient
19 program, which I kept going to daily. And
20 sometimes during the way, during that time, women
21 sometimes lose hope in that. But, like, Meta
22 House is really thorough. They are different.
23 I've been in different treatment programs. And
24 they listen. They are not like a hospital.

25 Sometimes, because what insurance kind

1 of thinks of as addiction as just as a disorder or
2 something, or just a symptom or something, but it
3 is actually, it is a disease. This could not be
4 treated as if I had a cut and put a Band-Aid and
5 it would heal.

6 You know, I'm still today, after four
7 years, I'm still trying to -- it's an
8 everyday struggle for me not to use drugs. You
9 know, because a lot of problems come up, you know,
10 Meta House is helping me and teaching me to cope
11 when things arise, you know, then I can, you know,
12 today I'm able to overcome a lot of things.

13 Also, Meta House doors are always open
14 to me, and I'm so happy for that. Thank you so
15 much, Ms. Francine. I've got a lot of others,
16 I've got to know a lot of women there, which I
17 never had women friends, never, and today I do.
18 And I'm just, I'm just grateful.

19 But also to that, what else, you know,
20 what I have a problem with is that people tend to
21 look at recovering addicts still with their nose
22 turned and roll of their eyes. You know, ask me,
23 I've got four years clean. You know, I'm a very
24 talented woman. I had a job before I started
25 using drugs. I had my job for 13 years, you know,

1 consistently. And I know how to wake up in the
2 morning, and I know how to go to work, but when I
3 go out there and try to find a job, they look back
4 at my history. Now, nothing in my history has
5 anything why I was arrested for drugs, or anything
6 like that, but see, that's just me. I just like
7 to be honest. Because I have a big space, a big
8 gap in between my last employment. And I'm not
9 ashamed of where I've been, or anything like that,
10 but it's just that now there's some people that
11 aren't willing to give us a second chance in the
12 work world. And that's, you know, that's keeping
13 me in poverty.

14 You know, I know how to manage my money
15 now because Meta House has taught me how to do
16 that. I even know how to get a little on the
17 side. I never had that before. But I'm still
18 struggling with that today. I don't let it get me
19 down, because I feel Meta House has taught me to,
20 you know, to accept a lot of things, reality. I
21 figure if I pay my bills, I got food in the house,
22 my kids have their basic needs, I'm okay. And
23 that little part that I have stashed apart, you
24 know, set aside, is just for emergency. But I
25 still look at it as I'm really broke. You know,

1 and even with that little piece set aside, I'm
2 still really broke.

3 But the thing is that, you know, I have
4 -- with the insurance thing that's going on, but
5 my son is not -- he's 20, he is not insured. He
6 is not insured, and then he has some medical
7 things going on, you know, mental things going on,
8 and he needs it too. But even with this insurance
9 that they said is available, he doesn't work, you
10 have to pay like \$95. He doesn't have \$95, you
11 know. And I made him pay the first month, but
12 what am I going to do for the second, the third
13 one? You know, so I find that a problem. I'm set
14 with that, and it's not helping. And that keeps
15 us, people like me, still in poverty.

16 And one more point I want to make that,
17 you know, being on W-2, is that this system is
18 really kind of out of whack to me. Because as
19 soon as -- if someone does -- from listening to my
20 friends, if somebody does get a job and it's
21 minimum wage, you're automatically dropped from
22 W-2. And you may be getting paid the same thing,
23 but you are still poor. Nobody, you know, nobody
24 is really hiring people, us, of us to making like
25 \$10 or \$15. I think, to me, \$15, I'll be all

1 right, an hour. But, you know, this \$8-thing,
2 that is not helping. This \$9-thing, it really
3 doesn't pull me out of poverty. You know, if I
4 worked, you know, had made \$9 an hour, I'm still
5 poor. You know, I'm still missing. You know, and
6 then, because another thing, if I make that much,
7 my food stamps are dropped. So whatever extra
8 money is there, there's no food, and I'm back to
9 ground zero. Thank you.

10 (Applause.)

11 MR. ROYAL: Thank you.

12 But, Ms. Hughes, if they don't ask,
13 don't tell.

14 MS. HUGHES: I'll remember that.

15 MS. VAN: Hi, my name is Marsha Van.

16 I'm here because -- I'm kind of glad the judge is
17 gone, I was one of those people that was in and
18 out of the correctional system. I'm a graduate of
19 Meta House also.

20 I was a substance abuser for 20 years,
21 and I was in and out of the criminal justice
22 facilities for small tickets, just anything. They
23 took me to jail for being involved in criminal
24 activity.

25 I've been a graduate of Meta House since

1 2005, no criminal activity, all of my debts are
2 paid. (Applause.) But now I'm at the hard part:
3 no one wants to hire me; no one wants to give you
4 a second chance. That keeps -- for me, it's okay,
5 I'm okay with that because I know better today,
6 that I don't have to go back to where I used to
7 be. But there are so many people out here who are
8 not as strong as I am, who doesn't have some
9 things that I might have, that run back to where
10 they are comfortable at. That keeps them in
11 poverty, keeps them going back to where they are
12 accepted because they don't feel accepted because
13 of their criminal history.

14 Thank God, today, I'm in school. I want
15 to learn how to work with women like me, who
16 started using drugs at 20 years old, never used no
17 other drug. I was introduced to cocaine, and it
18 took me for a downhill spiral, straight out of
19 college, everywhere.

20 So I really want to, I want to do
21 something about that because it's not easy when
22 you go for a job interview. I've been called to
23 job interviews twice, come to the first one and
24 they, "I want you to come back for a second one."
25 And then it's, "No, your criminal history --" you

1 know, and my criminal history, there are some
2 misdemeanors, but it's there. They don't have
3 anything to help people to work on that. They
4 don't have anything to, you know, I mean, if you
5 work on it, you got to buy, gotta pay a lawyer,
6 you know, they don't have anyone to help. They
7 let you -- I mean, so many times I went to jail,
8 and they let me out. I didn't have nowhere to go
9 but back to using. It wasn't until I opened my
10 mouth and said, "Could I please go to treatment?"
11 I had never been in a treatment center. I'd never
12 been offered a treatment center. And the judge
13 said, "I don't know, I don't usually do this." I
14 said, "Well, could you please this time?" And I
15 haven't looked back since he allowed me to go Meta
16 House.

17 I've been working, working my way out of
18 poverty, in school, signed up for school. And I'm
19 trying to find a way. I want to work, and I want
20 to help people that have criminal histories like
21 mine. It's not bad, it's just extensive, you
22 know. And sometimes when you go for a job
23 interview and they see two misdemeanors on your
24 case, and, "I'm sorry, we can't do it." That's a
25 big disappointment. Some people are not strong

1 enough to accept that. They only know how to use
2 drugs all their life, so they go back to using
3 drugs.

4 So I'm just, I'm one of those people
5 that wants to make a difference. I think if
6 people can help clean up some of their mistakes,
7 because no one is perfect, if you have someone to
8 help you clean up what you've messed up and start
9 out at a new track, I think that will help a lot
10 of people get out of poverty because they have an
11 opportunity, a chance, to do something better for
12 themselves. Thank you.

13 MR. ROYAL: Thank you.

14 (Applause.)

15 MR. ELLWANGER: I'm Joe Ellwanger, a
16 retired Lutheran pastor. And in my retirement,
17 working as a organizer with Wisdom and MICAH, I
18 have a lot that I could say. I'm going to try to
19 focus on two things. And listen carefully, Conner
20 -- Conner Williams is associated with me and
21 MICAH, and working on treatment instead of prison
22 and alcohol and other drug addiction treatment
23 issues -- and what I don't cover; you cover.

24 I was a pastor of Cross Lutheran Church
25 on 16th near Walnut for 35 years, now for the last

1 ten years at Hephatha Lutheran Church at 18th and
2 Locust. I live at 16th and Walnut.

3 And I see men and women and the families
4 connected with them as people, and this is not an
5 academic issue for me. As an organization of
6 congregations that came together to work on
7 justice issues, MICAH, some 20 years ago, we
8 started from the very beginning working on drugs
9 and the relationship to crime and poverty. We
10 first started out thinking that we're going to
11 shut all of the drug houses down in Milwaukee and
12 that will take care of it. We discovered that we
13 could close 350 drug houses down in a year, and we
14 did, and, of course, we all know that you close
15 the drug house down on this block today, and it
16 starts up on that next block the next day. So we
17 realized that if there is any possibility of
18 solving the drug dilemma and drug scourge that is
19 in our nation, we need to work at reducing the
20 market, and that means treatment.

21 And so, we've worked on this for years.
22 And you may not realize it, but Milwaukee County
23 at one time was putting \$14 million into drug
24 treatment for uninsured people. And then, of
25 course, it gradually got lowered and lowered and

1 lowered, until it's now at about one-and-a-half
2 million. And it probably would have gone out, the
3 one-and-a-half million would have evaporated if
4 MICAH had not literally sat in that county
5 executive's office overnight to say, "This cannot
6 be reduced any further." And ever since then, the
7 amount for the uninsured is 1.5 million. It
8 should be back up to the 14 million and beyond,
9 but as Francine Feinberg and others have said, the
10 mantra that you hear from folks who say that,
11 "Yeah, we need more treatment," and we need
12 treatment specifically when people sense their
13 need for it. If they can't get it, then we know
14 we probably have lost them for another 90 days or
15 another couple of years. And so it is absolutely
16 essential that we have drug treatment on demand,
17 or we create more and more and more people who are
18 out on the street.

19 And the question is, okay, where do you
20 get the money? Well, we've got an excellent
21 source for money in this state, and in almost
22 every state, and that is the money that we spend
23 on corrections. Because that is where, as you had
24 just heard from some testimony, that is where we
25 send people who are caught up on drugs and maybe

1 sell it on the street to feed their habit. And
2 maybe they don't even sell it, but they get caught
3 with the wrong number of ounces, and they go to
4 prison.

5 And very seriously, 75 percent of the
6 people in jail and prison have underlying alcohol
7 and other drug addiction issues and/or mental
8 health issues. And if we took -- this is very
9 simply math, and even Texas and Mississippi are
10 beginning to learn this, that if we took just a
11 small portion of that \$2 billion that we spend on
12 incarceration and spend it on treatment, we
13 discover that eventually, and fairly quickly, the
14 number of folks in prison is reduced. And we
15 discover a new way of living as a society. People
16 on drugs learn a new lifestyle, a new way of
17 living in a new community. We as a society have
18 to understand that we will never incarcerate
19 ourselves out of the problems of addiction; we
20 will only treat our way out.

21 And as a pastor in a church, I do have
22 to say that the church has a huge responsibility
23 in this whole area to encourage treatment and not
24 talk simply about addiction and mental illness as
25 something that people can get over if they just

1 want to get over it. Hephatha Church, where I
2 belong, not only has every Monday night a recovery
3 night for people from the community who are
4 looking for help or want to stay in recovery;
5 there are three women whose lives have been turned
6 around and who are giving back to the community by
7 opening the doors of the church every Monday night
8 to welcome people for this recovery circle. And
9 the congregation celebrates the anniversaries of
10 people who are in recovery 10, 12, 15 years. This
11 is something to be celebrated and to be
12 encouraged, not something to be swept under the
13 rug, people to be put at the margins.

14 And so, there is a need for a real
15 turnaround from our society to really do something
16 about taking the money that we're spending on
17 incarceration and spending it on treatment. It
18 makes sense. And I'm not going to go into this
19 issue, it's the elephant in the room that has to
20 be dealt with as a nation, and that is our drug
21 policy.

22 And the question about the
23 decriminalizing of drugs in some European
24 countries, we have got to look at how we, what
25 policy we have for picking up and arresting and

1 incarcerating people who use drugs and sell drugs.
2 There is just a plethora of negative results from
3 the current policy that drives the sale of illicit
4 drugs into the hands of street folks and the
5 Mafia. And that is a lose-lose situation.

6 We found that in the '30s with
7 Prohibition and we're finding now, but nobody
8 wants to look at it that closely. There is some
9 movement in Congress to have a blue-ribbon study
10 on this, and it needs to be supported. Our
11 congressional representation needs to support it.
12 We as a nation have got to really turn ourselves
13 around and learn new things so that the succeeding
14 generations don't say, "We did what in 2010?"

15 MR. ROYAL: Thank you.

16 (Applause.)

17 MR. ROYAL: Just for clarification, I'm
18 not advocating legalizing illegal drugs.

19 MS. BURGESS: Hello, my name is
20 Patricia, and I'm a resident from Meta House as
21 well.

22 MR. ROYAL: Patricia, could you state
23 your last name?

24 MS. BURGESS: Burgess, Patricia Burgess.
25 I started using drugs when I was 12. And I know

1 you guys are talking about abuse and poverty, but
2 I liked when the very tall gentleman got up here
3 and was talking about teaching our children at a
4 young age, about how to establish a positive way
5 of living. Because at a young age, I was
6 abandoned by my mom, and so, instead of learning
7 how to live and be guided as a young lady, I got
8 into the world of drugs. And I had a lot of
9 emotional and mental problems growing up. So I
10 started using drugs, and I've been using ever
11 since until I ran into Meta House. And they did a
12 lot of work helping me out, a lot of layers to go
13 through. And I've been clean four years now.
14 (Applause.) And they taught me how to be an
15 adult, because when I went to Meta House, I was
16 still a little girl on the inside, in a grown
17 woman's body. So they taught me how to be an
18 adult in order for me to take care of the children
19 that I had. And that was a big step for me. I
20 took parenting classes, anger management, you
21 know, which I needed. They taught me how to deal
22 with trauma issues that I had.

23 So it's not just about the addictions;
24 it's about all of the other stuff that's in there
25 where the addiction started at. So Meta House has

1 played a big part of not just helping me deal and
2 cope with my drug use, but to turn my whole life
3 around, you know, and make me the person that I am
4 today: a better person. And, like I said, it
5 starts at a young age for a lot of us. Because
6 today I see a lot of young kids out here, yeah,
7 not only are they using marijuana, they are using
8 ecstasy and crack cocaine, and all kinds of stuff.
9 They're sniffing paint, and, you know, all the
10 things like that. Things that are just really
11 dangerous to use. And you try to talk to them,
12 they don't want to hear what you are saying. And
13 I remember like yesterday, I was there, you know.
14 So all you can do is try to reach the ones that
15 are this tall yet, you know. Because the ones
16 that are up here, you know, it's going to be
17 harder to get to them. So just get to the smaller
18 ones and make sure that they don't get where we
19 are here today. We need to make sure our kids are
20 better than we are. You know, I'm an old antique.
21 You know, I've lived my life. All I can do is
22 make sure that the children have a better life,
23 you know, pave the way for them so they have
24 clearer waters to go through. Thank you.

25 (Applause.)

1 MR. ADAMS: Hello, everybody. My name
2 is Steve Adams. I just want to thank SDC for
3 sponsoring this public hearing. These are the
4 kind of things you don't want to talk about as a
5 community because they are very, very challenging.
6 I know the presenters that we had, the judge and
7 Dr. Carlson, as well as the folks that spoke
8 before me, I think you all did excellent jobs at
9 presenting different perspectives on this issue
10 because it is, it's very complex.

11 Even in my own personal life on that,
12 like some of you, while I've not had direct issues
13 with alcohol or drugs and poverty, it has been in
14 my family. I've had to deal with it as family
15 members on a very, very personal level: with
16 alcohol with my parents; drugs with my brothers
17 and sisters; and poverty, all of us. So I know
18 the issues that we're talking about, and I've had
19 experience with it.

20 But I think as all of a number of
21 presenters have said, you know, again, we've
22 really got to take a holistic approach in dealing
23 with this issue. I think we've heard a lot of
24 different perspectives on a personal level,
25 problematically, institutional levels, from the

1 government policy aspects. I mean, we've really
2 got to deal with this issue because it really is
3 holding us back as a country. This is not just an
4 inner-city issue. You know, one of the previous
5 ones said, this is a United States problem. This
6 really is. This is a United States problem. It
7 impacts all levels, you know, all incomes, I don't
8 care if you are Republic or Democratic or Catholic
9 or Protestant, you know, we've got to deal with
10 this issue.

11 And so, I'm just hoping that as a result
12 of this effort that we really come together.
13 Because I think the solution to this issue is
14 right here in this room, as well as others that
15 maybe couldn't make it. You know, the sky is not
16 going to open up and the heavens are not going to
17 open up and a solution is going to come out to
18 solve this issue. The solutions are right here in
19 this room and all of the entities that we
20 represent. We have -- I heard a whole lot of
21 solutions, you know, a lot of work that is being
22 done to address this issue. And, obviously, you
23 really have to go to have more prevention, and
24 hopefully there are people that won't have to face
25 these issues of alcohol and drugs and poverty.

1 We've just got to work at it. We know what the
2 answer is, so let's just do it. Let's solve this
3 issue. I'm tired of the runaround. I'm tired of
4 people trying to overcome these issues and getting
5 the runaround from all of these entities because,
6 "Well, we don't have enough money." Or "No, our
7 program only does this here." We've got to help
8 people solve these problems, and you've got to
9 also, hopefully, do prevention, help people to
10 avoid these problems. Because we got bigger issues
11 to solve as a nation, as a community.

12 So let's start connecting these dots
13 towards bigger solutions, helping people. And
14 let's stop giving people the runaround and start
15 moving them towards solutions of being able to be
16 productive citizens. Thank you very much.

17 (Applause.)

18 MR. ROYAL: Thank you. If we didn't
19 have a few more people to speak, those would be
20 our closing remarks.

21 MR. WILLIAMS: My name is Conner
22 Williams, and I'm the co-chair of the Mika/AODA
23 committee. I'm a member of the St. Matthew's
24 Lutheran Church in Wauwatosa.

25 And from a faith perspective, the issue

1 as we view it from MICAH, is, the basic injustice
2 is, that poor addicts go to prison and non-poor
3 addicts go to treatment. And there is a basic
4 injustice in there. And it's a basic injustice
5 that not only oppresses the poor addict, but it
6 also impoverishes us all in the city and the
7 state.

8 It costs \$30,000 to send somebody to
9 prison for a year. It costs about \$7,000 to send
10 somebody to an effective outpatient treatment
11 program.

12 And one of the things that Pastor Joe
13 mentioned earlier about that, there are other
14 states that are doing things differently. Next
15 door in Minnesota, we use that as a point of
16 reference for how we could do things differently,
17 in Minnesota, they have something called the
18 "community corrections act." And it's where money
19 is made available to communities for nonviolent
20 offenders to go through supervised programs in the
21 community rather than being incarcerated.
22 Minnesota has a slightly smaller population than
23 Wisconsin: just under five million. But
24 according to the SDI stats, classified statistics,
25 Minnesota has the same rate of crime as Wisconsin

1 does in broad terms. But they have 8,000 people
2 in state prisons; we have 22,000 people in state
3 prisons. They spend \$460 million on their
4 department of corrections; we spend \$1.4 million
5 on state department of corrections. That \$900
6 million difference, we get nothing of value for.
7 We just destroy the communities that are
8 impoverished with that \$900 million.

9 There is a huge amount of resources that
10 is consistent with the old adage that "an ounce of
11 prevention is worth a pound of cure." If we just
12 make a few tens of millions of dollars available
13 for treatment to be available on demand regardless
14 of your health insurance status in this state, we
15 would significantly decrease the number of people
16 going into our state prison system. And we would
17 bring health back to our community. MICAH,
18 together with the other Wisdom affiliates across
19 the state, together with Justice 2000, together
20 with community activists, together with Benedict
21 Center, and hopefully, together with the
22 organizations that are represented, including our
23 good host, Social Development Commission, are
24 working to try to have a community corrections act
25 passed in the state of Wisconsin. We would

1 appreciate any and every bit of help we can get
2 for that so we could make our city and our state a
3 heathier and more just place that we want it to
4 be. Thank you.

5 MR. ROYAL: Thank you.

6 (Applause.)

7 MR. ROYAL: I keep hearing the good
8 things going on in Minnesota. We've go to find
9 those things, look for the will to address the
10 poverty problems here in Wisconsin.

11 MR. MARSHAL: Good evening, my name is
12 Curtis Marshal, and I work in public health. And
13 I think connecting the dots and everything, it
14 sounds good to put a health perspective on this
15 thing. And I'm going to tell you, I've been in
16 public health about 20 years, and thanks to the
17 relationships that we have with the Cross Lutheran
18 Church and Meta House. I remember several years
19 ago Milwaukee had the highest rate of primary and
20 secondary syphilis. We had the highest rate of
21 African-American babies dying from moms who had
22 syphilis. But because of partnerships with the
23 Meta House and the church, we went in and gave
24 testing and screening to identify syphilis, and we
25 treated it.

1 And it's one thing, in public health, it
2 helps me stay grounded. I worked in a free clinic
3 where I had to take 15- and 16-year-old young men
4 and women that they not only had HIV, but they had
5 full-blown AIDS.

6 And now I work in child health and my
7 focus is on infant mortality. And I look at
8 medical records of the number of babies that are
9 dying at birth before the age of 1. We get
10 together twice, about three times, or once a
11 quarter. We pull back the records and see, what
12 were the risk factors? Why was this baby dying?
13 Why is this baby -- why was this a poor birth
14 outcome? And the common thread, when you have
15 this health disparity, the common thread is always
16 poverty and alcohol and drugs. And we look at the
17 medical records of the mom who had prenatal care,
18 and in the medical records, alcohol and drugs are
19 identified as a risk factor. And there was
20 absolutely nothing done to intervene because she
21 was on a public subsidy.

22 So when you -- in doing that outreach it
23 involves, doing the Milwaukee Syphilis Commission
24 Project, I was riding out in the outreach van at
25 3:00, 4:00 in the morning, and I'd see young men

1 and young women who are out there walking the
2 streets to sell their bodies, and I just didn't
3 test them for syphilis and HIV, I would ask them,
4 "Why are you out here doing this?" They were out
5 there to pay the rent, to buy food, to buy
6 Pampers, for a place to stay. And not just young
7 men and women, but just for leaving the back door
8 of the Milwaukee County Jail, a lot of them had
9 Band-Aids on their arms. They were tested in
10 jail. And they were out there walking the
11 streets. They were released from the back door of
12 the county at midnight.

13 So I think it's really important when
14 you talk about health disparity, you cannot
15 dismiss the fact that poverty and alcohol and
16 substance abuse plays a big part of that. So it
17 keeps me grounded in what I do. But I think it's
18 moved forth of whatever comes out of this
19 testimony. We just really need to say that public
20 health is a big part of that. And the common
21 thread through our public is that we strongly
22 believe that everything leads to everything, and
23 that is why we feel those partnerships. We know
24 with the churches, with the Meta House, and I
25 thank God for places like the Meta House, that

1 they allow us to come in there and do the
2 education of public health. We know that a lot of
3 individuals at Meta House don't have the jobs,
4 don't have the education, and they are building on
5 that level, and the Lord can now make growth. And
6 they do have those alcohol and drug programs and
7 those are the risk factors.

8 So whenever you hear people talk about
9 health disparities, best be mindful that we cannot
10 talk about health disparity in its own silo. We
11 have to bring the words "health disparities of
12 public health" into the conversations about
13 poverty and alcohol and drug abuse. Thank you.

14 (Applause.)

15 MR. ROYAL: Is there a No. 13?

16 MS. JOHNSON: Hello, everyone. I'm a
17 little nervous, but when I received this e-mail,
18 this topic kind of affects my family personally.
19 So I had to take the opportunity to come out, and
20 you can hear a little about myself today.

21 MR. ROYAL: Can you state your name?

22 MS. JOHNSON: Oh, I'm sorry. I'm Katy
23 Johnson. I actual work for the Social Development
24 Commission.

25 And I know firsthand about the Meta

1 House and how they help the community, being a
2 child of a parent that was addicted to heroin and
3 cocaine for 20 to 25 years. And here it is 20 to
4 25 years later, and this issue is still a major
5 issue in our community. It's just proof that this
6 needs some attention.

7 Our kids need to know that drugs and
8 alcohol is a major cause of poverty. My mother
9 was on drugs. She didn't pay much attention to
10 whether or not we went to school or even whether
11 we ate. I remember living in a shelter that, now
12 I actually work for a program that houses shelters
13 and food programs, that we looked forward to going
14 to these meal programs and actually being able to
15 eat a meal. Because my parent was gone and no one
16 to feed us. So this is a major issue. A lot of
17 kids go hungry late at night. And I actually work
18 at the meal programs to make sure that kids are
19 fed and get a free meal, at least one free meal a
20 day, and that actually helps.

21 That is kind of like my testimony. I
22 found the nerve to testify, and I just thought I'd
23 come.

24 (Applause.)

25 MR. ROYAL: Thank you.

1 MR. RUBIN: My name is Dr. Ned Rubin.
2 I'm a psychologist here at Aurora Sinai and an
3 addiction treatment specialist.

4 I wasn't planning to speak tonight when
5 I came. I came in to listen and hear what other
6 people had to say. But there was an important
7 issue that was actually touched on by a number of
8 people, that I thought I would begin to think a
9 little bit while I was listening and share some of
10 my thoughts with you. Because I think there are
11 some things that maybe we can all begin to do now,
12 today.

13 You had asked earlier, actually of
14 Dr. Feinberg, about why there seems to be less of
15 a drug problem in a country in Europe where there
16 is much more availability of drugs. I think at
17 least one of the reasons is attitude. It's the
18 attitude that the folks who live there have about
19 the people who use drugs. How many times have you
20 heard tonight about how difficult it is for people
21 who are recovered to get a job? It has to do with
22 the attitude the rest of us have about who those
23 people are, and what kind of lives they have
24 lived, and what is that stuff they have done that
25 we don't know about. So I think some of it has to

1 do with how we think about the folks who have
2 suffered, or are suffering with this particular
3 issue.

4 Part of this comes from our language.
5 I'm a psychiatrist, I spend a lot of time dealing
6 with words. If you'll think back a few years, you
7 may remember that we have been in a country that
8 is having a war on drugs. Is that familiar to
9 anybody? Actually, as I think about it, it's
10 really a war on drug abusers and the people who
11 then have tried to get themselves together, have
12 suffered with the consequences of our attitudes
13 about what we think about drugs and the people
14 that use drugs.

15 If we think about other -- somebody said
16 that it's a disease or illness earlier. If we
17 think about other illnesses, we don't say, "I am
18 prostate cancer." We say, "I have suffered from
19 --" or, "I have been treated." Fortunately, not
20 really, but you get my point. So why do we say
21 "I'm an addict," when we talk about people or when
22 we introduce ourselves? We could say, "I have
23 dealt with -- I'm dealing with -- I have a problem
24 with." We don't necessarily have to identify
25 ourselves with whatever that diagnosis means.

1 Because I think you hit the nail on the
2 head, the elephant in the room is the war.

3 MR. RUBIN: And we can change what we
4 say in our conversations, in our advertising and
5 the policy issues that can be effective pretty
6 easily, I think.

7 MR. ROYAL: I like that he is talking
8 about policy issues. Go ahead.

9 MS. WILLETTE: Good evening everyone.
10 My name is Rhonda Willete, and I am an overcomer.
11 (Applause.) I want to say, first of all, thank
12 you, for having such a public hearing that is
13 necessary to the growth and development of my
14 community, of my people. This issue has plagued
15 and affected me for the past 20 years of my life.
16 I have been in the struggle as a working woman
17 continuing to overcome and defeat addiction. I
18 came here tonight, wasn't going to break my
19 anonymity because a lot of you out here, I work
20 with. And I wasn't going to do it. It's very
21 difficult, but I am an overcomer. I stay in the
22 struggle as a community organizer because I know
23 firsthand how addiction of poverty connects to the
24 cycle of remaining in poverty.

25 I am part of the working poor. I have

1 eight children, and I went through addiction with
2 eight children. I have been through treatment and
3 I have been turned away at the front door. I've
4 been through the criminal justice system. I also
5 am a double felon. I have a job today, and I work
6 a job that does not have a glass ceiling that
7 keeps me down. I am active in my community. The
8 solutions start within. We have to want to change
9 this. We have to. And we have to give that ray
10 of hope to somebody else, and it starts one person
11 at a time, believing in someone, embracing,
12 holding on to her.

13 There are a couple sisters in the room
14 who I've been next door on the milk crate with.
15 And there are a couple of them I've been to church
16 with as well.

17 So I know that if we band together and
18 pull together, we can change this situation here
19 in our city with addiction. And stigmas have to
20 go. We've got to throw that stuff away. We have
21 got to, in order for people to move forward.

22 I live on a block where there are 17
23 people that live in a two-bedroom flat. So when I
24 get up and go to work in the morning, my neighbors
25 are there sitting on the porch with that mutant

1 can of beer, and when I get home, they're sitting
2 there with a mutant can of beer.

3 AUDIENCE MEMBER: Same one?

4 MS. WILLETTE: No, probably six more
5 since then.

6 But I came speaking for them, I came
7 speaking for my community, my neighbors who can't
8 even make it out of their house to say that they
9 need help. So I speak for them, that we must come
10 to some solutions.

11 I'm willing to come to the table and
12 share my experiences. I continue to give help.
13 There are other programs that are active in our
14 community, that are support systems that help. I
15 do visit into those groups. I don't go as
16 frequent as I used to, but they support and
17 sustain people with addiction issues.

18 And I do think that addiction has to be
19 dealt with holistically. It can't be dealt with
20 just treating that one person. And there are many
21 fathers, we need to pull those men in and keep
22 them connected because we lack fathers with our
23 family. And that's the biggest gap that keeps our
24 people from moving forward. Where are all the men
25 standing in front of us? And I just know the

1 importance of having men connected with our
2 treatment and with our recovery process. Because,
3 men, who has got to fend for the kids? Now I'm
4 carrying all eight of these kids on my back by
5 myself. I didn't do this by myself. And I didn't
6 get hurt as a child by myself either, okay.

7 So we need to have folks in place to
8 protect us as well, and to protect children. And
9 not so much to take them out of their house. Get
10 them the help they need at home with their
11 families. Because when you do that, that sends me
12 further out. You take my babies, I'm left with
13 disparity. I'm left with feeling like there is
14 nothing else to do. Don't take my babies.

15 So we need to come to an understanding
16 where we bring our families back to what's right
17 for the families. And that's for them to come
18 together and everybody to get the help that they
19 need in one place. And we can't keep --
20 definitely, the prison system is not the solution.

21 (Applause.)

22 MR. ROYAL: You can follow the
23 overcomer.

24 MR. FRASER: Thank you, for sharing,
25 thanks to everyone for sharing.

1 My name is David Fraser. And the one
2 good thing and bad thing about going last -- or am
3 I last -- is that there are no new ideas;
4 everything has been said, and much better than I'm
5 going to say it. And I also understand that SDC
6 is about action, so to go on record for tonight,
7 and also say I'm supportive of that.

8 If you look at disparity, and I know
9 many of us talked about it, there is a pathway
10 through it when helped. We're talking about help.
11 One, the beginning of it is the environment, where
12 we live, the corner stores, the liquor stores, the
13 churches, the Meta House. These are all part of
14 our environment.

15 The next step would be about our
16 exposure and our behaviors.

17 The final step, and really, it is about
18 healthcare. And we heard about healthcare. I
19 don't want to disrespect the healthcare facility,
20 my office is also in this building, but that is
21 the third step of the concept inequity. And what
22 we've heard tonight from the slides is that it's
23 really expensive, and healthcare payments are
24 great. But we have proven evidence, we have
25 practices that are very successful in the

1 community, in our environment, in that first step.
2 If we can go on record in looking for supporting
3 that particular area to help provide more money
4 for prevention, more money for the programming at
5 Cross Lutheran or Meta House or many of the
6 programs, we can properly resource the programs
7 that are working, so they can go to where they
8 want to go with the programming. If we do a
9 better job, it wouldn't be such a burden on the
10 healthcare system, three steps away from the
11 inequity.

12 So that is all that I would say, is that
13 if we go on record to do equality, can we support
14 our effort to get more prevention dollars for
15 Milwaukee, around it. And it's not even
16 prevention, it's case management. It's the thing
17 that gets the people out of poverty. Again, not
18 to disrespect the healthcare system, but the
19 thing, the actually part about addiction is real.
20 We can all -- we know that. Once we check that
21 though, it's getting jobs, and that's things like
22 Meta House and Cross Lutheran, and these programs
23 can do, help you get those barriers and help
24 remove the barriers if you have one of the issues,
25 addiction, managed. So I think that if we could

1 properly resource -- and Meta House has been
2 paying for this -- if we could possibly resource
3 these programs, I think we could do a lot better
4 job. That's all.

5 (Applause.)

6 MR. ROYAL: Thank you.

7 My understanding is, you are the 17th
8 and final speaker.

9 MR. CELATA: This is a little awkward:
10 speaking at a public hearing that I organized.

11 My name is Dave Celata, and after
12 hearing Katy speak and hearing a few other people
13 speak, I feel compelled to speak, because
14 substance abuse is something that has impacted my
15 immediate family. And I have seen firsthand and
16 experienced the impact this can have on
17 individuals' lives.

18 I'll take you back to 1969, the summer,
19 my parents were 18. Well, actually, my mother was
20 17; Dad 18, inconsequential. They were both
21 getting ready to go off to college. They had just
22 met. I'm originally from Massachusetts. They
23 were down in Cape Cod for the summer, and they had
24 just met. It was storybook right from the start.
25 My mother, a woman who is incredibly intelligent,

1 was from a small all-girls' Catholic college in
2 Boston. My dad was an all-conference football
3 player, well-liked. He was on his way to a full
4 academic scholarship to Columbia to play -- well,
5 they gave him an academic scholarship to play
6 football.

7 While he was in New York, my father
8 started experimenting with drugs. It was the late
9 '60s and '70s, and that happened. It became a
10 full-blown addiction without my mother realizing
11 it. The two were married in '73, had my sister in
12 '78, had me in '83.

13 And the -- his addiction just slowly
14 wore away at the core of our family to the point
15 where my mother had to leave with a bankruptcy
16 because he sold everything that we owned. He sold
17 engagement rings, wedding rings, borrowed money
18 from his parents. Eventually, the house was
19 foreclosed on.

20 And the funny thing is, is that when
21 Conner spoke earlier about the differences that
22 drugs and alcohol abuse can have on people from
23 different socioeconomic backgrounds, my father
24 came from a wealthy background. His abuse of
25 marijuana and heroin and cocaine didn't put him in

1 poverty. He moved back in with his mother and
2 eventually got himself to a better place. My
3 mother, my sister and I moved into housing for six
4 years. We lived below the poverty line for four
5 to five years, didn't have enough food, and the
6 cabinets in our house -- sorry, I usually don't
7 get very emotional. But I say these things not
8 because, "Woe is me;" we actually lived a fairly
9 privileged childhood. There was always a roof
10 over my head, went through a pretty good
11 educational system. But the thing that we too
12 often ignore is that collateral damage. When you
13 talk about, "where are the men?" My father's drug
14 abuse did not, it didn't affect him because he
15 didn't fall into poverty. It affected those
16 around him. And when we talk about sending people
17 to jail, when we talk about doing things like
18 that, we need to recognize the collateral damage
19 that is associated with that. That's all I've
20 got.

21 (Applause.)

22 MR. ROYAL: Thank you, Dave.

23 I would like to take one moment just to
24 recognize the policy and research. Alice, Vicki,
25 could you all stand up? Don't be shy, come on out

1 here, Bridgette, Dave. I want to thank you all
2 for putting this together. (Applause.)

3 For all those who gave their testimony
4 today, I want to thank you for sharing.

5 (Applause.) I think you want to say something,

6 MS. BLANKS: Thank you. I wish I had --
7 I'm not going after David, he has this calm, cool,
8 collected -- all of the time, seriously, focused,
9 academic. But he has that personal connection, as
10 I think many people at SDC have. And that's what
11 makes us continue to strive to improve.

12 I'd like to -- let's give Fred a round
13 of applause. (Applause.) I've been in SDC 13
14 years, I believe Fred is the ninth board chair I
15 have had, and he is by far the best board chair.
16 He will show up, he will contribute, he will -- he
17 is just fantastic. So we appreciate you.
18 Definitely appreciate our policy and research team
19 who put this together, as well as two other public
20 hearings: one on black male joblessness; and
21 another one on predatory lending. Each has had
22 its own flavor. This one, in its way, has been
23 just unique. And I think I continue to learn how
24 to make SDC better by listening.

25 One of the things, though, I'm going to

1 take away from this is, I want to thank the
2 doctors, the reverend, the psychologist and every
3 professional that came and gave their testimony.
4 But I also want to thank everyone else who shared
5 because you sort of take professional testimony
6 and give it life and give it credence and give it
7 testimony. Also, I want to thank everyone who
8 listened because I think by coming and listening,
9 we are enriched, and the work that we do perhaps
10 emboldens what we hear.

11 The young lady who talked about the
12 things in the neighborhood, the billboards. Now,
13 if I could, I would take those billboards and I
14 would write on those, because we have heard from
15 the young people and the older people how much
16 they feel like society is saying that they are
17 undeserving, that they don't matter, that we don't
18 hear, and I would change those billboards simply
19 to say, "We care about you, and we will overcome
20 together."

21 So I just want to thank all of you for
22 taking your time and to please know that SDC takes
23 your information, your testimony, very seriously.
24 And I think there are some partnerships that we
25 need to start developing.

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(Applause.)

MR. ROYAL: That concludes the event.

1 STATE OF WISCONSIN)
) SS:
 2 COUNTY OF WALWORTH)

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I, KAREN RENEE, Court Reporter and
 Notary Public in and for the State of Wisconsin, do
 hereby certify that the above hearing was recorded by
 me on October 13, 2010, and reduced to writing under my
 personal direction.

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I further certify that I am not a
 relative or employee or attorney or counsel of any of
 the parties, or a relative or employee of such attorney
 or counsel, or financially interested directly or
 indirectly in this action.

15

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In witness whereof I have hereunder set
 my hand and affixed my seal of office at Burlington,
 Wisconsin, this 25th day of October, 2010.

20

21

22

 Karen Renee
 Court Reporter and Notary Public
 In and for the State of Wisconsin

23

24

25

My Commission Expires: March 11, 2012.

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