

TESTIMONY OF ROBERT N. DELLAVELLA, J.D., CEO
SELF HELP MOVEMENT, INC.

DRUG TREATMENT FACILITY REFORM

Self Help Movement, Inc. was established in 1967 to address the needs of men involved in the criminal justice system during a time when access to substance use treatment was not easily achieved for this population. Since that time, we have grown into an organization that serves all adult men, regardless of legal involvement, who are seeking help in addressing their substance use disorders. We serve short and long term residential 3.5 level of care and halfway house 3.1 level of care. Almost all of our population is on Medicaid. We have witnessed men struggle and give up. We have witnessed men struggle, persevere, and remain sober. We have witnessed families devastated, and families reunited and healed.

Sadly, the CDC's current statistics show an overdose death total exceeding 100,000 lives. That is a 28.5% increase from the previous year. A significant part of the problem, which was enhanced by the Covid-19 Pandemic, is the fact that among individuals with a substance use disorder only one in ten people will engage in treatment. These results are from a 2019 national survey on drug use and health from SAMHSA.

Improving the system where individuals and families can have greater access to information on treatment programs and what they provide would be a positive step in getting people into treatment and giving them the opportunity to find the best program to fit their individual needs. We anticipate that the Atlas tool which we understand will be utilized by DDAP in the upcoming months will be very useful in helping individuals accessing treatment and showing the types of

treatment, lengths of stay, and resources available at each facility. The use of treatment facility surveys, and patient experience surveys will also be beneficial.

In our analysis of treatment facilities, we must be mindful that recovery is not a one size fits all.

There are a multitude of ways that an individual can be successful in their recovery. These include multiple evidence based behavioral therapies and access to medication assisted therapies, and the use of expanded Case Management. Additionally, treatment can be provided in a multitude of ways including outpatient; intensive outpatient; partial hospitalization, halfway house and short and long term residential treatment. Self Help Movement, as a program, follows a long term residential treatment model as we strongly believe it to be the one that best serves many of the Medicaid population that enters our doors.

It is recognized that addiction is a chronic disease, and, like other chronic diseases, its course is not necessarily predictable, and it may take more than “one course of treatment” to remedy the symptoms, underlying problems, and life-long issues that will likely arise over time, and, even in cases where the disease of addiction is treated successfully (i.e., no relapse/recurrence of use over prolonged period of time), the underlying or correlated problems (trauma, abuse, legal, financial, educational, employment, comorbid medical and mental health diagnoses), left untreated, remain a constant threat to the person’s long term prognosis and overall well-being. Consequently, we can also expect that the well-being of their family, workplace, and social community will suffer directly and indirectly as a result of untreated or insufficiently treated substance use disorder. Most professionals will agree on this point. However, the system we currently have in place does not support this holistic and long-term treatment necessity. We urge you to recognize the need.

Additionally, we must be mindful that many times the burdens of different regulatory practices, documentation demands, and the multitude of other requirements from DDAP, multiple MCOs,

CARF, JACHO, etc. are overwhelming. The additional burdens include but are not limited to:

- The amount of administrative time this consumes across a multidisciplinary facility;
- Additional requirements keep being added from all angles;
- Policies have to be continuously changed;
- More demands and requirements with no additional help or assistance;
- Less time available to provide services/attend professional training (including trauma certifications)/ expand or develop current clinical programming, and
- Increased demand for services.

We need to find a way to attract professionals back into addiction treatment centers. The availability of psychiatrists, medical doctors, certified nurse practitioners, nurses, and counselors willing to work under the demands, pressure, and increasing workloads is dwindling. These professionals are finding more lucrative and attractive offers in the private sector. With less professionals available it puts higher demands on those currently in the field. The mental health crisis is increasing at alarming rates, and significant damage is being done by opioids/ fentanyl/ methamphetamine/K2/PCP, and crack cocaine. Mental health is declining at rapid rates across the field, and the number of trained mental health professionals is dwindling rapidly. We desperately need increased funding to meet these needs.

We need to figure out a way so that admission officers, counselors, social workers, case managers, and medical professionals, and not those solely in administrative roles, but those currently practicing in the field, have more of a voice at these events, policy making panels, and regulatory based discussions.

We need to look at eliminating the designated time frames for levels of care – it is blanket based, not individualized; the number of hoops that clinicians and treatment teams have to go through to fight for extended stays and next level of residential care is time consuming and frustrating depending on the MCO. More focus has to be on those entities and their practices.

If we want to improve quality of care, treatment centers and outcomes, we need to get all parties (physical health MCO, behavioral/mental health MCO's, medical hospitals, treatment centers, community resources, etc.) to play on the same team, educate them on all levels of care and criteria, recognize that these are human beings, and stop deflecting blame or responsibility to other entities.

We must be mindful of the ever-increasing administrative demands placed on providers, the multitude of treatment options that work that must be individualized, and the woefully inadequate lack of funds especially those treating the poor, Medicaid funded individuals. Working together it can be done. It must be done.