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Testimony Regarding HR 590

David W. Crowe, Executive Director

Crawford County Drug & Alcohol Executive Commission

Good morning and thank you for permitting me to participate in this event. By introduction I am David Crowe and I have the honor of being employed by the Crawford County Drug and Alcohol Executive Commission. Previously I had served several years as the County Human Services Director and was once the County Adult Chief Probation and Parole Officer. Additionally, I am a person of lived experience having been in recovery for 27 years. I can say without fear of equivocation; I have been in and around programming and treatment of addictions for nearly all my 40-year career.

But this is not about me, or for that matter any single person—it is about finding solutions to age old difficulties in a system that has been routinely marginalized by those who discount the validity of the disease of addiction, but moreover by those who have the responsibility to adequately fund program development. It is one thing for stigma to exist in a community—it is inherent in humans to judge, but it difficult to acquiesce in the face of problems when funding falls well short of the borders of the problem. I have witnessed this disparity of funding for years. It is easy to spot the gulf between funding in the “safety net” allocations. I don’t advocate curtailing spending in any other categorical program such as Child Welfare or Mental Health—I am advocating the right sizing of funding to the problems in the community whose genesis is substance abuse.

In that equation, drug and alcohol concerns are intertwined with the nearly all other safety net services. Clearly, substance abuse is a major contributor to home and family difficulties which many times eventuate in Family Court. Substance abuse is a co-morbidity concern with the mentally ill—considered a secondary diagnosis, it nevertheless exacerbates issues with those diagnosed as Seriously Mentally Ill. It pervades the aging populations and even the Intellectually Disabled. And this is to say nothing of the criminal justice involvement, which is extraordinary. This leaves substance abuse issues as conversely the most prevalent concerns by numbers, but the least regarded, by funding.

This has been and will continue to be a significant problem and by my observation the main detractor from a responsive alternative to the growing difficulties we all contend with county to county with ever increasing substance abuse problems.

Before I leave the funding concerns, which I’m certain you have heard repeatedly throughout the state, I need to make a pitch for funding equality. To be certain the entire SCA field is underfunded as indicated above, but moreover the rural counties receive significantly less money per capita than their larger neighbors. There never seems to be a good reason for the disparity, mostly I have heard over the years that the oversight departments are aware of the concern—but I have never seen any change in the process. I’ll concede that rural counties don’t have the same population diversity or even the same

disenfranchised populations...but an opiate addict is an opiate addict no matter where he lives and access to help should not be predicated on his address. There need to be some attention spent on equalizing allocations, built upon a system sensitive to issues more than raw population, which is seemingly the main consideration. This continues to be a significant barrier to program development in our rural county.

## Additional Barriers

Notwithstanding the pervasive concern of lack of adequate funding, other concerns must do with timely admission to non-hospital rehab and or detox. We have found it can be a day or more of continuing phone calls to find a slot for an at-risk individual. Thankfully we have a 4A/4B program in our county which alleviates the processing of those in acute medical distress. However, for those not in emergent circumstances the delay in finding accommodations may disengage the client and send them back out. Substance abuse treatment is a “right now” consideration. If the troubled individual is given time to reconsider their decision, (sometimes this means they have sobered up sufficiently), their reason to pursue treatment pales in the face of the compulsion to use. At this point, DDAP with the Governor’s guidance has instituted a 24-hour help line. Its effectiveness, of course, is only going to be as good as the provider community’s ability to respond. Time will tell, but it is clearly a good idea, with laudable goals.

Locally we have installed a more comprehensive crisis line to hopefully catch those on the cusp of treatment and engage them at this critical crossroad, so far it has proven its worth, but it is still evolving and I can foresee, again, funding difficulties if it creates a marked increase in our client population.

As a primarily MA provider we are not necessarily having difficulties with coverage. Our local County Assistance Office has been especially sensitive to the concerns of our client population and we are deeply grateful for their expediency. Otherwise, we frequently refer out if a person has other insurance coverage. However, we do provide a sliding scale fee for service if the person finds themselves in a position where they do not have adequate insurance and do not qualify for MA. In many of these cases we receive far less than cost for our service—this is to be expected and not held ruefully, but it is a drain on a small budget.

There are other pragmatic concerns impacting on the client’s ability to engage in treatment. Notably transportation is counted foremost among these issues. In a rural county arranging a ride can be challenging. MATP, is the primary purveyor, but certain rules can appear counter intuitive to the person using our services thus creating less flexibility. For instance, there is a rule if the family has a working automobile, rides may be declined—however, our clients frequently have one or more DUI arrest which could preclude them from driving for years, if no one else is available to drive the car it creates difficulties which then manifest chronic no-shows and rescheduling for treatment.

Similarly, with the single parent receiving services we struggle with finding adequate childcare to allow their participation in treatment. In the discussion of addiction being a family disease, this issue poignantly demonstrates how this disease has a rippling effect and how it lends itself to becoming a multigenerational problem.

Also, there has been a lengthy process regarding a standardized assessment, if this was completed and approved it would create efficiencies both for the SCA and the provider community mitigating delays. Furthermore, there have been a long wait for Promise ID's and other functional difficulties relative to starting a new program. For us, a contracted facility for outpatient and Intensive outpatient services had a wait time of over 6 months for the OP and still have not had approval for IOP for well over a year. This has a significant impact on our continuum care in a remote setting in our County. We have also been made aware an unscrupulous provider of non-hospital rehab has somehow inveigled their way into the call-in number services monitored by SAMSHA—essentially overriding the modest purposes of trying to find appropriate placement for a person to directing them to a specific site if they have acceptable insurance. Clearly this creates a huge trust issue with people already inclined to misgivings about services.

Additionally, it has become more difficult to engage professionals in our field. Whereas we have had good fortune finding suitable candidates for openings, we have fewer qualified applicants at each opportunity. We anticipate this trend could have deleterious effects on the strength of our system if it is not addressed soon. The lack of remuneration stands as the primary concern—it appears the professionals in the drug and alcohol field are generally paid less than those of other categorical services. This returns us to adequate allocation.

I appreciate the opportunity to testify. I appreciate you have taken the time to listen. I know everyone has the best intentions. I know the appalling number of people dying from substance abuse has shined a very bright light of our system of prevention, intervention and treatment. I hope what you have found throughout the state is a SCA system which has ***“done so much, with so little, for so long, they are now qualified to do anything, with nothing.”*** (Mother Theresa) This a highly engaged group of professionals. Deeply and passionately devoted to the betterment of our communities, one recovery at a time. The challenges met, are innumerable—the challenges remaining the same. I am proud to be counted among their number—thank you.