Good Morning, and thank you for the opportunity to provide testimony for S.36 (an act relating to Medicaid coverage of long-term residential treatment for co-occurring substance use disorder and mental health condition).

My name is Chris Smith and I serve as the Chief Clinical Officer at Spectrum Youth and Family Services. Previously I have worked as a clinical supervisor with Howard Center's outpatient programs, a crisis clinician and have overseen residential programs for teens and children. I am dually licensed Mental Health Counselor and Licensed Alcohol and Drug Counselor.

Currently, we are facing systemic challenges to assisting Vermonters in accessing the type of treatment that they need in a patient-centered manner. I applaud the difficult work done by colleagues at Serentiy House, Valley Vista and other residential programs – and empathize with the difficult work that they engage in each day. It is my opinion that we have under-resourced the delivery of residential and impatient treatment at a cost to the most vulnerable of our state. Vermonters with Medicaid are too often refused a length of stay or access to a cooccurring system that can meet their needs in a controlled or supportive environment. I would like to highlight a few significant points:

1. Length of stay does not reflect a client centered or individualized assessment of the client's biopsychosocial needs. I understand that that Medicaid has the difficult responsibility of managing our state's finite healthcare resources – but it seems unlikely that everyone fits within the limited length of stay that is offered.
2. The drug supply has changed, and treatment needs to shift in step with these developments. I have heard that the current length of stay is based on research that people can generally stabilize on mOUD (medication for Opioid Use Disorder) in 14-17 days. Perhaps this was true when the primary opioids in circulation were not fentanyl and cut with xylazine - or when methamphetamine was less prominent in the patterns of use among the people we are trying to help. The times have changed, and so the treatment approaches need to change too. Buprenorphine is no longer as effective to combat the strength of these opioids. If it is, eventually, people need longer periods of time to initiate or reinitiate their buprenorphine mOUD. For others, methadone is more effective – but regardless, the presentations of these clients and patients has grown more complex, and we need to take a more nuanced approach to their treatment.
3. Our system is not universally co-occurring. Our hospitals and psychiatric programs are geared towards the treatment of mental health problems, and our residential treatment programs set up to address substance use disorders – while many programs can offer facets of both, there are often confusing and inconsistently

applied rules about what program “can,” serve a person. An outpatient program like ours at Spectrum is often tasked with assisting clients in navigating the two systems of care and what programs would best serve their needs. In a world where the consequences of using substances like methamphetamine, other stimulants and opioids create complex treatment needs, Vermont would benefit from a system where people struggling with addiction and mental health issues can access care for all of their needs.

4. Finally, while I appreciate our state’s longstanding commitment to local decision making, it has resulted in a fractured system of care that struggles to meet the needs of people with complicated treatment requirements. For example, a client leaving their 14-17 day Medicaid authorized stay is asked to coordinate care at a moment that is extremely vulnerable to the inherent disorganization of transition. To continue their care clients have to find an opening at an intensive outpatient or standard outpatient program, perhaps identify an addiction medicine provider to continue medications initiated at a residential program and navigate how to get there for treatment. In many communities these can be separate agencies or programs housed in different locations.

   Given the precarious nature of early recovery and stabilization, why do we ask people to navigate all of these changes at this time? Isn’t this the moment that we’d prefer to say to someone, “I am glad that you are finding success – let’s continue that work here while planning for what comes next.

To further illustrate my points, I’d like to briefly a sketch two contrasting stories based on past clients that I have helped with aftercare following a residential stays. For confidentiality, these are composites of issues I encountered a counselor, rather than unique or identifiable stories.

1. A middle aged man who came to my office at the encouragement of his wife to address his drinking – with support from his PCP we determined it was safest and in line with standards of care to cease his alcohol use under the supervision of a medical team. He did so at the local inpatient medical center, followed by 14 days of residential at one of our state’s programs. He was happy to learn new skills at this program, which served him exceedingly well. He returned home to a an “aftercare,” group and outpatient treatment with me. He was supported by his wife, stepchild and returned to his career in the building trades and his pastimes of fishing and hunting. I had a year-long relationship with him as his therapist before we decided he no longer needed counseling. I trust that while

his road may not have been without its bumps, he had access to much of what he needed.

2. A young man in his early 30's who had been referred to me following his release from incarceration. He was living temporarily in a motel, working part time and reported that he had previously used alcohol, stimulants and opioids. He was on an mOUD program as well. Within a few months, he was struggling to manage a relapse on alcohol and stimulants, and found that his medication for opioid use disorder was not as effectively treating his symptoms, likely due to the reality that many of the stimulants like crack cocaine also contained strong synthetic opioids. We worked to make a referral to an residential program that would be able to meet his needs – but, meanwhile the stress of his situation and due to his worsening substance use, cause a major mental health crisis. Now, the residential SUD program was understandably reluctant to admit him before his mental health crisis was addressed – but the mental health system attributed his crisis to his uncontrolled substance use and recommended he seek SUD care.
   With advocacy from his treatment team, he was placed for mental health care and then transferred to SUD treatment. However, the total length of his stay was only 2 or 2 and half weeks, and he was discharged home. Home, however, was not there – he'd lost his motel placement. On a waiting list for a sober home, he was homeless, staying occasionally with friends and family who had had thier own substance use problems and trying to work his program. He relapsed quickly, and again his use spun out of control within a matter of weeks.

If you are inclined to say that the second story is an outlier, I am here to confirm it is not. I have more experience dealing with scenarios that resemble the second story than the first. Those Vermonters that depend on Medicaid for their treatment and medical care deserve a chance to have their needs more individually considered, there treatment more centered around their unique circumstances and the state's system of care better suited to a cooccurring treatment. If S. 36 helps to expand the type of treatment available to those in need, please consider passing this bill.

As suggested, please find a few additional comments & areas of feedback generated from the meeting:

1. I agree with point made by the Deputy Commissioner and the Clinical Director for DSU that length of stay directive should be part of the legislation. However, I hold a different opinion related to the point that there is no current length of stay limit present in our system. DSU may not, in fact, limit the period of time that one can stay in a high level residential program. However, the funding model indirectly causes an upward length of stay that was well established in DSU's own data. Rarely, if ever, does it seem that clients receive a person-centered length of time. Medicaid functionally creates a length of stay via their own funding model – placing all the cost of treatment longer the 17 or so on the provider.
2. While I understand that Vermont does offer similar types of treatment levels across the state via high level intensity, low level intensity, PHP, and IOP – none of these programs are operated in a way that allows for seamless or concurrent treatment transitions. I think that it is wise to examine the operational benefits of co-located levels of care where individuals can continue their treatment in a manner that reduces the number of transitions.
3. I appreciate the fact that SUD has comparable rates of relapse and readmittance to treatment relative to other chronic conditions. And while those conditions have their own medical risks and complications, the current landscape for a person at risk of relapse involves an levels of risk for overdose that are not well managed by our current system of care.