Making the Public Mental Health, Developmental Disabilities, and Substance Abuse System More Accessible:
An Invitation to Recovery

Flo Stein, MPH

Problems with accessing health care in both the public and private sectors has been documented in the United States and in North Carolina for a number of years. Substance abuse disorders afflict approximately 13 million individuals nationally. Of those 13 million individuals only about 3 million are receiving treatment, leaving approximately 10 million people stranded in the "treatment gap."[1] The data for the public Mental Health, Developmental Disabilities, and Substance Abuse System in North Carolina shows a similar pattern; approximately 8% of those who needed treatment in SFY 2007-2008 received it; 546,796 adults and 53,144 children were in need of treatment with 45,224 adults and 3,689 children receiving treatment services respectively.

In 1998, the US Substance Abuse and Mental Health Services Administration tasked the National Center for Substance Abuse Treatment to begin a national treatment plan initiative. The goal was to reach a working consensus on an improvement process for the addictions treatment system in the United States. Panels from across the nation were convened and agreed on a final vision statement:[1]

> We envision a society in which people with a history of alcohol or drug problems, people in recovery, and people at risk for these problems are valued and treated with dignity and where stigma, accompanying attitudes, discrimination, and other barriers to recovery are eliminated. We envision a society in which substance abuse/dependence is recognized as a public health issue, a treatable illness for which individuals deserve treatment. We envision a society in which high-quality services for alcohol and other drug problems are widely available and where treatment is recognized as a specialized field of expertise.

In 2007, the North Carolina Institute of Medicine (NCIOM) began an investigation of the barriers to accessing care for those individuals and families seeking services for substance abuse problems. This vision statement reflects the commitment of leaders from across the state to conduct an inventory of system issues and to identify ways to close the treatment gap in the state. There are many reasons why individuals fail to get treatment, including stigma associated with the disorder, cost of treatment, unavailability of support, and failure of systems to effectively identify individuals and direct them into treatment. The NCIOM Task Force on Substance Abuse Services made recommendations that may result in a new, more effective system of prevention, treatment, and recovery in North Carolina. Many of these recommendations are presented in this issue of the *Journal*, starting on page 27.

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Flo Stein, MPH, is chief of the Community Policy Management Section in the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. She can be reached at flo.stein (at) ncmail.net.

Treatment in the Context of the Recovery Community

In his monograph *Recovery Management*, William L. White outlines the history of the addictions field by describing its organizing principles.[3] Beginning in 1978, the pathology paradigm describes addiction as a disease and breaks with the previous moral and religious frameworks. This was followed in the 1990s by the intervention paradigm that was marked by public investment in prevention and professionally directed treatment. The model being proposed now is known as the recovery paradigm. Recovery advocates began to work for this change starting in the late 1990s and now, years later, they confront a misguided public perception that people with substance abuse disorders cannot recover. These advocates are joining with elected leaders, policymakers, and treatment professionals to shift the focus from "treatment works" to "recovery as a reality." The movement towards a recovery paradigm is underway.[4]

What many think about the process of addiction may be part of the problem, as many people have a poor understanding of addiction. As with other diseases, our historical understanding of the addictive process has changed over time. The definition that has been developed by the National Institute on Drug Abuse is the one operationalized in the NCIOM report. This defines substance abuse and dependence as a "biopsychosocial" disorder which means that the nature of the disorder is influenced by a combination of biological, medical, psychological, emotional, social, and environmental factors. The disorder is progressive, chronic, and relapsing. Often substance abuse dominates an individual's life, with a profoundly negative impact on the individual and those around him or her. Addiction is defined as a chronic, relapsing brain disease that is characterized by compulsive substance seeking and use, despite harmful consequences. It is considered a brain disease because drugs can change the brain's structure and function. These changes can be long lasting and can lead to the harmful behaviors seen in people who abuse drugs. As a result of research, we know that addiction is a disease that affects both brain and behavior. We have identified many of the biological and environmental factors and are beginning to search for the genetic variations that contribute to the development and progression of the disease through research supported by the National Institute on Drug Abuse.[5]

Access to care is greatly affected by both stigma and common misunderstandings of the addiction process and of people who have substance abuse disorders. Stigma is the negative labeling and stereotyping of a group of individuals that is based on some observable trait they share that leads to discrimination against the individuals or society at large. For centuries, society as a whole has stigmatized individuals with mental and substance use illnesses and discriminated against them socially, in employment, and in their efforts to secure necessities such as housing. Perhaps due to the misconception that substance abuse is due to a moral failing, substance use illnesses are often times more stigmatized than mental illnesses. The failure to understand the biological mechanisms and consequences of drug dependence interferes with these individuals' ability to participate in and receive care that may be most effective in treating their chronic condition.[7] Nontherapeutic clinician attitudes and behaviors may have several sources. Graduate medical education has been slow to shift from commonly held social beliefs and practice settings often reinforce stereotypes. The Institute of Medicine of the National Academies found that in addition to the personal consequences of ineffective, unsafe, or no treatment for substance abuse disorders, the consequences are felt directly in the workplace; in the education, welfare, and justice systems; and in the nation's economy as a whole.[7]

Inter-System Linkages

Because of the nature of the disorder, individuals in need of treatment might appear in various settings, including health care, the justice system, welfare and social services, and the juvenile or education system. Inter-systems linkages that could increase the number of individuals able to receive treatment as well as the resources available for treatment and prevention have to be developed. Where they already exist, they must be enhanced and maintained. All caregivers must have informed referral practices and share a common approach for identifying the problem and determining the most appropriate treatment. North Carolina has the opportunity to develop an interactive system that matches care to need, regardless of the point of entry.

Inter-system issues that contribute to the treatment gap are not limited to the inability of systems to identify and move individuals toward appropriate treatment. They also include the difficulty associated with transferring patient-specific information form one system to another. New technologies require new principals and policies to protect privacy and encourage the effective use of patient information to improve care. Individuals with addictive disorders need an easy–to-read, standard notice about how their personal health information is protected, confidence that those who misuse information will be held accountable, and the ability to choose the degree to which they want to participate in information sharing.[8]

Resource Allocation and Financing

There must be an improvement in the process of allocating current resources as well as new resources to make more effective treatment and prevention accessible to a larger number of people who experience or are affected by problems with alcohol or drugs. The development of a standard insurance benefit that provides for a full continuum of appropriate treatment and recovery maintenance will increase accesses as well as address the inappropriate cost shifting that now occurs between the private and public sectors. Until very recently the majority of prevention and treatment has been supported by and provided in the public sector. The recent passage in Congress of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 will permit the state to strengthen a third-party reimbursement

system, increasing access to care by both public and private practioners.

Expanding Treatment and Recovery Options

In an interview with William White, Westley Clark, director of the Center for Substance Abuse Treatment discussed the construct for the new focus on recovery: "Communities across the country have been concerned about the misuse of substances and the wide range of people affected by such misuse. National leaders and local community leaders recognize that we need the community benefits of recovery, and we need local communities to support people in recovery. And we want to provide a framework through which people in recovery can help others in need of recovery... We want people in every community to know that treatment works and that recovery is possible, and that long-term recovery is a reality."[9]

Not all alcohol and drug problems are chronic and many do not require specialized treatment. Effective prevention and early intervention services and programs are essential to the maintenance of a healthy community. One example of a model designed to target users who may have a problem but do not yet recognize it is providing significant opportunities in primary care and emergency department settings. Screening, Brief Intervention, and Referral to Treatment (SBIRT) is a tool developed for use by the medical community. Once a problem is identified, the medical professional conducts an immediate brief intervention and those individuals with dependence are referred for treatment.[10] This type of new program can reduce the treatment gap and ensure that there is no "wrong door," focusing on unidentified users as an important segment of the population to target.

Improving access to long-term recovery will, by necessity, require a partnership among the recovery community, families, professionals, and policymakers. I am urging a commitment by these partners to do the work to ensure the development of a new system of care, or treatment assisted recovery, that respects the individual taking responsibility for his or her recovery while providing the necessary services and supports for these individual efforts. A review of the history of the development of treatment is instructive as it indicates that much of the treatment in this country has been organized around an acute care model. The effort beginning in the 1940s to convince the public that alcoholism was a disease led to landmark legislation in the 1970s that set the stage for the rise of an acute care model of community-based, time-limited addiction treatment in the United States. The onset, course, and resolution of an acute disorder can be intense and disruptive, but it generally leaves no lasting disability or compromise in functional capabilities. Substance abuse disorders, however, are often not resolved so precisely. William L. White and A. Thomas McClellan, PhD, have written extensively about a more accurate description of addiction as a chronic disease whose treatment should mirror the treatment of other chronic diseases. They argue that the similarities between serious substance dependence and other chronic illnesses are striking.

The work of the Task Force on Substance Abuse Services under the direction of the NCIOM is being marked by a pilot effort to move addiction treatment in North Carolina beyond acute biopsychosocial stabilization and patient education and toward the goal of long-term recovery. This shift from an acute care model to a recovery management model will require changes in programmatic and service practices and will require new financing strategies. These changes will result in improved access to recovery for people in our state. These changes will focus on the following treatment system performance indicators:[11]

- ***Attraction:*** Identifying and engaging individuals and families at an earlier state of problem development (e.g., assertive community education, screening, and outreach programs).
- ***Engagement:*** Enhancing access, therapeutic alliance, and retention (e.g., expedited service initiation, focus on relationship building and re-motivation, altered policies related to administrative discharge).
- ***Assessment:*** Developing protocols that are global, family-centered, strengths-based, and continual.
- ***Service planning:*** Transitioning from professionally developed treatment plans to client-directed recovery plans.
- ***Service menu:*** Focusing on services elements that have measureable effects on recovery outcomes and expanding the service menu to include nonclinical, peer-based recovery support services.
- ***Service duration:*** Shifting from emergency room models that emphasize brief, crisis-oriented servicers to recovery models that emphasize long-term lower intensity recovery maintenance services.
- ***Service location:*** Extending the reach of services from institutional environments to the natural environments of individuals and families (e.g., expansion of neighborhood-based, work-based, and home-based services).
- ***Service relationship:*** Shifting from a professional expert model to a long-term recovery partnership/consultant model with a philosophy of choice for individuals and families.
- ***Continuing care:*** Shifting from follow-up care as an unfunded afterthought to assertive models of continuing care for all clients regardless of discharge status (e.g., post-treatment monitoring, stage-appropriate recovery education and coaching, personal linkages to communities of recovery, early re-intervention when needed, and expanded use of cell phones and internet for long-term monitoring and support).
- ***Relationship to the community:*** Increasing utilization of local recovery support resources in the community (e.g., recovery support groups, recovery community organizations, recovery support centers, recovery homes such as Oxford House, recovery schools, recovery industries, and recovery ministries).

We have a historic opportunity to work together toward a system that supports long-term recovery. Reform for mental health, developmental disabilities, and substance abuse services is flexible and can accommodate change and improvement. A recovery-oriented system of care invites individuals and families to a life of recovery in the community. **NCMJ**

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