Domain III: Treatment and Recovery

Houston and Harris County are critically deficient in the array and adequacy of services and supports that are available for persons who need substance abuse treatment and recovery management. As examples:

- Over 780,000 Harris County residents have substance abuse issues (alcohol and/or other drugs).
- Very few residential beds are available for substance abusers with limited means.
- There are only a few detox beds in Harris County, and few publicly funded substance abuse treatment programs in the region.
- More than 1,000 people are turned away monthly for care.
- Individuals who are unable to access appropriate treatment for substance abuse problems end up in emergency rooms and jails.
- Prevention and treatment of substance abuse returns an average of $3-5 per $1 spent, yet millions of dollars in federal matching funds are lost each year because the state of Texas fails to meet matching grant requirements (Adams, February 23, 2007).

In addition to the statistics listed above, new priorities continue to emerge, such as the need for services for older adults and victims of trauma, including returning military and their families. Addressing new priorities places a strain on other areas of need where resources are already scarce. There are a myriad of barriers to accessible, appropriate substance abuse treatment and recovery services that affect the Houston and Harris County communities. Following are brief descriptions of just a few of the issues.

Stigma

All addicted individuals believe, in the beginning, that they can stop using drugs on their own, and most try to stop without treatment. However, most of these attempts result in failure to achieve long-term drug abstinence. Research has shown that long-term use results in significant changes in brain function that persist long after the individual stops using drugs. These drug-induced changes in brain function may have many behavioral consequences, including the compulsion to use drugs despite adverse consequences. *(Principles of drug addiction treatment: a research-based guide, n.d.)*

Stigma is defined as the negative labeling and stereotyping of a group of individuals that is based on some observable trait they share and that leads to discrimination against them by individuals or society at large (Corrigan & Penn, 1999; Link and Phelan, 2001). "Stigma" refers to the negative attitudes toward members of a group;

"discrimination" refers to the behaviors that result from these attitudes. (Institute of Medicine, 2006)

Substance misuse problems are still not widely perceived as a health condition requiring long-term care, but rather as a moral problem that indicates a lack of self-control, or a potential legal problem (Carlson, in Miller & Carroll, 2006).
Social stigma does act as a barrier to change. It is often given as a reason for not seeking help and may contribute to the greater isolation of groups and networks of substance users. Individuals who see themselves as having a stigmatized identity because of their drug use may over identify with peers, making change more difficult. DiClemente suggests that individuals who are more concerned about stigma may benefit from brief interventions that serve to tip their decisional balance and encourage some behavior change. (DiClemente, in Miller & Carroll, 2006)

Local communities need educational services to raise awareness about substance use disorders, the chronic nature of the illness, and the role relapse plays in the recovery process, among other issues. Educational services could also serve as an outreach opportunity where individuals affected by substance abuse, either directly or within their family and social networks, can hear a message of hope and learn about treatment and recovery choices that are available to them.

Research and Evidence-Based Practices

Research findings suggest there are many effective treatments for alcohol, opioid, stimulant, and marijuana dependence. Treatment variables associated with better outcomes include, for example: (a) longer periods of outpatient treatment; (b) reinforcement (via vouchers, removal of legal sanctions, etc.) contingent upon verifiable pro-social behaviors (e.g., negative urines, employment); (c) individual counseling; (d) proper medications (anti-addiction medications and medications for adjunctive psychiatric conditions; (e) supplemental social services for medical, psychiatric, and/or family problems; (f) participating in AA, some other mutual-help group, or aftercare following treatment (McLellan, in Miller & Carroll, 2006).

Introduction of research-based service models and practice guidelines provided by skilled mental health providers offers an opportunity for improving treatment in everyday practice. The Screening, Brief Intervention, Referral and Treatment (SBIRT) model is an excellent example of a highly effective practice that has yet to be diffused into the greater community. The gap between research, program, and practice is wide.

Flaum (2003) defines evidence-based practice(s) as "interventions for which there is consistent scientific evidence showing that they improve client outcomes." In theory, adopting evidence-based practices is desirable; in practice, implementation of evidence-based practices can be extremely challenging. Stigma, lack of awareness of effective treatment, inadequate supply of evidence-based services and trained providers, and benefits/regulations that limit payments for evidence-based practices all impact the use and availability of these services. Further, many of the evidence-based practice models require consumer involvement to evaluate how these models

can accommodate a recovery and resilience philosophy (Commonwealth of Pennsylvania Office of Mental Health and Substance Abuse Services, 2006).

At the service delivery level, implementing evidence-based practices requires an infrastructure, including leadership to address barriers and require implementation, technical assistance to learn about service requirements, and measurement of fidelity to evidence-based practices to support appropriate implementation and ongoing operations.

Even where evidence-based practices are available, implementation is often insufficiently faithful to the original model to achieve desired results. Calling a practice an "evidence-based practice" is not the same as actually implementing such a practice with fidelity, and fidelity to key processes is critical to ensuring positive outcomes. A host of structural and financial barriers hamper the wider dissemination of evidence-based practices, including:

- Fears that evidence-based practices are too expensive and that much vaunted "cost- benefits" will not be realized.
- Consumer disinterest in evidence-based practices that have coercive elements.
- Lack of fidelity to evidence-based practices due to costs of certain staff required for the model, e.g., nurses in Assertive Community Treatment teams (Commonwealth of Pennsylvania Office of Mental Health and Substance Abuse Services, 2006).

Services for the Uninsured and the Underinsured

- Of Harris County's 3.5 million residents, 1.1 million (31.4%) are uninsured.
- An additional 500,000 residents are underinsured, meaning that their plan is not adequate to meet their health care needs.
- 25% of Harris County's children are uninsured.
- 51.7% of Harris County's Hispanic population – the fastest growing ethnic group in the region – is uninsured.
- The vast majority of Harris County's uninsured are working people and their dependents; 43% of those have annual family incomes below $43,000.
- The fastest growing segment of uninsured in Harris County is the middle class, those with annual family incomes exceeding $50,000 (Adams, 2007).

Despite Houston's world-class medical center and globally renowned physicians, our underinsured residents are frequently unable to access the most basic of health care services. Limited access to outpatient preventive, primary and specialty care, fragmented public health delivery system, and an unacceptably high and growing number of underinsured residents obtaining non-urgent care from Houston/Harris

County's emergency rooms has weakened our area's already fragile health care safety-net (Adams, 2007).

Disparity between the insured and underinsured remains a negative mark on addiction treatment. It has been well documented that people with insurance are usually able to access treatment services in the private sector, whereas underinsured drug-dependent individuals have limited access to the most basic treatment. Nationally, inadequate funding has led to a longstanding shortage of publicly funded treatment. Data support the need for varying program services based on an individual's insurance status. Research indicates, for example, that Medicaid/Medicare and underinsured patients are more likely to have addictions to illegal drugs, whereas patients with private insurance are more likely to have alcohol addiction (Open Society Institute, 2007).

Expansion of publicly-funded treatment options would increase opportunities for all individuals suffering from addiction. Regardless of insurance status, individuals will be able to receive necessary treatment that could make a significant difference in recovery outcomes.

Advocacy

By hiding recovery, the most harmful myth about addiction disease has been sustained—that it is hopeless. Without the example of recovering people, it is easy for the public to continue to think that victims of addiction disease are moral degenerates—that those who recover are the morally enlightened exceptions. "We are the lucky ones, the ones who got well. It is our responsibility to change the terms of the debate for the sake of those who still suffer" (Senator Harold Hughes, cited in White, 2006, *Let's Go Make Some History*, p. 98).

William L. White has written extensively on the subject of recovery advocacy. There is, in fact, a grassroots recovery advocacy movement which is growing rapidly. Per White, "A qualitative shift is occurring in the conceptual foundation and design of behavioral health services. . . . Grassroots advocacy movements and a growing body of longitudinal research are challenging mental health and addiction treatment service providers to re-focus their services toward the goal and process of long-term recovery. . . . Recovery advocacy provides a means through which people in recovery can confront stigma and its resulting social and institutional obstacles to recovery and shape service systems that reflect their own aspirations and needs." (WL White, Recovery from Addiction and from Mental Illness: Shared and Contrasting Lessons, 2003)

Examples of goals established for grassroots recovery-advocacy organizations (for example, Faces and Voices of Recovery; Connecticut Community for Addiction Recovery, etc.) include:

- portraying alcoholism and addictions as problems for which there are viable and varied recovery solutions

- providing living role-models that illustrate the diversity of recovery solutions
- countering public attempts to stigmatize those with substance problems
- enhancing the variety, availability, and quality of local/regional treatment and recovery support services
- removing environmental barriers to recovery, including the promotion of laws and social policies that reduce alcohol and other drug problems and support recovery for those afflicted (White, 2000).

There is an immense need for advocacy related to substance abuse issues. As an example only, community advocates could implement activities that promote awareness about emerging trends such as the misuse of prescription medications. Current data suggest that many people are unaware of the dangers of prescription drugs because (1) they mistakenly believe that prescription drugs are safer to use than illicit street drugs; (2) they can obtain these drugs easily from friends and family, or online, and (3) most are not aware of the potentially serious side effects of using prescription drugs non-medically (Walters, 2008).

Beyond Acute Models of Addiction Treatment

At one time, addiction treatment was based on an acute model focused on brief bio-psychosocial stabilization. Addiction is now understood as a chronic disorder that in many cases necessitates a recovery-management model of care which emphasizes sustained recovery support. A number of recent legislative, policy, advocacy, and service trends support this philosophical shift, both for mental health and substance use disorders. Funding advocacy for recovery-focused services at the state level here in Texas has also begun to emerge. In preparation for the 81st Texas Legislative Session, the Texas Association of Substance Abuse Programs (ASAP) initially advocated for the introduction of exceptional item funding to support not only prevention and treatment, but also *recovery management*.

Recovery management centers on factors needed to sustain long-term recovery: sustained post-stabilization monitoring, stage appropriate recovery education and coaching, assertive linkage to local communities of recovery, and early re-intervention when needed. In an article entitled *"Recovery Management: What if we <u>really</u> believed that addiction was a chronic disorder?"* William L. White suggests a number of conceptual and institutional barriers to widespread diffusion of the recovery management model, including:

- Resistance to shifting from an acute bio-psychosocial model of intervention to a chronic model of care;
- Logistical concerns about the ability to integrate professional- with peer-based recovery support services;
- Fiscal and regulatory systems that do not support sustained recovery management systems;
- Lack of science-based knowledge of the long-term recovery process; and,
- Provider agencies whose organizational structure and high staff turnover hinder long-term relationships between the agency and its community, and

between front-line professionals and the individuals and families affected by substance use disorders.

Additional challenges for the Houston-Harris County area include the fact that there is no coordinated public system for behavioral health care that includes addiction services. Local mental health advocacy organizations exist, but these do not have strong substance abuse advocacy components, nor is there a local stand-alone substance abuse advocacy organization. The recovery-oriented-systems-of-care paradigm applies both to mental health and addiction disorders, but to date has not been a uniting factor. Individuals who have co-occurring disorders are particularly affected by the dearth of cross-competent behavioral health providers.

A number of providers in the Houston-Harris County area have developed proposals to provide recovery case management services in the past, to no funding avail. The coordinated, collaborative effort of state agencies and the local public and private sectors will likely offer the greatest chance of success in designing a regional system and service array that most closely fit the needs of the person in recovery. The Center for Substance Abuse Treatment (CSAT) compiled a summary of seven Regional Recovery Meetings held between April 2007 and January 2008, in which CSAT focused on recovery-oriented system change. Based on the input from stakeholders, CSAT compiled a list of recommendations, as follows:

- Pursue efforts where early successes can be achieved.
- Promote accomplishments to motivate additional change activities.
- Use all tools available to the State, such as peer-to-peer services and case management.
- Conduct process, evaluation, and performance measurement at the beginning of the implementation process, make changes based on these analyses, and enhance monitoring of contracts for increased accountability.
- Involve clients and families at the state, provider, and community levels and use financing and other incentives to leverage systems change.
- Develop job descriptions and standards, enhance recruitment and training efforts, provide competitive pay, and create a code of ethics.
- Invest in a skilled grant writer.
- Conduct ongoing stigma reduction efforts.
- Use managed care technologies to accomplish public sector goals and share the vision of systems change with other States and communities.

There is debate in the literature among providers and others about the definition of recovery, whether it devalues professionals and treatment, and a host of other concerns. The following quote sums these up well: “recovery is old news; recovery-oriented care is implemented only through the addition of new resources; recovery-oriented care is neither reimbursable nor evidence based; and recovery-oriented care increases providers’ exposure to risk and liability” (Davidson et al., 2006, p. 640). To counter these beliefs, the literature describes social inclusion and self-determination

as the underlying values of recovery. Further, if there is understanding that behavioral health disorders are "condition[s] that many people can learn to live with … choice and self-determination become inevitable rather than optional" (Davidson et al., 2006, p. 643).

Research on consumer-run recovery services is underway. Comparison of recovery in physical illness to that in mental illness and substance abuse suggests that people will accommodate to their illness or disability and have this be only one dimension of the personhood, while taking advantage of treatment and rehabilitative services.

Recommended strategies:

Participants felt that it was vital to identify funders, create a needs assessment, and map existing services in order to develop treatment options that allow families with children to remain together. This would result in decreased incarceration, gang activity, and the number of youth being referred to the Juvenile Justice System. It was also deemed important to increase community involvement in the drug conversation and community planning by providers and resources. As a result, a decrease/reduction in children using drugs and alcohol with parents would be evidenced. The following logic model delineates the summit participant's plans.

Treatment Logic Model					
Strategy	**Actions**	Who will be Responsible?	**Short-Term Outcomes One year**	**Intermediate Outcomes 1 to 3 years**	**Long-Term Outcomes 3 to 5 years**
1. Increase collaborative funding for treatment service by bringing more private/ corporate donations into the greater Houston area	• Community Meet and Greet/ informational seminar with local private and corporate foundation representatives and local treatment providers • Treatment providers submit applications based on results of informational seminar • Identify competent providers	• Coordination: HHDOP Treatment Committee • Meeting Set-Up: United Way	• Community leaders and funders are educated on the current status of chemical dependency in the Houston/Harris County area. • Community leaders and funders are educated on how chemical dependency relates with their foundation funding objectives	• Offer private/ corporate funders an oversight board to review applications • Provide bench-marks to funders for successful treatment programs • Provide technical assistance to applicants in an effort to help them write successful applications • Increase number of successfully funded applications • Increase in number of treatment beds, enhanced services, expansion of SBIRT	**Reduction in Crime and Substance Abuse** **An increase in Community Readiness and Involvement** **Increase number of youth and adults access to treatment programs**

Strategy	Actions	Who will be Responsible?	Short-Term Outcomes One year	Intermediate Outcomes 1 to 3 years	Long-Term Outcomes 3 to 5 years
2. Increase community- based services geographically with emphasizes on underserved areas and underserved populations	• Identify funders • Create a needs assessment and • Map existing services • Develop treatment options that allow families with children to remain together	• HHDOP Treatment Committee	• Expansion of relationships between funders and providers • Complete mapping process and distribute to stakeholders • Identify strategies that work with specific communities	• Gaps identified and funded, with new services initiated • Collaborate with community for additional resources • Create satellite treatment centers at city multipurpose/ health centers • Create satellite treatment centers at county health centers • Establish increased availability of services in geo- underserved areas, as seen by offices locations serving # of clients per year • Establish additional detox beds. Additional treatment services for families are available. • Turn foreclosed or abandoned homes or properties into affordable residential treatment centers	**Reduction in Crime and Substance Abuse** **An increase in Community Readiness and Involvement** **Increase number of youth and adults access to treatment programs**

Strategy	Actions	Who will be Responsible?	Short-Term Outcomes One year	Intermediate Outcomes 1 to 3 years	Long-Term Outcomes 3 to 5 years
3. Increase Government funding in the greater Houston/Harris County area for treatment services	• Educate populous of availability of Medicaid coverage • To mobilize community providers to apply for federal and state funding • Ensure that there is a coordinated approach to applying for government funding	HHODP	• Apply for funding through DSHS which will meet the needs of the treatment community and include funding for long term case management/ follow-up • Sub-committee within HHODP Treatment committee formed to collaborate on public funding opportunities	• Teach service providers to bill for Medicaid • Increase local, state, and federal dollars through Targeted Capacity Expansion grants or other appropriate funding for treatment in Greater Houston area • Create a liaison between the community and federal/state agencies to educate people that treatment funding is available through Medicaid and other sources	**Reduction in Crime and Substance Abuse** **An increase in Community Readiness and Involvement** **Increase number of youth and adults access to treatment programs**

Strategy	Actions	Who will be Responsible?	Short-Term Outcomes One year	Intermediate Outcomes 1 to 3 years	Long-Term Outcomes 3 to 5 years
4. Legislative Advocacy	• Educate legislature about the impact of substance abuse on the community that substance abuse is a public health issue and not a moral issue • To formulate an agenda that focuses attention on specific items • Organize so that we know what's going on legislatively • Clear and consistent message for advocates and other stakeholders • To get the healthcare professionals on board with • Depoliticize substance abuse treatment	• HHODP • Association for Substance Abuse Providers (ASAP) • Texas Association of Addiction Professionals (TAAP) • Local legislative representative • One Voice	• Provide training on how to be an effective advocate • To communicate that substance abuse is the number one problem in the United States • Frame a consistent message • Form a local advocacy group for addiction disorders (like MHA for mental health)	• Increase Medicaid coverage of substance abuse services • Change Medicaid rule so that LCDCs can bill for services • Reduce the stigma of substance abuse • Detoxification component in residential services • Advocacy group established and effective	**Reduction in Crime and Substance Abuse** **An increase in Community Readiness and Involvement** **Increase number of youth and adults access to treatment programs**

Strategy	Actions	Who will be Responsible?	Short-Term Outcomes One year	Intermediate Outcomes 1 to 3 years	Long-Term Outcomes 3 to 5 years
5. Collaboration with healthcare field	• Promote increase co- locations for health/ behavioral services	• HHODP	• FQHCs have expanded behavioral health component • Local hospitals/clinics supportive of including SBIRT within their facilities	• Select clinics in outlying geographic areas will offer IOP services • SBIRT implemented in local clinics, ERs, etc. • Reduction of stigma as substance abuse addiction recognized as a medical disorder	**Reduction in Crime and Substance Abuse** **An increase in Community Readiness and Involvement**
6. Engage the whole community in resolving the plight of substance abuse	• Increase community awareness • Educate community on 40 developmental assets, risk and protective factors, and other models that support healthy development	• HHODP • Local media partners	• Develop a speaker's bureau • Talking points and PowerPoint presentation have been developed	• Established presence in the community (measured by requests for speakers) • Reduction in stigma and increasing the availability of community resources	
7. Create a recovery oriented system of care that utilizes long term case management for recovery long term support	• Identify programs throughout U.S. that have successfully implemented ROSC. • Promote recovery communities. • Advocate for peer recovery support services.	• HHODP	• Identify and report steps to enhance current service delivery system.	• Conference on Recovery-Oriented Systems of Care held. • Reduction of relapse and recidivism	**Increase number of youth and adults access to treatment programs**