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THE BRIDGE
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Introduction to This Issue of *The Bridge*

By Paul Roman, Editor

For this issue of *The Bridge*, our editorial board members were presented with this challenge: What are the advantages (or disadvantages) of integrating SUD/AUD treatment into mainstream medical care? This is an issue of substantial prominence today, and an issue that has huge implications for the future of the treatment of SUDs.

If one looks at some aspects of the history of this field, having this question "on the table" might seem like a parallel to the discovery of the Holy Grail. The "alcohol side" of SUD treatment first made such integration its mission statement as early as 1943. The driving assumption was "alcoholism is a disease like any other," a clear call for mainstream medical attention and the inclusion of both diagnostic and treatment attention to alcohol dependence in all areas of medical care. The campaign, launched by the ancestor organization of today's National Council on Alcoholism and Drug Dependencies (NCADD), began with the formation of local "chapters" across the country and with steady lobbying efforts aimed at "recognition" of alcoholism by the American Medical Association (AMA). This led to one of the first uses of a majority vote to assert a scientific truth: After several unsuccessful attempts, in 1956 lobbyists led by Dr. Marvin A. Block brought a motion of the floor of the AMA business meeting that was passed by majority vote, with the result described in AMA's own historical timeline as "AMA declares alcoholism an illness." This perhaps anticipated later actions where in 1973 the American Psychiatric Association voted homosexuality out of its Diagnostic and Statistical Manual, and in 2013 an influential committee voted to transform the definition of the scope of autism spectrum disorders.

The relative influence on medical practice and public attitudes of the scientist's "Eureka!" versus the chairman's "the motion passes" remains to be measured. Yet it is clear to any observer that while the 1956 action was a definite step toward change, the implementation of integration remains an issue 58 years later.

The "drug side" of SUD treatment did not follow a similar path. There has never been a grassroots national organization pressing for the medicalization of drug issues, save for the efforts of NCADD to simply stretch its blanket of coverage by changing its name, or the current recovery movement, which does not distinguish in any way between alcohol and drugs, but the mission of which is unclear relative to the medical community. Nonetheless, the home base of the National Institute on Drug Abuse within the National Institutes of Health is a powerful societal signal of medicalization as well as a potent platform for promoting that perspective.

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Considering the integration of treating substance use disorders (SUDs) into other forms of medical care raises the initial question of “what is the problem?” Many different perspectives can shape the response to this question. The obvious “problem” is that treatment for SUDs is heavily delivered within a specialty treatment sector. So what?

Well, many problems have been identified with the SUD treatment specialty sector. First is the apparently tiny percentage of those needing SUD treatment who actually receive it. This strongly suggests defects in the current design of treatment, and the need for a re-design that would generate more patients. It also highlights the fact that while specialty sectors exist throughout medical care, the pattern of referral and service usage is generally referral from the general, primary care sector. This applies only to a small minority of treatment entries of patients in SUD specialty care.

Second is the observation that the current specialized treatment design is inadequate to address the multiple needs of patients, particularly their co-occurring mental and physical disorders. With a little reflection, this issue points to the importance of “medical homes” where knowledge of all of the patient’s needs is readily available, as well as ready access to appropriate services.

Third is the fairly nebulous concern with treatment quality, presently reflected in outcomes commonly viewed as less than optimal. Some of the quality concerns seem to come from a perspective that is highly critical of the prominence of 12-step ideologies and practices in SUD treatment. Linked to this is an implicit definition of “quality” in SUD treatment as being all things medical. Within these definitions and assumptions about quality improvement, it is quite clear that greater interaction, integration and involvement of other medical treatment personnel in the overall regimen provided to SUD patients would enhance treatment quality.

If integration has such promise, why don’t we just go for it? Obviously there are barriers upon barriers, as well as considerations not mentioned here that stand in the way. What follows are the ideas of a mixture of academics and practitioners whose work puts them up against these matters on a daily basis.

Holly Hagle first offers an enthusiastic endorsement of the integration processes, focusing on the potential range of health problems that could be effectively addressed. Mike Boyle follows with equal enthusiasm, but based on his assessment of the current status of SUD treatment and its potential for implementation of the policies embedded in the ACA. This is followed by Betsy Wells’ tempered enthusiasm, also pointing to potential pitfalls associated with the changes associated with integration into general medicine. Bringing in real-world examples, Louise Haynes builds on Boyle’s concerns about the readiness for change within the current SUD treatment system. At the editor’s invitation, Steve Martino exposes the “dark side” of integration, and does

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yeoman duty in producing empirical evidence for the many barriers to effective transition and implementation. Finally, carrying the theme of complexity, Dennis McCarty and Traci Rieckmann provide an overview of their developing research project in Oregon that promises to provide answers to many of the issues raised by the other commentators.

We welcome Dr. Elizabeth (Betsy) Wells of the University of Washington for her debut presentation in *The Bridge*.

Paul M. Roman
Editor in Chief

We invite readers to respond to these materials, including the workgroup report itself. To the extent they are appropriate, these reactions may be included in future issues of The Bridge. Please address your comments to Paul Roman at the University of Georgia (proman@uga.edu).

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What are the Advantages of Integrating SUD/AUD Treatment into Mainstream Medical Care?

Holly Hagle, IRETA

When considering the question “What are the advantages of integrating substance use disorder treatment into mainstream medical care?” I immediately see many advantages. In fact the first thing that I thought of when reading over the guidelines for this issue was a recent report on Interprofessional Collaborative Practice (2011). This report came to my mind because it espouses the importance of advancing patient centered and community/population oriented health care systems. I have recently been teaching this concept as part of my work at the Institute for Research, Education and Training in Addictions (IRETA) as part of several educational grants that we are currently facilitating. I am more and more convinced talking with advanced practice health professional students (medical students, nursing students, dental students and other allied health professionals) that integrating addiction services is the only way we will tackle the misuse and abuse of substances in the U.S.

Consider the role substances play in relation to physical and mental health -

- More deaths are caused each year by tobacco use than by human immunodeficiency virus (HIV), illegal drug use, alcohol use, motor vehicle injuries, suicides, and murders combined.
- Excessive alcohol use is the third leading lifestyle-related cause of death for the nation.
- Excessive alcohol use is responsible for 2.3 million years of potential life lost annually, or an average of about 30 years of potential life lost for each death.
- Over 5 million emergency room visits were related to drug use, a 100 percent increase since 2004.
- Cigarette use continues to be the leading preventable cause of death in the United States.
- The smoking rate is much higher among persons with mental illness and substance use disorders than among those who do not have these problems. On average, smokers die 10 years earlier than nonsmokers.
- Alcohol and drug abuse is a complicating factor in treatment or patient compliance for many physical health conditions (e.g., asthma, diabetes, tuberculosis).

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• One in three depressed people also suffer from some form of substance abuse or dependence.

• Thirty-seven percent of alcohol abusers and 53 percent of drug abusers also have at least one serious mental illness (CDC, 2013, SAMHSA, 2012, 2013).

Considering the spectrum of substance use ranges from – social and non-problematic use, misuse, abuse, problematic use and addiction, and the plethora of substances that can be abused: legal (tobacco, alcohol, and marijuana in some states); illicit drugs (cocaine and ecstasy); and prescription drug misuse, the scope of the problem is huge. It touches all of us individually and as part of communities.

Which brings me back to my original statement that teaching healthcare practitioners about treating people who have problems with substances will advance patient-centered care and will improve health for individuals and communities. We cannot ignore the role substances play in health and behavioral health. And as such we need to have the broadest approach to substance use possible, including addressing substances in all facets of society, especially medical care settings. Addressing substance use in medical care settings is part of health promotion, prevention, and early intervention.

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Better Treatment Through Medicine: A Case for Integration

Michael Boyle, University of Wisconsin

Perhaps the time has come to design and implement a new system to address substance use illnesses housed within the mainstream medical system.

Ironically, the medical field was a major factor in the development of the specialty alcoholism and drug addiction systems. In 1956 the American Medical Association defined alcoholism as a disease and declared an end to a common policy that barred alcoholics from admission to general hospitals. The results were not impressive, with continuing indifference or refusal of the medical profession to provide treatment beyond detoxification; detox was rarely available among alcoholics taken to jail. There were few treatment options except those provided in state psychiatric hospitals and in a few treatment units in community hospitals.

Additionally, when the medical profession did address substance use problems, some of the approaches, including the use of prefrontal lobotomies, were horrific. Medical attitudes toward alcoholics were evident in the provision of both mandatory and voluntary sterilization based on concepts of eugenics. “Voluntary” sterilization in state psychiatric hospitals was often required as a condition for discharge. It is not surprising that distrust for the medical profession existed among persons in recovery from drug or alcohol problems.

Thus, by the mid-20th century, approaches for treating alcoholism and drug addiction were developed for the most part independently of the medical profession.

The residential approach for treating alcoholism was developed by Pioneer House and then by Hazelden in the late 1940’s. This became known as the Minnesota Model with a 28-day length of stay. The conceptual belief that evolved was that alcoholism had physical, psychological, social, and spiritual dimensions. Alcoholics Anonymous (AA) served as the foundation of the treatment approach, requiring participation in AA and completion of the first several of the 12 steps. The staffing usually included a substantial number of people in recovery. Eventually, this approach spread nationwide.

For drug addiction, a very different treatment evolved in California within an organization called Synanon in the late 1950’s, becoming known as the Therapeutic Community (TC). This approach embraced the concept that drug addiction resulted from character flaws that developed from being immersed in an addiction subculture. The TC strategy assumed that the existing character had to be broken down and then rebuilt through confrontation with and pressure from the members of the staff and TC. This was envisioned as a long-term process, often consisting of one to three years of residential treatment. Ironically, many of the early TCs were focused solely on drug addiction and viewed use of alcohol as a privilege to be earned by the participants.

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The Minnesota Model and Therapeutic Community approaches still have a major presence in the substance use treatment field today, although 28-day treatment is increasingly rare (with most care delivered on an out-patient basis) and TCs have changed, becoming less confrontational today. Both models were based on the beliefs and experiences of their founders and alumni, as little research on effective treatments existed in the 1940s and 1950s.

Decades after the founding of the substance use treatment systems that exist today, several reasons support the idea of general healthcare assuming responsibility for the treatment of alcohol and other substance use disorders.

This change may come about by default since overall, specialty addiction treatment organizations are poorly prepared to participate in the changes required under the Affordable Care Act (ACA). These changes include the delivery of evidence- based treatments, use of electronic health records, and participation in electronic health information exchanges. The research team known as NIATx based at the University of Wisconsin developed a Health Reform Readiness Index to measure the preparedness of addiction treatment organizations to implement the ACA (Molfenter et al., 2013). The index covered 13 domains of organizational readiness with each being rated on a 4-point scale:

• 0 – needs to begin

• 1 – early stages

• 2 – on the way

• 3 – advanced

Representatives of 276 treatment organizations completed the index. The mean scores indicated most providers were in the early stages of developing and implementing changes. For example, the mean score for use of evidence-based treatments was 1.14; 1.12 for using administration information technologies, and .44 for use of patient health technologies. Catching up to the requirements of the new healthcare system mandated by the ACA will be extremely challenging for many of these organizations. Lack of resources, particularly in the publicly-funded sector, currently affects the ability of these organizations to attract and retain highly skilled clinical staff and medical professionals as well as to purchase and implement the technologies that are needed in a modern healthcare system.

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With the implementation of ACA, the demand for the treatment of substance use illnesses is projected to increase, largely because of increased insurance coverage through Medicaid. Expansion of treatment participation by members of the medical profession may assist in meeting this demand. Further, if such an increased medical presence occurs, some of the projected 90% of people who currently have alcohol or drug use problems but do not access treatment may be more likely to accept care in a medical setting rather than a specialized addiction treatment program.

Medications are now available for the treatment of alcohol or opiate use problems. Yet, most specialty alcohol and drug treatment organizations do not employ or have arrangements with medical providers who can or will prescribe and monitor the use of these medications. If the medical profession assumes greater responsibility for addressing substance use disorders (SUDs), the use of medications will surely increase, as that is the principal modality for the treatment of all other illnesses. While the medication options for the treatment of SUDs are currently limited, dozens of potential new medications are in development or being tested in research trials. When found effective, these new medications are likely to be more rapidly adopted by medical professionals than has shown to be the case in the specialty care system with a low level of medical presence. Further, for what is largely improbable within the current specialty care system, advances in personalized medicine research may allow physicians to select medications that are likely to be most effective based on a patient's genetic makeup.

Relatively painless and safe detoxification, whether provided in inpatient or outpatient settings, requires medical monitoring and utilization of appropriate medications. To illustrate what occurs without medical involvement, many specialty treatment providers provide detoxification without medication. Such treatment is frequently referred to "social setting" detoxification. The term sounds nice but in reality it means going "cold turkey" and suffering the side effects of withdrawal. In the not too distant future, people may look back at this practice as barbaric.

Despite over 15 years of research identifying the need for a disease management or continuing care approach to addressing substance use illnesses that are chronic in nature, the predominant models still use an acute approach to treatment and rapid discharge with little ongoing post-treatment monitoring or support. Whether this would improve with greater medical involvement is unknown.

General medicine is supposed to be oriented toward ongoing care of patients, and a major goal of the ACA is to increase this involvement. Even patients with no significant healthcare problems are scheduled for annual physical checkups while patients with chronic conditions such as diabetes and hypertension may have their physician appointments scheduled much more frequently depending on their response to treatment. This orientation would greatly facilitate the addressing SUDs as ongoing conditions that require monitoring.

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Recent research on the use of technologies delivered through computers, smart phones and tablets are demonstrating positive outcomes in all areas of medical care. These technologies can be used for both treatment and recovery support for those with substance use disorders. The medical field is oriented to the repeated introduction of new technology in contrast to the significant staff resistance to innovation that has often been found in specialty SUD treatment programs.

If general medicine assumes responsibility for treating substance use illnesses, it is important that the best psychosocial approaches be incorporated. Professionals such as psychologists and social workers who are highly trained in evidence-based cognitive behavior treatments need to be part of the treatment teams. In fact, the experience of using behavioral change techniques for substance use problems may lead to the adoption of these practices to address other healthcare conditions. Patients should also be encouraged to join and attend mutual aid groups. Voluntary attendance in mutual aid has been shown to increase positive outcomes.

It is time for the head and body of the treatment of SUDs to be reconnected, and the medical field offers the best opportunity for a rapid transformation to occur. Lack of resources, adherence to tradition, and resistance to changes directed toward the decades- old model of community-based substance use treatment make it unlikely that the current structures can adapt to the changing demands that will occur with continuing implementation of the ACA.

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Advantages of Integrating Care Outweigh the Challenges

Elizabeth A. Wells, University of Washington School of Social Work

Health policy in the U.S. is moving toward bringing behavioral health into the mainstream healthcare system. Achieving such integration is an enormous job, requiring changes in funding streams, organizations, and individuals. Facing such a large task, with all of its probable pitfalls, makes resistance tempting; but before opposing this course, one must examine the potential benefits of service integration, especially for individuals and families affected by substance use or alcohol use disorders (SUD/AUD). Keeping in mind what is possible to achieve through integration may also help us design systems that maximize potential benefits for patients. What follows is a brief discussion of possible advantages for both patients and society.

Integrating care would increase access to SUD/AUD services. Results from the 2012 U.S. National Survey on Drug Use and Health (NSDUH) indicate that only 2.5 million (10.8%) of the 23.1 million people age 12 or older classified as needing SUD or AUD treatment received treatment at a specialty care facility (SAMHSA, 2013). This translates into an unmet need for SUD/AUD treatment for 7.9 percent of the U.S. population age 12 or older. This large discrepancy between need and service constitutes one of the primary arguments for both parity in SUD/AUD treatment coverage and integrating treatment for these disorders into our mainstream medical system. It is widely held that more people in need of treatment can be reached in this way, especially with the Affordable Care Act's (ACA) expansion of health care coverage. Prior to implementation of the ACA, many of those in need of treatment lacked coverage1. A proportion was also not receiving regular primary care, and was likely to use emergency or urgent care clinics for any medical needs. Whether in emergency, urgent, primary, or specialized care, the number of substance users who can be treated would be greatly expanded by the integration of SUD/AUD services.

Integrating care would reduce stigma associated with substance use and seeking treatment. In a variety of situations, those who abuse drugs or alcohol are stigmatized because of their substance use. This is likely exacerbated by criminalization of drug use. While stigma has a function, in that it may serve to deter drug use in society, it also produces stress and may have detrimental effects on both mental and physical health (Ahern et al., 2007). In addition, stigma can act as a barrier to participation in needed treatment; worry about negative effects on employment or social distancing from neighbors or one's community are reasons given for not seeking treatment1. Stigma acts as a barrier when it keeps individuals from seeking care out of fear of being identified or labeled as a substance user. Mere attendance at a SUD/AUD treatment facility may be resisted due to fear of such labeling. Integration into mainstream medical care has the potential for reducing both the stigma associated with having a SUD and stigma associated with receiving treatment.

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Treating substance use problems like other health problems has the potential to reduce fear and marginalization of substance users. People with chronic health conditions, such as high blood pressure or asthma, are generally not avoided or discriminated against because of these conditions. To the degree that society can adopt a similar view of SUD, stigma will be reduced, lessening its negative effects on physical and mental health and lowering barriers to seeking treatment. In addition to changing people's views of substance use, locating SUD treatment in the settings where flu, broken bones, high blood pressure, cancer, and heart disease are diagnosed and treated could lessen the fear of being labeled simply by participating in SUD services.

The goal of reducing stigma can only be achieved, however, if stigma attached to substance use is not carried into mainstream medical settings. A number of studies have documented that health care providers are not immune to societal attitudes toward substance users (Skinner et al., 2007; Lloyd, 2013). If I believe that doctors and nurses will treat me badly if "alcohol dependence" appears in my electronic medical record, I will tend not to disclose my level of alcohol use to my family physician. To the extent that marginalization occurs or is anticipated in medical settings, use of such setting will lack effectiveness in both assessing and treating SUDs/AUDs. Perceptions of SUD/AUD problems and the patients presenting with them are, therefore, critical to address at all levels in any attempt at integration.

Integrating care will improve treatment of co-occurring SUD/AUD and medical problems. It is well known that dependence on drugs or alcohol is often associated with physical health problems, such as injury, infections, high blood pressure, asthma, heart disease, chronic obstructive pulmonary disease, liver cirrhosis, and Hepatitis C (Mertens et al., 2008). Substance use places individuals at greater risk of developing certain kinds of medical conditions; some medical conditions may be exacerbated by alcohol or drug use; and some medical conditions, while not made worse by use, may improve if use is decreased or stopped. When SUD/AUD treatment is delivered in specialty care that is not coordinated with medical care, both care systems may be operating in the dark. They lack a complete picture of their patient's needs and are likely not providing optimum treatment. Medical conditions may go undiagnosed because the patient's risk factors are not known. Addiction may be exacerbated by prescribing that is done without knowledge of the patient's substance dependence. Although communication is possible between separate treatment systems, it is costly in provider time and is therefore far less likely than would be the case with a shared medical record. The ideal of treating the whole person has yet to be realized but is in sight if current policy initiatives within the ACA can be implemented.

Integrating care will improve treatment of co-occurring SUD/AUD and psychiatric problems. SUD and mental health treatment programs have largely operated separately due to historical differences in philosophy and

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training. Given these differences, merging the two behavioral health disciplines has proven difficult; but there have been some successes. As is the case with physical health problems, co-occurrence of SUD/AUD with other psychiatric disorders is common, with the depression, anxiety and PTSD among the most prevalent. Currently, primary care and emergency care are common sites for mental health treatment, and only the seriously mentally ill are seen in specialty mental health centers. Integrating both behavioral health disciplines into medical care creates an opportunity to have treatment of each disorder informed by treatment of others, improving patient outcomes.

Integrating care will increase access to medication-assisted SUD/AUD treatment. Effective medications are increasingly available as primary or adjunct addiction treatments for a growing number of substances of abuse. Yet, many smaller specialty care clinics are not able to employ medical providers who can prescribe and provide adequate monitoring of these medications. Providing state-of-the-art treatment requires medical and behavioral health staff trained in evidence-based interventions, including medications. When SUD/AUD treatment is co-located or coordinated with mainstream medical care, this capability is expanded.

Integrating care will improve monitoring and intervention of addiction as a chronic condition. Single episodes of time-limited treatment do not adequately address what is increasingly understood as requiring a chronic care model. Many individuals with SUD/AUD return to treatment multiple times in order to achieve sustained recovery. Because it includes regular and preventive visits, mainstream primary care is in a better position to provide long term monitoring of substance use problems and service as needed than are specialty care programs. Chi and her colleagues (2011), studying Kaiser Permanente patients entering SUD treatment in a managed care health plan over 9 years, found those who had “continuing care”, i.e., yearly primary care and specialty SUD or psychiatric services when needed had twice odds of SUD remission at follow-up as those without. One difficulty is getting SUD patients involved in primary health care; integrating SUD care into a health care system increases the possibility of doing so.

Integrating care will reduce healthcare costs. Duplication of administrative costs and the additional provider time needed for coordination of care across systems are one source of the high price of U.S. healthcare. Greater integration and coordination among services, including integrated electronic health records, are expected to increase efficiency and improve patient care. Integration of behavioral health records with other medical records raises concerns about privacy, and this is associated with the problem of stigma, discussed above. However, the potential gains, in terms of better and less costly treatment, provide a strong rationale for working to eliminate such stigma throughout health care settings.

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The advantages of integrating care outweigh the challenges. Accomplishing this policy initiative will require, at the very least, new collaborations among disciplines, new financing and administrative models, development of integrated electronic health records, and changed attitudes and openness to new perspectives among providers on all sides. Progress on these fronts has been made, and a number of successful models exist (SAMHSA-HRSA, 2013). For SUD/AUD patients and families, the ultimate pay-off is a future in which access is increased to cost-effective state-of-the-art treatment.

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Can we Change and Keep the Best of What We Have?

Louise Haynes, Medical University of South Carolina

Neither people nor organizations welcome change with open arms. Yet, in the addictions field, change is constant. It takes a lot of effort to change, and we wonder whether the future result will indeed be that much better than the system we have today.

This article will focus on a change that currently challenges addictions treatment providers – the integration of addictions treatment into mainstream medical care. I ask the reader's indulgence as I first provide a little personal background as my entre to this subject.

My first job after graduate school was at an academically-affiliated hospital operated by the U.S. Department of Veterans Affairs (VA). I was a social worker serving on an addictions treatment team that included a psychiatrist, a family medicine specialist, nurses, an occupational therapist, psychologists, counselors and a biofeedback specialist. We participated in team meetings every morning where one of the medical students presented a structured, detailed medical and social history on all new admissions. Having no prior experience in the field of addictions, this resource-rich marriage of medicine and addictions care made sense, and at that point in my career, I assumed it was the norm.

My next job was for the Single State Authority (SSA) for the state of South Carolina, where I encountered a very different reality. I was hired because the SSA had signed the first-ever contract with the Department of Health and Human Services (DHHS), a contract that would provide payment through Medicaid for addictions treatment.

My job was to teach addiction treatment providers how to "diagnose" substance abuse and dependence as required by Medicaid. The resistance from the field was intense and passionate. In the beginning, some providers refused to participate or to sign the contract because to "medicalize" treatment in order to collect money was akin to a pact with the devil. Labeling people with specific diagnoses, calling them "patients," requiring credentialed staff – all were steps that were perceived with fear and as a move away from the art of recovery.

The providers asked why we, as the state's experts in addictions, would change our system of care, and agree to keep changing it, as directed by Medicaid administrators? What did they know about addictions? Why would we sign an agreement that required us to take orders from them? As I began to provide training to the community providers, I observed that the resource divide between addictions treatment at the VA hospital and our state treatment system was startling, and the cultural divide between a medical/academic treatment

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program and a system of care that had developed largely outside of medicine was equally so. They were worlds apart.

Despite the providers' resistance and fear, we moved forward with the procedural changes required by DHHS. And, after years of effort and leadership from the SSA, bio-psychosocial assessments became the norm in South Carolina, uniform clinical records were in place, and every clinical counselor in the field of addictions was expected to have full working knowledge of the criteria for diagnosis. This change was an early initiative that would integrate a medical model into addictions treatment. Over time, the culture had changed, and the carrot that had served as the initial stimulus for that change was money.

Although the use of medications to support recovery has not been widely implemented in South Carolina, many changes have occurred, and the adoption of evidence-based treatment is now widely supported. In retrospect, that first Medicaid contract not only pushed the system toward a medical model, but it also served as the catalyst that moved the state's treatment system toward accountability and evidence-based care. Similarly, the advent of the Affordable Care Act may drive changes that move the field further toward mainstream healthcare.

Does it makes sense, at this point in the development of the addictions field, to move addiction services into general medical practice, no longer restricting recovery oriented care to the programs that specialize in addictions services? After all of the work to "medicalize" addictions treatment, are we now ready to "addictionize" medicine? And, if so, what will happen to the culture of recovery when it is transplanted into mainstream medicine? What are the opportunities presented by such a change?

I recently saw an example of a successful transplant of addictions services into medical practice. The NIDA Clinical Trials Network (CTN) is currently conducting a study in HIV clinics. When we were selecting sites to participate in the study, I visited a number of community HIV providers across the country and was surprised to learn that despite the overlap of HIV and substance abuse, many of these clinics had little, if any, connection with addictions treatment programs in their communities.

Although there was a significant amount of substance abuse within their respective treatment populations, these clinics had elected to create their own in-house programs for substance abuse treatment, rather than referring these individuals to existing external community resources for substance abuse treatment. Why? Because their patients resisted referrals to programs that were not familiar with the issues facing people with HIV, and the patients would prefer to receive as many services as possible in one location with staff and culture that were familiar.

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If the HIV clinics had not offered their own recovery oriented care within their clinics, probably most of their patients' drug abuse would have gone untreated. Although the patients in these recovery groups faced many of the same issues that all recovering people face, the interface between drug/alcohol use and the health issues related to their HIV was a common recovery theme that was shared by all group members. The prevalence of associated problems, including housing instability, mental health issues and medication side effects, was significant. While these in-house programs definitely have addressed a need among this population, perhaps the opportunity exists for specialty substance abuse treatment programs to offer consultation and collaboration to infuse more of the traditions of recovery into these specialized HIV/addictions recovery efforts.

Through another CTN study conducted in sexually transmitted disease (STD) clinics across the country, we found that more than 50 percent of the people seeking services at the clinics reported illegal drug use in the past six months, and about one-fourth of the patients had assessment scores that were consistent with severe drug use. Yet, only six percent reported involvement with any form of substance abuse treatment.

Unlike the HIV clinics where medical care is long term with many opportunities to provide addictions treatment services, STD clinic care is typically short term, with one or two visits being the norm. Consequently, the patient flow in STD clinics does not lend itself to the development of traditional addictions treatment onsite. Yet, there is clearly a need to systematically ask questions about drug and alcohol use and have a readily available brief intervention and capacity for referral and linkage, when indicated.

The current call for change in addictions treatment offers a variety of opportunities to bring recovery services to people whose lives are negatively affected by their drug and alcohol use but who would not come to a specialty substance abuse treatment program. I believe that it is possible for the core values and principles of drug abuse treatment to remain intact as services are expanded into non-traditional treatment settings. Yet, we still have many challenges ahead as we work to determine the most effective way to integrate addictions treatment into new environments. Decisions about how to organize and deliver services are often more complex than are the decisions about what type of care to provide. As always, the devil will be in the details.

In conclusion, there is currently a broad continuum of integration of medical care and addictions treatment, but the trend is moving toward a greater level of integrated care. I do not envision a day when addictions care will be richly resourced and able to provide the level of medical and addictions treatment that I saw at the VA in 1983. But, realistically, we may someday evolve to a place where there is an expectation for medical care that includes addictions treatment, a change which has the potential to significantly decrease the stigma associated with addictions. As we move in that direction, treatment providers have the opportunity to shape the evolution

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of care so that recovery principles remain the foundation of addiction services. By actively seeking collaborators in mainstream medicine to explore community needs and design healthcare systems that are responsive to the needs of a broad range of constituents, many of whom seek care in settings other than traditional substance abuse programs, we may be able to keep the best of what we have by sharing our most effective recovery principles with mainstream healthcare.

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Integrating Addiction Treatment into Medical Care: The Devil's Advocate

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As a proponent of integrating addiction treatment into medical care, I find myself in the unique position of serving as the devil's advocate in this edition of The Bridge. The question I have been asked to address is: How could collaboration and coordination of health and addiction care among providers carry potential risks or complications?

An integrated care model has been the recent darling of our field, with the Institute of Medicine calling for the normalization of this model in the United States (National Academy of Sciences, 2006). To date, placing SBIRT (Screening, Brief Intervention, and Referral to Treatment) in medical settings is the most well-known and prevalent effort to promote integrated care. Indeed, the US Preventive Services Task Force (2013) the National Institute on Alcohol Abuse and Alcoholism (NIAAA, 2005) and American College of Obstetricians and Gynecologists (ACOG, 2004) now recommend universal screening for alcohol and drug use and brief intervention in primary care.

Reasons for integrating addiction treatment and medical care have been widely noted (Gordon et al., 2013; Walley et al., 2012):

1. Patients presenting to medical settings have plenty of risky tobacco, drinking and drug use;

2. Patients with substance use disorders often do not perceive a need for treatment and therefore do not seek care in specialty addiction treatment settings;

3. Improvement in one area (substance use) might mediate improvements in the other (medical);

4. Integrated care could create "one-stop shopping" for patients and spur more continuous relationships with treatment team providers;

5. Providers who work within an integrated model have more opportunity for direct communication and collaboration about patient care issues.

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Further bolstering the argument for integrated care is the Affordable Care Act. It will give more people access to health care and to services provided under mental health and addiction treatment parity rules. Therefore, more patients with unhealthy alcohol or other drug use will likely be seen in primary care and other medical settings. An integrated care model might be able to more efficiently manage the interconnected problems of patients and improve their treatment outcomes than the bifurcated system of care that still dominates the United States.

With all this promise, I will now transform me into the devil's advocate. I present potential unforeseen or unintended consequences of integrating addiction treatment into medical care. My aim is to point out the challenges of integration that, if addressed, could improve the integrated care model.

First, integrated care is a promising idea that has limited empirical support (Nilsen, 2010; Saitz, 2010; Saitz et al., 2010). For example, SBIs show consistent efficacy among primary care patients who drink alcohol in risky or unhealthy ways (Kaner et al., 2009). However, SBIs have unproven efficacy with alcohol dependent patients, illicit drug users or those who misuse prescription medications, and within different patient populations (e.g., adolescents) and medical settings (e.g., inpatient). A brief alcohol intervention designed to fit the demand characteristics of busy primary care settings might be inadequate when exported to new and often more complex applications. Moreover, the effect of SBIs on critical indices of health service utilization (e.g., emergency department admissions, re-hospitalizations) remains unclear. Despite this absence of evidence, federal and state authorities continue to encourage medical providers to use SBIs widely (Knopf, 2007; Madras et al., 2009). The same enthusiasm has been demonstrated for chronic care management to address medical and mental health issues simultaneously within patient-centered medical homes (Bindman et al., 2013; Katon et al., 2010). However, when applied to patients with alcohol and other drug dependence, a chronic care management approach compared with a primary care appointment only condition did not increase self-reported abstinence over one year (Saitz et al., 2013). The field is pushing approaches that might not work as intended and needs more research demonstrating the effectiveness and cost-effectiveness of integrating addiction treatment into medical care.

Second, it is unrealistic for medical providers to address all the preventive medical care mandates. Some estimate it would require between 3.5 – 10.6 hours per day for primary care clinicians to follow all recommended guidelines for screening and behavioral management of the top 10 chronic diseases (Ostbye et al., 2010). Medical providers consistently report lack of time, lack of training, insufficient knowledge of area referral and follow-up resources, and low confidence when addressing addiction issues (Delgado et al., 2011; Rose et al., 2008). These busy providers might simply vote with their feet and not integrate addiction treatment into their medical practices, as has often occurred with SBIs (Nilsen, 2010; Kaner, 2010). Integrative strategies that decompress the medical provider workload, rather than squeeze it further, could have a much greater likelihood of utilization. For example, "warm hand-offs", in which the health care providers literally walks the

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patient to a behavioral care provider co-located in the medical setting, might be a feasible model of integration (Cummings et al., 2009), though warm hand-offs as an integrative strategy has seldom been studied for its effectiveness in treatment engagement or outcome improvement.

Another way to address provider burden is to incorporate technology-based approaches to addiction treatment (e.g., computer- or web-delivered SBI) in medical settings. When used as brief alcohol interventions, these approaches are effective (Rooke et al., 2010). However, as with provider-delivered SBIRT overall, it is unknown if computer-based SBIs for alcohol use generalize to other substances and a range of patient populations and settings, and they may not be preferred by all patients even if they reduce provider burden. Recently, Cucciare and colleagues (2013) found that a web-based brief alcohol intervention using normative feedback delivered to veterans in a primary care clinic conferred no additional benefit to treatment-as-usual. While the authors discussed several possible reasons for the absence of differential effects, they speculated that brief alcohol interventions were originally developed to address college student drinking. The veterans in this study included older individuals with chronic alcohol problems/dependence. Older individuals may be less comfortable using technology-based approaches and prefer to talk with a provider. Offering patients choice in how they receive addiction treatment might maximize the benefits of integration. Research efforts should aim to identify specific integrated care approaches and models that work best for specific populations.

Even if medical settings could offer brief interventions delivered by person or computer, these interventions generally are not geared toward those with the most severe addiction problems, and health care providers often feel ill-equipped to handle alcohol and drug dependent patients. It remains to be seen if specialty addiction services (e.g., methadone maintenance, ambulatory detoxification) can be embedded within real-world medical settings or if in some cases it might be better to embed medical services in specialty addiction programs. In either case, both treatment systems would need the resources to deliver the absent element of care on site. A two-way street of integration may be necessary to accommodate the broad range of medical and addiction problems patients bring to both settings.

A question also exists about the degree to which the integration of addiction treatment into medical care might reach those most in need of it. Mulia, Schmidt, and Greenfield (2011) acknowledge efforts to bring more evidence-based behavioral practices, such as SBI, into primary care. However, they note that racial/ethnic minorities and low-SES members of these groups are less likely to be seen by primary care providers. Increasing the availability of addiction treatment in primary care, while generally good, could have the unintended consequences increasing disparities in access to health care for substance use problems. They and others (Saitz et al., 2013; O'Connor, 2013) underscore the need to broaden the venues for delivering integrated care in places where people with co-occurring addiction and medical problems are likely to go. These include schools, work settings, and community centers.

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In addition, integrating addiction treatment into medical care might reveal stigmatization of patients by health care professionals. Bitarello et al. (2012) showed that having drug dependence, with or without alcohol dependence, was associated with receiving significantly worse patient-rated quality of primary care across most domains involving physician-patient relationship. Specifically, injection drug use was consistently associated with lower quality of primary care, raising the possibility that methadone or buprenorphine maintained patients could be most prone to stigmatization when seeking care in medical settings. Current practices of withholding antiviral Hepatitis C treatment or dropping people from transplant lists because of relapse may be manifestations of the broader issue of stigmatization. Health care providers need more education and training about addiction and treatments as integrated care moves forward. Fortunately, the American Board of Addiction Medicine launched an effort in 2011 to train more physicians in addiction medicine, accrediting residencies and fellowships at 10 sites in the United States (Frisch, 2013).

Integrated care also might not result in expected improvements in inter-professional communication. For example, Kim et al. (2013) examined the degree to which non-physician primary care clinicians documented the results of substance use screening and brief interventions. They found that most patients with unhealthy substance use had no electronic medical record documentation of SBI even though all patients had received one. They state “that beyond the division of labor, team-based care requires effective forms of communication between team members (p. 207)”. Further, they call for active efforts to coordinate team activities and develop effective communication processes, lest the physician’s warm hand off might become an occasion to wash one’s hands of the patient’s addiction issues. Requirements for documenting behavioral interventions, such as SBI, in the medical record must be clear. Moreover, physicians must value the substance use screening results and brief interventions provided by nurses, medical assistants, or health educators and use them to guide the patient’s care.

Finally, integrating addiction treatment into medical care involves an implementation process. Effective implementation strategies that best support integrated care in medical settings are unclear, though many (e.g., academic detailing, information technologies, prompting, and performance feedback) show promise.18 As one example, the American Medical Association and the Centers on Medicare and Medicaid have adopted billing codes that directly reimburse physicians for providing SBI services (Knopf, 2007). The extent to which the magnitude of this incentive is sufficient for changing practice is unknown. Furthermore, the complex interplay of political policy, organizational, provider, and patient characteristics will influence the implementation of integrated care. The field needs to better understand these factors for integrated care to be sustainable in medical settings. In this regard, NIDA has funded six projects via RFA-DA-12-008, “Integration of Drug Abuse Prevention and Treatment in Primary Care Settings (R01)” to help illuminate this area.

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The field must address these devilish issues to avoid undermining the success of integrating addiction treatment into medical care. Forging ahead with the best intentions does not always yield hoped-for-results. Widespread implementation of debriefing after traumatic events is a case in point (Rose et al., 2003; Emmerik et al., 2002). Likewise, increased attention on pain treatment during the past decade may have contributed to recent increases in opioid analgesic misuse and overdose, and reducing the supply of prescription opioids to pain patients in reaction to this miscalculation could result in increasing heroin use (Gordon et al., 2013). If done poorly, integration of addiction treatment into medical care might yield poor outcomes or costly null effects, overburdened and poorly communicating health care providers, dissatisfied, stigmatized, and excluded patients, and abandonment by the addiction treatment and medical fields. ■

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Building 21st Century Systems of Care for Alcohol and Drug Use Disorders: Healthcare Transformation and Integration in Oregon

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Twentieth Century alcohol and drug treatment programs tended to be small, free-standing, not-for-profit corporations that provided specialty addiction treatment services with minimal interaction with physicians and medical care. Certified counselors guided patients on the use of 12-step programs. Women and men who failed to maintain abstinence were discharged as non-compliant and told to return to care when they were ready to change. An autonomous treatment system developed because health systems and healthcare practitioners failed to address alcohol and drug use and aggressively discriminated against and stigmatized those struggling with substance use disorders.

The individuals and families struggling with addictive disorders and the communities they live in no longer can afford the shortcomings of segregated medical and behavioral health care. Patients and their families require nurses, physician assistants, and physicians who recognize and address alcohol and drug misuse and abuse. Patients and their families need licensed psychologists, social workers and counselors trained in treating addiction using evidence-based behavioral and pharmacological therapies. Patients and their families need access to recovery medications, and medical care for co-morbid medical complications of alcohol and drug use disorders. A 21st Century system of care for alcohol, tobacco and drug use disorders must be integrated with mainstream medical care.

The organization and structure of an integrated medical and behavioral health care system, however, must evolve and develop over time with active planning. Roles, responsibilities, and relationships must be negotiated. Efficient patient identification, treatment, and referral systems must emerge.

Health Care Transformation in Oregon. Oregon is at the center of this conversation. The Oregon Health Plan (Medicaid) is changing. State legislation authorized Coordinated Care Organizations (CCOs) (similar to the Affordable Care Act's Accountable Care Organizations) and integrated care for alcohol, drug and mental health disorders within primary care systems to improve patient outcomes and reduce costs. Medicaid managed care organizations evolved in partnership with local stakeholders and consumers into CCOs and accepted a broad range of public health and population health mandates. CCOs are accountable for the cost of care, management of care, and access to care. CCOs receive a global budget that merges previously separated Medicaid funding streams for behavioral and physical health and creates incentives to incorporate behavioral health specialists to address alcohol, drug and mental health disorders as members of primary care medical teams. The Oregon Health Authority has approved 16 CCOs.

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CCO Study. With support from the National Institute on Health (R01 MH1000001; R21/R33 DA035640), our multi-disciplinary study team uses mixed methods research to assess CCO implementation and the impacts on prevention and treatment for alcohol and drug use disorders. A review of the CCO applications, the transformation plans, and interviews with stakeholders in each of the CCOs provide initial descriptions of integration strategies.

Screening for alcohol and drug use disorders is one of 33 CCO performance metrics; incentive payments require CCOs to achieve specified rates for population based screening. CCOs must develop intervention and referral systems for linking those who screen positive to brief interventions and referral to care when required. Our study monitors Medicaid utilization data and tracks access to outpatient and residential care and prescriptions for medications to treat alcohol and opioid use disorders. We anticipate that more aggressive CCOs will adopt the National Quality Forum's National Consensus Standard of Care for Substance Use Disorders. In addition to routine screening, the Standards require use of evidence-based pharmacological and behavioral therapies for alcohol, tobacco and drug use disorders. Changes in Medicaid utilization data should reflect implementation of these standards or failure to incorporate the standards into systems of care. Analyses also examine potential impacts on the number and costs of alcohol and drug related emergency visits and inpatient admissions.

To further understand variations in Medicaid utilization data, we interview CCO leaders, stakeholders, and providers. The interviews reveal CCO variation in adoption of standards, integration strategies, and roles for existing drug and alcohol treatment programs. CCOs differ in size, location, governance, and structure. Mixed methods analyses examine how these features affect change or lack of change in measures of integrated care.

The story is just beginning. We anticipate a complex set of case studies and aggregate summary analysis. Systems of care do not change without concerted attention and leadership. The analysis of Oregon's healthcare transformation should facilitate an understanding of how 21st Century systems of care will mature and how integrated care enhances treatment for alcohol and drug use disorders. ■