The Road to Recovery: Substance Use Disorder Treatment in Alaska

House Health & Social Services Committee
Alaska Legislature
February 14, 2017

ABADA Advisory Board on Alcoholism and Drug Abuse
AMHB Alaska Mental Health Board

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ABHA CELEBRATING 20 YEARS
ALASKA BEHAVIORAL HEALTH ASSOCIATION

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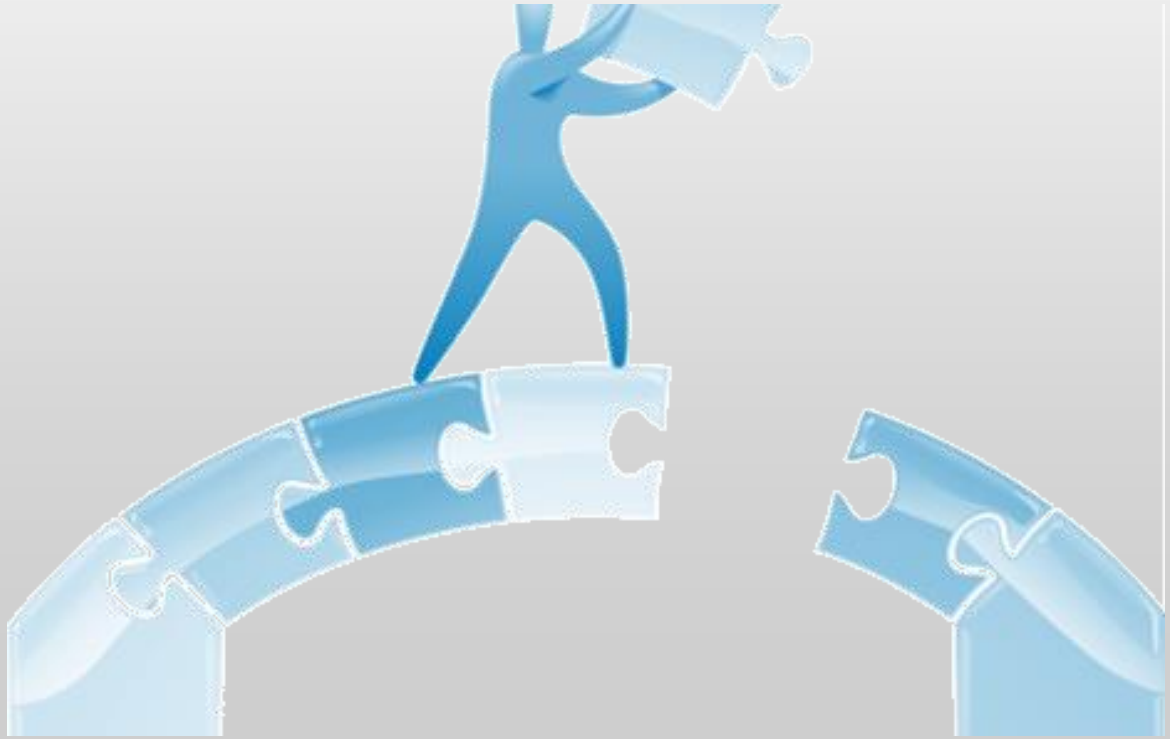
Objectives

- Provide an overview of the substance use disorder treatment system, its strengths and weaknesses
- Provide the perspective of one person's journey to recovery
- Provide the perspective of substance use disorder treatment providers



Setting the Stage

According to the National Survey on Drug Use and Health, an estimated 60,128 Alaskan adults (11.5%) need substance use disorder treatment.

Of these adults, 36.6% (22,006) have a co-occurring mental illness:

10.4% serious mental illness;
10.0% moderate mental illness;
16.3% mild mental illness.

In FY2016, state funded programs provided substance use disorder treatment to **7,808 people**.

Setting the Stage

The Behavioral Risk Factor Surveillance System 2013-2015 data, 66% of Alaskan adults report one or more adverse childhood experiences growing up:

- 21.4% of Alaskan adults report growing up in a household with one or more adults experiencing mental illness;
- 29.7% of Alaskan adults report growing up in a household with one or more adults abusing alcohol and/or other drugs; and
- 19.5% of all Alaskan adults – and 28.4% of Alaska Native adults – report four or more adverse childhood experience growing up.

Martha's Story

Martha is 30 years old. She lives in a small rural community in Western Alaska. Martha experiences the consequences of significant childhood trauma and untreated depression. She lives with her mother, who is also dependent on alcohol.

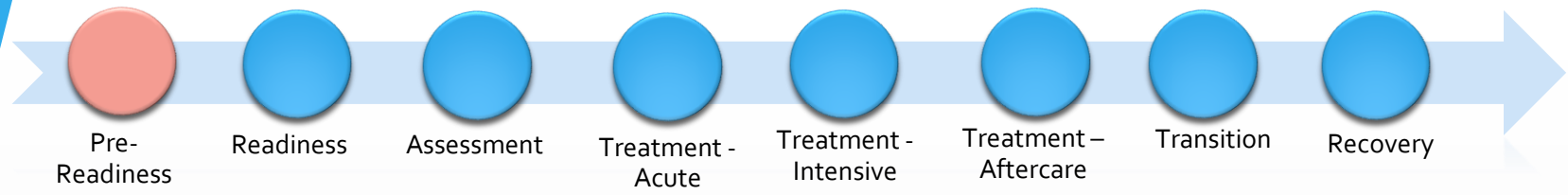
Martha was convicted of DUI five years ago.

She is a frequent user of the health clinic, seeking relief for a host of physical ailments and pain. She meets periodically with the itinerant mental health provider.

Missed Opportunities

The substance use disorder treatment system is funded and designed to serve the most acutely addicted. Priority is given to the highest risk populations. This means that the system is not always able to take advantage of opportunities for early intervention:

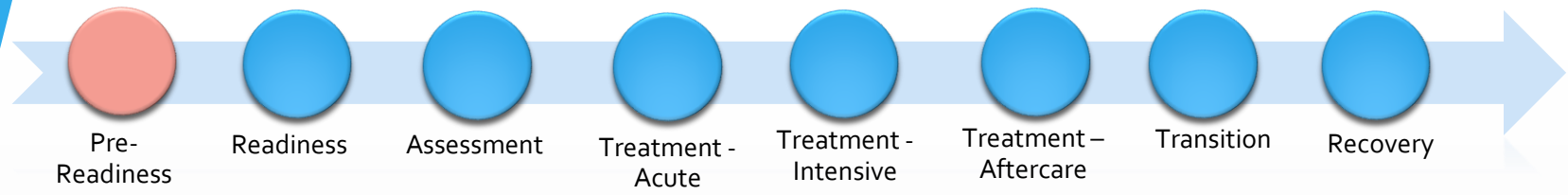
- Early childhood services to prevent, mitigate adverse childhood experiences (such as abuse, divorce, incarcerated parent)
  - Screening and intervention
    - Services for mild to moderate behavioral health conditions
      - Access to evidence-based treatment at the first negative consequence of substance use
        - Screening, brief intervention, and referral through primary care with warm hand-off
          - Integrated behavioral health care



Martha is scared – of the pain of withdrawal and the fact that she is desperate enough to consider using street drugs. She is also scared that, when she tried to stop using opioids, she had thoughts of suicide and she had no one to talk to.

Martha has an appointment at the health clinic. The provider, who knows Martha well, administered a substance abuse screening as part of the appointment.

Their conversation, supported by motivational interviewing techniques, allowed Martha to disclose that she is dependent on alcohol and other drugs, and she's scared of what might happen if she doesn't get help.



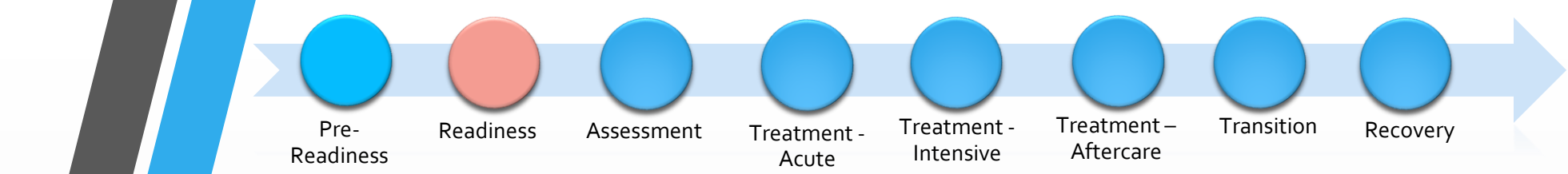
This "moment of clarity" is an opportunity to capitalize on one of the keys to successful treatment – the person's readiness.

Research indicates that only about 4.5% of the people who needed treatment for alcohol or illicit drug dependence recognized the need for treatment themselves.

Only about 1/3 of those who recognized they needed treatment tried to get treatment. Approximately 2/3 made no effort to get treatment.

One of the major reasons people did not attempt to access treatment was because they could not afford it or had no resources to pay for treatment.

Medicaid Expansion has helped to solve this problem in Alaska.

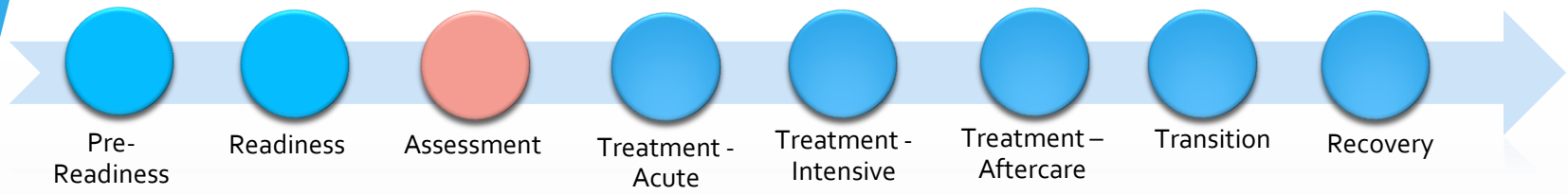


Martha is ready to get treatment. The health care provider at the clinic is able to connect her with the behavioral health department in the larger health organization. Martha is scheduled for an appointment at 9:00 am on Wednesday. She doesn't show up for her scheduled appointment.

Martha goes to the clinic the following Tuesday at 3:00 pm. The provider is unable to do much more than gather some basic intake information. They schedule an appointment for Thursday at 9:00 am.

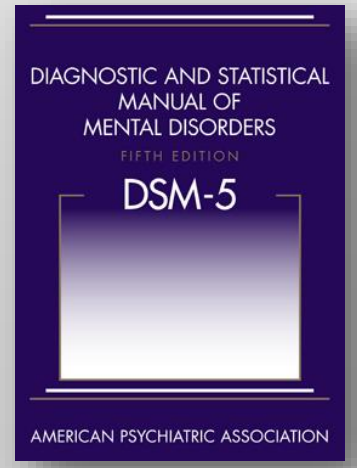
Martha shows up Thursday at 9:30 am. A counselor is able to speak with Martha, but they quickly recognize that she needs an integrated mental health and substance abuse assessment.

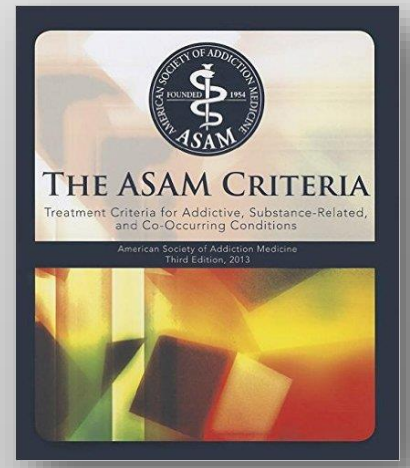
They make an appointment for an assessment with a mental health professional clinician via telehealth. The appointment is next week.



Martha meets via telehealth with a clinician for her integrated behavioral health assessment. Given that Martha's primary presenting issue is that of her alcohol and drug use, the focus of the assessment is on the substance abuse and dependence.

The assessment is a clinical tool based on the American Society of Addiction Medicine's research and guidance. It is used to guide the clinical decisions about what level(s) of treatment will best meet the person's needs.





Levels of Care

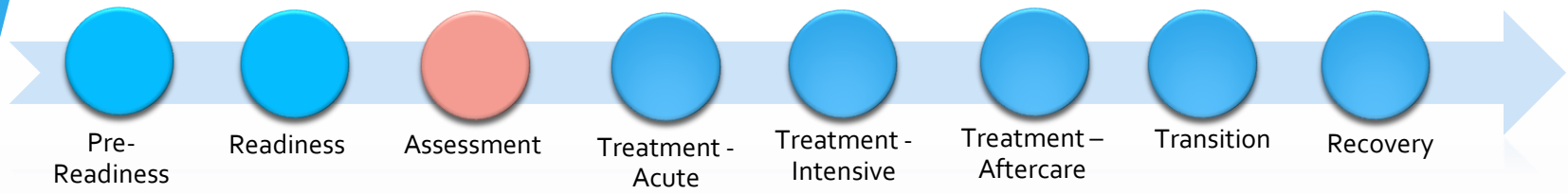
LEVEL OF CARE	ADOLESCENT TITLE	ADULT TITLE	DESCRIPTION
0.5	Early Intervention	Early Intervention	Assessment and education for at-risk individuals who do not meet diagnostic criteria for substance use disorder
1	Outpatient Services	Outpatient Services	Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for recovery or motivational enhancement therapies/strategies
2.1	Intensive Outpatient	Intensive Outpatient	9 or more hours of service/week (adults); 6 or more hours/week (adolescents) to treat multidimensional instability
2.5	Partial Hospitalization	Partial Hospitalization	20 or more hours of service/week for multidimensional instability not requiring 24-hour care
3.1	Clinically Managed Low-Intensity Residential	Clinically Managed Low-Intensity Residential	24-hour structure with available trained personnel; at least 5 hours of clinical service/week
3.3	**This Level of Care not designated for adolescent populations*	Clinically Managed Population-Specific High-Intensity Residential	24-hour care with trained counselors to stabilize multidimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community
3.5	Clinically Managed Medium-Intensity Residential	Clinically Managed High-Intensity Residential	24-hour care with trained counselors to stabilize multidimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community
3.7	Medically Monitored High Intensity Inpatient	Medically Monitored Intensive Inpatient	24-hour nursing care with physician availability for significant problems in Dimensions 1, 2 or 3. Sixteen hour/day counselor ability
4	Medically Managed Intensive Inpatient	Medically Managed Intensive Inpatient	24-hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2 or 3. Counseling available to engage patient in treatment
OTP (LEVEL 1)	**OTPs not specified here for adolescent populations, though information may be found in discussion of adult services*	Opioid Treatment Program (Level 1)	Daily or several times weekly opioid agonist medication and counseling available to maintain multidimensional stability for those with severe opioid use disorder

Levels of Care in Alaska

There are specialty substance use disorder treatment providers funded by the Division of Behavioral Health:

1 sobering center (Bethel)
1 will open in Fairbanks in 2017
3 withdrawal management centers
1 will open in Soldotna in 2017
21 residential treatment centers
1 will open in Mat-Su in 2017
2 non-profit Medication Assisted Treatment (MAT)
state grantee methadone programs (Anchorage, Fairbanks)
2 private for profit MAT programs offering methadone and buprenorphine, (Anchorage, Mat-Su)
2 OCS-engaged parents treatment programs (Anc, Mat-Su)

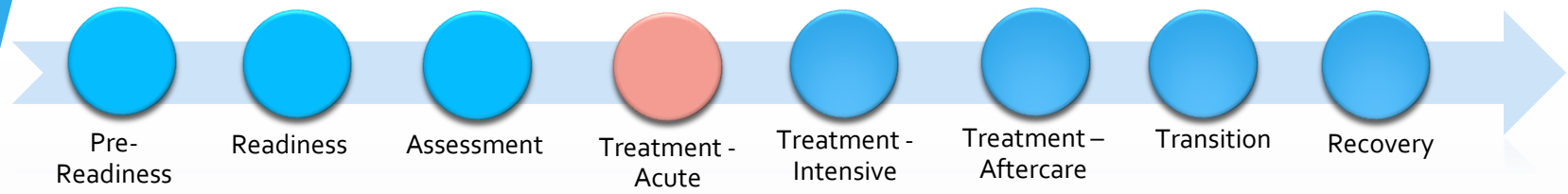
There are 45 outpatient substance use disorder treatment providers.



Based on her assessment, Martha needs intensive treatment to help her withdraw from alcohol and opioids: level 3.7.

Martha is nervous about going to a city for treatment, fearing she will not go to the treatment facility and instead take advantage of the increased access to alcohol and opioids and go find people to use with.

This is an important point in Martha's journey toward recovery. Martha can seek the recommended level of treatment in an urban center or seek a less clinically appropriate alternative closer to home.



Martha agrees to go to a withdrawal management program before moving to a residential treatment.

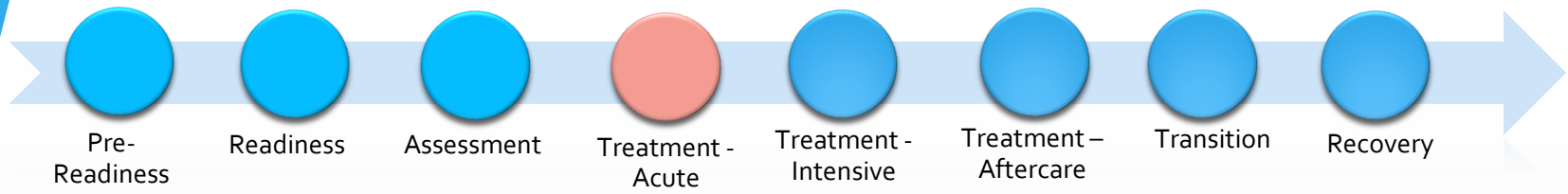
There are <u>34</u> withdrawal management beds in Alaska today.

These are available in Juneau, Anchorage, and Fairbanks.
Last year's appropriation will add 6-8 more withdrawal management beds in Soldotna.

The clinician starts to find a placement for her. Federal guidelines prioritize: 1) pregnant injecting drug users; 2) other pregnant drug users; and 3) other injecting drug users. Additional state guidance prioritizes families engaged with the Office of Children's Services. Martha is not part of a priority population.

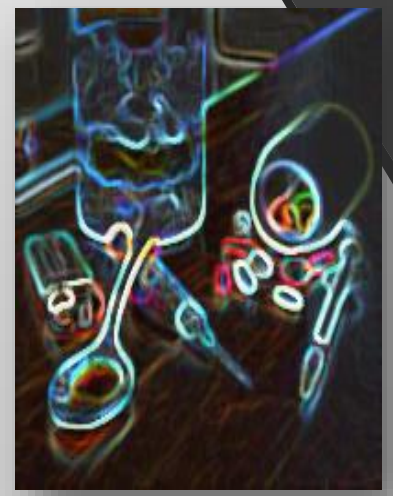
All of the withdrawal management centers are full. A bed is expected to become available in 3 weeks in Anchorage.

Martha and her clinician work together to develop a plan to help her maintain her treatment readiness while she waits for the withdrawal management bed to open up.



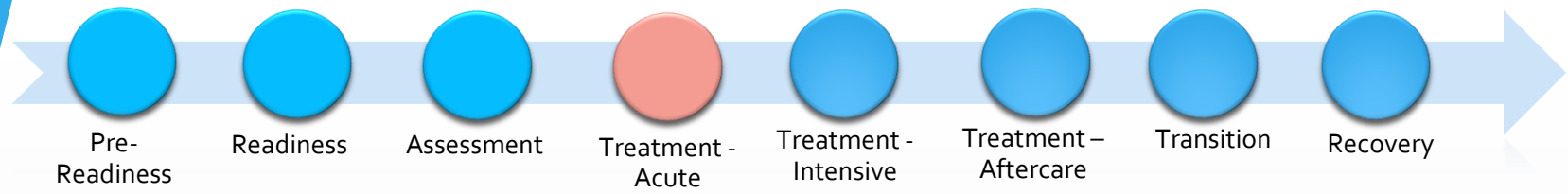
Because Martha has identified the risk she'll divert from treatment on the way, the treatment team arranges to have family members take and wait with her at the village and hub airports. They have also arranged for the provider to pick her up at the Anchorage airport.

Despite all the precautions and preparation, Martha shows up at the airport severely intoxicated. She is not allowed to board the flight to Anchorage. Martha's family member calls the local provider, who works with the withdrawal management treatment team in Anchorage to hold the bed.



Martha stays with a family member overnight, and they take her to the airport the next day.

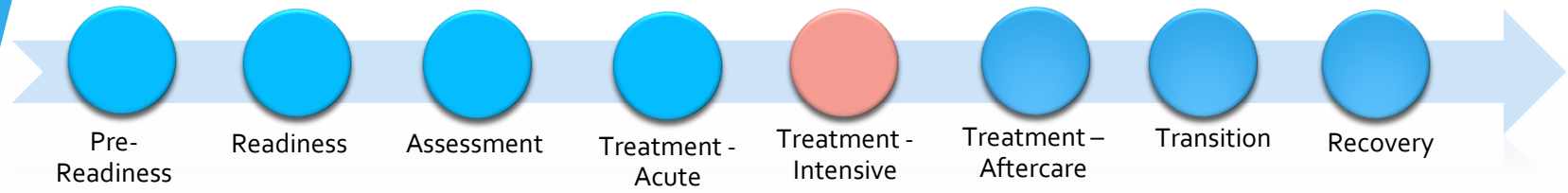
Martha arrives in Anchorage and is met at the airport by someone from the withdrawal management center.



Martha spends the next **7 days** in Anchorage in a medically monitored high intensity inpatient setting (withdrawal management).

The treatment team explores whether placement at a residential treatment setting closer to home following discharge from withdrawal management is available and the best option.

This is an another important point in Martha's journey toward recovery. The discharge and placement process can support or divert Martha's progress.

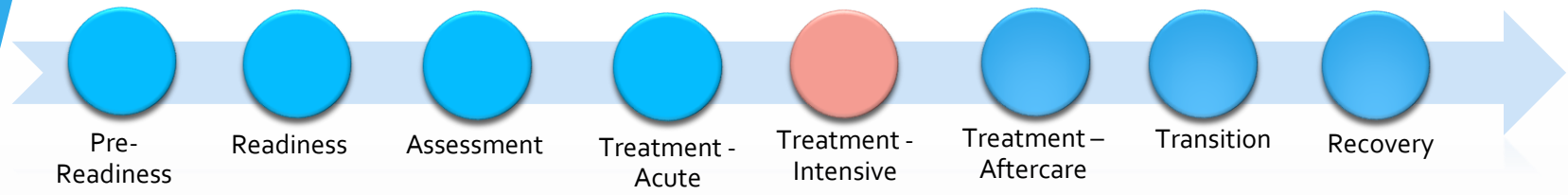


Martha is ready for an intensive residential program (level 3.5 or 3.1).

There are about 315 residential treatment beds in Alaska today.

Residential treatment programs are not one size fits all.
Some are male only, some female only, some co-ed.
Some are for women with children.
Some programs are 30-90 days long, and some are 6-12 months long.
Each one has unique features for specific client populations.

Additional capacity (16 beds) for women with children will come online in 2017 thanks to three years of funding appropriated by the Legislature last year.

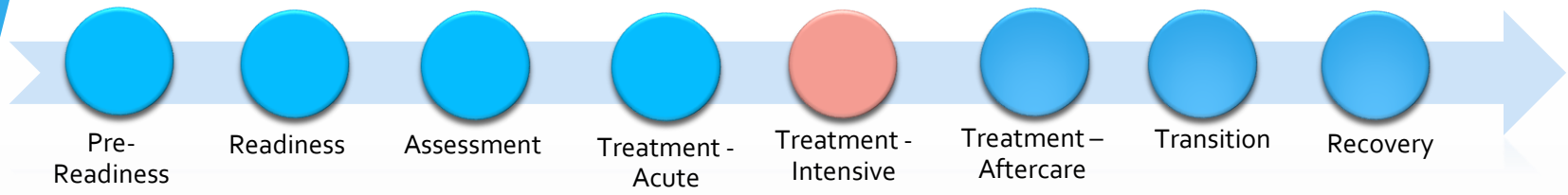


One of challenges faced by residential substance use disorder treatment providers is the Institutions for Mental Diseases (IMD) Exclusion, which prohibits use of Medicaid for care provided to people in mental health and substance use disorder residential treatment facilities larger than 16 beds.

Flat funding and funding cuts have resulted in staffing shortages that make it difficult to fully utilize the residential beds that are available.

Aside from withdrawal management, residential care is the most acute level of treatment in the continuum of care. To achieve the desired outcomes, highly trained staff must follow evidenced-based and research-based practices over a significant period of time.

The treatment is effective and recovery is possible.

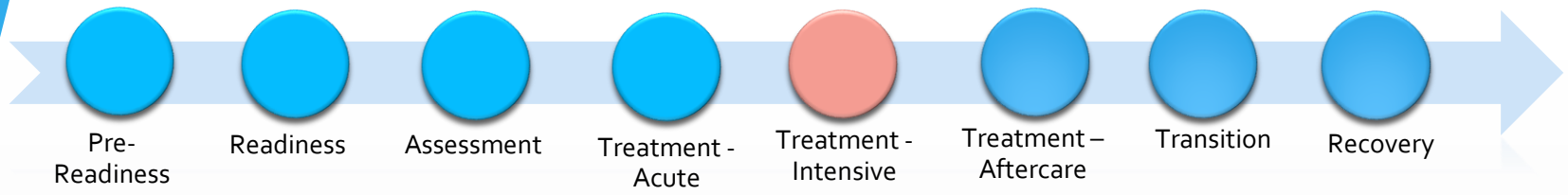


What if there is no residential treatment bed available for Martha when she finishes her withdrawal management?

Medication Assisted Treatment is an evidence-based treatment for opioid and/or alcohol dependence. It combines medication with behavioral health treatment to help the person achieve recovery.

Opioid MAT includes buprenorphine, methadone, and naltrexone.
Alcohol MAT includes disulfiram, acamprosate, and naltrexone.

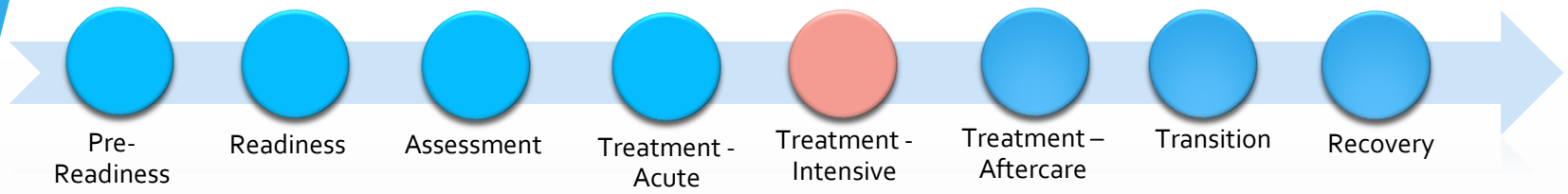
MAT has been shown to increase retention in treatment, decrease illicit opiate use and criminal activity, increase employability, improve birth outcomes among pregnant addicted women, and lower risk of contracting HIV or HepC by reducing the potential for relapse.



Medication Assisted Treatment is available through some community health centers, community behavioral health centers, and private physicians' offices.

Methadone treatment is available in Fairbanks, Anchorage, and Wasilla.

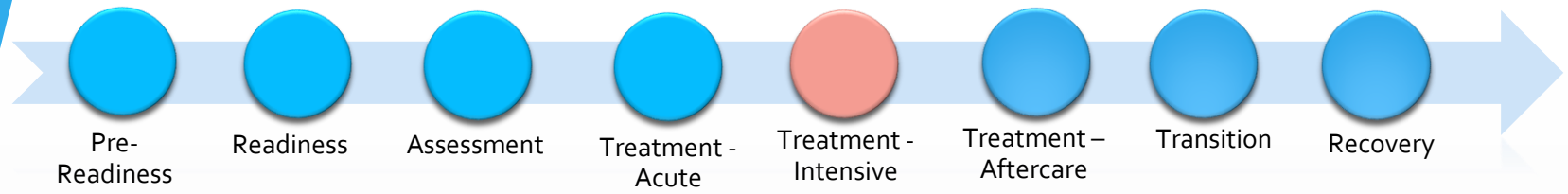
MAT capacity is actively being expanded thanks to a federal grant from the Center for Substance Abuse Treatment, SAMHSA. This project will focus on building capacity in Anchorage and Juneau.



Martha wants to find a residential program closer to her home community. There is a 3.3 level program in her region. It will have an opening in about 2 weeks.

Martha can't stay at the withdrawal management treatment center for the two weeks she has to wait for the opening in residential treatment. She works with the treatment team there, her behavioral health provider at home, and a case manager to come up with a plan for those two weeks.

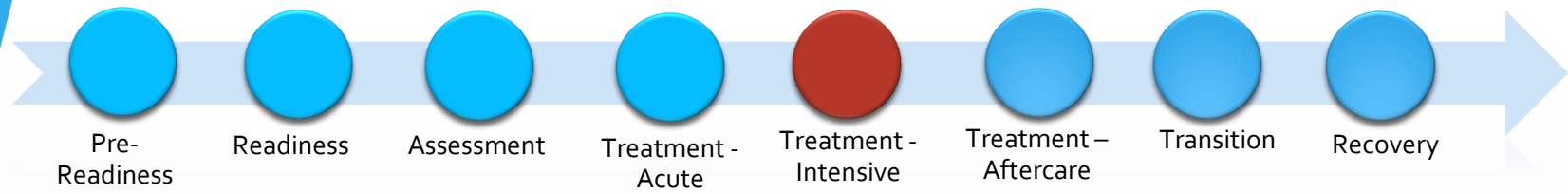
Martha can go back to the hub community and stay with a family friend who is sober and willing to help her stay sober during those 2 weeks. Martha can also attend the nightly AA meetings hosted at the residential treatment center she is planning to go to.



Martha spends **6 weeks** in the residential treatment program.

After residential treatment, Martha needs to move to a lower level of outpatient treatment to build on the progress she's made. Martha is able to transition to outpatient treatment in the hub community, staying with family.

Transitioning from the structure of residential treatment to outpatient treatment is another critical point in Martha's recovery journey. Martha's social and familial networks contributed to and supported her alcohol and drug use. She will be exposed to the triggers and temptations that can derail her progress.



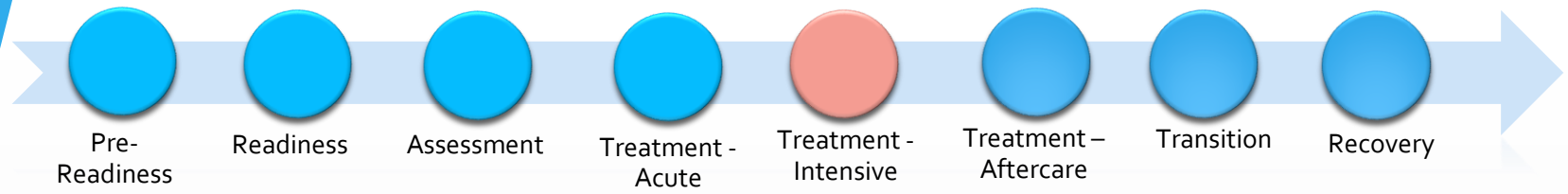
RELAPSE

Martha is invited to a family birthday party. She really wants to go, even though she knows that it's a risk to her sobriety. She has a safety/relapse prevention plan that she and her clinician developed as part of her outpatient treatment plan.

There is alcohol at the party, and everyone (or it seems like everyone) is drinking. Martha makes it through most the of the evening, but then decides "one beer won't hurt." She drinks until she passes out.

The next day, she is very hung over. Someone offers her opioid pain pills to "take the edge off."

Martha takes her usual dose of pills, but because she's been sober for almost 60 days, she doesn't have the same tolerance. **Martha overdoses.**



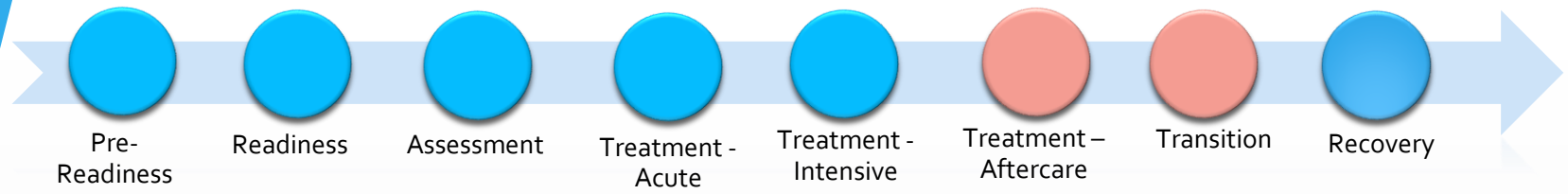
Rapid Relapse Mitigation

Thankfully, the first responders have Narcan onboard, so they were able to save Martha when they responded to her overdose.

Martha's outpatient treatment provider talks to Martha about going back into a residential program to help her avoid a long-term relapse.

Martha is worried that she won't be able to stay sober in her home community. She works with her clinicians to find a residential treatment program that includes aftercare, transitional living and recovery support services.

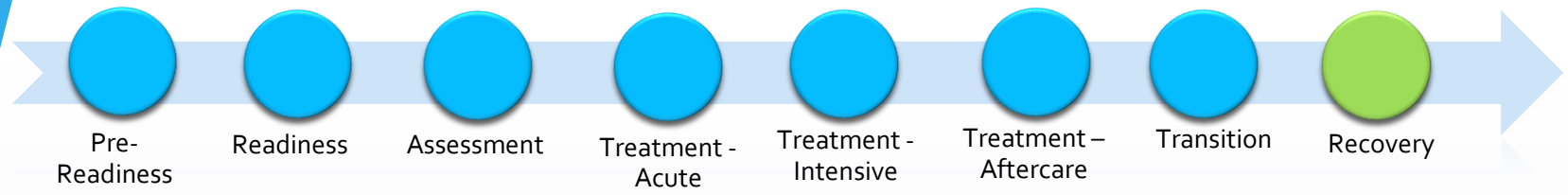
Martha has to wait 10 days to get in.



Martha moves successfully through the levels of treatment offered by the substance use disorder treatment provider. During that time, she connects with other women in recovery and starts to build a support network. She is homesick, but she is also afraid of relapse.

Martha works with a case manager to address barriers to her recovery:

- Housing – voucher
- Employment – vocational rehabilitation
- Health Care – primary care provider
- Community Supports – peer support, healthy activities



Martha just celebrated 12 months of sobriety. She is working full-time in a coffee shop and sharing an apartment with a friend she made at church. She goes to 12-step meetings 3-4 times a week.

Martha is seeing a mental health professional to address trauma and depression that she had been masking with drugs and alcohol. The coping skills she's learning in therapy help her navigate triggers that might lead her to use again.

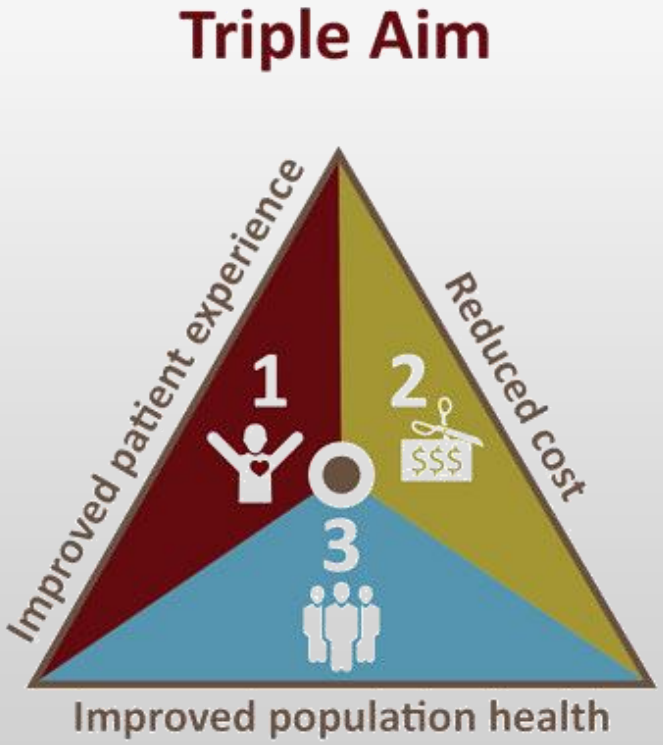
Martha felt strong enough in her recovery to go home to visit her mother. They had a good visit.

Several points along Margaret's journey to recovery hinted at problems the substance use disorder treatment providers have that are hampering their ability to provide the support she needs.

Providers and policymakers are working together to address a larger concern that is affecting healthcare delivery systems across the country.

The Institute for Healthcare Improvement's "Triple Aim" characterizes this as a focus on:

- ✓ ACCESS
- ✓ QUALITY
- ✓ COST



Source: Institute for Healthcare Improvement

System Challenges

- Patient and Provider Stigma
- Administrative Burden
- Reimbursement
- Workforce Capacity
- Access/Transitions – limited availability, waitlists, distribution across Alaska

Patient & Provider Stigma

You heard yesterday from Dr. Sonkiss about the science of addiction.

- Are individuals with a substance use disorder treated the same as individuals with other disorders and diseases?

  Think of someone with diabetes or cancer and how people react to their diagnosis and process of getting care.

  - Are substance use disorder treatment providers treated the same as other healthcare practitioners? If not, why?

    How we pay them, the documentation that we require of them for oversight, how we credential them.

    - How do we treat people in recovery interested in working in the field?

Administrative Burden

Behavioral Health providers in Alaska are required by regulation (7 AAC 70.150) to be accredited by a national accrediting body (Joint Commission, CARF, COA, or other).

Accrediting bodies maintain strict standards that ensure adequate oversight of clinical and business practices, treatment effectiveness, and continuous quality improvement.

There are duplicative reporting, documentation, and oversight requirements that divert resources from treatment.

The 2014 Streamlining Initiative was a successful public/ private partnership to help address these issues.

Workforce Capacity

One of the most significant factors affecting access to treatment in Alaska is availability of qualified workforce. Behavioral health workforce, particularly substance use disorder treatment professionals, are characterized as "difficult" to recruit.

Retention is another issue, and staff turn over affects access and the quality of care provided.

Alaska's Department of Labor reports that:

- the healthcare industry had the biggest job growth in 2016;
- healthcare is the only industry projected to experience job growth in 2017;
- behavioral health and substance abuse disorder counselor job growth "strong," but vacancies are rated as "high."

There are opportunities.

Workforce Capacity (cont)

The **Peer Support** workforce is a relatively untapped opportunity that has a lot of potential to fill vacancies with individuals who have lived experience that could help inform treatment and improve outcomes.

The way we handle the person's criminal background is still a major hurdle.

Advances in **Telehealth** have helped us extend the reach of the workforce we have.

Integrated Healthcare education, policy, and practice have helped us increase access to care and improve treatment outcomes.

Reimbursement

A history of treating substance use problems as a personal weakness or character flaw instead of the medical problem. It is has fed into stigma that is pervasive throughout the system.

That stigma has led to a lack of funding that has hampered research and education, provided challenges to the delivery of effective and efficient treatment, and created a unequal approach to that of the rest of medicine.

Fortunately, Mental Health Parity and Addiction Equity and recent policy changes at the federal and state level have started to recognize the disparity and its effects.

Reimbursement (cont)

Alaska's publicly funded substance use disorder treatment providers are transitioning from primarily operating with General Fund grant funding to a model that relies much more heavily on Medicaid reimbursement.

That transition is challenging:

- Current Medicaid reimbursement rates do not cover the cost of care.
  - Diminishing grant funds are used to help cover the difference.
    - Grant funding helps provide infrastructure to be able to deliver services whereas Medicaid reimbursement requires infrastructure already be in place.
      - Medicaid requires a different standard of program oversight and compliance.
        - Medicaid funding is not as flexible as grant funding.
          - Not all substance abuse providers can be reimbursed by Medicaid (ex. IMD).

Transitions in Care and Access to Treatment

Rather than provide every service in every community, publicly funded substance use disorder treatment providers operate in concert across the state of Alaska, each as a critical component in a larger system of care.

That system of care strives to meet every individual where they are on their journey and help them achieve recovery. It is a customized approach, operating in a system that seeks uniformity for policy and funding purposes.

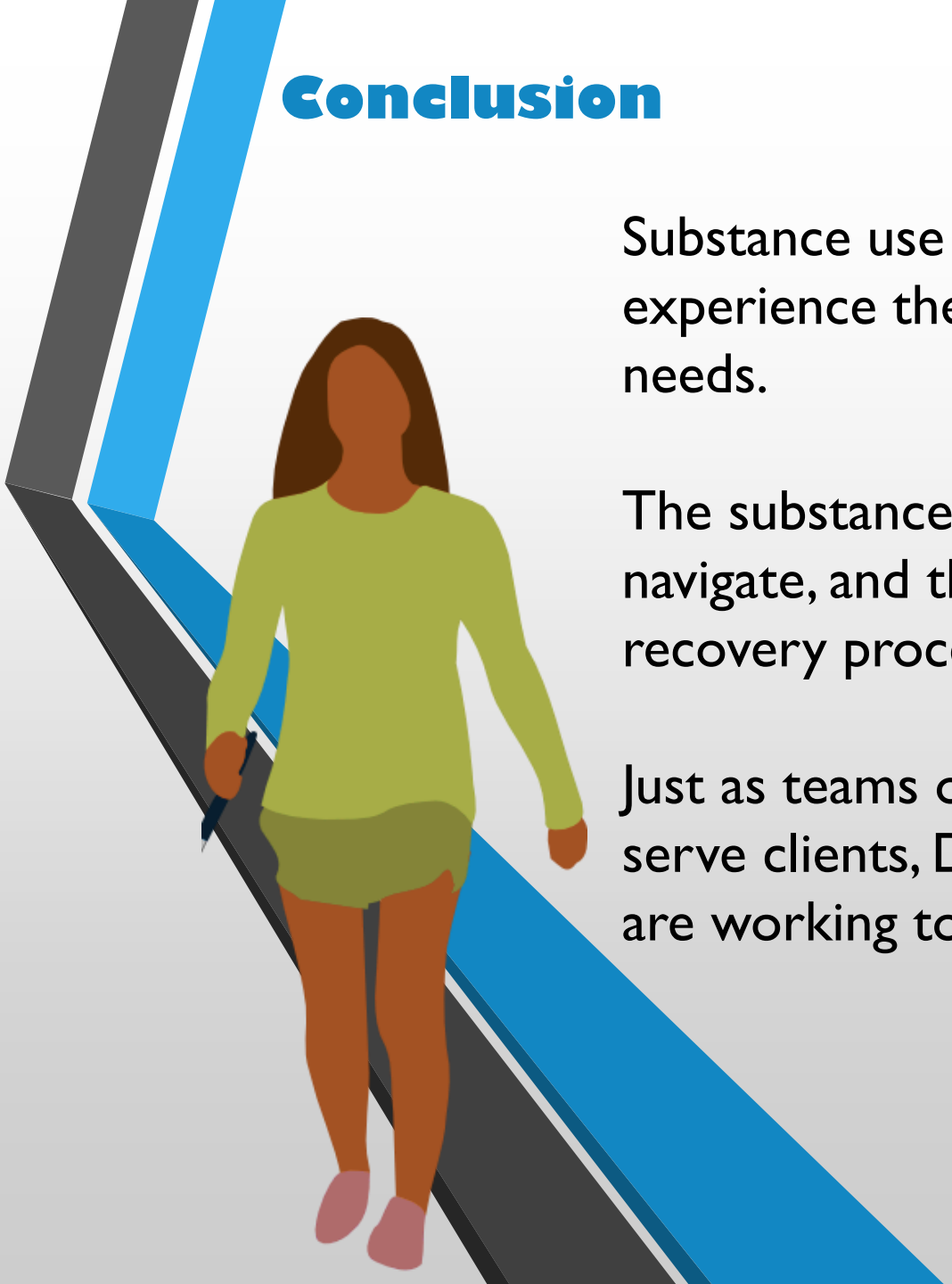
It is challenging for trained clinicians to find the best resources available to assist people in their journey to recovery. It is extremely difficult for someone, especially in crisis, to navigate the system themselves.

RECOVER ALASKA

Alaska 2-1-1 Get Connected. Get Answers. Alaska United Ways

United Way

Conclusion



Substance use disorders are complex, and the people who experience them have many behavioral, physical, and social needs.

The substance use disorder treatment system is difficult to navigate, and there are multiple transition points where a recovery process can be derailed.

Just as teams of health care professionals work together to serve clients, DHSS, ABHA, the Boards, and other stakeholders are working together to maintain and strengthen the system.

Questions?
Comments?

Thank you!

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