FEATURE

California's Substance Abuse Treatment System of Care:

Current Systems and Future Directions

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Introduction

Substance Use Disorders (SUDs) are the most prevalent behavioral health conditions and often co-present with other behavioral or physical health conditions. Additionally, SUDs are a significant public health concern, with opioid use disorders declared a public health epidemic at the federal level. While SUDs are chronic, relapsing conditions, effective treatments are available and specialty SUD treatment systems exist to effectively treat them. Despite having the perfect combination of scope and skill set needed to treat these complicated biopsychosocial conditions, California psychologists are underinvolved in this important area of healthcare and frequently do not identify SUDs as within their expertise. Further, SUD systems of care have historically been separated by location and funding from the treatment of other behavioral and physical health conditions. However, the Center for Medicare/Medicaid Services (CMS) and the California Department of Health Care Services (DHCS) have created a significant opportunity to simultaneously enhance the quality and availability of SUD treatment in California. As the preeminent behavioral health discipline, psychologists are well equipped to lead the transformation of the SUD system of care in California should they choose to do so. This article will provide an overview of the current specialty SUD system of care in California as well as identification of new and emerging opportunities for California psychologists to help address this significant public health concern.

Epidemiology and Burden

Use of alcohol and other drugs often begins in adolescence. By 11th grade, more than half of California students have used alcohol and almost 40% have used marijuana (California Health Care Foundation, 2018). SUDs often co-occur with other conditions, with up to 6 in 10 individuals with substance use disorders also suffering from another mental illness (National Institute on Drug Abuse, 2018).

In 2010, California had one of the highest rates of substance use disorders in the United States (Office of National Drug Control Policy, 2013). As of 2016, approximately 2.7 million

Californians, or about 8% of the population had an SUD, with another 2.1 million meeting criteria for an Alcohol Use Disorder (California Health Care Foundation, 2018). Between the years, 2013-2015, approximately 12 people per 100,000 died from drug overdose across California. In rural counties, such as Lake County nearly 50 people per 100,000 died from overdoses (Robert Wood Johnson Foundation, 2017).

Opioid use was declared a national public health emergency due to the significant increase in abuse of opioids and related deaths since 2000. Approximately 2 million people in the U.S. in 2018 are projected to be dependent on some form of opioid (Office of National Drug Control Policy, 2018). While California has not yet been as adversely affected by the opioid epidemic as some states, many rural counties, including Humboldt, Modoc, and Shasta counties, have overdose rates similar to the states most impacted by the epidemic (Figure 1).

There are significant disparities across race/ethnicity in disease burden and access to SUD treatment. In 2016, rates of alcohol induced deaths among Native Americans in California was more than double that of their Caucasian counterparts (28.5 vs 13.5 per 100.000) and nearly double for all other drug related deaths (33.0 vs 19.4 per 100,000) (California Health Care Foundation, 2018). Further, insurance coverage has historically had a significant impact on whether an individual with a SUD receives needed services. Commercial health plan members have engaged in SUD treatment at a higher rate than Medicaid members (29% vs. 11%, California Department of Health Care Services, 2015.) This is in part due to Medi-Cal not historically covering SUD services. Given that higher percentages of Native Americans, African-Americans, and Latinos utilized Medi-Cal as their primary insurance (Figure 3), this has implications on disparities in access to care.

SUD Treatment

Specialty substance use treatment systems exist within California. However, psychologists often lack a strong understanding of what formal SUD treatment entails. Treatment for SUDs has its origins with the 12-Step/self-help model. This model is an informal, peer-led, abstinence-based and support focused approach that was developed in the early-1900's with a focus on alcoholism. Proponents of this approach credit it with providing an effective, affordable and accessible path to recovery. While 12-Step approaches are often employed in formal SUD treatment programs, on its own, this self-help model is not considered formal treatment, is not reimbursed by funding sources and does not have a strong evidence basis due to its informal, heterogeneous, anonymous and self-directed nature.

The American Society of Addiction Medicine (ASAM) has developed an outcome-oriented, results-based approach to addiction treatment known as the ASAM Criteria (ASAM American Society of Addiction Medicine, 2018). These criteria utilize a biopsychosocial approach, divided into six dimensions, to assess a patient's acute intoxication and/or withdrawal potential (Dimension I); biomedical conditions and complications

(Dimension II); emotional, behavioral, or cognitive conditions and complications (Dimension III); readiness to change (Dimension IV); relapse continued use or continued problem potential (Dimension V); and recovery/living environment (Dimension VI). This assessment criteria assists in diagnosing SUDs and identifying the most appropriate level of care based on the patient's current condition to maximize the likelihood of a positive treatment outcome (Kan, 2014).

The SUD treatment system utilizes a continuum of care, similar to physical and mental health systems of care. These levels of care include Withdrawal Management, Residential, Partial Hospitalization/Intensive Outpatient, Outpatient, and Opioid Treatment Programs. By treating SUDs as a chronic disease and continuously offering and monitoring care, many individuals can establish recovery. However, given the relapsing nature of SUDs, multiple treatment episodes and readily readmitting patients back into treatment may be required when patients have relapsed (National Institute on Drug Abuse, 2018)

Medication Assisted Treatments (MAT) are FDA approved medications (Methadone, Buprenorphine, Naltrexone, Disulfiram, etc.) that are effective in treating SUDs while reducing the risk of overdose and can improve treatment outcomes for opioid and alcohol use disorders. MAT is never intended to be monotherapy and always utilized in addition to psychosocial interventions. Inclusion of MAT improves the percentage of people who sustain their recovery by up to 20 – 30% (Los Angeles County Department of Mental Health, 2018; Roman, Abraham & Knudsen, 2011). .

As with other behavioral health conditions, there are evidenced based practices (EBPs) for SUDs which are mostly adaptations of interventions already known to psychologists. EBPs such as cognitive behavioral therapy, motivational interviewing, and family and couples' intervention do not require extensive specialized knowledge to be modified and employed by psychologists to SUDs (McGovern & Carroll, 2003).

"System Transformation to Advance Recovery and Treatment-Organized Delivery System" (START-ODS)

Access to SUD treatment has historically been driven by insurance coverage and funding availability versus medical necessity. While private insurance companies cover SUD services, there is wide variation in coverage and utilization management standards. Further, private payers have long taken the lead of the Center for Medicare and Medicaid Services (CMS) in determining the type of services covered and the rates of reimbursement offered. CMS utilizes 1115 Medicaid (e.g. Medi-Cal) waivers to authorize states to engage in demonstration projects that promote new or innovative ways to deliver and pay for health care services (Centers for Medicare & Medicaid Services, n.d.) These waivers are one of the mechanisms avail-

able to CMS to encourage states to engage in demonstration projects to test the effectiveness of employing innovations to scale that would not otherwise be possible under existing CMS rules. One such demonstration project that California has enacted and that individual counties can opt into is the "System Transformation to Advance Recovery and Treatment-Organized Delivery System" (START-ODS), also known as the Drug Medi-Cal Waiver. This program expands Medi-Cal benefits in participating counties to include full spectrum SUD treatment should they meet medical necessity. This waiver mechanism allows for SUD services to be paid for by CMS similarly to other behavioral and physical health conditions. Counties that opt into this waiver become managed care entities for Drug Medi-Cal services, with all the regular requirements of managed care organizations (Brassil, Backstrom, & Jones, 2018) including ensuring network adequacy, access to high quality SUD services (including MAT), while establishing utilization management and implementing quality assurance processes. While complicated, START-ODS represents an opportunity to overhaul the SUD system of care in California, markedly expand access to SUD services by expanding the benefits of Californians who utilize Medi-Cal as their primary insurance.

As of July 2018, 19 California counties have opted into participating in the START-ODS, representing 75% of Medi-Cal recipients in California (Brassil, Backstrom, & Jones, 2018) (see Figure 1). Once the additional counties who are currently developing their implementation plans are included, this will increase to 97% of Californians with Medi-Cal who will have expanded access to SUD services.

While START-ODS provides the change in payment structures necessary to realign priorities, simply making funding available does not automatically translate to available high-quality services. This requires a commitment on the part of health care providers and agencies to accept the challenge of improving the availability and quality of care for SUD conditions.

Summary

We have presented evidence of the public health concern that SUDs represent, an overview of the current continuum of care within the specialty SUD system, and the unique opportunity the START-ODS provides California to markedly improve access and quality in SUD Treatment. At a minimum, psychologists need to have a solid understanding of the available SUD treatment services to refer appropriately and enable the patients with SUDs they encounter to have the necessary knowledge to make informed treatment decisions. However, given their knowledge of biological aspects of behavior, ability to assess and treat complicated biopsychosocial conditions, and their ability to work collaboratively with medical and other treatment providers to develop and direct care, psychologists are well suited to do more than provide referrals. Psychologists willing to address this prevalent category of behavioral health conditions are in a strong position to provide the needed leadership and clinical expertise to significantly transform SUD services in California. ■

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