

Substance Abuse Prevention:

A PATCHWORK OF LOCAL POLICIES

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HEALTHCARE FOR THE UNDERSERVED

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Substance abuse treatment remains a patchwork of local policies. Since 1998, the W. K. Kellogg Foundation's Community Voices: HealthCare for the Underserved initiative has been laying a foundation for change by example, creating and piloting models of best practices, and helping some of the hardest-to-reach populations access quality health care. Community Voices continues to address substance abuse prevention, treatment and recovery, creating sustained positive change in each of the communities it serves. The 13 communities are working to build comprehensive programs to weave this fragmented approach into a larger quilt that covers more people. This report discusses concerns, policies, and implications on the health care safety net and illustrates the innovative programs that some of the communities have put into place to prevent and treat substance abuse.

Concerns

Substance use disorders levy a high toll on the lives of individual Americans and on U.S. society as a whole. Attributable to problematic consumption or illicit use of alcoholic beverages, tobacco products, and drugs, including misuse of prescription drugs,¹ they affect a wide range of people, from pre-teens to seniors. According to the 2001 National Household Survey on Drug Abuse—

- Nearly half of Americans 12 years of age and older (48.3 percent or 109 million people) reported being current drinkers of alcohol in 2001, with about a fifth (20.5 percent) admitting that they had taken part in binge drinking, and a smaller percentage (5.7 percent) indicating that they had been heavy drinkers in the 30 days prior to the survey.²

- More than a quarter of the population—29.5 percent of Americans 12 years of age and older—acknowledged use of a tobacco product in the past month. Of those, 24.9 percent smoked cigarettes, 5.4 percent smoked cigars, 3.2 percent used smokeless tobacco, and 2.3 million smoked pipes.³
- An estimated 7.1 percent of the population—15.9 million Americans 12 years of age and older—had used an illicit drug during the month prior to being interviewed. Among those ages 12 to 17, drug use rose to 10.8 percent in 2001 from 9.7 percent in 2000; among those 18 to 25, it soared to 18.8 percent from 15.9 percent over the same period.⁴
- While the survey showed that a smaller proportion of older Americans (2.6 percent of those 55 and older) used illegal drugs, it indicated that nearly half of that age group had used alcohol in the past month, although binge and heavy drinking were fairly low. For example, 5.8 percent of people 65 and older characterized themselves as binge drinkers and 1.4 percent heavy drinkers.⁴

These disorders come at high personal and societal costs: social and physical dysfunction, family turmoil, and decreased economic productivity, as well as increased motor vehicle and other accidents, greater community violence, and higher morbidity and death. Some studies have estimated that up to half of all health care costs—for example, liver disease, personal injury, and depression—are related to excessive use of alcohol and

drugs.⁵ Substance use disorders are responsible for approximately 500,000 deaths each year and cost the national economy an estimated \$414 billion.⁶

Examples from communities across the country—reported by Community Voices grantees—put these numbers in human terms:

- Alcohol abuse has been a predominant problem for many years in New Mexico, with alcohol readily available at multiple locations, according to Wayne Powell of Community Voices New Mexico. Although drive-up windows have been closed and legislation to

enhance penalties has been enacted, alcohol-related deaths continue to be significant. As a result, the state's DWI injury and fatality rates are substantially higher than those of other states of similar population. In this very geographically diverse state, the roadways are often two-lane in rural areas, and heavily traveled multi-lane highways in more populated areas. Any impairment—sleep deprivation or alcohol use—increases the risk of motor vehicle crashes. There is a ripple effect through the economy, as

years of productivity are lost and the costs of rehabilitation, law enforcement, adjudication, and incarceration mount. The impact of alcohol and drug use on future generations is even more profound. Family social disruption, such as domestic violence, is obviously a risk factor that will affect children in the home and help shape their future behavior.⁷

- “We definitely have a high rate of tobacco use, especially among teens,” Melissa Watford of FirstHealth Community Voices, points out. A major reason is North Carolina's status as the largest producer of tobacco in the United States. With tobacco not only readily accessible but also cheaper than in states with sin [tobacco] taxes, Watford adds that 39 percent of high school students smoke in Montgomery County, one of the counties Community Voices serves. Statewide, that's high and, of course, nationally, that's really high.⁸
- “There's a problem with cocaine and crack; those are the major drugs,” asserts Sandra Harris of Northern Manhattan Community Voices Collaborative. “It's hard to say which one leads to the other. While the problems are most significant in young adults, you have people in their 30s as well as the older generation that were previously impacted and are still under or need treatment.”⁹
- “Approximately eight percent of the over two million people living in the Denver metropolitan area have substance abuse issues,” according to Elizabeth Whitley of Community Voices Denver Health. While alcohol is “the most used

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and abused substance in Colorado” where adolescents and adults drink more than the national average, other substances are significant, too. They include, but are not limited to, marijuana, cocaine, heroin, methamphetamine, club drugs, and prescription drugs. Additionally, it is estimated that 25 percent of individuals with substance abuse disorders have significant co-morbid physical and mental health issues.¹⁰

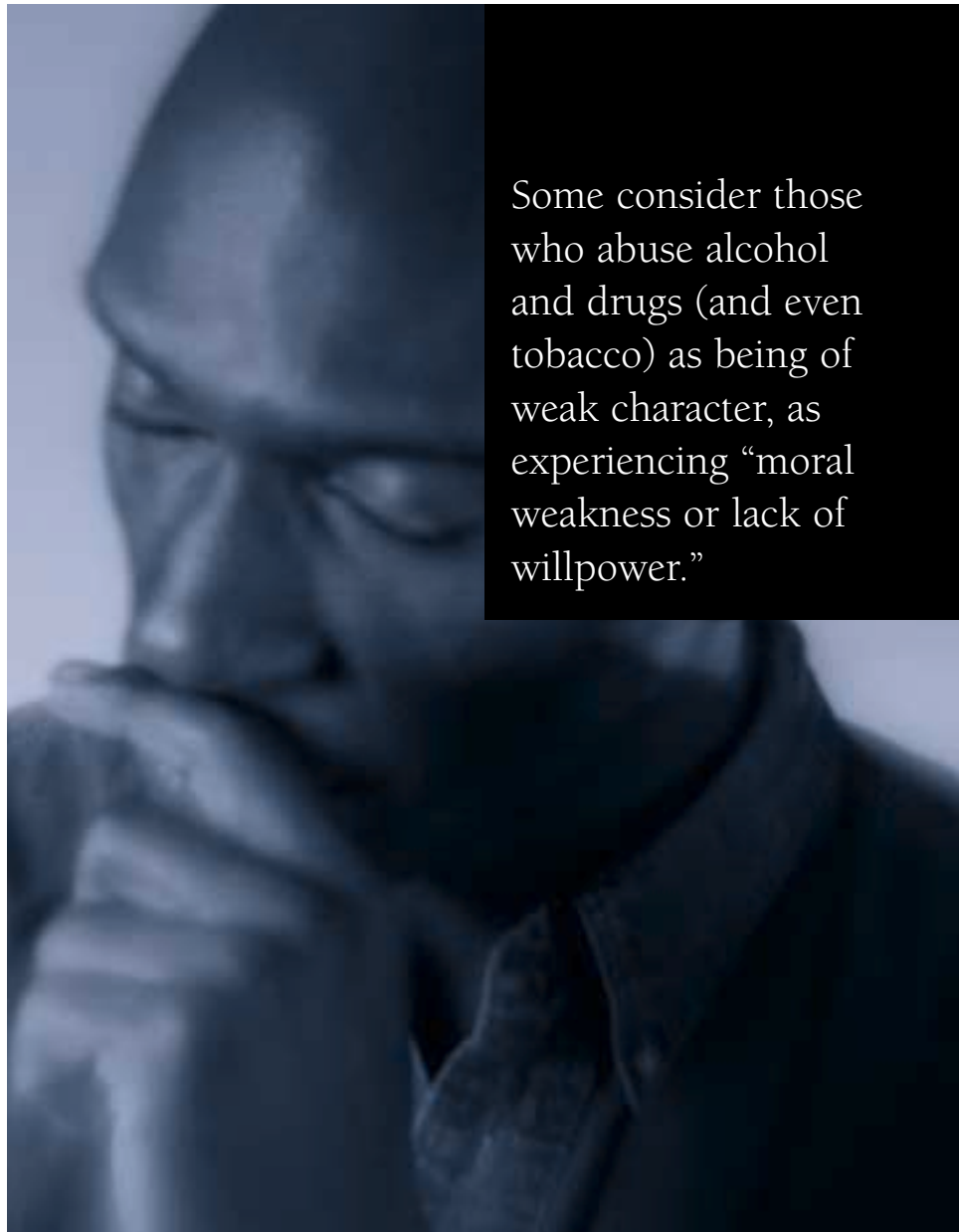
Policies

Public perceptions of persons with substance use disorders vary considerably. Some consider those who abuse alcohol and drugs (and even tobacco) as being of weak character, as experiencing moral weakness or lack of willpower. This perception correlates closely with the criminal justice model for dealing with substance use disorders.

Others view those with such disorders as caught in a family dynamic—drinking or taking drugs along with other family members or being encouraged or allowed to do so as part of a dependency-codependency model. Still others see substance use disorders as medical problems related to brain functioning, in which dependency becomes chronic or progressive unless intervention and treatment disrupt the cycle. However, there are others who think that substance use disorders are caused by external factors—the learning of maladaptive social habits through environmental, cultural, social, peer, and family influences. There are those who believe that substance use disorders reflect individuals’ attempts to self-medicate due to a psychiatric disorder or need to cope, to alleviate painful symptoms

or to fill a void in functioning. Finally, there is a biopsychosocial combination that combines the features of all these views.¹¹

Although there may be different theories to explain substance use disorders, there seems to be widespread agreement among experts in the field that prevention programs exist and are effective. This is an exciting time for alcohol and drug abuse prevention. In the past 20 years, the prevention field has matured past the early attempts of drug education or ‘scare-tactic’ interventions to well-researched,



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comprehensive, and effective prevention programs. There are three levels of such programs:

- a) universal—directed at an entire population, such as a school, a church, or a total community;
- b) selective—targeting high-risk groups, such as children of substance abusers, American Indian children, and prisoners; and
- c) indicated—aimed at youth or adults with identified precursors of alcohol or drug abuse, such as those with aggressive or conduct-disorder behaviors.¹²

Moreover, despite negative public perception about the effectiveness of treatment programs, empirical evidence shows that addictions can be addressed through behavioral intervention, medication, or combination of both.

“Both controlled clinical trials and large-scale field studies have shown statistically and clinically significant improvements in drug use and in the drug-related health and social problems of treated individuals,” writes A. Thomas McLellan, Ph.D. “Recent pharmaceutical research has produced effective medications for the treatment of alcohol, nicotine, and opiate dependence, and has identified promising candidate medications that will provide even more assistance to physicians in treating these illnesses.”¹³ McLellan reports that treatment outcomes can be measured by reduction of alcohol and drug use, improvement in personal health and social function, and reduction in public health and public safety threats.¹⁴

Community Voices programs illustrate some of the prevention and treatment approaches that are underway:

- The Rio Arriba Family Care Network—one of Community Voices New Mexico’s partners—draws attention to hard drug use in the community and to intervention and treatment strategies that might be used to support services in the community. The Network also focuses on care management for those individuals in substance abuse treatment programs and in primary care settings. (Rio Arriba County has high rates of heroin use and one of the highest rates of heroin-related deaths per capita.) The Rio Arriba Family Care Network

used W. K. Kellogg Foundation’s Community Voices and Robert Wood Johnson Foundation support, along with some county funds, to match grants from the criminal justice sector and the Substance Abuse and Mental Health Services Administration (SAMHSA). The community rallied support and resources to purchase a former psychiatric facility to house residential treatment and other relevant community programs into one site for individuals with substance use disorders and their families.¹⁵

- Coordination of care also figures prominently at Community Voices Denver Health, which involves “case-managing chronically ill adults who use the health system’s services more than three times a year,” according to Elizabeth Whitley. “The majority of individuals who are eligible for the case management program have comorbid conditions, either substance abuse or behavioral health issues,” along with whatever physical problems they are experiencing. Under the program, case managers refer these persons to appropriate services. In situations where there are wait times for treatment, the case managers will find some temporary—even outpatient—treatment for individuals who need inpatient treatment, and are very involved in ‘working the complex health system’ on their clients’ behalf. Moreover, community health workers are involved in identifying and helping people access needed services.¹⁶
- Northern Manhattan Community Voices Collaborative works with the Northern Manhattan Mental Health

Council, which represents most of the mental health service providers in Harlem. The patient population includes adults, some with dual diagnoses that include substance abuse problems. “Community Voices’ mental health partners provide outpatient care, medication, and support services to clients, in order to help them transition into independent living,” Sandra Harris explains. “Community Voices partners also work with mothers who have lost, or are at risk of losing, their children to foster care as a result of substance use disorders.” The program offers testing to oversee that mothers are drug-free (a court requirement for some), as well as provide mental health and family counseling, and child care services. One initiative of the program, “I Believe,” recruits mothers (and a few fathers) who have gone through the system for participation in a support group called “Women of Struggle.” The recruiters go out into the community to bring others in for services.¹⁷

- “FirstHealth of the Carolinas has a program called ‘Mastery’ that conducts a substance abuse prevention program in the local schools for elementary-age children who are demographically and behaviorally at-risk,” says Lisa Hartsock of FirstHealth Community Voices. FirstHealth also provides inpatient detoxification programs and intensive outpatient programs for persons with substance use disorders. They work with the local mental health authority to deliver services and treat those with Medicaid coverage, and provide services to persons categorized as underserved. FirstHealth also works with Alcoholics Anonymous

and others in the recovery community, and works with halfway houses and residential treatment programs in its target area.¹⁸

Prevention and treatment programs, depend upon competent professionals to conduct them. As part of the efforts of the Association for Medical Education and Research in Substance Abuse, various health professions have developed discipline-specific recommendations for faculty development and credentialing. Here are examples of the accrediting bodies to which these recommendations are directed:

- [Commission on Accreditation for Dietetics Education](#)
- [Accreditation Council for Occupational Therapy Education](#)
- [Commission on Accreditation in Physical Therapy](#)
- [Commission on Accreditation of Allied Health Education Programs](#)
- [Council of Academic Accreditation of the American Speech-Language-Hearing Association](#)
- [National Board of Dental Examiners, Liaison Committee for Medical Education](#)
- [Council on Predoctoral Education of the American Osteopathic Association](#)
- [National League for Nursing](#)
- [American Nurses Association](#)
- [American Nurses Credentialing Center](#)
- [American College of Nurse Midwives](#)
- [American Association of Colleges of Pharmacy](#)
- [American Council on Pharmaceutical Education](#)
- [National Commission on Certification of Physician Assistants.](#)¹⁹

Specific recommendations from numerous health profession accrediting organizations reflect sensitivity to the

diversity of the populations they serve. For example, 99 percent of nurse midwives surveyed for one study cared for women from vulnerable groups. Women were defined as being vulnerable if they were poor, adolescent, part of a minority ethnic group, of immigrant status, or living in medically underserved areas.²⁰ Another recommendation was to recruit faculty with substance use disorder expertise from diverse cultural groups to demonstrate commitment to foster cultural competence in teaching, practice, and research in the area of substance abuse.²¹ For yet another example, one of the physician assistant recommendations puts cultural competency at the center of integrating substance abuse education throughout academic and clinical training.²²

In addition to seeking diversity among health professionals, the emphasis seems to be on assuring that practitioners recognize the importance of cultural competency and incorporates its core elements in their practices. This is a first step in making sure that a diverse population has access to appropriate substance abuse diagnosis and treatment.

Safety Net Implications

In the United States, there are two methods of providing and paying for substance abuse treatment: one method for the private sector and another for the public sector,” researchers Mary R. Haack and Farrokh Alemi indicate. People who have employer-based insurance tend to receive treatment through their health plans, often through a carve-out covering private substance abuse providers and generally with service restrictions and higher deductibles and co-pays than for general health services. People without such insurance, because they are unemployed or

have employers who do not offer health benefits, receive services through the public system. According to SAMHSA, the federal, state, and local governments fund 46 percent of all substance use disorder treatment in the United States.²³ For example, in Moore County, North Carolina, FirstHealth Community Voices data show 1,948 uninsured persons between 0-18 years old, 1,886 uninsured unemployed, and 7,212 uninsured employed, 11,046 or 19 percent of 57,268 residents.²⁴

Public services for substance use disorders are often made through categorical health programs, such as special grants and block grants. These services also are provided through the Medicaid and Medicare entitlements. Identifying inpatient detoxification and clinic and rehabilitation options in the Medicaid program, the researchers say that coverage is inconsistent from state to state and program eligibility is restricted, as with other Medicaid benefits. They also cite the exclusion of institutions for mental disorders and managed care plans, as well as the lack of substance use disorder treatment standards and absence of set reimbursement rates for primary care interventions.²⁵

Northern Manhattan Community Voices Collaborative identified Medicaid budget neutrality in the state of New York as a problem. “Most of the outpatient substance abuse services have a mental health treatment component,” explains Sandra Harris. “So to the extent that we are mapping out community needs, assessing and identifying resources, and appealing to local departments of mental health and the state, we have a problem. We have to give up something in order to gain something else.”²⁶

For persons 65 and older or those younger with disability determina-

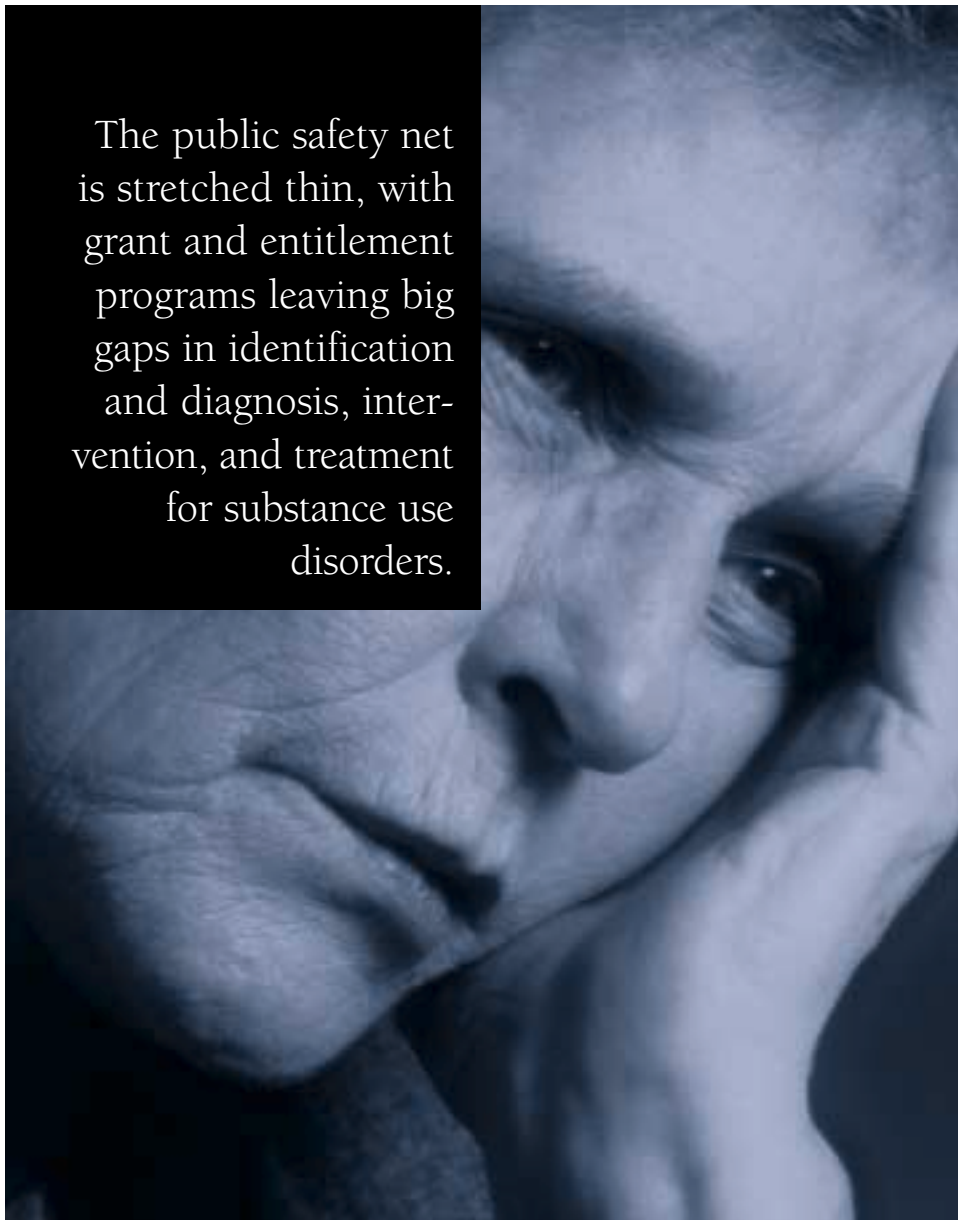
tions, Medicare also is a public provider. According to congressional sources, “17 percent of adults over 65 suffer from addiction or substance abuse, particularly alcohol and prescription drug abuse,” and “nearly one out of every four Medicare dollars spent in inpatient hospital care is associated with substance abuse.”²⁷ Tobacco is often singled out for the toll it has taken on long-time smokers’ health, in terms of cancer, cardiovascular disease, and other illnesses.

The public safety net is stretched thin, however, with grant and entitlement programs leaving big gaps

in identification and diagnosis, intervention, and treatment for substance use disorders. Even if there were sufficient funding and facilities to address the needs of persons with these disorders—regardless of public insurance or income—experts in the field question the capacity of primary care providers to recognize them. “The role of front-line health professionals in prevention, early identification, and referral remains largely untapped,” Mary Haack and Hoover Adger, Jr. contend.²⁸ This is affirmed by Community Voices leaders in New Mexico, New York, and North Carolina:

- “The primary provider, such as a family practice physician or a physician assistant, is not positioned for a number of reasons to do a lot of diagnostic workups beyond the primary care model,” according to Wayne Powell of New Mexico.
- “It’s really sensitive. We’re dealing with an increasingly culturally diverse minority population, with a limited number of providers that want to understand the culture and really develop the level of trust that would assure clear observation and communication in order to say that something’s wrong,” says Sandra Harris of Northern Manhattan.
- “I think that primary care providers could benefit from a whole lot more education and a whole lot more understanding,” asserts Lisa Hartsock of North Carolina.

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In Colorado, however, where Denver Health is a fully integrated system with a strong case management program, Elizabeth Whitley explains “primary care providers are the first line of focus in identifying substance use disorders and in getting people into treatment.” Arming the nation’s health professionals, whether physicians, nurses, nurse practitioners, physician assistants, allied health workers, or others, to serve on the “front line” is becoming a priority for both the public and private sectors.

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