A Changing Landscape for Treatment of Alcohol and Drug Use Disorders

See also Abraham et al., p. 885.

In 2013, the National Institute on Drug Abuse invested in a portfolio of awards assessing the impacts of health care reforms (e.g., the Mental Health Parity and Addiction Equity Act, the Affordable Care Act, and assorted state initiatives) on prevention and treatment services for alcohol and drug use disorders. The most ambitious of these studies conducted national surveys of addiction treatment services and the single state authorities responsible for funding prevention and treatment services. This issue of *AJPH* includes a new report from this important research initiative (p. 885).

STUDY SUMMARY

The 51 single state authorities (including Washington, DC) were surveyed in 2014 and again in 2017 to assess state efforts to help treatment providers take advantage of the implementation of the Affordable Care Act and the potential increase in Medicaid support for addiction treatment services. The analysis compared states that expanded Medicaid and states that opted out of Medicaid expansion.

Results, presented graphically in four figures, documented increased technical assistance for cross-sector collaboration and workforce development. Overall, the proportion of substance abuse prevention and treatment block grant funds allocated for outpatient services decreased for Medicaid expansion and nonexpansion states and increased for residential care (Medicaid does not routinely cover residential services). Expansion states increased the proportion of funds allocated to methadone services, whereas nonexpansion states reduced the allocation. Both expansion and nonexpansion states enhanced funding for short-term residential services, and nonexpansion states increased their investments in longer-term residential care. Expansion states increased technical assistance for collaboration with medical and mental health providers and promoted coordination with federally qualified health centers. Nonexpansion states, conversely, promoted collaboration with criminal justice systems and helping providers achieve in-network status. The concise, clearly written article provides useful information on how state authorities sought to prepare publicly funded systems of care for alcohol and drug use disorders and the opportunities to benefit from Medicaid expansion.

PUBLICLY FUNDED ADDICTION TREATMENT

Historically, services for alcohol and drug use disorders emerged from a legacy of self-help as freestanding nonmedical services with little connection to psychiatric and medical care.[1] Most of the publicly funded treatment of alcohol and drug use disorders is provided in freestanding not-for-profit organizations that specialize in addiction treatment.[2] Changes in federal policy associated with the Mental Health Parity and Addiction Equity Act and the Affordable Care Act are altering the environment for addiction treatment, opening the field to private for-profit service providers and enhancing links with primary care.

The opioid epidemic provides an additional opportunity for innovations in the treatment of alcohol and drug use disorders. The most effective treatments for opioid use disorders include medications (i.e., buprenorphine, methadone, and extended-release naltrexone) that require prescribers and links to health care. Because access to methadone is constrained by extensive federal regulations, states seek enhanced access to buprenorphine prescribers and models of care for primary care settings.[3] Patients and prescribers may also choose a treatment plan that includes an opioid antagonist medication (i.e., extended-release naltrexone). Relatively few addiction treatment programs routinely use medications for opioid or alcohol use disorders.[4] Prescribers in primary care settings may become more directly involved in addressing opioid use disorders and, by extension, alcohol and other drug use disorders.

To enhance population health, addiction treatment must become more integrated with primary care and promote the use of strategies to manage alcohol and drug use disorders as chronic conditions with ongoing medical monitoring and support, including pharmacotherapies that support recovery.[5] An analysis of Medicaid recipients in Oregon, for example, found increases in the number of individuals treated for alcohol use disorders in a primary care setting following the 2014 Medicaid expansion from 217 (second half of 2013) to 600 (first half of 2014) and a continued increase to 871 (first half of 2015).[6] The single state authorities who oversee publicly funded treatment of alcohol and drug use disorders must promote and encourage enhanced interaction and coordination between addiction treatment providers and primary care settings. As noted in the comparison of Medicaid and non-Medicaid expansion states (p. 885), the state authorities in expansion states are already facilitating stronger coordination with primary care.

The study documents change in the delivery of publicly funded care for alcohol and drug use disorders. Traditional freestanding alcohol and drug treatment programs may soon experience enhanced competition from primary care settings that actively promote the use of medications to support recovery from alcohol and drug use disorders. Individuals seeking care for alcohol and drug use disorders will benefit from enhanced integration of care between primary care

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CONFLICTS OF INTEREST

The author has no conflicts of interest to declare.

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Bias Against People Who Inject Drugs Undermines Police Training on Needlestick Injury

See also Arredondo et al., p. 921.

Policing and public health have the same goal: the creation and maintenance of safe and healthy communities. In practice, however, the two are often in tension. Whereas public health initiatives preferentially benefit the most vulnerable, policing—in both design and application—often reinforces existing social structures and perpetuates inequities based on race, class, and membership in stigmatized groups, including people who inject drugs (PWID).[1,2]

In particular, lack of access to new syringes increases bloodborne disease risk among PWID, and police actions such as syringe confiscation and possession-related arrests are a key barrier to the acquisition, use, and proper disposal of syringes.[3,4] These actions also increase needle stick injury (NSI) risk among officers by making it less likely that PWID will inform an officer that they are carrying syringes prior to a frisk or other search and may increase the likelihood that an NSI will result in bloodborne disease risk.[5]

Both changes to the "law on the books" and training to modify "law on the streets" can help reduce these risks to the health, safety, and dignity of police officers, PWID, and other community members.[6] As noted by Arredondo et al. (p. 921) in this issue, law in Tijuana, Mexico, is facially supportive of syringe access, which is not a crime in that jurisdiction. However, both police and PWID report widespread lack of knowledge of this fact, and many officers report that they confiscate and sometimes destroy syringes and engage in extrajudicial arrests for syringe possession, needlessly and often illegally increasing risk among these vulnerable individuals as well as among themselves and their fellow officers.

CHANGING POLICE BEHAVIORS

Arredondo et al. report on a training initiative designed, in part, to encourage officers to inform PWID whom they encounter that it is not illegal to carry syringes. The training was focused on conveying to officers the importance of providing this information as a means of improving their occupational safety, and the reported outcome was framed as an officer protection measure. Although the researchers did not ascertain whether trained officers changed their behavior, the training was associated with a significant increase in the percentage of officers who reported that they would inform PWID of the law. The increases were greater among individuals who engaged in interactive training as opposed to viewing a video and greater among female than male officers.

Previous research has demonstrated that officers systematically and dramatically overestimate the risks associated with NSI, which, although real, tend to be relatively low.[5,7] It may therefore be reasonable, from a pedagogical standpoint, to emphasize officers' own perception when attempting to change the ways in which they interact with PWID and other stigmatized groups in the context of syringe acquisition and disposal.[7] Indeed, the Arredondo et al. study suggests that such an emphasis can be effective in changing the self-reported predicted behavior of those officers.

ADDRESSING NEGATIVE STEREOTYPES

Many, including myself, have argued in favor of applying the harm reduction principle of meeting people where they are to engage law enforcement officers and others who interact with PWID as an effective method of understanding and addressing their concerns while simultaneously benefiting vulnerable populations.[7] That approach, which often stresses the benefits to law enforcement as well as community members of adopting evidence-based approaches to drugs and people who use them, has proved to be well received by officers in a variety of jurisdictions.[7] However, one must be careful how it is

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