Task Force on Mental Health and Substance Use

Input to the Workgroup on Prescription Opioid Abuse, Heroin Resurgence and Special Topics

3/10/2016

Recovery Community Input on Task Force Progress

A new recovery advocacy movement has emerged over the past 15 years that has resulted in an increased recognition of the prevalence and diversity of recovery experiences from substance use disorders.

Unfortunately, little is known about recovery and recovery as the desired outcome has largely remained an afterthought. In response to a call for recovery focused research, Faces and Voices of Recovery, the national recovery advocacy organization, in collaboration with Dr. Alexandre Laudet, conducted the first nationwide survey to document the benefits of recovery to individuals, families and communities.

The key findings of the "Life in Recovery" survey (2013) involve dramatic improvements in all areas of life: healthier/better financial and family life, higher civic engagement, dramatic decreases in public health and safety risks, and significant increases in employment and work.

Specifically, when comparing recovery experiences with an active substance use disorder, the "Life in Recovery" survey found:[1]

- Paying bills on time and paying back personal debt doubled
- Fifty percent more people pay taxes when in recovery
- Planning for the future (e.g., saving for retirement) increases nearly threefold
- Involvement in domestic violence (as victim or perpetrator) decreases dramatically
- Participation in family activities increases by 50%
- Volunteering in the community increases nearly threefold
- Voting increases significantly
- Frequent utilization of costly emergency room departments decreases tenfold
- The percentage of uninsured decreases by half
- Reports of untreated emotional/mental health problems decrease over fourfold
- Involvement in illegal acts and involvement with the criminal justice system (e.g., arrests, incarceration, DWIs) decreases about tenfold
- Steady employment increases by over 50%
- Twice as many people further their education or training
- Twice as many people start their own businesses

While the benefits of recovery are becoming better known, the majority of people in need of recovery are unable to access it. It is estimated that there are over 700,000 North Carolinians in need of services for a substance use disorder.[2] Approximately 10% of those in need of treatment for a substance use disorder will receive it.[3] For those who do, the acute care model of addiction treatment all too often fails to produce sustainable long-term personal and family recovery, particularly for those with the most severe, complex and chronic substance use disorders.[4] This is coupled with barriers and obstacles that many people in recovery face in employment, safe and affordable housing, education and citizenship.[5]

Members of the new recovery advocacy movement are mobilizing to demand changes to the conditions that give rise to substance use disorders, but more importantly the conditions in which people try to resolve substance use disorders. The goals are simply to help more people enter recovery, help more people sustain recovery and to increase wellness, opportunity and citizenship for those in recovery.

Lessons Learned from the January 19, 2016 Task Force Meeting

As members of the addiction recovery community, we applaud the efforts of Governor McCrory and those tasked with making recommendations for improving the lives of citizens with mental illness and substance use disorders. Four of us were invited as to provide input and feedback on the recommendations that were presented on Tuesday January 19, 2016. Unfortunately there was not time for us to provide our input. Some felt angry and others disappointed that we had taken a full day away from work or school to participate in this process without having an opportunity to provide input from the recovery community.

Reflecting on this, we gained some perspective. While we questioned whether our time was best utilized, we recognized that many people in need of addiction treatment and recovery often spend entire days trying to access services. Often they are told that they do qualify for services, but they will have to wait to access these services. We also reflected that if we had been permitted a few minutes at the very end of the Task Force meeting, how much of an impact would it really have made? We thought about those seeking recovery who did overcome the attrition of waiting lists; what services would they actually receive? Would they be of adequate dose and duration to make a meaningful impact?

As a rule, this is not the case. And after delays in accessing inadequate services, they are blamed when they don't sustain recovery. They are moved into systems of control and correction instead of systems of compassion. Their families and communities are robbed of the contributions and gifts that recovery brings.

The input we were prepared to provide follows here.

Input on the Workgroup on Prescription Opioid Abuse, Heroin Resurgence and Special Topics:

1. This workgroup needs to include members who have lived experience with recovery from opioid use disorders, including those with medication assisted recovery
2. This workgroup needs more cultural diversity, particularly representation of women
3. For stigma reduction, the word "abuse" should be eliminated from the workgroup name and any workgroup recommendations.[6]

Input on what is missing from the Work Product:

1. Recommendations for increasing access to addiction treatment and recovery support services
2. Recommendations for moving all addiction treatment from an acute care model to a recovery management model that is consistent with management of other chronic conditions
3. Input from other groups, such as, Addiction Professionals of North Carolina, Alcohol Drug Council of North Carolina, the North Carolina Harm Reduction Coalition, Recovery Communities of North Carolina and the Substance Use Disorder SUD Federation

Recommendations from members of the recovery community

1. **Use State monies to fund recovery support services**
   a. **Provide funding for the development of Recovery Community Organizations**
      - Recovery Community Organizations are comprised of individuals in recovery, their families, friends and allies and exist to enhance the quantity and quality of recovery supports available to people seeking recovery and those who are sustaining recovery.[7]

b. Recovery Community Organizations can operate Recovery Community Centers

- Recovery community centers can provide emotional, informational, instrumental and affiliational support.
- Recovery community centers can include addiction recovery peer support specialists.
- Addiction recovery peer support specialists are familiar with local resources and are skilled in assertive linkage to treatment, recovery, social, occupational, educational and housing resources.
- Addiction recovery peer support specialists can work with individuals in a social setting detox and recovery initiation center.
- They also draw upon volunteers from the larger recovery community.
- Governor McCrory and the Division of Mental Health, Developmental Disabilities and Substance Abuse Services have demonstrated a financial commitment to this as evidenced by the recent Invitation to Apply for Recovery Community Center funding.
- These could be strategically located next to social setting detox/recovery initiation centers

c. Addiction Recovery Peer Support Specialists

- Recovery Communities of North Carolina (RCNC) is presently implementing a directive from the Division of Mental Health, Developmental Disabilities and Substance Abuse Services to create an addiction specialty for peer support specialists.
- Addiction Recovery Peer Support Specialists can do outreach during critical opportunities for recovery initiation:
  - Post Naloxone overdose reversal
  - At emergency departments
  - Through law enforcement interactions (i.e. The Gloucester Angel Program)
- Addiction Recovery Peer Support Specialists can do outreach during critical opportunities for recovery maintenance:
  - Following discharge from ADATC and other treatment programs
  - Recovery-check ups
  - To assist with overcoming barriers to housing, employment and citizenship

State monies are more effective than funding through the Federal Block Grant for implementing recovery support services through new recovery community organizations.

2. **Build a network of social setting (non-medical) detox/recovery initiation centers**
   - They provide easy access to a lower level of care that can serve individuals who are intoxicated, individuals who are in withdrawal, and individuals who are at high risk for a return to substance use.
   - They can serve to help people initiate recovery.
   - They serve as an entry point into a larger continuum of care, without being the most expensive option in the continuum. These settings can serve to divert many people from higher levels of care (emergency departments), the wrong level of care (jail) and can serve as an entry point into an addiction treatment/recovery continuum of care.
   - They provide resources for diversion for law enforcement and EMS.
   - Social setting detox centers can work well with the previous recommendation.

3. **Provide long term, recovery-supportive systems of care**
   - Model addiction treatment services after the Physician Health Programs, which include sustained monitoring, support and re-engagement when needed.[8]

4. **Leaders at every level must fight stigma**
   - Have a statewide campaign led by Governor McCrory identifying himself as a Recovery Ally and highlighting the lived reality of recovery as an expectation, not an exception.
   - Implement changes in written and oral language that dispose of stigmatizing language and replace it with recovery-centered language (see below). This must happen in every agency at every level with consistency.[9]

5. **Controlled Substance Reporting System (CSRS)**
   - Mandate 100% registration and utilization of the CSRS by all DEA licensed physicians and pharmacists; providers have already been "encouraged" to participate and that tactic has proven ineffective. This is one aspect of solving the problem, but it is a crucial aspect that is within state control.

6. **Increase access to Naloxone**
   - Recommend pairing Naloxone with all opioid prescriptions regardless of amount or duration. This sends a clear message regarding the potential lethality of opioids (patient education) without the need to profile patients.

7. **Drug Treatment Courts**
   - The Task Force's mission specifically includes making recommendations regarding the justice system. As the Governor said at the last task force meeting, the recommendations must be specific and action-oriented in order to be viable. These recommendations are crucial for the future effectiveness of the Drug Treatment Courts (DTCs):
     - Reinstate funding for DTCs
       - Allocate funds sufficient to make DTC available to individuals in all districts.
       - Legislative defunding in 2011 nearly eliminated juvenile DTCs, closed some adult DTCs, and leaves the remaining DTCs inadequately funded.
       - Cost / benefit analyzes show a significant return on investment through savings in incarceration, reduced crime, community health, and other savings.[10]

     - Clarify that Medication Assisted Treatment (MAT) is an option for DTC participants pursuant to the existing standard of care in the treatment field.
       - For issues regarding application of the standard of care, the counselor on the DTC core team should make a treatment-based recommendation.
       - Where MAT is approved but proper use is at issue, courts should not summarily deny MAT, but should use methods suggested by the National Association of Drug Court Professionals for increasing proper use.

     - Rename DTCs as Recovery Courts
       - Align North Carolina with leaders in a national trend of identifying the courts as Recovery Courts, which places the focus on goals rather than on problems.[11]

8. **Collegiate Recovery and High School Recovery Clubs**
   - Recovery communities include individuals in recovery as well as allies. At the collegiate and high school levels, allies include students who have parents in recovery or active addiction, as well as students who just choose not to drink or use. Recovery communities in colleges and high schools provide a supportive environment and safe haven for students on campuses that universally feature frequent and heavy drinking.[12] Therefore, we recommend that North Carolina:
     - Establish high school recovery programs and develop more Collegiate Recovery Communities (CRCs).
     - Allow CRCs to associate with, assist, and sponsor local high schools with recovery supports, including recovery clubs. This will help students recover in high school and as they transition from high school to college.
     - The Governor and Task Force members can reduce stigma in educational institutions and among young people by identifying as recovery allies.

9. **Needle and Syringe Exchange Programs (SEPs)**
   - North Carolina should join twenty states in the U.S. that explicitly authorize SEPs, including Kentucky, Indiana and Nebraska, as well as major cities in Georgia and West Virginia. The following reasons are listed below:
     - SEPs can prevent HIV and Hepatitis C
       - North Carolina's Medicaid costs for patients with chronic hepatitis C rose from around $8 million in 2013 to over $50 million in 2014.[13]
       - The lifetime treatment cost for a person with HIV is estimated to be between $385,200 and $618,900, while hepatitis C costs $100,000-$500,000 to treat.[14]
       - Prevention is inexpensive, with individual needles and syringes costing less than 50 cents each.[15]
     - SEPs can be a gateway to treatment.
       - SEP participants are five times more likely to enter drug treatment than non-participants. SEPs connect participants to resources and assist in application processes.[16]
     - SEPs can decrease crime.
       - SEPs connect participants to drug treatment, housing, food pantries and other social services, alleviating the impetus for many crimes.[17]

- In one study, Baltimore neighborhoods with SEPs experienced an 11% decrease in crime compared to those without, which saw an 8% increase in criminal activity.[18]

The Importance of Language and a Constituency of Consequence

As members of the recovery community, a constituency of consequence, we are grateful to have a seat at the table. Beyond our input and feedback regarding the task force proposals, we can offer additional assistance. That assistance includes a research-based language transformation curriculum called Recovery Community Messaging Training. It also includes seasoned recovery advocates who are ready to join with Task Force members at legislative meetings.

The Recovery Community stands ready to present a research-based language transformation curriculum, Recovery Community Messaging Training to the members of the Prescription Opioid Abuse, Heroin Resurgence, and Special Topics Work Group. The task force's roll out will be more impactful if the presenters and their printed materials are uniform with purposeful language that is devoid of stigma-laden words and phrases.

The Recovery Community also stands ready to assist on the day that the task force rolls out its recommendations. We are organized, effective in our language, knowledgeable in this content area, and trained in advocacy techniques. We discovered when we participated in the national legislative advocacy day in Washington DC on October 5, 2015, that a team strategy for approaching lawmakers is most effective. In this instance, the ideal team consists of a lobbyist, a content area expert, and a person with lived experience. We have all three in our coalition of volunteers. Our NC Community Recovery Advocacy Day is scheduled for May 3, 2016. Perhaps we could coordinate our efforts.

Respectfully submitted by,

Chris Budnick | Donald McDonald | Karen Kranbuehl | Jesse Bennett

Chris Budnick is a Licensed Clinical Social Worker and Licensed Clinical Addiction Specialist who has worked in the addiction treatment and recovery field since 1993. Mr. Budnick is the Vice President of Programs for Healing Transitions (formerly The Healing Place of Wake County). He is the founding board chair for Recovery Communities of North Carolina. He is an Adjunct Instructor with the North Carolina State University Department of Social Work. Mr. Budnick serves on a number of boards and committees including the North Carolina Lawyer Assistance Program Board of Directors, City of Raleigh Substance Abuse Advisory Commission, the NC State Department of Social Work Advisory Board and the Recovery Africa Board of Directors. More importantly, Mr. Budnick is a person in long-term recovery, established in 1990.

Donald McDonald is a Certified Substance Abuse Counselor and has been working in the addiction treatment and recovery field since 2010. Mr. McDonald served in The United States Navy from 1986 to 1992. He graduated from NC State in 1997 with a Bachelor of Arts in English Teacher Education. Mr. McDonald will graduate from The UNC Chapel Hill School of Social Work in May 2016 with a master's degree. His concentration has been community, management, and policy practice in the licensed clinical addiction specialist track. He was a site monitor with SouthLight's opioid treatment program from 2010 to 2012, while he studied addiction counseling at Wake Technical Community College. Mr. McDonald was an intern from 2011 to 2012 with Healing Transitions International, Inc. and has been employed in case management with them since 2012. Mr. McDonald is the chairperson for RCNC's Capital Area Rally for Recovery and his professional interests are recovery advocacy, building recovery capital in individuals and communities, expanding access to treatment, enhancing recovery support services, and promoting recovery oriented systems of care. He is a person in long-term recovery, established in 2004.

Karen Kranbuehl is a licensed attorney and is completing her Masters in Social work at UNC Chapel Hill. She is the founder and CEO of ACT for Recovery NC, a nonprofit that provides training, consulting, and advocacy in the area of substance use disorders and social justice. Ms. Kranbuehl focuses on recovery access and support through treatment courts, including program innovations and development of collaboration among core court team professionals and the individuals receiving treatment through the system. She is a person in long-term recovery, established in 1995.

Jesse Bennett is completing a Bachelors of Social Work at North Carolina State University. He is the President of the Collegiate Recovery Communities at NC State, which welcomes all students who want to disengage from addictive behavior. Mr. Bennett is also a North Carolina Harm Reduction Coalition volunteer, focusing on harm reduction techniques in the community, including access to clean syringes and naloxone, as well as safe sex practices. He is a person in long-term recovery, established in 2012.

[1] Laudet, A. (2013). Life in Recovery: Report on the Survey Findings. Available at http://www.facesandvoicesofrecovery.org/sites/default/files/resources/Life_in_Recovery_Survey3.pdf

[2] Estimated Numbers of Persons with Substance Abuse in NC. Compiled by the North Carolina Department of Health and Human Services, Division of Mental Health/Developmental Disabilities/Substance Abuse Services QM Section. October 8, 2015.

[3] Substance Abuse and Mental Health Services Administration, Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings, NSDUH Series H-46, HHS Publication No. (SMA) 13-4795. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2013.

[4] White, W. (2008). Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices. Pittsburgh, PA: Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health & Mental Retardation Services.

[5] Baldwin, M. L., Marcus, S. S., & De Simone, J. D. (2010). Job loss discrimination and former substance use disorders. *Drug and Alcohol Dependence, 110*, p. 1 – 7; Jason, L. A., Olson, B. D., Ferrari, J. R., & Lo Sasso, A. T. (2006). Communal housing settings enhance substance abuse recovery. *American Journal of Public Health, 96*, p. 1727 – 1729, doi:10.2105/AJPH.2005.070839; Cleveland, H. H., Harris, K. S., Baker, A. K., Herbert, R., & Dean, L. R. (2007). Characteristics of a collegiate recovery community: Maintaining recovery in an abstinence-hostile environment. *Journal of Substance Abuse Treatment, 33*(1), p. 13 – 23, doi:10.1016/j.jsat.2006.11.005; Laudet, A. B., & White, W. L. (2008). Recovery capital as a prospective predictor of sustained recovery, life satisfaction and stress among former poly-substance users. *Substance Use and Misuse, 43*(1), p. 27 – 54, doi:10.1080/10826080701681473.

[6] Kelly, J. F. & Westerhoff, C. M. (2010). Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. *International Journal of Drug Policy,* 21, p. 202 – 207; Kelly, J. F., Saitz, R. & Wakeman, S. (2016). Language, Substance Use Disorders, and Policy: The Need to Reach Consensus on an "Addiction-ary." *Alcoholism Treatment Quarterly, 34*(1), p. 116 – 123.

[7] Faces and Voices of Recovery (2012). *Recovery Community Organization Toolkit*. Washington, DC, www.facesandvoicesofrecovery.org.

[8] Dupont, R. L., McLellan, A. T., Carr, G. Gendel, M., & Skipper, G. E. (2009). How are addicted physicians treated? A national survey of physician health programs. *Journal of Substance Abuse Treatment, 37*, p. 1 – 7.

[9] Kelly, J. F. & Westerhoff, C. M. (2010). Does it matter how we refer to individuals with substance-related conditions? A randomized study of two commonly used terms. *International Journal of Drug Policy,* 21, p. 202 – 207; Kelly, J. F., Saitz, R. & Wakeman, S. (2016). Language, Substance Use Disorders, and Policy: The Need to Reach Consensus on an "Addiction-ary." *Alcoholism Treatment Quarterly, 34*(1), p. 116 – 123.

[10] Downey, P. M. & Roman, J. K. (2014). *Cost-Benefit Analysis: A Guide For Drug Courts and other Criminal Justice Programs*. National Institute of Justice Research in Brief. U.S. Department of Justice. June 2014, https://www.ncjrs.gov/pdffiles1/nij/246769.pdf; North Carolina Drug Treatment Court Program History; http://www.nccourts.org/Citizens/CPrograms/DTC/History.asp.

[11] Personal communication with Terrence Walton, Chief Operating Officer with the National Association of Drug Court Professionals, February 24, 2016.

[12] Laudet, A. B., Harris, K., Kimball, T., Winters, K. C., & Moberg, D. P. (2015). Characteristics of Students Participating in Collegiate Recovery Programs: A National Survey. *Journal of Substance Abuse Treatment, 51*, p. 38 – 46; Harris, K., S., Kimball, T. G., Casiraghi, A. M. & Maison, S. J. (2015). Collegiate Recovery Programs. *Peabody Journal of Education, 82*(2), p. 229 – 243.

[13] deBruyn, J. (2015). Hike in Gilead Sciences Hep. C drug prices skyrocket N.C. Medicaid bill. *Triangle Business Journal*. November 24, 2015. http://www.bizjournals.com/triangle/news/2015/11/24/hepatitis-c-gilead-sciences-gild-harvoni-sovaldi.html.

[14] Schackman, B.R., Gebo, K.A., & Walensky, R.P., Losina, E., Muccio, T., Sax, P. E., Weinstein, M. C., Seage, G. R., Moore, R. D. & Freedberg, K. A. (2006). The lifetime cost of current Human Immunodeficiency Virus care in the United States. *Medical Care, 44*(11), p. 990 – 997.

[15] Mizuno, Y., Wilkinson, J. D., Santibanez, S., Dawson Rose, C., Knowlton, A., Handley, K., Gourevitch, M. N. (2006). Correlates of health care utilization among HIV-seropositive injection drug users. *AIDS Care, 18*(5), p. 417 – 425.

[16] Hagan, H., McGough, J. P., Thiede, H., Hopkins, S., Duchin, J., & Alexander, E. R. (2000). Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors. *Journal of Substance Abuse Treatment*, *19*, p. 247 – 252.

[17] Hagan, H., McGough, J. P., Thiede, H., Hopkins, S., Duchin, J., & Alexander, E. R. (2000). Reduced injection frequency and increased entry and retention in drug treatment associated with needle-exchange participation in Seattle drug injectors. *Journal of Substance Abuse Treatment*, *19*, p. 247 – 252.

[18] Center for Innovative Public Policies. Needle Exchange Programs: Is Baltimore a Bust? Tamarac, Fl.: CIPP; April 2001, http://www.cipp.org/pdf/BALT_BUST.PDF.