

Testimony of Dr. William R. Miller  
for the national panel:  
Blueprint for the States: Policies to Improve the Way States Organize and Deliver  
Alcohol and Drug Prevention and Treatment  
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With so much that could be said and needs to be said on this topic, I want to focus my brief remarks on three points, three controversial policy changes that could make a real difference in the impact of public funds spent to prevent and treat alcohol and other drug problems in our society.

First, we clearly should be using those prevention and treatment methods with the best scientific evidence of efficacy. We take this for granted when we go for health care, that the care given by our primary or specialist provider is based on the current science. For patients with a life-threatening illness like cancer or heart disease, it would be malpractice for a physician to ignore evidence-based treatment and instead offer therapy of unknown efficacy or known ineffectiveness. Yet this continues to be the normal state of practice in behavioral health. Mental health and addiction treatment providers are reimbursed simply for generic classes of services like “group therapy” or “evaluation,” without regard to the content of services. In essence, behavioral health providers can and do provide whatever services they please behind closed doors, within very broad boundaries of professional ethics. One can offer treatment that has long-since been shown to be ineffective for severe, even life-threatening conditions, and yet it is considered acceptable and reimbursable practice. That is wrong. Alcohol and drug abuse treatments can be and have been evaluated by the same methods used by the FDA in the rest of health care. There are now many hundreds of controlled clinical trials showing plainly that all treatments are not equally effective. There are treatment methods with consistent and strong evidence of efficacy, many of which are rarely found in community practice. There are other treatment methods, still widely practiced, for which dozens of trials show no

beneficial effect at best. We have a moral and professional responsibility to be offering patients with substance dependence - clearly a life-threatening condition - treatments that work.

I would argue that this obligation is doubly strong when we use the courts or other social sanctions to coerce people into treatment. About half of the people treated in many systems are there through some form of mandation. When we use the force of law to require treatment, we have a special duty to ensure that the services provided are likely to be beneficial and not harmful to the individuals and to society. The same is surely true of prevention services offered through our schools or other social systems. If we are going to use public funds and expose large numbers of children or adults to “prevention” services, we ought to be very sure that the interventions do indeed decrease problems. There are too many examples of programs offered in the name of prevention that have had no effect or even exacerbated rather than reduced alcohol and drug problems. We cannot rely on whether it sounds good, on testimonials or even common sense. We know how to scientifically evaluate the efficacy of addiction treatment. Let's use what works.

This means that we need to retool state systems to ensure that we are training, practicing, and reimbursing evidence-based prevention and treatment services. This is a challenge faced in all of health care, and clearly we ought to be moving behavioral health services in this direction. That also means that in the training of the next generation of providers, we must be teaching them what actually works rather than repeating the orthodoxy of the past.

Second, it is unfortunate that U.S. prevention and treatment services for substance use disorders have been historically segregated from the larger health care system. Most people entering treatment for substance dependence also have significant physical and mental health problems that require attention. Comorbidity is the norm, and the usual practice of referring people back and forth among

medical, mental health, and addiction services is inefficient and ineffective. In prevention, the primary risk and protective factors linked to substance abuse overlap heavily with domains of psychological and social welfare. It makes little sense, therefore, to try to treat and prevent substance use disorders as an isolated condition. Furthermore, sequestering of services has served to stigmatize prevention and treatment for addiction, rather than addressing it as a public health problem.

The challenge here is to mainstream addiction services within health care. Between 10 and 20% of all those seen in primary care are drinking in unhealthy ways - anywhere from risky periodic excess to outright dependence. In public programs and some specialist settings, the percentage can be even higher. Undiagnosed and untreated substance abuse among patients with the most common medical problems - diabetes, asthma, hypertension, heart disease, cancers, etc. - confounds physical diagnosis and compromises treatment, significantly increasing health care costs. Effective treatments are available, but patients often refuse referral to specialist addiction programs. If appropriate screening and services can be provided on-site, at the same points of service where ordinary health care is delivered, it will be possible to reach a larger proportion of people with undiagnosed and untreated alcohol/drug problems, and to reach them sooner. The same is true of social service settings. Substance use disorders are highly over-represented among people seen by correctional, probation, mental health, welfare, and child protective services, yet often little is done to address them there.

There are at least two ways to provide on-site intervention for substance abuse in existing health and social service settings. One is to train current personnel in the additional skills needed to address addictions. This is certainly feasible, and has been done in many places, because there are relatively brief interventions with a good track record of efficacy, at least for alcohol and marijuana abuse. The problem, of course, is that primary care providers are stressed and stretched to provide the

services that they are already expected to perform. There is a real danger, then, that if we leave it up to primary care workers, alcohol/drug problems will get lost in the many demands of practice and so remain unaddressed. A second avenue is to co-locate addiction services within primary care and social service settings, to have specialists working on-site so that the physician or patient needs only to walk down the hall for help. Given stereotyped stigma around people with alcohol/drug problems, we can expect some initial resistance to seeing “those people” in health care and social service settings, but the truth is that they are already there. Treating addictions in the context of normal health care would go a long way to remove the stigma and mark these as the common public health problems they are.

Third, we need to rethink *who* provides addiction services. This is becomes obvious in mainstreaming. If comorbidity is the norm, then the health care professionals who treat people with addictions should be trained and prepared to deal effectively not only with substance use disorders, but also with the behavioral health problems that so often accompany them, such as depression, PTSD, anxiety disorders, and relationship problems. Furthermore, the behavioral therapies with the strongest evidence base of efficacy in addiction treatment are not, ironically, addiction-specific, but focus on broader areas of psychosocial functioning such as social skills, community involvement, motivation, self-control, and relationships.

I believe that the era of counselors who treat only substance abuse is coming to an end. When I entered this field in the 1970s, there were no educational requirements for substance abuse counselors. The non-degreed counselor was the norm, and one could be licensed with little more experience than a year or two of being in recovery. Addiction counselors have been among the least-educated, least-trained and most poorly paid of health care providers. It was just last year that the New Mexico state legislature enacted a minimum bachelor’s degree requirement for licensure as an alcohol/drug abuse

counselor, and even this has met with resistance. There is an enormous gap between the qualifications for substance abuse providers and those for the lowest-level adjuncts to professional staff in any other healthcare field. Most substance abuse counselors could not meet minimum qualifications for a mental health caseworker, and in many states LPNs have higher requirements. Yet in addiction treatment, these counselors *are* the professional staff! There is no other life-threatening chronic disease with such low standards for its primary providers, and the United States is quite alone in this regard. The States should increase educational and training requirements to parity with licensed providers of other behavioral health services, where the practice norm has become a master's degree, and should do so sooner rather than later.

The advent of effective pharmacotherapies for alcohol, drug and related problems also makes interdisciplinary collaboration essential. Neither behavioral health providers nor prescribers of medication hold a comprehensive solution to this severe public health problem. Both prevention and treatment require integrated consideration of the psychological, biological, and environmental aspects of addiction. The mainstreaming of substance abuse services within health care can make this possible. There is a reasonable fear that if mainstreamed, addiction services could simply be swallowed up and become a low priority within the Gordian challenges of modern health care. We need to ensure that this does not happen, but this is no reason to continue the mistakes of the past.

In sum:

1. Let's make sure that the treatment and prevention services we provide not only do no harm, but have proper scientific evidence that they work and are good investments of public funds and trust
2. It is long overdue to integrate addiction prevention and treatment with mainstream health and mental health services.

3. Let's make sure that the professionals we entrust with addiction treatment and prevention are properly educated, trained, paid, and prepared to deal with the complex of behavioral health problems in which addictions are inevitably enmeshed.

William R. Miller, Ph.D.  
Distinguished Professor of Psychology and Psychiatry  
Center on Alcoholism, Substance Abuse and Addictions (CASAA)  
The University of New Mexico (WRMILLER@UNM.EDU)