The Affordable Care Act: New Opportunities for Social Work to Take Leadership in Behavioral Health and Addiction Treatment

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This invited article is based on the 2014 Aaron Rosen Lecture that Dr. Lundgren presented at the 18th Annual Conference of the Society for Social Work and Research. The Rosen Lecture was established in 2002 to honor the lifetime achievement of Aaron Rosen, and to advance the integration of social work practice and research.

ABSTRACT An estimated 23 million individuals in the United States meet criteria for a diagnosis of substance abuse or dependence; however, only about 4 million people enter treatment each year. The Patient Protection and Affordable Care Act (ACA) is likely to increase access to addiction treatment through the integration of behavioral health and health care services. However, this integration effort is at risk of excluding the most vulnerable population groups with substance use disorders. Further, key health and government agencies report an urgent need for more health professionals to be trained in empirically supported methods for screening and treating patients for abuse and dependence of alcohol and other drugs. The implementation of an integrated care model is threatened by the shortage of social workers who are sufficiently trained in these methods. This article argues that in this era of implementing the ACA, it is key that social workers not only become leaders in the addiction health services research field but also translate their knowledge to social work practice. Further, the article presents research on the Swedish addiction treatment system as a model of an alternative system in which social workers fill a central role in implementing a coordinated care model.

KEY WORDS: Affordable Care Act, behavioral health, addiction treatment, integrated care, social work and Affordable Care Act, Swedish addiction treatment

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The major health care reforms of the Patient Protection and Affordable Care Act (ACA), enacted in 2010, were designed to be rolled out over the course of 4 years. Among the ACA's key features, the Act expands access to public

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and private health insurance, moves the United States toward a system of universal health care, and promotes integration of addiction treatment with medical care. Specifically, ACA seeks to enhance access by integrating behavioral health care services (here, specifically addiction treatment) into general primary health care settings. The integration of services is envisioned as being achieved through *medical homes*, that is, care settings in which mental health and substance abuse treatment are offered in conjunction with other health services and care is coordinated across services and providers (Buck, 2011). Integration and a new emphasis on the medical home also have the potential to mediate restrictions on addiction treatment, such as insurance coverage limitations, that have historically been a formidable barrier in addiction treatment. The changes introduced in the ACA shift the responsibility for financing addiction treatment. Given the expansion of Medicaid coverage under the ACA that has been adopted by most states, the states and counties have a lesser role in funding substance abuse treatment. This change, in conjunction with new parity and coverage policies under the ACA, shifts more of the financing responsibility to health care plans.

By increasing access to insurance coverage, new health policy is aimed at both reducing the addiction treatment gap between need and treatment availability, and improving integration of care (Barry & Huskamp, 2011; Office of National Drug Control Policy, 2014). However, policy and program planning efforts are uninformed about whether and how this policy shift might increase consumers' use of addiction treatment, especially among highly vulnerable populations. Looking to the experiences of other nations can inform the transformation of systems of care in the United States, and shed light on patterns of use of addiction treatment in a universal care system.

This article is based in part on the 2014 Aaron Rosen Lecture given by the first author at the 18th Annual Conference of the Society for Social Work and Research. This article first describes key features of the current U.S. addiction treatment system with respect to access, cost, and workforce capacity, with a focus on both disparities and the role of social work. Second, we discuss the capacity of primary medicine to take on the medical home role for those with substance use disorders (SUDs). Third, using an example from Sweden—where the national social welfare system (not to be confused with public assistance) is the primary medical home for those with SUDs and where addiction treatment is universally available—we illustrate how a potential U.S. integrated care model could replicate aspects of the Swedish model where social workers, at a municipal level, organize and conduct the assessment, referral and delivery of integrated care, especially to vulnerable population groups.

The Current U.S. System (or Lack Thereof)

The U.S. has a multiple-payer addiction treatment system consisting of public funding in the form of block grants, payment for treatment through Medicaid

for low-income individuals, Medicare for the elderly and disabled, employer-provided private insurance, and self-pay or out-of-pocket payment (Mark, Levit, Yee, & Chow, 2014). This system is characterized by poor access, a significant gap between use and need, lack of trained workforce and high cost. These factors are discussed in detail below.

Access. Recent estimates of the prevalence of substance use problems among the U.S. population indicated that in 2012, nearly 24 million youth and adults (9.2% of persons 12 years and older) suffered from an illicit drug or alcohol use problem of severity enough to warrant treatment (Substance Abuse and Mental Health Services Administration [SAMHSA], 2013). However, of the 24 million needing treatment, only 4 million persons (16.7%) received treatment at a facility specializing in substance abuse treatment. Thus, 20 million youth and adults who needed such treatment either received no treatment or did not receive treatment at a specialty facility (SAMHSA, 2013). Moreover, research has indicated significant demographic disparities in access to treatment. Specifically, the treatment gap is disproportionately large for both young adults and racial/ethnic minority groups (McCarty, McConnell, & Schmidt, 2010; Schmidt, Greenfield, & Bond, 2007).

The disproportionate lack of access to addiction treatment is a significant health risk for adolescents and young adults (Knudsen, 2009; McLellan, & Meyers, 2004; Wong, Marshall, Kerr, Lai, & Wood, 2009). The lack of access is largely due to the treatment needs of this population being overlooked. Only recently has more attention been given to addiction treatment for youth and young adults in the training for addiction treatment staff, the organization of treatment programs, and the testing/implementation of new treatment interventions. Because of this historical gap, there have been few empirically supported treatment programs for adolescents (Knudsen, 2009; Mark et al., 2007).

A persistent health disparity stems from the fact that despite similar rates of drug use as compared with Whites, African American and Hispanic drug users experience greater levels of the negative consequences of drug use than their White counterparts. Specifically, drug use among racial/ethnic minorities has been implicated in a host of health disparities such as higher incidence of HIV/AIDS and hepatitis C, and negative social consequences such as disproportionate rates of incarceration and sentencing (Galea & Rudenstine, 2005; Lelutiu-Weinberger et al., 2009; Iguchi, Bell, Ramchand, & Fain, 2005). For example, in 2010, the greatest percentage of new HIV infections among U.S. women occurred among African Americans (64%) whereas White women represented 18% and Hispanics/Latinas represented 15% of new infections (Centers for Disease Control and Prevention [CDC], 2013). These rates reflect the disproportionate and elevated risk for HIV exposure/infection among African American women. The CDC (2013) estimates for 2010 predicted that 1 in 32 African American women will be diagnosed with

HIV infection at some point in their life course, as compared with 1 in 106 Hispanic/Latina women and 1 in 526 White women.

Further, studies have suggested Whites are more likely to receive addiction treatment than their Hispanic/Latino and African American counterparts, and Whites tend to receive more appropriate types of treatment. One of our studies compared patterns of treatment entry across a sample (N = 28,230) of African American, Hispanic, and White injection drug users (IDUs; Lundgren, Amodeo, Ferguson, & Davis, 2001). We looked at these patterns relative to three pathways: entry into detoxification only, entry into a residential treatment program, and entry into a program of methadone maintenance. As compared with White IDUs, Latino IDUs were approximately a third less likely to enter residential treatment, and African American IDUs were half as likely to enter a methadone program. Building on these findings in a presentation to the National Institute on Drug Abuse, we presented longitudinal data showing that these racial/ethnic disparities had not only increased but almost doubled over the course of 5 years (Lundgren, 2005).

A Knudsen (2009) study with a sample of 288 adolescent patients in publicly and privately funded addiction treatment programs examined whether the racial/ethnic composition of the patient caseloads was associated with an organizational characteristics, including whether the program offered prescription medications to treat addiction, psychiatric conditions, or pain. Knudsen found that addiction treatment programs with a greater percentage of racial/ethnic minorities were less likely to have medications available.

Lack of continuity of care. U.S. addiction treatment is also marked by a lack of continuity of care (i.e., receiving services other than detoxification within 14 days after a positive substance abuse assessment; Campbell et al., 2010; Garnick, Lee, Horgan, Acevado, 2009;), limited integration between types of treatment and care (Weisner, Mertens, Parthasarathy, Moore, Lu, 2001; Weisner, Hinman, Lu, Chi, & Mertens, 2010), and high prevalence of acute care (Dennis, Scott, & Funk, 2003; McLellan, McKay, Forman, Cacciola, & Kemp, 2005; SAMHSA, 2002). Our own statewide study covering all licensed addiction treatment in the Commonwealth of Massachusetts found the most common pattern of addiction treatment was use of detoxification in a cyclical pattern without any continuity to other levels of care (Lundgren, Amodeo, & Sullivan, 2006). Specifically, for a sample of approximately 3,000 individuals new to treatment, the 10 most common patterns of care covering approximately 50% of clients were a range of detoxification entries followed by no entry to treatment. Hence, our results suggest that for one of the states with the highest levels of access to addiction treatment, the Commonwealth of Massachusetts, data still indicated that for most clients, there is no system of treatment (Lundgren et al., 2006).

Studies on access to care and follow-up after care have also identified significant disparities in continuity of care. A 2001 study found a gap in unmet need for substance abuse treatment by racial category, with African Americans being more likely to have no access to treatment or to be receiving treatment (Wells, Klap, Koike, & Sherbourne, 2001). Participation in continued outpatient care after leaving inpatient care was significantly associated with being white with African Americans less likely to receive intensive outpatient care after leaving inpatient care (McKay et al., 2004).

Another study found racial/ethnic differences in rates of treatment completion among a group of publicly funded alcohol treatment programs in California (Jacobson, Robinson, & Bluthenthal, 2007). The researchers found that as compared with their White counterparts, African Americans were significantly less likely to complete alcohol treatment in either outpatient or residential treatment programs.

In summary, age and racial/ethnic disparities permeate all aspects of treatment use, ranging from initial access to the type of treatment accessed to the continuity of care available. One aim of an integrated care model is to merge behavioral health and medical care and thereby reduce these disparities. Research efforts are ongoing to assess whether the integration of behavioral and medical care is reducing age and racial/ ethnic disparities in treatment access, treatment use, and treatment outcomes; however, no consistent study results are currently available.

Inadequate trained workforce as a barrier to integration of addiction treatment. The shortage of health workers sufficiently trained in empirically supported practices for screening, assessment, and treatment of substance use disorders is widely acknowledged as a significant problem (D'Ippolito et al., 2013; Institute of Medicine, 2006; Krull, Lundgren, & Zerden, 2011; Lundgren, Amodeo, et al., 2011; Martino, 2010; McCarty, Edmundson & Hartnett, 2006; McCarty et al., 2007; Warren & Hewitt, 2010). The Institute of Medicine (2006) has emphasized the need to not only build this workforce but also assure the competency of the addiction treatment workforce. Further, the severity of this workforce shortage was concisely summarized by the members of the House Committee on Appropriations (2005, p. 117) in a report to the 109th Congress: "The Committee has concerns that people who are seeking substance abuse treatment are unable to access services due to the lack of an adequate clinical treatment workforce."

In our national study of community-based organizations, clinical staff (N = 349) who reported that their program had greater program and staff needs (needed improved staff assessment capacity, improved counseling capacity) and who reported high levels of organizational stress also reported greater barriers to implementing a new evidence-based practice (EBP; Lundgren et al., 2012). Multivariate modeling, described below in Table 1, identified that staff with more

Table 1

Results of Multivariate Linear Regression (N = 431)

Variable	β Standardized coefficients	T	Partial Correlation	P value	95% Confidence Intervals for β
Barrier rating	.229	4.870	.231	.000	[.294, .693]
Influence	.125	2.442	.118	.015	[.005, .508]
Mission	.008	.126	.006	.900	[–.240, .273]
Cohesion	–.053	–.832	–.041	.406	[–.380, .154]
Stress	.074	1.266	.062	.206	[–.240, .273]
Satisfaction with training offered at workshops available to staff in last year	–.048	–.978	–.048	.329	[–.300, .101
In the last year, how many times did your agency offer special, in-house training?	.038	–.796	–.039	.426	[–.275, .116]
In recent years, how often have you adopted (for regular use) new counseling interventions or techniques from a workshop?	–.130	–2.752	–.133	.006	[–.471, .079
5 or more years of experience in the drug abuse counseling field	.104	2.261	.110	.024	[.029, .409]
Program duration	.089	1.933	.094	.054	[–.003, .381]
Motivational interviewing	–.132	–2.881	–.139	0.004	[–.442, –.083]
R Square .155, Adjusted R-square .132, $p < .000$					

Reprinted from "Organizational readiness for change in community-based addiction treatment programs and adherence in implementing evidence-based practices: A national study" by Lundgren, Amodeo, Chassler, Krull, & Sullivan, 2013, *Journal of Substance Abuse Treatment, 45* (5), 457—465. Copyright by Elsevier. Reprinted with permission.

barriers to EBP implementation, and less experience in implementing empirically supported treatments had lower levels of adherence to manuals and standard in EBP implementation (Lundgren, Amodeo, Chassler, Krull, & Sullivan, 2013).

Our studies have clearly identified particular staff characteristics associated with treatment programs that reported difficulty with implementing new EBPs. Specifically, we found the combination of (a) shortage of knowledgeable counselors with (b) inadequate experience in implementing EBPs was associated with treatment programs staff that were more likely to perceive high levels of barriers to EBP implementation. Equally important, these characteristics were also shown to be associated with a lower likelihood that the staff would implement EBPs with fidelity. These results point to the importance of social workers being trained and experienced in the procedures and protocols of empirically supported screening, assessment, and treatment methods for substance use disorders.

Despite this clear need for a workforce better trained in substance use disorders and treatment, our national study of 210 master's of social work (MSW) programs found only 14% of accredited graduate schools of social work offered specialization in substance use and only 5% of accredited programs required students to complete at least one courses related to substance abuse. Social work education has not met the nation's need for the development of well-trained, competent addiction workforce, and currently there is little evidence to suggest this pattern will change (Wilkey, Lundgren, & Amodeo, 2013). Hence, in order for social workers to be participants and, hopefully, leaders in the integration of addiction treatment with medical care, our MSW programs need to immediately begin training our students in the knowledge and skills needed for addiction treatment.

Cost. The cost of addiction treatment is currently a key barrier to access and use of effective substance abuse treatment. The vast majority of the expenditures for treatment of alcohol and drug dependence are borne by public payers, accounting for nearly 78% of treatment costs (Mark et al., 2007). Similar to other health care costs, the costs of substance abuse treatment are escalating rapidly. For example, the average facility cost for a substance use treatment admission increased from $6,174 in 2009 to $7,230 in 2011, with per capita spending on substance use admissions growing by 28.9% from 2010 to 2011, and out-of-pocket payment averaging at $889 per admission (Health Care Cost Institute, 2013). In 2012, 50.2% of persons served at a specialty substance abuse treatment center reported using personal savings or income as a payment source (versus insurance or publicly funded payments), and the rate of using personal savings to pay for treatment has increased in past years (SAMHSA, 2013).

The availability of comprehensive, residential treatment services that range in duration from 3 to 12 months is increasingly limited to those who able to pay a large percentage of costs out-of-pocket. The approximate cost per person for a 28 day inpatient program is $11,000 (Waletzky & Handel, 2014). In addition, sig-

nificant variation exists among insurance plans regarding the coverage for addiction treatment. Some insurance companies might cover a strict time-limited amount of inpatient treatment whereas other might cover weekly or bi-monthly outpatient visits depending on insurance.

Costs of publicly funded treatment programs are administered through a range of Medicaid, Medicare, and federal/state-level specific program efforts. The federal/state program efforts often target community-based addiction treatment programs and highly vulnerable populations groups. These community-based programs range dramatically with respect to the type of services offered and the length of care funded. However, acknowledging not only the variations in funding levels but also the populations targeted and the practices recommended, over the past 20 years federal agencies such as SAMHSA and the CDC have enhanced the capacity of community-based organizations to better serve vulnerable population groups.

Improved access to addiction treatment is a key feature of the ACA that is achieved through the expansion of access to health insurance coverage, which could increase access to outpatient treatment (Mechanic, 2012). In addition, a fee-for-service model is increasingly used in reimbursing addiction treatment providers (Insel, 2011). However, the advent of the ACA should not, in our opinion, be coupled with a trend toward decreased federal funding for community-based organizations that treat vulnerable populations. Nevertheless, whether a consequence of the advent of the ACA or the need to reduce federal spending, the federal budgets of the past few years have had significantly reduced allocations for community-based addiction treatment programs. These budget cuts include federal funding for community-based organizations treating those with co-morbid mental health conditions, those at risk of HIV, and the homeless and racially/ethnically diverse populations. Therefore, while the cost of addiction treatment might go down for a large group of individuals who historically have not accessed treatment due to cost and cost itself might not go up for the most vulnerable population groups, the availability of community-based care through community-based organizations might go down, which is would lead to decreased access to addiction treatment for these populations.

U.S. primary care as the medical home versus the Swedish social work-based model of addiction treatment integration. Under the ACA, primary care practitioners (PCPs) are envisioned as the center for care. Historically, PCPs have not been the primary source of referrals to addiction treatment for those with severe SUD, including homeless populations. Among the many reasons for this situation, a key issue has been the PCPs' lack of substance use-specific clinical skills and training that would enable these providers to work effectively with clients with SUDs. Studies conducted by those in the medical/health profession have reported, "physicians receive little training in treatment of addictions and lack the clinical skills necessary to identify and intervene effectively with substance users" (Kahan, Wilson, Midmer, Ordean, & Lim, 2009, p. 1109). In turn, this historical lack of training

related to SUDs means that throughout the years of medical education, each new cohort of medical school students lack role models, instruction, and opportunities to gain clinical experience in addiction medicine (Miller, Sheppard, Colenda, & Magen, 2001). Indeed, Miller et al. (p. 410) reported, "most primary care physicians do not feel competent to treat alcohol- and drug-related disorders." Further, the medical profession does not treat SUD with parity to other diseases and conditions, and physicians' training emphasizes that the diagnosis and treatment of SUDs are separate from "medical matters" (Miller et al., 2001, p. 410).

Multiple studies have found a significant number of SUDs were overlooked or underdiagnosed by PCPs. For example, nearly half of patients seeking addiction treatment from their PCP were not recognized as having a disorder by their PCP (Reif et al., 2011). A 2000 survey of PCP behaviors found that when primary care patients were seen by their PCP for routine care but presented with the early symptoms of alcohol abuse, 94% of PCPs failed to diagnose their patient's substance abuse (CASA Columbia, 2000). Even reports of excessive alcohol consumption resulted in limited follow-up by PCPs, with many of the PCPs simply telling a problem drinker to "stop drinking," rather than the PCP referring or connecting the patient with additional substance abuse treatment or care (D'Amico, Paddock, Burnam, & Kung, 2005).

Possible additional implications of ACA: Is the primary care medical home model an access barrier for vulnerable populations? The most vulnerable population groups with SUDs—including those with multiple comorbidities, HIV, homelessness, and mental health problems—often do not have a usual place for medical care or see a PCP for routine care (Vijayaraghavan et al., 2011). Hence, it is probably not reasonable to assume that PCPs will be the primary medical home for these populations. This gap is worrisome because those with SUDs need a comprehensive range of services in addition to addiction treatment. It is not evident that weekly or bimonthly outpatient services, which are what is often covered by health insurance, can address the range of needs among these vulnerable groups. Moreover, given the expectation that the health insurance coverage introduced by ACA will now cover addiction treatment, it is likely that federal funding for community-based addiction treatment will continue to decrease. This prospect is troubling because it means the economic disparities associated with addiction treatment will continue unabated. That is, as funding for community-based organization treatment programs recede, the most vulnerable population groups will experience reduced access to treatment, whereas those with higher incomes will continue to have access to comprehensive treatment. New promising federal government efforts include testing alternative medical home models for vulnerable population groups; it is key that social work researchers take part in testing and evaluating these efforts.

In the following section, we describe the Swedish addiction treatment system that offers an alternative model to having the primary care medical system serve as the medical home for those with SUDs. Notably, the Swedish system is based

on social workers serving as the primary professional group for coordinating care for those with SUDs.

The Swedish Addiction Treatment System

The Swedish addiction treatment system provides universal coverage for SUDs, and is characterized by having no income limitations, and no restrictions on the number of days per year for either outpatient or inpatient treatment. Naturally, as in most societies, this system has geographic variations in terms of access to care, with highly rural communities having less access to treatment, and the largest urban areas (e.g., Stockholm) not only having the highest percentages of treatment slots but also the most pressure to provide treatment and care.

The Swedish system employs municipal-level clinical social workers to assess individuals' need for substance abuse treatment. These social workers most often work in what are defined as *care centers* (*vard centraler*), which are often located in the same buildings or nearby location as other care settings and services providers such as outpatient medical care centers, public employment agencies, pharmacies, and public health nurses.

Within each region, local municipalities implement the majority of treatment; however, the National Board of Health and Welfare oversees the social welfare office sites where social workers conduct assessments and make referrals to a range of care services. The National Board of Health and Welfare also provides practice guidelines to social workers and provides training in empirically supported methods such as motivational interviewing. The municipal-level social work offices are responsible for the direct integration of care across a variety of regional sources of care, including in- and outpatient treatment, primary care, the criminal justice system, and child welfare offices. Care center social workers are also expected to provide screening and assessment for SUDs, mental health status, and other needs. Hence, these examples from Sweden demonstrate the key role of social workers in providing integrated, multi-service care needed for individuals with SUDs.

Nevertheless, one critique of the Swedish model argues that social workers in this system lack adequate training. Specifically, even though the care center social workers are considered as professionals with significantly greater responsibilities than a case manager, the Swedish social work educational system has not kept up with training their students in the EBP interventions and techniques in addiction treatment commensurate with their professional roles and responsibilities. Hence, in light of our previous discussion of the lack of EBP training among graduate students in the United States, the inadequacy of education in EBPs in addiction treatment seems to be a multi-national concern.

The addiction treatment population in Sweden: What can be learned from research using register-based data? The majority of social workers in Sweden use the Addiction Severity Index (ASI) as a tool for assessing the severity of a client's SUD. In addition to assessing substance-abuse treatment needs, the ASI captures needs

related to housing, family/social networks, physical health, mental health, and employment status. These data are kept in a national ASI register; this national database includes both client self-report data and clinician assessment data. In addition, the Swedish National Board of Health and Welfare collects register data on all outpatient and inpatient behavioral and medical health episodes in Sweden, reasons for each episode, and length of each episode. Thus, the national register provides a comprehensive and rich database, and these data have been used to conduct research on access, need, treatment use, and outcomes to inform the addiction treatment field.

In one of our studies conducted with a Swedish sample (see Figure 1), we used a nationally representative sample of 12,833 individuals assessed for a SUD (Armelius & Armelius 2011; Lundgren et al., 2012; Lundgren et al., 2014). We conducted k-means cluster analysis to identify those clients with more severe problems and service needs, and assessed associations among sample characteristics, including demographic, health, mental health, substance use, family/social relationships, criminal justice involvement, and immigration status. Analyses of the study

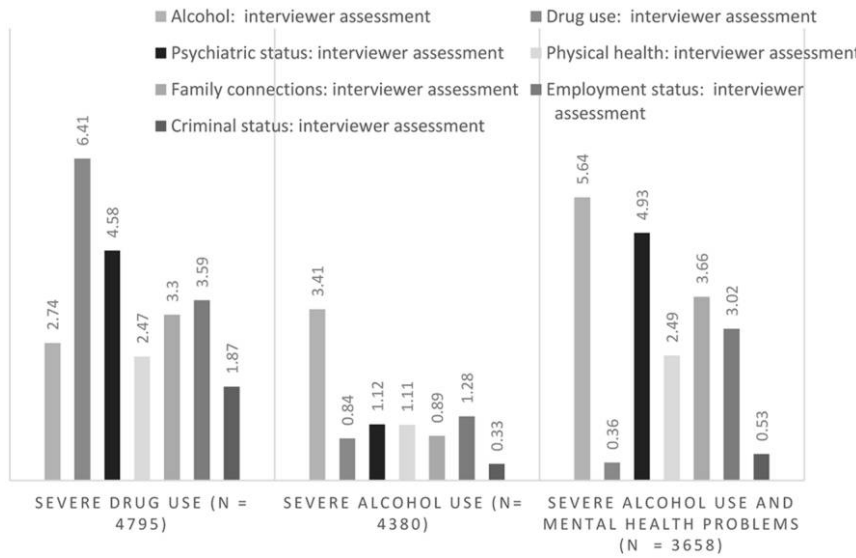

Figure 1. Interviewer assessment rating scores in the development of the cluster variable. Adapted from chart published in "Integrating Addiction And Mental Health Treatment Within A National Addiction Treatment System: Using Multiple Statistical Methods to Analyze Client and Interviewer Assessment of Co-Occurring Mental Health Problems" by Lundgren, Wilkey, Chassler, Sandlund, Armelius, Armelius, & Brännström, 2014, *Nordic Studies on Alcohol and Drugs, 31*, p.73. Copyright by Walter de Gruyter; and Adapted from chart published in "Beskriving av tre klientprofiler inom svensk missbruksvård [Description of the three client profiles in Swedish addiction treatment] by Lundgren, Armelius, Armelius, Brännström, Chassler, & Sullivan, 2012, *Social Vetenskaplig Tidskrift, 19*(3/4), 200–216. Copyright by the Association for Research in Social Work (FORSA; Förbundet för Forskning i Socialt Arbete).

Table 2

Descriptive Statistics: Client Characteristics by Client Cluster Group (N = 12833)

Independent Variables	Serious drug use % or *M* (SD) *n* = 4,795	Serious alcohol use % or *M* (*SD*) *n* = 4,380	Serious alcohol use & mental health problems % or *M*(*SD*) *n* = 3,658
Demographics			
*** Age [a]	33.3 (10.4)	44.0 (13.4)	43.5 (11.5)
*** Gender			
Male	71.7	72.8	61.2
Female	28.3	27.2	38.8
*** Homeless			
Yes	13.8	4.5	5.4
No	86.2	95.5	94.6
*** Number of years of education[b]	10.5 (2.4)	11.2 (3.0)	11.2 (2.9)
*** Has a job			
Yes	11.4	19.5	16.9
No	88.6	80.5	83.1
*** Parental status			
Yes	8.9	15.3	14.4
No	91.1	84.7	85.6
Health			
*** Has a chronic illness			
Yes	52.0	42.8	53.3
No	48.0	57.2	46.7

*** Has been diagnosed with Hepatitis C			
Yes	38.3	12.7	9.5
No	61.7	87.3	90.5
*** Has received medical care in the past 6 months			
Yes	38.4	35.4	43.3
No	61.6	64.6	56.7
*** Number of times in hospital[c]	4.4 (9.1)	3.0 (6.2)	4.1 (11.5)
Mental health			
*** Ever received medications for psychological or emotional problems			
Yes	13.7	10.3	15.4
No	86.3	89.7	84.6
*** Ever been in inpatient treatment for psychiatric problems			
Yes	28.1	14.5	28.3
No	71.9	85.5	71.7
*** Ever been in outpatient treatment for psychiatric problems			
Yes	46.2	33.0	54.8
No	53.8	67.0	45.2
*** Addiction Severity Index - mental health composite score[d]	.5 (.2)	.3 (.2)	.5 (.2)
*** Severe mental health problems			
Yes	30.2	5.5	26.9
No	69.8	94.5	73.1
Substance use			
*** Severe illicit drug use			
Yes	33.0	7.6	6.3
No	67.0	92.4	93.7

Table 2 (*continued*)

Independent Variables	Serious drug use % or *M* (SD) *n* = 4,795	Serious alcohol use % or *M* (*SD*) *n* = 4,380	Serious alcohol use & mental health problems % or *M*(*SD*) *n* = 3,658
*** Severe alcohol use			
Yes	8.0	9.7	21.3
No	92.0	90.3	78.7
Substance abuse treatment			
*** Number of times in substance abuse treatment[e]	2.8 (7.9)	.6 (3.5)	.3 (2.5)
*** History of compulsory treatment for drug use			
Yes	32.0	7.9	3.8
No	68.0	92.1	96.2
Family and social relations			
*** How important is it to get help for family/social relationships			
Not at all	51.5	48.0	84.6
Slightly	8.9	7.9	4.2
Moderately	9.6	10.7	3.6
Considerably	10.2	12.1	3.1
Extremely	19.9	21.2	4.5
Criminal justice involvement			
*** Currently on parole or probation			
Yes	22.1	8.8	6.0
No	77.9	91.2	94.0

*** Number of drug related crimes[f]	3.6 (7.7)	.7 (3.6)	.2 (1.2)
*** Number of property related crimes[g]	4.4 (13.0)	1.3 (6.3)	.8 (4.6)
*** Number of violence related crimes[h]	1.3 (3.3)	.5 (1.8)	.4 (1.6)
Immigration status			
*** Immigration status (a 5-category variable)			
Individual and parents born in Sweden	62.9	73.1	71.6
Individual born outside of Sweden but inside Norway, Denmark, or Finland	3.6	6.7	8.2
Individual born outside of Sweden, Norway, Denmark, and Finland	13.8	8.0	7.6
Individual born in Sweden and at least one parent born in Norway, Denmark or Finland	8.6	7.1	8.0
Individual born in Sweden and at least one parent born ouside Sweden, Norway, Denmark and Finland	11.2	5.1	4.6

Note. [a] Age: Post Hoc tests D < A, A/MH, A > D, A/MH; [b] Education: Post Hoc tests D < A, A/MH, A > D; [c] Times in hospital: Post Hoc Tests D < A, A < D, A/MH; [d] ASI score: D > A, A/MH, A < D, A/MH; [e] Number of drug treatments: Post Hoc tests D > A, A/MH, A > A/MH; [f] Drug crimes: Post Hoc tests D > A, A/MH; [g] Property crimes: Post Hoc tests D > A, A/MH; [h] Violence crimes: Post Hoc tests D > A, A/MH.

$^{*}p<.05$, $^{**}p<.01$, $^{***}p < .000$

Adapted from chart published in "Integrating Addiction And Mental Health Treatment Within A National Addiction Treatment System: Using Multiple Statistical Methods to Analyze Client and Interviewer Assessment of Co-Occurring Mental Health Problems" by Lundgren, Wilkey, Chassler, Sandlund, Armelius, Armelius, & Brännström, 2014, Nordic Studies on Alcohol and Drugs, 31, p.73. Copyright by Walter de Gruyter; and Adapted from chart published in "Beskriving av tre klientprofiler inom svensk missbruksvård [Description of the three client profiles in Swedish addiction treatment] by Lundgren, Armelius, Armelius, Brännström, Chassler, & Sullivan, 2012, Social Vetenskaplig Tidskrift, 19(3/4), 200—216. Copyright by the Association for Research in Social Work (FORSA; Förbundet för Forskning i Socialt Arbete).

data identified three clusters: (a) a severe illicit drug user cluster (n = 4,795), (b) a severe alcohol user cluster (n = 4,380), and (c) a severe alcohol user and mental health problem cluster, (n = 3,658; Armelius & Armelius, 2011; Lundgren et al., 2012; Lundgren et al., 2014).

This finding suggests that in a national population of clients assessed in Sweden's universal addiction treatment system , two-thirds of clients have multiple, complex care needs (Clusters 1 and 3) and need a substantial range of services in addition to addiction treatment. Given the extent of need for comprehensive services, this finding also suggests that weekly or bi-weekly outpatient treatment for SUD would be adequate treatment for only one-third of clients with SUDs.

As described in Table 2, demographic differences exist between these groups. Results of chi-square and one-way ANOVA analyses of respondent data identified that as compared with the other clusters (i.e., severe alcohol user cluster, and the severe alcohol user/mental health problem cluster) clients in the severe illicit drug use cluster were younger, less educated, more likely to report health and mental health problems, more likely to have been in compulsory drug treatment, more likely to have a criminal justice history, and more likely to be first or second generation immigrant from non-Nordic countries compared to their counterparts. The severe alcohol user cluster was more likely to be of Swedish descent, employed, have children, and not report mental health problems. Women were more likely than men to be in the third cluster; those with severe alcohol and severe mental health problems.

In both the United States and Sweden, differences exist between clusters of those in need of addiction treatment based on characteristis such as gender, race/ethnicity, age, and human capital. What do we know about the effectiveness of the Swedish system as compared to the U.S. system? Unfortunately, given the limited number of research studies, very little. A comparison of cross-national survey results for two specific geographic locations (Stockholm and California) has sugested that individuals in Sweden have less severe SUDs when entering treatment, and, for clients with SUDs in both countries, having mental health problems and not having family support for recovery efforsts are barriers to positive outcomes post-treatment (Trocchio et al., 2013; Witbrodt & Romelsjo, 2012)

In summary, research findings using Swedish national databases are consistent with the framework that addiction is a bio-psycho-social condition with multiple risk factors (e.g., biological/genetic, familial, psychological [trauma and loss], peer influences), and other environmental conditions that encourage early use (e.g., drug and alcohol availability), and dependence (e.g., drug potency; Fewell et al., 2011; Karila, Petit, Lowenstein, & Reynaud, 2012; Murphy, Taylor, & Elliot, 2012), The combination of these factors results in multiple consequences that are medical (e.g., liver and heart problems), psychological (e.g., depression, anxiety) and socioeconomic (e.g., job loss, homelessness, incarceration, child neglect; Baldwin,

Marcus, & De Simone, 2010; Buchholz et al., 2010; Kuzenko et al., 2011; Lechner et al., 2013; Volkow, 2010, 2014). The provision of treatment and related medical and support services necessitates not only multiple episodes of treatment but also multiple types of care services that can respond to each of the spheres, including addiction treatment, mental health services, medical services, unemployment services, housing services, and family support services. The Swedish studies have also confirmed that a health disparities framework is critical for understanding and conducting research on access, use, and outcomes of addiction treatment.

Conclusion

The Emerging Role of Social Work Under the ACA

Hopefully, the ACA will reduce the gap between those in need of addiction treatment and those who receive treatment. However, to better respond to the treatment needs of addicted patients, especially highly vulnerable population groups, we need to not only increase the amount of research in this area but also increase and improve the amount of SUD-specific training for all health and human services professionals, including social workers. Notably, U.S. social work educational programs will need to significantly increase the education and training of their students in EBPs for screening, assessment and treatment of SUDs (Wilkey et al., 2013). At a minimum, as recommended by the World Health Organization ([WHO], 2011) all health professionals need to be knowledgeable of brief intervention techniques, relapse prevention techniques, self-help groups, economic and family supports, and pharmacological treatments. Interventions directly responding to the WHO recommendations with the most comprehensive evidence include: Screening, Brief Intervention and Referral to Treatment (SBIRT), Motivational Interviewing Techniques (MI), Relapse Prevention Techniques, Alcoholic Anonymous and Narcotics Anonymous support groups, Needle Exchange to reduce harm related to injection drugs, as well as different pharmacological treatments such as Methadone, Naloxone, and buprenorphine for substance use disorders (A comprehensive list of EBPs for SUDs and summaries of research on these practices can be found at http://www.nrepp.samhsa.gov/, SAMHSA, 2014).

Further, social work researchers need to

- expand research on implementation of empirically tested, culturally adapted, screening, assessment, and treatment methods;
- support the use of an extensive range of health services by those with SUDs:
- promote the development of policies and programs to ensure the implementation of the ACA includes access parity to behavioral

interventions, medications, social support services, as well as both inpatient and outpatient treatment options; and
- ensure the implementation of ACA does not lead to decreased access to treatment options for those most in need.

What about social work as a profession? Social work is historically based on an integrated care model. (Think about the old case management model, which has now been newly found). Our social work programs focus on training students to have a strong social justice perspective and to understand clients and their lives using a bio/psycho/social perspective. Given this historical foundation and perspective, social workers should be leading the efforts to develop effective systems of integrated health and behavioral health care, as well as developing an expanded workforce with the specialized training required for integrative care settings. In addition, social workers should be leading efforts to reduce disparities in access, use, and outcomes of addiction treatment. This leadership is necessary at a policy, national, community, and agency level.

Indeed—with respect to the implementation of ACA and the need for an expanded workforce trained in empirically supported methods for screening, assessment, and treatment for SUDs in integrated models of care—Dr. A.T. McLellan, the former Director of the White House Office of Drug Control Policy has suggested

> . . . [the ACA] will likely create opportunities for counselors, **social workers** [*emphasis added*] and psychologists to work in primary care settings. Again, there are important opportunities for research in the best methods to train and sustain clinical behavioral change among healthcare professionals. There are additional opportunities for operations research on the most effective organizational and institutional incentives to make these new clinical care activities a routine part of the work day. (McLellan & Woodworth, 2014, p. 544)

We know from prior research studies that even the effectiveness of addiction treatment medications such as buprenorphine and methadone is enhanced **IF** used in combination with a range of empirically supported therapeutic, family and economic support services (McLellan et al., 2005; McLellan, Chalk, & Bartlett, 2007). These are the services social workers provide. We are at the forefront of implementation research, especially in our work in community-based organizations (Andrews, Darnell, McBride, & Gehlert, 2013; Guerrero et al., 2010; Guerrero, 2012; Krull et al., 2011; Lundgren et al., 2001; Lundgren et al., 2006; Lundgren, Amodeo, et al., 2011; Lundgren et al., 2012; Lundgren et al., 2013, Lundgren, Krull, Zerden, & McCarty, 2011; Marsh, Cao, Guerrero, E., & Shin, 2009). We work in community-based organizations that serve the most vulnera-

ble and diverse populations. We reach the most hard-to-reach populations, those who often do not have access to primary care. Andrews and her colleagues (2013) have also argued that the social work profession should take leadership role in the implementation of ACA, and described the unique contributions of social workers to the changing landscape of integrated care:

> Social workers' expertise makes them ideally suited to carry out . . . [patient] navigator duties. By law, the navigator programs must reach the uninsured and underinsured—the very populations that social workers regularly serve. Social workers also are prepared to provide services that are both linguistically and culturally appropriate. They routinely work with clients who have low health literacy and are accustomed to devising effective communication strategies that minimize the barriers caused by low literacy. (p. 2)

We should not simply ask that social work be included as an interested party in new research, training policy, program and practice efforts on integrated care efforts, especially to vulnerable populations such as those in need of integrated care associated with SUD. Rather, social workers should acknowledge and be recognized for our leadership in providing integrated care to highly vulnerable populations. We should increase our capacity to serve by providing the specialized training is needed by our clinicians and practitioners in other health professions. We should promote every opportunity to increase interdisciplinary research collaboration and practice to not only develop effective systems of integrated care but also to meets the needs of vulnerable groups in a changing landscape of health care.

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