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BUILDING A RECOVERY ECOSYSTEM FOR THE CATAWBA REGION

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ABSTRACT

The opioid and addiction crisis has become a defining characteristic of 21st century America, profoundly affecting the Commonwealth of Virginia in terms of lives lost, families devastated, communities compromised, and economic and opportunity costs at multiple levels. This scenario originated with a rapid increase in opioid prescriptions issued to patients by health care providers for various pain diagnoses during the 1990s and into the early 2000s. Despite early warnings that the new opioid formulations were far more addictive than indicated by faulty research trials and marketing claims, treating pain as the “fifth vital sign” became a widespread practice as a rationale for prescribing opioids for a broader array of health conditions. As federal and state policies sought to curtail the increasingly deadly flow of prescription opioids, some people suffering from opioid addiction turned to heroin as a substitute, resulting in additional waves of overdose deaths in the early 2010s and persisting into the current decade. Even as state government agencies and local grassroots organizations have implemented prevention and harm reduction approaches and policies over the past twenty years, the proliferation of illicit and powerful synthetic opioids, including fentanyl and carfentanil, has resulted in increased opioid and other substance use disorder (SUD) acuity, as well as persistently high overdose rates.

In response to this ongoing challenge, state legislative and administrative leadership are increasingly making and supporting proposals to transform our healthcare systems and communities into recovery-oriented ecosystems. These ecosystems can support everyone from individuals in acute crisis from SUD, to those thriving in long-term recovery. For example, a key bi-partisan effort from the 2023 Virginia General Assembly Session is a pilot project to transform Catawba Hospital into a treatment center for both acute mental illness and SUDs.¹ The transformation would utilize excess capacity at Catawba Hospital to provide SUD residential treatment and detoxification beds, along with onsite, step-down services to provide a much-needed bridge as individuals return to their home communities. As a first step, the General Assembly is providing \$500,000 in funding for the Virginia Department of Behavioral Health and Developmental Services to explore public-private partnerships that can bring SUD services to Catawba. In the years to come, the project will need additional support for capital needs, workforce development, and shoring up the recovery ecosystem.

This article explores the policy and sociological frameworks that have brought Virginia’s political and health and human service leadership to this

¹ H.B. 2192, 2023 Gen. Assemb., Reg. Sess. (Va. 2023).

point of innovation and change. Current shifts in policy and program approaches align with a healthcare movement to treat SUD as a chronic disease, following a long history of SUD being treated as a criminal offense and a moral issue. The time is right for immediate and ongoing commitment to innovative approaches to address the unprecedented crises of mental health and SUD among our fellow Virginians.

INTRODUCTION

The Commonwealth of Virginia is positioned to become a national leader in addressing the opioid and addiction epidemics by expanding residential treatment as an essential component to a recovery ecosystem and through the support of bi-partisan policy innovations. By leveraging existing infrastructure and service linkages between the state mental health hospital system and the growing need for integrated behavioral health services, the Catawba Hospital transformation project would expand access to much needed acute residential treatment for substance use disorder (SUD), which often occurs with a severe mental illness (SMI) diagnosis.²

Most importantly, the transformation proposal that has emerged over the past two legislative sessions recognizes that short-term residential treatment is only the first step in the continuum of services recommended by the American Society for Addiction Medicine (ASAM) that lead to long-term recovery and healing for individuals, families, and communities.³ The Catawba Hospital Campus Transformation Feasibility Analysis conducted by JLL Consulting, and presented to the Virginia Secretary of Health and Human Services on January 11, 2023, emphasizes the need for residential treatment as a key component in the continuum of a recovery ecosystem, which ranges from acute in-patient treatment to long-term community and social supports that include housing and employment.⁴ The realization of, and commitment to, this comprehensive vision of care and support for our community members with mental illness and SUD will require up-front capital investment, as well as sustained public investment in policies that support the full recovery ecosystem.⁵ This public sector commitment

² See Robert E. Drake et al., *A Review of Treatments for People with Severe Mental Illnesses and Co-Occurring Substance Use Disorders*, 27 *PSYCHIATRIC REHAB. J.* 360, 367, 371 (2004).

³ See generally Dennis McCarty et al., *Treatment and Prevention of Opioid Use Disorder: Challenges and Opportunities*, 39 *ANN. REV. OF PUB. HEALTH* 525, 532 (2018).

⁴ JLL CONSULTING, *FEASIBILITY ANALYSIS CATAWBA HOSPITAL CAMPUS TRANSFORMATION 3-5* (2023), <https://rga.lis.virginia.gov/Published/2023/RD64/PDF>.

⁵ See Robert D. Ashford et. al., *Building Recovery Ready Communities: The Recovery Ready Ecosystem Model and Community Framework*, 28 *ADDICTION RSCH. & THEORY* 1, 1-11 (2020).

can be leveraged with private sector investment—for both capital improvements and ongoing service provision—when policy mechanisms align to adequately incentivize private investment and ensure accountability for effective service provision.⁶ The plan approved during the 2023 Virginia General Assembly Session supports the Catawba Transformation through a feasibility study of public-private partnerships that can provide a continuum of care for individuals with dual diagnosis of SMI and SUD.⁷ The study also acknowledges the need for a plan to address current workforce shortages and support the innovative model for comprehensive care.⁸

I. FRAMING MATTERS: THE EVOLUTION OF TREATING SUBSTANCE USE DISORDERS (SUDs)

The United States has been struggling with how best to deal with the societal impacts of substance use for well over a century.⁹ Competing conceptions or framings of how to think about and address this evolving crisis have held sway at different times, yet all have proved insufficient. We explore the shortcomings of some prominent conceptions and suggest that a systems-thinking or ecosystem conceptualization is needed.

Although early efforts to address substance use and overuse in the first two decades of the twentieth century focused on consumer protection and regulation, the rise of the temperance movement's campaign against alcohol—which culminated with the Eighteenth Amendment and a thirteen-year era of prohibition—changed the narrative around substance use from one of health protection overseen by doctors to a moral crusade overseen by law enforcement.¹⁰ Despite the failure of this approach to address the ills of alcohol, from the 1930s onward, successive escalations of the “war on drugs” sought to conquer this societal ill through increased restrictions and

⁶ See Anne-Marie Reynaers, *Public Values in Public-Private Partnerships*, 74 PUB. ADMIN. REV. 1, 2-3, 9 (2013).

⁷ JLL CONSULTING, *supra* note 4, at 3.

⁸ *Id.* at 5-7.

⁹ See RUSSELL CRANDALL, *DRUGS AND THUGS: THE HISTORY AND FUTURE OF AMERICA'S WAR ON DRUGS* 7 (2020).

¹⁰ See Mary Dana Phillips, *Courts, Jails, and Drug Treatment in a California County*, in COMM. FOR THE SUBSTANCE ABUSE COVERAGE STUDY, *TREATING DRUG PROBLEMS: VOLUME 2: COMMISSIONED PAPERS ON HISTORICAL, INSTITUTIONAL, & ECONOMIC CONTEXTS OF DRUG TREATMENT* 136-37 (1992) (for example, certain provisions of the Pure Food and Drug Act of 1906 required that manufacturers label all products containing dangerous or addictive ingredients, and the Harrison Narcotics Tax Act of 1914 used the federal government's taxation authority to require registration and reporting of the importation, manufacture, distribution, and dispensing of opium, coca leaves, or their derivatives.)

escalating sanctions and punishments.¹¹ Unfortunately, many of the racial and societal stereotypes of substance users were incorporated into policies and enforcement priorities.¹² In the end, despite over a trillion dollars in spending, the war on drugs has been largely counterproductive, lowering the cost of illicit drugs, increasing the supply, exacerbating their negative health effects, and destroying communities in the process.¹³

A. The Drug Epidemic: Framing as a Medical and/or Behavioral Health Issue

Throughout the era of the war on drugs, which framed illicit drug use as a moral and criminal issue, an evolving minority sought to frame and address illicit drug use as a medical or behavioral health issue, although even this understanding has evolved over time.¹⁴ Over the course of its five major editions, the American Psychiatric Association's Diagnostic and Statistical Manual (DSM) evolved its understanding of "substance addiction" as a sociopathic personality disturbance toward the more complex and scientifically-based understanding of "substance use disorders," which vary in severity and incorporate both physiological and psychological dependence, resulting in harmful consequences from ongoing use.¹⁵

Thinking of substance use as both a behavioral health and medical disorder that can be managed and treated has led to advancements in effective therapies. One of the earliest and most enduring social approaches for addressing problematic substance use has been the abstinence-based mutual aid program Alcoholics Anonymous (AA), which published its basic textbook in 1939.¹⁶ In the 1950s, two clinicians at a Minnesota state psychiatric hospital combined abstinence and the other principles of AA with a blend of professional staff and trained peers in stable recovery. This has come to be known as the Minnesota Model.¹⁷ The model was taken up by the Hazelden Foundation and then proliferated across the country into the now

¹¹ Eric L. Jensen et al., *Social Consequences of the War on Drugs: The Legacy of Failed Policy*, 15 CRIM. JUST. POL'Y REV. 100, 100-02 (2004).

¹² Doris M. Provine, *Race and Inequality in the War on Drugs*, 7 ANN. REV. OF L. & SOC. SCI. 41, 50-51 (2011).

¹³ Trever Burrus, *The War on Drugs*, in CATO HANDBOOK FOR POLICYMAKERS 133 (9th ed. 2022); RUSSELL CRANDALL, DRUGS AND THUGS: THE HISTORY AND FUTURE OF AMERICA'S WAR ON DRUGS 3-4 (2020).

¹⁴ See Robert A Matano & Stanley F Wanat, *Addiction is a Treatable Disease, Not a Moral Failing*, 172 W. J. MED 63, 63 (2000).

¹⁵ Peter E. Nathan et al., *History of the Concept of Addiction*, 12 ANN. REV. CLINICAL PSYCH. 29, 40, 47 (2016).

¹⁶ See *The Start and Growth of A.A.*, ALCOHOLICS ANONYMOUS, <https://www.aa.org/the-start-and-growth-of-aa> (last visited Oct. 29, 2023).

¹⁷ D.J. Anderson et al., *The Origins of the Minnesota Model of Addiction Treatment – A First Person Account*, 18 J. ADDICTION DISEASES 107 (1999).

familiar twenty-eight-day, in-patient treatment program.¹⁸

The Narcotic Addict Rehabilitation Act of 1966 was an early piece of legislation that recognized how treatment under a medical model of addiction could be preferable to punishment.¹⁹ In 1970, Dr. Vincent Dole established the first methadone clinic for heroin addicts in New York City: becoming the first application of Medication Assisted Treatment (MAT) for opioid disorder that is widely practiced today.²⁰ Insurance coverage parity between medical and behavioral health coverage required by the Affordable Care Act (ACA), as well as federally subsidized Medicaid expansion initiatives in many states, have increased access to treatment for tens of thousands of individuals.²¹

Despite its many advantages over the “war on drugs” metaphor, the “drug epidemic” framing also comes up short. First, unscrupulous corporate interests seeking to profit from insurance-funded treatment alternatives have, at times, set up “treatment-mills” that push people through low-quality programs with limited long-term effect.²² Second, the workforce needed for quality behavioral health treatment has lagged far behind the demand, leading to long waitlists and geographic gaps that, in effect, deny treatment to countless individuals who should otherwise receive services.²³ Lastly, treating a SUD as an allopathic condition²⁴ and addressing only the presenting symptoms of the condition—in isolation from the larger social determinants of the patient’s health—fails to account for numerous additional factors that contribute to effective recovery, including housing, employment, and social support.²⁵

¹⁸ *Id.*

¹⁹ Richard Lindblad, *Civil Commitment Under the Federal Narcotic Addict Rehabilitation Act*, 18 J. OF DRUG ISSUES 595 (1988).

²⁰ CRANDALL, *supra* note 13, at 151.

²¹ See Joshua Breslau et. al., *Impact of the ACA Medicaid Expansion on Utilization of Mental Health Care*, PUBMED CENTRAL (Sept. 1, 2021), <https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7483910/>.

²² Andrew Engelson, *New Drug Possession Bill Emphasizes Coercive Treatment*, PUBLICOLA (Mar. 2, 2023), <https://publicola.com/2023/03/02/new-drug-possession-bill-emphasizes-coercive-treatment/>; see Rachel A. Rein, *Storms in Sunny States: Fraud in the Addiction Treatment Industry*, 16 AM. UNIV. WASH. COLL. L. HEALTH L. & POL’Y BRIEF 44, 59.

²³ Kate Masters, *A Shortage of Workers is Hindering Efforts to Improve Mental Health Care in Virginia*, VA. MERCURY (Oct. 27, 2021), <https://www.virginiamercury.com/2021/10/27/a-shortage-of-workers-is-hindering-efforts-to-improve-mental-health-care-in-virginia/>.

²⁴ Lauren Martin, *What to Know About Allopathic Medicine*, MEDICALNEWS TODAY (Oct. 14, 2021), <https://www.medicalnewstoday.com/articles/allopathic-medicine> (a condition that can be treated with conventional treatments and medications).

²⁵ Miriam Komaromy, et. al., *Project ECHO (Extension for Community Healthcare Outcomes): A New Model for Educating Primary Care Providers About Treatment of Substance Use Disorders*, 37 SUBSTANCE ABUSE 20, 23 (2016).

The proposed transformation of Catawba Hospital comes at a time when a period of federally mandated deinstitutionalization of public mental health hospitals and centers for disabled citizens has reached an equilibrium.²⁶ During this period, public-private partnerships have grown to provide short-term residential crisis care and stabilization, with the goal of coordinated return of the individual to their home community for outpatient, community-based treatment.²⁷ While many of these efforts have been successful, there still remains a significant gap in both acute residential treatment and community-based services that support longer term recovery. Rural and lower-income communities are especially impacted by gaps in the continuum of healthcare services in general, and for behavioral health.²⁸ A false dichotomy is created when policies and policymakers present a misleading choice between institutional (public) and community-based (private) responses to mental and behavioral health conditions when a combination of these resources is what is truly needed.

II. CATAWBA HOSPITAL HISTORY AND RELATED POLICY CHANGES OVER TIME

The Catawba Hospital site was originally established as a health resort in 1858, drawing on the red sulfur springs discovered on Catawba Mountain, and is located ten miles north of Salem, Virginia, in Roanoke County.²⁹ In the early 1900s, the facility began serving as a hospital for tuberculosis patients.³⁰ With the development of antibacterial medications, and once tuberculosis was eliminated as a major public health challenge between the 1940s and 1960s, Catawba Hospital became a residential mental health hospital in 1972 operated by the Virginia Department of Behavioral Health and Developmental Services (DBHDS).³¹ Catawba Hospital is one of nine mental health facilities operated by DBHDS in the Commonwealth, and one

²⁶ Laura Sloan, & Chinmoy Gulrajani, *Where We are on the Twentieth Anniversary of Olmstead v. LC*, 47 J. OF THE AM. ACAD. OF PSYCHIATRIC & THE L. 408, 410 (2019).

²⁷ *Id.*

²⁸ Francesca Mongelli et. al., *Challenges and Opportunities to Meet the Mental Health Needs of Underserved and Disenfranchised Populations in the United States*, 18 FOCUS 16, 19 (2020).

²⁹ *Catawba Hospital*, VA. DEP'T OF BEHAV. HEALTH & DEV. SERV., <https://dbhds.virginia.gov/facilities/catawba/origin-of-the-hospital/> (last visited Oct. 29, 2023).

³⁰ *Id.*

³¹ *Id.*

of three in Western Virginia.³²

Catawba Hospital and all the DBHDS training centers and mental health hospitals were significantly impacted by the 1999 *Olmstead v. L.C.* U.S. Supreme Court ruling.³³ The *Olmstead* decision represented a major landmark ruling to protect the right of people with disabilities to receive services in the “most integrated setting appropriate” to their needs and, when possible, in their community of origin.³⁴ The ruling and its enforcement propelled the downsizing and closing of large state mental health hospitals that provided long-term care for individuals with severe mental health conditions.³⁵ This shift required an accompanying movement of insurance, including Medicaid and Medicare, to provide coverage for home- and community-based services, as well as the infrastructure for these services to be available at the community level.³⁶

While there are clear positive outcomes of deinstitutionalization, there have also been negative consequences and disparities created by its implementation. While some communities have the resources and commitment to provide adequate home- and community-based services, others do not.³⁷ The deinstitutionalization period has been accompanied by increased homelessness and incarceration rates among those with mental illness and other disabilities, a trend that some attribute to the closing and downsizing of state mental health facilities without sufficient investment in community-based services.³⁸ There remains a demonstrated need for acute residential mental health care; however, with downsized public facilities,

³² *Behavioral Health Facilities*, VA. DEP’T OF BEHAV. HEALTH & DEV. SERV., <https://dbhds.virginia.gov/about-dbhds/facilities/> (last visited Oct. 29, 2023).

³³ See *Olmstead v. L.C.* by Zimring, 527 U.S. 581, 604 (1999); *Chronological History of the Virginia Department of Behavioral Health and Developmental Services*, VA. DEP’T OF BEHAV. HEALTH & DEV. SERV., (2022), <https://dbhds.virginia.gov/wp-content/uploads/2022/05/DBHDS-timeline2018-1.pdf>.

³⁴ See *Olmstead*, 527 U.S. at 602.

³⁵ *Tracking the History of State Psychiatric Hospital Closures from 1997 to 2015*, NAT’L ASS’N OF STATE MENTAL HEALTH PROGRAM DIRS. RSCH. INST. (July 2015), <https://www.nri-inc.org/media/1111/2015-tracking-the-history-of-state-psychiatric-hospital-closures-lutterman.pdf>; see Ronald S. Honberg, *The Olmstead Decision and Mental Health Systems Reform*, SPECIAL NEEDS ALL. (Jan. 6, 2013), <https://www.specialneedsalliance.org/blog/the-olmstead-decision-and-mental-health-systems-reform/>.

³⁶ Jennifer Ryan & Barbara Coulter Edwards, *Rebalancing Medicaid Long-Term Services And Supports*, HEALTH AFFS. (Sept. 17, 2015), <https://www.healthaffairs.org/doi/10.1377/hpb20150917.439553/>.

³⁷ See generally *Mental Health Disparities: Diverse Populations*, APA, <https://www.psychiatry.org/psychiatrists/diversity/education/mental-health-facts#:~:text=Racial%20Fethnic%2C%20gender%2C%20and,of%20awareness%20about%20mental%20health.> (last visited Nov. 7, 2023).

³⁸ Russell K. Schutt, *Social Environmental Illness: The Progress and Paradox of Deinstitutionalization*, 17 *ADVANCES IN MED. SOCIO.* 91, 101 (2016); see Dae-Young Kim, *Psychiatric Deinstitutionalization and Prison Population Growth: A Critical Literature Review and Its Implications*, 27 *CRIM. JUST. POL’Y REV.* 3, 10 (2014).

finding a placement for individuals in crisis can be difficult, especially for the un- and under-insured.³⁹ This need can best be met with a pragmatic balance of well-structured and supported inpatient options within a continuum of services that enables return to, and continued care in, the community.⁴⁰

A. The Growing Opioid and Addiction Crises

During the past decade, the opioid epidemic has been declared a public health crisis at the national and local levels.⁴¹ The opioid crisis is often divided into three phases, with the root of the crisis beginning in the early 1990s when OxyContin—at the time a novel, long-acting pain killer—entered the pharmaceutical market with false claims that the drug was much less addictive than other painkillers.⁴² The manufacturer, Purdue Pharma, aggressively marketed the opioid painkiller by leveraging the concept of pain as the fifth vital sign for effective treatment of patients and advocating that OxyContin could be used to manage pain as a chronic health condition.⁴³ In the process, the company targeted communities reeling from the loss of mining, agricultural, and manufacturing jobs where long-term disability rates and feelings of despair and hopelessness due to unemployment were significant.⁴⁴ This egregious commercial manipulation resulted in a wave of opioid addiction throughout the U.S. and an accompanying surge of opioid-related overdose deaths that began around 2010.⁴⁵

In response to the surge in reported addiction and overdoses, from 2008–2012, regulators, physicians, and health systems put mechanisms in place, such as drug monitoring programs, to curtail the flow of prescription opioids.⁴⁶ While these second-phase efforts were largely warranted, unintended consequences arose when individuals who had become addicted to the prescription opioids turned to illicit heroin to satiate powerful cravings

³⁹ See Mira S. Singer, *Virginia's Mental Health System: How it has Evolved and What Remains to be Improved*, 90 THE VA. NEWS LETTER 1, 2, 10 (2014).

⁴⁰ *Id.*

⁴¹ See Gopal K. Singh et al., *Opioid Epidemic in the United States: Empirical Trends, and A Literature Review of Social Determinants and Epidemiological, Pain Management, and Treatment Patterns*, 8 INT'L J. MATERNAL AND CHILD HEALTH & AIDS 89, 90, 96 (2019), <https://mchandaids.org/index.php/IJMA/article/view/284/132>.

⁴² See BETH MACY, DOPESICK: DEALERS, DOCTORS, AND THE DRUG COMPANY THAT ADDICTED AMERICA 8, 19-21 (2018).

⁴³ *Id.* at 27-28.

⁴⁴ *See id.* at 15-18, 31-32.

⁴⁵ *Understanding the Opioid Overdose Epidemic*, CDC, <https://www.cdc.gov/opioids/basics/epidemic.html> (last visited Oct. 30, 2023).

⁴⁶ Emily Rhodes et al., *The Effectiveness of Prescription Drug Monitoring Programs at Reducing Opioid-Related Harms and Consequences: A Systematic Review*, BMC HEALTH SERV. RSCH. 1-2 (Nov. 1, 2019), <https://doi.org/10.1186/s12913-019-4642-8>.

and prevent withdrawal.⁴⁷ The third phase, starting around 2013, has involved synthetic opioids, especially those containing illicitly produced fentanyl.⁴⁸ As reflected in Figure 1, this third wave saw a record number of annual deaths in 2020 and 2021 during the COVID-19 pandemic.⁴⁹ As this phase continues to evolve, some are forecasting a fourth phase, driven in part by the increasing presence of fentanyl in many substances, including cocaine, marijuana, and counterfeit prescription drugs such as Percocet and Ritalin.⁵⁰

Three Waves of Opioid Overdose Deaths

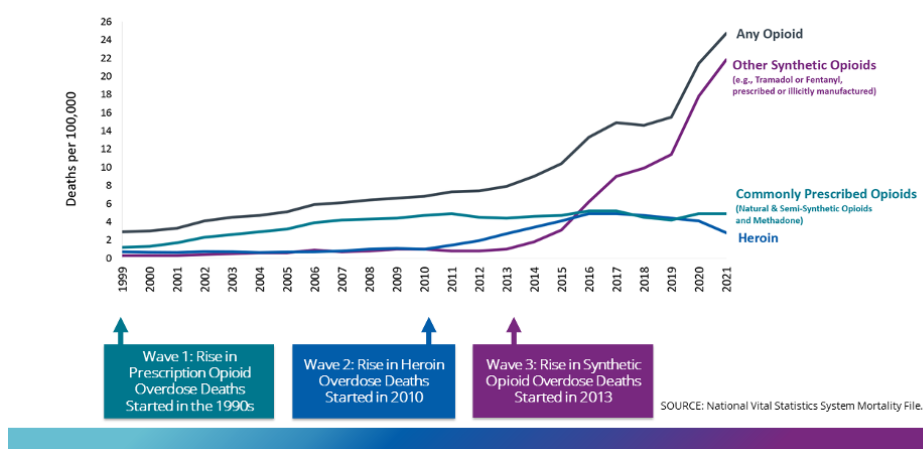


Figure 1. Three Waves of Opioid Overdose Death Rates by Type of Opioid in the United States, 2001–2021⁵¹

While the expansion of Medicaid in forty-one states and the District of Columbia since 2014 has provided notable increases in addiction treatment, these services vary widely from state to state because services through

⁴⁷ See Nick Werle & Ernesto Zedillo, *We Can't Go Cold Turkey: Why Suppressing Drug Markets Endangers Society*, 46 J. OF L., MED. & ETHICS 325, 325 (2018).

⁴⁸ *Understanding the Opioid Overdose Epidemic*, *supra* note 45.

⁴⁹ *Id.*

⁵⁰ Kaitlin Sullivan, *Fentanyl Plus Stimulants Drive 'Fourth Wave' of Overdose Epidemic in the U.S.*, NBC NEWS (Sept. 14, 2023), <https://www.nbcnews.com/health/health-news/fentanyl-stimulants-drives-fourth-wave-overdose-epidemic-us-rcna104953>; see Daniel Ciccarone, *The Rise of Illicit Fentanyls, Stimulants and the Fourth Wave of the Opioid Overdose Crisis*, 34 CURRENT OP. PSYCHIATRY 344, 344-45 (2021).

⁵¹ *Understanding the Opioid Overdose Epidemic*, *supra* note 45.

Medicaid are largely available at the discretion of state policymakers.⁵² In addition to Medicaid expansion, other revenue sources such as the State Targeted Response to the Opioid Crisis grant program (STR) and additional specified funding from the Substance Abuse and Mental Health Services Agency (SAMHSA), the Centers for Disease Control and Prevention (CDC), and related federal agencies have sought to abate the impact of the addiction crisis and reduce overdoses—with only isolated success.⁵³ A 2020 review by the U.S. Department of Health and Human Services (HHS) Office of Inspector General indicated that administrative and bureaucratic barriers delayed the allocation of funds to increase access to treatment for opioid use disorder (OUD).⁵⁴ Specifically, the Department noted that very few state and regional agencies have had sufficiently comprehensive plans and strategies to guide the utilization of funding.⁵⁵

Even amidst declarations of public health emergencies related to the opioid and addiction crisis, and significant financial resources deployed to combat this complex situation, few communities are gaining ground in the battle. In the 2018 nonfiction book *Dopesick: Dealers, Doctors, and the Drug Company that Addicted America*, Beth Macy asserts, “America’s approach to its opioid problem is to rely on Battle of Dunkirk strategies—leaving the fight to well-meaning citizens, in their fishing vessels and private boats—when what’s really needed to win the war is a full-on Normandy Invasion.”⁵⁶ In her 2022 follow-up book, *Raising Lazarus: Hope, Justice, and the Future of America’s Overdose Crisis*, Macy highlights that federal and state resources can best be used to curtail the addiction and overdose crisis when policymakers, community members, and organizations assess their unique circumstances and cooperate to determine what actions and strategies are most appropriate for their local and regional context.⁵⁷

Underscoring the reality of what Macy prescribes, many of the mechanisms to access mental health and substance use services are transactional at the local and regional levels.⁵⁸ These transactions require

⁵² Joshua Clinton & Michael Sances, *The Politics of Policy: The Initial Mass Political Effects of Medicaid Expansion in the States*, 112 AM. POL. SCI. REV. 167, 169 (2018).

⁵³ See U.S. DEP’T OF HEALTH AND HUM. SERVICES OFF. OF INSPECTOR GEN., OEI-BL-18-00460, STATES’ USE OF GRANT FUNDING FOR A TARGETED RESPONSE TO THE OPIOID CRISIS (2020).

⁵⁴ *Id.*

⁵⁵ *Id.*

⁵⁶ MACY, *supra* note 42, at 24.

⁵⁷ BETH MACY, *RAISING LAZARUS: HOPE, JUSTICE, AND THE FUTURE OF AMERICA’S OVERDOSE CRISIS* 152 (2022).

⁵⁸ See Cullen C. Merritt, *What Makes an Organization Public? Managers’ Perceptions in the Mental Health and Substance Abuse Treatment System*, 49 AM. REV. PUB. ADMIN. 411, 412, 421-22 (2019) (explaining the public-private distinction and the ways that varying interests create a similar tension in the public sector that exist in the private sector).

communication and collaboration among those on the front lines of human interaction during crises.⁵⁹ In the case of the opioid crisis, these front-line responders include policymakers, human service agencies, law enforcement, criminal justice officials, emergency medical service providers, and local and regional for-profit and nonprofit healthcare systems. It is within this context over the past five to ten years that cross-sector community coalitions have started forming to address the complex challenges of the opioid and addiction crisis.⁶⁰ In the Catawba Region, the Roanoke Valley Collective Response to the Opioid and Addiction Crisis (RVCR) was at the forefront in recognizing the profound need for increased access to residential treatment for SUD as part of an integrated system of care.⁶¹

B. *The RVCR Blueprint*

The RVCR was initiated with much enthusiasm and impetus, and timed to launch with the release of Beth Macy's book *Dopesick*, parts of which were focused on the Roanoke Valley.⁶² Throughout 2018 and into 2020, more than 200 coalition members representing a cross-section of community organizations and individuals and families with lived experience came together monthly as a whole, and more frequently in workgroups, to discuss challenges and develop strategic plans to address the opioid crisis from a continuum perspective.⁶³ This continuum included preventing the use of opioids, addressing the impact of addiction on families and children, addressing overdose and other harms of addiction, and treatment and long-term recovery from addiction.⁶⁴ Five workgroups were tasked to focus on each area.⁶⁵

Attendance at the monthly stakeholder meetings averaged around 100 individuals who worked from late 2018 to 2019 to develop a Blueprint for Action, which launched just as the world, nation, and Virginia faced the

⁵⁹ See *Continuity and Coordination of Care*, WORLD HEALTH ORG. 68 (2018), <https://iris.who.int/bitstream/handle/10665/274628/9789241514033-eng.pdf?sequence=1>.

⁶⁰ See generally Mari-Lynn Darinoni et al., *Community Coalition and Key Stakeholder Perceptions of the Community Opioid Epidemic Before an Intensive Community-level Intervention*, 138 J. OF SUBSTANCE ABUSE TREATMENT 1 (2022).

⁶¹ See Elham Morshedzadeh et al., *Tapping into Community Expertise: Stakeholder Engagement in the Design Process*, 5 POL'Y DESIGN & PRAC. 529, 531-532 (2022).

⁶² Ruth Cassell, *Roanoke Valley Collective Response to Combat Opioid and Addiction Crisis Gaining Momentum*, FAM. SERV. OF ROANOKE VALLEY (Sept. 21, 2018), <https://fsrv.org/roanoke-valley-collective-response-to-combat-opioid-and-addiction-crisis-gaining-momentum/>.

⁶³ See Morshedzadeh et al., *supra* note 61, at 538-539.

⁶⁴ See ROANOKE VALLEY COLLECTIVE RESPONSE, BLUEPRINT FOR ACTION (2020), <https://static1.squarespace.com/static/5dccc0cb7895c203d4ed8f00/t/5fd7c4f537169356c46233bb/1607976185421/RVCR.Blueprint.9.8.2020.pdf>.

⁶⁵ See *id.*

COVID-19 crisis.⁶⁶ One of the primary recommendations in the Blueprint for Action was to improve access to treatment through “increased interagency collaboration to ensure that best treatment practices are available and applied across the continuum of care.”⁶⁷ In April 2023, nearly three years after the release of the Blueprint for Action, the Roanoke area reported the second highest nonfatal overdose rate in the nation—underscoring the need for increased acute care for SUD.⁶⁸

III. TREATMENT AND RECOVERY FRAMEWORKS AND MODELS

The American Society of Addiction Medicine (ASAM) has a widely recognized and broadly implemented set of criteria for “conducting a comprehensive biopsychosocial assessment to inform patient placement and treatment planning.”⁶⁹ It considers six dimensions, including: the individual patient’s potential to withdraw and their acute intoxication; biomedical, emotional, and/or behavioral complications; the individual’s readiness to change; their potential for relapse or a return to use; and their recovery and living environment.⁷⁰ The ASAM Continuum of Care (Figure 2) ranges from Level 0.5 (Prevention/Early Intervention) to Level 4 (Intensive Inpatient), demonstrating how the intensity of care increases depending on the severity of the individual’s SUD and need for treatment as defined by the six dimensions.⁷¹

⁶⁶ *See id.*

⁶⁷ *See id.*

⁶⁸ Lauren Helkowschi & Brittny McGraw, *Roanoke Ranked Second Nationwide for Non-fatal Overdoses*, WLSL (Apr. 14, 2023), <https://www.wsls.com/news/local/2023/04/14/roanoke-ranked-second-nationwide-for-non-fatal-overdoses>.

⁶⁹ *About the ASAM Criteria*, AM. SOC’Y OF ADDICTION MED., <https://www.asam.org/asam-criteria/about-the-asam-criteria> (last visited Oct. 29, 2023); *ASAM Criteria Intake Assessment Guide*, AM. SOC’Y OF ADDICTION MED., <https://www.asam.org/asam-criteria/criteria-intake-assessment-form> (last visited Oct. 29, 2023).

⁷⁰ *About the ASAM Criteria*, *supra* note 69.

⁷¹ *Id.*

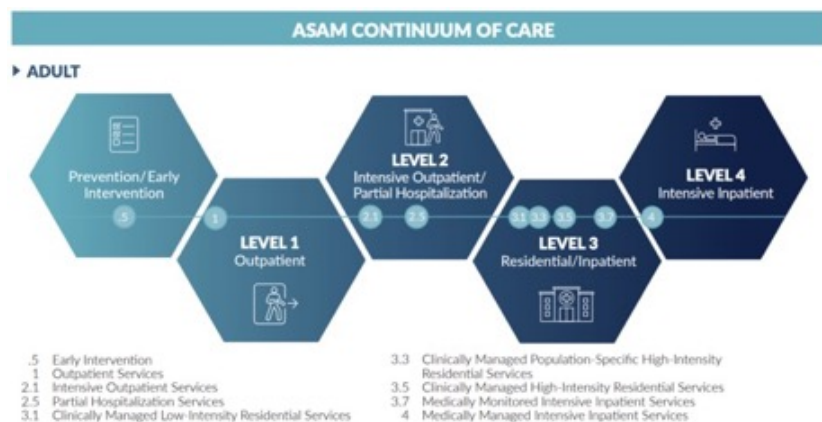


Figure 2. The ASAM Continuum of Care for Adults⁷²

Virginia launched its Addiction and Recovery Treatment Services (ARTS) program in 2017.⁷³ The program is based on the ASAM criteria, as demonstrated by its coordinated and recovery-oriented systems of care approach to treating SUD as “chronic disease management” rather than disconnected, acute episodes.⁷⁴ Children and adults enrolled in Medicaid, FAMIS and FAMIS MOMS are generally covered for ARTS and can receive integrated physical and behavioral healthcare where medically necessary.⁷⁵ It’s been observed, however, that some stakeholders in our region have experienced limitations with Medicaid ARTS implementation, such as insufficient coverage for certain levels of care due to low reimbursement rates, or delays or conflicts in transitioning clients to the appropriate provider and level of care.⁷⁶ However, research analyzing claims data before and after Medicaid expansion of the ARTS program found that beneficiaries with OUD were less likely to have an emergency department visit or inpatient

⁷² *Id.*

⁷³ *Addiction and Recovery Treatment Services*, DEP’T OF MED. ASSISTANCE SERVS., <https://www.dmas.virginia.gov/for-providers/addiction-and-recovery-treatment-services/#:~:text=In%202017%2C%20DMAS%20launched%20an,use%20disorders%20across%20the%20state> (last visited Oct. 25, 2023).

⁷⁴ DEP’T OF MED. ASSISTANCE SERVS., ADDICTION AND RECOVERY TREATMENT SERVICES PROVIDER MANUAL 16 (2023), https://vamedicaid.dmas.virginia.gov/sites/default/files/2023-08/ARTS%20Provider%20Manual%20Chapter%20IV%20%28updated%208.2.23%29_Final.pdf.

⁷⁵ *Addiction and Recovery Treatment Services*, *supra* note 73 (Family Access to Medical Insurance Security Plan (FAMIS) provides affordable healthcare coverage in Virginia for the children of qualifying families. The FAMIS MOMS program provides health care coverage during pregnancy and for a full year after the birth).

⁷⁶ The assertion is supported by anecdotal observations from the authors’ work.

hospitalization after the expansion of treatment coverage.⁷⁷ ARTS has also significantly increased access to MAT, an evidence-based approach endorsed by SAMHSA.⁷⁸

More Medicaid members are getting treatment following an ED visit or stay at a SUD residential treatment center. Among Virginia Medicaid members who had an ED visit with a principal diagnosis of a SUD, receipt of some type of ARTS addiction treatment services has increased since ARTS implementation. Use of pharmacotherapy within 30 days of an ED visit increased from 5.6 percent in 2017 after ARTS implementation, to 12.2 percent by 2019. Use of outpatient, residential treatment and medically managed inpatient treatment has also increased. Nevertheless, 41.1 percent of members with a SUD-related ED visit still had no treatment services within 30 days of the visit in 2019.⁷⁹

Recovery-oriented systems of care (ROSC) have a decades' long history of being a form of integrated behavioral health model that, over time, places varying emphasis on the individual- versus community-level interventions that are required for successful recovery.⁸⁰ Conceptualization of recovery-oriented programs has been linked to the:

[C]onsumer/survivor and new recovery advocacy movements, which themselves are rooted, in part, in the civil rights movement of the 1950s and 1960s and the independent living and disability rights movement of the 1970s. It was these movements, and the legislation inspired by them (e.g., the Rehabilitation Act of 1973, the Americans with Disabilities Act of 1990), that established the rights of persons with functionally disabling conditions (based on a medical assessment of functional impairment) to be provided not only with medical care for their health condition but also with the community supports needed to be able to live full and dignified lives in the communities of their choice.⁸¹

While an individual is responsible for their success in recovery, there are a variety of external factors that will also influence their success, such as the social determinants of health (SDOH) including: economic stability, education access and quality, healthcare access and quality, neighborhood and the built environment, and the social and community context.⁸² More specifically, the individual's access to recovery capital, social inclusion, and

⁷⁷ Andrew J. Barnes et al., *Hospital Use Declines After Implementation of Virginia Medicaid's Addiction and Recovery Treatment Services*, 39 HEALTH AFFS. 238, 238 (2020).

⁷⁸ *Id.* See *Medications for Substance Use Disorders*, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN. (Oct. 3, 2023), <https://www.samhsa.gov/medications-substance-use-disorders>.

⁷⁹ SUBSTANCE ABUSE SERVS. COUNCIL, *SUBSTANCE USE DISORDER SERVICES COUNCIL REPORT ON TREATMENT PROGRAMS FOR FY 2021 20* (2021), <https://dbhds.virginia.gov/wp-content/uploads/2022/08/FY21-SASC-Comprehensive-Interagency-State-Plan-Final.docx>.

⁸⁰ See Larry Davidson et al., *Recovery-Oriented Systems of Care: A Perspective on the Past, Present, and Future*, 41 ALCOHOL RSCH. 1, 6-7 (2021).

⁸¹ See *id.* at 8.

⁸² *Social Determinants of Health*, U.S. DEP'T OF HEALTH AND HUM. SERVS., <https://health.gov/healthypeople/priority-areas/social-determinants-health> (last visited Nov. 6, 2023).

a sense of full citizenship and agency within their community will impact their success in recovery.⁸³ While primary and behavioral healthcare providers are central to coordinating treatment and recovery services, they must work closely with a diverse, multidisciplinary team. To be truly recovery-oriented, this team must include members of local government, workforce developers, housing providers, educational institutions, and community organizations.⁸⁴

Similarly, an individual who completes a residential treatment program may quickly relapse if they return to the people, places, and things that led to their SUD.⁸⁵ Accordingly, “Step-Down” programs and community-based supports that are part of a recovery ecosystem and coordinated with facilities like the Catawba Hospital will be critical for individuals’ long-term success in recovery. Therefore, it is equally important for state legislators to direct sufficient funding to strengthen the SDOH that support the ROSC, such as developing more recovery housing and building a recovery-friendly workforce. Transforming and expanding Catawba Hospital is one of many important steps towards achieving a model recovery ecosystem.

Evidence suggests that investing in or strengthening one part of the continuum of care—such as the ROSC or the recovery ecosystem—can lead to cost savings elsewhere. For example, “[s]everal studies find that crisis services can lead to significant cost savings due to reduced inpatient utilization, emergency department diversion, jail diversion, and a more appropriate use of community-based behavioral health services.”⁸⁶ Treatment costs today may lead to longer-term societal benefits, such as keeping more people employed, able to care for dependents, and less reliant on other healthcare or social services. Integration of behavioral and medical healthcare services has been projected to lead to substantial annual cost savings that are up to 28% of all spending for mental health and substance use services.⁸⁷

⁸³ See Davidson, *supra* note 80, at 9.

⁸⁴ See NAT’L COUNCIL FOR BEHAV. HEALTH, TRAUMA-INFORMED, RECOVERY ORIENTED SYSTEM OF CARE TOOLKIT 29, https://www.thenationalcouncil.org/wp-content/uploads/2022/02/IN-gov_TI-ROSC_Toolkit_Final_4.20.pdf.

⁸⁵ Amanda L. Giordano, *Why Change People, Places, and Things in Early Recovery?*, PSYCH. TODAY (June 18, 2021), <https://www.psychologytoday.com/us/blog/understanding-addiction/202106/why-change-people-places-and-things-in-early-recovery>.

⁸⁶ Stuart Yael Gordon, *Building State Capacity to Address Behavioral Health Needs Through Crisis Services and Early Intervention*, MILBANK MEM’L FUND (Nov. 2020), https://www.milbank.org/wp-content/uploads/2020/11/Building-States-Capacity-for-BH-Crisis_4.pdf.

⁸⁷ Stephen P. Melek, et. al, *Potential Economic Impact of Integrated Medical-behavioral Health*, MILLIMAN RSCH. REP. (Jan. 2018), <https://www.milliman.com/-/media/milliman/importedfiles/uploadedfiles/insight/2018/potential-economic-impact-integrated-healthcare.ashx>.

Virginia and other states have been successful in funding and conducting SUD treatment through integrated primary and behavioral healthcare approaches and expanding accountable public-private partnerships.⁸⁸ This success can be further leveraged by utilizing opioid abatement settlement dollars, funding grants to provide opportunities for treatment and recovery innovations now and into the future. In June 2023, the Virginia Opioid Abatement Authority (OAA), established by the General Assembly in 2021, announced \$23 million in grants to local communities and regional partnerships to plan innovative programs to address the ongoing crises.⁸⁹ This investment represents an initial step in applying opioid settlement funds, with an expectation that Virginia will receive nearly \$550 million in settlement funds in the coming decade.⁹⁰

IV. CATAWBA AS A CORNERSTONE IN THE RECOVERY ECOSYSTEM

It is well-established that Virginia needs a change in policy and program direction to achieve a comprehensive recovery ecosystem that will produce the most effective outcomes. The RVCR's Blueprint for Action maps a holistic view of resources and gaps in the greater Roanoke region, and targets priorities for developing a regional recovery ecosystem.⁹¹ The third treatment priority, to "strengthen [the] continuum of care and transitions in care to reduce gaps and interruptions in treatment," is at the heart of developing treatment options across the ASAM continuum of services.⁹² The underutilized Catawba Hospital campus is an opportunity to take the unused floors of the current acute-care psychiatric hospital and develop residential treatment and detox beds.⁹³

The JLL Consulting study for Catawba Hospital indicated that the hospital is only funded to care for 110 patients, but has excess capacity that could

⁸⁸ Mirella M. N. Minkman, *Developing Integrated Care. Towards a Developmental Model for Integrated Care*, 12 INT'L J. OF INTEGRATED CARE 1, 3 (2012).

⁸⁹ *Opioid Abatement Authority Considers Award of \$23 million in Grants to 76 Cities and Counties*, OPIOID ABATEMENT AUTH. (June 12, 2023), <https://www.oaa.virginia.gov/media/governorvirginia.gov/oaa/pdf/June-12-OAA-Press-Release.pdf>.

⁹⁰ *Virginia Receives Initial Payment of \$67.4 Million from Johnson & Johnson Settlement*, OFF. OF THE ATT'Y GEN. (Oct. 19, 2022), <https://www.oag.state.va.us/media-center/news-releases/2475-october-19-2022-virginia-receives-initial-payment-of-67-4-million-from-johnson-johnson-settlement>.

⁹¹ See ROANKOE VALLEY COLLECTIVE RESPONSE, BLUEPRINT FOR ACTION, *supra* note 64.

⁹² *Id.*

⁹³ JLL CONSULTING, *supra* note 4.

optimally be used for residential treatment.⁹⁴ Given that a significant portion of Catawba patients may have a dual diagnosis—including SUD—providing Step-Down treatment on the same campus is an innovative approach in Virginia that will provide a critical bridge for a successful return to the community.⁹⁵ Under this model, an individual experiencing an acute psychiatric episode in relation to or in tandem with an SUD diagnosis could be discharged from the hospital and admitted to residential treatment on the same campus. This could help slow the revolving door of SUD hospital admissions and the often-related involvement with the criminal justice system.

Underscoring this need, in 2022 there were 123 fatal overdoses recorded in Roanoke City alone.⁹⁶ Roanoke City is just one community in the Catawba Hospital catchment area that has experienced persistently high overdose rates, and demonstrated its need for increased inpatient treatment services.⁹⁷ Timely state investment and leadership can make a difference for these communities, and provide a pilot for other regions of Virginia deeply impacted by the opioid and addiction crises.⁹⁸ Additional public and private investment will be needed in the coming years to create a recovery-to-wellness ecosystem that will reverse the devastating trends of overdoses that we have seen for too long. To achieve a well-functioning ecosystem, Virginia communities will need continued support and collaboration from each of the multidisciplinary areas that comprise the recovery-to-wellness ecosystem (*See Figure 3*).

⁹⁴ *Id.* at 15. *See also*, *O. Winston Link Museum: History Museum of Western Virginia*, THE HIST. SOC'Y OF W. VA., <https://hswv.pastperfectonline.com/bysearchterm?keyword=Catawba+Sanatorium> (last visited Nov. 30, 2023) (discussing how Catawba Hospital was re-opened after the Civil War to support 300 occupants).

⁹⁵ JLL CONSULTING, *supra* note 4.

⁹⁶ Luke Weir, *Workforce Woes Complicate Catawba Hospital Plans*, ROANOKE TIMES (Sept. 17, 2023), https://roanoke.com/news/state-regional/government-politics/workforce-woes-complicate-catawba-hospital-plans/article_f09c0a00-53d9-11ee-9e5f-7fc4a1c14c58.html.

⁹⁷ Helkowski & McGraw, *supra* note 68.

⁹⁸ Weir, *supra* note 96.

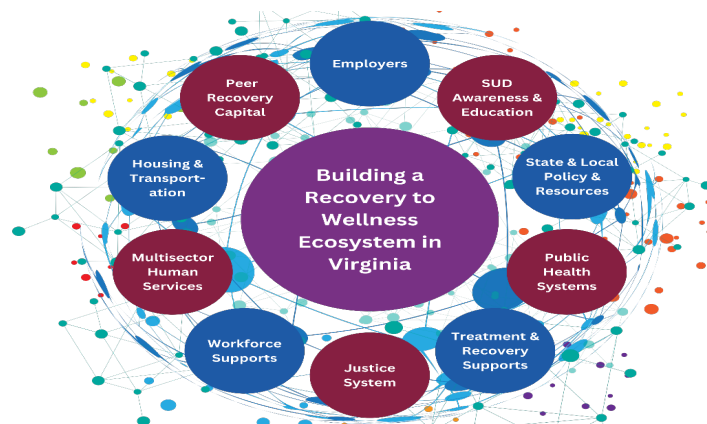


Figure 3. Components of a Recovery to Wellness Ecosystem (Adapted)⁹⁹

The residential treatment and detox services pose an opportunity for public-private partnerships. Under this partnership, a private provider could meet the acute care needs of an individual and ensure proper transition of care; then, the provider could work with other ecosystem partners once an individual is ready for community re-integration.¹⁰⁰ Because an ecosystem fosters person-centered care, it allows for many of the recovery priorities listed in the RVCR Blueprint for Action to be addressed. While all functions along the ASAM continuum of care must be well-resourced—including recovery housing, peer recovery support services, access to MAT, and outpatient services—access to residential treatment helps significantly to stabilize the individual and successfully start their recovery journey. The addition of the acute and residential treatment services at Catawba Hospital can serve as a cornerstone for building a recovery ecosystem in Virginia that supports individuals and communities to move from crisis to wellness.

CONCLUSION

The opioid and addiction crises are an unprecedented challenge that merit an innovative response. The Commonwealth of Virginia is known for innovative, yet pragmatic, policy and program shifts that benefit all

⁹⁹ *Substance Use Disorder Recovery to Work Ecosystem*, ARC (2023), <https://www.arc.gov/wp-content/uploads/2023/01/2023.01-SUD-Recovery-Ecosystem-1.pdf>.

¹⁰⁰ Ashford et al., *supra* note 5, at 2.

Virginians while carefully balancing regional differences. The transformation of the Catawba Hospital campus to serve the needs of Virginians with co-morbid mental health and substance use diagnoses as a pilot for the state and the nation has been thoughtfully proposed, and the time to begin the phased implementation plan is upon us. The transformation of the Catawba Campus through public investment and private partnerships is reflective of the forward-looking approach that brings Virginians and their policymakers together.

The Catawba Campus offers a beautiful and therapeutic setting that is a natural sanctuary for individuals in crisis, with capacity for Step-Down treatment and services that can serve as a bridge back to the individual's home community once the crisis has been addressed. The proposed coordination of ongoing treatment and recovery services, along with employment and housing supports, will help to ensure long-term recovery success. The transformation proposal also looks toward workforce and educational partnerships to build the qualified workforce needed to implement a robust recovery ecosystem. The identification of these strategies has come together at a time when the resources needed to address and overcome the effects of the opioid and mental health crises are available through ongoing revenue generation and the opioid settlement funds.