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This is to certify that the doctoral study by

Alanna D’Avanzo-Horberg

has been found to be complete and satisfactory in all respects,
and that any and all revisions required by
the review committee have been made.

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Walden University
2023

Abstract

Practitioners’ Perceptions of New Jersey's Chapter 28 Mandate for Funding

Substance Use Disorder Treatment

by

Alanna Rose D’Avanzo-Horberg

MA, Rider University, 2019

BA, Rider University, 2017

Doctoral Study Submitted in Partial Fulfillment

of the Requirements for the Degree of

Doctor of Human Services

Walden University

December 2023

Abstract

In 2022, New Jersey reported 85,266 admissions for primary substance abuse disorder treatment. Under the Chapter 28 mandate, a covered service user is entitled to a limited amount of addiction treatment: 28 days of partial hospitalization and/or intensive outpatient treatment during the first 180 days of a plan year. Benefits for a continued stay after the initial 28 are subject to concurrent and retrospective reviews. This results in a gap of access and funding for continued addiction treatment for individuals. The purpose of this qualitative action research study was to identify the existing implications of applying the New Jersey Chapter 28 Substance Abuse mandate through the knowledge, experiences, and opinions of licensed practitioners about providing treatment to substance use disorder service users. The study participants included 16 licensed practitioners in New Jersey who participated in focus groups. Using the transtheoretical stages of change model as a framework, practitioners were presented with questions applying the objective, reflective, interpretive, decisional (ORID) model for action research, which was later coded by category and theme. Results of the analysis of the qualitative data revealed four major themes: (a) complexity of each client, (b) clinical prognosis as a chronic condition, (c) barriers to insurance funding treatment, and (d) recommendations for practice. This study contributes to social change and a better understanding of the social detriments of health by informing policymakers about this research to better understand the necessary steps to achieve full addiction treatment parity.

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Dedication

To my angels -- this one’s for you.

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Section 1: Introduction to the Problem

Background of the Human Services Program

The need for mental health and addiction parity in healthcare in the United States can be traced back over 60 years. President John F. Kennedy became the first world leader to publicly speak on the challenges of mental health, calling for reform of existing mental health care, and subsequently signing the Community Mental Health Act of 1963 (Kennedy & Fried, 2015). More recently, over the past 2 decades, there has been significant advocacy in the field of human services to have mental health and substance abuse disorders covered and funded by insurance in the same way as the treatment of physical health diagnoses. The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) is a federal law in the United States that was enacted to prevent insurance companies from their previous practice, which historically provided less favorable benefit limitations on mental health and substance use disorder treatment compared to benefits for medical/surgical needs (Center for Medicare & Medicaid Services, n.d.). While there has been much advocacy toward mental health parity legislation in New Jersey, the current legislation falls short of providing service users with funding for substance use disorder treatment.

Since the MHPAEA was first introduced, there have been several barriers to implementation, requiring advocacy at the state and federal levels. It has become apparent that transforming payment and delivery of services will need to be addressed to fully understand the scope of parity for mental health and substance use disorders (Kirby et al., n.d.). Wit vs. United Behavioral Health continues to be a landmark case addressing

mental health parity. In this case, the plaintiff asserted that their son was denied residential substance use disorder treatment based upon United Behavioral Health's assessment of standards of care and clinical necessity. The plaintiff's son overdosed and died a few short months later. In the initial ruling in 2019, the United States District Court of Northern California found United Behavioral Health did not follow the widely practiced clinical standards of care for mental health and addiction. As a result, the Judge ordered the reprocessing of 70,000 claims for 50,000 service users, half of which were children. In March 2022, this ruling was overturned by U.S. Ninth Circuit Court of Appeals reversed the District Court's order with a seven-page ruling where the panel stated it is "not unreasonable" for insurers to determine coverage inconsistently with accepted standards of care (The Kennedy Forum, n.d.). This decision was overturned yet again in January 2023, where the same panel issued a corrected ruling, ascertaining that United Behavioral Health violated both its fiduciary duty by creating medical necessity criteria that put its self-interest ahead of plan members. This resulted in more than 50,000 individuals being denied mental health or addiction coverage (Bloomberg Law, n.d.; The Kennedy Forum, n.d.; Partnership to End Addiction, 2020). A promising decision came in August 2023, where a third ruling reevaluated some aspects of the District Court's findings. This overturned the January 2023 ruling, allowing certain plaintiff claims to be reviewed again. In addition, the panel ordered a rehearing and directed the district court to address a question regarding the plan's administrative exhaustion requirement (The Kennedy Forum, n.d.). This case has the potential to have a lasting impact as the precedent for mental health and addiction coverage (The Kennedy Forum, n.d.).

Similar discrepancies in parity have also been identified in other states. In August of 2021, in New York State, a suit was filed and settled regarding United Healthcare improperly denying or reducing thousands of claims that individual members had filed for coverage of critical health services pertaining to behavioral health. The settlement included approximately $14.3 million in restitution to service users impacted by the policies for the 20,000 New Yorkers with behavioral health conditions who received denials or reductions in reimbursement (Heebink, 2021). Since 2018, seventeen states have passed laws to expand the medical necessity for mental health and substance use disorder treatment (Kirby et al., n.d.). These legal cases highlight the stark disconnect between coverage decisions and commonly accepted standards of care in the mental health field. While not directly tied to federal parity laws, these cases underscore how insurers use internal guidelines that can negatively affect their members, potentially undermining these federal laws meant to ensure equal coverage for mental health (Bedoya, 2023).

As of July 2023, the Biden-Harris administration acknowledged the discrepancies of true parity for mental health and the shortcomings of the existing legislature and its applications in practice. The MHPAEA Comparative Analysis Report to Congress published in July of 2023 has underscored significant issues that remain. Some issues include: excluding certain treatments for mental health and substance use disorders, setting different reimbursement rates for mental health and substance use disorder providers compared to medical/surgical providers, identifying plan practices that could create barriers to accessing mental health and substance use disorder benefits, and stricter

prior authorization or medical necessity reviews and more rigorous reviews for mental health and substance use disorder (MH/SUD) coverage approvals (Su et al., 2023). The comparative analysis report revealed that many plans and providers were underprepared to present data, thus there was not enough information to complete a full analysis. Moving forward, the MHPAEA will focus on changing or eliminating these restrictions in line with the MHPAEA guarantees that individuals have fair access to MH/SUD benefits, like medical/surgical benefits (Su et al., 2023).

Further development of this bipartisan initiative will be addressed under the Unity Agenda, and new measures are being introduced to enhance and reinforce mental health parity requirements, enabling over 150 million Americans with private health insurance to access mental health benefits more effectively. The proposed rule emphasizes equal access to mental health and substance use benefits compared to physical health benefits. This law will mandate health plans to rectify insufficient mental health care access and evaluate coverage outcomes. Additionally, the rule prohibits health plans from using tactics that make it harder to access mental health benefits than medical benefits, and it closes a loophole to ensure more governmental health plans adhere to these standards (The White House, 2023).

Human services professionals can continue to advocate for true parity of treatment for mental health and addiction, where many barriers to full parity presently exist. In this study, I explored how professional stakeholders experience and view current implementation of New Jersey’s funding policy for substance use disorder treatment and

recommendations and next steps required to move closer to full parity of mental health and addiction treatment.

Social Problem

Approximately 162.5 million people in America aged 12 and older used tobacco or nicotine, alcohol, or an illicit drug in the past month, and 41.1 million people needed substance use treatment in the past year (National Survey on Drug Use and Health, 2020). This results in a treatment gap affecting more than 20 million Americans. Several people report wanting treatment but cannot receive treatment due to cost and lack of insurance. Of those who can access treatment, half (48.4%) reported using their own money to pay for their care (Partnership to End Addiction, 2020).

It is reported that only four million of these people received any type of substance use treatment as of 2020, and this is due to the underfunding of substance use disorder treatment (Substance Abuse and Mental Health Services Administration, 2020). The same report found that 19.1% of those who met criteria for substance use disorder in the last year wanted to receive treatment but were unable to, with reasons including lack of insurance or cost of treatment (Substance Abuse and Mental Health Services Administration [SAMHSA], 2020). Another report by the Substance Abuse and Mental Health Services Administration (SAMHSA) revealed even more disparate findings. Of the estimated 43.7 million people needing substance use disorder treatment in 2021, only three million (6.8%) received treatment at a specialty substance use disorder treatment facility and only 4.1 million (9.4%) received any type of treatment, including visits to a

primary care doctor or self-help meeting (Substance Abuse and Mental Health Administration, 2022).

Local Problem

The New Jersey Drug and Alcohol Abuse Treatment Substance Abuse Overview (2023) reported 85,266 admissions to a higher level of care for primary substance abuse disorder treatment. The median length of stay at the partial hospitalization level of care was reported at 28 days, while the intensive outpatient level of care median was 62 days (New Jersey Drug and Alcohol Abuse Treatment Substance Abuse Overview Statewide, 2023). This same study included data that 79% of service users required readmittance to treatment at a higher level of care (detox, inpatient, partial hospitalization, or intensive outpatient) within the first 30 days of first discharge from treatment, an additional 12% between 31 and 90 days, and 9% beyond 91 days.

The Public Laws of 2017 legislated the New Jersey Chapter 28 mandate. The mandate states that a patient is entitled to 28 days of partial hospitalization and/or intensive outpatient treatment during the first 180 days of a plan year. Benefits for a continued stay after the initial 28 days within the first or second 180-day period are subject to concurrent and retrospective reviews (Senate Health, Human Services and Senior Citizens Committee, 2017).

Practitioners report that service users are denied further coverage upon retro review, leaving a large bill for services deemed to not meet medical necessity criteria for continued stay by the insurance provider. In paragraph J, sections 1–10, the mandate outlines additional uses for unused inpatient days, which can be traded for two outpatient

visits, excluding partial hospitalization or intensive outpatient care. While this could increase the third bucket of 180 days allotted for outpatient visits for a person who does not use any inpatient days to receive outpatient services for 180 days plus days from 56 visits, it does not include the spectrum of care required to treat addiction and the increased need for partial hospitalization and intensive outpatient care.

At the outset, this mandate made insurance companies finally recognize substance use disorder as a diagnosis receiving treatment; however, over time it is showing that this population is only getting part of the full course of treatment they need as evidenced by the maximum length of stay in discharge summaries in the NJ American Society of Addiction Medicine (NJASAM) database. Some insurance companies are following the mandate by providing the minimum amount of required treatment. This leaves the facility providing care for this population in a difficult position. One option could be to discharge service users with aftercare that would be funded 1 day per week for 1 hour via outpatient services and hope they do not relapse. The alternative option is to keep the service user enrolled in a higher level of care treatment setting, such as intensive outpatient. In the intensive outpatient level of care, treatment is 3 days per week for 3 hours per day (9 hours per week of treatment) that is nonfunded, discharging service users with a large bill. This positions social workers and counselors in an ethical practice dilemma when providing treatment to this population.

In 2019, New Jersey's Governor Murphy drafted new legislation to ensure mental health and addiction treatment parity. Murphy cited stigma, and cost of treatment under insurance as barriers to those seeking treatment (Office of the Governor, n.d.). The

administration has called for human services professionals and other stakeholders to advocate for the continued need to expand upon current legislation (Office of the Governor, n.d.).

Purpose of the Study

In this qualitative action research study, I identified the existing implications of applying the New Jersey Chapter 28 Substance Abuse mandate through the knowledge, experiences, and opinions of licensed social workers and counselors about providing treatment to substance use disorder service users. This study is significant in that it may be used to gain insight and inform advocacy about the implications counselors and social workers face when delivering substance abuse treatment within a limited time. This information may be used to produce future policy regarding funding or management for length of treatment for substance use.

Research Questions

The research question for this study was: What do social workers and counselors perceive to be the consequences of imposing a limit on time for treatment of substance use disorders? The sub-question for the study was: If a time limit must be imposed, what would social workers and counselors recommend being the minimum treatment period and why?

Conceptual Framework

The theory and model that I used to ground this study was the transtheoretical model, also known as the stages of change model by Prochaska and DiClemente (1982). The change model was suitable for my study because it is used to describe the behavioral

cycle one undergoes when modifying a problem behavior. This model identifies six stages of behavior change: precontemplation, contemplation, termination, action, maintenance, and relapse. This model has been applied in addictions research to understand the etiology of addiction and includes relapse as a part of recovery (Prochaska & DiClemente, 1982). The model can be used as a tool to comprehend the treatment process and the time needed for transitioning through the stages for successful treatment outcomes.

I used the transtheoretical model as a lens to frame the study's research questions. I focused on identifying the optimal length of treatment for a service user undergoing substance use disorder treatment based on the stages of change identified in the model. I posed the research questions via a focus group format. I focused on practitioners' perceptions of a limit being placed on covered substance use disorder treatment and asking these practitioners to identify an acceptable minimum treatment period based on their professional experiences.

Nature of the Study

To address the research questions in this qualitative study, I followed Stringer's (2021) recommended method for action research. For this study, I conducted structured focus groups with professional social workers and counselors who provide treatment under the Chapter 28 Mandate. Stringer et al. (2021) outlined three main steps in action research: look, think, and act. The look step requires observing a problem in the field. Think requires assessing the problem and collecting data, and act is the researcher's response and suggested course of action moving forward based on the data results.

Defined Terms

Insurance: Health insurance is a type of insurance coverage that provides financial protection against the cost of medical expenses for individuals or groups. Health insurance policies may cover the costs of preventive care, medical treatments, hospitalization, and other related expenses (U.S. Department of Health and Human Services, 2021).

Intensive outpatient program (IOP): Substance Use Disorder Treatment is a highly intensive treatment program provided in a licensed IOP facility. It involves a broad range of clinical interventions and is delivered in a structured environment. Intensive outpatient programming is for at least 9 hours per week, requiring a minimum of 3 hours of treatment services to be provided on each billable day, and including at least one individual counseling session per week (*Department of Human Services: Division of Mental Health and Addiction Services ASAM service descriptions,* 2016).

Partial hospitalization program (PHP): Partial Care/Partial Hospitalization Substance Use Disorder Treatment is a clinically intensive treatment program provided in a licensed Partial Hospitalization facility. It involves a broad range of clinical interventions and is delivered in a structured environment for at least 20 hours per week. A minimum of 4 hours of treatment services must be provided on each billable day, including at least one individual counseling session per week (*Department of Human Services: Division of Mental Health and Addiction Services ASAM service descriptions,* 2016).

Service user: A broad term used to refer to an individual who receives health and/or social care services from providers. (*S*egen's Medical Dictionary, 2011)

Significance of the Study

Significance of the Study for Community or Organization

In this study, I examined the consequences of the Chapter 28 mandate on substance abuse treatment and offer a guideline for a treatment minimum based upon the perspective of practitioners working with service users receiving substance use disorder treatment. These findings can be used to inform advocacy and policy within New Jersey.

Significance of the Study for Human Services

The findings from this study include additional information to identify continued barriers of current mental health and addiction parity laws in the United States. Additionally, practitioners may use the findings from this study to change their approach to addiction treatment and normalize the need for retreatment. This research may positively impact service users by improving access to less restrictive treatment options for their addiction.

Literature Review

Literature Search Strategy

The keywords that I used to search for literature in this literature review included: *substance use disorder treatmen*t OR *retreatment, substance use disorder treatment duration, access to substance abuse treatment and funding, substance abuse policy,* and *law regarding treatment funding*. The dates included in the literature search were from 2019 to 2023. The main themes from the literature search included stigma, substance use

disorder as a chronic condition, and barriers to receiving treatment. Databases that I used for this review included: Google Scholar, Science Direct, Taylor & Francis Online, Oxford Academic, JSTOR, Wiley Online Library. I focused on the history of addiction in America, the struggles an individual experiencing a problem with addiction faces, best treatment practices for addiction, and current legislation supporting addiction treatment.

Conceptual Framework

The transtheoretical model, or stages of change theory, has been applied across many disciplines and conditions including smoking cessation, stress management, weight loss management, and addictions (Raihan et al., 2023). The theory has roots in developmental psychology, examining the process and the stages required for change to occur. Prochaska and DiClemente (1982) analyzed and synthesized over 18 therapy modalities to identify six distinctive stages of change either experientially or environmentally and occur in those who are and are not in therapy, thus a comprehensive model to understand behavior change. The first pilot study investigated individuals who achieved successful smoking cessation, and six main stages were identified: precontemplation, where an individual is not able to recognize smoking as a problem and has no desire to change; contemplation where an individual is thinking about stopping smoking; determination, committed to stop smoking and thinking of ways to change; action, actively modifying behaviors to stop smoking; maintenance, actively not smoking; and relapse, returning to smoking. An individual may become stagnant or stall in any of these stages, where a commitment must turn into a decision. These stages can

be continuous and are often referred to as “a revolving door,” (Prochaska & DiClemente, 1982).

Reuter et al. (2022) published a study in which they used the stages of change as a predictive indicator for treatment readiness for initiating medication for opioid use disorder for those receiving treatment in local emergency departments. The findings of the study indicated that treatment adherence at 30 days was significantly higher for those with an advanced stage of change including preparation, action, and maintenance compared to those in an earlier stage of change including pre-contemplation and contemplation. The stages of change model can be used to conceptualize an individual’s stage of change and assist a treatment team in identifying the necessary treatment interventions to help an individual progress through the stages. Current research on the stages of change indicates that an individual's stage of change impacts the treatment process and commitment to sobriety. The New Jersey Chapter 28 mandate fails to address an individual’s readiness to change as a factor to determine treatment funding, leaving service users in a precontemplation stage of change less likely to be able to receive necessary retreatment for their subsequent relapses.

Literature Review

There are many barriers one struggling with addiction will face: stigma, the chronicity of the disease, and limitations placed on treatment (Andersson et al., 2019; Douglas et al.; Hansen et al., 2020; Yang et al., 2017). While best practices in the field have been outlined to treat addiction, little research is available on professional

practitioners working in the field's viewpoint of how to address the epidemic from a treatment length and treatment funding perspective.

The History and Experiences of Those Living with Addiction

The prevalence of substance use disorders is on the rise in the United States, yet these disorders remain seriously under-treated (Yang et al., 2017). Substance abuse is not a new issue plaguing society, as there is evidence of psychoactive substances traced back to 10,000 BCE (Trickey, 2018). Addiction in American society began in the 1800s with the opioid epidemic. During this period, morphine was used to treat injuries sustained from the Civil War, menstrual cramps, and for teething toddlers (Trickey, 2018). Physicians prescribed morphine readily, which led to an addiction epidemic that has affected 1 in 200 Americans. Before 1900, the typical individual in America struggling with opiate abuse was an upper-class or middle-class White woman (Trickey, 2018). Beginning in the 21st century, opioids continued to be widely prescribed; however, now, the average small-town American is becoming addicted, from football players who sustained injuries in high school and college to older people who have a variety of chronic degenerative diseases (Trickey, 2018). In 1971, President Richard Nixon initiated the modern-day drug war in the United States by signing the Controlled Substances Act. Since then, billions of dollars have been spent annually on drug enforcement and punishment at the local, state, and federal levels. This war on drugs has led to the criminalization and incarceration of millions of people. This has resulted in disrupted or loss of access to necessary resources and support for living healthy lives, and many have ended up with lifelong criminal records (Cohen et al., 2022).

Despite the long history of addiction in America, it was not until 1980 that substance use disorder was finally included in the Diagnostic and Statistical Manual of Mental Disorders (DSM) as a primary mental health disorder (Robinson et al., 2016). The diagnosis has undergone many iterations and criteria. It was not until the DSM 5 that legal problem was removed as a qualifier for the disorder and added craving and severity specifiers as an additional criterion, a subtle shift to decriminalize substance users (Robinson et al., 2016).

Currently, approximately twenty-three million Americans who are 12 years old or older are currently addicted to alcohol and other drugs (Partnership to End Addiction, 2020). One in five children in the United States grows up in a household where someone misuses alcohol or has a substance use disorder (Bergland, 2016). During the 12-month period ending in April 2021, over 100,000 Americans died of overdose, a figure that represents a 30% year-over-year increase (U.S. departments of Labor, Health, and Human Services, 2022). The current fourth wave of the overdose crisis is due to a drug supply contaminated with fentanyl, caused by drug prohibition. The stigma and fear of punishment associated with criminalization also deter people from seeking support, and there is a lack of investment in harm reduction and evidence-based treatment services (Cohen et al., 2022). Thus, addiction in America is an important topic to be studied.

One study reported that children who grow up in homes with substance abuse are more likely to mistreat alcohol and drugs. This keeps the cycle of addiction to drugs, along with parental instability due to the impacts of addiction. Children in these homes are often neglected concerning these families for generations. At the same time, these

children are also being exposed to the toxic effects of drugs, along with parental instability due to the impacts of addiction, where children in these homes are often neglected in their physical and emotional well-being (Bergland, 2016). This underscores the myriad of consequences facing the daily lives of Americans impacted by addiction.

Barriers of Those Living with Addiction: Stigma, Chronic Disease Model, and Insurance Limitations

Although federal laws under the Parity Act mandate equal coverage for physical and mental health conditions by most health insurers, a lack of enforcement has enabled these companies to reduce benefits (Healing the Nation Wellbeing Trust, 2020). One hundred thirty Americans die every day from opioid overdose, and only 10% of those with alcohol or substance use disorder receive treatment annually (Healing the Nation Wellbeing Trust, 2020). To further complicate matters, when someone may be ready to treat their addiction, they are faced with many barriers, including stigma, chronicity of the condition and financial barriers due to funding for treatment. While science and policy have shown consistent struggles to appropriately address and treat this disorder, the substance use disorder community has been faced with stigma and treated with uncertainty. Yang et al. (2017) conducted a metanalysis of studies exploring the stigma surrounding substance abuse and identified those with substance use disorders were likely to be seen as dangerous and unpredictable, unable to make decisions about treatment or finances, and to be blamed for their own condition. Such stereotyping can lead to negative emotional reactions, consistent with emotions reported by those with a substance use disorder, including pity, anger, fear, and a desire for social distance. This

same study also showed stigmatizing reactions to substance use disorders were stronger than toward other psychiatric disorders (Yang et al., 2017). Stigma has a negative impact on those struggling with substance use disorders and can reduce willingness of policymakers to allocate resources and may limit willingness of individuals with such problems to seek treatment. Another study found stigma served as a barrier to 20% of participants thinking about seeking treatment (Tomko et al., 2022). It is imperative for the community to understand the legitimacy of a substance use disorder, and policymakers to confront their own stigma toward the substance using population, and advocate and allow for accessible and clinically indicate treatment without limits to best tackle the substance abuse problem in the nation.

Addiction is a highly stigmatized disorder, as evidenced by interactions with family members and medical professionals. Stigma is defined as a social process that involves labeling, stereotyping, separation, status loss, and discrimination within a power context (Earnshaw, 2020). The stigma associated with substance use disorders serves a societal function of enforcing conformity to social norms surrounding non- or moderate use of substances. Stigma is a fundamental cause of health inequities and is recognized to be intersectional, with individuals living with multiple interconnected statuses. Stigma is manifested at the structural and individual levels (Earnshaw, 2020). Oftentimes, healthcare professionals possess a biased understanding of substance use disorders and may have negative attitudes and intentions toward service users, which can create barriers to treatment engagement (Moon et al., 2020). Parthasarathy et al. (2021) underscored the

importance of intervention in a trusted, non-stigmatized, and accessible healthcare setting to avoid further stigmatization.

There is a consensus across disciplines in literature indicating that substance use disorder is a chronic condition that involves cycles of treatment and relapse. Treatment efforts are framed within a disease management framework, like other chronic medical conditions such as diabetes and hypertension, often requiring multiple treatment episodes (McKay, 2021; Proctor et al., 2014). More recently, substance use disorder has been recognized as a chronic disorder that requires multiple treatment episodes throughout an individual's life. Adding to the complexity of the etiology of substance use disorders is the comorbidity of other mental health disorders serving to maintain the addiction. Geilen et al. (2016) identified a strong link between craving, relapse, and Post Traumatic Stress Disorder (PTSD) symptoms, where service users indicated a need for a whole-person approach to treatment for their diagnoses.

There is a wide prevalence of substance use disorders across the United States. Young adults aged 18 to 25 had the highest percentage of people needing substance use treatment, while adolescents aged 12 to 17 had the lowest percentage. In 2015, around 1.3 million adolescents, 5.4 million young adults, and 15.0 million adults aged 26 or older required substance use treatment in the past year. 19.3 million people aged 12 or older who needed substance use treatment did not receive treatment at a specialty facility, accounting for 89.2% of people who required substance use treatment (Lipari et al., 2015). However, most of those needing substance abuse treatment cannot receive it due to insurance and finances serving as a barrier. Tomko et al. (2022) indicated insurance-

related barriers interfered with 39% of the sample receiving the treatment they needed. Further impacting substance use disorder treatment, there have been quantitative limits imposed on aspects such as the number of urine drug screens or visits allowed, which has caused complaints from providers who argue that many treatments require prior authorizations (Dickson-Gomez et al, 2022). Additionally, it can be challenging to establish equivalent coverage for behavioral health services and providers due to their unique nature, such as non-hospital residential treatment, partial hospitalization, and peer support specialists. Parity should apply to both quantitative and non-quantitative limits, but studies show that non-quantitative limits are more frequently imposed on mental health and substance use disorder care compared to other health conditions when assessing for medical necessity and prior authorization (Barry et al., 2016).

Addiction Treatment Outcomes: Relapse Rates and Comorbidities

For those fortunate enough to gain access to substance use disorder treatment, treatment outcomes are quite poor. According to Andersson et al. (2019), 37% of the sample had a relapse within 3 months of follow-up. Younger age, having a psychiatric diagnosis, and treatment at a short-term clinic increased the risk of relapse (Andersson et al., 2019). Completing the inpatient treatment stay reduced the risk of relapse. It is suggested to identify patient characteristics associated with the risk of relapse after substance use disorder treatment, as it is crucial for developing customized treatment programs for individuals at risk. Pre-treatment psychological factors, such as mental distress and motivation to change substance use behavior, may be potential targets for intervention (Andersson et al., 2019). Hansen et al. (2020) had similar findings,

indicating that psychiatric health problems, younger age, and longer treatment, predicted readmission.

Hansen et al. (2020) reported that 8% of the sample was readmitted to treatment for relapse and that premature treatment drop-out was the most important predictor of readmission to outpatient substance abuse treatment increased the risk of readmission by 41%. These findings emphasize the need for recurrent treatment episodes to treat the chronicity of substance use disorders. Rowell-Consulo et al. (2020) reported that substance use disorder diagnoses were linked to longer hospital stays and higher rates of readmission, though some prior research had inconsistent findings. The article proposes that a comprehensive approach to treatment that integrates substance use treatment with other medical care may be effective for substance use disorder (SUD) patients. Reuter et al. (2022) conducted a study and found that greater stage-of-change was significantly associated with treatment retention at 30 and 90 days. The study's results indicated that patients with higher levels of readiness for change (measured by a stages of change assessment) were more likely to remain in treatment at 30 and 90 days. Furthermore, the study reported that patients who were older, had medical insurance, and were employed were more likely to remain in treatment. Reuter et al. (2022) suggested that assessing readiness for change could identify patients who are more or less likely to remain in treatment, and this could be used to tailor care to the patient population.

Addiction Treatment Best Practices and Lack of Research

There is a lack of consensus in the literature regarding the most effective treatment modalities for substance use disorder. However, significant research on the

transtheoretical model reports that relapse is a common factor in behavior change and should be discussed and normalized (Raihan et al., 2023). Change behavior can often take a spiral or recycling of stages rather than a linear progression. Relapse should not be viewed as a failure but rather as an opportunity for growth and improvement. Individuals require constant active maintenance in the first 3 to 6 months of abstinence since this period is considered the most tempting time for relapse (Raihan et al., 2023). Certain factors are required to assist with stage progression, including the processes of change, decisional balance, and self-efficacy, which should be addressed in the treatment setting. There is a growing body of literature to address distinct populations (such as women, early adulthood, and specific ethnic and racial groups), with a treatment plan unique to the needs of the individual (Dalton et al., 2021).

One of the most important best practices for substance abuse treatment is the use of evidence-based interventions. According to the National Institute on Drug Abuse (NIDA), evidence-based treatments have been proven through scientific research to be effective in treating substance use disorders (NIDA, 2018). These treatments include behavioral therapies such as cognitive-behavioral therapy (CBT), contingency management (CM), and motivational interviewing (MI), as well as medication-assisted treatments (MAT) such as methadone, buprenorphine, and naltrexone (NIDA, 2018).

Another best practice for substance abuse treatment is the use of a multidisciplinary team approach. A multidisciplinary team includes a range of healthcare professionals such as physicians, nurses, psychologists, and social workers, who work together to provide comprehensive care to individuals with substance use disorders

(Substance Abuse and Mental Health Services Administration [SAMHSA] 2018). This approach can provide a range of services, including medical management, counseling, and case management, to address the complex needs of individuals with substance use disorders (SAMHSA, 2018).

Additionally, individualized treatment plans are a critical best practice in substance abuse treatment. Each person with a substance uses disorder has unique needs, and treatment plans should be tailored to address those needs (NIDA, 2021). This may include a combination of behavioral therapies, MAT, and other services, such as mental health care and vocational support (NIDA, 2021). Individualized treatment plans can improve treatment outcomes and increase the likelihood of sustained recovery. Furthermore, best practices in substance abuse treatment emphasize the importance of continuing care and support. Addiction is a chronic disease, and individuals with substance use disorders often require ongoing care and support to maintain recovery (SAMHSA, 2018). After completing initial treatment, continuing care may include regular check-ins with healthcare providers, support group attendance, and other forms of ongoing support (SAMHSA, 2018).

Other best practices for substance abuse treatment emphasize the need for cultural competence. Substance use disorders can affect individuals from all backgrounds, and healthcare providers must understand and respect the cultural norms and values of their patients (NIDA, 2021). This may include providing services in the patient's preferred language, considering cultural factors in the development of treatment plans, and involving family and community members in treatment (NIDA, 2021).

Substance abuse treatment requires a comprehensive, evidence-based approach that considers the unique needs of each individual. Best practices in substance abuse treatment include the use of evidence-based interventions, a multidisciplinary team approach, individualized treatment plans, continuing care and support, and cultural competence.

The available research on the most effective treatment for substance use disorders in addition to the above interventions has continually addressed the importance of a continuum in care and step-downs in levels of care as a crucial factor in adequately treating addiction. Waite et al. (2023) found that those receiving inpatient care were usually readmitted inpatient, while patients who were discharged from residential or partial hospitalization programs often stepped down to intensive outpatient programs. The timing of these transitions was important, with patients being most likely to step down within 14 days of discharge to continue treatment at another level of care. The likelihood of stepping down from treatment varies based on age, gender, race/ethnicity, insurance type, completion of the index treatment program, and behavioral health diagnoses. Younger patients, males, and patients of all race/ethnicity categories, except Black patients, were more likely to step down to lower levels of care in treatment, while Medicare patients were less likely to step down than exchange, commercial, or Medicaid-insured patients. Additionally, comorbidity played a significant role for service users receiving substance abuse disorder, as those also diagnosed with bipolar and psychotic disorders were less likely to step down within 14 days.

While there is variability in the type of modalities best served to treat substance use disorders, there is an evident and increasing need for culturally competent care that addresses the needs of each unique service user across the continuum of care. Future research should address the most effective treatment modalities and lengths of treatment based on individual need and clear medical necessity guidelines that are followed.

Review of Current Parity Laws for Addiction Treatment in the United States

States have been tasked with the challenge of enforcing and implementing mental health parity at the state level beyond federal mandates. The promise of parity in mental health and substance use disorder care remains unfulfilled for many individuals who are often denied the care they need and lack resources to advocate for themselves. While federal and state governments share enforcement authority, states play a crucial role in ensuring compliance with the Federal Parity Law and other related laws (Douglas et al., 2018). However, despite efforts from policymakers and advocates, significant disparities in coverage and access persist even after a decade. Most states have not enacted strong parity statutes, which would hold both health plan executives and state officials accountable and provide the necessary tools for enforcing parity. Strong state parity laws are essential for effective enforcement, as they promote transparency and accountability in health plans' compliance and regulatory agencies' enforcement activities (Douglas et al., 2018). Apart from Wyoming, every state in the United States has implemented one or more laws supporting parity (Douglas et al., 2018). These state statutes and regulations were primarily enacted in 2008 and 2010, following the Federal Parity Act. However, many states have since updated their parity laws, often making them more comprehensive

and robust than the federal protections. These state laws also empower regulatory agencies to provide further guidance through administrative rulemaking and other forms of sub-regulatory guidance (Douglas et al., 2018). Douglas et al. (2018) conducted a study that included coding of statutory for parity across all 50 states and concluded that the states with the highest grades and points for their parity statutes are Illinois (A, 100), Tennessee (C, 79), Maine (C, 76), Alabama (C, 74), Virginia (C, 71), and New Hampshire (C, 71). However, even in these higher-scoring states, there is still room for improvement in their laws. On the other hand, the states with the lowest grades and points are Wyoming (F, 10), Arizona (F, 26), Idaho (F, 36), Indiana (F, 38), Alaska (F, 43), and Nebraska (F, 43). New Jersey falls in the middle of the ratings, with a score (F, 54).

California has had improvements in mental health parity from Senate Bill 855 which instated that coverage should include the full range of mental illnesses and substance use disorders (Kirby et al., n.d.). The previous law had limited clarity on the definition of "medically necessary treatment" and criteria for the level of care for nine serious mental illnesses. In 2020, new legislation was implemented, requiring health plans and insurers to monitor clinical review criteria and utilization review decision making. This legislation, based on California's model, is named after former Congressman Jim Ramstad and has been adopted by the District of Columbia and seventeen states including Arizona, Colorado, Connecticut, Delaware, Illinois, Indiana, Kentucky, Maryland, Montana, New Jersey, Nevada, Oklahoma, Oregon, Pennsylvania, Tennessee, and West Virginia (Kirby et al., n.d.).

Illinois has the best mental health parity law as of 2018, The Illinois House of Representatives passed Senate Bill 1707, which is hailed as the strongest mental health parity law in the United States, with a vote of 106-9 (The Kennedy Forum, 2019). The bill, supported by The Kennedy Forum Illinois, aims to enforce parity laws, and ensure equal coverage for mental health and addiction treatment as mandated by state and federal laws. The legislation resulted from a multi-year campaign that involved a workgroup and a provider survey on treatment denials. It addresses the opioid crisis by expanding access to addiction treatment and prohibits certain requirements for FDA-approved medications (The Kennedy Forum, 2019). The bill also enhances transparency, accountability, and enforcement of parity laws through various measures, including compliance analyses, oversight, and reporting. In addition, it closes a loophole that allowed discrimination in mental health and addiction coverage by school district health plans (The Kennedy Forum, 2019). The passage of SB1707 is considered a significant milestone not only for Illinois but for the entire country in the fight against coverage discrimination and improving access to necessary treatment.

Practitioner's Perceptions of Addiction Treatment and Call to Advocacy

There is a consistent call to action for social workers and counselors to advocate for the communities they serve to result in positive social change. Social workers and counselors work with service users receiving addiction treatment on the frontline, and thus can assess and advocate for policy change. Saha (2021) emphasized the vital role of mental health workers informing advocacy, who have become more involved in protecting patients' rights and promoting awareness for improved mental health services,

especially with the shift from psychiatric hospitals to community services. Mental health workers are to advocate for core principles of advocacy including unaffordable cost and the parity between mental health and physical health (Saha, 2021). Professional counselor advocacy aims to promote the profession by minimizing or removing barriers that hinder counselors from providing services (American Counseling Association, 2020). Despite the growing relevance of advocacy, professional advocacy has received less attention and made less progress compared to client and social issues advocacy over in recent years (American Counseling Association, 2020). Walker et al. (2018) advised for higher level of professional engagement in policy processes, using psychological evidence to form alliances with common interest groups and lobby ministers for specific reforms or initiatives.

Summary

The United States has been facing a centuries-long epidemic regarding addiction. In New Jersey, the Chapter 28 Mandate was created to address the ongoing Parity Act, and while it had positive intentions, there are still vast gaps in coverage impeding upon true parity for addiction treatment. There are many barriers an individual faces should they make the decision to receive treatment, including stigma, managing addiction as a chronic disease, and barriers such as treatment availability and funding. While the literature has identified a high relapse rate for the treatment of addiction and several evidence-based modalities, a continuation of care model addressing each person's unique needs is necessary to best treat substance use disorders. Social workers and counselors

can identify and assess barriers for addiction parity in the field impacting service user treatment.

Section 2: The Project

Introduction

The research project was conducted in partial fulfillment of the capstone requirements. This section will expand upon the research methodology for the qualitative action research aiming to understand the perspectives of social workers and counselors providing treatment to service users receiving addiction treatment under the New Jersey Chapter 28 mandate. The study's findings will be included in a White Paper in Appendix A.

Purpose Statement

I conducted this qualitative action research study to identify the existing implications of applying the New Jersey Chapter 28 Substance Abuse mandate through the knowledge, experiences, and opinions of licensed social workers and counselors about providing treatment to substance use disorder service users. This study is significant in that it may include insight and inform advocacy about the implications counselors and social workers face when delivering substance abuse treatment within a limited time. This information may inform future policy regarding funding or management for length of treatment for substance use.

Methods

Role of the Researcher

As a qualitative researcher, I remained objective and unbiased while collecting and analyzing data. Stringer et al. (2021) stated that qualitative research is an appropriate method to provide robust and meaningful understanding of human life and societal

issues. A preconceived notion about the topic of substance abuse treatment is that stigma plays an influential role in how policy makers view legislation for this population, (Earnshaw,2020). In addition, Kirby et al. (n.d.) underscored the shortcomings of current legislation on parity, where it is highlighted that the Chapter 28 mandate in New Jersey is that it restricts complete parity of substance abuse treatment. As a qualitative researcher, I followed the framework for action search outlined by Stringer et al. (2021). I followed this framework and mitigated preconceived notions and biases by developing a sound qualitative research methodology from participant recruitment, data collection via focus groups and analyzing key themes that emerge from the qualitative data, as well as understanding how and what is happening out in the field under the Chapter 28 mandate. As a researcher and practitioner in the field, I was cautious to not impose any leading questions or perceptions during focus groups. Additionally, I recruited participants with no direct professional or affiliation to me to capture an objective viewpoint of practitioners in the field treating service users under the New Jersey Chapter 28 mandate.

Participant Recruitment and Sampling Strategy

I recruited a convenience sample of participants by emailing a flyer to therapists that work at a mental health agency using convenience sampling. I recruited participants that I readily had access to as it is convenient, efficient, and cost effective. The original recruitment strategy to obtain participants from online networking groups via Facebook and LinkedIn did not yield participants. The recruitment plan needed to be revised, and I obtained Partner Site Agreement permission to collect data through the agency where I am employed. The mental health agency operates several locations across New Jersey,

and participants for this study do not directly report to me to avoid any complications related to dual-relationships, perceived obligation to participate, and confirmation biases.

Inclusion criteria for participants included social workers and counselors licensed to practice substance abuse treatment in the state of New Jersey and have provided care to service users under the Chapter 28 mandate in a partial hospitalization and/or intensive outpatient level of care. Participants completed an inclusion criteria pre-screening via email which will ask a series of questions such as what type of license the participant holds, the population they provide treatment to, what level of care they work in, and if they are aware of the New Jersey Chapter 28 mandate. Once the prescreening was completed and passed, the participant was sent a follow up email with the consent form, choices of a few dates and times for a focus group to participate in the study via email, or a follow up email thanking the person for their interest and stating the participant does not qualify for participation in this study.

The sample size included 16 participants, across four separate focus groups. The rationale for five to six participants per focus group is to allow ample time for each participant to explain their experiences, while also being considerate of participants' time, as the focus group will be no longer than 60 minutes (Saldaña, 2016). As outlined by the guidelines of Saldaña (2016), for this study, 15 total participants from three different focus groups will result in saturation of the data. Participants' personal identification was not included in the study; however, their profession (social worker or counselor) is included for aggregate descriptive data purposes.

Data Collection

I recorded the focus groups using the recording option on the Zoom platform. Four focus groups were conducted, with a total of 16 participants across all groups combined. The audio recording of the focus group is stored on a password protected OneDrive for one year post study completion. The focus group question protocol by Bhattacharyya et al. (2017) was followed, using objective, reflective, interpretive, decisional (ORID) structured method for engaging a group. Structured questions followed the objective (fact based), reflective, interpretative, decisional, and summary related questions format. In addition, I phrased questions using a narrative interview format to follow a natural progression of the way the phenomena are experienced by participants as suggested by Auberach and Silverstein (2003).

Participants engaged in a 45-minute structured focus group. The group began with a review of informed consent to address any remaining questions prior to participation, followed by the start of the focus group data collection, which included ORID questioning format to capture the participants' responses to the research questions. Approximately six questions were asked throughout the focus group, in line with the recommendation of Auberach and Silverstein (2003). At the conclusion of the focus group, participants did not require debriefing. Participants were thanked for their participation, notified they would be sent an email for theme member checking during data analysis and given the option to receive notification of the study results via email when completed. I recorded the focus group using the Zoom recording feature and will

store it on password-protected OneDrive for one year post data collection in accordance with the institution's requirements.

Data Analysis Plan

For the qualitative data analysis plan, I followed the steps outlined by Saldaña (2016) and Auberach and Silverstein (2003). I transcribed the audio from the focus into a Word document, separated by focus group session, and distilled to relevant text (Auberach & Silverstein, 2003). Then, I examined relevant text for repeating ideas, which were organized by theme. I stored the audio transcriptions on OneDrive, where access is restricted through a password. During coding, any potentially identifying information of participants from the focus groups was omitted.

I organized the data by reading the content, highlighting relevant sections and aspects of the data following the steps outlined by Saldaña (2016). Based on this, I identified categories and sorted evidence. Next, I coded the data, reviewed, and narrowed the codes, followed by interpreting and validating the findings. The purpose of the data was to identify what practitioners know about the Chapter 28 mandate, how they feel about it, what it means and what is recommended to be done moving forward.

A data analysis matrix was used to identify key themes and phrases from the focus group transcription in a Word document. Saldaña (2016) discussed the purpose of coding as an interpretive act beyond reducing data, with a goal to summarize, distill, or condense data to create meaning. Coding data is an iterative process, where many phases of coding take place to ensure proper summarization and categorization, leading to emerging themes and ideas that are connected back to the theoretical framework of stages

of change theory. Next, I reviewed the subcategories across the four different focus groups to identify consistent themes. I shared the key themes with the focus group participants to develop interpretive validity via member checking. I used the identified key themes to formulate the results section of this paper and to impose recommendations and future research which is presented in a White Paper [Appendix A].

Ethical Considerations for Data Collection

Upon completion of the prescreening and selection to be included in the focus group, prospective participants received informed consent, including more detailed information about the study, to be returned to me with acknowledgment of consent. Finally, I reviewed the informed consent orally at the opening of the focus group session. This study adhered to all Walden University Institutional Review Board approvals, with the approval number 07-03-23-1158000. The transcription process removed any identifying information from the data, except for indicating whether the participant is a social worker or counselor. I will store the data on OneDrive and retain it for approximately 1 year after study publication, after which it will be destroyed. The data will be stored on a password-protected OneDrive, and only my faculty chair and I will be able to access them.

Summary

I conducted a qualitative action research study to learn about the experiences of social workers and counselors providing treatment at a higher level of care under the Chapter 28 mandate to service users receiving addiction treatment. There were four focus groups conducted with two to six participants in each group. The focus group followed a

structured ORID questioning process. I coded and analyzed the data to identify key themes, which were used to produce a White Paper on the topic.

Section 3: Results of the Study

Introduction

I will present the results of the study in the following sections, focusing on the processes of data analysis for this study. I conducted four 45-minute focus groups using the action research model by Stringer et al. (2021) and utilizing the ORID question structure (Bhattacharyya et al., 2017). The initial participant recruitment plan to recruit participants via online Facebook Networking groups resulted in no participants, thus, I revised the recruitment strategy to involve participants working at the agency where I am employed. I obtained a partner site agreement and did not use any participants who directly report to me.

Participant recruitment and data collection occurred in a 5-week period from August 2023 through September 2023. Program directors at each site invited prospective participants to join the study via email. Interested participants then emailed me with available dates and times to meet. I reviewed the prospective participant's licensure credentials (obtaining a social work, counseling, or addictions license in the state of New Jersey, and working with dual diagnosis populations) to verify the correct criteria for participation in the study. Once the prospective participants passed the prescreening, I invited them to a focus group to be held via Zoom on a date and time, according to the participant's availability. Four focus groups took place, each ranging between two and six participants, and each focus group was between 45 to 60 minutes in length. The final sample included 16 participants, the breakdown of which was ten counselors and 6 social

workers recruited from a Partial Hospitalization/Intensive Outpatient Program agency with several locations across New Jersey.

I conducted data coding and thematic analysis by following the structure outlined by Auberach and Silverstein (2003). I transcribed each of the four focus groups separately into a Word document. I read each transcript thoroughly, and then returned to each transcript separately to highlight common categories within each transcript. Common categories of data were grouped together and coded with a name that represented the qualitative data. Themes emerged from the grouping of categories that each focused on similar aspects of treatment of the client, barriers, and recommendations for treatment. The themes were separated based on categories that fit each theme.

I presented this data, which included categories placed into corresponding themes, to focus group members for proper member checking through email and verbal conversations. All members agreed with themes that emerged. Results indicated key findings to inform recommendations for policy advocacy pertaining to the Chapter 28 Mandate across four major themes.

Research Questions

The research questions consisted of a main question with a sub-question. The research question was: What do social workers and counselors perceive to be the consequences of imposing a limit on time for treatment of substance use disorders? The sub-question was: If a time limit must be imposed, what would social workers and counselors recommend being the minimum treatment period and why?

The results section will include the participant responses to the research questions.

Presentation of the Results

Thematic Results

Four themes emerged during the coding of the data, each theme including insight and context to treating the substance use disorder population from the experiences and perceptions of social workers and counselors having experience with this population. The sample of 16 participants included ten counselors and six social workers, with areas of expertise including the treatment of adolescents, adults, eating disorders, substance use disorders, trauma, and dual diagnosis populations. The four themes identified included complexity of each client, clinical prognosis, barriers to insurance funding treatment and recommendations for practice. The themes emerged in two groupings. The first three themes addressed the main research question. This encompassed categories related to the complexity of each client, regarding how the client presents upon admission. Additionally, this theme included the acuity of presenting problems, such as co-occurring disorders, as well as risks and protective factors. The third theme clinical prognosis highlighted the client's past treatment history, commitment to the recovery process, and barriers to insurance funding treatment. This underscored that treatment is funded only as long as an insurance sees medical necessity for treatment. The fourth theme addressed the research sub-question and included recommendations for practice, encompassing clinical treatment recommendations from practitioners for best treatment outcomes.

Complexity of Each Client

The complexity of each client theme yielded rich data to better understand the myriad of clinical complexities involved in the treatment of those with substance use

disorders. The complexity of each client captured data categories including family history and genetics, dual diagnosis/co-morbidities, age of individual receiving treatment, depending which substance(s) are being used, and commitment to treatment/readiness to change. Participant 1 explained,

> You are also going through the stages of change with a substance use client and assuming that they are coming in at pre-contemplation. You are going to have to work through all those stages with them which, if anybody's ever worked with the substance clients, the pre-contemplation and contemplation stage transition alone can take like 4 months. Clients might need some more treatment episodes, or some more time to move through those stages depending on what other factors there are that we are taking into consideration.

This data highlighted the need for individualized treatment based on clinical needs.

Additionally, participants expressed the complexity of addressing co-morbid and dual diagnosis clients, Participant 2 stated "What comes first? Is it the co-occurring? Is it the depression that leads to substance use? Or is it the substance use that leads to depression? So, I think that's an important component." Participant 2 also stated,

> They are using the addiction to numb the anxiety, the depression that is going on. And so as much as it is two components, I also look at it as the same, you know? Alcoholism is a specific coping method, maladaptive, obviously[...] I look at it as two diagnoses.

and

> With substance abuse, you follow the dual diagnosis, […] someone with PTSD used alcohol, well, you know, it might take you 2 or 3 weeks to make sure they are stable functioning without the alcohol and medication. So then, it is really, […] to work on any of the trauma, any of the other stuff.

Furthermore, treatment teams must prioritize treatment and triage based on the acuity of each presenting problem, Participant 3 stated, "We must consider the co-occurring. Now we are juggling, let us say self-harm, and substances." Practitioners must often triage symptoms upon admission in terms of acuity and lethality, where often two factors are equally important to treat with immediacy.

Additionally, factors such as genetics and family history and support of the client in recovery are key factors. Participant 4 explained the importance of family as a support or barrier to recovery,

> If the parents use, you know, even with adults, if they are in a household that has alcohol or other substances in it, it makes it extremely difficult for that individual to try to find a path without veering off onto that path of addiction.

Overall, the varying factors impacting the complexity of each client receiving treatment emerged as a vital theme to understand the unique treatment needs of clients with substance use disorders.

Clinical Prognosis as Chronic Condition

The clinical prognosis as a chronic condition for a client receiving substance use treatment became a relevant theme, underscoring the chronicity of substance use disorders across the lifespan. The clinical prognosis theme encompassed the following

categories: need for repeated treatment, relapses, high mortality rates. Within this theme, practitioners discussed the need for retreatment across the lifespan, as soon as just a few months from previous treatment episode completion for the same diagnosis, Participant 5 underscored,

> The clients that I have had some do return so quickly, and how much can happen in that time, even if they are not here for a month. If they are not here for 2 months, if they are not here for 3 months, things can get really bad again, really quickly,

followed up with,

> There could be trigger points throughout the year, like it could be starting school or the holidays, or lapse in treatment, or something like that, we see them coming back.

Practitioners also emphasized the need for early intervention as a part of treatment, Participant 6 explained, "Relapse, you know, is something that comes up. I do feel like early intervention is also really important that, if you are able to catch it, you know […] give them the right coping skills."

In a similar vein, practitioners highlighted the nuances of the clinical prognosis for someone with a substance use disorder. Participant 7 explained the differences between eating disorder recovery, versus substance abuse recovery, stating,

> In substance use, reincorporating, it isn't an option so full recovery in that respect like isn't a thing, you are constantly having to abstain from these substances […] you can become fully recovered from an eating disorder, and I wouldn't say the

> same about substances. You're never going to reach a point where you are able to moderately engage in these. So, it is a very long-term process.

The clinical prognosis theme illustrates the various treatment needs across the lifespan, and the value of early intervention and treatment of substance use disorders. On the other hand, the high mortality rate of those abusing substances was mentioned as a crucial factor in acknowledging the severity and progression of addiction as an astute reminder of the impact and consequences of the disorder in the long-term.

Barrier of Insurance Funding Treatment

An additional significant theme that emerged in the focus groups was the barrier of insurance funding treatment as a significant barrier to appropriate access and funding of substance use disorder treatment. This theme included categories pertaining to insurance as a barrier and ethical dilemma. Practitioners reported on their experiences working with clients and their insurance plans, and Participant 8 reported,

> And from my experience. usually, when there is any type of relapses, 28 days is not enough for PHP and IOP [...] sometimes we have to discharge clients who are not ready for this because they ran out of days, not because it was clinically justified.

Along with this, practitioners discussed the interpretation of the mandate in practice under insurance, Participant 9 shared, "Chapter 28 was intended to be a minimum, but it's turned into a maximum," and "So maximum, this is how much clients are getting, and it does not make sense. Why are you doing this for this diagnosis, but not any others?" which highlights the discrimination of substance use disorder treatment. It was also

expressed that insurance as a barrier causes serious treatment implications, where Participant 10 stated, “Putting clients in a position where, if they've used up all of their outpatient and partial days, are they going to relapse harder to get access to higher levels of care to get treatment?”. Practitioners also reported that navigating the conversation around the limitations of insurance is a significant clinical barrier for clients, Participant 11 shared,

> They already have a lot of stressors in their life. That is one of the reasons they are also relapsing. So, relapse is a part of the prognosis and funding for lack thereof can be an additional stressor that might lead someone to relapse,

and “the affordability of them paying for this out of pocket is probably nonexistent.” This theme illustrates the challenges and ethical dilemmas a practitioner may face when working with substance use disorder clients.

Recommendations for Practice

Throughout the focus groups, practitioners produced their best practices and recommendations based on their expertise and experience working with individuals receiving substance use disorder treatment. This theme included the following categories: (a) no one size fits all approaches, (b) treat substance use disorders like mental health disorders, (c) the need to find support outside of treatment, (d) the amount of treatment recommended, and (e) the days allocated based on acuity. Practitioners explained their concerns with the current access and funding of treatment for substance use disorders, Participant 11 stated,

> I think that we would be dehumanizing if we were to treat clients like subjects, and I mean, you know, being in graduate school, they drill it in our brain that it is person first, the person comes first and then diagnosis. So why are we being billed based off diagnosis and not person?

Practitioners called attention to the disconnect between substance use disorder and mental health disorder treatment being viewed separately, Participant 12 stated,

> I think if we compare it to mental health, mental health also is easier and allows us to extend those things and get more time if it's clinically indicated. I feel like with Chapter 28, we struggle sometimes to even get more time with that mental health component as well, since a lot of it is dual diagnosis. So, we cannot even use the mental health component to get more time, which is frustrating.

Practitioners also addressed concerns further stigmatizing certain disorders, Participant 13 recommended, "treat substance uses as a mental health disorder, I don't think there should be a difference, it's very similar." Practitioners also expressed the importance for clients to find support within the treatment setting, and outside of the treatment setting for best outcomes, Participant 14 stated, "Recovery is very based on people, places, and things. We have to look at those events going on in their life, and that might determine what kind of support they need,"

and

> It takes a village. It is not just one person's job to help, it requires a lot of supports and a lot of change to pull them out of that cycle they got there for a reason, whatever their trigger was in that environment.

Practitioners used their expertise to make recommendations for substance use disorder funding through insurance, Participant 15 shared,

> The idea of having that cap on […] treatment is concerning just for how long it takes to even stabilize the behaviors itself," and "you're putting these people back in these in these places with all the same people and expecting in a very short amount of time for them to readjust to what they learned in a higher level of care and make it work. And 28 days is not a long time.

Participant 16 emphasized the need for, "equal distribution of days between inpatient and IOP and partial care [as separate levels of care]." Practitioners also identified harm in the current barriers, Participant 3 shared, "Clients are being discharged when they are not ready for discharge. It is going to cost everybody, the client, and insurance even more, because they will continue treatment for next couple of years, instead of doing the longer, say one time" and "It is not like a broken leg, you know. It should be healed in 8 weeks.", and "give leniency for them to readmit, should it be needed later in the year."

Relevant Categories of Data that did not Correspond Within the Identified Themes

Two relevant categories remained that did not fit into the four main themes. These outliers included two categories: (a) an individual's feelings about the outcomes from the Chapter 28 mandate, and (b) their affirmation that addiction is a disease that anyone can experience at any time. Practitioners shared their feelings about the mandate, and Participant 9 cautioned,

> We want to speed up the process. But at the end of the day, we are extending the stay of somebody in a mental health system and increasing the expenses as it might seem like a good short-term solution. But long-run? I do not think it is that efficient,

and "it ties our hands and what we can and can't do realistically." Practitioners also emphasized that there is no one distinct cause of addiction across the lifespan, and addiction is more prevalent than most people realize, Participant 7 rationalized,

> Is it more normal for people to have, you know, some type oof addiction to substances, whereas people who can have a drink on the weekends and not feel an addiction to it. That is less, that is rarer. And that is not something that I started to realize until I've started working with clients. It is very easy to fall into the addiction out of nowhere.

While not significant for the themes, the feelings of practitioners providing treatment under the Chapter 28 Mandate, and the idea that addiction is quite common and can develop at any point in life are notable findings to support the research questions.

Answering the Research Question

The research question of the study included one main research question, with a follow-up sub-question. I conducted the study to gather information to understand how social workers and counselors perceive the consequences of imposing a time limit on the treatment of substance use disorders. The answer to this research question arose in the analysis of the data for the complexity of each client, clinical prognosis, and barriers to insurance funding treatment theme results.

The follow-up sub-question to the initial research question sought to understand if a time limit on treatment must be imposed, what would social workers and counselors recommend being the minimum treatment period and why. The findings to this sub-question from the analysis of the data were found in the fourth theme: recommendations for practice.

Connection to the Conceptual Framework and Literature Review

The data from the focus groups were in alignment with the conceptual framework and literature review, establishing justifiability of interpretations and transferability of theoretical constructs. In all four focus groups, the application of the stages of change model, by Prochaska and DiClemente (1982) was referenced by participants. Practitioners identified and referenced that most of their substance use disorder clients are in precontemplation or contemplation stage when receiving treatment at the PHP and IOP level of care, often experiencing environmental stressors and setbacks, suggesting that it realistically may take up to 4 months for a client to progress through any one of the stages. This data corresponded with the conceptual framework, as it established a clear link that clients receiving substance use disorder treatment may require several rounds of treatment, dependent upon their commitment at time of admission, and need for continued treatment based upon subsequent relapses. This underscores the need for insurance to continue funding treatment as medically necessary to individuals with a substance use disorder diagnosis.

Practitioners in the sample discussed substance use disorder as a chronic condition, comorbid with another mental health diagnosis, consistent with the findings

citing multiple treatment episodes to manage these disorders (Hansen et al., 2020, McKay, 2021; Proctor et al., 2014). Practitioners in the sample also emphasized the link between substance use serving as a coping skill to mask another underlying mental health condition, consistent with the findings of Geilen et al. (2016) linking relapse, and PTSD symptoms, advocating for a “whole-person approach” to treatment for these diagnoses.

In this study, the topic of insurance as a barrier emerged as a theme, paralleling efforts across the nation much of the efforts to drive new policies to continue to strive for mental health parity in the nation. Douglas et al. (2018) discussed that states play a crucial role in ensuring compliance with the Federal Parity Law and other related laws, where New Jersey is ranked with moderate efforts toward mental health parity.

Summary

This research was conducted to better understand the experiences of professionals providing treatment under the current policy, and recommendations for further establishing full parity compliance and increasing access and funding to service users in New Jersey.

Four themes emerged from the focus group data collection, emphasizing the (a) complexity of each client, (b) clinical prognosis as a chronic condition, (c) barriers to insurance funding treatment and, (d) recommendations for practice. The summary analysis of the data from the focus group was used to construct a White Paper to inform key stakeholders regarding the current state of substance use disorder access and funding in New Jersey.

Section 4: Conclusion and Reflections

Introduction

In this section, I reflected on the doctoral study process as an individual and scholar-practitioner through the lens of personal and professional development. I developed recommendations to assist the field of Human Services moving forward in addressing the fight for mental health parity under the New Jersey Chapter 28 Mandate, including future action steps for the profession.

Reflection of Self

The past 2 years have had a profound impact on my development as an individual encompassing several roles in life (spouse, pet parent, daughter, family member, friend, therapist, supervisor, and student). Taking on an advanced degree was an additional responsibility. Throughout this time, I was able to fine tune my values and boundaries in everyday life. Throughout 2020, I found myself having less time to spend with friends and family due to a lack of work-life balance. Once I started my doctoral studies, I found I had more intentional control of my time, which led me to better work-life balance. These boundaries were difficult to adjust to at first, however I was pleasantly surprised and grateful for the outpouring of support from my family, friends, and colleagues during this challenging endeavor.

As an individual in everyday life, I have continuously found myself growing more open-minded. I can view each person and their lived experiences with more empathy and greater understanding for the systems at work in our everyday lives that have come to influence us and our current held perspectives. While part of these realizations were

difficult and eye-opening, it has helped me become more aware of the factors at play. This had given me a more dialectical approach to how I view the world.

Reflection of Scholar-Practitioner

Over the past 2 years, I have undergone a transformation as a doctoral student. At the start of my degree, I had a motivation for more knowledge on how to help continue to contribute to the field but was unsure how I could create that change. I was fortunate to earn two promotions during my time working toward this degree: clinical coordinator and program director, opening a private practice with a dear colleague-turned-friend, as well as achieving two milestones in licensure: licensed professional counselor and licensed alcohol and drug counselor. I adjusted to two new promotions/roles while also working toward an advanced degree, which was an added challenge. However, my coursework consistently turned into an opportunity and outlet for me to seek change in the field for imbalances I encountered from the perspective of therapist and supervisor to my team and clients I serve each day.

I have witnessed my advanced ability to problem solve and view many perspectives at once develop during my time as a scholar-practitioner, and while this is a great asset, it is also something that has made me realize there is also value in patience and slowing down processes. Change does not happen overnight, and there is much to learn and grow from a process, rather than just an outcome. In addition, I have been challenged to learn how to present my findings to a non-academic audience. This has allowed me to make my research more applicable and easily understood to the many different stakeholders I will be working with. I look forward to many continued years of

personal and professional growth as a human services practitioner, where I hope to continue my clinical work and begin to venture into the much-needed areas of policy advocacy for mental health equality and parity.

Recommendations for Human Services Field Advocacy

Through extensive research in the field of mental health and addiction, along with the evidence in this doctoral research, there is a clear need for the profession to advocate for reform of the current mental health parity laws in the United States, as well as on the state level, specifically the Chapter 28 Mandate impacting substance abuse treatment in New Jersey. At the outset, this mandate was written to require all insurance plans to cover substance abuse treatment for at least 28 inpatient days, 28 PHP/IOP days, and 180 outpatient days. In practice, this mandate is being enforced as a maximum amount of treatment rather than a minimum. An individual seeking treatment is in a vulnerable position for relapse within the first 90 days of treatment. Some studies estimate relapse rates between 40-60% within the first 90 days of sobriety (NIDA, 2023). Those who are at a higher risk of relapse are often due to factors like ongoing substance use during the initial phase of treatment, lack of social support, or low motivation, and could experience greater benefits from ongoing care (McKay, 2023). This evidence further highlights the importance and need for intensive treatment within the first 90 days of treatment.

This completed study includes data analysis regarding the consequences of limiting addiction treatment and recommendations for treatment length. I conducted this qualitative action research study in line with the standards by Auberach and Silverstein (2003) for justifiability, transparency, and communicability. Qualitative research methods

acknowledge both justified and unjustified applications of subjectivity, where subjectivity can inform data analysis but not impose it. As a licensed professional counselor in the field, I possess subjectivity in understanding the treatment needs and consequences of limited access and funding to addiction treatment, however, I did not share my professional opinions with participants, nor did I impose my analysis of the data. The data analysis process was influenced solely based on the participants' experiences, which at times, did align with my knowledge in the field as a practitioner experiencing the same issue. Thus, it can be concluded that the data analysis is justifiable. An example of justifiability in the analysis of the study included that participants often referenced the conceptual framework of the study, stages of change theory (Prochaska & DiClemente, 1982). The common knowledge of stages of change theory as a standard model in practice, as well as being used for the conceptual framework identified an overlap in the knowledge of the researcher and the participants, both as practitioners. The data analysis plan is transparent in that each step in the analysis is clearly identified and shared, by which anyone can follow the steps to understand the final interpretation (Auberach & Silverstein, 2003). Lastly, the data analysis is communicable, as the categories and themes can be understood by the participants in the study (verified through member checking), and other researchers or professionals in the field (Auberach & Silverstein, 2003).

While the method of this completed study demonstrates justifiability, transparency, and communicability, there are limitations to be acknowledged. This study included participants all employed at one mental health agency with several locations

across the state. Thus, it is possible that the opinions, perceptions, and experiences of the participants could be unique to this specific agency and treatment setting, or treatment settings that primarily provide treatment to stakeholders with a federal or state funded insurance policy. An additional limitation is that the largest state provider of insurance coverage did not provide information on the mandate being applied under member policies. The insurance provider had the opportunity to participate but failed to respond to formal attempts to participate in the study.

The field of human services has been strong in leading advocacy efforts toward full mental health and addiction parity. From the review of current literature and the findings of this study, it is evident that much more research and advocacy efforts are needed to continue to identify areas to strengthen the current parity implementation and continued legislative efforts. Human services practitioners must continue to identify gaps and problem in practice pertaining to areas including stakeholder treatment needs and policy in the community that may be continued barriers to full parity of mental health and addiction treatment in the nation.

From a thorough review of the current literature and evidence from this study, recommendations are proposed to support increased advocacy for policy change of the current New Jersey Chapter 28 mandate to remove barriers impacting access and funding to substance use disorder treatment. First, there is agreement across the research sample that substance abuse disorder is a type of mental health disorder and should not be subject to more strict continued stay requirements. In fact, someone being treated for a substance use disorder is often struggling with a comorbid mental health diagnosis, requiring more

treatment. Treatment will be needed to stabilize addictive behaviors, incorporate replacement behaviors, and resolve the core conflict of mental health disorders, needing additional time to treat the intersectionality of these complex disorders. Additionally, the mandate must recognize IOP and PHP as separate levels of care, where IOP requires 3 hours of care per day, 3 times per week, and PHP requiring 5 hours per day, 5 times per week. Grouping IOP and PHP days together is creating a disservice and lack of available treatment funding. Lastly, outlining clear expectations in policy change is needed. This can include that insurance companies must require concurrent review, rather than retrospective review for continued stay of those receiving substance use disorder treatment, and for insurances to increase transparency of medical necessity and continued stay criteria for substance use disorder cases.

There are two takeaways for the profession for continued research and advocacy for policy reform. One action step includes advocating for substance use disorder to be recognized as a mental health disorder. With this, those being treated for a comorbid mental health and substance use disorder diagnosis can have the same insurance utilization review policies, allowing for concurrent review as opposed to the current model, which includes retrospective review any time a substance use disorder is present. Next, the profession should work with policy makers in New Jersey to have the PHP and IOP levels of care recognized as separate levels of care under the Chapter 28 mandate, each with distinct and separate authorized days for each level of care to assist in greater length of treatment and coverage. Advocacy efforts for these two steps can lead to removing two large barriers impacting mental health and addiction parity in New Jersey.

Stakeholders are urged to recognize the need for additional action steps to achieve mental health parity in the state. I am hopeful for the impact of this research in the field of human services in the drive for greater mental health parity in New Jersey.

Summary

I used the results of this study to draft a White Paper, which I will disseminate to local policy makers, national foundations centered on mental health and addiction parity, as well as online professional networking platforms. I will disseminate the White Paper to inform stakeholders about addiction and mental health and advocating for the continued need for policy revision and reform to achieve full mental health parity in New Jersey and the United States as a whole.

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Appendix A: The Project

Barriers to Addiction Treatment Equality in New Jersey and Practical Solutions

Introduction

The New Jersey Drug and Alcohol Abuse Treatment Substance Abuse Statewide Overview published in 2023 reported that in 2022, New Jersey had 85,266 admissions for primary substance abuse disorder treatment including inpatient and outpatient levels of care. The typical course of treatment for a substance use disorder consists of inpatient detox and rehab, followed by a step down in care to full-day treatment 5x per week (partial hospitalization program), with a subsequent step-down decrease to full-day treatment 3x per week (intensive outpatient program). Upon completion of the intensive treatment at the inpatient, partial hospitalization and intensive outpatient treatment, an individual will attend outpatient talk therapy 1x per week for one hour, and medication management sessions anywhere from 1x per week, to once per month.

The current legislation under the Chapter 28 mandate enforces a minimum 28 days of inpatient treatment, 28 days of partial hospitalization/intensive outpatient treatment per insurance benefit period, where additional treatment is subject to retrospective review under insurance. This results in many people being unable to receive adequate access and funding to medically necessary treatment.

According to the New Jersey Drug and Alcohol Abuse Treatment Substance Abuse Overview Statewide (2023), the median length of stay at the partial hospitalization level of care was reported at 28 days, while the intensive outpatient level of care median length of stay was 62 days. Additionally, the data reported that 79% of those admitted to

inpatient detox, rehab, partial hospitalization, or intensive outpatient treatment required readmittance to treatment at a higher level of care (detox, inpatient, partial care, or intensive outpatient) within the first 30 days of first discharge from treatment. An additional 12% between 31-90 days, and 9% beyond 91 days were readmitted for treatment.

The Ongoing Struggle for Addiction Treatment Equity

Over 15 years ago, The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) was instated. This is a federal law in the United States that was enacted to prevent insurance companies from addressing the long history of which insurance historically provided less favorable benefit limitations on mental health and substance use disorder treatment compared to benefits for medical/surgical needs (Center for Medicare & Medicaid Services, n.d.). While there has been much advocacy toward mental health parity legislation in New Jersey, the current legislation falls short of providing service users with funding for substance use disorder treatment. Under the Public Laws of 2017, The New Jersey Chapter 28 Mandate was passed into practice. The purpose of the mandate was to assist in moving policy forward to achieve mental health and addiction parity in the state, finally recognizing and mandating the need for addiction treatment. The mandate stated that a covered patient is entitled to 28 days of partial hospitalization (treatment 5x per week for 5 hours per day) and/or intensive outpatient treatment (treatment 3x per week for 3 hours per day) during the first 180 days of a plan year. Benefits for a continued stay after the initial 28 days

within the first or second 180-day period are subject to concurrent and retrospective reviews (Senate Health, Human Services and Senior Citizens Committee, 2017).

In paragraph J, sections 1-10, the mandate states additional uses for unused inpatient days, which can be traded for two outpatient visits, excluding partial hospitalization or intensive outpatient care. This system aims to increase the accessibility of treatment at the outpatient level of care, where unused days from inpatient and partial hospitalization/intensive outpatient treatment can be exchanged for up to 56 regular outpatient provider sessions (therapy once per week, medication management once per week, where each visit is 1 unit). This exchange system falls short in recognizing the chronicity of a substance use disorder treatment, which can require several treatment episodes at a higher level of care (inpatient detox and rehab, partial hospitalization, and intensive outpatient), where outpatient services fall short of providing the structure and support required to maintain sobriety.

Two years after the Chapter 28 mandate was implemented, New Jersey's Governor Murphy drafted new legislation to ensure mental health and addiction treatment parity. Murphy discussed the history of stigma in society against recognizing mental health disorders, and cost of treatment under insurance as barriers to those seeking treatment (Office of the Governor, n.d.). The administration has called for human services professionals and other stakeholders to advocate for the continued need to expand upon current legislation (Office of the Governor, n.d.). The analysis of the data collected from the current study underscores the need for revised legislation of the

mandate based on the experiences of practitioners providing care to clients receiving addiction treatment.

Shortcomings and Loopholes of the Chapter 28 Mandate in Practice

Currently, all medical plans that are required to comply with the Chapter 28 mandate and are often using the minimum required amount of treatment as a maximum. This makes it extremely difficult for an individual to receive treatment beyond 28 days, or for subsequent treatment episodes required after the initial 28 days have been exhausted within the same benefit period.

There is substantial evidence supporting the need for continued advocacy and policy for access and funding to substance abuse treatment for New Jersey residents. Under the current mandate, many barriers to parity continue. The public remains with the need for addiction treatment, which is at an all-time high. An individual should be permitted access to timely and sufficiently funded addiction treatment. Current policymakers are called on to revise the current mandate as it is currently being misinterpreted as a maximum amount of care under insurance policies.

Research Process

The data and findings presented in this paper are from an analysis of an action research study that consisted of an inquiry using focus group interviews to identify the perspectives and opinions of 16 licensed clinicians in New Jersey who have experience working with individuals receiving substance use disorder treatment. The participants were comprised of ten counselors and six social workers, with areas of expertise

including the treatment of; adolescents, adults, people with eating disorders, people with substance use disorders, people experiencing trauma, and dual diagnosis populations. The purpose of the research was to learn more about the experiences and opinions of professionals in the field who work with individuals receiving treatment for a substance use disorder diagnosis.

The research questions included: What do social workers and counselors perceive to be the consequences of imposing a limit on time for treatment of substance use disorders? With a sub-question: if a time limit must be imposed, what would social workers and counselors recommend be the minimum treatment period and why? Participants of focus groups were asked a series of open-ended questions following the objective, reflective, interpretive, decisional (ORID) model.

Findings From the Research

Four themes emerged from the analysis of the data collected from the focus groups, each theme providing insight and context to understanding treating the substance use disorder population from the experiences and perceptions of social workers and counselors.

Focus Group Themes

The four themes identified within the analysis of the data included: (a) complexity of each client, (b) clinical prognosis, (c) barriers to insurance funding treatment and (d) recommendations for practice. The first two themes (a) complexity of

each client and (b) clinical prognosis underscore the clinical representation and needs of an individual receiving treatment.

Complexity of Each Client

The theme complexity of each client focused on family history and genetics, dual diagnosis/co-morbidities, age of individual receiving treatment, depends which substance(s) are being used, commitment to treatment/readiness to change. This theme encompasses the myriad of complicated health issues and risk and protective factors an individual presents with when seeking treatment.

Clinical Prognosis

The second theme, clinical prognosis captured the needs of an individual with a substance use diagnosis, and included the amount of treatment recommended, need for repeated treatment, relapses, high mortality rate. This theme captures the needs across the lifetime once experiencing an active addiction, including the need for continuous treatment, and several episodes of treatment at various levels of care throughout the lifespan, in addition to the dangers of continued active addiction, which can result in death.

Barrier to Insurance Funding Treatment

The third theme, barrier to insurance funding treatment included ideas related to insurance as a barrier for access and funding of treatment. Additionally, this theme focuses on the ethical dilemma clinicians may be faced with when an individual does not have sufficient funding or access to treatment. In these situations, clinicians report

individuals may accrue a large, uncovered bill for treatment, or drop out of treatment earlier than clinically indicated if continued stay is denied by insurance.

Recommendations for Practice

The final theme, recommendations for practice highlighted the recommended practice for providing treatment to individuals diagnosed with a substance use disorder. Clinicians underscored the need to treat each person as an individual, where public policy and health insurance short of recognizing the nuances and needs of each person receiving treatment. Also, clinicians recommend treating substance use disorders like mental health disorders coverage, which currently has more treatment accessibility and funding available under insurance plans. Within this, clinicians emphasized the importance of an individual having support outside of treatment, along with a recommendation of intensive treatment within the early stages of sobriety, and insurance coverage and funding to be determined based on the acuity and symptoms of the individual.

The Proposed Solution Based Upon the Research Findings

Through extensive research in the field of mental health and addiction, along with the evidence in this doctoral research, there is a clear need for the profession to advocate for reform of the current mental health parity laws in the United States to policymakers and legislators on the national and state levels. The Chapter 28 mandate is impacting accessibility and funding for substance abuse treatment in New Jersey. At the outset, this mandate was written to require all insurance plans to cover substance abuse treatment for at least 28 inpatient days, 28 partial hospitalization and intensive outpatient treatment

days, and 180 weekly outpatient days. The findings of the research study identified key themes which have been used to create the following recommendations.

The analysis of the data included a theme on insurance as a barrier to treatment, as well as complexity of each client and clinical prognosis. In practice, this mandate is falling short of addressing the needs of the individual, oftentimes falling short of necessary coverage. In practice, the mandate is being enforced as a maximum amount of treatment rather than a minimum. An individual seeking treatment is in a vulnerable position for relapse within the first 90 days of treatment. Some studies estimate relapse rates between 40-60% within the first 90 days of sobriety (National Institute on Drug Abuse, 2023). Those who are at a higher risk of relapse are often due to factors like ongoing substance use during the initial phase of treatment, lack of social support, or low motivation, and could experience greater benefits from ongoing care (McKay, 2021). This evidence further highlights the importance and need for intensive treatment within the first 90 days of treatment.

From a thorough review of the current literature and evidence from this study, recommendations are proposed to support increased advocacy for policy change of the current New Jersey Chapter 28 mandate to remove barriers impacting access and funding to substance use disorder treatment. First, there is agreement across the sample in the complexity of each client and clinical prognosis theme that substance abuse disorder is a type of mental health disorder and should not be subject to more strict continued stay requirements. In fact, someone being treated for a substance use disorder is often struggling with a co-morbid mental health diagnosis, requiring more treatment. Treatment

will be needed to stabilize addictive behaviors, incorporate replacement behaviors, and resolve the core conflict of mental health disorders, needing additional time to treat the intersectionality of these complex disorders.

Additionally, the analysis of the data focuses on insurance as a barrier, and best practices. As such, the mandate must recognize partial hospitalization and intensive outpatient as entirely separate levels of care, where partial hospitalization requires treatment 5 hours per day, 5x per week and intensive outpatient treatment requires 3 hours of care per day, 3x per week. Grouping partial hospitalization and intensive outpatient treatment days together is creating a disservice and a lack of available treatment funding. Lastly, it is posited that insurance companies should require concurrent review, rather than retrospective review for continued stay of those receiving substance use disorder treatment, and for insurances to increase transparency of medical necessity and continued stay criteria for substance use disorder cases. There is a call to action for policymakers to recognize the need for additional action steps to achieve mental health parity in the state and am hopeful for the impact of this research in the field of human services in the drive for greater mental health parity in New Jersey.

Recommendations for Next Steps and Call to Action

Action steps are presented to address the next steps policy makers can explore and implement to achieve addiction parity in New Jersey. It is recommended for current policymakers to become aware of the barriers impacting funding and access to clinically appropriate and chronic need of substance use disorder treatment for those struggling

with addiction. Proposed revisions of the current Chapter 28 mandate to close loopholes are presented below.

Recognize Partial Hospitalization and Intensive Outpatient as Separate Levels of Care

Based on the professional experiences of practitioners in the state through this study, there was consensus that the current mandate be revised to recognize Partial Hospitalization (PHP) Intensive Outpatient (IOP) and as two different levels of care, each with a separate 28 days of authorization per benefit period. Under the current mandate, an individual is authorized 28 days of treatment for Partial Hospitalization and Intensive Outpatient levels of care combined. Along with this, practitioners proposed that days authorized for alternative levels of care (inpatient and outpatient) can be exchanged for additional treatment days at the PHP and IOP levels of care to allow for continued supportive daily treatment to maximize treatment gains within the first 90 days of recovery. A similar exchange system of days is written in the mandate to exchange inpatient days for more outpatient treatment and would benefit from allowing an exchange system for more days at the partial hospitalization and intensive outpatient levels of care.

Utilize Concurrent Review as with Mental Health Disorders Rather Than Retro Review Under Insurance

Practitioners urged for the solution to incorporate concurrent insurance review as with mental health disorder treatment, and to move away from retrospective review for substance use disorder treatment to help eliminate the unknown of approved funding until

the end of the treatment. Mental health disorder treatment undergoes concurrent review for more covered time, while an individual is still in treatment. Current individuals receiving treatment for substance use disorder that have exhausted their 28 initial days under mandate are not notified of continued coverage until discharge, after insurance conducts a retro review of the clinical information. A retro review decision, as opposed to a concurrent review decision result in a provider and individual to have to make the decision to continue treatment knowing that insurance could deny the claims upon discharge, leaving the individual with a large, uncovered bill for continued treatment beyond the initial 28 days.

Conclusion

Given the consistent need and rise for addiction treatment in New Jersey residents year after year, coupled with the increased efforts of the current governor and Biden Administration, it is vital for current policymakers to take additional steps to assist the public with this matter. It should be a standard of care to receive access and funding for substance use disorder treatment on an ongoing basis, in line with the research emphasizing the chronicity and etiology of addiction. Based on this research and proposed suggestions, there is a call to action for all New Jersey policymakers to support a revision of the current Chapter 28 mandate.

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Appendix B: Interview Protocol

The facilitator will review the informed consent procedure and begin recording. The facilitator will begin to ask participants the questions below.

1. Objective: The facilitator asks the group questions about facts and data.

    a) How long have you been working with service users receiving treatment for substance use disorders, and in what settings have you worked?
    b) What do you know about the New Jersey Chapter 28 mandate?
    c) What do you think about limiting the amount of treatment?

2. Reflective: The facilitator will next ask questions to help the group reflect and sense their own response to what they all now know.

    a. What concerns you about there being a limit imposed on funding for substance use disorder treatment?
    b. What concerns you about this limit given your education and clinical experience working with this population?
    c. How do you feel about the New Jersey Chapter 28 mandate?

3. Interpretive: The facilitator will next ask questions about how the group interprets the information they have.

    a. What are the implications of this mandate?
    b. What would it mean if treatment were funded based on medical necessity rather than a limit?
    c. What is the trajectory or prognosis of a service user receiving treatment for a substance use diagnosis?

4. Decisional: At some point when all the information is known and considered, the facilitator can then guide the group to consider what their next step should be. At this point some decision can be made together.

a. What would be the logical next step?

b. What more information is needed before we plan?

c. What would you suggest we do first?

5. Summary: At the end of the conversation, the facilitator will summarize and share the groups' agreed next steps.