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Commentary

Converging advances in science, policy and public awareness: A time of great opportunity and change in addiction treatment

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ABSTRACT

Scientific advances, increased public awareness about addiction as a disease, and significant changes in public policy have led to transformational changes in this field. Preclinical and clinical studies highlighted in this issue have supported the emerging concept of substance use disorders as a novel major concern within the healthcare community. In this Commentary, we discuss the potential impact of recent legislation (Affordable Care Act and the Mental Health Parity and Addiction Equity Act) when fully implemented to end the real and perceived segregation of addiction and substance abuse disorders from mainstream healthcare and insurance reimbursement. These legislative changes, along with the diligence of public interest and scientific advances, have the potential to move prevention and treatment of substance use disorders to mainstream healthcare, and to educate professionals appropriately on the prevention and treatment of substance abuse.

1. Introduction

This is a seminal moment in the history of mental health and addiction care in this country. Scientific advances, increased public awareness about addiction as a disease, and significant changes to public policy have all converged to create an opportunity for transformational change in this field. Previous articles in this special issue have discussed some of the research advances in understanding the etiology and course of addiction – and this knowledge will inform new approaches for treating and managing all of the 'substance use disorders' – not just addiction. The press coverage and political debate surrounding the current opiate epidemic in this country are examples of the public's increased awareness about problems related to addiction and their demand for solutions. Finally, the Affordable Care Act (ACA) and the Mental Health Parity and Addiction Equity Act (Parity Act) (Patient Protection and Affordable Care Act of 2010; Wellstone and Domenici Mental Health and Addiction Equity Act of 2008) – when fully implemented – have the potential to end the longstanding segregation of substance use disorders from the rest of healthcare; and to provide the same kind of advanced medical care that has never been possible for addiction. Together, these two acts assure that care for substance use disorders has the same type, duration, range of services and patient financial burden as the care currently available to patients with comparable chronic physical illnesses; and that this type of insurance coverage is available to virtually all citizens.

The implications following these scientific, public interest and legislative changes are significant—particularly for the future of research-derived interventions, medications and services. First, these changes place the prevention and treatment of substance use disorders squarely in the realm of healthcare. In turn, young physicians, nurses, pharmacists and other healthcare professionals will soon be properly educated and trained about substance use disorders: this has never been the case before.

Increasing the amount and type of health insurance benefits will also create opportunities. Specific coverage includes prevention, primary care office-based treatment of 'medically harmful substance use,' and specialty treatment of chronic addiction. With a new range of eligible care providers, venues for care delivery, and a dramatic increase in the total number of individuals covered, there are now markets for medications, interventions, services and software that have never existed.

The idea that addiction is a disease and that it deserves prevention and healthcare comparable to that provided for other illnesses may seem obvious to those who do research in addiction—but this has never been the case in practice. In the past, addiction services were almost always provided in a separate specialty care addiction treatment program, in a time-limited manner. The financing of that care was also separated from other healthcare coverage, typically 'carved out' and managed separate from the larger health-

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care plan. With the implementation of Parity and ACA, insurers are beginning to 'carve in' behavioral healthcare under their major medical benefits in order to improve total health outcomes and reduce overall healthcare costs (Federal Register, 2013). The implications for improved access, choice and quality of substance use care are significant and far reaching—particularly for research.

2. The evolution and consequences of segregated addiction care

As noted above, addiction treatment has been almost entirely separate from the rest of medical care in this country. The national treatment system evolved before many of the seminal scientific advances that now inform our understanding of addiction as a chronic medical disease. The prevailing clinical and public perception at the time that the treatment system was being developed was that substance use disorders resulted from a moral failure, and therapy was thus focused on improving the sufferer's spiritual condition. In addition, the financing model for addiction treatment did not comport with the financing of other healthcare, and so the segregation of services was seemingly sensible from a therapeutic, as well as an administrative perspective. The impact of this segregation has been significant, affecting not only the delivery of care, but also shaping public perception and policy-making.

Until very recently, most private insurance plans never covered addiction treatment at all. More than 80% of addiction treatment financing has come from government sources (State Block grants, VA, etc.) with only about 12% from private insurance (NSSATS, 2008). Even then, government insurance coverage has always been restricted to just the most advanced and severe form of a substance use problem: addiction. Coverage for the less severe but far more prevalent forms of substance use disorders has never been included.

The view that addiction was more a lifestyle issue than a health condition led to lack of interest and training in substance use disorders among physicians and other healthcare professions. At this writing, very few physicians have received any formal training in this area, and consequently the great majority are unprepared to manage patients whose substance use is impacting their medical care. Once again, the consequences of failing to acknowledge the health consequences of substance use disorders within general medical settings have been devastating to both the quality and costs of mainstream healthcare delivery. Numerous prevalence studies in emergency rooms, hospitals and general medical care settings document high rates of harmful use, abuse or dependence among patients, yet very few physicians have done screening, early intervention, office-based care or referral to specialty care (Saitz et al., 2010).

The annual costs of these undetected, unmanaged substance use problems within general healthcare settings have been more than $120 billion dollars (National Drug Control Strategy, 2012). Some of these costs are due to avoidable, substance use-related readmissions to hospital and ER care (Gilmer and Hamblin, 2010; Mark et al., 2013; Raven et al., 2009; Cherpitel and Ye, 2008). Other costs derive from failure to address the less serious, but far more prevalent cases of 'medically harmful substance use,' which so regularly interfere with the management of other chronic illnesses (Mark et al., 2013; Smothers et al., 2003; Billings and Mijanovich, 2007; Reid et al., 1999).

These documented and avoidable healthcare costs were the impetus for including substance use disorders as an essential health benefit in the Affordable Care Act, and reducing these costs will be a driver for changing the way in which substance use disorders (SUDs) are identified and managed within the broader healthcare system over the next several years. In the text that follows, we provide some detail about the design elements of the ACA and their implications for contemporary research and care of substance use disorders.

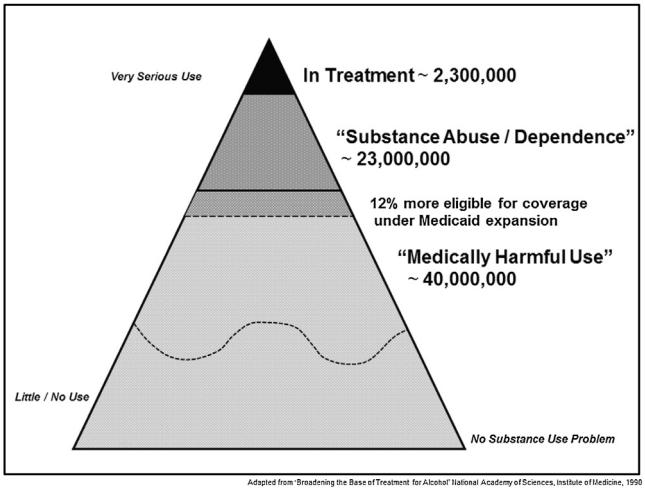

Fig. 1. Prevalence of substance use disorders in US adults.
Note: Estimates include alcohol, illicit and non-prescribed illicit drugs – but not cigarettes – for US population 12 years of age or older. Adapted from 'Broadening the Base of Treatment for Alcohol' National Academy of Sciences, Institute of Medicine (1990).

2.1. The basic elements of the affordable care act and their impact on the field

The Affordable Care Act was passed in 2010 but only began to be implemented nationally in 2014 due to court challenges, political opposition and pervasive misunderstandings. The ACA was generally designed to increase availability of healthcare insurance, to reduce increases in annual healthcare expenditures and to improve the overall quality of US healthcare. The broad package of incentives, regulations and initiatives within the ACA has already changed all of healthcare in this country—but no illness will be more affected than substance use disorders. Here, we review four major provisions of the ACA and briefly analyze the impact of each on the overall management of SUD.

2.1.1. Requirement for all Americans to purchase healthcare insurance.

This has been the most contentious of the many provisions, but is central to the overall goal of increasing the number of individuals with insured access to healthcare (from about 20 million to approximately 32 million). While this is a very dramatic increase in coverage, at this writing there are still more than 13 million adults and children without insurance coverage.

How will this impact the SUD field? This provision means that new populations – particularly those who had been unemployed or under-employed without benefits – will be covered and eligible for care. Also, because of the Parity Act, those newly insured individuals will have coverage for substance use treatment that is at par with the coverage for medical and surgical care. Fig. 1, an adapted diagram from the 1990 Institute of Medicine report (Institute of Medicine, 1990), provides a graphic illustration of the number of US adults who use alcohol, illicit and non-prescribed licit drugs (cigarettes are excluded) at various levels of frequency and intensity. As can be seen, there are about 23–25 million adults who meet the diagnostic criteria for addiction; but only about 10% of them receive any type of treatment, and usually from the 12,000-specialty care programs in the US. The number of addicted