

Substance Use Disorder Treatment: The Good, the Bad, and the Ugly

By Harry Nelson, JD, American Addiction Treatment Association

Addiction is widely recognized as a national and international health crisis. It knows no bounds, afflicting millions of people, with many millions more at risk. In 2013, 23 million people sought treatment for various substance use disorder problems. The number at risk in the U.S. alone is estimated to be triple or maybe even quadruple that number. Of the 23 million seeking help last year for alcohol use disorder, prescription painkillers, marijuana, and illegal drugs, a mere 2.5 million actually received treatment at a specialized treatment facility.¹ Of these 2.5 million who entered rehab, the vast majority are likely to relapse.² These numbers help explain the massive scope of the problem of addiction. Below, we've tried to identify some of the progress that's been made (i.e. the good), the challenges ahead (i.e. the bad), and problems that the addiction treatment industry needs to come to grips with (i.e. the ugly).

The Good: Scientific Progress, More Humane Politics, and Expanded Access to Care

On a societal level, we've made some progress in responding to the problem of substance use disorders. Science has begun to understand brain neurochemistry and the factors contributing to addiction better. It was not until 1956, only sixty years ago, that the American Medical Association

recognized alcoholism as a disease. In the intervening years, we've learned about the links between many addictions and mental health issues, such as depression and anxiety. In many cases, addiction begins as a form of "self-medication" to cope with life's challenges, get pain relief, or to fit in socially. In theory, everyone is at risk, because there is a substance out there that will address our neurochemical needs. A person with hyperactive tendencies, for example, may find stimulants help her slow down and focus. A person with anxiety or a social phobia may be looking for something that calms him down. Still others are looking for drugs with antidepressant qualities.

As a result of scientific progress, we are beginning to develop a more nuanced clinical understanding of addiction. In the current psychological model (the Diagnostic and Statistical Manual of Mental Disorders, DSM-5), "substance use disorder" is defined on a spectrum from mild to moderate to severe. It is based on a series of indicators, such as wanting to cut down or quit but being unable to do so. These indicators enable a clinician to identify the extent to which the "intense activation of the reward system" as a result of "using" the substance causes the addicted person to neglect "normal activities." In the coming years, ongoing advances in understanding our brain neurochemistry are expected to lead to more effective treatment.



Scientific progress has also been accompanied by greater sensitivity in the political realm. Forty-five years ago, in 1971, President Richard Nixon declared a “War on Drugs.” The effort to control substance use disorders in the subsequent four decades filled American prisons through a “zero tolerance” approach of criminalization and law enforcement crackdowns on manufacturers, distributors, and consumers of illegal drugs. We’ve evolved to a much more reflective acceptance that addiction is a health problem, not just a law enforcement issue. For evidence of changing attitudes, consider the openness of multiple candidates in the current presidential election cycle who shared stories of how addiction touched their families. We have progressed from a simplistic focus on punishing wrongdoers to a recognition of the need for community care and a humane treatment approach.³

The best news for people struggling with addiction and people who treat it is the availability of treatment resources. Until the enactment of the Affordable Care Act (ACA) in 2010, few people with substance use disorders could afford to get treatment, let alone an expensive stay at a residential treatment facility. The 2008 Mental Health Parity Act laid the foundation for greater access to treatment by prohibiting insurance companies from discriminating against mental health and addiction treatment with respect to coverage and benefits in comparison to medical needs.⁴ With the prohibition of discrimination and the ACA mandate to include substance use disorders as an essential elements of health benefits,⁵ access to addiction treatment is significantly expanded. Similarly, the expansion of Medicaid, along with some reforms at the state level, have opened up opportunities for treatment to many more people.

As a result of greater awareness of the public health crisis and expanded funding and coverage, the good news is that resources available for addicts and their families far surpass what was available a few years ago. In the pre-ACA days, Alcoholics Anonymous (AA) was the only option for many people in recovery who lacked the resources for residential treatment, outpatient programs, or clinical care. AA provided the “12-step” approach, anonymous support groups for people dealing with alcoholism and other addictions, and peer-to-peer support. Today, primary care providers are learning to integrate an approach known as SBIRT — Screening, Brief Intervention, and Referral to Treatment⁶ — to ensure patients with substance use disorders are identified and get appropriate referrals for treatment. The options include residential and outpatient programs with different approaches, including medical and non-medical, social model options. In addition to traditional resources, such as group and individual counseling, treatment increasingly integrates wellness and other ways to help people reach and learn how a healthy, calm state in which they don’t feel the need to “use.”

The solutions are not just treatment of addiction through services. As modern science progresses, researchers have been able to develop several prescription medications that doctors can give to patients with substance use disorder problems. The use of medications to suppress or blunt the desire and craving for substances is also growing.⁷ Doctors can prescribe these medications to help patients reduce the desire to “use” while they address the underlying issues to sustain recovery from addiction. In addition to an increasing understanding of neurochemistry enabling doctors to use existing medications more effectively, the pharmaceutical industry is expected to develop more medications to treat addiction in the future. In addition, tools like virtual reality are expected to play a growing role in helping addicts overcome the underlying issues that led them to use.

The Bad: Lack of Evidence-Based, Effective Treatment and Significant Cost

With respect to finding effective treatment, huge challenges remain ahead. The high relapse rates highlight the extent to which addiction is not an easy disease to “cure.” Think of the familiar image of the celebrity entering an addiction treatment center, relapsing, returning to rehab, in a “revolving door” cycle.

Part of the problem is the lack of evidence-based approaches to treatment and effective models. As noted above, the longstanding model of 12-step and AA have been cornerstones of the treatment world, but due to their emphasis on participants being anonymous, there is little to no research establishing its effectiveness.⁸ At the same time, there is also a dearth of evidence of alternatives being highly effective. While different numbers are cited by different sources, it seems that the majority of patients in drug rehabilitation treatment continue to suffer post-treatment and that the minority who are helped remain at high risk of relapse.

The other bad news is cost — both of treatment and of the social costs of the problem of addiction. According to the National Center on Addiction and Substance Abuse, when you add up the lost productivity, healthcare costs, substance use disorder treatment and prevention programs, and the cost of prosecuting and incarcerating the people responsible, the state of California spends 19.5% of its budget on substance use disorder, with 2% of the funds going to prevention/treatment of substance use disorder and 98% going to the consequences of addiction.⁹ The costs for people both with and without substance use disorders are staggering, with people with substance use disorders spending on their addictions and people without such addictions paying taxes that fund government spending. The high cost of various forms of treatment has led to a situation where insurers who are now required by the Affordable Care Act to cover treatment are struggling with soaring costs, even as access to care remains woefully inadequate for those in need.

The Ugly: Fraud and Abuse in Addiction Treatment

With the explosive growth in the industry the last few years, one of the biggest challenges that addiction treatment faces is a set of bad practices that have elevated the quantity of profits over the quality of care. As in any case where economic opportunities beckon, some of the people attracted to the treatment industry are motivated more by the financial opportunity than by the opportunity to help people in need. In many more cases, people seeking to grow and attract new patients cut corners. They use prohibited marketing practices, like paying marketers for each patient they bring in and use of other kickbacks. In some cases, they engage in billing practices around services like urine drug testing or other services that are difficult to defend. They turn a blind eye to the limitation on their scope of services and provide services that are unauthorized at drug and alcohol treatment facilities, in violation of the law.¹⁰

Sometimes the “ugliness” extends to taking in inappropriate patients who need care that centers cannot provide, placing patients at risk in the process. In other cases, the issue is not the condition of patients at the time of admission, but rather holding onto patients who need emergency or urgent care and potential hospitalization. In recent years, addiction treatment facilities have been the site of patient suicides. In other cases, facilities have discharged noncompliant patients, only to find out that they overdosed soon after. These tragic stories highlight the high price when facilities are not careful about their limitations and patients’ healthcare needs.

Meanwhile, state governments have struggled to take on industry problems. In many cases, states were caught flat-footed as the industry experienced explosive growth, without the trained personnel to exercise needed regulatory oversight. In California, for example, a decision was made to close the California Department of Alcohol and Drug Programs in 2013, assigning its functions to the Department of Health Care Services. This transfer of responsibility and reorganization was ill timed, coinciding with massive growth in the number of operators and facilities.

It is no surprise that major changes in industry-wide compliance take time. The business of substance use disorders is making strides, as a growing number of operators are sensitized to the legal and safety risks. Progress cannot happen fast enough, as the number of people with substance use disorders needing help (as well as the numbers of addictive substances presenting public health problems) continue to grow, translating into a shortage of access for people in need of treatment. Existing treatment programs, hospitals, and doctors cannot accommodate the surge of patients who now have insurance coverage. Let's hope that 2016 will be a time to begin building a more accessible, effective, affordable, and safer substance use disorder treatment infrastructure.

ENDNOTES

- ¹DrugFacts: Nationwide Trends (Revised 2015, June). Retrieved from: <http://www.drugabuse.gov/publications/drugfacts/nationwide-trends>.
- ²Drugs, Brains, and Behavior: The Science of Addiction (Last Updated 2014, July). Retrieved from: <http://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery>.
- ³Dahr, M. (2014, March 4). How Obamacare Is Changing Addiction Treatment Coverage. Retrieved from: http://www.huffingtonpost.com/2014/03/04/obamacare-addiction-treatment-coverage-aca_n_4896388.html.
- ⁴Mental Health Parity. Retrieved from: <http://www.dol.gov/ebsa/mentalhealthparity>.
- ⁵Substance Abuse and the Affordable Care Act. Retrieved from: <http://www.whitehouse.gov/ondcp/healthcare>.
- ⁶Substance Abuse and Mental Health Services Administration. (2015, June 4). About Screening, Brief Intervention, and Referral to Treatment (SBIRT). Retrieved from: <http://www.samhsa.gov/sbirt/about>.
- ⁷Glaser, G. (2015, April). The Irrationality of Alcoholics Anonymous. Retrieved from: <http://www.theatlantic.com/magazine/archive/2015/04/the-irrationality-of-alcoholics-anonymous/386255>.
- ⁸Kaskutas, LA. (2009). Alcoholics Anonymous Effectiveness: Faith Meets Science. *J Addict Dis*, 28(2):145–157. doi: 10.1080/10550880902772464; Glaser, G. (2015, April). The Irrationality of Alcoholics Anonymous. The Atlantic. Retrieved from: <http://www.theatlantic.com/magazine/archive/2015/04/the-irrationality-of-alcoholics-anonymous/386255>.
- ⁹The National Center on Addiction and Substance Abuse. (2015, November 3). Effects of Risky Drinking, Tobacco and Drug Use. Retrieved from: <http://www.centeronaddiction.org/addiction/effects-of-risky-substance-use>.
- ¹⁰California Senate Office of Oversight and Outcomes. (2012, September 4). Rogue Rehabs: State failed to police drug and alcohol homes with deadly results. Retrieved from: http://sooo.senate.ca.gov/sites/sooo.senate.ca.gov/files/Rogue%20Rehab%209_4_12.pdf.



Harry Nelson is the managing partner of Nelson Hardiman, LLP, a healthcare law firm that works closely with a wide range of behavioral care providers nationally, giving strategic advice on emerging issues and advising on traditional business, transactional, and regulatory compliance matters. Harry is also a founding board member of the American Addiction Treatment Association (AATA), a national trade association for owners and operators of facilities and programs that serve the addiction recovery community and professionals working in the addiction treatment community. The Association tracks developing federal and state regulations and government enforcement, providing practical, actionable information on compliance with government and payor requirements, fraud and abuse avoidance, and operational risk management. AATA also offers essential compliance resources through training events, detailed content and other resources that include state-by-state requirements for licensing and certification, operations, reimbursement and risk management.

Inaba, continued from page 24

with up to 90% accuracy.¹⁵ The good news is that the brain is resilient and able to regain its functionality if given sufficient time to do so — at least 14 months to 2 years from current studies — which can lessen the relapse potential. (Volkow ND, Hitzemann R, et al., 1992; Volkow ND, Chang L, et al., 2001).

ENDNOTES

- ¹Volkow, ND, Hitzemann, R, Wang, G-J, Fowler, JS, Wolf, AP, Dewey, SL. (1992). Long-term frontal brain metabolic changes in cocaine abusers. *Synapse*, 11(3):184–190; Volkow, ND, Chang, L, Wang, GJ, Fowler, JS, Franceschi, D, Sedler, M, Gatley, SJ, Miller, E, Hitzemann, R, Ding, YS, Logan, J (2001). Loss of dopamine transporters in methamphetamine abusers recovers with protracted abstinence. *Journal of Neuroscience*, 21(23):9414–9418.
- ²Fowler, JS, Volkow, ND, Kassed, CA, and Chang, L. (2007). Imaging the Addicted Human Brain. *Sci Pract Perspect*, 3(2): 4–16.
- ³Meier, MH, Caspi, A, Ambler, A, Harrington, HL, Houts, R, Keefe, RSE, McDonald, K, Ward, A, Poulton, R and Moffit, TE. (2012). Persistent cannabis users show neuropsychological decline from childhood to midlife. *Proc Natl Acad Sci U S A*, 109(40).
- ⁴Gould, TJ. (2010). Addiction and cognition. *Addict Sci Clin Pract*, 5(2): 4–14.
- ⁵Martin, PR, Singleton, CK, and Hiller–Sturmhöfel, SH. (2003). The role of thiamine in alcoholic brain disease. *Alcohol Research & Health*, 27(2):134–142.
- ⁶Gramage, E & Herradón, G. (2011). Connecting Parkinson's disease and drug addiction: common players reveal unexpected disease connections and novel therapeutic approaches. *Curr Pharm Des*, 17(5):449–61.
- ⁷Inaba, DS, and Cohen, WE. (2014). *Uppers, Downers, All Arounders: Physical and Mental Effects of Psychoactive Drugs* (8th Edition). CNS Productions, Inc., Medford, OR.
- ⁸National Institute on Drug Abuse (2016). "The science of drug abuse and addiction: the basics." *The National Institute on Drug Abuse Media Guide*. Retrieved from: <https://www.drugabuse.gov/publications/media-guide/science-drug-abuse-addiction-basics>.
- ⁹McLellan, AT, Lewis, DC, O'Brien, CP, Kleber, HD. (2000). Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. *JAMA*, 284(13):1689–95.
- ¹⁰Inaba and Cohen.
- ¹¹Paulus, MP, Tapert, SF, and Schuckit, MA. (2005). Neural activation patterns of methamphetamine-dependent subjects during decision making predict relapse. *Arch Gen Psychiatry* 62(7):761–768.
- ¹²Kasai, H, Fukuda, M, Watanabe, S, et al. (2010). Structural dynamics of dendritic spines in memory and cognition. *Trends Neurosci*, 33(3), 121–29; Luo, AH, Tahsili-Fahadan, P, Wise, RA, Lupica, CR and Aston-Jones, G. (2011). Linking Context with Reward: A Functional Circuit from Hippocampal CA3 to Ventral Tegmental Area. *Science*, 333(6040): 353–357; Inaba and Cohen.
- ¹³Kreek, MJ and Koob, GF. (1998). Stress and dysregulation of brain reward pathway. *Drug Alcohol Depend*, 51:23–47; Kreek, MJ, et al. (1984). ACTH, cortisol, and b-endorphin response to metyrapone testing during chronic methadone maintenance treatment in humans. *Neuropeptides*, 5:277–278; Heilig, M and Koob, GF. (2007). A key role for corticotrophin-releasing factor in alcohol dependence. *Trends Neurosci*, 30(8):399–406; Lowery, EG, Sparrow, AM, Breese, GR, Knapp, DJ and Thiele, TE. (2008). The CRF-1 receptor antagonist, CP-154,526, attenuates stress-induced increases in ethanol consumption by BALB/cJ mice. *Alcohol Clin Exp Res*, 32(2):240–248.
- ¹⁴Bonson, KB, Grant, SJ, Contoreggi, CS, Links, JM, Metcalfe, J, Weyl, HL, Kurian, V, Ernst, M and London, ED. (2002). Neural systems and cue-induced cocaine craving. *Neuropsychopharmacology*, 26:376–386.
- ¹⁵Paulus, Tapert, and Schuckit, 761–768; Bando, K, Hong, K-IK, Bhagwager, Z, Li, C-S R, Bergquist, K, Guarnaccia, J and Sinha, R. (2011). Association of Frontal and Posterior Cortical Gray Matter Volume with Time to Alcohol Relapse: A Prospective Study. *The Am. J. of Psychiatry*, 168(2):183–192.



Dr. Darryl Inaba is Director of Clinical and Behavioral Health Services for the Addictions Recovery Center and Director of Research and Education of CNS Productions in Medford, Oregon. He is an Associate Clinical Professor at the University of California in San Francisco, CA., Special Consultant, Instructor, at the University of Utah School on Alcohol and Other Drug Dependencies in Salt Lake City, UT and a Lifetime Fellow at Haight Ashbury Free Clinics, Inc., in San Francisco, CA. Dr. Inaba has authored several papers, award-winning educational films and is co-author of *Uppers, Downers, All Arounders*, a text on addiction and related disorders that is used in more than 400 colleges and universities and is now in its 8th edition. He has been honored with over 90 individual awards for his work in the areas of prevention and treatment of substance abuse problems.