*American Journal of Public Health*



May 1999, Vol. 89, No. 5

# Editorials

## An Expensive Policy: The Impact of Inadequate Funding for Substance Abuse Treatment

Broad public health policies and practices are making slow but sure progress toward improving the health of particular groups of Americans through insurance coverage, screening, and treatment of certain diseases. Meanwhile, prevention and treatment of substance use has gotten the short shrift at a high price.

Failure to provide accessible and effective substance abuse treatment costs US taxpayers up to $276 billion per year.[1] Included in these costs are expenditures for medical care, law enforcement, motor vehicle accidents, lost productivity, and incarceration; not included are the consequent foster care and social service costs for children whose parents fail to receive needed substance abuse treatment. Approximately 55% of the economic burden of alcohol and drug problems is borne by those who do not use these substances.[1] Commenting on the significant increases since 1985 in the costs of drug addiction, Alan Leshner, the director of the National Institute on Drug Abuse, notes that the "emergence of health problems from the cocaine and HIV epidemics during this period substantially increased drug-related costs to society."[2]

### *Drug Use and Addiction*

The future costs to US society of substance use and addiction will depend in great part on the trend of chronic drug use as well as the initiation of use among youth. Indicators of chronic drug use (e.g., mortality, emergency room admissions, drug treatment admissions, and arrest urinalysis data) show that crack cocaine and heroin use are the predominant sources of illicit drug problems.[3] While indicators of chronic use suggest a leveling off in crack use, heroin use continues to increase.[3] Chronic methamphetamine use is also increasing in many parts of the country.[3]

The Monitoring the Future Survey on substance use and attitudes toward substance use among young people produced both good and bad news. Despite decreasing trends in the use of some drugs among youths (e.g., marijuana, alcohol, and cigarettes among 8th graders) and a leveling off in drug use among some groups (e.g., most illicit drugs among 12th graders), substance use remains stubbornly common among adolescents and young adults.[4] Approximately 41.4% of 12th graders, 35% of 10th graders, and 21% of 8th graders reported using an illicit drug in the last year.[4] The bad news is also echoed in the findings of the National Household Survey, which reported an increase in current use of drugs, mainly marijuana, among young people aged 12 to 17 years.[5]

Overall, adolescents and young adults today report significantly higher levels of lifetime and past-month illicit drug use than were observed in 1991. Lloyd D. Johnston, the principal investigator of the Monitoring the Future Survey, concedes that any "improvement so far is very modest."[6] Along with reported increases in protective attitudes and perception of drug use (e.g., the perception of risk in marijuana use), there has been a reported decrease among 8th graders of personal disapproval of people who use LSD and a decrease among 10th graders of perceived harm in taking powder cocaine.[4]

### *Funding for Demand Reduction vs Supply Reduction*

The federal government's continued policy of spending nearly double the amount on supply reduction (interdiction) as on demand reduction (prevention and treatment) is

perplexing. Treatment has been convincingly demonstrated to be more effective than law enforcement and incarceration in reducing the demand for illicit drugs.[7,8] Yet, in 1998, 66.6% of the $16.18 billion federal drug control budget was allocated for supply reduction activities and only 33.4% for demand reduction activities.[9] The total federal drug control budget was increased to $17.9 billion in fiscal year 1999 and is expected to reach $17.8 billion in the budget for fiscal year 2000, but the proportions dedicated to demand reduction will be only slightly increased.[9]

## *The Treatment Gap*

It is estimated that although over 5.3 million persons in the United States are in severe need of substance abuse treatment, only 37% receive such treatment.[10] If the proposed budget for fiscal year 2000 is approved, the Substance Abuse and Mental Health Services Administration will be charged with administering $55 million in treatment capacity expansion grants and $30 million in substance abuse block grants, most of which will go for treatment.[9] At first glance, the proposed increases for prevention and treatment appear to be substantial. Nonetheless, they together represent only 3% of the total federal drug-related activities budget and are woefully inadequate to meet the pressing need for substance abuse treatment. Unfortunately, the modest increase will hardly make a dent in the treatment gap.

Inadequate provision of funds to close the treatment gap is an expensive societal course. Providing treatment to all in need could save more than $150 billion over the next 15 years, at a price tag of just $21 billion in treatment cost.[11] Funding treatment for persons addicted to drugs is prudent fiscal policy: every dollar invested in drug treatment generates $7 in savings of future costs.[12]

Although the public and policy makers remain skeptical, a number of studies[11–16] have demonstrated that substance abuse treatment has a pronounced positive impact on reducing illegal drug use, criminal activity, victimization, hospital visits, inpatient mental health visits, homelessness, exchange of sex for money or drugs, HIV-related risk behaviors, welfare dependency, relapse and criminal activity among inmates who receive treatment in prison, and unemployment. Treatment of women addicted to drugs has been shown to improve rates of healthy pregnancies as long as 1 year after treatment.[17] Failure to treat pregnant women addicted to cocaine alone can cost up to $352 million per year for services to cocaine-exposed children.[18] The California Drug and Alcohol Treatment Assessment Study[12] found conclusive evidence that treatment more than pays for itself, because the benefits exceed the costs.

## *A Comprehensive Strategy*

In order to close the treatment gap, we need a major, albeit low-cost, change in the coverage for substance abuse treatment. In 1996, Congress passed, and President Clinton signed, the Mental Health Parity Act, which requires that health plans provide the same annual and lifetime coverage limits for mental health as for other health care. While the original legislation was intended to include substance abuse treatment, the final legislation left it out. By 1997, 12 states had enacted parity laws that mandated more generous benefits despite great variation in the coverage for substance abuse treatment. A recent study of the impact of state parity laws concluded that "[b]ased on an updated actuarial model, full parity for mental health and substance abuse services is estimated to increase premiums by 3.6 percent on average."[19] Full parity for substance abuse treatment accounts for a mere 0.2% increase in average premiums.[19] Nelba Chavez, the head of the Substance Abuse and Mental Health Services Administration, agrees that "[e]qual access to these services is a sound, rational investment."[20]

Although many remain concerned that including substance abuse treatment in health care plans will drive up the costs of health care insurance, recent data from managed care plans indicate that such fear is unfounded. The RAND Corporation investigated the costs of substance abuse treatment in 25 plans managed by United Behavioral Health and found that removing limits on substance abuse benefits would result in a small increase of annual insurance premium payments of $5.11 for substance abuse treatment per member.[21] Another recent study reported an even smaller per-member increase ($1 per month) for full and complete substance abuse treatment parity in commercially available benefit plans.[22]

On the other hand, any cost savings from limiting substance abuse treatment are expected to be small at best. For example, capping care for substance abuse treatment to an annual limit of $10 000, $5000, or $1000 would result in annual cost savings of $0.06, $0.78, and $3.40, respectively, per member.[21] A related issue is the impact of managed care on actual utilization and the quality of care substance users receive. Recent studies indicate that higher copayments result in lower levels of follow-up care after inpatient detoxification[23] and that fewer preauthorized visits for outpatient care result in fewer outpatient sessions even when authorization for more sessions was not generally denied.[24] Experts in the field have noted that "we know very little about the process of rationing in managed care."[25] Research is needed on decision making in managed care plans and the impact on access, utilization, and the type of care available to patients.

An independent panel convened by the National Institutes of Health called for broadened access and insurance coverage for methadone treatment, but this call needs to be expanded to include all scientifically proven treatment methods.[26] Publicly funded treatment should pave the way. An effective strategy might be to make significant improvements in the coverage and quality of substance abuse treatment under Medicaid and the Substance Abuse Treatment Block Grant Program, which currently requires insufficient accountability for the use of treatment dollars. Increased public coverage would reach the poorest populations, among whom the most chronic and complex drug users are most prevalent. At the same time, it is critical to improve the delivery of substance abuse treatments funded by Medicaid and the block grants through the adoption of protocols and models based on proven methods. This would enable providers to staff programs with appropriately trained staff, match the length of treatment to the level of client impairment, and provide the more comprehensive services that are needed by many individuals addicted to drugs and alcohol. Since the majority of current illicit drug users (73%) and alcoholics (75%) are employed, similar changes are needed in private insurance coverage for substance abuse treatment.[27]

To get treatment to those who need it, greater efforts in outreach, screening, and referral are required. Medical care should integrate substance abuse screening, referral, and treatment. It has been estimated that 2 out of 3 substance abusers or dependents will see a primary or urgent care physician in the next 6 months,[28] and that untreated alcohol and drug users occupy a significant number of hospital and emergency room treatment beds, mostly for illnesses secondary to the addiction.[29] Yet, medical care visits continue to be greatly underutilized for substance abuse screening, referral, and treatment.[30] Public education about alcohol and drug dependence is also needed to reduce stigma, ignorance about treatment, and denial, which are pervasive among Americans and pose significant barriers to treatment.[31]

## *A Call to Action*

A recent review of managed care systems for mental illness and substance use by the Institute of Medicine (IOM) called for reforms in public and private systems that provide reimbursement for full and effective treatment of substance abuse and mental health conditions.[32] The IOM further recommended that accreditation of provider organizations should feature mechanisms to ensure valid and reliable measures of outcome and quality improvement and should use clinical practice guidelines that are evidence based. The report also emphasized the need for cultural competency and targeted programs for women. Public health professionals should take the lead in moving forward policies that implement these recommendations.

Substance use is a major public heath problem: it affects the health of a vast number of Americans and results in tremendous costs to US society overall. The public health community must provide strong and decisive leadership in informing policy, advocating for needed research funds, and bringing practice in line with scientific advances in substance abuse prevention and treatment. The current treatment gap unduly affects children, who through the failure of US society to address their parents' addictions, are at profound risk of becoming the next generation in need of treatment. □

*Hortensia Amaro, PhD*
*Boston University School of Public Health*
*Boston, Mass*

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