Surveys Show Paths to Addiction Treatment in U.S.

Only 9% of the estimated 22.5 million people with a drug or alcohol problem actually received specialty treatment.

BY JEFF EVANS

Senior Writer

BETHESDA, MD. — Treatment for substance use disorders continues to be out of reach for many people who need it at a time when funding for treatment and health plan coverage of substance abuse remains stagnant, Constance M. Horgan, Sc.D., said at the annual conference of the Association for Medical Education and Research in Substance Abuse.

Dr. Horgan used data obtained from the 2003 and 2004 National Survey on Drug Use and Health (NSDUH, formerly called the National Household Survey on Drug Abuse) and her own two surveys of behavioral health service coverage in managed care health plans to chart recent trends in substance abuse treatment.

"Not many people are making the link to specialty treatment" of substance use disorders, said Dr. Horgan, director of the Center for Behavioral Health at the Schneider Institute for Health Policy at Brandeis University in Waltham, Mass.

Only 9% of the estimated 22.5 million people 12 years of age or older with a drug or alcohol problem needing treatment actually received specialty treatment in an outpatient or inpatient rehabilitation setting, a mental health center, or as a hospital inpatient, averaged data from the 2003 and 2004 NSDUH show.

Of the people who were thought to need treatment but did not receive specialty treatment, 94% felt that they did not need treatment, according to the 2004 NSDUH. Among those who thought they needed treatment, 2% made an effort to receive it, and 4% did not.

Of the 6% who felt they needed treatment, most reported that they had not received specialty treatment because they were not ready to stop using drugs (40%), had cost and insurance barriers (35%), were afraid of stigma (22%), felt they could handle the problem themselves through friends or other support (14%), did not know where to go for treatment (12%), or had barriers to accessing treatment (13%), such as transportation, no openings, waiting lists, or unavailable services.

The people who thought that they needed treatment but had cost and insurance barriers fell into groups of those who had no health coverage and could not afford the cost of insurance (28%), and those who had health insurance that did not cover the cost of treatment (7%).

Among those who had no health insurance and could not afford the cost of the treatment, 32% still made an effort to get treatment. "This says something about access issues and the need for public payment," Dr. Horgan said.

In the past year, individuals paid for their last substance use treatment at a specialty facility most often with their own money (43%), with funds from their family (21%), or with private insurance (38%).

Some patients also reported paying for their last treatment with Medicaid (29%), Medicare (23%), or another public sector payer (22%). (Some respondents reported more than one source of payment.)

People typically think that most of these patients use public sector payers and do not have much out-of-pocket expense, Dr. Horgan said at the conference sponsored by the Brown Medical School.

In 2001, most of the $18.3 billion spent on the direct treatment costs of substance abuse in any medical setting—1.8% of all health care expenditures—came from public sector payers: Medicaid (19%), Medicare (5%), and other state and local (38%) or federal (14%) means. The bulk of expenditures for substance abuse were distributed to inpatient (30%) and residential (24%) settings of care. Only 40% of expenditures went to outpatient services, although most patients receive care in that setting, she said. Insurance administration collected 6% of the expenditures.

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In a survey of U.S. managed care health plans that Dr. Horgan and her colleagues conducted in 1999 and 2003, the percentage of plans that contracted behavioral health services out to specialty vendors grew from 58% in 1999 to 71% in 2003.

The percentage of plans in which network providers were internal to the plan declined in the same period from 28% to 15%. The percentage of plans in which behavioral health services were contracted out but remained as a part of general health coverage stayed steady at 14%.

Across the country, 95%-100% of all health plan products covered outpatient, inpatient, and residential detoxification, outpatient rehabilitation, intensive outpatient services, and intensive hospital treatment.

Coverage extended to methadone maintenance in 65% of health plans and to residential rehabilitation in 84%.

Prescription benefits for medications used in substance abuse treatment are part of the main health plan, not the behavioral health plan, "so it's important to look at what your prescription drug benefit is and where do the substance abuse medications fall in your health plan," Dr. Horgan advised.

In 2003, about 90% of health plans covered alcohol abuse medications, but in some instances these drugs were given the highest copayment rates, such as with ReVia (naltrexone, 41%), or Antabuse (disulfiram, 27%).

The opioid abuse drug Suboxone (combination of buprenorphine and naloxone) was excluded from coverage by 33% of health plans; 53% of the plans that covered Suboxone placed it on the highest copayment rate.

Health plans that used high cost-sharing schemes for outpatient visits increased from 24% in 1999 to 41% in 2003. A similar, but sharper, increase occurred in general medical outpatient visits, from 4% of plans in 1999 to 37% in 2003. High cost-sharing was arbitrarily defined as coinsurance greater than 20% or a copayment greater than $20, Dr. Horgan said. ■

Dual Diagnosis? Treat Substance Abuse First

BY TIMOTHY F. KIRN

Sacramento Bureau

SCOTTSDALE, ARIZ. — Treating dual diagnosis patients—those with concurrent psychiatric and substance abuse disorders—requires a readiness to use a medication for the substance abuse, perhaps first and foremost, Dr. John W. Tsuang said at the annual meeting of the American Academy of Addiction Psychiatry.

For the substance abusing patient who may have some other psychiatric condition, it is best to wait until the patient is abstinent for some time before making a definitive diagnosis—but without proper treatment, few can get sober, said Dr. Tsuang, who is director of the dual diagnosis program at the Los Angeles County Harbor–UCLA Medical Center.

Dr. Tsuang described a study in which he was once involved to illustrate the conundrum and the difficulty in getting a handle on substance abuse in dual diagnosis patients.

In the study, the patients to be enrolled—presumably with schizophrenia—were actively seeking help and attending a program daily. They also needed to be abstinent for 6 weeks to be given a definitive diagnosis of schizophrenia. Of the candidates, 81% could not stay abstinent long enough, "despite our best intentions," Dr. Tsuang said.

"I will use whatever I can to help a patient initiate and achieve abstinence," Dr. Tsuang said in the workshop that he conducted with Dr. Timothy Fong, also with the University of California, Los Angeles.

Buprenorphine is an excellent medication for narcotics abusers, he said. For alcohol abusers, he mostly relies on disulfiram, but he acknowledges that what works and is appropriate for one patient is not necessarily right for everyone. "A lot of clinicians shy away from disulfiram," he said.

Some drugs that can be used for the mental health diagnosis may also help with substance abuse. Some of the newer atypical antipsychotics, when used in patients with schizophrenia, may reduce drug-high cravings. Clozapine, for example, appears to reduce alcohol use and smoking. Theoretically, it may reduce craving for cocaine, though there is no evidence yet, said Dr. Tsuang.

"Clozapine is one of our best medications," though it does require close monitoring in substance abusers and may interact badly with methamphetamine use, he said.

In an experiment, risperidone (Risperdal) was given to individuals who were using cocaine, and it was found to interfere with the high, Dr. Tsuang said

Since then, studies have shown that risperidone treatment reduced cravings and relapse in patients with either schizophrenia or bipolar disorder who used cocaine.

Risperidone, however, has been tried in primary cocaine abusers who did not have a dual-diagnosis, and it was not helpful, he said.

Quetiapine (Seroquel) is a popular medication in general, because it reportedly ameliorates anxiety and helps with sleep problems, two difficulties that substance abusers who become abstinent often have.

There have been suggestions that the drug may be of use in bipolar disorder patients who are cocaine dependent. However, there is less evidence of its efficacy than there is for some other drugs, and it has never been given a trial to see if it helped substance abusers with no second diagnosis, Dr. Tsuang pointed out.

Whatever medications are used, psychosocial substance-abuse treatment of some kind is essential for these patients, because no single drug is a panacea. In his experience, most patients will continue at least some substance abuse, Dr. Tsuang said.

Dr. Fong said that despite the conundrum faced by the clinician who has a patient who may have a dual diagnosis but cannot get sober long enough for symptoms to become clear, it is often necessary to make some primary diagnosis to initiate timely treatment.

Delay "may make them harder to treat over the long term," he said. "Ongoing untreated psychosis is very bad for the brain. That's going to make it more difficult to treat the psychosis and to treat the substance abuse."

At UCLA, said Dr. Fong, the solution is to take a meticulous history and try to establish a time line. The doctors ask patients if they had psychiatric symptoms or treatments before the substance use started. They also ask about symptoms during periods of abstinence. Finally, they ask about the patient's last use in relation to the most recent symptoms. ■