



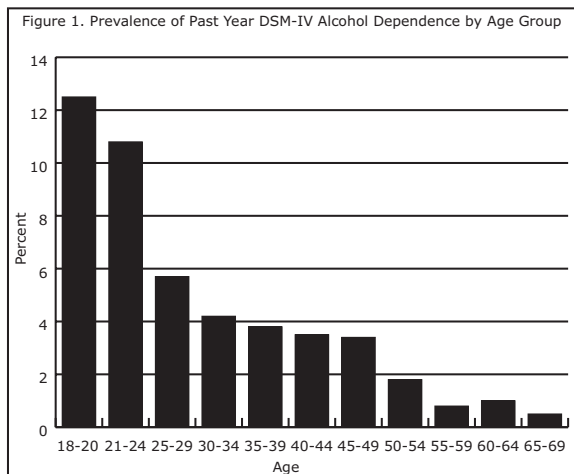
Substance Abuse

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How significant is the substance abuse problem? What are the most commonly abused substances?

In 2005, 22.2 million individuals—9.1 percent of the U.S. population age 12 or older—met the criteria for substance abuse and dependence, according to the [National Survey on Drug Use and Health](#). The



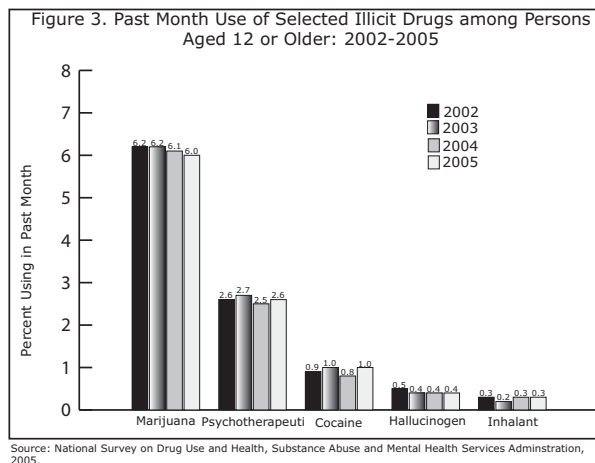
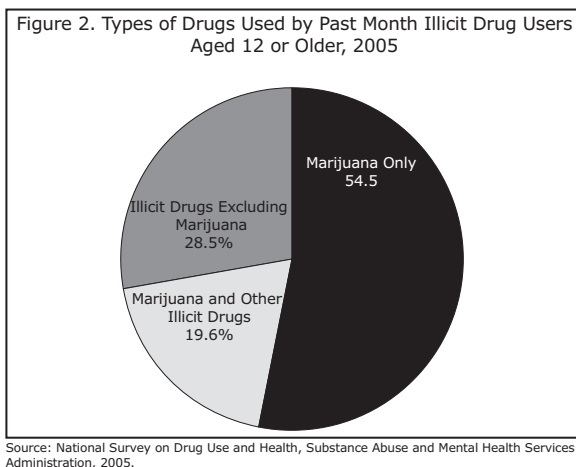
Source: The Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, 2007.

percentage of Americans with substance abuse disorders has decreased consistently since 1997, when 11.4 percent of Americans were reported to have such problems.

Alcohol is the most commonly abused substance. Approximately 15.4 million individuals are dependent on alcohol alone, while an additional 3.3 million are dependent on, or abuse, alcohol and illicit drugs.

Another 3.6 million people abuse, or are dependent on, one or more illicit drugs. Of those who have problems with illicit drugs, the most common drug of abuse is marijuana, followed by prescription drugs and cocaine (See figures 1, 2 and 3).





Is addiction a lack of will power or a brain disorder?

Society historically has viewed addiction as a moral weakness and failing, and that perspective remains despite a wealth of recent scientific research. Although the first drink or injection may be voluntary, researchers have found that the continued use of a mind-altering substance literally alters brain function.

Alcohol and other drugs not only interfere with normal brain function by creating powerful feelings of pleasure, but they also have long-term effects on brain metabolism and activity. Addictive substances can damage the frontal cortex, the part of the brain that enables us to control our actions. The addicted person may realize that continued drug use will have severe adverse consequences, but is unable to stop.

Because addiction is so tied to the body's physiology, treatment professionals and researchers now consider alcoholism and drug addiction as chronic, relapsing conditions, much like disorders such as hypertension, diabetes and asthma.

In groundbreaking research, researchers compared hypertension, diabetes and asthma to addiction and found strong parallels. For example, fewer than 60 percent of people with hypertension take their medications regularly; fewer than 30 percent lose weight and exercise. Within 12 months, 50 percent to 60 percent have relapsed to an acute phase of the disease and have to be treated by a physician or in the hospital.

It is much the same with substance use disorders. More than half of patients who have been ordered by courts to participate in treatment drop out, and 60 percent use drugs within six months of discharge from a treatment program. Like diabetes and hypertension, substance use disorders require treatment and ongoing monitoring. An occasional relapse is part of the pathology.

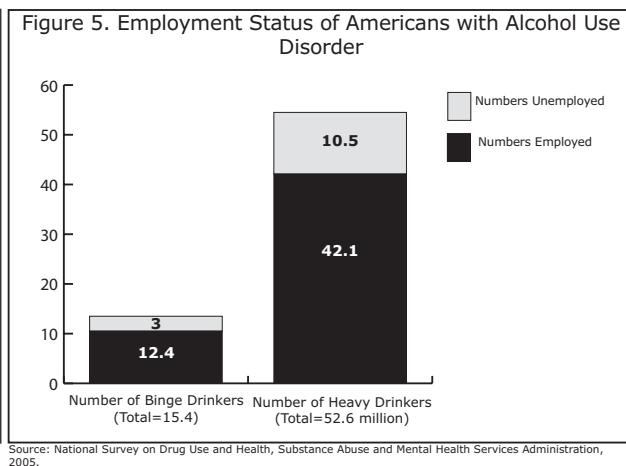
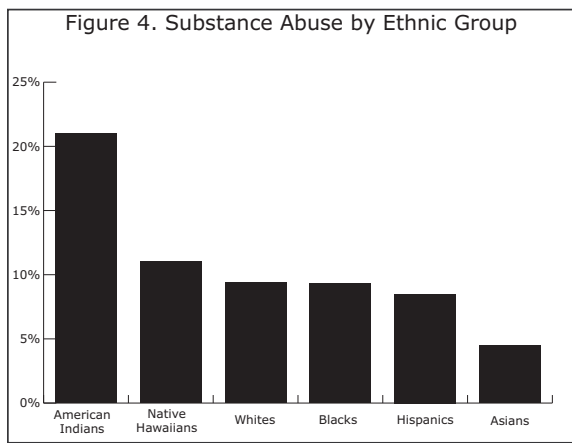
Researchers are testing programs under which addicts who undergo treatment are monitored by a substance abuse specialist who may, for example, telephone the patient regularly and send him or her back to outpatient treatment if a crisis appears imminent. Initial results are promising. Unfortunately, the only two widely available chronic care systems currently available for addicts are Narcotics Anonymous or Alcoholics Anonymous and methadone maintenance.

(The accepted Institute of Medicine terminology for alcohol and drug abuse and addiction is “substance use disorders,” which serves as an umbrella term for all levels of problematic substance use.)

Do rates of substance use disorders vary by ethnicity and employment status?

Rates of substance abuse and dependence are highest among American Indians and Alaska Natives (21 percent), followed by Native Hawaiians and other Pacific Islanders (11 percent). Whites, Hispanics and blacks have similar rates of addiction (9.4, 9.3 and 8.5 percent, respectively), while Asians (4.5 percent) report the lowest rates of addiction (see Figure 4).

Although documented rates of heavy alcohol and illicit drug use are highest for the unemployed, substance use is a problem that disproportionately affects working Americans. Of the 52.6 million adult binge drinkers in 2005, 42.1 million (80 percent) were employed either full- or part-time. Among the 15.4 million heavy drinkers age 18 or older, 12.5 million (80 percent) were employed (see Figure 5).




What is the relationship between mental illness and substance use disorders? What are the obstacles to treating co-occurring disorders?

Mental illness often is linked to substance abuse because people with mental illnesses often use alcohol and/or drugs to “self medicate.” An estimated 5.2 million people who have substance use disorders also have a mental illness. Eighty-nine percent of people with a co-occurring disorder developed a mental illness before they had a substance use disorder. On average, mental illness precedes a substance use disorder by six years. If people with mental illness are diagnosed and treated shortly after their symptoms begin, they are much less likely to self-medicate with alcohol and illicit drugs.

Historically, it has been difficult to coordinate services for these co-occurring disorders. Substance abuse and mental health systems generally operate independently of each other and have developed unique cultures, languages and jargon; administrative structures; and funding mechanisms.

For example, addiction is a major cause of homelessness. Of all homeless people, between 30 percent and 40 percent have alcohol problems, and another 10 percent to 20 percent have problems with other drugs.¹ Homelessness can intensify existing drug and alcohol problems and cause a return to substance abuse even after a long period of abstinence. Nevertheless, federal law denies some housing assistance programs—

such as the Section 8 program—to those who are involved with illegal drugs or are convicted of drug offenses.

A key challenge is ensuring that mental health and addiction professionals are cross-trained to understand their counterpart's system, establish similar standards to measure performance, and establish flexible funding streams to guarantee that funds are available for the right system at the right time. 

Who pays for substance use disorders treatment service? What Medicaid coverage exists?

Addiction treatment is subsidized by federal, state and local governments and is covered by private insurance. The most recent Substance Abuse and Mental Health Administration (SAMSHA) data indicate that \$18 billion was spent nationally on treatment for substance use disorders in 2001. The same data show that the majority of funding for substance use treatment expenditures came from the public sector (76 percent). The federal Substance Abuse Prevention and Treatment Block Grant provides states with approximately 40 percent of the funds that they spend on treatment and prevention. Many other grants are available from various federal agencies, ranging from the Centers for Medicare and Medicaid Services to the Department of Defense.

Medicaid, Medicare, TRICARE, supplemental security income (SSI) and social security disability insurance (SSDI) are entitlement programs that enable eligible recipients or states to receive income support maintenance and health care. All these programs have services that can be used for substance use treatment and services.

In 1996, President Clinton signed P.L. 104-121 ([The Contract With America Advancement Act](#)), eliminating addiction as a qualifying disability for SSI/SSDI. Benefits were terminated on Jan. 1, 1997, for individuals who were receiving benefits based on substance use disorders; costs were shifted to state and local programs.

Coverage of substance use treatment varies widely among private insurers. However, many states have laws that mandate coverage of some level of benefits for the treatment of substance use disorders. A small number of states require at least an offering of benefits, while others do not address the issue at all.

State Funding

State government is the largest single purchaser of treatment services for substance use disorders, with most states using block grants to make these purchases. Each state has made a single state agency responsible for the allocation and use of funds for substance use treatment. Funds from state government sources include, but are not limited to:

- State general fund revenues;
- Medicaid funds that are used for drug and alcohol treatment;
- Earmarked taxes;
- Seized assets, money or property that are derived from drug crimes and specifically appropriated for support of drug and alcohol treatment programs; and
- Fines, fees and/or assessments earmarked for drug and alcohol treatment.

Medicaid Coverage

Federal Medicaid guidelines require that states provide a core of basic services, including hospital inpatient and outpatient care; early and periodic screening, diagnosis and treatment of physical and mental illnesses

for individuals under age 21; rural health clinic services; physicians' services; and nurse-midwife services. Those with substance use disorders may qualify for treatment under some of these programs.

States may choose to cover “optional” services that are aimed specifically at treating substance use disorders in qualifying individuals. Examples are treatment and inpatient hospital care in mental institutions for those under age 21 and substance abuse treatment by psychologists, substance use counselors, and licensed social workers. 🏛️

What is insurance parity legislation?

Insurance parity legislation seeks to ensure that substance abuse and/or mental illnesses receive the same levels of coverage as physical health conditions. A federal law—the [Mental Health Parity Act](#) (MHPA) of 1996—required health plans that provide mental health coverage to provide those benefits at the same level as physical health coverage. The [World Health Organization](#) (WHO) and the [American Psychiatric Association](#) (APA) define substance abuse as mental illness, which lead some to assume the MHPA included substance abuse. As passed, however, the bill contained several provisions that allow insurers to maintain their benefit packages at prior levels and excluded substance abuse treatment benefits. Spurred by passage of the act, lawmakers in many states have sought or are seeking some form of parity between substance abuse and physical benefits in all health plans.

These legislators often encounter several arguments. The first contends that parity would inflate insurance premiums, which would lead to more people without insurance. The second argument is that many professional definitions of mental illness are too broad, particularly those in the APA's *Diagnostic and Statistical Manual* (DSM IV). According to critics, the DSM IV includes even such maladies as jet lag in its definition of mental illness.

Proponents of parity offer several answers to those arguments. A 1999 report from the Substance Abuse and Mental Health Services Administration, for example, estimated that the average yearly cost increase for insurance with full parity for substance abuse treatment would be \$5 per person. A 1994 study—[Evaluating Recovery Services: The California Drug and Alcohol Treatment & Assessment](#) (CALDATA)—found that every \$1 spent on treatment saved state taxpayers \$7 in future costs (emergency health care, imprisonment, court costs, etc.). Legislators in many states also have found success by tailoring definitions in the DSM IV and the WHO's *International Classification of Disease* manual to their state's unique needs.

Under these standards, only nine states to date—Connecticut, Indiana, Kentucky, Maine, Maryland, Minnesota, Oregon, Rhode Island, Vermont and Washington—have full parity for substance abuse. These laws require equality between substance abuse and physical care services across five categories:

- Scope of inpatient treatment;
- Scope of outpatient treatment;
- Scope of partial or residential treatment;
- Copayments and coinsurance; and
- Lifetime and annual dollar limits.

Two states—Idaho and North Carolina—offer substance abuse parity, but only in the state employees' health plan. 🏛️




Are prevention and treatment cost effective for states?

Substance abuse costs states billions of dollars each year, most of which goes to pay for criminal justice, Medicaid, mental health services and public safety. Prevention and treatment efforts seem to pay off. A 14-year longitudinal study² found that health plans reduced their costs for treating diagnosed alcoholics by 24 percent after initiating substance abuse treatment. Another [study](#)³ found that Medicaid participants who had been identified but not treated for substance abuse cost \$761 per month; treated participants cost only \$224.

A 2002 study⁴ examined giving residential treatment to pregnant women in Arkansas, compared to standard care in geographically proximate areas. The net economic benefits of treatment in this study (including medical and psychiatric problems, medical and psychiatric care, employment and days engaged in illegal activities) were substantial: \$17,143 in cost offsets for each individual who received specialty care and \$8,090 in cost offsets for those who received standard care.

Results of a [recent study in Washington](#) show that untreated chemically dependent supplemental security income (SSI) recipients had \$490 per month more Medicaid, medical mental health, and nursing home costs than did treated recipients—\$341 per month after adjusting for the cost of chemical dependency treatment.⁵

Another study demonstrated that, of the 534 patients discharged from a residential chemical dependency treatment program for people with co-occurring disorders (chemical dependency and mental illness), overall Medicaid-paid medical and psychiatric services decreased by 44 percent, from almost \$5 million in the year before treatment to \$2.8 million in the year after treatment.⁶

Effective substance abuse prevention efforts can pay major economic dividends. A study in the *Journal of Primary Prevention*—“Cost-Benefit Estimates in Prevention Research” by John D. Swisher, Ph.D., and his colleagues—finds that the savings per \$1 spent on substance abuse prevention can be substantial, ranging from \$2 to \$19.64, depending on how costs were calculated, outcomes included and the differences in methodologies.⁷ 

What are sentencing reform, diversion programs and drug courts?

Substance use disorders frequently lead to prison: drugs and alcohol are implicated in the crimes of 81 percent of state prison inmates.⁸ In addition to buying and selling illegal substances, many offenders have committed crimes while under the influence, stolen money or goods to buy drugs, driven drunk or under the influence, or have acted violently because of their addiction.

Prison overcrowding and recidivism have forced states to develop new means of alleviating growing pressures on the criminal justice system. So far, states have found that the three most effective methods to achieve these goals are sentencing reform, diversion programs and drug courts and diversion programs.

The theory is that mandatory treatment in lieu of (or in addition to) incarceration will reduce dependence on drugs and thus reduce drug-related crime. As the body of research supporting this notion has grown, so has the number of jurisdictions that use these approaches.

Sentencing reform developed because the lengthy incarcerations issued under mandatory minimum sentencing laws were overcrowding facilities and did not prevent recidivism. To reduce overcrowding and costs, some states revised, eliminated and enacted new sentencing guidelines and eliminated or revised



their punitive scoring systems. Sentencing reform provides states with immediate cost savings because as the population of inmates declines, the states need fewer facilities and prison services. Sentencing reforms alone do not sufficiently address the issue of recidivism, however. As a result, they are used in combination with diversion programs and drug courts.


Although similar in intent, diversion programs and drug courts differ. Many **diversion programs** offer offenders (generally those with no or few prior offenses) the option of waiving a jury trial and entering treatment instead. Each case is overseen by a case manager or probation officer, and noncompliance with program rules or failure to complete the program may result in a trial. However, the reward for successful completion of the program may be dismissal of the case.

Conversely, **drug courts** are programs with strong judicial oversight. In the drug court model, a trial judge supervises a defendant's case in conjunction with treatment professionals, probation officers, the prosecutor, the defense counsel, and law enforcement and educational/vocational professionals. Because the model is an alternative to incarceration, the judge has great flexibility to impose sentences for noncompliance with program rules or failure to complete the program.

The [Office of Justice Programs Drug Court Clearinghouse and Technical Assistance Project](#) (OJP) reported that, as of November 2006, 1,665 drug courts were active in the 50 states, the District of Columbia, Guam, Puerto Rico and one federal district court, with an additional 386 in the planning phase. The sharp increase in the number of active drug courts since 1989, when the first one opened in Dade County, Fla., is attributable to the model's success in controlling costs and reducing criminal behavior.

A [Columbia University study](#) estimated that, for every \$1 spent on drug courts, a jurisdiction realizes \$10 in savings. A comparison between the daily cost of drug courts and incarceration reveals similar results. The average daily cost of a drug court in 2001 ranged between \$8 and \$14, depending on services and level of supervision provided. Average daily incarceration costs in 2001 were approximately \$40 per day, excluding facility construction costs.

Research also finds that drug courts reduce recidivism. A December 2000 OJP study reported that three-quarters of drug court participants were incarcerated previously—nearly 225,000 of 300,000 participants. Drug courts retained more than 70 percent of all enrolled offenders, with a corresponding reduction in recidivism rates of up to 29 percent. Recidivism rates average 48 percent for the offender population who are not involved in drug courts.

Mandatory weekly drug testing in the drug court model shows that drug use decreases as length of time in the program increases. Overall benefits to the community include retaining or securing employment, retaining or obtaining custody of children, and an increase in births of infants who are drug-free. 

What barriers prevent people from entering treatment?

The stigma of addiction can be a substantial barrier for individuals who need treatment. Addicts may feel a sense of shame or humiliation at what they perceive as their own failing, and many may fear ostracism by family and friends.

One of the first barriers encountered by many addicts is the paucity of screenings for addiction. Few providers are trained to screen for addiction. In some cases, however, state law serves as a barrier to screening. Uniform accident and sickness policy provision laws (UPPL) allow insurers to deny claims

precipitated by drug- or alcohol-fueled mishaps. A UPPL discourages providers—through denial of claims and, thus, reimbursement—from screening patients for substance use disorders. In 2001, the National Association of Insurance Legislators advised the repeal of the UPPL. To date, Colorado, Connecticut, Indiana, Maryland, Nevada, North Carolina, Rhode Island and Washington have revised their statutes.

Following a criminal conviction for a drug offense, addicts may be denied access to a multitude of public assistance programs—education, housing and human services—that commonly are available to others who are seeking to recover and rebuild their lives.

The [Drug-Free Student Aid](#) provision of the federal [Higher Education Act of 1998](#) denies assistance to those who are convicted of drug offenses for a length of time determined by the number and type of convictions. Proven completion of an approved substance abuse treatment program can restore aid benefits, however.

As mentioned above, federal law denies housing assistance—such as the Section 8 program—to those who are involved with illegal drugs or are convicted of drug offenses. Housing agencies have limited flexibility to prevent eviction of tenants; as with education assistance, benefits can be restored only following completion of a treatment program. In addition, Section 115 of the welfare reform act ([the Personal Responsibility and Work Opportunity Reconciliation Act of 1996](#)), stipulates that those convicted of drug offenses are subject to a lifetime ban from cash assistance and food stamps.

Through Temporary Assistance for Needy Families, states have begun to break down some barriers to care. For example, some states are providing incentives to businesses that hire welfare recipients; this addresses a key issue mentioned by many addicts as a reason for not seeking treatment—a negative effect on employment. Nevertheless, a history of addiction is frequently, but tacitly, the reason that many are denied employment or further promotion and, occasionally, are fired. 🏛️

Notes

1. Tammy L. Anderson et al., “Welfare Reform and Housing: Assessing the Impact to Substance Abusers,” *Journal of Drug Issues* (Winter 2002): 265-294.
2. H. Holder and J. Blose, “The Reduction of Health Care Costs Associated with Alcoholism Treatment: a 14-year longitudinal study,” *Journal of Studies on Alcohol* 53, no. 4: 293-302.
3. Lowell Gerson et al., “Medical Care Use by Treated and Untreated Substance Abusing Medicaid Patients,” *Journal of Substance Abuse Treatment* 20, no. 2 (2001): 115-120.
4. M. French, et al., “Benefit-Cost Analysis of Addiction Treatment in Arkansas: Specialty and Standard Residential Programs for Pregnant and Parenting Women,” *Substance Abuse* 23, no. 1 (March 2002): 31-51.
5. Elizabeth Kohlenberg, David Mancuso and Daniel Nordlund, *Chemical Dependency Treatment for Disabled, Blind and Aged Clients: Alternative Health and Nursing Home Cost Offset Models* (Olympia, Wash.: Research and Data Analysis Division, Department of Social and Health Services, 2005).
6. Charles Maynard, Gary Cox, Antoinette Krupski and Ken Stark, “Utilization of Services for Mentally Ill Chemically Abusing Patients Discharged from Residential Treatment,” *The Journal of Behavioral Health Services & Research* 26 (1999): 219-228.
7. J.D. Swisher, J. Scherer, and K. Yin, “Cost-Benefit Estimates in Prevention Research,” *The Journal of Primary Prevention* 25, no. 2 (October 2004).
8. National Center on Addiction and Substance Abuse at Columbia University, *Behind Bars: Substance Abuse and America’s Prison Population* (New York: CASA, 1998), 2.



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Other Sources

The official government Web sites for information about substance use disorders:

- Center for Substance Abuse Treatment (CSAT), <http://csat.samhsa.gov>
- Center for Substance Abuse Prevention (CSAP), <http://prevention.samhsa.gov>
- National Institute on Drug Abuse (NIDA), www.nida.nih.gov
- National Institute on Alcohol Abuse and Alcoholism (NIAAA), www.niaaa.nih.gov
- Office of National Drug Control Policy (ONDCP), www.whitehousedrugpolicy.gov

Non-government organizations that address substance use disorders:

- Community Anti-Drug Coalitions of America (CADCA), www.cadca.org
- Join Together, www.jointogether.org
- National Association of State Alcohol and Drug Abuse Directors (NASADAD), www.nasadad.org
- State Associations of Addiction Services (SAAS), www.saasnet.org
- Treatment Alternatives for Safe Communities (TASC), www.tasc.org

Good sources for research studies about substance use disorders:

- American Society of Addiction Medicine (ASAM), www.asam.org
- Ensuring Solutions to Alcohol Problems, www.ensuringsolutions.org
- National Center on Addiction and Substance Abuse at Columbia University (CASA), www.casacolumbia.org
- Substance Abuse Policy Research Program, www.saprp.org
- Treatment Research Institute, www.tresearch.org

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