Drug Abuse and Healthcare Administration

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Background

The 2014 National Survey on Drug Use and Health found that roughly 27 million Americans aged 12 or older (10.2% of the population) were current users of one or more illicit drugs. An estimated 7.1 million of those illicit drug users (2.7% of the population) had a drug use disorder. In that same year, 4.1 million persons (1.5% of the population) received treatment for a problem related to the use of alcohol or illicit drugs.[1]

The Mental Health Parity and Addiction Equity Act of 2008 required large group health plans to offer financial requirements (such as co-pays, deductibles) and treatment limitations (such as limits on number of visits) for mental health and substance use disorder benefits that were no more restrictive than the limitations applied to medical/surgical benefits. With the passage of the Patient Protection and Affordable Care Act (ACA) in 2010, mental health and substance use disorder services were listed as an essential health benefit and became a component of all ACA-compliant individual and small-group health insurance policies and parity in coverage was required for all the essential health benefits, thus extending insurance coverage for treatment of substance use disorders to an additional 62 million Americans who previously lacked such coverage.

This large and growing number of patients entering various health care facilities to receive care for drug dependence, drug abuse, or drug-related problems is one reason why drug policy should be a subject of critical concern to the field of health care administration.

The aging of the "Baby Boom" generation is resulting in long-term care facilities and other providers of healthcare to the aged being increasingly faced with issues of drug use and abuse among their patients.[2] In addition, growing numbers of older Americans are making use of medical marijuana.[3] Thus, geriatric facilities are increasingly being faced with issues regarding drug abuse, recreational drug use, and medical use of marijuana or other illicit drugs.

"The US government's 'War on Drugs' has become a war on drug users -- a public moral crusade and law enforcement extravaganza that cordons off a rigid public policy from badly needed insights of medical and public health professionals who have spent a lifetime studying addiction, its causes and consequences." -- David C. Lewis, M.D. [4]

Drug Policy Shapes Treatment

Public policy on drugs can adopt a position of prohibition, restriction, discouragement, regulation, or even such positions as encouragement, subsidization, or mandate in regard to the production, distribution, or possession of a particular drug or group of drugs. For more than a century, US drug policy has been based on dichotomizing drugs into two groups: most drugs, which are to varying degrees regulated, and a limited (but growing) group of drugs for which the policy is one of prohibition. With few exceptions, it is a crime to produce, distribute, possess, or use these drugs.[5]

For many, the existing policy's dichotomy of drugs into good drugs (legal) versus bad drugs (illegal) leads naturally to an insistence on abstinence as the only acceptable goal of treatment for those who suffer from drug dependence or abuse. Given that abstinence-based treatments generally have a poor record of success,[6,7] this presents a serious problem for healthcare administrators dealing with drug abuse treatment in today's value based reimbursement environment.

While current national drug policy supports the predominance of the abstinence model for treatment and helps legitimize compulsory treatment, it also tends to result in alternative public health approaches such as harm reduction being suspect and devalued. For example, in the treatment of dependence on opioid drugs, such as heroin or Oxycontin(R), abstinence-based treatments have shown little success. Maintenance treatment, in which the drug of abuse is replaced with methadone or buprenorphine® under medical management, have shown far greater success at retaining patients in treatment, reducing or eliminating heroin use, encouraging employment, and lowering crime rates in the surrounding community. But such treatment has been controversial in the context of prohibitionist drug policy primarily because it does not involve abstinence from the prohibited class of narcotic drugs.[8]

Controlled drinking, or moderation management, has gained growing acceptance as a treatment approach for alcoholism in the US over the past twenty years, but a similar approach to illicit drug dependence has not shown any such gain in acceptance.[9] Heroin maintenance has been accepted practice, however, in the United Kingdom since the 1920s.[10] Today, a growing number of European nations are adopting heroin maintenance. Over the past two decades, clinical trials conducted in six different countries and involving more than 1,500 patients, provide strong evidence, both individually and collectively, in support of the efficacy of treatment with self-administered injectable heroin. [11]

Drug Policy Shapes Patient Care

In the word of Pauly, McCall, Parker, et al., "People who use, previously used or are presumed to use illicit drugs face challenges getting good health care and often have poorer health than the rest of the population. The stigma and criminalization associated with illicit drug use is increased for people living in poverty, impacting health and acting as a barrier to accessing care. Negative experiences in hospitals can lead people to avoid seeking care and, if admitted, to leave before their care is complete."[12]

The American Society for Addiction Medicine has addressed this in stating, "Due to the deeply-rooted stigma around the disease of addiction and misperceptions about treatment options, efficacy and availability, additional barriers to treatment like coverage limitations put an already undertreated and vulnerable patient population at even greater risk in the midst of the epidemic."[13]

The negative attitudes of many health care professionals toward illicit drug users have been well documented over a period of decades now.[14] McLaughlin, McKenna, and Leslie go so far as to say that "drug users are loathed and feared by health care staff."[15] While these negative attitudes may have many sources, it is not unlikely that they are rooted in the criminal status of the drug user that results from our national drug policy.

Drug Policy Shapes Treatment of Drug-Related Disorders

Drug policy also shapes the ways that people are treated for drug-related disorders such as HIV, Hepatitis C, and cognitive dysfunction and can have a major effect on the cost of treatment, affecting the bottom line that health care managers will have to deal with.

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