Addiction Treatment: Healthcare May Be Part of the Problem

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Problem Frame

Anxiety and mental health problems are common experiences shared by many, in fact, about 1 in 5 adults (roughly 47.6 million people) in the U.S. have been diagnosed with some form of mental illness, but less than half (43.3%) received treatment for their mental illness this past year (NAMI, 2019). The treatment gap that exists in the US is mirrored in the United Kingdom as well. In the UK, 1 in 6 adults were diagnosed with a mental health disorder as of 2014, but roughly only 38% of individuals with mental health problems reported receiving treatment (NHS, 2016). This disparity between those who need and those who actually complete treatment, known as the mental health treatment gap, is due to barriers created by societal stigmatization, lack of readily available resources, cost of service, unavailability of insurance coverage, lack of motivation, and mistrust of psychologists and other mental health professionals (Andrade et al., 2013). A class of mental illness in which this treatment disparity has the potential to cause serious harm and even death in the population of those suffering from it is substance use disorder (SUD). A significant, public portion of modern addiction is the addiction to opioids such as OxyContin and heroin. This “opioid crisis,” as it is referred to in its current state, has been fueled by the excessive marketing of OxyContin and the lies spread by Purdue Pharma regarding the efficacy and addictive nature of OxyContin. Because of the excessive and unprecedented marketing of OxyContin in the drug’s early days, doctors have overprescribed opioids to patients in pain, spinning the endless cycle that is the life of many addicts (Van Zee, 2009).

Addiction crises such as this have been widening the mental health treatment gap, but what we don’t know is how this problem is being treated, or mended. Addiction treatment is a factor that could be paramount in beginning to narrow the overall gap, but addiction has been

historically treated as a character issue, not a medical one. The United Kingdom and the United States have both been deeply affected by addiction crises such as the opioid crisis. Though addiction is similar in each country, the way that the healthcare systems are organized in each is vastly different. Analyzing this difference in regards to drug addiction and treatment could prove an important insight for either side if significant change is needed. I plan to outline the background of these addiction crises in the UK and the US and how each nation's healthcare systems handle the prevention of drug abuse, focusing on the treatment of those suffering from substance use disorder. In doing so, I hope to show how the differences in these countries provide both good and bad outcomes for addicts, in an attempt to provide better care for addicted patients.

Current State

The plight of the addict is similar in every setting, so the addicted population in both the US and UK can be assumed to be the same in terms of behavior. The agenda of the addict is one of two storylines: finding the next fix, or finding a way out. The latter is the vast minority here. Those who have found a way out and are in recovery are taking their lives one day at a time trying to stay sober, as well as trying to help those currently struggling in addiction (usually). Shifting the focus from those directly affected by addiction, we find individuals involved with healthcare, namely those in charge of major health insurance providers in the US and those involved with the NHS in the UK.

The group of healthcare providers is the key group here in terms of establishing a direct link between addicts and treatment, and it's also the one that is different in the case of the US and the UK. The UK has the universal National Health Service (NHS), while the US's health insurance system is mostly private and varies per organization. The NHS has historically been

underfunded and undersupplied, whether it be from a personnel or equipment standpoint. This has tended to result in some rundown hospitals, long waiting lists, and a shortage of specialists in just about every field. In short, the NHS is a system that is designed to have free, widely available programs that are focused on harm reduction, but a shortage of funding can sometimes hold it back (Light, 2003). To contrast, the US health insurance system is very well-funded, but its design seems to maximize inefficiency and inequity. The US relies on employers to offer health insurance coverage to employees and dependents, while government insurance programs are reserved for the elderly, disabled, and some of the poor (de Lew et al., 1992). This data may seem a bit outdated, but it still holds true today. In 2018, "private health insurance coverage continued to be more prevalent than public coverage, covering 67.3 percent of the population and 34.4 percent of the population, respectively. Of the subtypes of health insurance coverage, employer-based insurance remained the most common, covering 55.1 percent of the population for all or part of the calendar year" (Berchick et al., 2019). This same report shows that a majority of insured individuals with a disability received public coverage, and that over 94% of individuals aged 65 or more received public coverage, while only around 22% of individuals under 65 did (Berchick et. al , 2019). There is almost no coordination between private and public programs, and all programs differ in terms of benefits, financial sources, and payments to medical care providers. Some people have both public and private coverage, while others have none. However, those who are uninsured may still receive health care services through public clinics or hospitals, state and local programs, or even private providers who finance care through charity (de Lew et al., 1992). There is nothing universal when it comes to US healthcare, and this takes the same dilemmas that UK policymakers may face and muddles them even further for US policymakers. Not only must one now find balance between individuals and state, but there must

also be balance between individuals, state, and every health insurance provider that is relevant in said state.

These are the respective positions that each healthcare sector is in, and the agendas of each are assumed to be the same: help those in need of helping. However, when private companies are in the picture (US), the motivation to help may be mixed in with the motivations to make money, advance the company, advance one's own career, or do what one's boss or authority desires. As for the UK, the desire to help seems to be there, but the question remains, "Who can we help?" The structure of their healthcare system incurs massive wait times for services, especially for those seeking addiction treatment, so the agenda here may be best characterized as wanting to help, but strictly abiding by the queue. Once again, the discussion of health insurance services on the topic of addiction is paramount because these services are the primary "cure" for the disease known as addiction.

Addiction as a Disease

> "The silver lining of the opioid epidemic--if a silver lining can be found for a public health tragedy that has killed more people than the Iraq and Vietnam wars combined--is the medical profession is finally forced to contend with the problem of addiction. Our complicity through egregious opioid overprescribing, and the sheer scale of drug overdose deaths, has meant we can no longer turn a blind eye" (Lembke, 2018, n.p.).

A blind eye had been turned for nearly two hundred years, dating back to when we first saw evidence of the fight for the disease model of addiction in 1819. A man by the name of Dr. Benjamin Rush published an inquiry in which he argued that chronic drunkenness was a biological disease, a belief that was not well-received during its time. Most of Dr. Rush's colleagues still viewed addiction as a failure of morals; a sin (Lembke, 2018). For so long, the

view on excessive and problematic substance abuse stayed this way, leading to fear-based approaches to drug education. This approach has been proven to be ineffective and even counterproductive, creating a stigma towards people who use drugs, and this stigmatization has resulted in systemic discrimination against these individuals. Not only do young people experimenting with drugs already report feeling ostracized, they often experience barriers to accessing support and/or advice regarding their drug use (Meehan, 2017). In order to break these types of stigma, a change in our thinking was needed in the form of the disease model for addiction. The premise of this model is that drug addiction is a chronic disease, that results in the loss of control over the use of a substance due to the physiological and/or psychological reactions caused by the substance. This view began its ascent in the early 1970s and, over forty years later, is now the dominant model of thinking in regards to addiction (Wiens & Walker, 2014). In a recent study done in 2013, it was found that a majority of family physicians (92%) and psychiatrists (96%) agreed that addiction was either "somewhat" or "a lot" a disease. This mode of thinking is also backed by the National Institute on Drug Abuse (NIDA), who describe addiction as a "chronic, relapsing brain disease that is characterized by compulsive drug seeking and use" (Wiens & Walker, 2014, p.1). Also included in this thought model is the declaration that an addict no longer makes the conscious choice to use drugs, after a certain point, and that the desire to use drugs is out of their own control. As a recovering alcoholic/addict who has spent time with many other addicts, I tend to agree with this declaration, but one might ask, "What science backs these claims?"

There is a multitude of neuroscientific data showing structural and functional brain changes resulting from drug consumption, and such studies have demonstrated that drug addicts' brains have experienced physical changes in the regions associated with decision making,

judgement, learning, memory, and behavior control. The scientists conducting these studies point to these changes as a major cause of the compulsive behaviors associated with addiction (Wiens & Walker, 2014). The neurobiology behind these claims is strong, as drugs and alcohol have been proven to change the conventional motivations and reward processes that your brain's neural pathways are accustomed to (see Fig. 1). Conventional motivational items that can drive an individual to do or feel good, such as their career or a relationship, can quickly be replaced by

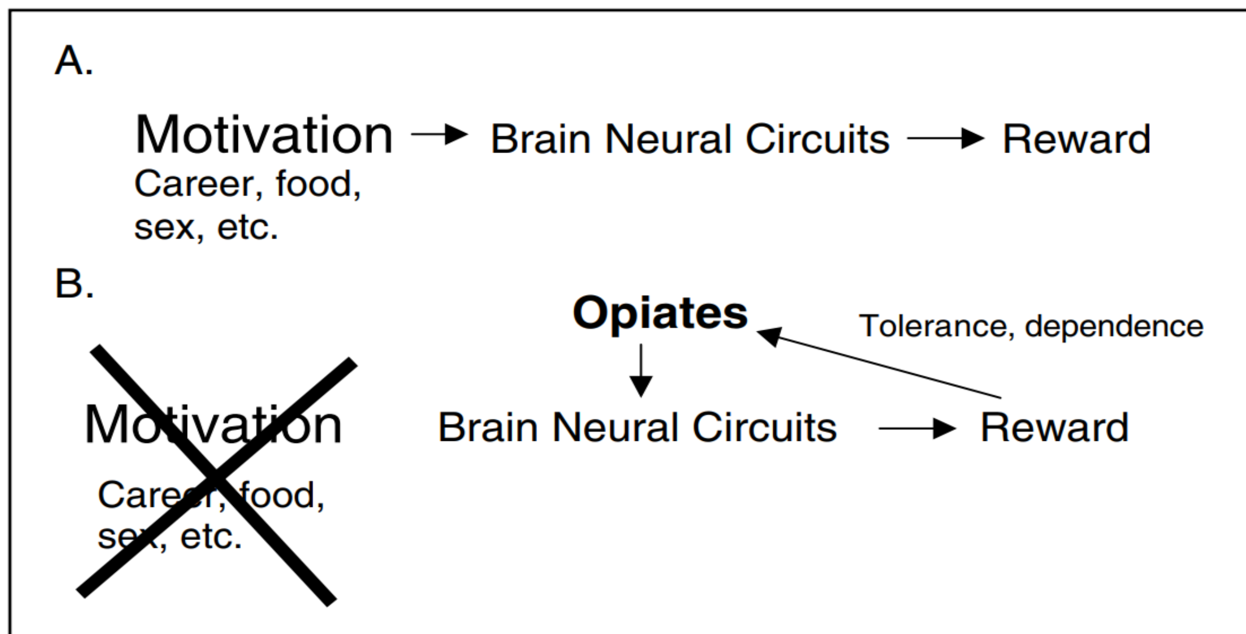

Figure 1. How addiction affects the brain. From "The neurobiology of pleasure, reward processes, addiction and their health implications," by T. Esch and G. Stefano, 2004, *Neuroendocrinology Letters*

the high they feel when taking drugs. If a drug is taken as "an escape", a "de-stressor", or in relation to any external factor of the like, then normal motivational stimuli are lost and, as use heightens and increases, the brain starts to become accustomed to this much quicker avenue to the feelings of reward. This "short-circuit," once created, is difficult to break, and tolerance and dependence tend to follow soon after (Ecsh & Stefano, 2004). Herein lie the core scientific principles of the disease model.

Not only does science agree with the disease model contention, but there are other *moral*

factors that need to be considered when addressing the thinking that addiction is a disease. Anna Lembke, medical director of addiction medicine at Stanford University, outlines three important reasons we must all shift our thinking to the disease model of addiction: 1) “The disease model of addiction is the model for our time. It destigmatizes, legitimizes, and opens the way to health insurance and research dollars” (Lembke, 2018, n.p.). 2) “We need a robust infrastructure within mainstream medical care, such that anyone struggling with a substance use disorder (SUD) can walk into any primary care clinic, maternity ward, or emergency department in the country; say, ‘I have addiction; will you help me?’; and hear a resounding, ‘Yes!’” (Lembke, 2018, n.p.). This works much better than sequestered care in a privatized facility. 3) “If we in the medical profession fail to take the lead in addressing what many have rightly likened to the modern-day plague, we will continue to perpetuate the problem” (Lembke, 2018, n.p,). It’s difficult to argue against both the scientific and moral reasoning behind the disease model, and so this is the model of thinking I shall approach my analysis with. The theory that addiction is a disease and that addicts are, in fact, patients will define the frame through which I will look in order to analyze avenues of addiction treatment in both the US and the UK. *Addicts are patients*, no different from those visiting the ER on a daily basis, and we must find a way to create a system that balances the efficacy of treatment centers in the US and the affordability of treatment in the UK, so that this growing health epidemic can potentially be slowed.

Generally, addiction treatment has three main steps: detoxification, rehabilitation, and continuing care. Detoxification is a short term medical procedure designed to stabilize the acute withdrawal effects someone experiences when quitting drug use. One can undergo effective detox without rehab and continuing care, but this is almost never associated with sustained abstinence. There is universal agreement that rehabilitation is necessary for true recovery.

Almost all rehabilitation centers offer detoxification upon arrival as the beginning part of their procedure and ongoing, holistic therapy, treating addiction as a chronic illness with multiple underlying causes. Most rehabilitation is done in residential treatment centers, with programs usually ranging from 30-90 days. Continuing care usually involves weekly or monthly group support meetings, involving free community programs such as Alcoholics Anonymous and/or Narcotics Anonymous (McLellan & McKay, 1998). For the sake of this paper, I will focus mainly on treatment that can be received with the aid of healthcare or health insurance funding, in which the focus is residential rehabilitation centers.

Treatment in a Privatized System (U.S.)

In regards to treating addiction in the US, there are three main avenues that health insurance offers aid with: admission into a treatment center, pharmacological substitutes, or addiction counseling on its own. As we know, there is a great divide between the number of those in need of treatment and the number of those who actually receive it, and the most commonly cited reason reported for foregoing treatment in a rehab facility was due to the inability to pay or lack of health insurance coverage (Foundations Recovery Network). This is not surprising when we take a deeper look at the population of individuals who reported suffering from a substance use disorder. The National Survey on Drug Use and Health (NSDUH), a nationwide report on the use of illicit drugs funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), separated those suffering from SUD into categories of employment (seen in Fig. 2). Of all occupations of individuals suffering from SUD,

those in the accommodations and food services industries accounted for nearly 17% of all cases.

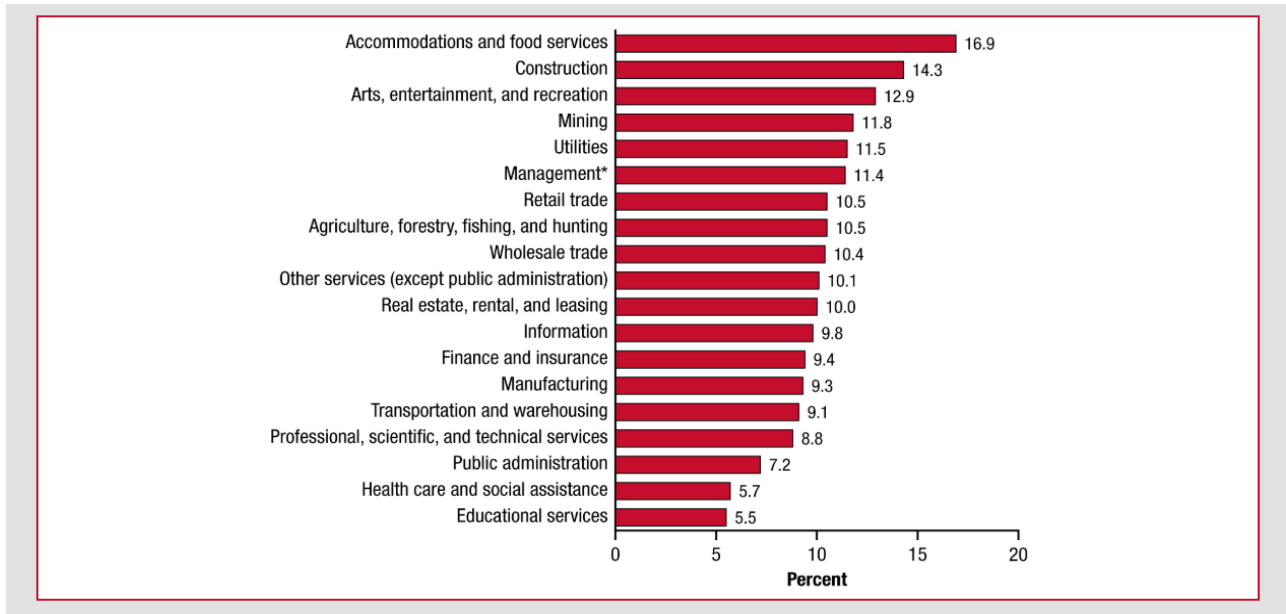

Figure 2: SUD among employed adults, ages 18-64, by industry (2008-12). From "Substance use and substance use disorder by industry," by Dr. D. Bush & Dr. R. Lipari, 2013, *Substance Use and Substance Use Disorder by Industry*

Not only do a majority of these professions not offer insurance to its employees, but these industries are some of the lowest-paying, in terms of yearly salary, in the country at an average well below the median wage of $32,420 (Business Insider, 2020). Furthermore, this study doesn't account for individuals who are unemployed and/or homeless. A statistic from CNN places the number of unemployed individuals suffering from SUD at about 17%, and SAMHSA reported that nearly 35% of homeless individuals in shelters have chronic substance abuse problems. The common denominator illuminated by these numbers is that there is a massive number of sick individuals who cannot afford to pay for adequate treatment on their own, or maybe even cannot afford treatment at all. In order to find out how health insurance may help these individuals, I went and got a quote myself from US United Healthcare.

US United Healthcare Insurance, ranked first in the US in terms of market value and amount of clientele (Forbes, 2014), offers a variety of insurance plans. In choosing to focus on the most prevalent health insurance provider, I tried to find out just how cheap their most available health

insurance plan is in terms of addiction treatment, taking all costs into account. The cheapest of these plans that offers addiction treatment is the Short Term Plus plan, with a monthly premium of $66.60 with a $10,000 deductible (the policy holder would have to pay this before the insurance begins their copay – worst option). This plan partially covers pharmaceuticals, paying for 70-80% of the cost; however, the policy holder must pay full price up front and submit a claim to United Health for later reimbursement. Mental and substance use disorders are covered at 20-30% after deductible as well, but there are caveats. Outpatient doctor visits are covered up to $50, and the maximum cumulative coverage over a single term (30-184 days) for any individual with a substance use disorder is $3,000. Naturally, the cheapest plans seem to be the worst in terms of addiction coverage. Lined up with the common prices of addiction treatment in the US, these benefits really don't help much at all. The cost of a 30-day program at an inpatient rehab center can range from $6,000 to $20,000. Thirty-day treatment programs can be extremely beneficial, but many addicts may require 60- or 90-day programs, which ups the cost range to $12,000-60,000 (Addiction Center, 2018). For those who need medication for SUD, the commonly used methadone might be deemed necessary, which usually runs at about a $4,700 yearly prescription (Addiction Center, 2018). As for therapy sessions, those are usually way out of the $50 price range. It's obvious that a $3,000 cap on all SUD benefits per term leaves a lot of leftover payment that the patient will be held responsible for, and for individuals in situations of homelessness, unemployment, and earning well below the median wage, making all of these hefty payments simply is not realistic. This leaves one of two options: find a low-income, non-profit rehabilitation center, or try and secure Medicaid funding. There are many requirements for Medicaid, which a lot of these individuals may not meet, such as being pregnant, elderly, disabled, a parent, or a child, *and* making less than 100-200% of the federal poverty level. As for

non-profit rehabilitation centers, they still cost money but provide payment assistance through Medicaid or other insurers. So "free" really isn't free in the sense that we want it to be. The amount of money required of these suffering individuals by the US's healthcare system is just another reason that makes addiction so hard to recover from today. This is something that universal healthcare should aim to fix, right? Well, the United Kingdom's system of universal healthcare may appear better than the US's, but it possesses some serious issues of its own.

Treatment in a Universal System (UK)

To help treat those suffering from SUD, the NHS offers free therapy sessions, pharmacological solutions, and even free admission into a treatment facility, but like the US, there are some major caveats that come with these services. The NHS programs treat addiction as a disease; however, they fail to recognize its true longevity. Addiction cannot be treated as a short-term issue because, once you begin recovery, the road doesn't stop until you're dead. The timeliness of the services the NHS provides do not take this account. In order to receive counseling, one must first meet with their general practitioner (GP) to get a referral for counseling sessions. A caveat here is that the counselor may not specialize in addiction treatment, and is more likely to have a background in only general counseling. A GP will usually refer someone for eight free sessions, and then they're on their own after that (Addiction Helper, 2020). These services are also very much in demand, and, with an undermanned and under-funded system such as the NHS, demand equates to long waiting times. In this case, a patient will likely have to wait another eight weeks before they are even seen. A lot can happen in eight weeks, such as a relapse or death by overdose. Another service a GP can refer a patient to are local drug and alcohol services, which provide holistic therapy, facilities where one can swap illegal drugs out for substitute prescriptions, and a key worker responsible for a group of

patients, who can come up with a plan and work with patients attempting to navigate a newly sober life. Once again, the service provides affordable options for those struggling with addiction, but availability can be hindered due to demand in the area, the services available in the area, and the subsequent wait list (Addiction Helper, 2020). As for inpatient treatment, it is much more difficult to obtain access to through the NHS. Free rehabilitation centers are only granted to the most severe and critical cases of drug and alcohol addiction, and one must apply through the government to obtain the large sum of money needed for individual treatment. The application process is very lengthy, and it takes a lot of work to obtain funding. If funding is approved, then you are placed on a waiting list, which can range from 6 months to a year, until you are able to select a rehab facility to enter (Addiction Helper, 2020). Once again, significant waiting time can create major problems for addicts, but if you can’t afford private treatment these are your options in the UK. There are many addicts that fit this profile in the UK, as more than 30% of substance abusers aren’t employed or employed part-time, and lower income jobs make up almost 40% of the addicted population (UKAT, 2018). The issue with private treatment centers are quite similar in the US and the UK – they are too expensive for a massive number of addicts. However, if the NHS had great funding and more professionals on staff, then their system would be second to none in terms of treatment. They offer all of the services that the US offers for free – they just aren’t always accessible.

Creating a Balanced System

The mental health treatment gap, namely that having to do with SUD, is quite prevalent in both societies, one with a privatized healthcare system and one with universal healthcare. There are many suffering individuals dying from the disease known as addiction, but they aren’t treated as patients. Rather, they feel stigmatization at every turn and don’t have access to the help

they so desperately need. Whether if health insurance is free or if it costs a monthly premium, the services needed to live in recovery from addiction are not accessible to a large amount of the population suffering from SUD. A solution in this case must involve a more balanced system between the two analyzed here. The US's system possesses the funding and staff expertise, but high costs tend to discriminate against many who seek help. On the other hand, the UK's healthcare system possesses all the affordable services without the resources to treat many individuals. A health insurance system that can offer all addiction treatment services at an affordable rate with the resources to make it immediately impactful is ideal; however, this concept may seem rather utopian and unattainable. Furthering this research should involve a deep dive into how the systems themselves function internally, in order to assess the possibility of this type of balanced system.

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