Op-ed/Editorial: Overcoming the U.S. Substance Use Treatment Crisis Requires a Focus on Issues of Equity

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Editor's note: This op-ed was written by Dr. Ben Cook, Director of the Health Equity Research Lab and the Center for Multicultural Mental Health Research at Cambridge Health Alliance. It is part of our Special Series on Disparities in the Experience and Treatment of Addiction.

From a policy and public health perspective, the U.S. health care system is failing individuals with substance use disorder. Many of us know family or friends that struggle with substance use, and this is backed up by 2014 statistics that show that 27 million people age 12 or older, or 10.2% of the population, had a substance use disorder in the past year. Numerous recent articles in major U.S. newspapers have turned the spotlight more specifically on opioid and heroin use, e.g., [1,2,3] announcing that heroin and prescription opioids "form an especially toxic mix,"[2] that the epidemic "increasingly seeps into public view,"[1] and that alarms should be sounded as "prescription drug abusers turn to heroin."[3] The recent statistics match the concern in the press. Heroin use has more than doubled over the last decade among adults age 18 to 25, and 45% of those using heroin were addicted to opioid pain medications.[4]

The opioid epidemic has hit low-income, non-Hispanic whites the hardest

Any discussion of how race and ethnicity intersects with this epidemic should include the fact that it is low-income, middle age non-Latino whites that are more likely to have negative outcomes of substance use disorders. A recent study[5] demonstrates how illicit substance and alcohol use underlies increased mortality rates among middle aged whites in the U.S., with increases in mortality for whites accounted for in large part by drug and alcohol poisonings, and chronic liver diseases and cirrhosis. This increase in mortality is an astonishing reversal of

trends, the only such reversal in mortality seen in decades in the U.S. Disparities by socioeconomic status play a large role, and more attention needs to be paid to the relationship between decreased employment opportunities, poor education infrastructure, the fraying of the safety net, and increased rates of addiction among the poor in the U.S. For those with a high school degree or less, deaths caused by drug and alcohol poisoning rose fourfold between 1999 and 2013, and deaths caused by liver disease and cirrhosis rose by 50 percent.

While the decrease in price and increase in availability of heroin and opioids has been a root cause of this epidemic, it is also the manifestation of the failure of the healthcare and substance use treatment systems to provide adequate prevention and treatment services. Astonishingly, only about 10% of individuals with substance use disorder have had any treatment.[6] This lack of treatment for those in need is unlike any other area of health care. By comparison, approximately 50% of those with a mental health disorder receive treatment, and the lack of treatment in this sector has been considered by advocates to be a crisis[7] and a system failure.[8]

Breaking the trend of increasing mortality among middle-aged whites requires devoting our full attention to improving substance use treatment and prevention. It also requires broader policies that increase economic opportunity and improve social services in poor communities in cities, towns and rural areas where the rates of use and the availability of opioids have spiked.

A review of the evidence on racial/ethnic differences in substance use disorder and treatment disparities

The epidemiology of substance use disorder demonstrates that the intersection of race and ethnicity and substance use still requires attention. In 2010, Native Americans continue to have drug-induced death rates similar to whites (17.1 per 100,000 for Native Americans compared to 16.6 per 100,000 for whites).[9] In 2013, Native Americans, Blacks, and Hispanics had similar or higher rates of substance use disorder than whites (7.4% among blacks, 8.4% among whites, 8.6% among Hispanics, and 14.9% among American Indians or Alaska Natives).[10] The burden of substance use disorder can be tragic and continues to cross racial and ethnic boundaries.

Two findings are of importance when evaluating racial/ethnic disparities in substance use treatment. First, after adjusting for involvement with criminal justice system, Blacks and Latinos are significantly less likely to access substance use treatment.[11] The criminal justice system is a main entry point for substance use treatment in the United States. Blacks' and Latinos' greater interaction with the criminal justice system under charges of substance use possession or disorderly conduct related to substance use, increases the likelihood that individuals from these minority groups are mandated to attend treatment sessions.[12] Such treatment is more likely to be perceived as coercive and dehumanizing,[13] and not the ideal system for improving access and quality of substance use treatment.

Second, once treatment is accessed, completion rates were especially low for blacks and Latinos in alcohol and drug treatment, and for Native Americans in alcohol treatment.[14] Improving training for providers in delivering culturally competent care, increasing the supply of bilingual and bicultural providers, increasing resources for language interpretation, and better integration of spiritual and cultural practices are all promising approaches to improve these disparities.[15]

Reducing disparities while keeping the epidemic from spreading

Unfortunately, the limited resources available to improve substance use treatment might require policymakers and budget allocators to treat addressing the opioid epidemic and disparities in treatment as an either-or proposition. This fact has not been lost on minority scholars that view the current emphasis on prevention, diversion, and treatment of substance users as unfairly ironic given the years of punitive measures and casting of substance use as a collective moral failure when the crisis was seen as largely situated in the minority neighborhoods of the inner city.[16-18] Those historical debates should not be cast aside as irrelevant but rather provide guidance to policymakers and system administrators as they decide with whom to intervene and how. Recently funded interventions that aim to improve prevention and treatment for lower income Americans could raise all boats, but need to be monitored for equity across racial/ethnic groups. A move to improving access to substance use treatment outside of the criminal justice system is urgently needed. The intersection of culture, class, societal values, and

substance use and treatment pervade our willingness to fund these initiatives and should continue to be examined.

Moving those in need into treatment

As with many families in the US, I have had experience with the difficulties of finding substance use treatment for loved ones. Getting them into treatment was made difficult, first and foremost by the fact that our loved ones did not believe that they needed treatment and did not want to quit. We were not alone. In 2013, there were 20.2 million individuals age 12 and above in the U.S. classified by structured diagnostic instruments as having a substance use disorder that received no care. Of this group, only 4.5% reported that they perceived a need for treatment. Even among those that did feel that they needed treatment, about 71% of them reported making no effort to get treatment.[6]

When one family member was finally ready to go to treatment, it was because she had hit rock bottom at work, with her family, and her physical health was failing. During that elusive window of opportunity, there were many obstacles to treatment. First, the options for treatment, even with insurance, were far and few between with long waiting lists. Treatment options covered by insurance were often in blighted, unsafe neighborhoods. Primary care referrals were needed. By the time she made it into inpatient care, she was so severe that half of the 30 days in the $30,000 out-of-pocket treatment facility was spent in detox. As with most others that enter treatment, relapse followed shortly after treatment completion.

This is one example of millions in our country where healthcare system and financial barriers make it nearly impossible to access treatment, even during those small windows where the person with the illness decides he or she is ready for treatment. Cultural factors further complicate the situation. Religious faith does not have a presence or may be at odds with the treatment center facilities. Relatives may be unsure of the effectiveness of Western treatment, and believe that we can pull ourselves up by our bootstraps – meanwhile, the addiction intensifies and the optimal times for prevention and outpatient treatment pass.

A bumpy road ahead

Resources continue to be directed towards ending the opioid epidemic and in slowing down the alarming trends in mortality invoked by substance use disorder. One major new policy is the Affordable Care Act which insures millions of

previously uninsured individuals with behavioral health disorders, and directs insurers and providers to provide substance use and mental health treatment at parity with physical health treatment. However, early studies suggest that insuring this population needs to be coupled with improved outreach strategies and increased provider supply. The ACA's young adult dependent provision enacted in 2010 improved rates of mental health treatment but had no impact on substance use treatment.[19] Our preliminary analyses of nationally representative data demonstrate that in 2014, the first year of Medicaid expansion in many states, and newly constructed insurance exchanges, there was likewise no improvement in rates of accessing substance use treatment.

More needs to be done to build engagement in substance use treatment, to de-stigmatize seeking treatment, to improve access to prevention outside of the criminal justice system, and to reduce obstacles to accessing urgently needed preventative and outpatient treatment. While reforming the substance use treatment system is daunting, there are models in other parts of the world. As just one example, the CAS network in Barcelona is part of a national network of outpatient substance use treatment centers in Spain that are open long hours in easily accessible locations, and have the near immediate ability to screen, refer, and treat individuals that walk in concerned about their escalating substance use. Closer to home, the police department in Gloucester, Massachusetts has implemented a policy whereby people who want help with opioid problems can come in and be referred to treatment by the police without fear of arrest or other legal ramifications. The success of these efforts suggest that policymakers should strive towards a greater balance in interventions, shifting resources from punitive supply-side, law enforcement interventions to developing a more accessible system of substance use treatment linked to employment, housing, and other social services.

The evidence shows that the hidden epidemic in the United States is growing and is likely to worsen given the infrastructure in place to help those with substance use disorder. Attention to overcoming the barriers that prevent access to prevention and outpatient treatment, and allocating resources to address the multiple familial, social, cultural and economic factors underlying treatment access and completion barriers will help us to move forward.

— Dr. Ben Cook

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