Drug Treatment and the Affordable Care Act

The president and CEO of Exponents on treating addiction as a chronic condition.

April 14, 2014 By Howard Josepher

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With the passage of the Affordable Care Act, Congress has provided us with a historic opportunity to reduce the demand for illegal drugs. The law requires health insurance companies, Medicaid and Medicare, to cover treatment for substance abuse disorders. It will make drug treatment more available than ever before. The U.S. government estimates that illicit drug use costs more than $193 billion annually in crime, health care and loss of income. More effective treatment will likely save money as well as lives. The question is, will greater availability of drug treatment bring more problematic drug users into treatment? If we build it, will they come?

President Obama's Office of National Drug Control Policy (ONDCP) estimates there are 23.1 million drug users in need of treatment; historically, only 10 percent of them ever access these services. Health insurance will eliminate one of the barriers. Others remain. For most addicts drug treatment is identified with the criminal justice system and viewed as a punishment. Admission of a drug or alcohol problem can also be humiliating and stigmatizing. It puts people at risk of being discriminated against in employment, housing, and health care. Moreover, the help being offered, whether voluntary or coerced, is a one-size-fits-all treatment. It requires abstinence prior to entering a program and abstinence while in the program. For the treatment to be considered successful, lifelong abstinence post-treatment is also necessary. The majority of drug users are unable to overcome these barriers. Only the most desperate or those coerced by the criminal justice system show up in our public programs.

There is also evidence that insurance by itself is not likely to change this. When Massachusetts enacted universal health care and increased appropriations for drug treatment by $60 million, enrollment in treatment services remained flat. Clearly, the overwhelming majority of those in need of drug treatment do not want the help we have been offering.

Bringing unengaged substance abusers into treatment will require us to think differently about addiction, its treatment and how one overcomes or recovers from it. We need to enlarge our all-or-

nothing abstinence approach and give those in need a choice in the kind of recovery available. Rather than demand they cease all substance use prior to treatment, we can create programs that are willing to meet addicts where they're at and work with them while they are still using drugs. Programs like this were developed at the height of the AIDS epidemic when it was urgent we engage addicts, even if they were unwilling to get off drugs. We offered them sterile syringes, HIV/AIDS education and, in some programs, coping and stress reduction skills to help them self-manage their many chronic health and mental health conditions.

I helped create a program like this 25 years ago at the height of the AIDS epidemic before effective medications for HIV/AIDS existed. At that time, tens of thousands of injecting drug users were showing up in our emergency rooms and hospitals with HIV and dying from AIDS. It was urgent we find ways to engage and help them. Aware of their reluctance to go into existing drug treatment programs, we created an approach that looked like a three-credit college course. It consisted of 24 classes that met three times a week over an eight-week span. It was our hope that seeing a clearly defined beginning, middle and end, a prospective participant would be more willing to commit. Abstinence was not a condition for participation in the program. We wanted our instructors to have similar backgrounds and life experience as our students. We strove to create a respectful, non-judgmental environment that would be welcoming to all and conducive to learning. We held our first class in a church basement on Manhattan's Lower East Side with seven participants who voluntarily showed up.

Twenty-five years later, this program called ARRIVE continues to play a significant role in our fight against AIDS and drug abuse. We just completed our 128th eight-week cycle of classes and there are more than 10,200 graduates. All attended voluntarily. This program put many on the path to recovery from addiction.

Taking advantage of the opportunity presented to us by the Affordable Care Act will require a willingness to learn this lesson and to create many programs based on the same principles as ARRIVE. As our drug laws become more moderate, treatment services must attract participants rather than rely on coercion by the criminal justice system. We need to treat addiction as a chronic condition. Treatment services must include self-management skills to prevent existing chronic conditions from deteriorating. We must engage and work with people, whether they want to stop using drugs or not. We need to recognize that lifelong sobriety is not the only way to overcome addiction and that successful recovery can include responsible use of some substances. If we make these changes, and create programs that make good sense to addicts they are likely to make constructive use of them and take full advantage of the Affordable Care Act.

Howard Josepher, LCSW, is founder, president and chief executive officer of Exponents, an organization dedicated to improving the quality of life of people affected by drug addiction. Having overcome his own addiction to heroin many years ago, he has been a long-term advocate for drug law reform. This article was originally published on The Huffington Post.

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