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ADDICTIVE DISORDERS

CURRENT DEVELOPMENTS[1]

SUMMARY

An examination of the national trends in drug use and abuse, including the use of heroin, crack and powder cocaine, marijuana, methamphetamine, Ecstasy and other club drugs, and synthetic opioids.

ARTICLE

National Trends in Drug Use

In 2000, Americans spent about $36 billion on cocaine, $10 billion on heroin, $5.4 billion on methamphetamine, $11 billion on marijuana, and $2.4 billion on other substances. During the latter part of the 1990s, Americans consumed about 270 metric tons of cocaine per year, down from over 300 metric tons earlier in the decade. Also during the latter part of the 1990s, Americans used close to 14 metric tons of heroin. Americans used nearly 1000 metric tons of marijuana and 20 tons of methamphetamine toward the end of the decade.

Many closely related factors determine the drug people take. Young people may be more likely to use illicit drugs; older people may take prescription pharmaceuticals. Women may be more likely to use tranquilizers. The sons of alcoholics are four times as likely to abuse alcohol as the sons of nonalcoholics. Orthodox Jews use alcohol in religious ceremonies and rarely develop alcoholism.

Drug abuse including the use of tobacco and alcohol has mushroomed into one of the greatest public health problems of all time. The health and social problems associated with drug abuse present complex difficulties for society as a whole, and for individual abusers and their families.

If you include the mood altering substances defined by the DSM IV, alcohol, tobacco, prescription and over-the-counter mood-altering drugs, and caffeine in the definition of drug use, virtually every American is a drug user (although not a drug abuser, and most do not suffer harmful effects).

In 2000, there were 601,563 drug-related Emergence Department (ED) admissions. Several of the less frequently mentioned major substances of abuse showed substantial increases from 1999 to 2000:

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- MDMA or Ecstasy (up 58%, from 2,850 to 4,511),
- PCP (48%, from 3,663 to 5,404)
- Amphetamines (37%, from 12,496 to 17,134), and
- Methamphetamine (29%, from 10,447 to 13,505)

Nature and extent of drug use including alcohol
Drug-Related Emergency Department (ED) Episodes:

- From January to June 2001 there were an estimated 308,368 drug-related ED episodes.
- In 2000, there were 601,563 drug-related ED episodes.
- From 1999 to 2000, there were significant increases in ED mentions of heroin (15%), amphetamines (37%), and methamphetamine (29%).
- Amount the major substances of abuse and the highest rates of ED episodes in 2000 occurred for:
  - Alcohol-in-combination (83 per 100,000 population),
  - Cocaine (71),
  - Marijuana (39), and
  - Heroin (38).
- Alcohol-In-Combination
  - Alcohol-in-combination was mentioned in 34 percent (204,510) of ED drug episodes in 2000 and remains the most common substance reported in drug-related ED visits.
- Cocaine, Marijuana, Heroin
  - Cocaine continues to be the most frequently mentioned illicit substance, present in 29 percent of ED episodes.
  - Almost a quarter of the cocaine episodes in 2000 (22%, 39,266) are attributed to “crack,” which showed no significant change since 1994.
  - Heroin episodes increased 15 percent (from 82,192 to 94,804) from 1999 to 2000; cocaine and marijuana episodes were stable.
- Other Trends:
  - There were no significant changes in any of the major substances of abuse from the first half of 2000 to the first half of 2001.
  - No significant changes from 1999 to 2000 were evident for:
    - GHB (4,969 episodes in 2000),
    - LSD (4,016),
    - Miscellaneous hallucinogens (1,849),
    - Inhalants (1,522), and
    - Ketamine (263).

How Many People use Illicit Drugs?

In calendar year 2000, an estimated 14.0 million Americans were current illicit drug users. This estimate represents 6.3 percent of the population 12 years old and older. Men continued to have a higher rate of current illicit drug use than women (7.7 percent vs. 5.0 percent) in 2000. However, the rates of nonmedical use of psychotherapeutic drugs (pain relievers, tranquilizers, stimulants, and sedatives) were similar for males (1.8 percent) and females (1.7 percent)

In 1998, approximately 5.1 million persons initiated the use of alcohol. The largest contributors to this rise are youths aged 12 to 17, who now constitute about 67 percent of total new users. In 1998, the number of new users among youth grew dramatically to 3.4 million,

while the users among young adults increased slightly to 1.2 million. The 3.4 million new users aged 2 to 17 represents about 15 percent of all youth in the nation.
What are the Patterns of illicit drug use?

People take illicit drugs mainly for the effects they produce. The effects may be mood change, excitement, relaxation, pleasure, analgesia, stimulation, or sedation. Some drugs are taken in the belief they enhance physical and mental performance.

In addition to altering moods many illicit drugs are taken for their mind-altering effects.

Drugs such as heroin have at best very limited legitimate medical purposes. Other drugs such as stimulants, sedatives, tranquilizers, and analgesics have distinct medical uses including sedation, weight control, and pain control, and they are available by prescription. Because of their mind-altering effects, such prescription-type psychotherapeutic drugs may be desired and obtained illegally or used illicitly.

Many drugs of abuse are sought for the euphoria they produce, but they are also used to produce other types of mind-altering effects. Some people take heroin to reduce pain, cocaine to produce excitement, marijuana to promote feelings of relaxation and intoxication, stimulants to increase alertness.

People take drugs for a variety of other reasons, some because their peer groups use drugs or because drug use is unconventional or rebellious.

More than 75 million persons in the U.S. household population have used illicit drugs. The prevalence of drug use is usually examined for the lifetime, past year, and past month.

Between 1999 and 2000, the rate of past month marijuana use among women aged 12 and older increased from 3.1 percent to 3.5 percent.

Among youth aged 12 and 13, the rate of past month illicit drug use declined from 3.9 percent in 1999 to 3.0 percent in 2000. This change was primarily the result of a significant drop in inhalant use (from 1.3 percent to 0.7 percent).

Characteristics of Drug-Related Deaths

In most metropolitan areas, men constituted more than half of all drug related deaths. Drug abuse deaths among adolescents and young adults were relatively rare. Decedents under age 25 accounted for fewer than 10 percent of all drug abuse deaths in about half of the major metropolitan areas. In contrast, decedents over the age of 45 accounted for more than one-third of all drug abuse deaths in 20 major cities, ranging as high as 50 percent in most cases. In 30 major cities, drug-induced (overdose) deaths accounted for more than half of all deaths reported to the Drug Abuse Warning Network (DAWN).

In the average metropolitan areas, 17 percent of all drug abuse deaths were ruled as suicides, while 53 percent were ruled accidental and 30 percent were due to undetermined or other causes. There was no single drug that accounted for the majority of suicide deaths, although cocaine (both alone and in combination with alcohol) tended to be mentioned most frequently in suicide cases.

Drug Combination Patterns

The most common drug combinations reported to DAWN were alcohol and cocaine; alcohol and heroin/morphine; cocaine and heroin/morphine; alcohol, cocaine, and heroin/morphine; heroin/morphine and other narcotic analgesics; alcohol, heroin/morphine, and other narcotic analgesics; and amphetamine and methamphetamine.

Major Drugs of Abuse

In nearly every major metropolitan area, heroin, cocaine, and alcohol (in combination with other drugs) were the 3 most frequently mentioned drugs in reported cases of death.

Other Drugs of Abuse

Marijuana was very often reported in combination with other substances. There were also a number of deaths associated with the abuse of prescription and over-the-counter drugs abuse deaths. Most were benzodiazepines or narcotic analgesics.

Heroin

In 2000, an estimated 130,000 Americans were current heroin users. This represents 0.1 percent of the population aged 12 and older.

There were an estimated 104,000 new users of heroin in 1999. Comparisons for youth and young adults show no statistically significant difference between the 1998 and 1999 numbers of new users. The number of new users among those aged 18 to 25 (53,000) was larger than the number among those aged 12 to 17 (34,000), as has been the historic pattern.

Heroin: The Drug

Law enforcement sources consider heroin to be widely available in most communities. Heroin availability remained stable between fall 2000 and spring 2001. Increased availability is reported in three sites: Portland (ME) in the Northeast; and Birmingham and Washington, DC, in the South. The availability of heroin in most major cities appears to remain the same and little evidence of declines in heroin use is reported.

White heroin appears to be the most common type of heroin in use. By contrast, most users describe this high-purity, snortable heroin as “not very available” or “not available”. Mexican black tar, a lower purity, injectable heroin, is ranked as a type of heroin and is more widely available in most cities.

According to law enforcement sources, street-level Colombian heroin purity ranges from as low as 7 percent in New Orleans too as high as 95 percent in Philadelphia. Typically, however, purity is at the higher end of that range. Street-level Mexican black tar heroin purity ranges from 14 to 58 percent.

A wide range of heroin adulterants are added to increase (“cut”) the amount of heroin and reduce the purity, but some adulterants can benign and some are also harmful. Various adulterants include, rat poison, powdered milk, baking soda, coffee creamer, quinine and sugar, baby powder, baking soda, baby laxatives and sugar.

The most commonly reported heroin street sales unit is 0.1 gram, which sells for as little as $4 to as much as $120 for Mexican black tar. Purity, sales quantity, and dealer competition all play a part in determining heroin price.

Heroin: The Users

The vast majority of users are individuals older than 30. However, younger adults (18-30 years) sometimes comprise substantial proportions of users in some cities.

Males are more likely than females to use heroin, at least among the largest user groups. Heroin users are most likely to be White. Whites and Blacks are equally in the southern portion of the nation while Hispanics are the predominant user groups in El Paso and Los Angeles.

How have heroin use patterns changed across the country?

- Increased snorting: While injecting still predominates, snorting has increased in several major cities. The stigma of abuse and or dependence is not associated with snorting due to the route of administration.
- Increased smoking: Smoking has increased in several cities, but injection remains the primary route of administration.
- Increased crack combinations: Speedballs containing heroin plus crack have increased in several major cities.
- Increased ecstasy use: Heroin combined with ecstasy has recently been reported in Memphis and Miami.

How is heroin impacting the health of users?

The impact of heroin use on acquired immunodeficiency syndrome (AIDS) and human immunodeficiency virus (HIV) seems to have stabilized. By contrast, cases of hepatitis C have increased among heroin users. This may be due to the fact that increased screening, awareness, and early detection are included in most treatment programs. Overdose cases have also increased due to the mixing of drugs.

Crack Cocaine

Crack cocaine is considered the most commonly used drug in most major cities. Crack is also considered as the drug with the most serious consequences.

How available is crack cocaine?

Crack cocaine appears to be widely available in most major communities. Crack tends to be sold in 0.1 and 0.2 gram rocks, which generally cost approximately $10 and $20, respectively. Gram prices tend to be approximately $100, but prices are as low as $24 in New York and as high as $250 in Honolulu.

How old are crack cocaine users?

The age groups will vary from city to city in which the age groups are most likely to use crack. Young adults are considered the primary user in most major cities.

Is there any gender differences in who uses crack?

In New York, females are the predominant crack users for that city. Females and males are evenly split among crack users in most major cities.

Is any racial/ethnic group more likely to use crack?

Blacks account for the largest proportion of crack users in 11 of 21 major cities in the country. Treatment sources report that crack users are generally found in the lower Socio-Economic Status (SES) groups.

Powder Cocaine

The highest number of users of cocaine (including crack) occurred in the late 1970s and early 1980s, when there was approximately 1.0 to 1.5 million new users each year. The total number of new users of cocaine rose to 882,000 in 1998. The total increased between 1991 and 1998 both for youths aged 12 to 17 and young adults ages 18 to 25; however, the number increased more for youths than for young adults. In 1998, the number of new cocaine users among youth had risen to 339,000. This represents a higher rate of increase and a higher absolute increase than for young adults, which rose from an estimated 284,000 new users to 444,000 during the same period.

The estimates of the number of cocaine users and age-specific rates for 1999 appear to be generally lower than the corresponding estimates for 1998. The average age of cocaine users in 1999 was 19.5 years.

A majority of cities report powder cocaine as the second most widely abused drug, while cities such as Denver and Memphis report powder cocaine as the drug with the most serious consequences, whether medically, legally, societally, or otherwise.

How available is powder cocaine across the country?

Powder cocaine is considered widely available in 18 of 21 major cities across the country. Powder cocaine availability has remained stable between the fall of 2000 and spring 2001.

What are powder cocaine prices and purity levels across the country?

Grams and “eightballs” (1/8 ounce) are the sales units most commonly reported by law enforcement. Grams range in price from a low of $28 in New York to a high of $150 in New Orleans, with $100 the most frequently reported price. Eightballs sell for as low as $80 in Seattle and as high as $400 in Memphis. Gram-level purity ranges from a low of 20 percent in Denver to a high of 90 percent in Detroit and Miami.

Are there any gender differences in who uses powder cocaine?

Males are more likely than females to use powder cocaine. Powder cocaine users resemble heroin users (who are more likely to be males) rather than crack users (who are equally likely to be males and females in many cities).

Is any racial/ethnic group more likely to use powder cocaine?

Powder cocaine users, compared with crack users, are more likely to be White. Black are the predominant group in Chicago. Hispanics, however, are considered the likeliest racial/ethnic group to use powder cocaine in El Paso and Miami.

What is the most common socioeconomic background of powder cocaine users?

Low and middle SES backgrounds are reported approximately equally. Powder cocaine users appear to come from all backgrounds.

Marijuana

More Americans used marijuana than either cocaine or heroin. During 1999, about 11.9 million Americans use marijuana or hashish at least once in the month.

The estimated annual number of new marijuana users has declined from 2.6 million in 1996 to about 2.0 million in 1999. Youth aged 12 to 17 have constituted about two-thirds of the new users of marijuana in recent years, with young adults aged 18 to 25 constituting most of the

remaining third. Rates of new use for both youth and young adults decreased between 1998 and 1999 (from 85.2 to 73.0, and from 44.1 to 31.7 respectively).

The average age of initiation of marijuana use in 1999 was 17.0 years. The average age of marijuana users has generally declined since 1965, during 1970-1991 it ranged from 17.4 to 19.2 years of age.

Nationally, law enforcement sources consider marijuana to be widely available in their communities. The most common variety of marijuana is locally produced commercial-grade marijuana, ranked as widely available in most major cities. Sinsemilla, or the seedless variety of marijuana, is to second most common variety of marijuana. Other types of marijuana include Mexican commercial-grade and hydroponically grown marijuana, which are both widely available in most major cities.

During the 1990s the average THC content of commercial grade marijuana increased from about 4 percent to about 5.5 percent. The THC content of Sinsemilla increased from about 8 percent to about 12 percent.

Marijuana prices were roughly $385 per ounce in the late 1980s. The prices jumped to closer to $500 per ounce during the 1990s.

Methamphetamine

How available is methamphetamine across the country?

Methamphetamine as somewhat or widely available in most communities and availability varies widely by region. The West is considered widely available to very available than most other regions in the country.

Between the fall of 2000 and spring 2001, prices remained relatively stable. Methamphetamine purity levels vary widely, ranging from 15-35 percent in Los angels to 90-95 percent in Memphis.

Ecstasy and other Club Drugs

Ecstasy, considered the Rave Generation's cocaine, has become more popular among teens, even though overall drug use remains steady. According to the 2001 Partnership Attitude Tracking Study (PATS) ecstasy use among young people jumped an additional 20 percent, and since 1999, teen ecstasy use has increased by 71 percent. Another study, Monitoring the Future National Survey, from the White House Office of National Drug Control Policy shows that lifetime use of ecstasy among 12th graders has doubled from 1996 to 2001. The changes in MDMA (or Ecstasy), Ketamine, and GHB mentions over the 7-year period 1994 to 2000 are very large in percentage terms, the result of very small numbers in the earliest years. Each of these drugs remain relatively infrequent in ED visits with no more than 2 mentions per 100,000 population in 2000. Substantial increase from 1999 to 2000 occurred with the drug MDMA or Ecstasy, up 58% from 2,850 to 4,511.

Although not currently considered the drug contributing to the most serious consequences in any city, ecstasy is reported as an emerging drug in most major cities across the Nation. Ecstasy remains the most available of club drug. GHB follows ecstasy as the most available club drug.

Synthetic Opioids

The category synthetic opioid includes a wide range of prescription pain medication, and the diversion and abuse of synthetic opiates, specifically OxyContin. Since the drug became available in 1996, there have been reports on the diversion and abuse of OxyContin.

Reports of crimes committed in order to obtain OxyContin (such as pharmaceutical burglaries, home invasions, and prescription fraud) and negative health consequences (including deaths, overdoses requiring emergency department visits, and addiction requiring treatment) increased through 2000 and 2001. Although the nonmedical use of OxyContin was rare in 2000, the most recent (2000) National Household Survey on Drug Abuse (NHSDA) shows a significant increase ($p<0.01$) in the number and percentage of lifetime nonmedical use of OxyContin since 1999.

Finally, the most recent data from emergency department mentions of the synthetic opiate, oxycodone, which includes OxyContin, Percocer, Percodan, and Tylox, increased 68 percent (from 6,429 to 10,825) between 1999 and 2000, according to the Drug Abuse Warning Network (DAWN).

Males are the predominant OxyContin abusers, or they are evenly split between the genders. Whites are the predominant OxyContin abusers and are overrepresented compared with the general population. Most OxyContin abusers are of low or middle SES.

The costs of illegal drug use

According to the Office of National Drug Control Policy. Federal spending on drug control programs has increased from $1.5 billion in fiscal year 1981 to $18.8 billion in fiscal year 2002. In 1998 States spend conservatively $81.3 billion dollars on substance abuse and addiction. – 13.1 percent of the $620 billion in total State spending.

According the National Criminal Justice Reference Service, incarceration of drug-using offenders costs between $20,000 and $50,000 per person per year. The capital costs of building a prison cell can be as much as $80,000. In contrast, a comprehensive drug court system typically costs less than $2,500 annually for each offender (National Association of Drug Court Professionals).

Drugs and the Justice System

In 1999, drug offenders accounted for 21% of the State prison population and 61% of the Federal prison population (Prisoners in 2000).

Drug use is reported to be substantially reduced among defendants while they are participating in drug court programs. For most participants who graduate from the programs (ranging from 50% to 65%), drug use is eliminated altogether. (Summary Assessment of the Drug Court Experience).

Juvenile courts have changed their approach to drug cases. Traditionally, juvenile justice was oriented toward rehabilitating juvenile offenders. In many States, the trend has shifted toward holding juveniles accountable for their actions.

In 1990, more than 200,000 men and women were serving time for drug offenses in local, State, and Federal correctional facilities on an average day. About 8% of the juveniles in custody in 1989 were detained or committed for drug offenses.

Sentencing and sanctions

There were almost 1.1 million arrests for drug abuse violations in 1990. Two-thirds of the drug abuse violation arrests in 1990 by State and local agencies were for possession. Breakdown for drug possession was 33% for heroin or cocaine possession, 24% for marijuana possession, and 21% for heroin or cocaine manufacture or sale.

In terms of the number of arrests for specific offenses, drug abuse violations rank third behind driving under the influence and larceny. The proportion of total arrests made up by drug abuse violations has been increasing drug abuse violations made up 6% of all arrests in 1980 compared to 8% in 1990.

Since 1987, States have increased drug law violation penalties. States have increased penalties for some possession offenses, basic manufacturing, delivery, and sale offenses. Other States have added new provisions for drug sales near schools, and greater penalties for targeted drugs. Juvenile drug law violators are starting to be treated more severely. From 1988 to 1997, the number of juvenile drug violation cases increased 125%. (Juvenile Court Statistics, 1997).

Drug offenders are a growing proportion of the sentenced inmate population. Between 1984 and 1999, the number of defendants charged with a drug offense in Federal courts increased from 11,854 to 29,306. (Federal Drug Offenders, 1999 with Trends, 1984-99). An estimated 61, 000 (16%) of convicted jail inmates committed their offenses to get money for drugs. (Drug Use, Testing, and Treatment in Jails, 2000). In addiction, courts are giving drug offenders longer prison sentences. For Federal drug offenders, the average sentence to prison increased by 59% between 1980 and 1989.

Getting tough on drugs has had the inevitable consequence of getting soft on nondrug crimes. Researchers estimate that more than 50% of defendants convicted of a drug possession will recidivate within 2 to 3 years. Recidivism among all drug court participants has ranged from 5 to 28% and less than 4% for drug court graduated. (Looking at a Decade of Drug Courts, 1999).

Current Drug Treatment Programs

How effective are treatment programs?

The goal of treatment is to return the individual to productive functioning in the family, workplace, and community. Overall, treatment of addiction is as successful as treatment of other chronic diseases, such as diabetes, hypertension, and asthma.

According the several studies, drug treatment reduces drug use by 40 to 60 percent and significantly decreases criminal activity during and after treatment.

Research shows that drug addiction treatment reduces the risk of HIV infection and that interventions to prevent HIV are much less costly than treatment of HIV-related illnesses. Treatment can improve the prospects for employment, with gains of up to 40 percent after treatment.

Individual treatment outcomes depend on the extent and nature of the patient's presenting problems, the appropriateness of the treatment components and related services

used to address those problems, and the degree of active engagement of the patient in the treatment process.

Successful outcomes may require more than one treatment experience. Many addicted individuals have multiple episodes of treatment, often with a cumulative impact. (Principles of Drug Addiction)

Major therapeutic interventions provided by drug treatment programs include individual counseling, group counseling, urine surveillance and referral to a support group.

Many police agencies are trying to reduce demand for drugs by preventing drug use. Drug Abuse Resistance Education (DARE) is an example of the type of programs used by local police departments and schools. Police officers teach classes on resisting drug use for students primarily in the fifth and sixth grades. These classes are likewise available to teachers and parents and participation is strongly encouraged.

Conclusion

What can we expect from substance abuse treatment?

Expectations for substance abuse treatment often clash with reality. Many people, including drug users themselves, have mistaken beliefs about drug addiction and recovery from addiction. Expectations are high. Notions that continued drug use is voluntary and that a person's inability to overcome addiction stems solely from character flaws or lack of willpower. Society has differing standards of success for treating chronic conditions such as nicotine or alcohol addictions than for treating addiction to injection drugs. Little stigma is attached to a relapse to smoking. The public also has a more evolved understanding of alcoholism as a disease and more realistic expectations about the success of treatment. The potential for relapse after treatment for alcoholism is generally recognized and accepted. In contrast, societal reactions when a person relapses to injection drug use are usually highly negative.

Reality does not often meet these expectations. Studies have shown that it is very hard for injection drug users (IDUs) and others addicted to drugs like cocaine to quit on their own. Research has also shown that relapse to drug use is common and that it is difficult for IUDs and those addicted to other drugs to attain a permanent drug-free state, even after treatment. Many people with addition problems also have mental health disorders and this makes recovery even more difficult.

What are some realistic expectations for substance abuse treatment?

Research has shown that comprehensive and sustained substance abuse treatment can help individuals reduce or stop illegal or dangerous drugs, thereby greatly improving their functioning in the family, at work, and in society and is as effective as the treatments for other chronic conditions, including diabetes and asthma. Research has also demonstrated that a variety of effective approaches to substance abuse treatment exist that can help people achieve long-term control. This control allows people to reach important goals, including reduced drug use, reduced criminal activity, gainful employment, and more stable life situations.

Key components to successful substance abuse treatment should include readily available treatment to individuals who need services. Individuals need to be engaged in treatment for an adequate length of time. Treatment for many chronic conditions involves daily decisions about issues such as diet, exercise, or medication. Addiction often occurs simultaneously with other physical or mental health problems. The treatment plan should

address these conditions in an integrated manner. Treatment programs work better if they are tailored to the person's characteristics and needs. No single type of treatment is appropriate for everyone, and treatment must be reassessed periodically so it can be adjusted as needed. Big gaps exist between the need for treatment and availability of services. A large gap exists between the number of people who want or could benefit from substance abuse treatment and the number of people who actually receive services. The Office of National Drug Control Policy's national Drug Control Strategy 2001 states that about five million drug users needed immediate treatment in 1998, while only 2.1 million received it. The National Center on Addiction and Substance Abuse at Columbia University (CASA) estimates that more than 800,000 people in the criminal justice system would benefit from substance abuse treatment, but fewer than 150,000 receive treatment due to negative attitudes and limited understanding which, unfortunately, gives substance abuse treatment a low priority. A greater emphasis is placed on criminal sanctions for drug use, which leads to a surge in the number of people in prisons and jails. Community resistance to substance abuse treatment facilities and programs in the justice system is on the rise due to the belief that they contribute to increased crime, which attracts undesirable groups of people, and encourage the drug trade.

Substance abuse treatment's low priority is reflected in limited insurance coverage. Despite that fact that managing addiction is similar to managing other chronic diseases, most employers providing health insurance policies place greater burdens on patients of substance abuse treatment programs in terms of cost sharing, co payments, and deductibles. At the same time, many plans provide less coverage for the number of visits or days of coverage and annual dollar expenditures for treatment. Many health insurance companies have lower lifetime limits on amounts that can be spent on drug and alcohol treatment than on other illnesses.

Public and private funding for substance abuse treatment is far less than what is needed. Limited funding is an important reason why the availability of substance abuse treatment is restricted. An analysis report on the impact of substance abuse on state budgets published in 2001 by CASA showed that of every dollar a state spent on substance abuse and addiction, 96 cents went toward dealing with the consequences and only 4 cents was used for prevention and treatment. As substance abuse treatment increasingly comes under managed care, resources are being more tightly controlled. This has resulted in decreases in the types, duration, and intensity of services provided and a decline in essential complementary services, such as psychological counseling and help with medical, legal, financial, and employment issues.

Substance abuse treatment has historically operated outside the health care mainstream. Substance abuse treatment facilities and programs have evolved separately for several reasons. Many programs have been created by individuals who have overcome their own addiction and gone on to build support systems to help others.

Lastly, lack of insurance coverage for treatment, stigma attached to substance abuse and addicted individuals, and insufficiency trained physicians and mental health therapists having expertise in substance abuse issues also contribute to the isolation of substance abuse treatment from other health care and mental health services.

SUGGESTED ADDITIONAL READING

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