



ASAM

American Society of Addiction Medicine

Public Policy Statement on Core Benefit for Primary Care and Specialty Treatment and Prevention of Alcohol, Nicotine and Other Drug Abuse and Dependence

PREFACE

Statement of the Problem:

Alcohol, nicotine and other drug dependencies are widespread primary chronic diseases [1,2,3,4]. A study of nearly 20,000 adult Americans in the general public, found a 13.5% lifetime prevalence of alcohol abuse or dependence, and a 6.1% lifetime prevalence of other drug abuse or dependence, exclusive of nicotine [5]. The prevalence rates of substance use disorders for children are also significant. Additionally, about 17% of American adults are dependent on the nicotine in tobacco [6]. Alcoholism is associated with 25% of all general hospital admissions [7] and alcohol abuse and dependence cause an estimated 100,000 deaths annually. Smoking of tobacco is responsible for 434,000 deaths per year [8].

The health costs, exclusive of tobacco costs, are estimated at \$140 billion per year [9]. Substance use disorders lead to a wide variety of long term disabling diseases such as hepatic cirrhosis, cancer, cardiovascular diseases, cerebral atrophy, and fetal alcohol syndrome, and to an increased incidence of HIV/AIDS and antibiotic resistant tuberculosis. In society as a whole, substance use disorders also adversely affect family members [10], increase absenteeism and poor job and school performance, and are associated with crime, violence and accidents.

Cost Benefits of Treatment:

The cost benefit of treatment has been demonstrated [11,12,13]. Studies also demonstrate cost offsets for alcoholism treatment within the healthcare system [14,15], including a 1993 report [16]. Additional cost offsets are produced by decreased vehicle crashes, family violence, work and school absenteeism, and industrial accidents [17].

Objective Basis for Determining Need, Level and Continuum of Care:

The need for and level of treatment must be a clinical judgment based on objective guidelines derived from research literature and clinical consensus such as the guidelines in the *ASAM Patient Placement Criteria For The Treatment of Substance-Related Disorders: Second Edition (ASAM PPC-2)* [18]. The goals of objective criteria are to match intensity of service to severity of illness in a continuum of care, prescribe a treatment level that can accomplish the objectives safely, and provide a framework in which clinical outcomes and cost benefit may be assessed. These goals and concepts have been widely accepted. The *ASAM PPC-2* contains separate criteria for adults and children.

Principles:

Alcohol, nicotine, and other drug dependencies are primary diseases which produce serious secondary physical and psychiatric complications. Principles that govern the development and implementation of the Core Benefit are:

- A. Primary care and specialty treatment for substance use disorders should be specifically included in any basic health benefit, rather than be subsumed under some other category, such as mental health.
- B. Coverage should include a continuum of primary care and specialty services that provide effective treatment for substance use disorders.
- C. Provision should be made for simultaneous treatment of substance use disorders and their physical and psychiatric comorbidity, wherever indicated.
- D. Ongoing treatment evaluation, case management, cost benefit and outcome studies should be an integral part of the ongoing evaluation of all substance use disorder services.
- E. Eligibility should be based on competent diagnosis of substance use disorders by use of objective criteria such as the DSM IV or ICD 10, and on medical necessity.
- F. Patient placement should be based on objective criteria with quality of care assured by appropriate review.
- G. Where specialized substance use disorder services are provided, these services must be linked to the rest of the health care system.
- H. Medicine must work closely with other professional providers and self-help groups, and all must avail themselves of the broad network of community services to address the long-term vocational, education, and other needs of people with substance use disorders.
- I. Linkage between medical institutions and nonmedical rehabilitative services should be assured by requiring such institutions to be licensed and accredited (e.g., state licensing boards, JCAHO and CARF).
- J. Coverage for alcohol, nicotine and other drug dependencies should be nondiscriminatory on the same basis as any other medical care.
- K. Caps or limits on numbers of treatment visits, days or payments should be applied in the same manner as with any chronic disease.
- L. Treatment should be financed from the same source as any other primary disease. Additional revenue could come from taxes on alcohol and tobacco products, but the budget for substance use disorder treatment should not be contingent on sales of these products.

CORE BENEFIT

The Core Benefit is a statement of the minimum services that must be available to an individual and his/her family. The Benefit is:

1. *Prevention through Patient Education:*

- on the harmful effects of the use of alcohol, tobacco, and other drugs
- on the risk factors for the development of drug dependency.

These services are offered to patients and their families in a health care setting and are analogous to dietary and exercise counseling for patients at risk for myocardial infarction or diabetes mellitus.

2. *Assessment and Treatment:*

- history
- physical examination
- mental status examination
- screening and diagnosis
- provision of treatment as is required of any chronic disease.
- management of acute exacerbations and relapse
- detoxification at appropriate levels of care

SCOPE OF BENEFIT

Treatment should be provided in the most appropriate and cost beneficial setting. Inpatient treatment should be used when justified by illness severity; e.g., when the illness meets the criteria for Level III or IV placement according to the *ASAM Patient Placement Criteria for the Treatment of Substance-Related Disorders: Second Edition (ASAM PPC-2)*.

When significant social problems are the major factor determining the need for inpatient care, such care would preferably take place in residential settings, with appropriate cost sharing between the health care and social service systems.

Patients with physical or psychiatric comorbidity may need additional care or consultation from other disciplines. Some patients with severe physical or psychiatric comorbidity may require treatment in or referral to appropriate settings.

Linkages among all service systems should be maintained and monitored.

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