# Public Policy Statement on Government Strategies to Foster Ethical Addiction Treatment

## Introduction

America is at a crossroads with confronting addiction, which is one of the most prevalent medical conditions in the country, and poses socially and politically complex policy challenges.[1] While almost one in five individuals had a substance use disorder (SUD) in 2022, on a lifetime basis, nearly one in three Americans meets criteria for alcohol use disorder, making alcohol a major underprioritized and costly public health problem.[1–3] The prevalence of high potency synthetic substances, including opioids, in unregulated drug markets has caused unrivaled overdose deaths,[4] while solutions remain elusive. Simultaneously, billions of dollars are beginning to flow into American communities from opioid litigation settlements, but risk becoming an opportunity squandered, if not spent wisely.[5,6]

The practice of medicine is buoyed by the four pillars of medical ethics – patient autonomy, nonmaleficence, beneficence, and justice.[7] Codes of ethics assist clinicians with the complex ethical dilemmas that arise in the practice of medicine.[8] While ASAM has adopted the *Principles of Medical Ethics* of the American Medical Association, with annotations delineating the ethical responsibilities unique to the practice of addiction medicine, addiction medicine clinicians practice in environments where powerful economic, political, social, and other drivers can undermine ethical principles, fostering instances of fraudulent and abusive business practices, racial bias in services and disparate access to care,[9] coercive strategies causing harm,[10] excessive and unfair profit-seeking (or profiteering), and subquality approaches in addiction treatment.[8,11,12]

Well-recognized factors hindering ethical addiction treatment like stigma and discrimination, underfunding, and 'siloed' systems of care have also created substantial difficulties in measuring – and thus, verifying – the quality of addiction care.[13] Addiction treatment has historically been relegated to operating outside general medical care, receiving scant attention to its regulation, delivery, coverage, or outcome measurement.[14] Therefore, despite efforts to define addiction in medical terms and employ rigorous scientific methods for improving its medical treatment, significant challenges remain in finding quality addiction care. This has immense consequences for individuals with addiction, who have a shorter life expectancy than compared to those without addiction.[15]

Historically, the politics around addiction have devalued its medical treatment,[16–18] resulting in common paternalistic and moralistic treatment methods that would be unconventional anywhere else in medical care.[19] This has been justified through the state's authority to protect those who are vulnerable (*parens patriae*) and public health and safety (police power).[20,21] The ethics of medicine and public health, however, call for upholding the individual patient-clinician

relationship, informed consent,[22] and addressing social determinants of health.[10,20,22] Thus, ASAM urges policymakers to prioritize policies that foster quality addiction treatment and enact long-term government strategies to address persistent unethical practices.

## Background

### *Instances of fraudulent and abusive business practices involving addiction treatment*

While instances of fraudulent and abusive practices are not unique to the field of addiction medicine, seeking addiction treatment is often under emergency circumstances, making individuals with addiction particularly vulnerable to fraudulent and abusive business practices. These practices include call center employees obtaining personal information patients submit online and brokering it to the highest bidding treatment provider.[23,24] Internet search engines have taken steps to block related online tactics, including partnering with a monitoring and certification firm.[25–28] Patients also may be enticed to enter, stay, or switch addiction treatment programs with payments or gifts.[24] Perhaps most egregiously, addiction services may be provided in exchange for sex or labor, which is commonly known as human trafficking.[24,29,30] In response, governments have passed laws banning such practices and implemented voluntary sober home licensure and certification programs to help eliminate patient brokering and human trafficking in connection with addiction treatment.[31–35]

Some addiction treatment programs may file false or fraudulent insurance claims for services not rendered, and these practices have increased in conjunction with the expansion of health insurance coverage of addiction treatment benefits.[36–38] The U.S. Department of Justice Criminal Division launched the Sober Homes Initiative[31] that has targeted almost $1 billion in allegedly false and fraudulent claims in connection with addiction treatment facilities or sober homes in its first two years.[39,40]

### *The role of coercion in addiction treatment*

Addiction[41] affects behaviors and decision-making, but does not make individuals with addiction wholly incapable of making decisions about their treatment.[42] Nevertheless, coercive strategies that consist of legal, formal, and informal "social controls"* aimed at causing a person to take a prescribed action through the use of force or threats, rely on an assumption that addiction undermines individuals' autonomy and capability to make well-reasoned decisions.[10,42] These types of coercive strategies often accompany addiction treatment or make participation in it contingent on compliance.[10,43,44] Others contend that such coercive strategies can sometimes be effective nonetheless, or are justified by the ethical principle of beneficience.[45,46] The assumed efficacy of social controls involving force or threats is woven throughout the fabric of addiction treatment, including related social services programs, as well as legislative practices.[47] Social controls involving force or threats are widespread in addiction treatment, but have not been sufficiently studied.[10] Research is often based on how individuals are referred to or monitored in treatment, and rarely includes how these coercive strategies are perceived or experienced,

* Legal strategies include civil commitment, court-ordered treatment and diversion-to-treatment programs, as adjuncts or alternatives to criminal sanctions. Formal strategies are not issued by the criminal legal system, but include institutional facilitation of treatment, like mandatory referrals from employee assistance programs that require drug testing, social assistance, like government benefits or custody of children made contingent on treatment attendance. Informal strategies include family and friends initiating persuasive interpersonal threats and ultimatums (see Wild, 2006).

whether they affect individuals' motivation, interest, and intent to pursue and engage in treatment, and the impact on long-term outcomes in addiction treatment and population health.[10,47–51] Some theories suggest that individuals have a fundamental need for autonomy to change behavior, including in social contexts.[10,52] Thus, well-rounded research is needed on the role and efficacy of social controls, using force or threats, in addiction treatment.[51]

### *Profiteering in addiction treatment*

Complex ethical questions have long been raised over the evolving relationship between medical and for-profit commercial enterprise.[53] Against this backdrop, ASAM has adopted the ethical principle of supporting access to medical care for all individuals with addiction, and the affordability of quality addiction treatment, and relatedly, the lack of health insurance parity between mental health/addiction services and medical/surgical services, are direct challenges to this principle.[12,54–60] Individuals' financial well-being is often affected by the time they seek addiction treatment and their receipt of evidence-based addiction treatment should be based on their need for it, rather than the ability to pay.[61] (Moreover, many do not have access to health insurance, particularly in states that have not expanded Medicaid.[62]) Yet, up-front payment is often required by residential addiction treatment programs, with some for-profit programs charging more than twice as much as nonprofit programs.[63] Generally, cash is the most commonly accepted form of payment at addiction treatment facilities, surpassing private insurance, Medicaid, and Medicare.[64] While cash's prominence may be intuitive, the significant administrative burden that accompanies accepting health insurance and low reimbursement rates in addiction treatment likely contribute to the persistent disparities among forms of payment accepted in addiction treatment.[65,66] Some clinicians and programs in addiction treatment do not accept health insurance at all.[67] Sometimes cash-only practices can lead to perverse incentives that could cause harm.[67] Furthermore, plans' limits on mental health/addiction services benefits that are more restrictive than those imposed on medical/surgical (or physical health) benefits are not in compliance with parity requirements.[68] Unfortunately, noncompliance remains widespread within public and private plans, in part due to the complexities of insurance coverage.[69,70]

### *Suboptimal approaches and lack of quality measurement in addiction treatment*

Despite the historical lack of consistency of addiction treatment with evidence-based practices,[68] over the last half a century, options for addiction treatment have expanded from abstinence alone to multiple medications with proven efficacy in treating substance use disorders.[69] However, uptake of these evidence-based medications remains quite poor in addiction treatment – only one in three specialty addiction treatment facilities offer medications for opioid use disorder, and far fewer offer all forms of addition medications.[70,71]

In medical practice, the use of nationally-recognized performance measures,[†] or tools to improve transparency, accountability, and overall quality of health care, can help to ensure the quality of the treatment provided; when quality measurement does not exist, differences in levels of quality

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[†] Classic quality or performance measures are **structural**, which indicates capacity, systems, and process; **process**, which indicates what one does to maintain or improve health and reflect generally accepted recommendations for clinical practice; and **outcome**, which reflects the impact of services on patients (see AHRQ, 2015), but measures important to addiction treatment also include: **access**, which assesses the extent to which a person who needs and wants care is able to obtain it; **composite**, which combine results of measures for comprehensively assessing quality care across systems; **contextual**, which define the context for other measures' interpretation, and **patient experiences of care**, which record patients' perspectives and satisfaction with care received (see ASAM, 2015).

of care cannot be well understood, and claims can be made about care that are not true.[13,72–75] Accrediting and certifying bodies provide third-party recognition of competency to perform certain tasks and can develop quality measures across health care delivery, including for addiction treatment.[74,76,77] Improvements to the historic lack of insurance coverage of benefits and to the few medical treatments available for addiction treatment have put a spotlight on the need for effective performance measures in addiction treatment.[72,74,78–85] While not necessarily exclusive to the practice of addiction medicine, certain deterrents to the adoption of performance measures in addiction treatment include policies that separately finance general medical and addiction care and do not align addiction treatment program licensing at the state level with nationally recognized program standards, as well as burdensome reporting requirements for quality measures for value-based care.[86,87] For measures to be used in federal programs, they must be endorsed through the National Quality Forum's (NQF) rigorous assessment process.[88‡] ASAM published performance measures after the release of the *Standards of Care for the Addiction Specialist Physician,* which have not been endorsed by the NQF.[86,89] Renewed efforts will be required to identify effective performance measures in addiction treatment, to ensure measures are patient-centered,[90] accurately reflect positive patient outcomes and cost-effective care, and anticipate and mitigate potential adverse and unintended consequences.[87,91] CMS' noteworthy effort to align quality measurement across its programs, with preliminary Universal Foundation Measures, include initiation and engagement in addiction treatment.[92]

While the adoption of electronic health records (EHR) provides clinicians with access to standardized, shareable, legible, and complete patient data, the adoption of certified EHRs and associated data standards in addiction treatment has been slow for a variety of reasons, including the exclusion of such providers from federal incentive programs, interoperability barriers, including privacy laws necessitating that substance use disorder (SUD) records be segregated within EHRs, and financial challenges.[93–96] Yet, developing and testing clinical quality measures require conceptual and technical specifications definition, testing to ensure reproducibility across diverse systems, consideration of data elements and inclusion/exclusion criteria, and further testing in existing, capable healthcare systems with large datasets, which are facilitated by EHR adoption. Misalignment of federal and state regulations governing the privacy of addiction treatment records also poses challenges to using large datasets for quality measurement in addiction treatment.[95] Significant intellectual and financial capital will be required for the development and testing of a core set of measures for national endorsement and use. (Fifteen years ago, the costs of refinement, testing, and analysis for developing a measure ranged between half a million and four million dollars, depending on the measure type.[97])

Lastly, the heterogeneity in the organization, oversight, and financing of addiction treatment systems contributes to high variability in the quality of care delivered.[14] While *The ASAM Criteria* is a comprehensive guideline for conducting multidimensional patient assessments, identifying an appropriate level of care based on patient needs, and defining the services that should be provided at each level of care, including capacity to support broad access to addiction medications, it is not always accurately, effectively, and comprehensively deployed.

‡ The NQF develops consensus through the independent review of a multistakeholder panel of measures' importance, scientific acceptability, feasibility, and usability for quality improvement.

## Recommendations

The American Society of Addition Medicine recommends that:

1) Governments at all levels implement multifaceted strategies to foster high-quality, evidence-based, ethical addiction treatment that is accessible to all who need it.

2) Federal, state, or local governments establish confidential mechanisms to field and investigate patient, family, and provider reports of unethical practices involving addiction care, and as is prudent, align those efforts with the sober homes enforcement initiative at the federal level.

3) The federal government ensure fair and truthful advertising for addiction treatment programs on the internet, encourage internet search engines to work with addiction treatment stakeholders to ensure that certification fee scales for participation in internet advertising are not unfairly prohibitive, and ensure certifiers have well-established accreditation and certification standards.

4) To inform addiction policy and practice, governments fund research on the role and efficacy of coercive strategies that consist of social controls aimed at causing a person to take a prescribed action through the use of force or threats, which includes patient perceptions and experiences and the impact of such social controls on their motivation, interest, and intent to pursue and engage in addiction treatment.

5) Governments enact policies that facilitate and incentivize addiction clinicians and treatment programs to accept public and commercial insurance, such as increasing reimbursement rates for addiction treatment services, fully extending federal mental health and addiction parity protections under the Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA) to Medicare, all of Medicaid, and TRICARE, and enforcing parity laws.

6) The federal government provide the resources necessary to advance long-term strategies for the development and testing of a core set of performance measures in addiction treatment, for the purpose of national endorsement and use.

    a. The federal government convene an interagency working group supported by a consortium of stakeholders to renew efforts for quality measurement of addiction treatment, drawing from CMS's Universal Foundation Measures as is sensible.

    b. Congress pass legislation amending the Public Health Service Act to extend health information technology (IT) assistance eligibility to mental health and addiction professionals and facilities. In addition, federal agencies provide guidance to states on available federal authorities and resources to promote adoption and interoperability of IT in mental health and addiction care.[98]

    c. Governments ensure any such national or state-level quality or performance measures for addiction treatment outcomes are patient-centered and align with addiction as a chronic disease, remission as a treatment goal, and recovery as an

ongoing process, and refrain from using as the desired or measured outcome, "completion of treatment" or cessation of professional services.

d. State governments enact policies to better harmonize state regulations governing the privacy of SUD treatment records with federal regulations. The federal government continue to take actions to ensure 42 CFR Part 2 regulations do not impede coordination of care or the adoption of EHRs in addiction treatment.[101,102]

7) Congress pass legislation directing the Substance Abuse and Mental Health Services Administration (SAMHSA) to develop and regularly update national model standards for state licensure of addiction treatment programs that meet the nationally-recognized program standards in the most current edition of *The ASAM Criteria*.[103] In the absence of Congressional action, the Office of National Drug Control Policy (ONDCP) should fund the development of such national model standards for use in state licensure.

   a. Congress pass legislation that would encourage states to adopt such model standards for licensure, including the most current edition of *The ASAM Criteria*'s level of care nomenclature, as well as educate individuals and families on the importance of matching patients with the appropriate level of care.[103]

8) SAMHSA align the addiction service settings in its online treatment locator[104] with ASAM levels of care.

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