

Commentary

Can the national addiction treatment infrastructure support the public's demand for quality care?[☆]

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Abstract

As part of a larger study of the national substance abuse treatment system, the authors had an opportunity to interview the directors and key staff from a nationally representative sample of 175 drug and alcohol treatment programs. Results indicated that within the previous 16 months, 15% of facilities had closed or stopped addiction treatment and an additional 29% had been reorganized under a different agency. There was a 53% turnover among directors and a similar rate among counselors within the previous year. Less than half the programs had a full-time physician or nurse, and very few programs had a social worker or psychologist. The predominant form of treatment was abstinence-oriented group counseling. The intake process typically required 2 to 4 hours to collect data required by managed care and city, state, and federal agencies. Very few programs had computers for clinical operations or decision support. These findings are disturbing and call into question the ability of the national treatment system to meet the complex demands of both the patients that enter this system and the agencies that refer to it. © 2003 Elsevier Inc. All rights reserved.

1. Introduction

The great majority of substance abuse treatment in this country has been provided by specialty sector programs funded primarily through the State Block grant, the Department of Veterans Affairs, Medicaid, private medical insurance, and other sources (Horgan & Merrick, 2001). Two sets of forces have combined to affect this national treatment system over the past decade. First, the wide recognition that the abuse of alcohol and other drugs is associated with serious public health and public safety problems (McLellan et al., 2000; Office of National Drug Control Policy, 1998) has led to an increase in substance abuse treatment referrals from agencies that have been affected by addiction-related problems. For example, national statistics for the year 2001 indicate that the criminal justice system accounted for

approximately 55% of all patients referred to substance abuse treatment, while the welfare system accounted for approximately 10% and mental and physical health clinics accounted for an additional 10% to 15% of referrals (Drug Abuse Services Information System, 2001). While these referrals are quite appropriate, these clients typically present for substance abuse treatment with a complex and generally serious set of problems requiring experienced professionals and a range of medical and social service options (Belenko, 1998; Kessler et al., 1994; Woolis, 1998).

A second force that has affected the substance abuse treatment system over the past decade is the transformation in management of health care (Institute of Medicine, 1997). For example, in 1990, there were over 16,000 substance abuse treatment facilities operating in this country; approximately 55% of those were residential or inpatient hospital, approximately 30% were outpatient programs, and approximately 15% were methadone maintenance programs (Uniform Facility Data Set, 1990). Figures from 2002 indicate that there are currently less than 14,000 programs; only 10% are residential or inpatient hospital, approximately 12% are methadone maintenance programs, and approximately 78% are abstinence-oriented outpatient programs (National Survey of Substance Abuse Treatment Services, 2001).

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Given these imposing forces, it is reasonable to question how the national treatment system has accommodated to these changes. The authors had an unplanned opportunity to gather information on this question in the course of implementing a national study of substance abuse treatment effectiveness (Carise et al., 1999). We conducted interviews with program directors and other staff from a nationally representative sample of 175 substance abuse treatment programs. Through the process of collecting what we thought would be basic administrative information from those program directors, we uncovered surprising findings about the instability of the treatment system, and indications about its ability to meet the complex needs of patients and the expectations of the referral agencies.

2. Methods

2.1. The sampling frame: the National Survey of Substance Abuse Treatment Services

The sampling frame was a subset of the 13,484 “facilities” listed in the 2000 edition of the National Survey of Substance Abuse Treatment Services (N-SSATS) published in October 2001. The N-SSATS is an exhaustive survey of all specialty sector services—including government-owned, private nonprofit, and private for-profit programs—representing all 50 states and the District of Columbia.

2.2. Developing the treatment program sample

The unit of reporting within the N-SSATS was the “facility”; this was problematic for our purposes, because the facility could take many different and simultaneous forms. For example, an N-SSATS facility could be a single, stand-alone, outpatient treatment program or it could be an entire treatment system consisting of several modalities (e.g., detoxification, outpatient, methadone, residential, hospital). To standardize our unit of reporting, we moved to the treatment program as the unit of analysis: a single modality (e.g., methadone, inpatient/residential or outpatient) at a single site. In cases where a facility with many programs was selected, the largest program was chosen with the expectation that it would be the most stable and enduring.

Four types of facilities were excluded from the sampling frame:

- adolescent-only facilities (approximately 12%), because the larger study only focused on adults
- in-prison facilities (less than 1%), because access is quite difficult
- private office practices (approximately 2%), typically individual therapists who do not provide specialty addiction treatment

- very small facilities (approximately 8%), that had less than 50 admissions per year because they were thought particularly vulnerable to closure

These exclusions left a sample of 10,334 facilities. Within that sample, approximately 60% were private nonprofit, approximately 26% were private for-profit, and 11% were government-owned (e.g., Department of Veterans Affairs; state-owned facilities, etc.). Outpatient, abstinence-oriented treatment (intensive outpatient and traditional outpatient) accounted for approximately 78% of all facilities, while inpatient or residential care accounted for 12% and methadone maintenance accounted for approximately 10% of all facilities.

2.3. Validity of the sampling frame

To partially validate the national listing, our research group performed an additional test of the N-SSATS validity in two city samples (Carise et al., 2003), personally searching five different sources to identify operational treatment programs in two predefined geographic areas. There were some differences due to the definition of “treatment,” but the correspondence was over 80%.

2.4. The sampling plan

The general parameters of the sampling plan were initially developed through a national advisory board familiar with both the features of the N-SSATS and with the substance abuse treatment system. An examination of the N-SSATS indicated that treatment programs were clustered in larger cities, thus urbanity (i.e., urban vs. nonurban) was one of two selection strata. The other stratum was treatment modality (e.g., detoxification, inpatient/residential, outpatient, methadone maintenance). Using data reported on the annual admissions to these programs, we developed a selection proportionate to admissions formula—stratified on urbanity and modality—and drew primary and back-up samples of 250 treatment programs each. Here we discuss our experiences with the first 175 programs contacted prior to the administrative closing of the study in February 2003.

2.5. Program interview procedures

The initial call was made by the senior author, who introduced the project, validated the information from the N-SSATS, and discussed the larger project with the person designated as the program director in a 40 to 60 minute unstructured call. Treatment Research Institute project coordinators collected additional information about the programs in subsequent telephone discussions with the clinical and administrative staffs.

3. Results

3.1. Operational status of the programs

Of the 175 programs contacted, we found that 14 had closed altogether and that an additional 12 programs, though still in operation, had changed their mission to provide social or mental health services. Thus, approximately 1 year after publication of the 2000 N-SSATS, 26 programs (15%) were no longer providing substance abuse treatment. Because our sampling had purposely eliminated very small N-SSATS programs, these data probably underestimate the true closure rate within the national system.

Approximately 43 other organizations (25% of the original sample, 29% of the programs that had not closed) had been taken over or “reorganized” under a different administrative structure—usually a mental health firm or agency.

3.2. Program directors

3.2.1. Background and training

Fifteen percent of program directors had no college degree, 58% had a bachelor’s degree, and 20% had a masters degree. One program was under the direction of a physician.

3.2.2. Percent effort

Seventy-two percent of the directors were employed full-time; the rest worked part-time.

3.2.3. Tenure in position

Fifty-four percent of the program directors had been in their position less than 1 year. However, most of those directing the programs (71%) had actually been working within the program more than 1 year, usually in a clinical position.

3.3. Complement and tenure of the treatment staff?

Apart from counselors, there were very few other professional disciplines represented in most of these programs. For example, only 54% of the programs had even a part-time physician on staff. Outside of methadone programs, less than 15% of programs employed a nurse. Social workers and psychologists were rarely mentioned.

3.4. Admission/intake process

3.4.1. Quantitative findings

Only 54% of the programs reported that they performed an on-site physical examination at intake. All programs reported the collection of administrative forms for city, state, federal, and managed care requirements; this administrative data was the only information collected by 30% of programs.

Thirty-five percent of treatment programs reported collecting Addiction Severity Index (McLellan et al., 1980, 1992), and approximately the same proportion indicated that they collect data to complete the American Society of Addiction Medicine patient placement criteria (American Society of Addiction Medicine, 1996; Mee-Lee et al., 2001).

3.4.2. Qualitative findings

Most of the programs had contracts with multiple managed care organizations and state agencies (e.g., justice, employment, welfare), each requiring different data. Several programs cited staff burden of 2 to 4 hours per admission, simply to collect the administrative information required by these agencies. The American Society of Addiction Medicine patient placement criteria were considered valuable because they offered justification to a managed care organization for a requested admission to a more intensive level of care. The Addiction Severity Index was collected in most cases because it was required by some administrative agency or organization, but it was rarely used for any clinical planning. Almost no program director considered any of the data that were collected at assessment to be clinically or administratively useful.

3.5. Computer and information resources?

Twenty percent of programs had no information services, e-mail, or even voice-mail for their phone system. In contrast, 30% of the programs—mostly those that were part of larger hospital or health systems—had access to seemingly well-developed information systems, e-mail, and Internet services.

The remaining 50% had some form of computerized administrative information system dedicated to billing or administrative record keeping. At the same time, these computer and information services were typically only available to the administrative staff. Only three of the treatment programs we contacted had an integrated clinical information system for use by the majority of their treatment staff.

4. Discussion

As part of a larger study of the national substance abuse treatment system (Carise et al., 1999) we had opportunity to interview the directors and key staff in a nationally representative sample of 175 drug and alcohol treatment programs from all settings, modalities and types of ownership. Only adolescent, very small, or in-prison programs and office-based private practices were excluded. The experience of talking to these treatment directors about their organizations, staffing, and clinical operations revealed some disturbing findings about the national substance abuse treatment infrastructure that we felt were important to report.

4.1. Limitations to the data presented

Although the data reported here are relatively contemporary (summer 2002), given the time lag in publication, changes in state-operating budgets, and other political and economic factors, it must be admitted that the sample may not be representative of the national treatment system at the time of publication. Indeed, the outright closure of substance abuse programs (15%) and administrative reorganizations (29%) within a 1- to 2-year period make it unlikely that any statistics about the national treatment system will be representative for very long. On the other hand, we feel that the organizational and personnel changes seen in this sample are representative of the changes throughout the substance abuse treatment system (Johnson and Roman, 2002; Knudsen et al., 2003; D'Aunno and Pollack, 2002).

Because of the unplanned nature of this report, the unstructured interview methods we used cannot provide a full picture of the subject. Thus, one important conclusion to be drawn from this effort is that there is a need for more focused health services research into the organizational, administrative, financial, and operational aspects of the substance abuse treatment system. Given these important caveats on the sampling and data collection processes, we have restricted our discussion to the three key findings of which we are most certain.

4.2. Summary of key findings

4.2.1. The organizational and administrative infrastructures of many programs are inadequate and unstable

Approximately one sixth of the programs in our sample had either closed or ceased providing addiction treatment. This finding is consistent with the 16% annual closure rate documented by the national contractor maintaining the national treatment registry (National Survey of Substance Abuse Treatment Services, 2001) and the closure rate reported by Roman's group (Johnson and Roman, 2002; Knudsen et al., 2003) among private for-profit treatment programs. In addition, we found that almost one third of the remaining programs had undergone some type of major reorganization in the previous year.

Although there were computers and information systems in 80% of the programs, these were generally dedicated to administrative and financial record keeping, not clinical services. Only a handful of programs used a clinical information system for conducting or monitoring care.

4.2.2. There is extreme instability of the workforce at all levels within the national treatment system

Most programs did not have a full-time physician or nurse, and very few programs had any social workers or psychologists. Within the programs we found a disturbing amount of staff turnover at all levels. Despite recent studies showing relatively stable tenure among counseling staffs

(Mulvey, 2003), most other reports have indicated high counselor turnover rates (Gurel et al., 2003; Institute of Medicine, 1998; Alcoholism and Drug Abuse Weekly, 2002). What we had not expected was the similar rate of turnover among the program directors: over half had not been in their jobs for even a year. In the course of our interviews, two program directors in California quit their jobs to become prison guards — with substantial pay raises.

4.2.3. Treatment programs are choking on data collection requirements

The data collection and reporting requirements for most of these programs were truly daunting. Program directors reported dedicating one or more full-time clinical staff to collecting information required by government agencies and managed care organizations. Many admission intake procedures were reported to take 2 to 4 hours. To make this already-problematic situation worse, staff indicated that almost none of the data collected were used in clinical decision-making or program planning — it was just “paperwork.”

5. Conclusion

These data question the ability of the national addiction treatment infrastructure to adopt or support the many potentially effective new therapies, interventions, and medications emerging from the National Institute on Drug Abuse and the National Institute on Alcohol Abuse and Alcoholism. Researchers supported by both of these institutes have developed effective medications for nicotine, alcohol, and opiate dependence (O'Brien, 1996; Institute of Medicine, 1995); there are at least four empirically validated forms of individual therapy (McLellan et al., 2000); and there are multifocal interventions for families and partners of substance abusers (McCrary et al., 1986). Unfortunately, all of these potentially effective methods involve sophisticated clinical personnel and information management resources that are not currently available in the great majority of the treatment programs we contacted. If this picture of the national addiction treatment infrastructure is accurate, there is a need for action.

At the personnel level, there is a need to provide meaningful financial incentives to physicians, nurses, social workers, psychologists, and counselors to make clinical careers within this treatment system economically viable. Educational loan forgiveness programs contingent upon working a number of years in addiction treatment could help to attract and retain clinically valuable personnel.

At the organizational, fiscal, and administrative levels, there is a need for training in budget administration, cost accounting, personnel management, business law, and other essential tools of small business administration. Some of this may be supportable by the Center for Substance Abuse Treatment, but within cities and communities it should be possible to recruit experienced management firms

and/or business schools to provide courses and mentoring opportunities for program directors. Academic credits toward a management degree (e.g., a B.A. or M.B.A.) could serve as incentives.

There is a need for leadership to consolidate data collection and reporting requirements around a core set of clinically relevant admission, treatment progress, and discharge information. This could lead to three improvements. Immediately, programs and patients would have relief from a significant data collection burden. Second, managed care companies would feel pressure to accept these national standards rather than demand different types of data. Finally, national standards could create an attractive market for information management companies to develop decision support software and training in critical clinical processes such as initial placement, diagnosis, problem prioritization, service planning, referral, and long-term monitoring. Infrastructure development grants for Internet connections, computers, and basic computer training would further stimulate this necessary activity.

These suggestions are purposely not “get tough” actions designed to regulate, monitor, or credential the system into better quality. Like other troubled industries, addiction treatment needs financial and technical investment as well as incentives to raise quality and to attract the best personnel. Indeed, like the long-neglected national electrical grid that recently failed so dramatically, without modernization and investment the addiction treatment system will also fail to meet the public’s needs.

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