

# **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 we had 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 prior sixteen months, 15% of facilities had closed or stopped addiction treatment and an additional 29% had been reorganized under a different agency. There was 53% turnover among directors and a similar rate among counselors within the prior year. Less than half the programs had a full-time physician or nurse and very few programs had a social worker or psychologist. By far the predominant form of treatment was abstinence-oriented group counseling. The intake process typically required 2 – 4 hours to collect data required by managed care, city, state and federal agencies. Very few programs had computers for clinical operations or decision support.

These findings are disturbing and question the ability of the national treatment system to meet the complex demands of the patients that enter, or the agencies that refer to this system.

## INTRODUCTION

The great majority of drug 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 and Merrick, 2001). Two sets of forces have combined to affect this national substance abuse treatment system over the past decade. First, the wide recognition that alcohol and other drug abuse are 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 – 15% of referrals (DASIS, 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 healthcare (See Institute of Medicine (IOM), 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 15% were methadone maintenance programs and about 30% were outpatient programs (Uniform Facilities Data Set (UFDS), 1990). Figures from 2002 indicate that there are less than 14,000 programs; only 10% are residential or inpatient hospital, about 12% are methadone maintenance programs and approximately 78% are abstinence-oriented outpatient programs (National Survey of Substance Abuse Treatment Services (N-SSATS), 2001).

Given these imposing forces, it is reasonable to question how the national treatment system has accommodated. We 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). Prior to the administrative closing of that study, we were able to complete 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 the entering patients and the expectations of the referral agencies

## **METHODS**

The Sampling Frame – The National Survey of Substance Abuse Treatment Services (N-SSATS) – The sampling frame was a subset of the 13,484 “facilities” listed in the 2000 edition of N-SSATS published in October, 2001. The N-SSATS is an exhaustive survey of all specialty sector services including government owned, private not-for-profit, and private-for-profit programs, representing all 50 states and the District of Columbia.

Developing The Treatment Program Sample – The unit of reporting within the N-SSATS was the “facility” and this was problematic for our purposes since it 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 (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 (methadone, inpatient/residential or outpatient) at a single site. In cases where a facility with many programs was selected, the largest program was chosen – expecting it to be the most stable and enduring.

Exclusions – Four types of facilities were excluded from the sampling frame:

*Adolescent-only facilities* – (approximately 12%) because the larger study only focused upon 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%) programs that had less than 50 admissions per year since they were thought particularly vulnerable to closure.

These exclusions left a sample of 10,334 facilities. Within that sample, approximately 60% were private, not-for-profit, about 26% were private, for-profit and 11% were government owned (Department of Veterans Affairs; state owned facilities,

etc). Outpatient, abstinence-oriented treatment (intensive outpatient and traditional outpatient) accounted for about 78% of all facilities, while inpatient or residential care accounted for 12% and methadone maintenance accounted for about 10% of all facilities.

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 pre-defined geographic areas. There were some differences due to the definition of “treatment” but the correspondence was over 80%.

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 (urban, non-urban) was one of two selection strata. The other stratum was treatment modality (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 a 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.

Program Interview Procedures – The initial call was made by the senior author. He 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 – 60 minute unstructured call. Treatment Research Institute (TRI) project coordinators collected additional information about the programs in subsequent, telephone discussions with the clinical and administrative staffs.

## **RESULTS**

### 1) Operational Status of the Programs –

Of the 175 programs contacted, we found 14 had closed altogether, and an additional 12 programs, though still in operation, had changed their mission to provide social or mental health services. Thus, within approximately one year after publication of

the 2000 N-SSATS, 26 programs (15%) were no longer providing substance abuse treatment. Since our sampling had purposely eliminated very small N-SSATS programs, the true closure rate within the national system is probably under-estimated by these data

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

## 2) Program Directors

*Background and Training* - 15% of program directors had no college degree, 58% were bachelors degreed and 20% were masters degreed. One program was under the direction of a physician.

*Percent Effort* - 72% of the directors were employed full-time; the rest worked part time.

*Tenure in Position* - 54% of the program directors had been in their position less than one year. However, most of those directing the programs (71%) had actually been working within the program more than one year, usually in a clinical position.

## 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.

## 4) Admission/Intake Process

*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 the Addiction Severity Index (ASI) (McLellan et al., 1980; 1992) and approximately the same

proportion indicated that they collect data to complete the American Society of Addiction Medicine (ASAM) patient placement criteria (ASAM, 1996; Mee-Lee et al., 2001).

*Qualitative Findings* - Most of the programs had contracts with multiple managed care organizations and state agencies (justice, employment, welfare), each requiring different data. Several programs cited staff burden of 2 - 4 hours per admission, simply to collect the administrative information required by these agencies. The ASAM 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 ASI 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 (hence the phrase “paperwork”).

#### 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.

## **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.

### **Limitations to the Data Presented**

While the data reported here are reasonably 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 this reading. Indeed, the outright closure of substance abuse programs (15%); and the administrative re-organizations (29%) within a one to two-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 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.

### **Summary of Key Findings**

1) *The organizational and administrative infrastructures of many programs are inadequate and unstable.* About a sixth of the programs in our sample had closed or stopped providing addiction treatment. This finding is consistent with the 16% annual closure rate documented by the national contractor maintaining the national treatment registry (N-SSATS, 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 a third of the remaining programs had undergone some type of major reorganization in the prior year.

Though there were computers and information systems in four fifths 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.

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 disturbing levels of staff turnover at all strata. Despite recent studies showing relatively stable tenure among counseling staffs (See Mulvey et al., 2003), most other reports have indicated high counselor turnover rates (e.g. Gurel et al. 2003; IOM, 1998; *Alcoholism and Drug Abuse Weekly*, August 24, 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.

3) *The 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 - 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.”

### **Recommendations and Conclusions**

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 (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA). NIDA and NIAAA-supported researchers 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 multi-focal 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 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 (BA or MBA) could serve as incentives.

There is 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 and 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.

## REFERENCES

- Alcoholism & Drug Abuse Weekly (2002) *Special Report: Workforce Issues*. Vol. 14, No. 15. Manisses Communications Group Inc., Providence RI.
- American Society of Addiction Medicine. (1996) Patient placement criteria for the treatment of substance-related disorders. Chevy Chase, Maryland. ASAM Inc.
- Belenko S. (1998). Behind Bars: Substance abuse and America's prison population. New York. National Center for Addiction and Substance Abuse at Columbia University.
- Carise D, Festinger D.S., McLellan A. T. and Kleber H.D. (2003) Identifying the United States Population of Substance Abuse Treatment Programs: A Partial Test in One Mid-Sized City. Journal of Substance Abuse. In press.
- Carise D., McLellan A.T., Gifford L. and Kleber H. (1999) A National System for Monitoring Changes in the Substance Abuse Treatment Population: The Drug Evaluation Network System. Journal of Substance Abuse Treatment. 17(1-2): 67-77
- D'Aunno,T. and Pollack H.A. (2002) Changes in Methadone treatment practices: Results from a national panel study, 1998 – 2000. JAMA, 298 (7): 850 – 856.
- Drug Abuse Services Information System (DASIS). (Aug 2001) Substance Abuse and Mental Health Services Administration. Rockville, Maryland.
- Gurel O., Carise D., Kendig C., McLellan A.T. (2003 in press) Development of an Electronic Resource Guide to Health and Social Services. J. Substance Abuse Treatment. In press.
- Horgan, C., & Merrick, E. (2001). Financing of Substance Abuse Treatment Services. In M. Galanter (Ed.), Recent Developments in Alcoholism, Vol 15. Services Research in the Era of Managed Care. New York: Kluwer Academic/Plenum Publishers.
- Institute of Medicine. (1995). Development of Medications for the Treatment of Opiate and Cocaine Addictions: Issues for the Government and Private Sector. Washington, DC: National Academy Press.

- Institute of Medicine (1997). Managing Managed Care: Quality Improvement in Behavioral Health. Washington, DC: National Academy Press.
- Institute of Medicine (1998) Bridging the Gap: Forging new partnerships in community-based drug abuse treatment. Washington, DC: National Academy Press.
- Johnson J.A. and Roman P.M. (2002) Predicting closure of private substance abuse treatment facilities. Journal of Behavioral Health Services and Research. 29: 115 – 125.
- Kessler, R.C., McGonagle, K.A., Zhao, S., Nelson, C.B., Hughes, M., Eshleman, S., Wittchen, H-U., Kendler, K.S. (1994) Lifetime and 12 month prevalence of DSM-III-R psychiatric disorders in the United States: Results from the National Comorbidity Survey. Archives of General Psychiatry, 51: 8-19.
- Knudsen H.K., Johnson J.A. and Roman P.M. (2003) Retaining counseling staff at substance abuse treatment centers: Effects of management practices. Journal of Substance Abuse Treatment. In press.
- McCrary B.S., Noel N.E., Abrams D.B., Stout R.L., Nelson H.F. & Hay W.M. (1986) Comparative effectiveness of three types of spouse involvement in outpatient behavioral alcoholism treatment. J. Studies on Alcohol, 47:459-467.
- McLellan A.T., Cacciola J., Kushner H., Peters R., Smith I., and Pettinati H. (1992) The Fifth Edition of the Addiction Severity Index: Cautions, additions and normative data. J. Substance Abuse Treatment, 9(5) 461-480.
- McLellan, A.T., Luborsky, L., O'Brien, C.P., Woody, G.E.: An improved diagnostic instrument for substance abuse patients: The Addiction Severity Index. J. Nerv. & Ment. Diseases, 168:26-33, 1980.
- McLellan A.T., O'Brien C.P., Lewis D. L. and Kleber H.D. (2000) Drug addiction as a chronic medical illness: Implications for treatment, insurance and evaluation. JAMA 284: 1689 – 1695 .
- Mee-Lee D., Shulman G.D., Fishman M., et al. (2001) ASAM patient placement criteria for the treatment of substance-related disorders. Second Edition. (ASAM-PPC – 2R) Chevy Chase, Maryland. ASAM Inc.

Mulvey K. (2003) Substance abuse counselor characteristics. Journal of Substance Abuse Treatment In press.

National Survey of Substance Abuse Treatment Services (N-SSATS). (October. 2001)  
Substance Abuse and Mental Health Services Administration. Rockville, Maryland.

O'Brien, C. P. (1996). Recent developments in the pharmacotherapy of substance abuse.  
Journal of Consulting and Clinical Psychology 64, 677-686.

Office of National Drug Control Policy. (1998 -2002). The National Drug Control  
Strategy, 2000. U.S. Government Printing Office, MS SSOP, Washington, DC  
ISBN 0-16-048978-4.

Uniform Facility Data Set (October 1990) Substance Abuse and Mental Health Services  
Administration. Rockville, Maryland.

Woolis, D.D. (1998) Family Works: Substance Abuse Treatment and Welfare Reform.  
Public Welfare. (Winter) 24 – 32.