

NASADAD Policy Position Paper Recommendations Related to Closing the Treatment Gap (June, 2003)

The Substance Abuse and Mental Health Services Administration (SAMHSA) Office of Applied Studies (OAS) has estimated that over four million individuals who meet the diagnostic criteria for addiction and need addiction treatment do not receive it. Since this estimate, derived from the National Household Survey on Drug Abuse (*SAMHSA, 2000*), does not include incarcerated individuals or those who are homeless or transient, it should be viewed as conservative at best. Individual state estimates of treatment need range from 8 to 15 percent for adults, and from 10 to 25 percent for youth. Although there are no estimates of how many individuals seeking treatment are unable to pay for treatment themselves and require public assistance, it can be inferred that the number needing the services of the public treatment system continues to grow as more and more individuals and families become uninsured or underinsured. Prevailing estimates do not include those who are affected by someone else's alcohol or other substance abuse, who would probably benefit from services including family counseling. Estimates also do not include individuals who may not have a DSM IV diagnosis, but would benefit from early intervention. Many states estimate that the amount of funding required to meet these and other treatment-related needs would in the hundreds of millions of dollars.

In his remarks when announcing the nomination of John P. Walters to head the Office of National Drug Control Policy (ONDCP), President Bush acknowledged the need to close the treatment gap, and pledged "in order to close that treatment gap, we'll provide \$1.6 billion over the next five years." Soon after, the ONDCP National Drug Control Strategy identified two specific goals related to closing the treatment gap. The two-year goals are to achieve a "10 percent reduction in current use of illegal drugs by the 12-17 age group," and a "10 percent reduction in current use of illegal drugs by adults age 18 and older." Five-year goals seek to reduce use in each group by 25 percent (*ONDCP, 2002*).

To achieve these goals, the additional financial resources targeted to closing the treatment gap as well as existing resources must be maximized. Partnerships between the state and the federal systems and between the states and their communities should be strengthened by improved coordination that utilizes the unique assets that each entity can bring to existing and future efforts. Partnerships should support the development of appropriate resources, improvement in coordination of efforts, and close consultation in the development of cross-cutting accountability standards.

These partnerships should be formalized through the development of instruments that articulate common goals and objectives. Such instruments would insure the sustainability of resource and systems development as administrations change and financial resources diminish or grow. They would provide the infrastructure to support specific activities including:

- Expansion of treatment capacity through Federal financial support. It is the goal of all State Alcohol and Other Drug (AOD) Agencies to provide appropriate, effective substance abuse addiction treatment to all those who need treatment. Any efforts that are targeted to closing the treatment gap must have as their first priority the expansion of treatment capacity to meet the existing demand for treatment, as the need is assessed by the State AOD Agency through the State Treatment Needs Assessment Program (STNAP). This is a priority that can largely be achieved by "an increase in total resources for substance abuse treatment" (*SAMHSA, 2000*). Tying capacity expansion revenues to competitive grants can have the effect of increasing the gulf between the "have" states, with the resources for extensive data collection, reporting and the staff for grant-

writing, and the “have-not” states who are under-resourced in these areas, and that such grants are intended to help.

Expansion of treatment capacity through the removal of legislative obstacles. As you know, Medicaid payment is prohibited for any services provided in an Institute for Mental Disease (IMD) to individuals between the ages of 21 and 65. An IMD is defined as "...a hospital, nursing facility, or other institution of more than 16 beds that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases..." This exclusion as it applies to substance abuse treatment contributes to the treatment gap. The Center for Medicaid/Medicare Services (CMS) has provided a list of exceptions to this statute. We believe, along with the National Governor’s Association (NGA), the National Community-based Care Coalition (NCCC), and a host of experts in the government and medical care field, that this list should include substance abuse treatment.

Expansion of treatment capacity through parity in Medicaid. The number of individuals who lack health insurance is increasing. For those who do have insurance, substance abuse treatment is usually not adequately covered. State substance abuse treatment systems that were originally intended to be a safety net instead have become the primary option for many individuals in need of treatment. Government insurance packages, specifically Medicaid, provide “limited and often inconsistent coverage that leads to inappropriate and insufficient care with less than positive outcomes” (SAMHSA, 2000). The standard benefit endorsed by Panel I in *Changing the Conversation* (SAMHSA, 2000) balances appropriate coverage that is based on treatment needs with fiscal responsibility and economic feasibility, and contributes to the better coordination of public and private resources.

- Improvement of workforce. After capacity, the most important issue that many States are facing concerns recruiting and retaining qualified treatment professionals. States have taken steps to cope with this particular problem. For example, every State has counselor-credentialing processes in place, and most processes feature an entry-level credential for individuals interested in entering the field of addiction treatment.

But it is evident that more needs to be accomplished. According to the Bureau of Labor Statistics Occupational Projections, a total of 61,000 individuals were employed as substance abuse and behavioral disorders counselors in 2000. By 2010, there will be a need for an additional 21,000, an increase in demand by 35%. There is an identical level of anticipated increase in demand for licensed professionals who have received graduate-level educations (Hecker, 2001).

Other facets of the public health care system are responding to similar anticipated shortages by creating an infrastructure that promotes the recruitment and retention of staff in positions such as personal and home care aides, medical assistants, physician assistants, home health aides, and physical therapy assistants. This infrastructure could be reviewed for programs, initiatives and funding mechanisms that would translate to the substance abuse sector. These and other actions could be considered by a National Workforce Development Office. In *Changing the Conversation* (SAMHSA, 2000) Panel V recommends the creation of such an office within CSAT, noting the need for a federal entity dedicated to supporting the development of the substance abuse treatment workforce at a national level.

This office would also be in an ideal position to link with other federal agencies involved in addiction treatment to focus on the further development of resources to better support counselor cross-disciplinary training and compensation. The recruitment and retention of qualified substance abuse treatment professionals in agencies that operate treatment services in parallel to the State AOD Agency, including criminal justice, mental health, public health, social services and child welfare, is also central to closing the treatment gap. Only a universally competent workforce can ensure that evidence-based treatment is effectively implemented in these various treatment settings, thereby maximizing the effectiveness and value derived from each treatment dollar.

- The strengthening of publicly supported addiction treatment services through improved coordination at the federal level. There is a need for improved coordination at the federal level between the Center for Substance Abuse Treatment (CSAT) and other federal agencies including various offices under the Department of Justice, Housing and Urban Affairs, and many others. If substance abuse treatment were coordinated with CSAT, it would permit better coordination among state-level agencies that currently fund substance abuse prevention and treatment services in parallel to State Alcohol and Other Drug (AOD) Agency funded efforts. For example, in a recently released report “*Identification and Description of Multiple Alcohol and Other Drug Treatment Systems*” (NASADAD, 2002) all of the 42 responding states identified some aspect of their state’s Department of Corrections as operators of addiction treatment services. Yet more than half of the respondents noted that they are not required to meet State AOD Agency licensing/accreditation standards. Almost two-thirds said that they are not required to participate in the State AOD Agency client level data system. Half explained that there is no coordination of services between the two offices, and almost half noted that the State Department of Corrections is not at all involved with the State AOD Agency or the services system it supports. Better coordination and improved treatment outcomes could be achieved through the development of common treatment standards, common outcomes measures, the review of data collection and reporting methodologies, and the sharing of facility and aggregated client-level data.
- Improvement in the utilization of federal funding streams for substance abuse prevention and treatment. State AOD Agencies have, as their legislated responsibility, the planning, development and funding of substance abuse treatment and related services. Block Grant requirements include estimation of service need and service delivery by sub-state area, as well as plans for systems development and service delivery. State AOD Agency Directors are the authorities on their state’s treatment and prevention needs, and know how their state dollars as well as their Block Grant dollars are being spent. Logically, it would seem that effective development would exploit this knowledge in planning for the expenditure of federal resources.

Yet funding from various federal agencies frequently bypasses the State AOD Agency, going directly to the treatment facilities themselves. Large facilities receive this funding based on their size, stage of development and their ability to hire grant writers. Communities with few resources may have the greater need, but are unable to compete as effectively as their better-resourced cousins. Rather than alleviating problems, such funding may actually contribute to problems by creating significant disparities in the availability of services from locality to locality.

Lastly, funding that bypasses the State AOD Agency may not be reported to the State AOD Agency. There is usually no mechanism in the grant or contract itself requiring even the simplest notification to the State AOD Agency of the award. Unreported funds can’t be considered state needs assessments, state monitoring, data collection, services coordination and outcomes analysis.

In addition, the State AOD Agency cannot work to successfully integrate these efforts into the state and local services networks, making the community-based efforts unsustainable when federal funding stops.

- Evaluating and eliminating policies that shift funding from one segment of the treatment population to another segment of the treatment population. Taking needed dollars from one subgroup of the treatment population in order to shore up treatment efforts aimed at another subgroup threatens the stability of the treatment infrastructure, and does not have the effect of improving substance abuse treatment for any single group. Different States have different needs, and such policies force States to supply funding where there may not be a pressing need. Additional funding would help State AOD Agency Directors effectively address gaps in treatment capacity or services without depriving any single group of necessary resources.
- The development of intervention services to address substance abuse before it escalates from experimentation to addiction. Many of the individuals who begin to use drugs do so experimentally when they are adolescents or young adults for various social and developmental reasons. Such experimenting can quickly become addiction, with rapidly escalating negative social and economic consequences to both the individual and to society. Developing effective methods for intervening during the initial stages of alcohol or drug use for youth and adults could be the single most cost-effective effort that a local-state-federal partnership undertakes.
- The development of a coordinated and focused public awareness campaign identifying addiction as a disease that is both preventable and treatable. While the initiation of substance use is a voluntary action under the control of the individual, research has established that addiction itself is the result of complex neurochemical and neurobiological processes. Depending on individual intrinsic vulnerabilities, experimental use can quickly escalate into addiction, a disease that involves permanent and irreversible changes in the biochemical functioning of the individual's brain. Campaigns should appreciate the significance of these and other research-based insights into the nature of addiction, and target the need to bridge the "denial gap" recently identified by John Walters in the ONDCP review of the 2001 National Household Survey on Drug Abuse (*SAMHSA, 2002*).
- A continuation of the focus on creating maximum flexibility in federal funding so that State AOD Agencies have not only the responsibility for reporting treatment outcomes, but the power to influence those outcomes. Such flexibility would allow states to provide services to communities and populations that they determine are most in need and/or most at risk, using treatment methods that have been demonstrated to be effective. The states are currently engaged in a process with SAMHSA to address the legislative mandate that SAMHSA, in cooperation with the States, develop performance measures for activities supported through the SAPT Block Grant as part of its transition to a Performance Partnership Grant (PPG). This effort will contribute to the development of the prevention and treatment data necessary to informing the effort to close the treatment gap. During the initial stages of this effort, federal authorities have repeatedly demonstrated the willingness to work with the states regarding the lack of data collection and reporting infrastructure support, consensus on uniform clinical instrumentation, and consensus on cost-efficient and effective methods for tracking outcomes. Implementing the partnership will require a significant investment in data infrastructure for both improvements and modifications. Since each State data collection system differs from the next in terms of administration authority, systems used,

hardware and software, and available resources, the same degree of flexibility will be necessary to attaining mutual goals.

Summary

The substance abuse prevention and treatment system as it is administered by the State AOD Agencies is perhaps one of the most chronically and severely under-resourced areas in the public health/social services system. Consideration of various approaches to closing the treatment gap should include:

- Expansion of treatment capacity that maintains a focus on improved workforce recruitment and training.
- Federal funding to expand capacity and improve workforce competency that allows State flexibility to address individual State needs.
- Improvement in efficiency regarding the expenditure of resources, including better coordination at the federal level.
- Improvement of the treatment system infrastructure, including improved processes for data collection and reporting.

References

Hecker, D.E., (November, 2001). Occupational employment projections to 2010. Monthly labor review, 124:11. Office of Occupational Statistics and Employment Projections, Bureau of Labor Statistics, U.S. Department of Labor: Washington, DC.

Substance Abuse and Mental Health Services Administration/Center for Substance Abuse Treatment, (November, 2000). Improving substance abuse treatment: The national treatment plan initiative. Panel reports, public hearings, and participants acknowledgements. Changing the conversation. U.S. Department of Health and Human Services: Washington, DC.

Substance Abuse and Mental Health Services Administration/Office of Applied Studies, (2001). Summary of findings from the 2000 national household survey on drug abuse. NHSDA Series H-13, DHHS publication No. (SMA) 01-3549. Rockville, MD

Substance Abuse and Mental Health Services Administration/Office of Applied Studies, (2000). Summary of findings from the 2000 national household survey on drug abuse. NHSDA Series H-13, DHHS publication No. (SMA) 01-3549. Rockville, MD

The White House,,(2002). Office of National Drug Control Policy (ONDCP) National drug control strategy. NCJ 192260. Author: Washington, DC.