

Publicly Supported Alcohol and other Drug Treatment Systems: 1985 through 1997

Background

Despite its relative youth as an area of clinical practice and as an academic discipline the subject of chemical dependency has provided the impetus for a significant level of diverse research activities. Substantial bodies of literature now exist in a wide range of subject areas related to both the abuse of alcohol and other drugs (AOD) and the phenomenon of dependence. This diversity of research initiatives acknowledges both the complex natures of the processes associated with substance abuse and dependency and the pervasive influences of abuse and dependency on the individual and society. A sense of the range and the research activity surrounding chemical dependency can be found in, among many other sources, the Institute of Medicine's 1996 report entitled Pathways of Addiction: Opportunities in Drug Abuse Research. It is further reflected in the broad content areas addressed in The Tenth Special Report to Congress on Alcohol and Health which was published by the National Institute on Alcohol Abuse and Alcoholism (NIAAA) in June of 2000.

While the breadth of research on substance abuse revealed through the literature is gratifying, it is, as an ongoing enterprise, necessarily incomplete and less than comprehensive. Surprisingly, one of the areas that has received scant attention from researchers is also one that draws most heavily, at least on the demand side of the drug control equation, on government support: The State administered alcohol and other drug treatment systems. Neither the composition nor the utilization patterns of the publicly supported AOD treatment system have been extensively analyzed.

Several factors have contributed to the dormancy of this potential research area. There is, for example, no commonly accepted definition of the publicly supported AOD treatment system. Is it simply the aggregate of those treatment facilities that will accept medically indigent clients? Some would suggest that it is those treatment facilities that are operated by an arm of government or by private non-profit organizations. Another reasonable suggestion might be that it includes all providers that accept any public monies, including Medicaid and Medicare, for services associated with treatment of substance misuse.

Each of these possible definitions includes factors that would argue for and against their adoption. All, appropriately, have in common the explicit recognition of government as a source of revenues. They are also, however, so broad that they fail to exclude many providers more properly assigned to the ranks of practitioners and facilities which focus almost exclusively on a clientele with insurance coverage or sufficient private resources to pay treatment costs. In many instances, especially in rural settings, it is not unusual to find only a single AOD treatment provider serving an extensive

area. Of necessity these providers tend to treat a mix of clients with little regard for the client's financial or insurance status.

Several critical considerations suggest that, despite difficulties in arriving at a precise definition of the public AOD treatment system, it is important that it be examined in some detail. The most obvious of these considerations is the need to show what the expenditure of public monies has purchased. Secondly, only an examination of the public AOD treatment system over time can provide a sense of the efficiency of the system, e.g., is the system accommodating an increasing or decreasing number of clients when one period in time is compared to another? Knowledge of the public AOD system structure and utilization patterns also provides policy makers and administrators with the basis upon which system remediation or refinement decisions may be made. A review of admission patterns, for example, may reveal a clinically unwarranted level of utilization of costly inpatient detoxification and rehabilitation services.

The concept of accountability for the manner in which public monies are expended is not, of course, either new or unique to AOD treatment. Several unusual conditions, however, have influenced the evolution of accountability in the field and placed the responsibility for leadership in this area on two Federal agencies, the Substance Abuse and Mental Health Services Administration (SAMHSA) and its Center for Substance Abuse Treatment (CSAT) and their predecessors. Throughout the short history of publicly supported AOD treatment these Federal agencies have been a major source of funding. In the 1970s the National Institute on Alcoholism and Alcohol Abuse (NIAAA) and the National Institute on Drug Abuse (NIDA) provided formula grants to the States for that purpose. During the very early 1980s Congress created the Alcohol, Drug Abuse and Mental Health Administration (ADAMHA) which continued to support State AOD treatment systems through a block grant mechanism which included funding for State public mental health services. When ADAMHA was reorganized in the early 1990s SAMHSA was created along with CSAT which shared responsibility for administering a new block grant, the Substance Abuse Prevention and Treatment (SAPT) Block Grant, with the Center for Substance Abuse Prevention (CSAP). According to State reported expenditure figures in recent State Alcohol and Drug Abuse Profiles (SADAP), published by NASADAD, the SAPT Block Grant accounts for about one-third of all monies collectively controlled by the State AOD agencies. This large Federal "share" has ensured that SAMHSA and CSAT have had the ability to shape those accountability measures, which are now employed at both the State, Federal and sub-state levels. Past legislation has focused SAMHSA's and CSAT's State accountability initiatives primarily on those processes necessary to demonstrate compliance with fiscal guidelines and regulations and on determining if States had satisfied specific "set-asides" and eligibility criteria.

Beginning in 1995 discussions on a new form of accountability between the Federal government and State AOD Agencies were initiated. The core of those discussions revolved around the promise of greater State flexibility in exchange for information on how the publicly supported treatment system was performing. CSAT and the States, working through NASADAD, began the consensual development of performance measures in 1997 and continue through the present. The Children's Health Act of 2000 both re-authorized SAMHSA and re-designated the SAPT Block Grant as the Substance Abuse Prevention and Treatment Performance Partnership Grant (PPG) program. SAMHSA and CSAT must present Congress with a plan to implement performance measurement at the State level in October of 2002.

The second condition placing an accountability leadership role on the Federal government is that the public AOD treatment system has evolved, to a large measure, independent of mainstream medical practice and its many conventions and regulatory provisions associated with safety and effectiveness. Both through default and through legislative mandate many of those roles have been assumed by State government and by SAMHSA and CSAT which frequently are in a position to apply dedicated resources not available to individual States.

The imminent implementation of PPG performance measurement requirements establishes another context in which it is important to have knowledge of the structure and dynamics of the State AOD treatment systems, at both the national and individual State levels. Although all States will utilize common data elements to express performance, a specific State's performance must be understood to be more than the simple aggregation of individual client data. A State's performance data can be accurately assessed only if it is placed within the context of the unique system that provides treatment within each State. It would be wholly inappropriate, for example, to compare changes reported by States in client criminal justice system involvement at admission and six months later when one State made extensive use of long-term residential programs and the other did not. Those in residential treatment would have significantly fewer opportunities to come into conflict with the legal system than clients in outpatient. In a similar vein a State with a substantial portion of its treatment resources committed to long-term residential services could not reasonably be expected to demonstrate the same level of system access or penetration as a State that delivers predominantly outpatient care. Long-term residential services, regardless of how appropriate they may be for a client, consume a disproportionately larger share of available resources than outpatient treatment.

Data sources germane to the examination of the public AOD treatment system are extremely limited. The composition of virtually the entire national set of AOD treatment facilities may be studied through the Drug and Alcohol Services Information System (DASIS) administered by

SAMHSA's Office of Applied Studies (OAS). Fundamentally, DASIS consists of two separate but related subsystems – one focusing on facilities and one capturing information on admissions to those facilities. Both subsystems exclude individual practitioners and the patients they serve.

The facility oriented subsystem is currently referred to as the National Survey of Substance Abuse Treatment Services (N-SSATS) and formally carried the titles of the Uniform Facility Data Set (UFDS) and the National Alcohol and Drug Abuse Treatment Unit Survey (NDATUS). In addition to collecting information on the characteristics of treatment facilities N-SSATS includes a point-prevalence census of clients in treatment as of a specified date for most years.

N-SSATS's client-oriented counterpart with DASIS is the Treatment Episode Data Set or TEDS. TEDS was previously known as the Client Data System (CDS). With few exceptions the TEDS information provided by the State AOD agencies to the SAMHSA Office of Applied Studies is limited to that which is collected at the time of admission to treatment facilities.

Extensive efforts are made within the N-SSATS and TEDS data collection processes to cast as large a net as possible. The underlying intent of both subsystems is to capture facility and client information from the entire universe of organized AOD treatment providers, public or private. Neither subsystem offers a convenient means for examining only the publicly supported treatment system if that system is defined more precisely than all facilities that accept any public monies. Sorting N-SSATS facility information by ownership type and revenue source provides such an approximation but with significant inexactitude. N-SSATS data, for example, is reported directly by providers who are frequently unable to identify the origin of monies they receive in payment for services, especially under some managed care arrangements.

Given that the intent of this study is to provide contextual information to supplement the measurement of performance under the SAPT PPG a relatively simple definition of the publicly supported AOD treatment system may be adapted. For purposes of this study the system may be thought of as that set of providers that received at least some monies under the direct control of the State Alcohol and Drug Abuse Agencies. Since the early 1980's the State AOD Agencies have provided limited information on facilities that meet that definition to the National Association of State Alcohol and Drug Abuse Directors (NASADAD) on an annual basis. That information is supplemented by data on admissions to those facilities and materials on other subjects related to the administration of the public AOD treatment and prevention systems in each participating State. State specific submissions to NASADAD have been compiled and published in reports commonly referred to as the State Alcohol and Drug Abuse Profiles (SADAP) on an annual or biannual basis since 1984. Those documents have been utilized as the primary data source for this study.

Beyond providing a general historical perspective on State AOD system configurations and utilization, as expressed by admission patterns of the nation's public AOD treatment system, this study was undertaken for several additional purposes. State AOD Agency Directors, for example, have not previously had ready access to materials that would allow them to view the consequences of State system changes over time. Additionally they have not been able to review system change in their State as it may contrast with changes in other States or within the context of national trends.

At the State aggregate or national level, CSAT and SAMHSA have not had an information source specific to the public treatment system from which they could draw information needed for policy, technical assistance, and administrative purposes. At both the State and national levels, for example, it has been generally acknowledged by many that managed care and other cost containment pressures have significantly reduced the utilization level of inpatient (hospital) and residential services. It has been difficult, however, to locate information that would quantitatively measure such a change over time. To the extent that the limited data points available permit, this study attempts to facilitate such examinations. Specific subjects addressed by the study purpose include (at both the individual State and the national level):

- Changes in the percentage of all organized treatment facilities that receive funding under the control of the State AOD Agencies: 1985 through 1997.
- Changes in the percentage of facilities offering alcohol treatment only, drug treatment only, or combined alcohol and drug treatment among treatment units receiving funding under the control of the State AOD Agencies: 1985 through 1997.
- Changes in the pattern of alcohol and other drug client admissions by type of service among treatment facilities that receive funding under the control of the State AOD Agencies: 1985 through 1997.

The balance of the body of this report will include three additional sections. A Methodology section will provide a brief explanation of the process used to collect, verify and analyze the study data. The Findings section will present the results of the analysis at the State aggregate or national level. A separate Appendix will present the individual State profiles which constitute the basis for the construction of the aggregated findings. A final section, Discussion, will present possible explanations for selected findings and explore additional research needs suggested by the study.

Methodology

NASADAD compiled data from State Alcohol and Drug Abuse Agency submissions to the State Alcohol and Drug Abuse Profiles for fiscal years 1985, 1989, 1993, and 1997. These data were utilized to produce individual State-level facility and client admissions data profiles of 48 States and the District of Columbia, each spanning this period of thirteen years. The individual State profiles incorporate an analysis of changes in the number of treatment facilities by funding source and by type of treatment unit, and client admissions by type of admission (i.e., Detoxification, Residential, and Outpatient).

Each State profile is comprised of five tables. Table 1 reflects changes in the total number of treatment units receiving funding from the State AOD Agency. Table 2 captures information on facility type (alcohol only, drug only, and alcohol and drug combined). Table 3a provides an overview of alcohol and other drug client treatment admissions by type of service (Detoxification, Residential, and Outpatient). Table 3b provides a more detailed breakout of Detoxification admissions (Hospital, Residential, and Outpatient) and compares them with all other admissions (Residential and Outpatient). Table 3c provides a similar detailed breakdown of Residential treatment admissions (Hospital, Long-term, and Short-term), contrasted with all other admissions (Detoxification and Outpatient).

Raw State profile tables were sent to the current AOD Agency Directors of each submitting State for their review. Comments regarding the reasons for changes over time were also invited. Upon their return to NASADAD, the individual profiles were analyzed for changes in facilities data and client admissions data from one time interval to the next. The material was again distributed to the States, but with the descriptive analysis included (comments from the States were again invited). All comments from the States were included as a part of the individual State profiles.

Using the data that the States had reviewed, NASADAD created five aggregate tables identical in format to the five individual State profile tables. For eight of the 49 profiles, a portion of either client data or facilities data was missing for one of the time periods specified. For example, although the State of Florida reported facilities data for the entire time-span, they did not report client data by type of admission for 1985. Therefore, the data from that State are not included in the aggregate tables.

Findings

The presentation of study findings is split between this section and an appendix devoted to individual State results. This section will present only the aggregate of individual State tables. States

are not included in the aggregate tables unless their SADAP facilities and admissions data for 1985, 1989, 1993, and 1997 were complete. Forty-one States met this criterion. Nine additional States or jurisdictions had submitted sufficient information for the creation of partial profiles which are a part of the State profile appendix. Those States include Florida, Kentucky, Nebraska, North Carolina, North Dakota, Oklahoma, Rhode Island, Washington, and the District of Columbia. There was insufficient data over the four years analyzed to develop profiles for Idaho, Minnesota, and Wyoming.

Certain formatting liberties have been taken in this section to permit the presentation of tabular results and its associated narrative in appropriate proximity. Table 1 summarizes changes in the proportion of all treatment facilities that receive funding through the State AOD Agency. Table 2 captures change in treatment units offering drug treatment only, alcohol treatment only, or combined alcohol and other drug treatment. Tables 3a, 3b, and 3c provide admissions figures by service type over the study period. Table 3a provides an overview of admission while 3b and 3c provide a more focused examination of those admissions, e.g., detoxification admission by treatment setting compared with all non-detoxification admissions.

Table 1. Aggregate of 41 States: Change in Number of Total Treatment Units Receiving Funding from the State AOD Agencies For Fiscal Years 1985, 1989, 1993, 1997

Year	Est. Total Number Treatment Units	Units Receiving State Funding	Est. Percent Total Units Receiving State Funding	% Change
1985	8,359	5,289	63%	
1989	10,298	6,170	60%	
89-'85 Change	1,939	881		-3%
<hr/>				
1989	10,298	6,170	60%	
1993	10,697	6,273	59%	
93-'89 Change	400	103		-1.28%
<hr/>				
1993	10,697	6,273	59%	
1997	10,162	5,792	57%	
97-'93 Change	-535	-481		-1.64%
<hr/>				
1985	8,359	5,289	63%	
1997	10,162	5,792	57%	
97-'85 Change	1,803	503		-6%

ANALYSIS: The number of Units Receiving State Funding increased in number but decreased as a percent of the Estimated Total Units between '85 and '89. Between '89-'93 this trend continued, with an increase in the number of Units Receiving State Funding, and a slight decrease as an Estimated Percent of Total Units. The number of Units receiving State Funding decreased during '93-'97, and decreased as a percent of the Estimated Total Number of Units, as well. For the period of time being studied, the overall number of Units Receiving State Funding increased, but decreased as the Estimated Percent of Total Units.

Table 2. Aggregate of 41 States: Alcohol Only, Drug Only, and Combined Alcohol and Drug Treatment Units Receiving Funds Administered by the State AOD Agencies For Fiscal Years 1985, 1989, 1993, and 1997

Fiscal Years	Alcohol Only		Drug Only		Alcohol and Drug		Total	
	# of Units	% of Total	# of Units	% of Total	# of Units	% of Total	# of Units	% of Change
1985	2,286	43%	1,327	25%	1,676	32%	5,289	
1989	1,439	23%	1,211	20%	3,520	57%	6,170	
89-85 Change	-847	-20%	-116	-5%	1,844	25%	881	17%
1989	1,439	23%	1,211	20%	3,520	57%	6,170	
1993	647	10%	1,006	16%	4,620	74%	6,273	
93-89 Change	-792	-13%	-205	-4%	1,100	17%	103	2%
1993	647	10%	1,006	16%	4,620	74%	6,273	
1997	515	9%	715	12%	4,562	79%	5,792	
97-93 Change	-132	-1%	-291	-4%	-58	5%	-481	-8%
1985	2,286	43%	1,327	25%	1,676	32%	5,289	
1997	515	9%	715	12%	4,562	79%	5,792	
97-85 Change	-1,771	-34%	-612	-13%	2,886	47%	503	10%

ANALYSIS: The number of Alcohol Only treatment units decreased substantially between '85 and '89 (by -847, or -20%) both in relation to itself and as a percent of the Total Units. The number of Drug Only treatment units also decreased (-116 units or -5%), The number of Combined Units increased by 1,844 (from 32% to 57% of the Estimated Total Units) This was repeated through '89-'93, when Alcohol Only units decreased (-792 or -13%), Drug Only units decreased (-205 or -4%) and Combined Units increased (1,143 or 17%). The pattern in the decrease in Alcohol Only and Drug Only units continued through '93-'97, (-132 or -1% and -291 or 3%, respectively) but for the first time, the number of Combined Units also decreased as a number (-58). This decrease did not result in a decrease as a percent of Estimated Total Units, where it increased by 5% of the Estimated Total. Between '85 - '97, the number of Alcohol Only units decreased by -1,771 or -34% of the Estimated Total, the number of Drug Only units decreased by -612, or -13% of the Estimated Total, and Combined Units increased by 2,886, or 47% of the Estimated Total.

Table 3a. Aggregate of 41 States: Number of Alcohol and Other Drug Client Treatment Admissions by Type of Service for Fiscal Years 1985-1997. Treatment Settings Overview

Fiscal Years	Detoxification		Residential		Outpatient		TOTAL	
	# of Admits	% of Total	# of Admits	% of Total	# of Admits	% of Total	# of Admits	% of Total*
1985	373,094	32%	173,755	15%	607,896	53%	1,154,745	100%
1989	380,123	26%	245,029	17%	855,981	58%	1,481,133	100%
89-85 Change	7,029	-7%	71,274	1%	248,085	5%	326,388	
1989	380,123	26%	245,029	17%	855,981	58%	1,481,133	100%
1993	381,548	25%	246,331	16%	913,076	59%	1,540,955	100%
93-89 Change	1,425	-1%	1,302	-1%	57,095	1%	59,822	
1993	381,548	25%	246,331	16%	913,076	59%	1,540,955	100%
1997	365,136	24%	244,942	16%	895,074	59%	1,505,152	100%
97-93 Change	-16,412	-1%	-1,389	0%	-18,002	0%	-35,803	
1985	373,094	32%	173,755	15%	607,896	53%	1,154,745	100%
1997	365,136	24%	244,942	16%	895,074	59%	1,505,152	100%
97-85 Change	-7,958	-8%	71,187	1%	287,178	7%	350,407	

ANALYSIS: Although the number of Detoxification admissions increased between '85 and '89, it decreased as a percent of Total Admissions. Residential admissions increased substantially during this interval, but increased moderately as a percent of Total Admissions. Outpatient admissions also increased substantially, but increased by only 5% of Total Admissions.

Between '89-'93, the number of Detoxification admissions remained stable, as did Residential admissions. Outpatient admissions increased moderately in number and as a percent of the Total Admissions. Between '93 -97, Detoxification admissions decreased in number, and by -1% of the Total Admissions. Residential Admissions also decreased in number, but remained unchanged as a percent of the Total. Outpatient admissions decreased in number, and also remained unchanged as a percent of the Total. Between '85 and '97, Detoxification admissions decreased as a number and as percent of the Total, Residential Admissions increased in number but remained relatively unchanged as a percent of the Total, and Outpatient admissions increased both in number and as a percent of the Total.

Table 3b. Aggregate of 41 States: Data Number of Alcohol and Other Drug Client Treatment Admissions by Type of Service for Fiscal Years 1985-1997. Detoxification Admissions Detail

Fiscal Years	Detoxification Admissions								All Other Admissions		Total Admissions	
	Hospital		Residential		Outpatient		Total		(Residential and Outpatient)		(Residential, Outpatient, and Detox)	
	# of Admits	% of Detox Admits	# of Admits	% of Detox Admits	# of Admits	% of Detox Admits	Total # of Admits	% of All Admits	# of All Other Admits	% of All Admits	# of All Admits	% of All Admits*
1985	155,339	42%	198,754	53%	19,001	5%	373,094	32%	781,651	68%	1,154,745	100%
1989	45,234	12%	328,882	87%	6,007	2%	380,123	26%	1,101,010	74%	1,481,133	100%
89-'85 Change	-110,105	-30%	130,128	33%	-12,994	-4%	7,029	-7%	319,359	7%	326,388	
1989	45,234	12%	328,882	87%	6,007	2%	380,123	26%	1,101,010	74%	1,481,133	100%
1993	44,015	12%	298,985	78%	38,548	10%	381,548	25%	1,159,407	75%	1,540,955	100%
93-'89 Change	-1,219	0%	-29,897	-8%	32,541	9%	1,425	-1%	58,397	1%	59,822	
1993	44,015	12%	298,985	78%	38,548	10%	381,548	25%	1,159,407	75%	1,540,955	100%
1997	16,778	5%	291,300	80%	57,058	16%	365,136	24%	1,140,016	76%	1,505,152	100%
97-'93 Change	-27,237	-7%	-7,685	1%	18,510	6%	-16,412	-1%	-19,391	1%	-35,803	
1985	155,339	42%	198,754	53%	19,001	5%	373,094	32%	781,651	68%	1,154,745	100%
1997	16,778	5%	291,300	80%	57,058	16%	365,136	24%	1,140,016	76%	1,505,152	100%
97-'85 Change	-138,561	-37%	92,546	27%	38,057	11%	-7,958	-8%	358,365	8%	350,407	

*Where percents of "all admits" do not equal 100% it is due to rounding.

ANALYSIS: Admissions to Hospital-based Detoxification decreased between '85 and '89, both in number and as a percent of the Total Detoxification Admissions. There was an increase in the number of Residential Detoxification Admissions, and this also increased as a percent of Total Detoxification Admissions. Outpatient Detoxification Admissions decreased in number and as a percent of Total. During '89-93, Hospital based Detoxification admissions remained relatively stable, Residential Detoxification admissions decreased in number and percent of Total, and Outpatient Detoxification increased in number and as a percent of Total. Between '93-97, Hospital based Detoxification admissions declined again, both in number and as a percent of Total, Residential Detoxification Admissions decreased in number but increased slightly as a percent of the Total, and Outpatient Detoxification Admissions increased both in number and as a percent of the Total Detoxification Admissions.

Table 3c. Aggregate of 41 States: Number of Alcohol and Other Drug Client Treatment Admissions by Type of Service for Fiscal Years 1985-1997. Residential Admissions Detail

Fiscal Years	Residential Admissions							All Other Admissions		Total Admissions		
	Hospital		Short Term		Long Term		Total		(Detoxification and Outpatient)		(Residential, Outpatient, and Detox)	
	# of Admits	% of Res. Admits	# of Admits	% of Res. Admits	# of Admits	% of Res. Admits	Total # of Res. Admits	% of All Admits	# of All Other Admits	% of All Admits	# of All Admits	% of All Admits*
1985**	29,801	17%	143,954	83%	0	0%	173,755	15%	980,990	85%	1,154,745	100%
1989	12,732	5%	143,467	59%	88,830	36%	245,029	17%	1,236,104	83%	1,481,133	100%
89-'85 Change	-17,069	-12%	-487	-24%	88,830	36%	71,274	1%	255,114	-1%	326,388	
1989	12,732	5%	143,467	59%	88,830	36%	245,029	17%	1,236,104	83%	1,481,133	100%
1993	12,818	5%	115,650	47%	117,863	48%	246,331	16%	1,294,624	84%	1,540,955	100%
93-'89 Change	86	0%	-27,817	-12%	29,033	12%	1,302	-1%	58,520	1%	59,822	
1993	12,818	5%	115,650	47%	117,863	48%	246,331	16%	1,294,624	84%	1,540,955	100%
1997	6,845	3%	103,191	42%	134,906	55%	244,942	16%	1,260,210	84%	1,505,152	100%
97-'93 Change	-5,973	-2%	-12,459	-5%	17,043	7%	-1,389	0%	-34,414	0%	-35,803	
1989	12,732	5%	143,467	59%	88,830	36%	245,029	17%	1,236,104	83%	1,481,133	100%
1997	6,845	3%	103,191	42%	134,906	55%	244,942	16%	1,260,210	84%	1,505,152	100%
97-'89 Change	-5,887	-2%	-40,276	-16%	46,076	19%	-87	0%	24,106	0%	24,019	

*Where percents of "all admits" do not equal 100% it is due to rounding.

**1985 Non-Hospital Residential Treatment Admissions were not identified as either Long Term or Short-Term admissions. Non-Hospital residential admissions for 1985 are identified as Short-Term admissions here, with the understanding that at least some of these admissions were for Long Term Residential Treatment.

ANALYSIS: Hospital based Residential Treatment decreased substantially between '85-'89, both in number and as a percent of the Total Residential Admissions. Hospital based Residential Admissions were essentially stable between '89 and '93, then decreased substantially between '93 and '97. Admissions to Short Term Residential Treatment decreased between '89 and '93 then decreased again between '93 and '97. It also decreased as a percent of Total Residential Treatment Admissions. Long Term Admissions increased between '89 and '93, then increased again between '93 and '97. It also increased each time as a percent of Total Residential Admissions.

Discussion

In the introductory section of this paper three specific subject areas were identified as of primary interest in this study. Those include:

- Changes in the percentage of all organized treatment facilities that receive funding under the control of the State AOD Agencies: 1985 through 1997.
- Changes in the percentage of facilities offering alcohol treatment only, drug treatment only, or combined alcohol and drug treatment among treatment units receiving funding under the control of the State AOD Agencies: 1985 through 1997.
- Changes in the pattern of alcohol and other drug client admissions by type of service among treatment facilities that receive funding under the control of the State AOD Agencies: 1985 through 1997.

The first area explores the gross relationship between AOD treatment facilities receiving monies from State AOD Agencies and the total number of organized treatment facilities recognized by the State. It is important to track the nature of this relationship over time as it provides administrators with a rough measure of the relative degree of availability of publicly supported treatment and private treatment. Significant shifts in those proportions, in either direction, would be meaningful. Marked reductions in the percentage of facilities receiving funds from the State might suggest diminished access to treatment among the medically indigent. A dramatic shift in the other direction, an increase in the percentage of facilities receiving monies from the State AOD Agency, may indicate either the closing of treatment facilities in the private sector or changes in third party payor coverage and practices which make the lower rates frequently associated with public funding more financially attractive.

Over the time intervals examined the percentage of all treatment facilities which receive funds from the State AOD Agencies has remained remarkably stable (63% in 1985 as opposed to 57% in 1997 or a decrease of six percentage points). Both the total number of facilities and those receiving State funds increased when 1997 figures are compared with 1985 figures. Total facilities for 1997 were estimated at 10,162 or 1,803 more than the 8,359 estimated for 1985. Funded facilities in 1997 were reported as 5,792 or 503 more than the 5,289 reported in 1985. Changes in the percentage of

funded facilities for the intervening periods (1985 vs. 1989, 1989 vs. 1993, and 1993 vs. 1997) were all less than 5% although all were negative, -3%, -1.28%, and -1.64%, respectively.

The second area of interest relates to changes over time in the proportion of treatment facilities providing alcohol only, drug only, or both alcohol and other drug treatment services. Of all the changes identified in this study the magnitude of change in this variable was the most dramatic. In 1985, 43% of all treatment facilities offered alcohol only services, a quarter of the facilities treated only drug problems, and 32% treated both alcohol and drug disorders. By 1997 the States reported that only 9% of facilities restricted their treatment services to those with only alcohol disorders and the percentage of drug only treatment facilities had dropped to 12%. The percentage of facilities providing both alcohol and drug treatment had jumped from about one-third to nearly four-fifths over the same period. Observations obtained for the intervening comparison periods indicated that the trend toward combined alcohol and drug treatment facilities was constant.

A substantial portion of the early separation of alcohol treatment from drug treatment reported here may be an artifact of distinct Federal funding streams commented on in the introductory section of this report.

The first form of Federal assistance to States for substance abuse treatment services was through formula grants from NIAAA and NIDA. NIAAA was created by P.L. 91-616 and NIDA was established under provisions P.L. 92-255. As may be inferred by the public law designations both pieces of legislation were enacted in the very early 1970's. In addition to creating the two Institutes and authorizing formula grants the legislation required participating States to designate units of State governments as being responsible for specific planning and administrative processes associated with those formula grants. Under P.L. 91-616 States identified governmental entities designated to serve as State Alcohol Authorities (SAAs) as well as a governmental unit termed a Single State Authority (SSA) for drug abuse to comply with similar, but not identical, requirements established under P.L. 92-255. States accommodated the designation of SAAs and SSAs in a variety of forms. A significant number of States established separate and distinct entities for drug treatment purposes and for alcohol treatment purposes. Others combined the functions of the SAA and the SSA into a single unit.

Regardless of the nature of the States response, differences remained in terms of the separate continuing eligibility criteria established for funds from NIAAA and NIDA. Both NIDA and NIAAA developed unique treatment standards for those facilities receiving a portion of their respective formula grants through the States. In addition participation in distinct facility and State reporting systems was mandated. At the facility level these requirements translated into the establishment and operation of services that were, to varying degrees, restricted to the treatment of alcohol problems or to drug

disorders. The tendency towards separate alcohol and drug treatment services and systems was reinforced by differing therapeutic and consumer cultures that existed at that point in time.

It seems likely that, to a significant degree, the large number of alcohol only and drug only facilities reported by the States in 1985, as opposed to the lower number reported for later years, simply reflects the lingering effects of Federal requirements which are no longer in operative. The 1981 legislation that established ADAMHA and the Alcohol, Drug, and Mental Health (ADM) Block Grant also removed the separate Federal funding criteria that had characterized the earlier formula grants. Concern over the potential for disproportional emphasis of either alcohol or drug use disorders was, however, recognized by Congress. Congress accommodated that concern by mandating that States expend a minimum of 35% of each block grant award for alcohol related activities and a minimum of 35% for drug oriented activities. It should be noted that even when the separate alcohol and drug provisions were in effect many clients presented with both alcohol and other drug problems. Many States and facilities unofficially recognized that reality and provided a full range of appropriate services. Acknowledging the fact that many instances of dependence involved multiple agents, and developing appropriate treatment responses, was probably a significant factor in the trend toward the current predominance of treatment facilities that serve clients without regard to their specific substances of abuse.

With the advent of ADAMHA the legislative basis for separate SAAs and SSAs was removed. Not all States with distinct alcohol and drug authorities responded immediately by merging those functions into a single entity. The last State with separate alcohol and drug agencies, New York, did not combine its alcohol and drug administrations until 1994. The consistent movement toward combined alcohol and drug treatment facilities apparent in Table 2 clearly reflects the gradual nature of these State government reorganizations. Even in those States in which the SSA and the SAA were already joined, time was needed for the States to develop and implement treatment standards applicable to combined alcohol and drug treatment services.

The final objective of this study was to explore changes in selected types of admission patterns between 1985 and 1997. Admissions to treatment services can be broken down into three gross categories: Detoxification, residential, and outpatient. During 1985, detoxification admissions accounted for 32% of all admissions, residential 15%, and outpatient the remaining 53%. By 1997 those figures were 24%, 16%, and 59% respectively. As a percentage of all admissions residential admission demonstrated remarkable consistency, a variance of only 1% (from 15% to 16%). More variability was evident for detoxification, which dropped from about a third of all admissions to

slightly less than one fourth, or a decrease of 8%. Outpatient admissions was the only category to evidence a significant increase when expressed as a percentage of all admissions.

Analysis at the level of gross admission categories has value in documenting overall shifts and trends but provides few clues about why the changes identified took place. For that reason NASADAD attempted to look within the broader categories to the extent that available data made possible. Detoxification, for example, takes place in a variety of settings. Since 1985 States have reported detoxification admissions to three settings: Hospital, residential, and outpatient. By comparing the detoxification admissions across both settings and time, detail of significant interest are revealed. Hospital detoxification admissions accounted for 42% of all detoxification admissions for 1985. In 1997 the States reported that hospital detoxification admissions represented only 5% of all such admissions, a drop of 37%. Of special interest is the fact that over 80% of that decrease took place between 1985 and 1989, several years before any large-scale implementation of managed care.

Residential (non-hospital) detoxification admissions registered the greatest proportional level of growth when compared with other forms of detoxification admissions over the study period. In 1985 residential detoxification accounted for 53% of all detoxification admissions. For 1997 the comparable figure was 80%. Here again the time period responsible for the greatest degree of change was 1985 to 1989, prior to the advent of managed care.

Outpatient detoxification admissions show a pattern quite different from those of hospital and residential detoxification. Growth in outpatient detoxification admissions was not evident until 1993 when it accounted for 10% of all detoxification admissions (up from only 2% in 1989). By 1997 outpatient detoxification admissions still accounted for only 16% of all detoxification admissions.

Detoxification admission patterns have clearly been dynamic throughout the study period. The time periods in which the major changes occurred for both hospital and residential detoxification admissions rule out managed care as a cause. It does not, however, exclude the application of principles now commonly held by managed care organizations as powerful influences. One such principal relates to the preferential utilization of treatment services provided in the least medically intensive environment consistent with the provision of quality care.

State AOD Directors, born of limited resources, have always sought options that offer clinical safety and effectiveness at lower costs. During the early 1980s evidence mounted supporting the position that the vast majority of detoxifications could be accomplished both safely and effectively in a non-medical (non-hospital) setting. As a consequence significant effort was devoted to building capacity for social setting detoxification (residential non-hospital). To a considerable degree, that capacity building was aided by the earlier passage in virtually every State of legislation removing

criminal penalties from acts of public inebriation per se. With jails no longer an option for public inebriates the law enforcement community frequently partnered with components of State AOD systems to create social setting detoxification centers. These centers provide detoxification services at a compelling cost advantage when compared to hospitalization. Both alcohol and drug detoxifications are now carried out in social settings as a matter of routine. It should be noted that social setting detoxification does not typically occur in isolation from intensive medical intervention when circumstances warrant. Rather, arrangements are in place to assure access to hospital resources in the event of a clinical crisis.

The detoxification figures contained in this report also speak of the publicly supported AOD system's evolving refinement in client assessment and placement. At the study's earliest measurement point, 1985, nearly one admission in three was for detoxification. In 1997 detoxification accounted for less than one in four of all admissions. Even in terms of absolute numbers detoxification admissions represented fewer individuals in 1997 than was the case for 1985.

This refinement in clinical practice is further reflected in the pattern apparent for outpatient detoxifications. In 1985, only 5% of all detoxification admissions were to outpatient settings. The comparable figure for 1989 fell to 2%. By 1997, however, 16% of all detoxification admissions were reported as outpatient. That growth reflects both a new level of clinical competency and an extension of the applications of cost effectiveness principles noted in explaining the high relative utilization of social setting detoxification.

Table 3c provides a comparison of admissions to various residential treatment settings over time. Interpretations of residential admissions are complicated by certain data issues. In 1985, for example, all residential, non-hospital admissions reported did not differentiate between short-term and long-term and have therefore been excluded for purposes of longitudinal analysis. In addition, long-term residential as a category, includes a variety of services. Those services range from adolescent chemical dependency programs to therapeutic communities to halfway houses and custodial care facilities.

Despite these data deficiencies, significant shifts in residential admission patterns are still identifiable. As has been noted elsewhere in this report there was an early movement away from hospital based services. In 1985 hospital admissions accounted for 17% of all residential treatment admissions. In 1989 the comparable figure was only 5% and was subject to even further reduction by 1997 (to 3%). Here again that decline followed the accumulation of clinical evidence that strongly suggested that the outcomes achieved by hospital based treatment did not justify its higher relative

cost. Exceptions may be found, of course, among select clients who present with co-existing medical and psychiatric conditions.

Many quarters have expressed concern that the public AOD treatment system is losing its necessary residential treatment base. In our earlier discussion of Table 3a it was noted that, as a percentage of all admissions, residential admissions were remarkably stable, 15% in 1985 and 16% in 1997. A more detailed picture is available in Table 3c. That table reveals more dynamics interior to residential admissions including the shift away from hospital admissions discussed above. Although comparison of short-term and long-term residential treatment admissions is possible only for 1989 through 1997 trends still appear to be evident. In 1989 admissions to short-term residential treatment accounted for 59% of all residential treatment admissions. Reported short-term admissions for 1993 showed a drop of 12% for the comparable figure (47%). That decline continued for 1997 when it was registered at 42%. For the entire 1989–1997 period, short-term admissions as a percentage of all residential treatment admissions dropped 16%. Over the same time frame, long-term residential admissions grew as a proportion of all residential admissions (from 36% in 1989 to 55% in 1997).

For those working in “28 day” residential chemical dependency programs, such as those based to some degree on the “Minnesota Model,” it will come as no surprise that the greatest shift downwards in short-term admissions took place between 1989 and 1993. During that period it became essentially standard practice for both State systems and insurance companies to deny authorization for a full 28 days of treatment. Rather, authorization was provided for only short segments of treatment with reauthorization required for each subsequent segment. In addition, many States and insurance companies would not authorize short-term residential treatment at all unless certain new criteria were met. Frequently those criteria took the form of requiring documentation that a client was in need of services not available in an outpatient setting. In other instances, clients were not viewed as eligible for short-term residential treatment unless there was evidence of previous failures in outpatient treatment.

Reasons for the growth of long-term treatment admissions while short-term admissions fell, is unclear. Some portion of that lack of clarity can be ascribed to the fact that long-term admissions include admissions to several types of treatment facilities. Some portion of the differential might be assigned to the nature of the relationships that exist between long-term providers and payor organizations. Medicaid and insurance coverage for long-term treatment services has historically been sparse or non-existent. There are, for example, few instances of Medicaid reimbursement for halfway houses or custodial care facilities although the value and necessity of those transitional services are recognized by State AOD systems. It is suspected that the historic lack of dependence on insurance

and similar payor sources may have resulted in the stability and growth evident in this study. Perhaps the strongest rationale for the robustness of long-term treatment admissions over the study period can be found in the fact that, as of yet, no less expensive alternatives have been found which would meet the several purposes filled by long-term treatment facilities.

The data utilized for this study have significant limitations and weaknesses. They demand that the figures themselves be viewed as somewhat suspect and that any conclusions drawn from them be judged as indicative in nature and not absolute. It is well known, for example, that there are many instances of hospital detoxification that are not reflected in State AOD Agency client level data systems. Are there enough such admissions to invalidate the findings presented here? The answer is that we simply do not know. In the vast majority of cases, however, those admissions were never considered a part of the publicly supported AOD treatment system as defined for purposes of this study, i.e., those facilities receiving at least some funds controlled by the State AOD Agency. From that perspective our findings related to hospital based detoxification probably are defensible.

Another limitation inherent in the data used is that the admissions reported here are not unduplicated. That is, a single individual may account for multiple admissions. It is impossible to determine what affect this phenomenon might have on the study finding. It is suggested, however, that annual admissions constitute relatively large numbers. As large numbers they are capable of accommodating a substantial number of duplicate admissions without invalidating trends of the gross nature identified in this study.

While the study data had several limiting factors the most constraining weakness was that it is devoid of client level indicators beyond the point of admission. Without an aggregate sense of the nature of the treatment experience, e.g., retention, completion, transfers between level of care, it is impossible to determine how well admissions alone may capture the dynamics of the system. It most certainly limits the value of studies such as this in illuminating State-to-State differences. This limitation would be especially telling in attempting to explain State system differences as influences on measures of efficiency and effectiveness. In addition, data that depicts client treatment episodes rather than facility based admissions is clearly another long time information deficit that must be addressed.

Serious thought must be given to creating an expanded categorization of treatment facilities and settings for reporting purposes. First, it is suggested that the facility category of Residential Long-Term be broken into meaningful subcategories. Given that Residential Long-Term now dominates residential admissions it is critical that system administrators be able to distinguish between such fundamentally dissimilar facilities as Therapeutic Communities, halfway houses, and residential chemical dependency programs of extended duration. The second treatment categorization demanding

attention is that of outpatient. Many treatment modalities, ranging from intensive day treatment to ad lib counseling sessions, are too frequently lumped together under the Outpatient headings. Data systems such as N-SSATS collect more definitive information but those data are difficult to apply to only the public treatment system as was noted in the introductory section of this report. Regardless of reasons that may be advanced for not utilizing a set of subcategories when examining outpatient programs it is clear that as much information may be obscured as is revealed when only data representing the broad category is considered.

The concept of “treatment episodes” was mentioned above. If an information system capable of capturing individual treatment episodes is desired, significant and costly changes in existing data systems must be made. It is also critical that core information system capabilities be held in common by all State AOD Agencies. The development and implementation of an enhanced national AOD information capability may realistically be approached only through the true State/Federal partnership. Both the Health Insurance Portability and Accountability Act (HIPAA) and the transition to PPGs will require changes to State AOD information systems. The proximate and nearly simultaneous implementation schedules for HIPAA and PPGs create a unique window of opportunity in which States will have an active interest in modifying and improving their information capabilities.

CSAT, and other components of SAMHSA, have recognized the unique nature of this opportunity. Several initiatives are now either in place or planned which will provide forums for collaboration with the State AOD Agencies. While this is cause for optimism, considerable effort must be devoted to ensuring that those separate initiatives are carefully coordinated. Finally, the State AOD Agencies will require both technical and financial assistance to implement and maintain a revamped system. The identification and actualization of appropriate financing options warrant the same level of Federal attention now evident on the information technology side of the equation.

Bibliography

Institute of Medicine. (1996). *Pathways of Addiction: Opportunities in Drug Abuse Research*. Washington, DC: National Academy Press.

U.S. Department of Health and Human Services. (2000). *The 10th Special Report to the U.S. Congress on Alcohol and Health*. (NIH Publication No. 00-1583). Washington, DC: National Institute on Alcohol Abuse and Alcoholism.

National Association of State Alcohol and Drug Abuse Directors, Inc. (1986). *State Resources and Services Related to Alcohol and Other Drug Problems for Fiscal Year 1985*. Washington, DC: Alcohol, Drug Abuse, and Mental Health Administration.

National Association of State Alcohol and Drug Abuse Directors, Inc. (1990). *State Resources and Services Related to Alcohol and Other Drug Problems for Fiscal Year 1989*. Washington, DC: Alcohol, Drug Abuse, and Mental Health Administration.

National Association of State Alcohol and Drug Abuse Directors, Inc. (1994). *State Resources and Services Related to Alcohol and Other Drug Problems for Fiscal Year 1993*. Washington, DC: Substance Abuse and Mental Health Services Administration.

National Association of State Alcohol and Drug Abuse Directors, Inc. (1998). *State Resources and Services Related to Alcohol and Other Drug Problems for Fiscal Years 1996 and 1997*. Washington, DC: Substance Abuse and Mental Health Services Administration.