SUBSTANCE ABUSE TREATMENT PROVIDER SURVEY REPORT

Summer, 2016

Center for Human Services Research
University at Albany State University of New York

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2016

INTRODUCTION

The Alcoholism and Substance Abuse Providers of New York State (ASAP) contracted with the Center for Human Service Research (CHSR) at the University at Albany to conduct an on-line survey of New York State substance abuse treatment providers. The purpose of the survey was to identify the unmet needs and issues that impact the substance use disorders field to inform ASAP's advocacy efforts. In particular, it was hypothesized that areas of the state outside of New York City (NYC) may have greater difficulty in meeting the treatment needs of their local populations.

METHODS

The survey was developed by the director of the Center for Addictions Research at the University at Albany, survey design specialists at CHSR, and substance abuse treatment system experts at ASAP. It included questions about the respondents' treatment programs (types of services provided, location, number and demographics of clients and staff), waiting time to receive services, length of waiting lists, concerns about service provision issues, service needs for special populations, and unmet community needs for treatment.

The OASAS Treatment Provider Directory was used to obtain treatment provider e-mail addresses. After duplicate e-mail addresses and gambling addiction treatment providers were excluded, a link to the on-line survey was sent to 689 e-mail addresses. Eight reminders were sent to those who did not finish the survey; one from ASAP and seven from CHSR.

CHSR staff telephoned 184 people who did not respond to the survey to encourage their participation. When the contact could not be reached directly, messages were left on voice-mail or with office staff. If the contact was no longer working at the organization, staff attempted to obtain the name and e-mail address of another appropriate contact (Figure 1). Six to ten percent of the follow-up calls resulted in an additional survey completion.

Figure 1. Outcomes of follow-up calls (N=184)

Left messages	115	63%
Talked directly to participant	29	16%
Contact no longer there	24	13%
Obtained new contact	*11*	
Unreachable	16	9%

The survey was live on-line from April 12th - May 23rd, 2016.

RESULTS

A total of 376 surveys were submitted. Thirty-eight of these were discarded because they were not filled in past the first item or because the same person submitted the survey twice. This resulted in **338 valid surveys**.

The response rate was 52%. The survey was originally sent to 689 addresses. 32 e-mail addresses consistently bounced, plus 13 contacts were confirmed to be no longer at the organization and alternative respondents at the organization could not be obtained, so we had 644 valid contacts. Based on the number of contacts in the subset that CHSR staff telephoned who were no longer employed at the agency or who could not be reached, it is likely that additional e-mail addresses were no longer valid, so the actual response rate may be higher.

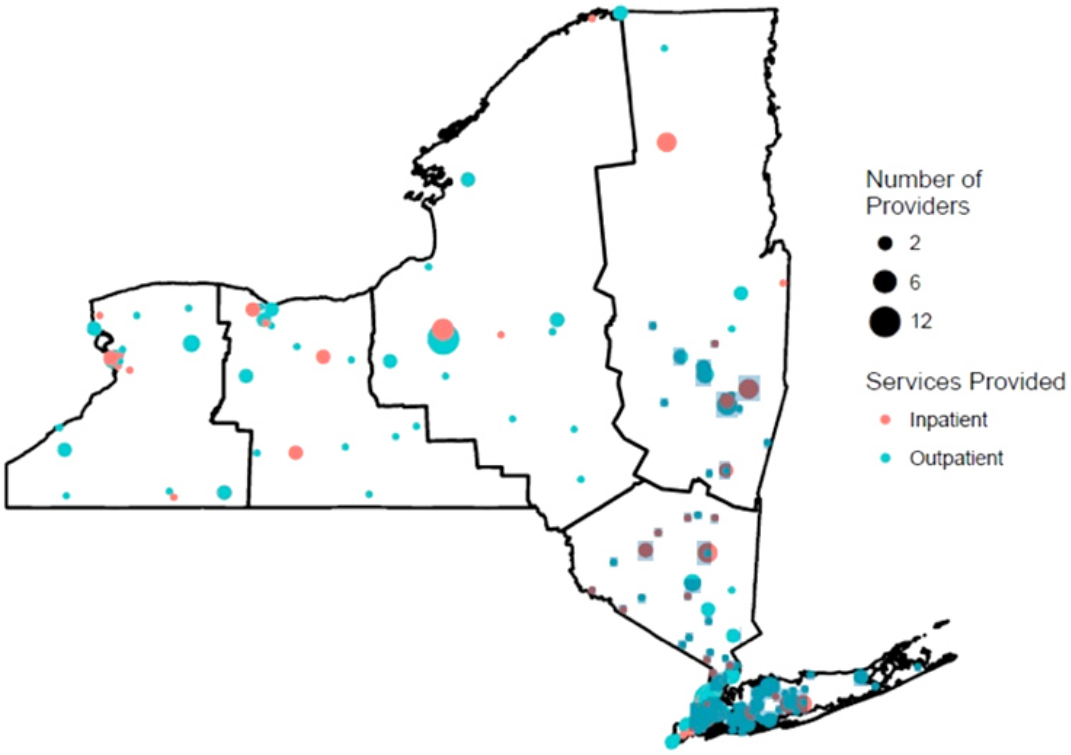


Figure 2 shows the distribution of inpatient and outpatient program respondents across the state. Red dots show inpatient providers and blue dots show outpatient providers. If more than one facility was located in the same ZIP code, the dot was enlarged based on the number of facilities. One-third of the programs were located in NYC.

Program Type

Most respondents (N=215) were employed at outpatient clinics (Figure 3). Some respondents answered questions about multiple program types at their organization, so the Figure 3 total is greater than the number of respondents.

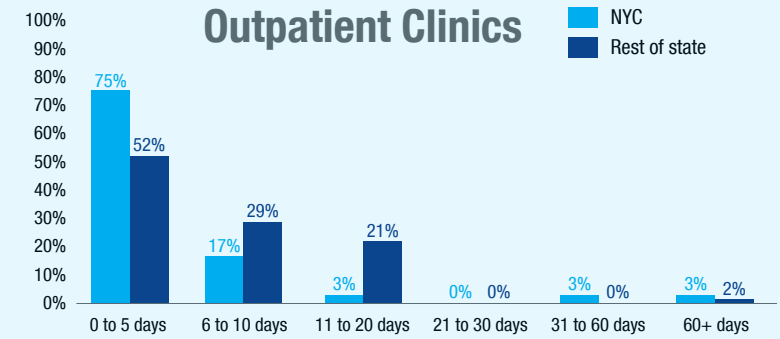
Figure 3. Program Types

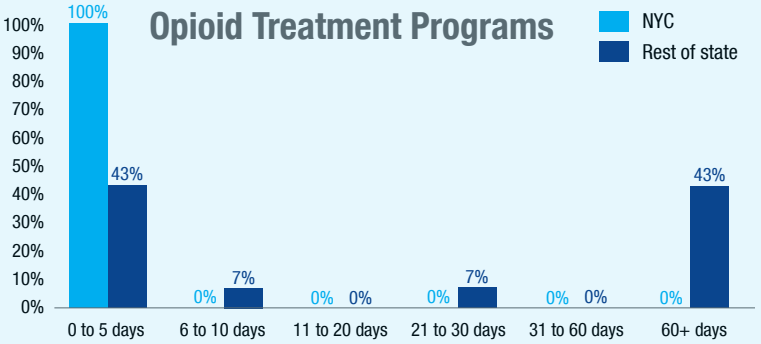
Outpatient:	N
Clinic (822, etc.)	215
Opioid Treatment Program	59
Outpatient Detox	17
Inpatient:	
Inpatient Rehabilitation	37
Residential Detox/ Crisis Center	23
Residential (therapeutic community)	37
Recovery/ Re-entry	52

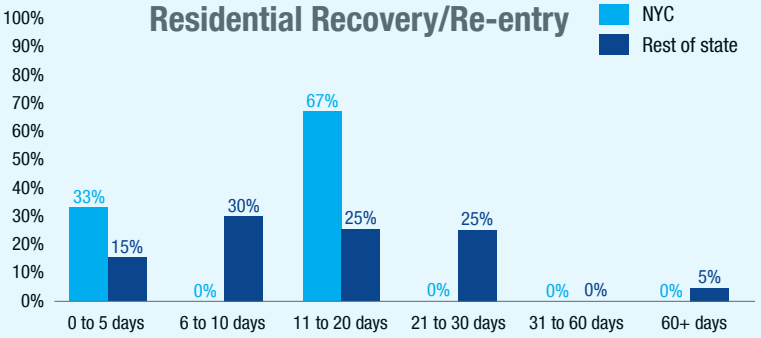
Wait Times and Wait Lists

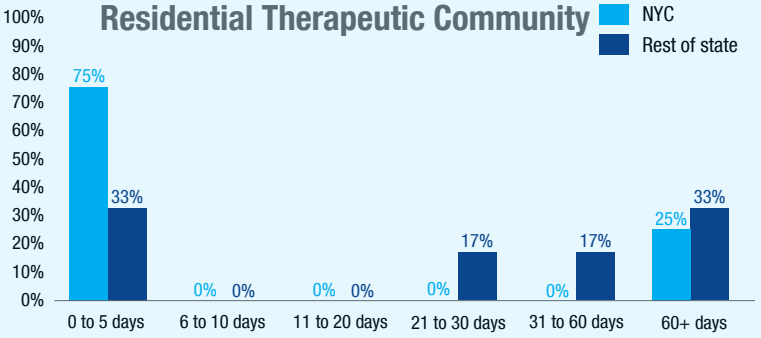
The length of time clients waited between their first contact with a program and the beginning of treatment varied significantly based on program type and whether the program was located in NYC. Outpatient detox, inpatient rehab, and residential detox programs all had wait times of 0-5 days. Other program types had greater variation, as shown in Figure 4. NYC programs had shorter wait times on average.

Figure 4. What is the typical length of time a client will wait between first contact with your program and the beginning of treatment? ____ days









Waiting lists were maintained by 35% of NYC programs and 42% of programs in the rest of the state. Inpatient programs (on the right side of Figure 5) were more likely to keep waiting lists.

Of the programs that kept waiting lists, inpatient waiting lists were often longer (Figure 6), as were those for upstate programs. Only three NYC programs reported having anyone on their waiting list, and those had no more than five people on them.

Needs and Concerns

Figure 7 shows the percentage of respondents that felt that the issues listed were at least somewhat a concern for their programs. More than half considered the transition to managed care and the integration with primary health care to be of concern.

For the most part, upstate organizations had greater concerns than NYC organizations about these issues. Concerns about availability of medical staff, availability of direct service staff, and waiting lists were ten or more percentage points higher outside of NYC. NYC organizations were however more concerned about low utilization rates (54% vs. 40%).

Respondents expressed significant concerns about unmet community needs for specific types of treatment.[1] More than 75% cited

Figure 5. Does your organization keep a waiting list for your services? (Percent yes)

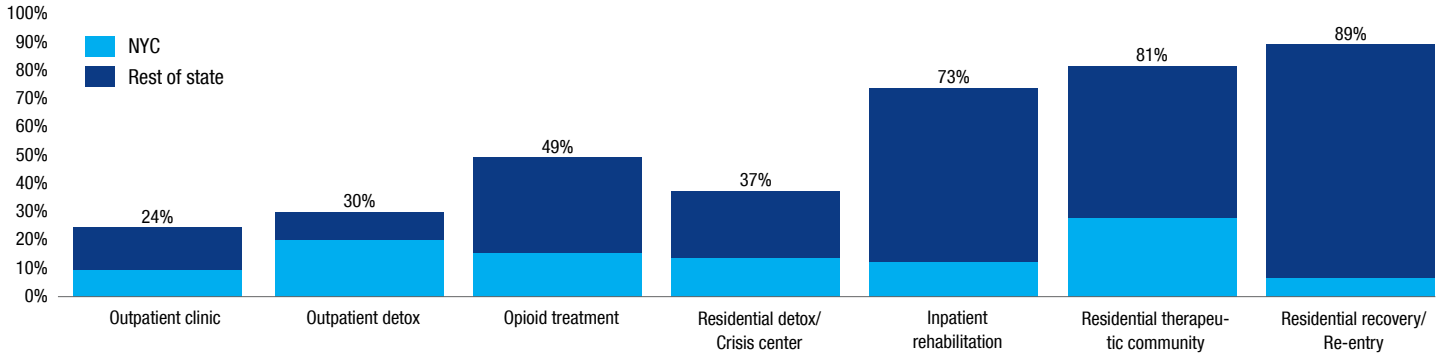
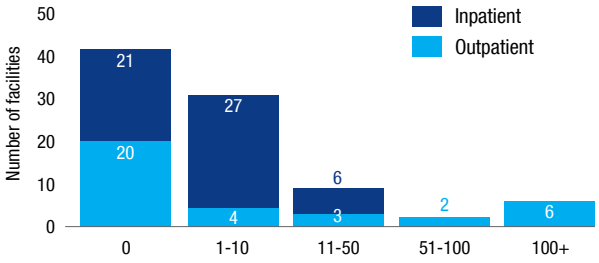


Figure 6. As of today, how many people are currently on the waiting list?



co-occurring disorders, capacity expansion, and treatment for opioids, alcohol, and other emerging drugs as at least somewhat a concern, and more than half had at least somewhat of a concern about unmet needs for medication assisted treatment, recovery supports, early intervention, technology enhanced services, and harm reduction (Figure 8).

Specific populations were viewed as having significant service needs, with criminal justice, women, and homeless populations

Figure 7. Please indicate how much of a concern each of the following issues are for your program.
(Percent responding somewhat a concern, a moderate concern, or a serious concern)

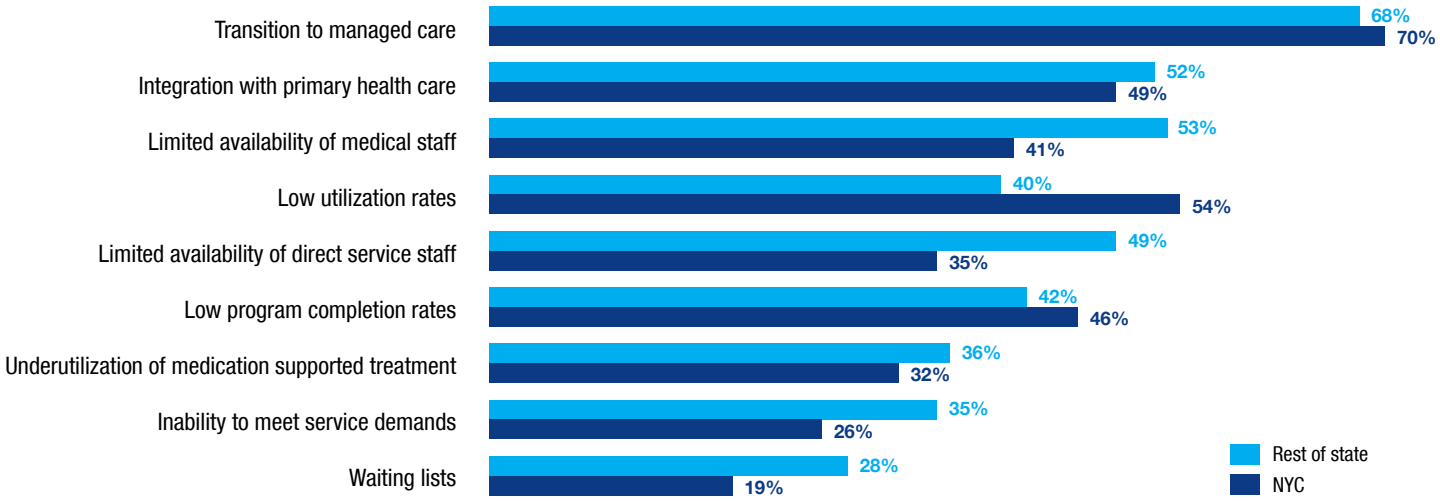
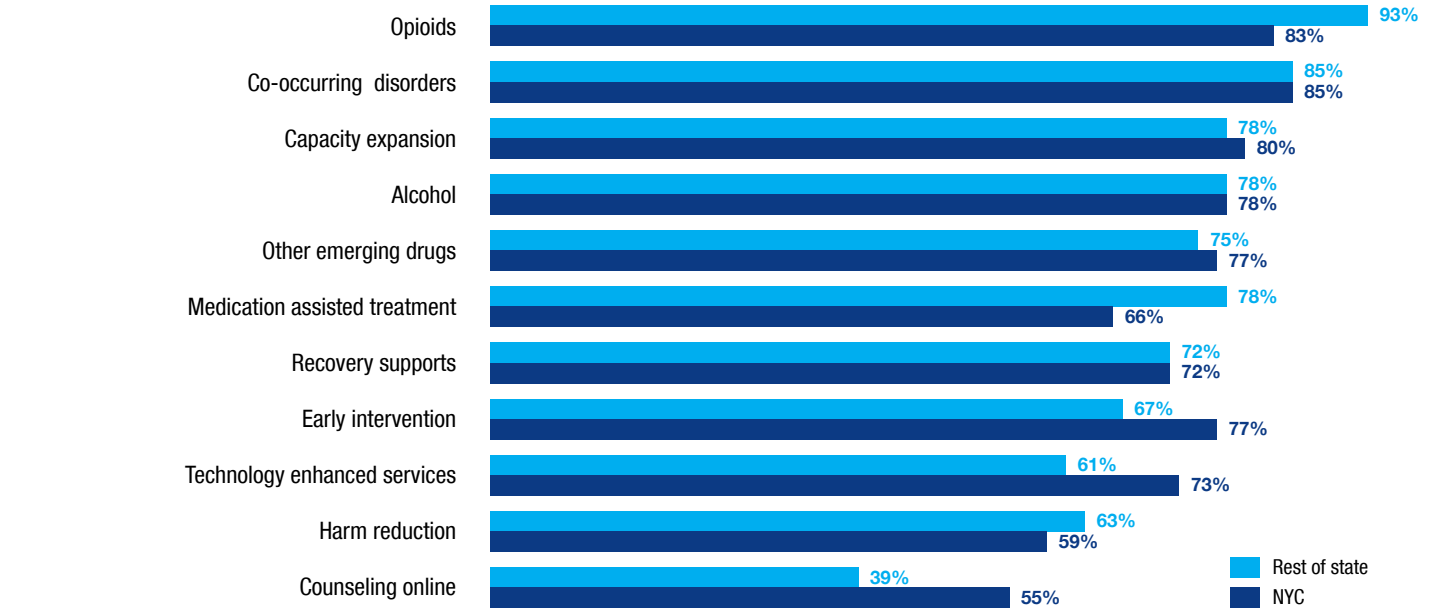


Figure 8. Please indicate how concerned you are about unmet needs in your community for each of the following areas.
(Percent responding somewhat a concern, moderate concern, or serious concern.)



[1]Response choices were Not At All A Concern; Slight Concern; Somewhat a Concern; Moderate Concern; and Serious Concern.

cited as a moderate or serious need for over 70% of the programs (Figure 9).[2] Veteran, children/adolescent, LGBTQ, and senior citizen populations were seen as having at least moderate needs by 52%-62% of NYC programs, and 36%-47% of programs in the rest of the state.

Program Descriptives

Figure 10 shows the number of people who received treatment at each program in 2015, and Figure 11 shows the race and gender of those clients. The average number of clients served annually was 432. Nearly half of these clients were white, and about two-thirds were men.

Staffing

Because of the different types of the programs that participated in the survey, their number of employees and these employees' length of service and rate of turnover varied dramatically across programs, but the average number of full-time employees was 14.6 and their average length of service was about 6.5 years (Figure 12).

The top reasons for staff leaving were personal reasons (such as retirement, family reasons, etc.) and inadequate pay, which

Figure 9. Please indicate the level of service needs for the following populations that your program serves. (Percent responding a moderate or a serious service need)

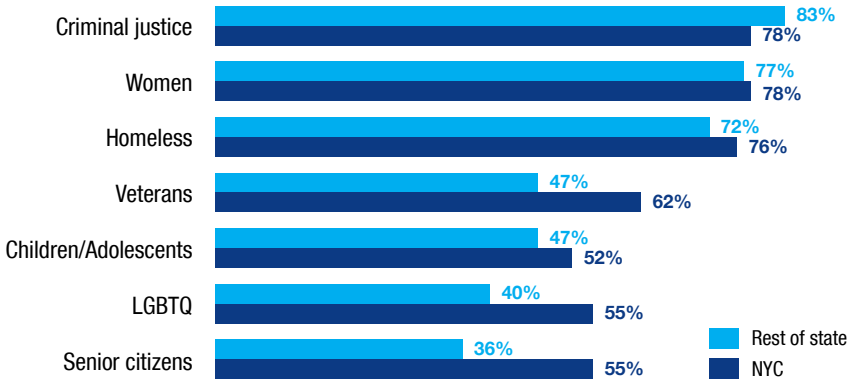


Figure 10. How many people did you provide treatment to in 2015?

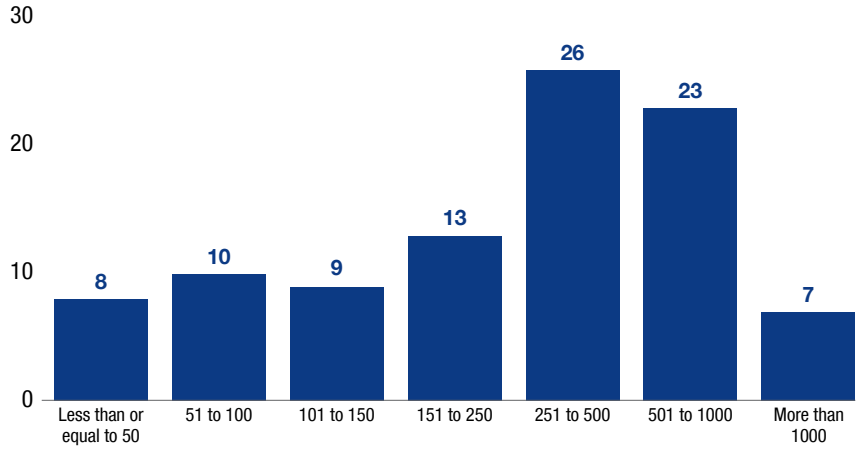
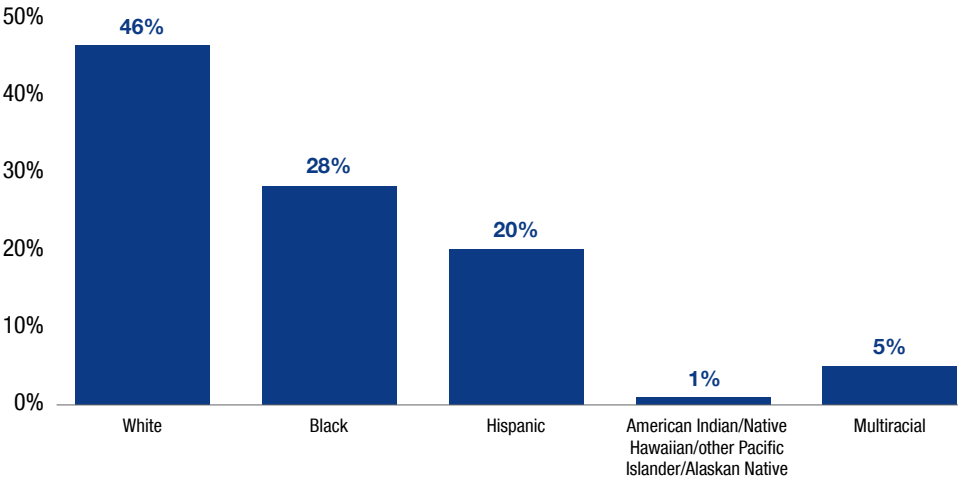
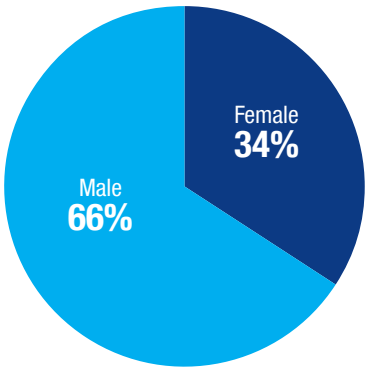


Figure 11. 2015 Client Population Race and Gender





[2] Response choices were No Service Need; Slight Service Need; Moderate Service Need; and Serious Service Need.

Figure 12. Employee Information

	Mean
Number of full-time employees	**14.6**
Number of part-time employees	**3.4**
Length of service (months)	**78 months**
Percent staff vacancies per year	**12.4%**

were each cited by about 60% of programs (Figure 13).

Staff turnover rates were higher, and length of service shorter, at organizations outside of New York City and at those that had greater concerns about service provision (Figure 14). Greater concerns had a greater impact than NYC location; programs within NYC had higher turnover if they had higher concerns, as did programs outside of NYC.

Figure 13. Please select the top three reasons why service staff decide to leave. (N=219)

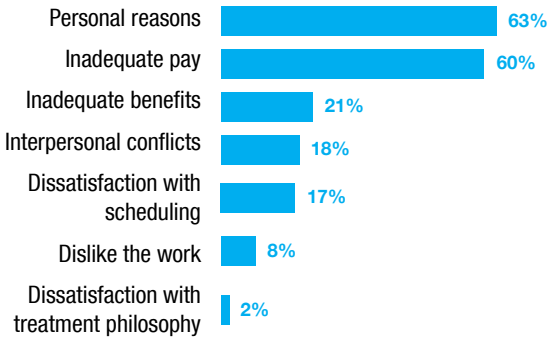
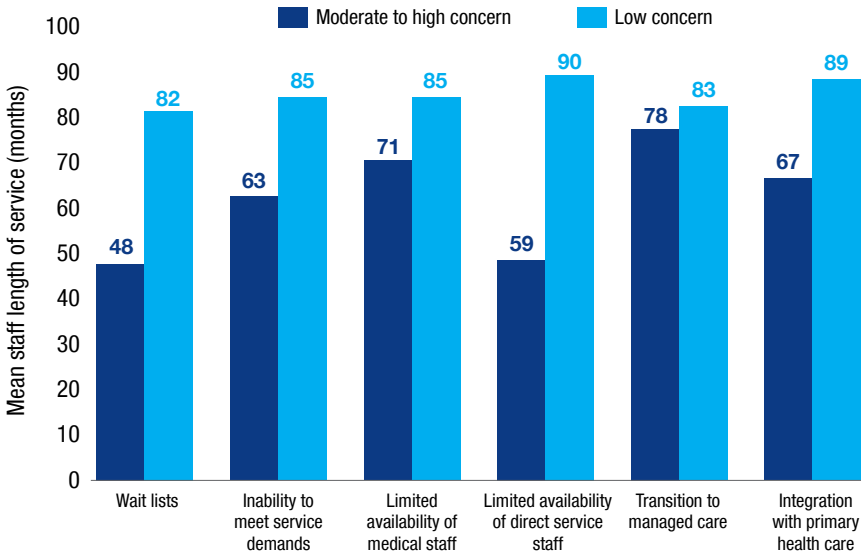


Figure 14. Staff length of service by high or low concerns



Statewide, more than 70% of programs were at least somewhat concerned about the transition to managed care, as well as unmet needs for co-occurring disorders, capacity expansion, medication assisted treatment, recovery supports, early intervention, and treatment for opioids, alcohol, other emerging drugs, and co-occurring disorders. Programs with greater concerns tended to have greater staff turnover.

Programs outside of NYC are more likely to have longer wait times before service receipt, to maintain waiting lists, and to have more people on waiting lists. These programs also were more concerned about the availability of medical staff and direct service staff, and saw higher staff turnover rates.

Because treatment needs and capacities vary across the state, different regions may require different types and amounts of resources to build and maintain effective programs.

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