

An Integrated Substance Abuse Treatment Needs Assessment for Alaska

EXECUTIVE SUMMARY FROM FINAL REPORT

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January 2002

**For the Center for Substance Abuse Treatment/SAMHSA
And
State of Alaska, Department of Health and Social Services
Division of Alcoholism and Drug Abuse/Division of Public Health**

EXECUTIVE SUMMARY

This final report describes the integrated results of a family of studies of the substance use disorder treatment needs of Alaska's citizens, especially those who are most in need of services. Problems and issues addressed included the answers to three basic planning questions:

- How many people are in need of treatment in the State? The goal was to have an adequate supply of services to meet the absolute level of demand that these cases would produce.
- Where are services located? The goal was to locate where services are needed most.
- What mix of treatment modalities do these clients need and want? The goal is to match additional treatment services to the needs and desires of those who need and want them in order to achieve maximal effectiveness and efficiency.

Alaska's Needs Assessment Studies:

Alaska conducted two rounds of needs assessment studies. The first round of studies included a household telephone survey, a SANTA study of arrestees, and a social indicator study. The first Round One study was the Adult Household Survey (Gallup 1998). The Round Two studies included a needs assessment of recently incarcerated prisoners, a social indicator study, and an integrated needs assessment.

The integrated analysis presented in this report employed a series of methodologies to estimate the overall level of treatment needs in the State. First, the study examined national trends in the past decade with regard to the need for treatment and the supply of services nationwide. Second, the study compared the State with other states to assess the comparative level of needs and services. Third, the analysis developed estimates of the past-year treatment needs of components of the State's population. The study integrated estimates of treatment need and services received for residents aged 12 and older of households with and without telephones, the homeless, and recently incarcerated prisoners. The sum of these estimates was a statewide estimate of the number of people who had a substance use disorder in the past year, how many of them have not received treatment, and how many would seek treatment if it were readily available.

Integrated Analysis:

National Trends. Analysis of a series of indicators of need and treatment services revealed that over the past decade the gap between the number of people in need and the amount of treatment services provided to them appeared to have been widening. Alcohol indicators were somewhat mixed. While alcohol use, alcohol mortality, DUI arrests, and alcohol treatment clients and admissions have declined, survey estimates of alcohol dependence and liquor law violation arrests have increased in the last decade.

Some drug need indicators (e.g., positive drug tests among employees) suggested a long-term decline, other indicators (e.g., drug dependence rates, treatment measures) have been mixed or relatively stable, while yet other indicators (e.g., mortality, emergency room episodes, arrests, and survey reports of use) suggested increases, especially among young people, in the second half of the last decade. Cocaine use has declined, but use of stimulants and club drugs (e.g., Ecstasy) has increased.

To measure the relative gaps between the measures of treatment need and services, the study divides the service rates by need indicators. Regardless of which measures of need (dependence, mortality or arrests) or services (survey, UFDS or TEDS) were considered, the gap between alcohol need and treatment increased over the decade of the 1990s. The alcohol treatment gap appeared to widen because there was a sharper decline in the number of persons receiving treatment than in the indicators of need that declined, and some of the indicators of need increased. Depending on which drug need and service indicators were used, the analysis suggested that the drug treatment gap widened or at best stabilized. Thus, over the past decade the amount of treatment service per need decreased.

Interstate Comparisons. To measure the adequacy of the State's treatment services relative to treatment services of other states, the authors created a series of composite treatment need indexes. The Drug Need Index (DNI) consisted of the sum of standardized mean rates per 100,000 of explicit-mention drug mortality and drug possession/sale arrests. Similarly structured, the Alcohol Need Index (ANI) consisted of the sum of explicit-mention alcohol mortality rates and arrests rates for driving under the influence (DUI) and liquor law violations. The Substance Need Index (SNI) combined standardized explicit-mention drug and alcohol mortality rates and the sum of the drug and alcohol arrest rates.

Alaska's biggest substance use problem is alcoholism. Its alcohol treatment need as measured by the ANI (86) ranked 2nd highest in the country in 1994-1996. Alaska's alcohol mortality rate was the highest in the country, and its alcohol arrest rate ranked 7th highest. Alaska ranked 31st on the BRFSS's measure of driving after drinking too much, and 19th on the alcohol-related traffic fatality rate. The adequacy of the State's alcohol treatment services relative to need depended on which measure of alcohol services the analysis considered. That is, while the State's alcohol treatment needs were in the highest quintile in the country, its treatment services were also in the highest quintile by one measure (TEDS alcohol admission rate) and in the second highest quintile by the other measure (UFDS alcohol-only treatment client rate).

Alaska's controlled drug treatment needs were in the moderate range of severity. The State's DNI score of 36 ranked 31st nationally, but Alaska ranked first in the nation according to the NHSDA's 1999 household survey estimates of drug dependence. Unlike the DNI, the NHSDA's dependence measure consists mostly of cases of marijuana dependence. Consistent with Alaska's NHSDA dependence measure, Alaska had one of the highest percentages of marijuana arrests (7th highest nationally) and marijuana treatment admissions (11th highest in the nation). Alaska's drug mortality rate increased from 1.4 per 100,000 (ranked 31st) in 1991-1993 to 4.3 per 100,000 (ranked 18th) in the nation, but its overall drug arrest rate (313 per 100,000) ranked 38th in the

country. Alaska's rates of drug-only treatment clients in the Uniform Facilities Data Set (UFDS) increased from 30 per 100,000 (ranked 40th nationally) in 1991-1993 to 44 per 100,000 (34th nationally) in 1994-1996. Alaska's rates of Treatment Episode Data Set (TEDS) drug admission rate in 1994-1996 ranked 19th out of 41 states in the country. Consequently, Alaska's relative adequacy of drug treatment to need depended on which measure of services was used. The State's drug treatment needs were in the 2nd lowest quintile. Its UFDS drug-only treatment client rate was similarly in the second lowest quintile, but its drug treatment admissions rate was slightly above the state median.

Alaska's Substance Abuse Need Index (SNI) ranking was 2nd highest in the country, clearly attributable to its high level of alcohol treatment needs. The State's combined UFDS substance abuse client rate (alcohol-only, drug-only, and drug plus alcohol) ranked 14th in the country for 1994-1996. By this measure, Alaska's treatment services were one quartile below its high treatment needs.

Trends in Alaska. Alaska's alcohol arrest (DUI, disorderly conduct, and liquor law violations) rates and explicit-mention alcohol mortality rates declined slightly from 1993 to 1998. The sharpest decline was for alcohol-related motor vehicle fatalities. Alcohol treatment admissions (TEDS data) also declined slightly over the years between 1994 to 1998. It appears that the ratio of admissions to arrests and deaths has increased slightly over time, suggesting a slight reduction in the treatment gap. In contrast to the slightly downward trends observed for the alcohol indicators, the controlled drug indicators in Alaska increased during the period from 1993 to 1998. The number of drug deaths in the state is small, and virtually all of the increase over the period occurred in Anchorage. While drug admissions and drug clients increased as well, the largest increase was in the drug arrest rates. These trends suggest a widening of the drug treatment gap.

Statewide Treatment Need Estimate. To estimate the absolute number of persons in Alaska who had a past-year substance use disorder, the study combined prevalence and population estimates of treatment need for adults (18 and over) in households with telephones, adolescents in households with telephones, persons 12 and older living in households without telephones, recently incarcerated state prisoners and training school inmates, and homeless people. Applying these estimates to population statistics from the 2000 Census count resulted in an estimated total of 38,790 people with a substance use disorder in Alaska during the past year. Whenever possible, the authors made conservative assumptions. It would be reasonable therefore to assume that there were at least 38,790 people with current substance use disorders in the State. If these individuals sought treatment, they would meet the minimum medical necessity criteria employed by treatment programs and managed care organizations.

Although residents of households with telephones account for the largest proportion of cases in the total, generalizing the prevalence rate for that group (7.4%) to the rest of the population would have clearly produced an underestimate of the total number of people in need. In its report of the household survey, the Gallup Organization (1998) applied the telephone survey estimate to the entire population aged 18 and older rather than just the population of adults in households

with telephones. After the present authors took the prevalence estimates for the other groups, the estimated total state prevalence rate for persons 12 and older increased to 7.8%. The only group to have a lower prevalence rate than the adults in households with telephones were adolescents in households with telephones. In some instances (residents of households without telephones, recently incarcerated prisoners, and homeless), the subpopulations that were not covered by the telephone survey had substantially higher estimated rates of current substance use disorders (15.8%, 79%, and 47% respectively). Although the prisoners and homeless had the highest estimated prevalence rates, they were small populations and therefore contributed relatively few cases to the total population in need. Persons 12 and older in households without telephones had a prevalence rate that was a little more than twice as high the prevalence rate of the adults in households with telephones. Because people in households without telephones was a relatively large subpopulation, they contributed the most (4,456 cases or 11.5%) to the overall increase in the estimate of the total need for treatment. By estimating the rates for the groups other than those covered by the telephone survey rather than generalizing the prevalence rate from the telephone survey, the present integrated analysis arrived at an estimated number of people in need that was higher by 2,044 people.¹

Treatment Gap. There were clearly many people in Alaska with a substance use disorder who did not obtain treatment in the past year. In 2000, an estimated 6,039 Alaska residents received treatment for a substance use disorder. This number equals 15.6% of the estimated 38,790 people in need of treatment that year. Therefore, about 1 out of every 6.5 people in need obtained treatment. These figures are probably the most reliable measure of the treatment gap in Alaska.

The telephone survey also asked about lifetime treatment history. Of the respondents who had a lifetime substance use disorder, 31% had received treatment at some time in their lives. It is important to bear in mind that the number of people who received treatment based on the telephone, the NHSDA, and the prison surveys was substantially lower than the number of State and TEDS admissions statistics for Alaska (see the chapter on the gap analysis). There are several reasons why the survey estimates might be lower than the State's count of the number of treatment admissions. The treatment covered in the survey questionnaires included specialty treatment services as well as nonspecialty treatment such as attending self help meetings, whereas the State admission statistics covered only specialty care. The surveys referred to a period several years earlier than the time covered by the treatment client figure. As the analysis of trends showed, the treatment gap for drugs has been increasing. Of course, the survey estimates are subject to sampling error. The State treatment admissions include multiple admissions and admissions that were changes of services within an episode of care. Whichever measure of met demand is used, it is clear that only a relatively small percentage of Alaska's residents with an active addictive disorder received treatment in the past year.

Unmet Demand for Treatment. Even if treatment were readily available to all who needed

¹38,790 - (7.4 x 496,567)

it, only a portion of those in need would seek care in a given year. The surveys from which the study drew information asked respondents who had a substance use disorder but who had not obtained treatment, whether they thought they needed treatment and if they would have sought it had it been readily available. The integrated analysis estimated that 3.5% of the persons with a current disorder who did not obtain treatment in the past year said they thought they needed treatment and would have sought it if it were more readily available. Compared to other states, that percentage was relatively low.

Applied to the state's population, the study estimated that 1,140 Alaskans needed and wanted treatment but had not obtained it. This number would be a reasonable target for providing additional services, if the State maintained a policy of providing treatment to all that wanted and needed it. Experience in other states suggests that survey estimates of unmet demand have successfully predicted the utilization of new substance abuse treatment services. This success appeared to depend on the type of treatment and location of the services in areas that clearly had relatively high levels of unmet need. If the State increased the number of people in need who obtained treatment by 1,140, the number who received treatment would increase by 19%. The total number who would receive care (7,179) would be 18.5% of the 38,790 who needed it. Analysis of the telephone survey data showed that a slight majority (51%) of the subjects who needed treatment and had not obtained it but wanted it should receive residential or hospital care in accordance with the patient placement criteria of the American Society for Addiction Medicine (ASAM). Most of the remaining subjects should receive intensive outpatient treatment. When compared to similar survey statistics from rural states such as Montana and North Dakota, these figures suggest that the Alaska residents who would be most likely to receive any new services have relatively severe disorders.

When asked what prevented them from obtaining treatment, Alaska telephone survey respondents and prison inmates were most likely to cite lack of insurance, "red tape", facilities were located too far away, programs were full, and lack of transportation.

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Location of Treatment Needs:

To address the travel issue directly, the authors compared the average annual treatment admissions rate for 1994-1998 (State data) with the SNI to determine how well the observed regional treatment admissions rates compared to the rates predicted by the Substance Abuse Need Index. In general, the greatest gaps were in regions that are somewhat distant from urban centers. The Northcentral Region, which contains the Denali Borough and the Yukon-Koyukuk Census Area, had the largest gap (the observed average annual admissions minus the average admissions expected on the basis of need). Adding 108 more admission per year would bring its admissions rate in line with the rate predicted by its SNI score. When making these recommendations, the authors sought to bring each region up to the levels relative to need enjoyed by the regions with positive residuals. The North Slope Region had the highest SNI score (69), but the analysis did not recommend additional treatment admissions for that region because its admissions rate was substantially higher than the rate predicted by its need score. The

Yukon Delta Region had the second greatest treatment gap, even though its SNI score (62) ranked fourth among the regions. Although the Bristol Bay/Aleutians Region had an SNI score of 68, the recommendation for it was modest because its observed admissions rates was third highest in Alaska. The Kenai Peninsula et al., Southcentral, and Central Regions had the lowest SNI scores (37, 31, and 30 respectively), but the first two had a lower treatment rate than predicted. Because of their population size, they received the largest number of recommended admissions.

It is important to bear in mind that these gap estimates are relative. The statewide estimate of the treatment gap described above indicated that a large proportion of the people in need throughout the state have not received treatment services in the past year. Consequently, having a larger number of admissions than predicted by the analysis may say surprisingly little about the absolute degree to which services met the needs of a region's residents.

The authors recommend that the State consider using the results of this analysis as one part of its decision making process for allocating services if additional funds become available. The authors analyzed the indicator data at the regional level to maximize the reliability and validity of the need index, but the component rates of the indexes and treatment rates may be influenced by random distortions in small population areas. Accordingly, the estimates should be used along with other qualitative and quantitative information (e.g., knowledge of waiting lists in specific areas or concerns by other medical personnel or social agencies regarding the availability of specific services). Responses of local providers to the reasonableness of the estimates should also be considered. The social indicator methodology has been developed over a period of years, and has been used in other states. Whenever it is employed in a new state for the first time, there is always the possibility that modification must be made to refine the indexes.

Conclusions:

The results of the needs assessment suggest that Alaska would be justified in expanding its treatment services. The analysis of national, interstate, longitudinal data, and cross-sectional survey data produced evidence that a substantial number of the State's residents had an active addictive disease in the past year, but only a small percentage of them received treatment in the past year. While many of those individuals would probably not seek treatment immediately if the supply of services were increased, an estimated 1,140 people indicated that they wanted treatment even though they did not obtain it. Only experience will show how many of even that group will obtain care, but the number is sufficiently large to suggest that an increase in the number of facilities would be reasonable. Recent statistics suggested that the treatment gap, especially regarding drugs, has been widening, and a reversal of that trend appears to be in order. The analysis suggested that the State may wish to consider programming (e.g., outreach) directed towards increasing the proportion of persons in need who actually seek treatment. The persons who said that they wanted treatment was relatively small, and this group, especially in high-risk groups such as prisoners-to-be and homeless people, appeared to need relatively high levels of care, mostly residential and hospital treatment at the onset of treatment. Many of the household residents who wanted treatment appear to need intensive outpatient treatment to initiate

treatment. Research suggests that location of future services in accordance with the indicators of unmet need, especially in rural areas, may be a key step for increasing the demand for treatment. Several administrative changes, such as identifying and reducing any “red tape” factor as mentioned by survey respondents, could make a difference. To increase access to treatment in rural areas, especially for youth, the State may wish to investigate the feasibility and efficacy of online counseling, assessment, and referral. Analysis of survey data from other states indicated that adolescents obtain a large proportion of treatment services from nonspecialty providers (e.g., clergy, school health counselors, general psychological counselors, and social workers). An important consideration for youth and residents of small towns and rural areas is the stigma attached to obtaining treatment services from specialty providers. Of course, attention to cultural issues and identification is important for Alaska Natives.

Although the Alaska Prisoner Study was not designed to assess the adequacy of treatment services inside of state prisons, the extremely high rates of substance use disorders found among inmates in the Alaska Prisoner Study and the Alaska Arrestee Study, as well as the reports of officials regarding the shortage of prison-based treatment suggests that additional services for prisoners would also contribute to the State’s struggle to control substance abuse. When nine out of ten prisoners have a lifetime substance use disorder and virtually all use drugs and alcohol, it may be time to assume that all prisoners need some type of substance use disorder intervention. Qualitative evidence indicates that the current services in Alaska have not kept up with prisoner demand. According to a report by the Alaska Justice Statistical Analysis Unit and Justice Center (2000c), the available treatment services in Alaska’s prison system are limited, the programs are reportedly always full, and more inmates request treatment than receive it. Despite the more than two-fold increase in prisoners with drug offenses, the Alaska DOC’s budget for substance abuse services had not increased in eight years.

The integrated analysis indicated several areas for which additional research should be considered. The need indexes developed for the study should be updated and refined. A commitment to ongoing data collection and updating of the social indicator data each year could provide the State with timely data for future planning. The study had to estimate the treatment needs of homeless and adolescents from other studies conducted in other states. Native Alaskans, who had high rates of substance use disorders and relatively low rates of telephone coverage, are another group that should be considered for future research.

For ways to obtain the full document contact The Advisory Board on Alcoholism and Drug Abuse, Juneau, Alaska: Pam_Watts@health.state.ak.us.