States and Substance Abuse Treatment Programs: Funding and Guidelines for Infection-Related Services

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Community-based substance abuse treatment programs provide HIV, hepatitis C virus, and sexually transmitted infection services. To explore how state funding and guidelines affect practice, we surveyed state agency administrators and substance abuse treatment program administrators and clinicians regarding 8 infection-related services. Although state funding for infection-related services is widely available, substance abuse treatment programs do not always access it. Substance abuse treatment program guidelines are clearer in states that have written guidelines. Improved communication between state agencies and substance abuse treatment programs may enhance service. (*Am J Public Health.* 2008;98:824–826. doi:10.2105/AJPH.2007.119578)

HIV infection, hepatitis C virus (HCV) infection, and sexually transmitted infections are highly prevalent among substance abusers and are often transmitted by drug use and associated risk behaviors.[1–9] Community-based substance abuse treatment programs are the primary health care providers for many substance abusers and offer an important opportunity to prevent and treat these infections.[10–15] Although most substance abuse treatment programs are privately run, they generally operate within state guidelines and receive substantial state funding.[16] As part of a larger study conducted within the National Drug Abuse Treatment Clinical Trials Network, we explored the relations between state (including Washington, DC) funding and guidelines and substance abuse treatment program practices.[17]

METHODS

State health and substance abuse department administrators and substance abuse treatment program administrators and clinicians were surveyed regarding funding, guidelines, and practices for 8 infection-related services: (1) provider education, (2) patient education, (3) risk assessment, (4) medical history and physical examination, (5) biological testing, (6) counseling, (7) medical treatment, and (8) medical monitoring for HIV, HCV, and sexually transmitted infections.

For this study, we examined survey sections that focused on reimbursement and on policies, regulations, or guidelines for each infection-related service for each infection group. Surveys were completed between July 2003 and January 2005. In addition, we limited our results to only those 24 states and Washington, DC, in which Clinical Trials Network substance abuse treatment programs existed during the study period.

Cross-tabulations were compiled for variable relations. Significance of bivariate relations was assessed by the χ^2 test. Analyses regarding receipt of funding and clarity of program guidelines were limited to substance abuse treatment programs actually providing the specific infection-related services.

Completed surveys were returned by health or substance abuse department administrators from 48 states and Washington, DC (96%). State HIV/AIDS directors were not surveyed directly, but they contributed to survey completion in several cases.

At the time of the survey, the Clinical Trials Network included 319 substance abuse treatment programs; surveys were returned by administrators (the local program directors) from 269 substance abuse treatment programs (84%). Those 269 administrators identified 2210 clinicians (e.g., counselors, nurses, social workers, physicians) within their programs; 1723 of these clinicians returned surveys (78%).

RESULTS

Funding for most infection-related services was more widely available (according to state administrators) than was funding received by substance abuse treatment programs (according to substance abuse treatment program administrators; Table 1). This was the case

TABLE 1—Comparison of Funding Availability Reported by States (and Washington, DC) and Receipt of Funding Reported by Substance Abuse Treatment Program Administrators: July 2003–January 2005

	HIV/AIDS Treatment Programs		HCV Treatment Programs		Sexually Transmitted Infection Treatment Programs	
Infection-Related Service	Funds Available, %	Funds Received, %	Funds Available, %	Funds Received, %	Funds Available, %	Funds Received, %
Provider education	93	60[a]	62	61	87	58[a]
Patient education	100	59[a]	71	61	91	60[a]
Patient risk assessment	98	48[a]	67	48[a]	96	62[a]
Patient counseling	98	60[a]	80	61[a]	98	54[a]
Medical history and examination	93	54[a]	89	50[a]	96	48[a]
Biological testing	93	65[a]	71	60	93	57[a]
Patient medical treatment	96	72[a]	76	69	98	66[a]
Patient medical monitoring for HIV, HCV, and sexually transmitted infections	93	72[a]	64	64	84	59[a]

Note. HCV = hepatitis C virus. Percentages are of those adminstrators who reported funds were available or were received.
[a]Differed from state response, $P < .05$.

TABLE 2—Clarity of Substance Abuse Treatment Program Guidelines in States (Including Washington, DC) Without and States With Written Guidelines Governing Services: July 2003–January 2005

	HIV/AIDS Treatment Program				HCV Treatment Program				Sexually Transmitted Infection Treatment Program			
	% of Administrators Reporting "Clear" Program Guidelines		% of Clinicians Reporting "Clear" Program Guidelines		% of Administrators Reporting "Clear" Program Guidelines		% of Clinicians Reporting "Clear" Program Guidelines		% of Administrators Reporting "Clear" Program Guidelines		% of Clinicians Reporting "Clear" Program Guidelines	
Infection-Related Service	States Without Guidelines	States With Guidelines	States Without Guidelines	States With Guidelines	States Without Guidelines	States With Guidelines	States Without Guidelines	States With Guidelines	States Without Guidelines	States With Guidelines	States Without Guidelines	States With Guidelines
Provider education	44	64[a]	29	51[a]	37	48[a]	44	48	29	51*	37	48[a]
Patient education	50	68	49	57	45	52[a]	52	51	49	57	45	52[a]
Patient risk assessment	57	81[a]	50	69[a]	40	57[a]	51	55	50	69[a]	29	57[a]
Patient counseling	74	77	63	67	56	66[a]	57	69[a]	63	67	56	66[a]
Medical history and examination	77	77	67	70	43	45	49	40[a]	67	70	43	45
Biological testing	59	65	49	52	41	48[a]	48	47	49	52	41	48[a]
Patient medical treatment	61	78[a]	57	80[a]	47	57[a]	47	57[a]	57	80[a]	47	57[a]
Patient medical monitoring for HIV/AIDS, HCV, and sexually transmitted infections	62	81[a]	52	73[a]	36	51[a]	44	33[a]	52	73[a]	36	51[a]

Note. HCV = hepatitis C virus.
[a]Differed from states without guidelines, $P < .05$.

for 23 of 24 comparisons, reaching statistical significance in 19.

Substance abuse treatment program guidelines for infection-related services were more likely to be perceived as clear by substance abuse treatment program administrators and clinicians in states that had written policies or guidelines governing services than in states that did not (Table 2). This was the case for 41 of 48 comparisons, reaching statistical significance in 26.

DISCUSSION

The discrepancy between funds availability and funds receipt is particularly striking in light of the fact that these data reflect only substance abuse treatment programs actually providing the specific services in question. Potentially, programs already providing such services would do even more if they were more fully aware of funding opportunities or if funds were more readily obtainable.

The 2000 Center for Substance Abuse Treatment's Substance Abuse Prevention and Treatment Block Grant survey on HIV funding to the states highlighted that state dissemination of funding information directly to providers was ranked only fifth of 7 methods listed.[18] This is noteworthy because funding was most frequently reported by substance abuse treatment programs as the greatest barrier to providing services, particularly in the context that state funding, some of it through Medicaid, is the largest revenue source for substance abuse treatment programs.[17] Clearer roadmaps directing substance abuse treatment program administrators as to how to obtain funding might help.

Substance abuse treatment program guidelines in jurisdictions with written policies, regulations, or guidelines were perceived to be clearer than in jurisdictions without these. Although the comparison was not direct (written state agency policies, regulations, or guidelines vs clarity of treatment program guidelines), treatment program guidelines were likely based on written agency guidelines when these existed, and if so, all jurisdictions in the United States could benefit from such guidelines.

Limitations

A shortcoming of the study was that the surveys did not ask about level of funding. This may have provided additional insight into the lack of association between state responses regarding availability of funding and substance abuse treatment program responses regarding receipt of funding. In addition, given that agency directives in the form of regulations, policies, or guidelines carry somewhat different levels of mandate at the substance abuse treatment program level, evaluating them separately, as opposed to lumping them together, may have been useful in determining best policy practices.

Conclusions

Community-based substance abuse treatment programs are an important access point for infection-related prevention and treatment services for a high-risk population. Funding is widely available to support these services, but is not accessed as often as possible. In states with written policies, regulations, or guidelines, substance abuse treatment program guidelines were perceived by administrators and clinicians to be clearer than they were in states without such guidelines. Both findings present low-cost opportunities to deliver more and better services. ■

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Contributors

S. Kritz was a member of the protocol development team, was national project manager for the study, and wrote the final article. L.S. Brown Jr originated the study protocol and was the principal investigator. R.J. Goldsmith and E.J. Bini were members of the protocol development team. J. Robinson was a member of the protocol development team and supervised data collection and analysis. D. Alderson performed data analysis. P. Novo was involved in study implementation. J. Rotrosen was a member of the protocol development team and is principal investigator of the New York node of the National Institute on Drug Abuse Clinical Trials Network. All authors contributed to the editing of the final article.

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Human Participant Protection

This study was initially approved through expedited review and waiver of informed consent by the institutional review board of Addiction Research and Treatment Corporation. Additional approval and waiver of informed consent were obtained from the appropriate institutional review boards from all 17 nodes of the National Institute on Drug Abuse Clinical Trials Network.

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