System Under Stress

Pennsylvania Drug and Alcohol Service System Environmental Scan

June 27, 2013

Pennsylvania Recovery Organization - Alliance
900 S. Arlington Avenue, Suite 254A
Harrisburg, PA 17109
717.545.8929

TABLE OF CONTENTS

I. Introduction

From the inception of the addiction treatment field when recovery advocates broke their anonymity and very publically worked to pass the Hughes Act in the 1960's there has been a close connection between recovering individuals, their families, and the treatment field. Those early pioneers worked tirelessly to make treatment services available to millions of Americans. In Pennsylvania, most if not all of the gains in service delivery have been realized only with the deep support of recovering persons and their families. Today, although many people are able to gain and sustain recovery without formalized treatment services, many others require access to a full system of care provided in a continuum to those of us in need of professional help. The majority of those who pass through this service system may never know if they received clinically appropriate services in the duration recommended and/or if their legally protected right of confidentiality is being honored and upheld.

Failure to properly assess our service system could lead to a distorted view of the efficacy of the services provided. As with any other medical problem, not treating or under treating this condition leads to poor results. In respect to addiction, those consequences are far reaching and costly to all of our institutions. We believe it is critically important to gain insight into the state of our workforce and the services that are being provided to our citizens. We need to do this in order to improve and expand our service system. Understanding the challenges we face is a vital part of this objective.

We are deeply grateful to the drug and alcohol service system and those that choose to be involved in this challenging yet rewarding work—thousands of lives have been saved by their committed efforts. We hope to assist in strengthening and transforming this system to meet the needs of our communities for the next generation.

II. Executive Summary

In an effort to understand our current service system counselor workforce, the challenges it faces and their collective perspectives on the services being provided, self administered questionnaires were distributed via a web link to the service provider system in Early March 2013. Paper copies of the survey were sent out to all 2,288 certified drug and alcohol counselors using the database of same obtained from the Pennsylvania Certification Board and then manually entered into the survey monkey database.

We were able to get a robust response to our survey; we received completed surveys from all regions of the state, with the highest number of survey respondents at 300 or 38% coming from the Northeast and the lowest reporting region 63 and 8% being from the Northwest. The response was somewhat overwhelming. At the point we closed the survey on June 10th, 837 responses had been recorded.

We intended to obtain a perspective of how clinicians see the identified issues in their own words by offering sections for open ended responses throughout the survey. A substantial number of written comments were submitted and are included as an appendix to this report (see Appendix II).

Beyond demographic information, we included questions on the following areas of interest:

- Whether the individuals they work with get the proper level and duration of services across all funding sources

- Whether funding sources for publically funded clients in Pennsylvania are being asked to provide unnecessary and personal information about clients and families
- Whether they feel pressure to provide more information than is necessary and allowable under the confidentiality laws in order to get proper levels of or lengths of care for clients
- Whether they feel that the persons that they serve end up getting the proper level and duration of services for their needs
- Whether the persons that serve are a good match for the capabilities and structure of the program they work

Questions related to workforce include:

- Whether paperwork requirements have decreased, stayed the same or increased over the last five years
- Whether they intend to stay in their current jobs, advance, switch out of drug and alcohol services to another human service area or leave the workforce entirely.
- Open-ended comment sections were used throughout the survey, including an open-ended question asking survey participants to identify what they saw as the primary barrier that interferes with helping people they work with in obtaining long-term recovery.

The typical survey respondent was a 50 year old, Caucasian female, holding a master's degree, working at an Outpatient/IOP program, who was not in recovery, with over 20 years of work experience.

From this survey, it is apparent that we have a highly experienced workforce providing services to our communities across the state in a wide range of settings, with over 40% reporting that they have over 20 years experience in the field with the majority, over 65%, holding a master's degree of higher.

A significant portion of the respondents were in recovery, with 276 or 33.3% of those who answered the question identifying themselves as in recovery. Seventy percent of those who identified themselves as in recovery indicated that they were in recovery for 20 years or longer. Considering that the majority of persons in recovery identified themselves as in recovery for over 20 years, this may be an indication that those in recovery are more likely be those who have been in the workforce the longest. This could suggest a need to increase recruitment efforts within our recovery communities. It is important that we identify and train persons in recovery for our workforce in order to sustain high representation of recovering person in our field. One area of potential investigation that we would suggest from this survey is to determine the extent to which persons in recovery are working as counselors in our system. That Pennsylvania could lose a significant portion of its recovering workforce over the next five years may have significant implications for our service system.

A little more than half of the survey respondents or 52% indicated that they had a family member or close friend in recovery.

In regards to specific questions our survey found the following:

- On the question addressing if clients receive the proper level and duration of care from funders, 376 or 53.1% of the respondents who identified the question as applicable reported that none or only some of our clients are getting the proper level and duration of services from funders.

- On the question dealing with paperwork, the total number of respondents who identified that the question was applicable and were working more than five years reported that the paperwork requirements have increased was 527 or 77.7%.

- There was a combined total of 285 or 48.2% of applicable respondents who reported being frequently or always asked to provide unnecessary and personal information about persons they serve and their family histories that exceed the PCPC.

- 435 or 57.9% of those who responded indicated that they feel pressure to provide more information than is necessary and allowable under the confidentiality laws in order to get proper levels of or lengths of care for their clients.

- 522 out of 699 or 74.6% of respondents for whom the question applied indicating that a client gets a shorter duration, lower level of care, or that the service required is not funded or offered.

- In regard to fit of services, the combined total responses from those to whom the question applied reported that the clients they serve exceed the capabilities of the programs they are in because it is probably less expensive or the service needed is not offered was 239 or 37.7%.

- In regard to the question on intention to stay in the workforce, the combined responses of those respondents who intend to leave drug and alcohol or the human service field entirely within the next five years of the total respondents was 173 or 22%.

The survey would suggest that people seeking help for addiction problems are served in lower levels of care and for shorter durations of time than the treating clinicians would consider as clinically indicated. Many survey respondents indicate that funders request information about persons seeking help that exceed the law, with some mixed indications that services are being withheld unless information that is not necessary or legal is provided to them. This is a serious issue that even without the possibility of undue pressure from funders, providing lower levels of care for shorter durations than indicated would negatively impact the efficacy of those services and the individuals who depend on them.

Strains on the workforce are evident by the numbers of people identifying that they are considering leaving or face overwhelming barriers to providing counseling from a number of directions. Many of the respondents indicated that ever-increasing paperwork, high case loads, poor funding, high stress, and poor compensation are factors in their consideration of no longer doing this kind of work. Some are already leaving our field.

This survey was completed as a deliverable to DDAP. We consider this survey as a preliminary report. We believe that the data it contains would benefit from a deeper examination and may very well offer significant policy and practice implications across the full spectrum of service and workforce areas if more fully analyzed. We would recommend that DDAP review this survey and consider engaging with PRO-A to examine any or all of the topic areas at a deeper level to understand these policy and practice implications at the discretion of DDAP. As advocates for recovery, we understand the critical importance of having a strong and functioning drug and alcohol service system to serve our communities into the next generation. These services are a fundamental aspect of the recovery process for many Pennsylvanians and their families.

III. Survey Objectives and Methodology

This survey of the counseling workforce of Pennsylvania was intended to be an environmental scan and exploratory in nature. We wanted to obtain some basic demographics about the workforce, a sense of how persons with addiction are being served in Pennsylvania, as well as to get a sense of the trends of documentation requirements and pressures, if any, to provide information about clients that is not legal or necessary for funding. In addition, we wanted to get a sense of the number of persons who are considering leaving the field. As this survey was intended to obtain a wide scan of issues impacting the workforce and the persons that it serves, great effort was taken to include ample room for comments in order to obtain qualitative information about the questions included in the survey. It is our hope that this survey will serve to inform more concise measures on both our workforce and the treatment system in the future.

The population sampled was the drug and alcohol counseling workforce of Pennsylvania. As a person can be recognized in Pennsylvania as a drug and alcohol counselor based on education and experience and/or certification. There was no way to definitively survey the entire population of workers who provide counseling for persons with addiction in Pennsylvania. We believe that the majority of the counseling workforce holds a certification with the Pennsylvania Certification Board, however this was not verified. As an individual can counsel persons with addiction without certification, it was identified that statewide organizations such as the Drug and Alcohol Service Providers Organization of Pennsylvania, the Pennsylvania Halfway House Association as well as individual agencies around the state were resources for survey distribution. To the best of our knowledge, this is the largest survey of its kind that has been done in Pennsylvania focusing on the status of the workforce as well as getting a sense of how people are being cared for within our service delivery system.

Areas of interest and data collected:

Demographic questions included: Age, Gender, Ethnicity, Region of State, Area of Work, Time in Field, Recovery Status/Time in Recovery if relevant, and if respondent had a family member or person close to them in recovery.

Questions on persons being served include:

- Whether individuals served get the proper level and duration of services across all funding sources
- Whether funding sources for publicly funded clients in Pennsylvania are requesting unnecessary and personal information about clients and families served
- Whether counselors feel pressure to provide more information than is necessary and allowable under the confidentiality laws in order to get proper levels of or lengths of care for clients
- Whether counselors feel that individuals served end up getting the proper level and duration of services for their needs
- Whether individuals served are a good match for the capabilities and structure of the programs treating them

Questions relating to workforce include:

- Whether the paperwork requirements have decreased, stayed the same, or increased over the last five years
- Whether counselors intend to stay in their current jobs, advance, switch out of drug and alcohol services to another human service area, or leave the workforce entirely
- Open-ended comment sections were provided throughout the survey, including an open-ended question asking survey participants to identify what they saw as the primary barrier which interferes with helping the individuals they work with in obtaining long term recovery

To get a sense of common themes within the survey's comments, each section was searched for keywords [i.e. "level of care"] to see if they were used in a favorable or unfavorable context. The results of these keyword searches are included in the Results section.

Once again, as an environmental scan, this survey is intended to provide some relatively quick metrics on the areas of interest identified above, and is not a precise or comprehensive measure of the areas covered. The purpose of the survey is to begin to inform our system and policy makers about some of the challenges facing our workforce and the individuals that they serve across Pennsylvania. As such, this is exploratory research and a fair amount of uncertainty has been tolerated in the design and implementation of this survey.

The survey was closed on June 10, 2013.

IV. Results

Total number survey respondents through 06/10/13 were 837:

- **Reported Age of Respondents:**

  Average reported age of respondent drug and alcohol counselors in PA: **50.06**
  Skipped responses: 15 Total Responses: 822

- **Reported Gender of Respondents:**

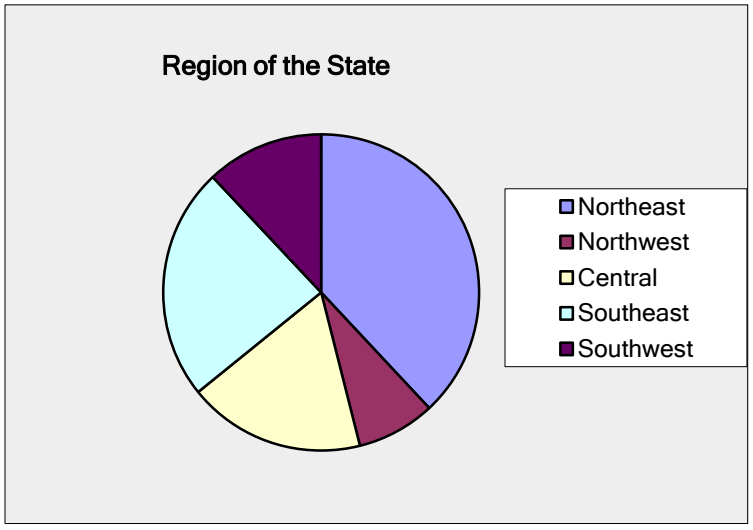
Gender		
Answer Options	Response Percent	Response Count
Male	35.3%	292
Female	64.7%	535
answered question		827
skipped question		10

- **Reported Ethnicity of Respondents:**

Reported Ethnicity of Respondents:		
Answer Options	**Response Percent**	**Response Count**
Caucasian	77.8%	604
African American	13.3%	103
Latino / Hispanic	6.4%	49
Native American	1.4%	11
Other	1.1%	9
	answered question	776
	skipped question	61

- **Reported Region of the State:**

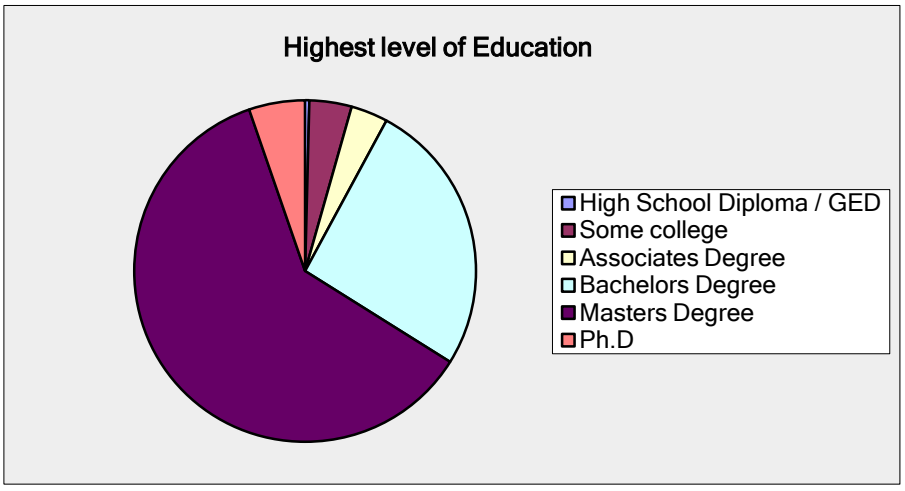
Region of the State		
Answer Options	**Response Percent**	**Response Count**
Northeast	38.0%	300
Northwest	8.0%	63
Central	18.1%	143
Southeast	23.8%	188
Southwest	12.0%	95
	answered question	789
	skipped question	48



SURVEY QUESTIONS

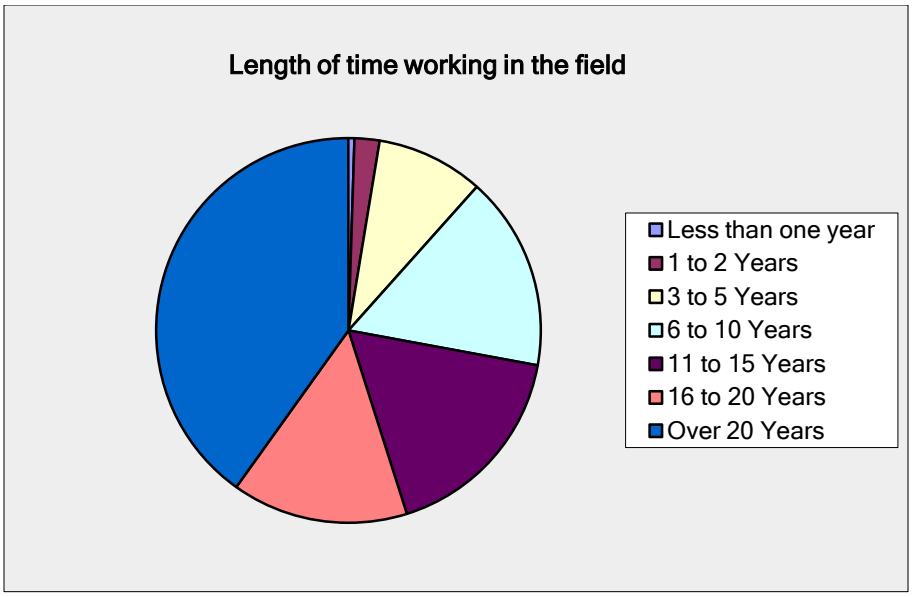
- **Question 1: Level of Education**

Answer Options	Response Percent	Response Count
High School Diploma / GED	0.4%	3
Some college	4.0%	33
Associates Degree	3.5%	29
Bachelors Degree	26.0%	216
Masters Degree	60.8%	505
Ph.D.	5.3%	44
	answered question	830
	skipped question	7



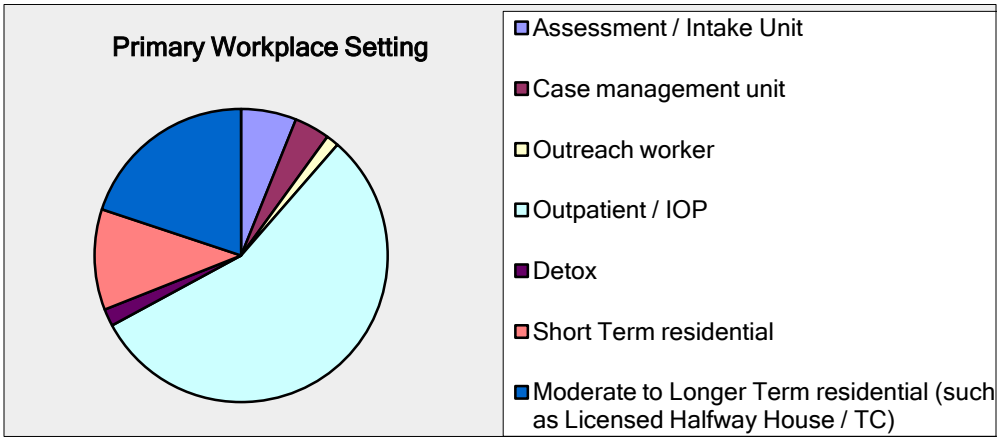
- **Question 2: Reported length of time working in the field:**

Answer Options	Response Percent	Response Count
Less than one year	0.5%	4
1 to 2 Years	2.1%	16
3 to 5 Years	9.0%	70
6 to 10 Years	16.3%	127
11 to 15 Years	17.2%	134
16 to 20 Years	14.8%	115
Over 20 Years	40.1%	312
	answered question	778
	skipped question	59



- **Question 3: Primary workplace setting:**

Answer Options	Response Percent	Response Count
Assessment / Intake Unit	6.1%	39
Case management unit	3.9%	25
Outreach worker	1.4%	9
Outpatient / IOP	55.7%	356
Detox	1.9%	12
Short Term residential	11.1%	71
Moderate to Longer Term residential (such as Licensed Halfway House / TC)	19.9%	127
Other (please specify)		220
	answered question	639
	skipped question	198



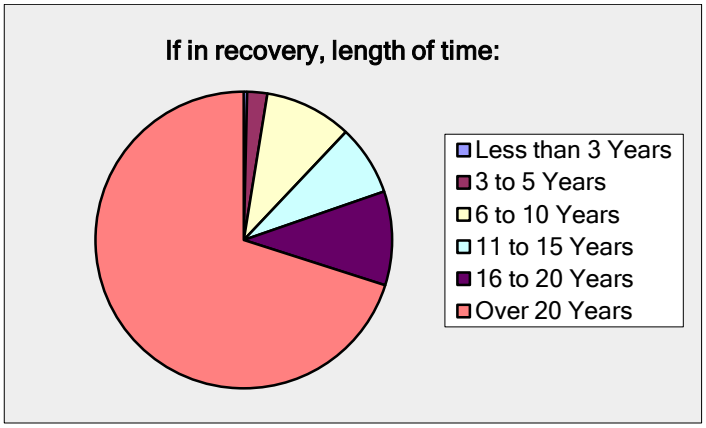
Primary workplace setting breakout on "other": 220 responses

"Other" workplaces		
Answer Options	Response Percent	Response Count
Private Practice	25.5%	56
Other misc.	15.0%	33
School-based	14.1%	31
Retired	11.3%	25
MMAT	10.9%	24
Hospital / Medical setting	9.1%	20
Correctional	7.7%	17
Insurance	6.4%	14
Total "other" responses		220

- **Question 4: Are you in recovery from drug and alcohol Dependency?**

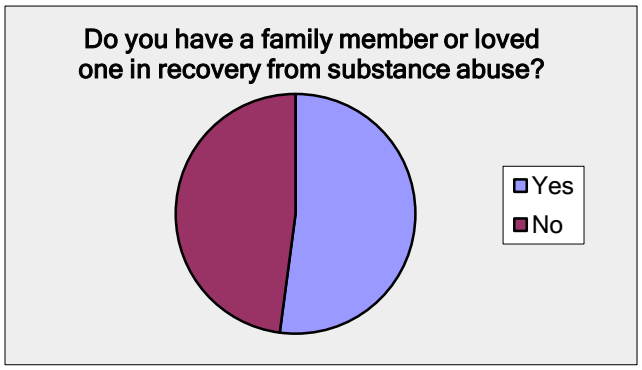
Answer Options	Response Percent	Response Count
Yes	33.3%	276
No	66.7%	552
	answered question	828
	skipped question	9

If in recovery, length of time:		
Answer Options	Response Percent	Response Count
Less than 3 Years	0.4%	1
3 to 5 Years	2.2%	6
6 to 10 Years	9.5%	26
11 to 15 Years	7.7%	21
16 to 20 Years	10.2%	28
Over 20 Years	70.1%	192
	answered question	274



- **Question 5: Do you have a family member or loved one in recovery from substance abuse?**

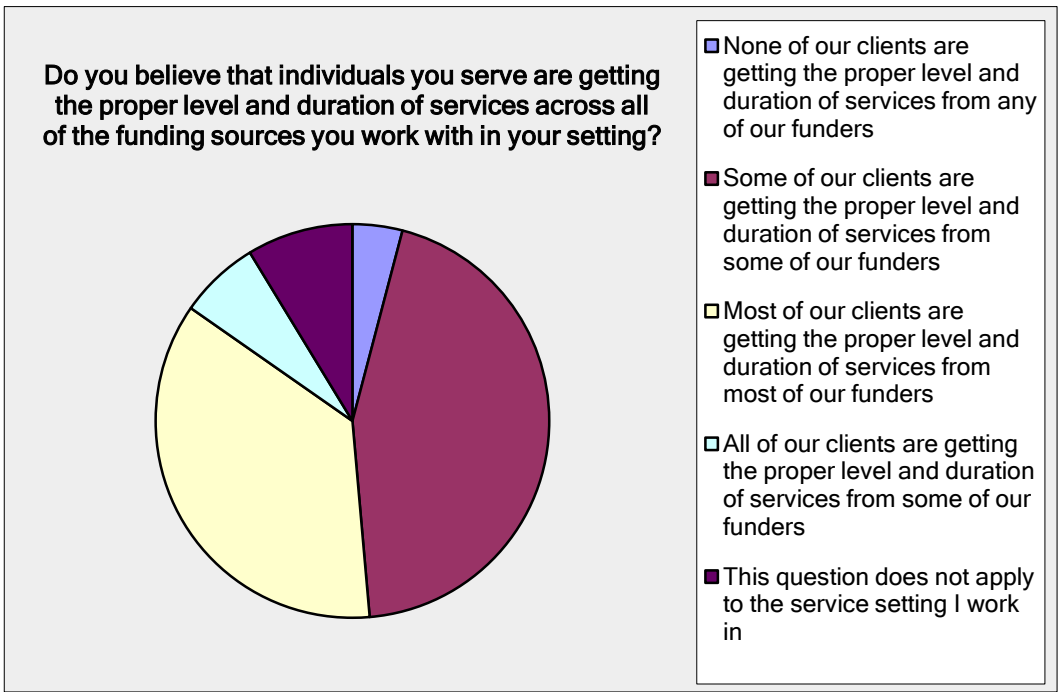
Answer Options	Response Percent	Response Count
Yes	52.1%	403
No	47.9%	370
answered question		773
skipped question		64



- **Question 6: Do you believe that individuals you serve are getting the proper level and duration of services across all of the funding sources you work with in your setting?**

Answer Options	Response Percent	Response Count
None of our clients are getting the proper level and duration of services from any of our funders	4.1%	32
Some of our clients are getting the proper level and duration of services from some of our funders	44.5%	344
Most of our clients are getting the proper level and duration of services from most of our funders	36.1%	279
All of our clients are getting the proper level and duration of services from some of our funders	6.6%	51
This question does not apply to the service setting I work in	8.7%	67
answered question		773
skipped question		64

Question 6 con't.



- Respondents who identified the question as applicable and reported that none or only some of their clients are getting the proper level and duration of services from funders:
  Response Count: 376 out of 707 ***Percent Response: 53.1%***

Total number of comments for Question 6: 295

Question 6 Keyword Results found in "favorable" and "unfavorable" comments regarding proper care		
Key Word	**Favorable**	**Unfavorable**
Insurance	9	56
Treatment	11	42
Services	11	26
Inpatient	1	20
Private Insurance	3	16
SCA	0	15
Residential	0	13
Access	1	11
Level of care	1	10
Managed care	0	7

Type of comments:
There were 295 comments, many of them detailed. The vast majority identified issues surrounding private insurance, public managed care organizations or single county authorities not providing the proper level and / or duration of care. Answers other than that include terms of contracts that limit care, companies limiting care to persons using opiates, that clients do get adequate care, that getting proper care requires the

violation of confidentiality standards, that reduced care is driven by a lack of resources, that clients are getting sicker, that there is less pressure on providing services in some settings such as private practice, that some services such as detox are simply not available in some areas, or that better coordination could improve services. Comments to this question be read in full in Appendix II, starting on page 30.

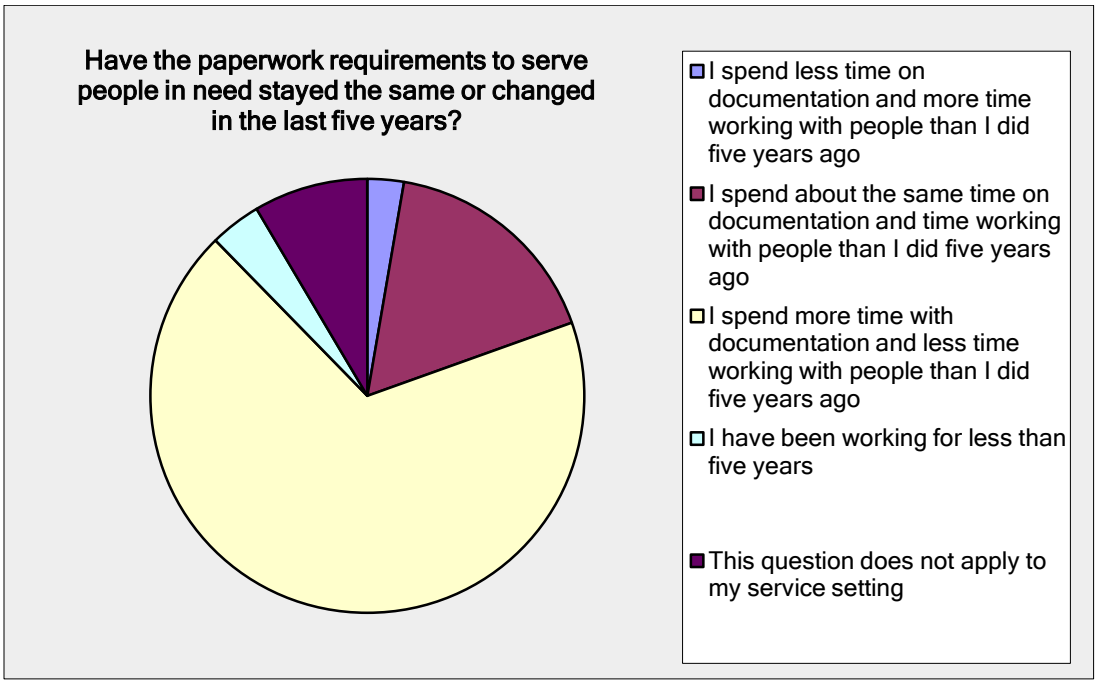
Selected comments:

- *"services are fairly standard and do not appear adequate for about 50% of our clients"*
- *"Duration of inpatient treatment is inadequate from funders unless forced to grant adequate LOS by Act 106. The situation appears to be worsening, not improving. Some funder personnel who make authorizations seem to treat addicts like pariahs."*
- *"length of time in treatment is about four months too short"*
- *"private insurance and government funding at the local level difficult to convince what is a proper level of care"*
- *"Whilst understanding that budget issues exist, the continual shortening of length of stay for residential treatment is making treatment less effective over the long term and setting up a system of "triage" and crisis management opposed to effecting actual long-term shifts in thoughts, attitudes and behaviors. Ultimately, I believe that this is creating further budgetary concerns and reinforces the "revolving door" of treatment."*
- *"It is very difficult to get inpatient services if they are needed. Many 3rd party payors have very high deductibles the client must pay before their benefits actually kick in, and we have many more uninsured due to limits on access."*

- **Question 7: Have the paperwork requirements to serve people in need stayed the same or changed in the last five years?**

Answer Options	Response Percent	Response Count
I spend less time on documentation and more time working with people than I did five years ago	2.7%	21
I spend about the same time on documentation and time working with people than I did five years ago	16.8%	130
I spend more time with documentation and less time working with people than I did five years ago	68.1%	526
I have been working for less than five years	3.8%	29
This question does not apply to my service setting	8.5%	66
answered question		772
skipped question		65

Question 7 con't.



- Total respondents to whom the question applies working more than five years reporting that the paperwork requirements have increased:
  Response Count: 527 out of 678 Percent Response: 77.7%

Question 7 Keyword Results found in "favorable" and "unfavorable" comments regarding paperwork		
Key Word	**Favorable**	**Unfavorable**
Paperwork	9	103
Documentation	7	34
Requirements	1	29
Information	2	5
Authorizations	0	2
Stipulations	0	1

Total Comments: 229

Type of responses:

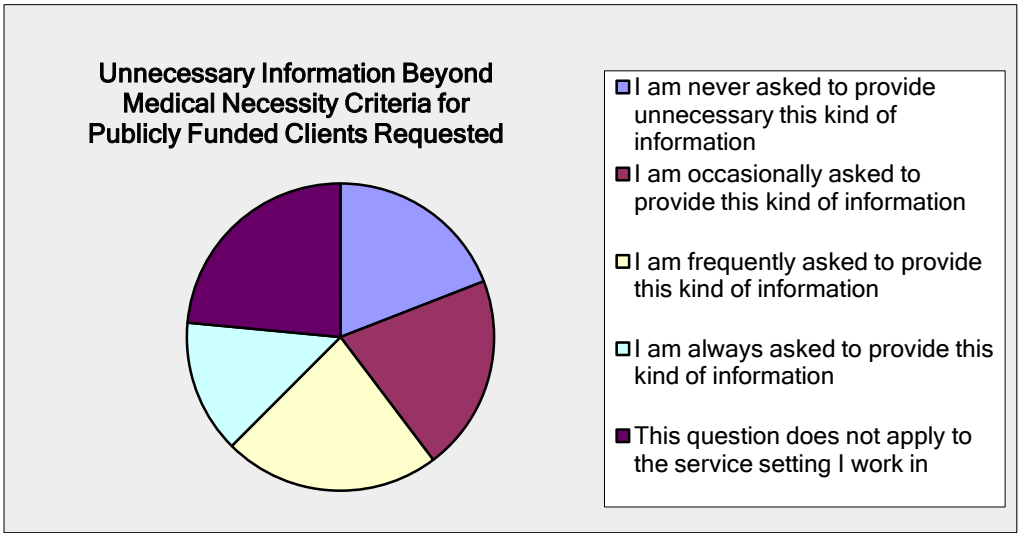
Nearly all the comments identify that documentation demands have increased, and many of those identify that these increases have a negative impact on clinical care and are not necessary for good clinical care. Many comments cite insurance, state and county documentation requirements as challenging. Several indicate that Electronic Health Records help. A number of comments cite documentation demands influencing their desire to work in the field or switch into private practice to not work with clients from some funding sources because of documentation demands. The full list of comments is attached to this report in Appendix II, starting on page 38.

Selected comments:

- *"Paperwork requirements increase every year – it is deterring people from entering the field and causing others to leave it."*
- *"Clearly, more and more paperwork to be done in a relatively short period of time. This prohibits time to build rapport and establish some kind of relationship with our clients at the front end when it is most important."*
- *"The documentation demands have increased especially with managed care, although electronic health records help, the volume compromises services."*
- *"Not only is there more paperwork, various insurance providers require duplicate yet similar paperwork!"*
- *"Way too many masters to serve, no time for clients."*
- *"Data is useless to serve clients but is collected to satisfy funders."*

- **Question 8: The only medical necessity criteria for publically funded clients to get treatment in Pennsylvania is the PCPC. Are you being asked to provide unnecessary and personal information about your clients and their family histories beyond the PCPC to obtain authorization for admission to or continued stay for drug and alcohol services?**

Answer Options	Response Percent	Response Count
I am never asked to provide unnecessary this kind of information	19.1%	147
I am occasionally asked to provide this kind of information	20.6%	159
I am frequently asked to provide this kind of information	22.8%	176
I am always asked to provide this kind of information	14.0%	108
This question does not apply to the service setting I work in	23.5%	181
	answered question	771
	skipped question	66



- Combined total number of respondents to which the question applied who reported being frequently or always asked to provide unnecessary and personal information about persons they serve and their family histories that exceed the PCPC:
  Response count: 285 out of 591 Percent Response: 48.2%

Question 8 Keyword Results found in "favorable" and "unfavorable" comments on the request for unnecessary and personal information being requested

Key Word	Favorable	Unfavorable
Insurance	4	20
Information	3	17
Managed Care	2	3
Funding	2	6
Denied	0	4
Authorize	0	1

Total Comments: 172

Type of responses:

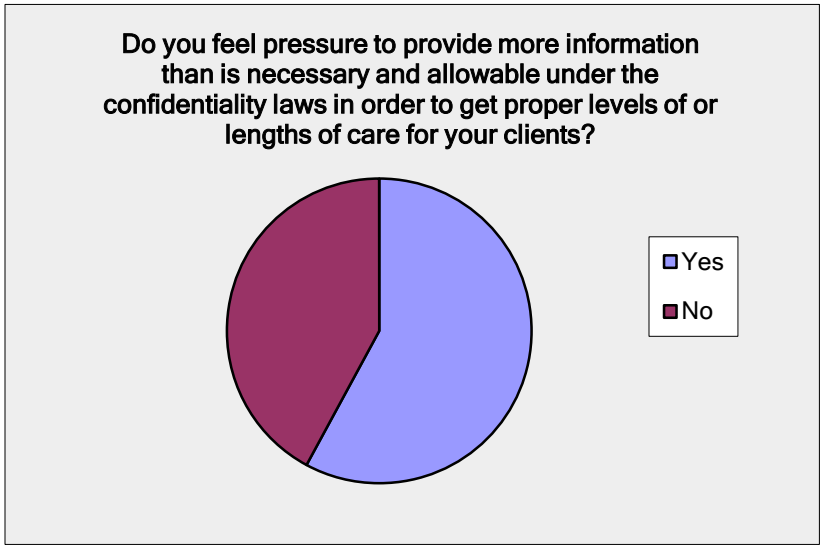
Many of the respondents identified that they are asked to provide unnecessary and personal information about the people that they serve and their families. Some cite specific companies or funding entities or that it happens in some levels of care such as residential more than other levels of care such as outpatient. Many correctly identify that it is not legal to exceed the confidentiality standards, although multiple respondents indicate that if this kind of information is not provided, individual care is denied. Many note that these protections are necessary; a few identify confidentiality as a barrier to care. The full list of comments is attached to this report in Appendix II starting on page 44.

Selected comments:

- *"at times we are torn between getting the person treatment or fighting for confidentiality"*
- *"Insurances don't want to pay - so if you don't give it, they STOP PAYMENT!"*
- *"Managed care asks information that violates the confidentiality of our clients routinely. If they do not receive the information they request, they reduce the number of authorized days."*
- *"At times, it appears the person is being judged as to their worthiness rather than clinical need".*
- *"Some funding providers WILL NOT authorize funds without info not in the PCPC regardless of confidentiality laws protecting the client".*

- **Question 9: Do you feel pressure to provide more information than is necessary and allowable under the confidentiality laws in order to get proper levels of or lengths of care for your clients**?

Answer Options	Response Percent	Response Count
Yes	57.9%	434
No	42.1%	316
answered question		750
skipped question		87



Question 9 Keyword Results found in "favorable" and "unfavorable" comments regarding pressure for information beyond the PCPC		
Key Word	**Favorable**	**Unfavorable**
Information	6	31
Insurance	8	18
Funding	6	17
Managed Care	0	5
Authorize	1	3
Denied	0	2
Requirements	1	0

Total Comments: 187

Type of responses:

Many of the respondents identified that although they are pressured to provide information and yet are able to get individuals services while adhering to confidentiality requirements. Others indicate that they are never or infrequently asked to provide information that exceeds the confidentiality standards. Several identified specific funders who asked questions that exceed confidentiality. There are conflicting comments as to how confidentiality standards are being honored by funders and other

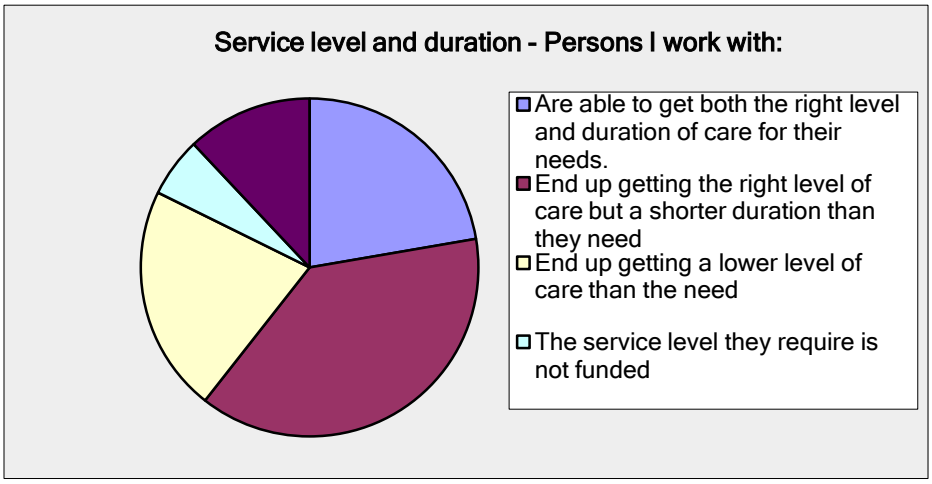
entities in Pennsylvania. The full list of comments is attached to this report in Appendix II, starting on page 48.

Selected comments:

- *"Always need to be careful not to provide too much information."*
- *"Many funding sources refused to provide funding without additional information. When you would push back and not give illegal information the staff would become rude, mean and difficult to work with."*
- *"Funding sources are respectful when told we are not allowed to give information."*
- *"In order to obtain authorizations from MCO's we have to give too much information to get authorizations."*
- *"I have learned methods to cue reviewers that do not exceed the confidentiality laws."*
- *"Due to years of experience I challenge these requests however; I can see how someone less seasoned could fall into that trap/ manipulation."*

- **Question 10: Service level and duration - Persons I work with...**

Answer Options	Response Percent	Response Count
Are able to get both the right level and duration of care for their needs.	22.3%	177
End up getting the right level of care but a shorter duration than they need	38.3%	304
End up getting a lower level of care than the need	21.7%	172
The service level they require is not funded	5.7%	45
This question does not apply to my service setting	12.0%	95
answered question		793
skipped question		44



- Combined total of respondents for whom the question applied indicating that a client gets a shorter duration, lower level of care or that the service required is not funded or offered:

  Response Count: 522 out of 699 Percent Response: 74.6%

Question 10 Keyword Results found in "favorable" and "unfavorable" comments regarding level and duration of care		
Key Word	**Favorable**	**Unfavorable**
Clients	10	31
Insurance	7	23
Level of care	8	20
Funding	5	20
Time	6	18
Services	4	15
Inpatient	1	15
LOC	6	7
Discharged	0	3
Limits	1	2

Total Comments: 202

Type of responses:

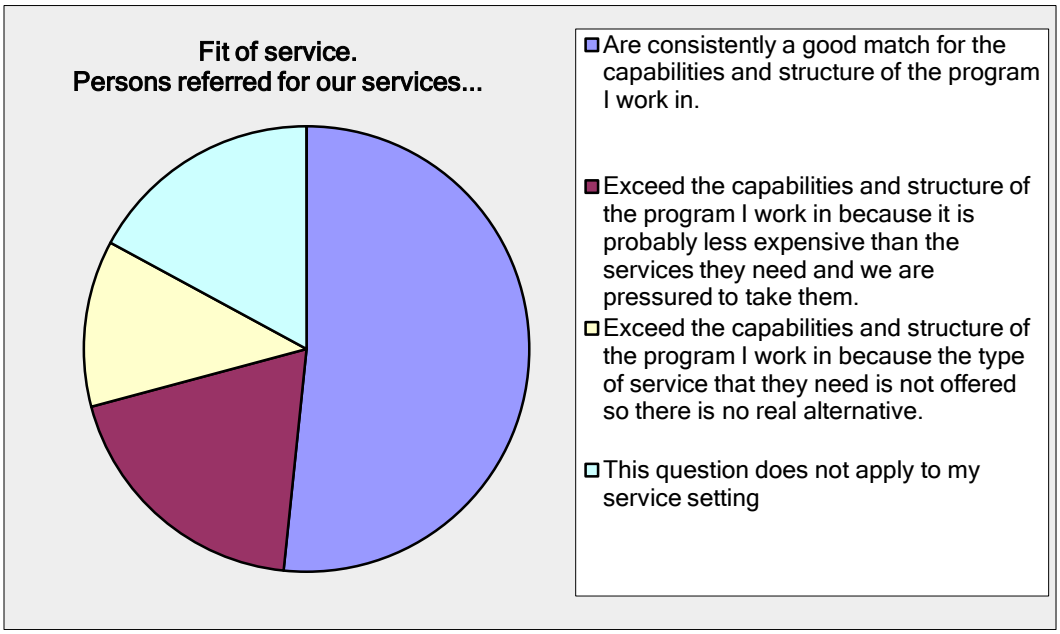
There was a mixed response to this question with answers indicating that clients do get appropriate services while others identify that services fall short of the clinical needs of the client. Some respondents indicate that client's service needs are not being met and that there are difficulty getting individuals into specific levels of care. The full list of comments is attached to this report in Appendix II, starting on page 52.

Selected comments:

- *"Commercial and Medicaid insurance dictate level of care despite patient meeting diagnostic criteria."*
- *"Many clients do not get the time they need to establish hope, consistency and the structure required for their recovery."*
- *"Persons in recovery are presenting more frequently with co-occurring disorders that cannot be adequately treated in service provider time lines."*
- *"About 50% of our clients get the right service and duration, the others do not."*
- *"Pts who have never been in treatment who are usually young adults are required to "fail" in an outpatient setting before accessing rehab level of care."*
- *"Most Clients do need longer in in-patient care so they can stabilize better and develop a stronger aftercare plan. Pushing them into IOP before they are ready hurts, and does not save funds in the long run as the chances are the person will relapse."*

- **Question 11: Fit of service. Persons referred for our services...**

Answer Options	Response Percent	Response Count
Are consistently a good match for the capabilities and structure of the program I work in.	51.7%	394
Exceed the capabilities and structure of the program I work in because it is probably less expensive than the services they need and we are pressured to take them.	19.2%	146
Exceed the capabilities and structure of the program I work in because the type of service that they need is not offered so there is no real alternative.	12.1%	92
This question does not apply to my service setting	17.1%	130
answered question		762
skipped question		75



- Combined respondents among those whom the question applied who reported that the clients that they serve exceed the capabilities of the programs they are in because it is probably less expensive or the service needed are not offered:
  Response Count: 239 out of 633 **Percent Response: 37.7%**

Question 11 Keyword Results found in "favorable" and "unfavorable" comments regarding fit of service		
Key Word	Favorable	Unfavorable
Clients	12	19
Level of care	2	10
MH	2	10
Services	5	8
Referral	5	6
Co-occurring	0	6
Structure	1	3
Referred	6	3

Total Comments: 141

Type of responses:

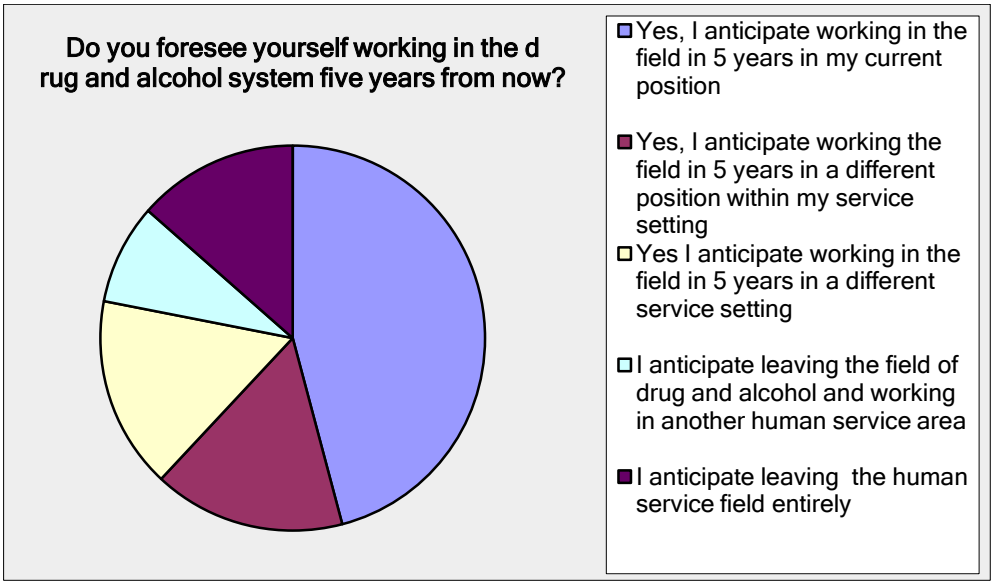
There was a wide variety of answers from respondents indicating that services are a good fit to respondents who indicated that clients are getting less than is clinically indicated. Respondents indicated that client needs have gotten more complex or that they end up being served in a program that does not fit their respective needs. There were many comments related to challenges serving the dually diagnosed MH client. Clients with special needs, such as adolescents or those who are in MAT programs are noted to face additional challenges getting services that fit their needs. The full list of comments is attached to this report in Appendix II, starting on page 57.

Selected comments:

- "*Since the state hospitals have closed down we have been forced to take in many, many individuals who require a higher level of care. They do not do well in these agencies because we cannot meet their needs and we have nowhere to discharge them to afterwards because their needs are so high.*"
- *"Overall I feel it's a good match. Do not feel there is adequate training and providing for dual diagnosis at times. Do the best we can for them."*
- *"We have learned to work with more complex clients with less time and resources".*
- *"Clients come to us because the appropriate facility was unavailable or no funding".*
- *"Often the client is diagnosed and the LOC must be changed."*
- *"Not equipped to deal with the severity of MH problems we face."*

- **Question 12: Do you foresee yourself working in the drug and alcohol system five years from now?**

Answer Options	Response Percent	Response Count
Yes, I anticipate working in the field in 5 years in my current position	45.8%	359
Yes, I anticipate working the field in 5 years in a different position within my service setting	16.1%	126
Yes I anticipate working in the field in 5 years in a different service setting	16.1%	126
I anticipate leaving the field of drug and alcohol and working in another human service area	8.4%	66
I anticipate leaving the human service field entirely	13.5%	106
answered question		783
skipped question		54



- Combined responses of those respondents who intend to leave drug and alcohol or the human service field entirely within the next five years of the total respondents
  Response Count: 173 out of 784 Percent Response: 22%

Question for comment: Please explain your answer, what if any do you see as the pressures on you as a Counselor?

Question 12 Keyword Results found in "favorable" and "unfavorable" comments regarding pressures on counselors with "favorable" suggesting perceived positive quality of work and "unfavorable" suggesting negative pressure

Key Word	Favorable	Unfavorable
Paperwork	0	50
Retire	5	46
Client	7	37
Documentation	0	18
Pay	1	18
Funding	0	8
Stress	1	7
Money	1	5
Resources	0	4

Total Comments: 339

Type of responses:

There were many comments on how paperwork and related duties is negatively impacting client care. Inadequate pay and training as well as higher risk clients, heavy regulation, poor supervision and reduced funding are also cited as pressures counselors face. There were comments about people feeling isolated and overburdened, and frustrated that funders dictate clinical care. A number of responders indicated that the field has changed and it is difficult or not possible to properly provide for client needs in the current environment. The full list of comments is attached to this report in Appendix II, starting on page 61.

Selected comments:

- "*Overworked and underpaid. Too much paperwork. I can't even see 5 years ahead."*
- *"Providing the time for individual sessions or as opposed to the time spent on documentation and phone time with several case managers."*
- *"This is my calling and will be my career I plan on getting my PhD in addictions counseling"*
- *"Paperwork/less time with clients, increased caseloads means meeting with patients for the minimum required per month rather than the actual needs which can vary from month to month or crisis to crisis."*
- *"I am driven to work in this setting but I see the effects the demands of the field can have. I started at my position 4 years ago and have seen eight people leave. And we are a small facility!"*
- *"documentation, burn out not enough clinical support and supervision not enough self development opportunities"*

- **Question 13: What is the greatest barrier that interferes with helping people you work with in obtaining long term recovery?**

Question 13 Keyword Results found in "favorable" and "unfavorable" comments regarding factors interfering with long-term recovery, with "favorable" suggesting an asset and "unfavorable" suggesting a barrier

Key Word	Favorable	Unfavorable
Funding	0	107
Client	13	39
Work	5	33
Resources	0	33
Paperwork	0	22
Patients'	3	13
Pay	0	14
Education	0	12
Managed Care	0	11

Total Comments: 704

Type of responses:

There were many comments about funding, client's motivation for recovery and paperwork. Respondents saw lack of training, lack of programming, transportation and housing as concerns, as well as the techniques used with individuals in care. The full list of comments is attached to this report in Appendix II, starting on page 70.

Selected comments:

- *"Insurance funding being cut off, negative stereotypes in the community about methadone maintenance causing patients to feel pressured to leave when they are not ready."*
- "*The client them self - most are court stipulated and aren't internally ready, but we plant the seed*."
- *"The amount of paperwork is now so extensive that a lot of activities are now not incorporated into treatment that helped people stay in recovery for a longer period of time."*
- *The standardization of addiction treatment and lack of counselor knowledge and willingness to deviate from 12-step philosophy for EVERY patient (not all are appropriate).*
- *"Poor opportunities for people in recovery to become self-sufficient."*
- *"Mountains and mountains of paperwork, stipulations, standards, bylaws, policies, managed care regulations. It's a juggling act."*

V. Survey Limitations

PRO-A believes that this study raises many important and valid issues. However, as in any study of this nature, there are significant limitations to this survey. These limitations include those associated with how the survey was distributed. Surveys were collected in two ways, the first being through email to providers and provider groups operating around the state. As such, there was no way to control for sample integrity to make sure that only persons who provide counseling services or who provide those services within Pennsylvania were included in the sample. A similar limitation exists in respect to those surveys sent out by mail to all of the certified drug and alcohol counselors through the Pennsylvania Certification Board. It is probable that persons who are not currently providing services to this population have completed this survey as it is possible to maintain certification in retirement or if a person leaves counseling for other types of work. Multiple respondents did indicate that they were retired at this time and answered the survey at the point of time that they retired or in some other fashion. These types of responses can and will skew or distort the results of the survey as it was not possible to insure that the respondents were limited to the population we intended to sample. Also, as the survey was sent out in two ways, via email and in hardcopy, it is possible that individuals filled out more than one survey and there was also no way to ultimately control for this, although survey monkey is set up in a way that does not allow a respondent to complete the survey multiple times from one computer.

Another significant limitation is that the survey collects data from a single point in time. Individuals can have a difficult time gauging change over long durations which can also affect the results. Surveys can be more powerful if repeated at different point in time and measured against each other, which may be a consideration with this survey.

The methodology of the survey did try to limit sample bias by mailing out the survey to the entire list of certified drug and alcohol counselors. However as noted in a prior section, people can work with this population without holding a certification, so sample bias is a potential limitation particularly with those surveys that were sent out by email as there was no way to control for sample bias in respect to the methodology employed. We did see some examples of persons identifying themselves as working for managed care organizations who completed the survey which may also skew the results as they are not providing or involved in client care.

There is also the potential for response bias in that respondents may have completed the survey not in the way that they really see things but how they perceive that the researchers wanted them to, which is an inherent limitation of surveys.

There is an inherent likelihood of self-selection bias as respondents as we were unable to collect responses from every single person in Pennsylvania who works with this population in a clinical capacity. Those who answered the survey self selected themselves into the sample by answering the questions and either logging onto survey monkey or mailing in the survey to do so. We were unable to select out persons who were in more administrative positions but either decided to fill out the survey online or have retained their certification as a drug and alcohol counselor and received a survey in the mail. We believe that their perspective may add to the survey as they may have a greater system perspective to contribute to the survey. However, they are also probably less involved in direct counseling which may also detract from the results. It is possible that the results are skewed because the respondents may have a stronger opinion on the topics covered than those who decided to not complete and submit the survey.

Additionally, as the survey was done late in the fiscal year—in a year when multiple funding sources were out of money and not able to provide care to individuals and families seeking help—answers may have been distorted by the point in time factors during which it was conducted.

VI. Conclusions and Recommendations for Services and Policymakers

It may be beneficial to compare the results of this survey to other data sets that are available with similar samples. Although it may not possible for a direct comparison to other studies and populations due to the types of questions we were focused on and the methodology employed, we would recommend that this draft report be reviewed by DDAP for further considerations of policy and practice implications to explore. Although preliminary in nature, we do believe that that this survey shows some indication that we have a service system and workforce under severe stress.

The responses indicate that people seeking help for addiction problems are served in lower levels of care and for shorter durations of time than many of the treating clinicians would consider as clinically indicated. Many survey respondents indicate that funders seek information about persons seeking help that exceed the law, with some mixed indications that services are being withheld unless information that is not necessary or legal is provided to them. This is a serious issue that deserves more attention as providing lower levels of care for shorter durations than indicated would negatively impact the efficacy of those services and laws protecting confidentiality within our system need to be adhered to.

Strains on the workforce are evident by the numbers or people identifying that they are considering leaving or face overwhelming barriers to providing counseling from a number of directions. Many of the respondents indicated that ever-increasing paperwork, high case loads and poor funding, high stress and poor compensation are factors in having them consider no longer doing this kind of work.

This survey was completed as a deliverable to DDAP. We consider this survey as a preliminary report. We believe that the data it contains would benefit from a deeper examination and may very well offer significant policy and practice implications across the full spectrum of service and workforce areas if more fully analyzed. We would recommend that DDAP review this survey and consider engaging with PRO-A to examine any or all of the topic areas at a deeper level to understand these policy and practice implications at the discretion of DDAP. As advocates for recovery, we understand the critical importance of having a strong and functioning drug and alcohol service system to serve our communities into the next generation. These services are a fundamental aspect of the recovery process for many Pennsylvanians and their families.

Appendix I: Sample of Blank Survey

Counselor - SERVICE SYSTEM ENVIRONMENTAL SCAN

PRO-A is sending out this questionnaire to all Alcohol and / or Drug Counselors that we can identify to better understand some of our service system challenges. The service system is a critically important part of the recovery process for the thousands of Pennsylvania citizens who need help addressing their addiction problems. Please take the time to answer these questions and to return in the enclosed postage paid envelope so we can better understand your perspective on these challenges. All individual responses will be kept in strict confidence.

The aggregate responses will be complied into a summary with no individual identifying information disclosed. The survey is anonymous.

If you wish to become a member of PRO-A information on our web site is located at the end of the survey

Thank you,
Bill Stauffer, LSW, CADC
Executive Director

Date: ____ **Age**: _____ **Gender**: ____ **Ethnicity**: _____

Region of the State: ____ NW ____ NE ____ Central ____ SE ____ SW

1. **Highest level of Education** (Please Check)

____ High School Diploma / GED
____ Some college
____ Associates Degree
____ Bachelors Degree
____ Masters Degree
____ PhD

2. **Length of time working in the field** (Please Check)

____ Less than one year
____1 to 2 Years
____3 to 5 Years
____6 to 10 Years
____11 to 15 Years
____16 to 20 Years
____ Over 20 Years

3. **Primary Workplace Setting**

____ Assessment / Intake Unit
____ Case management unit
____ Outreach worker
____ Outpatient / IOP
____ Detox
____ Short Term residential
____ Moderate to Longer Term residential (such as Licensed Halfway House / TC)
____ Other _____

4. **Recovery Status**: Are you in recovery from Drug and /or Alcohol Dependency? Yes: ____ No: _____

If in Recovery, Length of Time:
____ Less than 3 Years
____ 3 to 5 Years
____ 6 to 10 Years
____ 11 to 15 Years
____ 16 to 20 Years

____ Over 20 Years

5. **Do you have a family member or loved one in recovery from substance abuse**? Yes: ____ No: _____

6. **Do you believe that individuals you serve are getting the proper level and duration of services across all of the funding sources you work with in your setting**? (Circle one)

   1 None of our clients are getting the proper level and duration of services from any of our funders
   2 Some of our clients are getting the proper level and duration of services from some of our funders
   3 Most of our clients are getting the proper level and duration of services from most of our funders
   4 All of our clients are getting the proper level and duration of services from some of our funders
   5 This question does not apply to the service setting I work in

   Please let us know more: _____
   _____
   _____

7. **Have the paperwork requirements to serve people in need stayed the same or changed in the last five years?** (Circle one)

   1 I spend less time on documentation and more time working with people than I did five years ago
   2 I spend about the same time on documentation and time working with people than I did five years ago
   3 I spend more time with documentation and less time working with people than I did five years ago
   4 I have been working for less than five years
   5 This question does not apply to my service setting

   Please let us know more:_____
   _____
   _____

8. **The only medical necessity criteria for publically funded clients to get treatment in Pennsylvania is the PCPC. Are you being asked to provide unnecessary and personal information about your clients and their family histories beyond the PCPC to obtain authorization for admission to or continued stay for drug and alcohol services?** (Circle one)

   1 I am never asked to provide unnecessary and personal information about persons I serve and their family histories that exceed the PCPC
   2 I am occasionally asked to provide unnecessary and personal information about persons I serve and their family histories that exceed the PCPC
   3 I am frequently asked to provide unnecessary and personal information about persons I serve and their family histories that exceed the PCPC
   4 I am always asked to provide unnecessary and personal information about persons I serve and their family histories that exceed the PCPC
   5 This question does not apply to the service setting I work in

   Please let us know more:_____
   _____

9. **Do you feel pressure to provide more information than is necessary and allowable under the confidentiality laws in order to get proper levels of or lengths of care for your clients**?
   Yes ___ No ____

   Please let us know more: _____
   _____

10. **Service level and duration - Persons I work with**: (Circle one)

    1 Are able to get both the right level and duration of care for their needs.
    2 End up getting the right level of care but a shorter duration than they need
    3 End up getting a lower level of care than the need
    4 The service level they require is not funded
    5 This question does not apply to my service setting

    Please let us know more: _____
    _____

11. **Fit of service**. Persons referred for our services: (Circle one)

    1 Are consistently a good match for the capabilities and structure of the program I work in.
    2 Exceed the capabilities and structure of the program I work in because it is probably less expensive than the services they need and we are pressured to take them.
    3 Exceed the capabilities and structure of the program I work in because the type of service that they need is not offered so there is no real alternative.
    4 Other _____
    5 This question does not apply to my service setting

    Please let us know more: _____
    _____
    _____

12. **Do you foresee yourself working in the drug and alcohol system five years from now? (**Circle one)

    1 Yes, I anticipate working in the field in 5 years in my current position
    2 Yes, I anticipate working the field in 5 years in a different position within my service setting
    3 Yes I anticipate working in the field in 5 years in a different service setting
    4 I anticipate leaving the field of drug and alcohol and working in another human service area
    5 I anticipate leaving the human service field entirely

    Please explain your answer, what if any do you see as the pressures on you as a Counselor?_____

    _____
    _____

13 What is the greatest barrier that interferes with helping people you work with in obtaining long term recovery?

_____
_____

If interested in joining PRO-A, please go to our web page at:

www.PRO-A.org

….and follow the link to our membership form

Thank you for your time and effort in completing this survey!

WBS 02/08/13

Appendix II: All comments collected from survey

Q6 Proper level and duration of services across all of the funding sources

- Due to our location limited providers and increased need for services. Hospital discharges are often referred to IOP instead of the higher level of care that they need.
- Insurance companies are getting tougher to deal with.
- Some need more help than others.
- MMAT does not accept private insurance so those that are not MA are self pay for services
- Due to limited funding streams, clients are often released from services prematurely
- At the OP levels most services are supported. However, over OP level services tend to be too short and often less intense than supported by assessment.
- All depends on insurance coverage and terms of contracts.
- Many clients have no insurance and they aren't able to go to rehab due to the shortage of funding.
- Many clients are being placed in a higher level of care than necessary and are being kept in Tx longer than necessary. I feel people would benefit from longer inpatient tx.
- Biggest concern on this questionnaire is a ruling by CCBH managed care oversight for MA. Ruling limits agency to no more than 10 clients in a group. While working in another state as a d&a counselor 1997-2007, there was a state requirement that allowed 15 clients in one group with one counselor. There could be 16-20 clients in a group with 2 counselors. I found this system worked well. The only exception I had was a dual diagnosis group I had for 3 years. Our agency limited the group number to no more than 12 based on the challenges the dual population can present.
- We only take medical assistance or personal self-pays.
- However, more funders are trying to dictate the amount of days and not considering the individual needs.
- I do not receive any public funding.
- Hospital setting on medical floors progressed alcoholism/addictions with medical needs that not even level 4 will accept often Medicare 18 days max and facility Eagleville, VFMC unwilling to fund with zero dollars for Lancaster County people from hospital setting. Individuals on MHU often have zero funding and can't access bed to bed due to low county funding criteria - zero bed-to-bed transfer.
- There should be a time limit on agonist treatment procedures. Some of my clients have been on methadone or suboxone for over 7 years. I don't believe this was the intent of the agonist treatment programs.
- More 6 months - 2 year residential programs needed.
- Length of time in treatment is four months too short.
- Commercial/ private insurance often doesn't cover or co-pay is very high.
- No funding for most services.
- Medicare patients seem to have a lot of difficulty with funding.
- Too many funding/ insurance companies don't think opiate addicts need detox.
- We are not providing services for individuals new to the system who are county funded.
- There are very limited detox/residential/inpatient facilities that can accommodate services to fit the medical needs of dialysis patients.
- I feel most are able to obtain what they need.
- Sometimes we are referred clients that are MH/MR and we are not equipped to deal with a lot of MR clients.
- Only one IOP for adolescents without insurance in our city.
- In the past when dealing with funding, many clients did not get the proper level of care. Funding sources do not pay for those services for as long as a client needs them.
- Local funding difficult to get, not long enough. Helps when they are able to get Medicaid. If they have Medicare can't access 2nd insurance source to treatment for D/A.

- Work in a strictly private pay setting. So most get excellent care or they will sue you! But no place is perfect.
- I do D&A therapy in a private practice outpatient setting.
- Continuity of care has been compromised over the years due to funding.
- Length of stays for short term residential treatment have been decreased due to funding.
- Halfway homes are unavailable to clients unless they are willing to commit to follow through 100% because facility does not want to take risk of loss of funding for future.
- However I do make several referrals to treatment centers and because of my affiliation with the local county, the clients do get adequate services. Not so much with private insurances.
- Throughout my 40 years with the agency, inadequate funding, limited stays approved when funded, continual insurance barriers negatively impact access.
- Half or better of our clients have public funding. They generally get the appropriate LOC and length of stay. Private ins. makes getting a client covered very difficult. At times they "require" information that exceeds confidentiality.
- If patients have 3rd party insurance, for the most part, they can access appropriate lOC. Duration is sometimes and issue. Medicaid and uninsured have MUCH less access. Medicare is non-existent!!
- Sometimes there are difficulties to get a person proper higher level of care when they are not doing well in OP or IOP. We are told they have to "fail at IOP" – what does "fail" mean?
- Some of the PTs are getting longer term treatment for free than is necessary.
- no problems with / OP services difficulty lies with our halfway house receiving funding for the amount of time we need to work with people
- Come of the clients are self pay due to the agency does not accept private HMO's and some income is higher than the income requirements of public funding.
- Private insurance, JACO, CBH
- we primarily work with DOC
- Clients who have more serious legal issues do get longer services. Washington county is cutting people off at 6 months in OP.
- The amount of time and steps a person goes through to get into treatment is way beyond physical or mental health systems.
- with exception to individual private insurance companies
- Sometimes not always receiving the necessary length of stay at a rehab level.
- My clients are almost exclusively individual with private insurance plans. In situations where an insurance company will not pay for a service, the individual or family does so.
- the drug court treatment program offers some clients services however this is very expensive and very few people ever stay clean and sober in recovery for long periods of time
- CBHNP will ONLY fund for 90 days of treatment in halfway house LOC regardless of length of program. CCBHO care managers attempt to dictate treatment by only funding one or two weeks at a time and telling counselors to "start planning for discharge" even if the client clearly meets PCPC criteria. VBH seems to have the best care managers that do not attempt to dictate treatment by misinterpreting PCPC criteria.
- I believe that clients are being assessed incorrectly in order to fill capacity within an organization. Often a higher level of care is needed than is provided
- If client is willing they can have proper duration of treatment.
- Insurance is a huge issue/ funding.
- I work for an insurance company, some individuals are only getting detox before leaving to short partial or IOP.
- It's hard for our patients to get their insurance to pay for the length of care they need or they don't have insurance and are not eligible for medical assistance.
- Services are shortened and those who are not directing care request more than 255.5 and still deny treatment. VBH in particular. Also DPW has issues giving benefits within the 30 days and keeping them on benefits so many get DC

- If they are committed and make the best of available resources.
- OHIO patients cannot access TX easily but will not allow their patients to come here unless they self pay
- the IOP groups are too long actually. People on methadone stay in IOP forever, 9 hours per week
- there are patients on county funding who benefit from full coverage
- People are being forced into lower levels of care and not even getting inpatient time.
- some clients are not eligible for 3B due to county funding restraints
- methadone maintenance treatment is not a county funded service NOR does it even appear on the PCPC
- EAP services are working very well
- not long enough
- patients do not get their individual needs met majority funded by MBH
- case loads are too high to render proper services to clients
- there are more stringent criteria for assessing and referring people to longer TX stays along with admission to long term
- we need more detox beds!
- people are not even in treatment long enough to even be fully detoxed
- people are not the same - insurance limits without understanding the recovery process
- lack of service providers in the area
- I refer regularly to facilities
- more and more difficult to get 3B approval from commercial insurance plan
- no money from the state
- However up to 2009 I did own and operate a BDAP licensed D&A outpatient facility. The clients got sicker and sicker over the 23 years I was in the field and the funding got less and less.
- Private insurances are often problematic.
- There are significant differences between most funders definition and allocation of duration of service.
- As the SCA we are dealing with less funding and trying to serve as many people as we can in all levels of care, it gets more difficult every year.
- I work in a state prison.
- We generally have little problem getting proper level of care and duration for OP, PHP, IOP however getting someone admitted to detox and IP is very difficult. The longest length of stay is two weeks.
- Funders want to dictate length of stay.
- Limits on insurance toward end of year, limits on SCA funds.
- county is good until money runs out,
- State DOC / Parole funding exists for State Parole but lack of county funding for TX for county offenders
- Funding is being restricted more and more, when evidence dictates longer inpatient treatment reflects higher rates of sobriety.
- MCO's are violating Pa laws by requiring more information than allowed under 255.5 and using this information to restrict care.
- 7 days inpatient treatment for heroin addiction will not begin to address the needs of the client
- Because I work in a correctional setting, this target population are in need of individual sessions and treatment plans prior to being released.
- Local SCA very politically motivated—they have "favorite" providers.
- We serve adolescents 12-18 and our option for extended care/long term is not covered under insurance. Therefore only private pay clients are getting this level and duration. Most of our clients are low income and are not able to stay long term.
- However, the state is trying to mandate the amount of time a patient is in MMT which I feel is wrong
- No 2A partial
- Length of stay should not be determined by funding restrictions.
- reduced funding for both inpatient and outpatient care for this population and for the dually diagnosed
- Follow through for the population is lacking
- I believe that some of our clients need more than OP or IOP but our funding sources are limited.

- Delaware county funding is limited to one detox and one rehab per year. Only with MA does one get to stay in treatment until they are stable.
- Private insurance is more difficult to obtain authorizations for rehabs
- Public funds always run out and while private insurance will typically pay for admission the length of stay is shorter than I agree with.
- We are fortunate to have a couple of state grants to work with criminal justice populations.
- Service provides have unrealistic expectations of timelines appropriate to treat the plethora of issues clients present with
- Feel they could use more inpatient time, before halfway house level of care.
- Depends of severity of addiction and other factors.
- SCA funded clients have less authorized services for both IOP and OP treatment.
- This answer only applies to MA clients and clients funded by school districts. It does not apply to private insurance clients.
- Need for more re-entry D&A case managers.
- services are fairly standard and do not appear adequate for about 50% of our clients
- Our organization is funded primarily through private insurance(s) and many of May our clients are denied continued stay prematurely. Especially with Horizon, sometimes with Cigna and value options. ITR process can be a barrier to completing the recommended length of stay. 116 Addicts are more than likely relapsers and need at least 90 days of ongoing isolation and daily treatment in order to sustain sobriety.
- I also work as a DOT SAP - it is difficult getting major providers to work with anything other than their specific protocol programs.
- Patients are sometimes limited because of insurance.
- Some clients aren't given enough authorizations for I/P or O/P aftercare in order that they can have a better chance for recovery than relapse.
- Some clients would benefit from longer duration of services but with private insurance companies will not continue paying for services.
- I am the only CADC in a 23 employee practice.
- Services to clients are dependent upon administrative policies. Poor administrators no training, no realistic workload management =’s just meeting paper deadlines and marginal treatment.
- There are few options for recovering people to enter a system based on harm reduction as opposed to an abstinence model.
- Funding sources, running out of money, shorter stays on average. May
- funding has only decreased over the years in direct opposition to the rising numbers of persons with addictions
- I work in a university setting currently and there is little pressure from insurance companies on LOC
- able to get proper level - perhaps not when high utilization and repeated use of high level costs of care with more follow up of aftercare
- I find that the insurance panels we have say that they provide the right levels of care but we struggle to get paid
- research indicates that longer stays would benefit most clients
- some don't because the client is not willing to accept a higher level of care, some do not because of their insurance not covering quality providers and longer stays
- services have been cut back and caseloads increased because of funding cuts
- 30% DUI Court ordered 30% MAT 40% Dual Diagnosed
- SCA can be problematic when funds run dry - typically at the end of the fiscal year
- insurance MCO level of care criteria is too restrictive want to save $ before helping people
- in our service area, IOP and Partial programs are scarce. Why? Either not cost effective or political infighting with the county
- funding provides limited options and durations of TX
- While I working in an OP facility I saw insurances companies (mostly commercial) deny care or force clients into levels of care that weren't appropriate for his or her needs.

- As a functional unit I see 1st hand what this SCA pays for. I know that we seldom don't pay for, unfortunately, with funding cuts lengths of stay are reduced.
- See jail and lack of MH issues appeared to determine length of stay.
- Very limited services in our area.
- Those with insurance recovery very little if any residential those funded by SCA's are also limited due to funding with residential being 28 vs 90.
- Often insurance will not authorize what is requested in length of time and or level.
- Duration of service is decreasing and jeopardizing effectiveness at times.
- Too much worry on time spent on funding issues not tx issues.
- We are an extended care program that is self pay only.
- IP stays are too short. Halfway and 3/4 houses scarce.
- In some cases funding is simply not available for long term care necessary for same patients.
- Politics and greed prevent adequate tx for those in need.
- There is a critical need for more long term residential facilities especially for co-occurring.
- We need more funding for patients.
- They can't access adequate inpatient tx.
- County funding is decreasing and is unable to serve all the individuals, pick and choose most "severe". Also, insurance wait fund due to hx if don't complete past programs insurance doesn't take profession into account.
- Insurance criteria is always problematic.
- However I think way too much is spent funding the inmate population for IP Tx. Used to get out of jail and not deal with their addiction. 4 to 5 IP experiences while others cannot get help. As a taxpayer, it is a joke, and waste.
- Our 6 week 30 group program is somewhat effective as introduction are zero 5 week programs are fair for men, poor for women, our stress and anger good and 3 month rehab is great.
- Private insurer dictates level and length of care.
- Just within the past few weeks, Berks county funding does not have the money to fund for short term residential.
- Private pay with scholarship funds, insurance reimbursement post TX
- N/A since I'm not directly serving this population I'm in a school setting for the past 4 years.
- For severely addicted clients, IP Tx is less than adequate at this time.
- Recently working with adolescence, something has to be done to hold the parents more accountable and change the home life that they will return to.
- The funding is less and less making Tx shorter and shorter. May
- Sometimes it's less others have tx's average LOS 21-30 day 3B 20+plus tx rehab.
- However if pt requires detox or rehab level of care, often denied.
- Long term treated clients benefit from program 90 days or more the FIR and halfway back county clients stipulated have little progress.
- SCA funding virtually nonexistent for outlet, MA finds ways to end funding with little or no notice.
- Clients need more inpatient and icp coverage.
- HMO and BHSI funded often only have 14-21 days of residential tx. Commercial insurances often make it very difficult for residential services.
- Recovery celebrates time from drugs and changes necessary to get that time. That time needs to be quality not quantity. A paradox-system does not allow time to get time.
- Private MMTP I believe many are getting the D/A treatment they need but lack MH treatment.
- services are harder to access; treatment duration is shorter.
- The welfare system is so bogged down that by the time benefits are turned on, clients are using again.
- Lack of funding other than MA and County funding.
- I come from the old school where you start with higher levels of care then work down. I felt that it gave clients a better foundation.

- Even though I am not currently working due to funding clients are not capable of receiving the appropriate treatment they need.
- Medicaid clients get 28 days when private ins 7-14 max and pushed to IOP
- private insurance does not offer the same benefits as government benefits
- our local SCA has limited funding for all levels of care many clients must wait for funding to enter TX or pay out of pocket for services
- More of the clients in short term residential would benefit from additional lengths of stay
- Assessments are frequently inaccurate and aftercare is so critical and not always on the continuum of TX as the vital link to recovery
- some clients use long term TX for housing and there is a lot of over medication
- Some insurance companies do not understand this disease and make decisions based on ignorance
- I work for the Philadelphia VA and they get what they need
- SCA's shorten TX significantly towards the end of the year
- our SCA is out of money for inpatient treatment - we offer only detox for outpatient treatment
- documentation time interferes with client care and we lose them
- some private and public insurances offer very limited LOS some clients leave TX with withdrawal symptoms and without meds
- county does provide adequate LOS
- loss of rehab, detox through SCA
- most do not get time and aftercare is a problem - I work with adolescence
- self pays take precedence over insurance clients
- clients who are parole violators are often DC early to make room for new clients it does not seem like it is about TX
- Tx is dictated by prison sentence
- MA clients do get funding county clients get minimal $ parole clients get too much time - punitive
- Private practice small groups we accept most insurance
- There are currently two in-prison recovery / treatment programs 1 for men and 1 for women
- when we call from hospital ED rarely is a detox bed available
- Poor access to inpatient and detox
- CCBH is consistent for funding sources for as long and as much as needed.
- County funding cuts have caused problems for service access in some populations
- Insurance companies approving less and less time for opiate residential Awful!
- Some of our clients have issues with large insurance deductibles which is making it difficult for them to participate in treatment. Many of our clients cannot pay these out of pocket expenses.
- Some insurance companies are consistent in giving 30 days of TX a good number of them automatically cut insurance during certain time frames
- Managed care is often an impediment to effective level and length of care
- Private pay clients get care they need
- We cannot accept Medicare clients for IOP due to Gov Regulations since we are an OP Hospital based provider" the SCA funding is not sufficient, little case management funds and thus the decision to end our contract is becoming a reality - impacting those that are the most vulnerable! Access to Medicaid can take up to one month or more.
- managed care agencies have denied funding for clients after 90 days in our Adolescent 3C LOC. Primarily CCBH has done this. They deny continued funding when a client transitions from residential to independent living treatment.
- Private Insurance clients are always in treatment for a shorter amount of time than the county funded clients
- inpatient treatment harder to obtain, IOP length is shorter than would be beneficial
- There is limited access to residential services due the lack of money the SCA has for that level and the restrictions of insurances. Some insurances will not cover the full duration of PHP or IOP services as well.
- Getting adequate inpatient days for individuals has been exceedingly difficult.

- Not enough county funding (Montgomery county) for those who need treatment the most.
- We frequently have individuals who are automatically cleared for 3C when they do not need it and others who desperately need but are pushed out the door in two weeks.
- Need improvement in the information we present.
- due to shortened inpatient stays fueled by lack of coverage by insurance companies the relapse rate is far greater
- services are more money driven instead of client driven
- People with D/A problems need more than 1-14 days of inpat. rehab. The brain is just starting to clear and attention span returning. There's still insurance plans that charge more for mh/sa coverage which is unfair. This disease is just as devastating as any physical problem or disease. It could possibly be a reason for that physical problem. The insurance companies need to cover all problems.
- Some private insurance companies have strict amounts of time or levels of care and it makes it difficult at times.
- Many of those I provide service to really need more than 90 days of treatment to help them maintain their recovery.
- I think that insurance coverage at time dictates length of stay, especially in inpatient levels of care.
- There is a need to link together mental health treatment and addiction
- private insurance and government funding at the county level are difficult to convince what is proper level of care needed.
- we should be able to provide adolescents with Intensive OP
- There are individuals who might need more time for treatment and don't get the length of time needed for proper and effective treatment.
- Lengths of stay insufficient
- Funder's tend to drive the duration of treatment, meaning the length of time individuals should stay in treatment. Most clients leave treatment with a min. of tools to maintain recovery.
- Some clients new more treatment time than funding allows
- Work in MMTP-patients average over 1 year in tx
- Public funders are doing a better job than commercial insurances at providing funding for the proper level of services
- my clients have private insurance which is relentless in denying benefits and support
- It is not the decade for substance abuse funding by the city, state or government
- some clients struggle with getting coverage we have a difficult time regarding the welfare system
- would like to have more individual sessions, recent change in agency limiting these services
- We have a nine month program with six half-way house plus follow up services upon release from Federal prison.
- It is very difficult to get inpatient services if they are needed. Many 3rd party payors have very high deductibles the client must pay before their benefits actually kick in, and we have many more uninsured due to limits on Access.
- Private insurances are limit higher levels of care. County has no money for inpt. treatment other than for detox.
- Detox beds are in short supply.
- Some of them are at correct level and some are not it just the level that they are actually able to get funding for.
- Sometimes due to the lack of funding from the state some of our clients do not get the LOC needed at certain times
- County funding for partial hospital services has stopped.
- It is difficult for the "working poor" to have treatment funded.
- there are some folks who come to halfway house who really need more time to reintegrate into the community, because they have fewer skills than others, or greater MH issues than others.
- Inpatient stays are significantly decreasing with patients having state insurance.

- I believe that the many service providers in there many different areas of service are doing the best job they can with what is available to them. The problem I'm seeing is the sometimes breaches in service to the client caused because of the lack of intentional collaboration between the many service providers.
- I'm in private practice. Most insurance policies cover services.
- At times continued care is not able to be provided due to lack of funding for extensions
- BHSI has made it difficult to provide care for uninsured.
- LOS keep getting shorter and shorter and jumping through hoops to get someone in treatment.
- managed care's interpretation of "medical necessity" is inconsistent & formulaic giving no consideration to individual needs for LOS
- They are getting pushed out of inpatient programs prematurely.
- County funded clients have the shortest treatment episodes
- Lack of funding does not allow clients to stay in inpatient treatment as long as necessary.
- county funding is very limited and clients do not get enough time inpatient and none for outpatient
- Duration of inpatient treatment is inadequate from funders unless forced to grant adequate LOS by Act 106. The situation appears to be worsening, not improving. Some funder personnel who make authorizations seem to treat addicts like pariahs.
- Authorizations for treatment, especially IOP, are too often very difficult to get approved.
- Some clients just use the system and manipulate and then when they really do want help sometime it isn't available. Others may reach out and be told that they must go into IOP until they fail and then the insurance will consider a bump up. The problem with this is that some may not make it back.
- Insurance appears to be the issue
- If the clients are making it to a HWH, usually they are getting the extended care they need; although we do run into clients being pushed out the door at the 90 day mark as managed care is tightening their belts.
- There is pressure from Managed Care - especially in Private Insurance to shorten treatment and lower level of care to less expensive alternatives (IOP instead of inpatient, OP instead of IOP, etc)
- County funding has been exhausted since February, 2013 for individual without insurance
- Medical Insurance companies continue to dictate length of care.
- We need more funding and more providers for drug and alcohol counseling \ I think that funding sources are limiting the amount of work that needs to be done with a client in my line of work. It seems that money is getting in the way of what is important and that is the health and welfare of the client. I feel that treatment, at times, is being dictated by the amount of funds that a particular client has. That's not good enough and needs to change.
- insurance companies almost always under approve level of care and duration of care
- Whilst understanding that budget issues exists, the continual shortening of length of stay for residential treatment is making treatment less effective over the long term and setting up a system of "triage" and crisis management opposed to effecting actual long-term shift in thoughts, attitudes and behaviors. Ultimately, I believe this is creating further budgetary concerns as it reinforces the "revolving door" of treatment.
- So many clients who utilize services over and over again and not receiving long enough stays due to this.
- Due to funding agencies the clients are not getting appropriate time in the setting to learn the information needed to maintain sobriety.
- some funding sources ask for more info than allowed and are more difficult to get funding regardless of PCPC criteria
- Most of the people referred to our levels of care are appropriate, however there are clear times when someone who is fragile in their not using is sent to our level of care and it seems they need a higher level of care. We have been told that someone has to be unsuccessful at this level of care before we can make a referral to a higher level. Also, there have been times when the county reviewer seems to want to debate our recommendation when someone is actively using in outpatient. Most recently, a man admitted to be using two substances while in outpatient treatment and felt out of control with his use. We referred for inpatient and were originally told that he would have to go to IOP and not be successful

before an inpatient experience would be approved. It ended up that he was allowed 14 days of funding for inpatient.

- Funders seek to spend less on treatment because they want to treat more people instead of assuring all get correct Lengths of stay. Staff often "go along" rather than fight for EACH case which marks the agency as non-cooperative or adversarial.
- It is a constant struggle with insurance companies for us to get our clients the time they need. We are a MINIMUM 90-day program and insurance is unwilling to fund beyond this.
- My main concern is that while it is understood we are a 3 to 6 month program, majority of funders expect us to have a person ready to go in exactly 3 months. At times funders become unwilling to extend funding past 90 days regardless of the residents need. This forces me to rush treatment and not spend the time needed on certain aspects of my residents treatment.
- Shorter stays are being funded. Clients have trouble getting and maintaining benefits or transferring benefits from one county to another.
- some clients that definitely display the need for 3c aren't getting it, therefore increasing recidivism.
- Often we have to utilize a lower level of care authorization (rehab) while providing a higher level of care service (detox). Some patients have to move directly from detox to out-patient when it's not appropriate.
- Lengths of stays are too short
- POWER is an excellent recovery resource - especially for women who are healing from trauma.
- Funding restrictions and bureaucratic regulations are inhibiting the treatment and recovery opportunities and process
- Funding sources cut off treatment too early. County funding is being cut and is not financially motivating for out facility to continue to take. Medicaid's sad attempts to create arbitrary rules to claw back what little money they pay is causing reductions in services.
- funding seems to dictate treatment lengths of stay and are not truly in the best interest of the client.
- It is getting more and more difficult to get more than the minimum length of stays, especially for managed care funded clients. Also, the physical and mental health issues are increasing fir a residential n I n hospital setting..
- Very dependent on Act 106; public funding streams are not held to this and the SCA is the worst at funding proper level
- It is getting increasingly harder to get clients served properly

Q7 Paperwork requirements to serve people in the last five years

- Our agency utilizes electronic records and paper charts. Paperwork has become very excessive.
- As a Clinical Supervisor I spend more time with paperwork and management than I do with clients
- The documentation demands have increased specially with managed care, although electronic records help the volume compromises services
- More and more info is required to discharge services.
- Most individual sessions are nearly all paperwork and very little counseling.
- I send reports to case managers after woman's group.
- DDAP wants paperwork one way and other managed care will want it their way, etc.
- Epic computer system requires typing and dictation services no longer exist in last 1-5 years. EBP are consuming a great deal of documentation time despite increase in better clinical care.
- Treatment plans, updates, counseling notes, letters to agonist treatment clinics or court re: court ordered treatment and compliance.
- Although I keep up with my CAC and I'm aware of the increase.
- I became out-of-network insurance provider (self pay only) 4 years ago.
- Front line staff are having more demands on detailed documentation so that MCO's will pay for services. Numerous audits and documentation changes adding work also.
- Seems like paperwork requirements continue to increase.

- The time spent on paperwork has always (since 1992) taken up more time than the time spent with clients and it is worse now.
- Way too much paperwork that distracts from true therapy!
- Not only is there more paperwork, various insurance providers require duplicate/yet similar paperwork!
- Ack!!! Glad I'm close to retirement!
- Too much documentation creating too much stress!!
- The client is the most important priority, therefore I donate several hours to complying with paperwork and phone calls.
- BIG TIME! My paperwork covers so many requirements (Dept. of corrections, PCPC, MH licensing, IOP, Inpatient requirements) that the amount of client contact is limited.
- Licensing audits keep requiring more. Forms change, no symmetry in requirements.
- So I recently moved to outpatient care and some follow up, research based practices.
- Seems like a new requirement every few weeks.
- The state has also added the STAR systems for county funded clients/counties are requiring paperwork as well as STAR entries.
- When I broke into the field in 1973, myself and my counselors used 100% of our time on face to face patient care; today because of paperwork it is less than 50%.
- I spend more time on paperwork and the same amount of time with clients. I work on my lunch and stay after hours regularly.
- Way too much repetitive paperwork is involved.
- As an outreach counselor, I assess and refer - much less documentation required. In the many years I have worked inpatient it was crushing!
- I have to make a time for paperwork
- More forms, packets to apply for higher level of care through county.
- Paperwork is often redundant and overkill asking us to repeat the same information over and over.
- Each time the program is reviewed external or internal there is more and more paperwork and forced to do paperwork with clients in order to meet the demands.
- The paperwork has increased, which some is redundant due to trends on best practices.
- paperwork requirements increase every year - it is deterring people from entering the field and some are leaving the field
- More stipulations/standards/guidelines, insurance requirements. Higher expectations.
- Increasing paperwork leads to treating files, not people
- Authorizations take too much time.
- County spends more time getting their database right than finding ways to treat people.
- It's crazy PCPC language is not working, STAR is not helpful (too LONG)
- I was made to go FFS and there is more paperwork \I have been in the field for 5 years exactly. It's more paperwork on each year.
- More specific areas of required documentation which interferes with direct care.
- the paperwork has increased due to the inability at the state and federal levels to streamline policies
- Electronic records seems to take less time, but I feel like I document more thoroughly with electronic records.
- the paperwork is astronomical and redundant!
- Increased paperwork due to state requirements.
- Again, I am now working for the insurance company for the past 2 1/2 years.
- I feel like a babysitter who puts out fires all day there is still time for paperwork licensing requirements have not changed payer requirements have increased and surpass the demands of licensing
- There is more paperwork then when I started in the field.
- It is difficult and tiring to overstate problems, tx plans far too burdensome for caseloads.
- VBH is riding roughshod over TX providers, create extra documentation requirements so that they can delay and deny claims. State of PA needs to get rid of VBH monopoly
- We use the sigmond system which helps with paperwork

- Switched to private practice because of this.
- MCO and DOH DDAP require more paperwork than I have time to finish. The clients become frustrated and it brings on burnout
- EHR have helped
- lately I am moving more towards MH mostly because of the massive paperwork the government requires
- way too much paperwork
- CBH specifications are ridiculous, heavy handed and overbearing
- This applies to assessment / intake t paperwork requirements continue to grow and are unnecessary the paperwork is so overwhelming out of control as to make individual counseling and support impossible
- Too much paperwork. It is redundant and often not clinically relevant except for insurance purposes and audits by county, state, city.
- I left the field because for 23 years after doing my best to keep up Monday through Friday with paperwork and spending almost every Saturday away from my kids DOING PAPERWORK, I had had enough.
- Paperwork has been taking over the profession
- Insurance companies are dictating paperwork and state required forms so we get paid.
- Due to having to provide an overwhelming amount of clinical justification for service provided.
- I feel how state, local, and federal requirements continue to change and many agencies are not following through giving extra time to update documentation to satisfy an it's thus causing reduced therapeutic attention to the clients.
- Case managers spend more time documenting and less with people in need.
- Although SCI's are not held to the same DDAP standards regarding documentation. SCI D&A counselors are required to do a lot of paperwork.
- Paperwork requirements are ridiculous.
- Documentation standards are excessive, and counselors spend 1 to 1 ½ documentation to every hour of counseling. The new star program for county funded clients has increased documentation to another 1/2 to 1 hour.
- I am in private practice documentation requirements are not excessive.
- Documentation requirements are getting lengthy.
- more paperwork is added every year rarely is consideration given to streamline it or making it more efficient! It does not help clients to have professionals overwhelmed w/ paperwork
- Case management information paperwork and documentation has increased many times over.
- IN the new STAR system, new paperwork, new admin, new data entry all more
- time but not an effective use of time
- prior to retiring, paperwork always increased
- Pushing the paper gets the most time. State regulations and JAYCO regulations for documentation of case management needs to be condensed.
- The DOC has decided to address paperwork separate from DDAP
- Magellan is the worst payor and incidentally the most stringent with care
- There's not enough time to spend with the client because there is always paperwork to get caught up on.
- It seems to increase with each licensing visit - regs are open to interpretation by Lic staff with inconsistent applications of regs from agency to agency
- If my paperwork is not completed I would not be able to stay working in the field. The government requires unnecessary paperwork.
- Requirements by the state have always been out of control, e.g. treatment plans - 60 days.
- It should be noted that I do not work for a licensed state facility. The SA paperwork has always been much worse than MH.
- In need of electronic record keeping!!!
- While documentation is important and necessary, more time should be spent addressing client issues. Paperwork is too time consuming
- Intake paperwork and documentation requirements deter people from returning to sessions.

- Increased documentation coupled with less therapy and more case management.
- So true!! Way too much time on documentation.
- STAR system has increased paperwork and time spent in getting continued stays and authorizations.
- Documentation requirements take an exorbitant amount of time—try comparing to MH standards!
- Paperwork is redundant, excessive, some of it unnecessary and excessive. It interferes with the quality of care we can provide our clients.
- I worked in an inpatient setting and with an SCA in prior years and there was a ridiculous amount of paperwork
- Much is redundant documentation of which more is needed to satisfy insurance companies. The more they request the more time away from clients. IE. Contact with clients is PCP, not once but multiple times in a 4-5 week period even when the client is not a medical risk. Ex0 2 days of rehab authorized and if a family session, the client agreeing to enroll in MAT and recovery house placement are not secured, that individual is expected to step down to the next level of care, regardless of if s/he still meets ASAM criteria for 3B.
- This is as a result of working out patient currently. But working for an inpatient program, paperwork responsibilities are different.
- Paperwork has quadrupled in 5 years. With the advent of paperless computer charting, makes it worse as currently computer is frozen.
- Unrealistic expectations from funding and inspection agencies have created less value on individual client care.
- Interpretation of rules by different payors and inspectors produces too many questions which yield little insight to the client's problem or issue.
- MCO's primary adding to the documentation requirements.
- Counselors work more hours than ever before with the paperwork requirements trying to meet state and federal requirements
- I consult with an outpatient where there is a lot of documentation demands.
- The implementation of the new STAR system has led to an increase in documentation requirements
- the paperwork requirements are a burden and can be changed to still get to some outcome. The STAR system has added a huge additional burden and is meaningless
- paperwork is the priority
- crossing T's and dotting I s has taken from client care
- I still spend the same amount of time with my clients but spend tremendously more time on necessary paperwork
- the paperwork is always frustrating
- I work in a prison so the paperwork is about the same inordinate amount of time doing paperwork always crunch time to get ready for inspection
- paperwork has increased dramatically
- We use electronic charting, our agency still uses wants information that seems redundant and not useful but if you leave a blank you get a deficiency
- There is absolutely too much time spent on paperwork
- Paperwork is never streamlined and redundant info is collected over and over.
- We ask the clients the same questions the result is not better care.
- paperwork has tripled
- the last residential program I had was more paperwork then I've ever done since I started counseling in 1988. I spent very little time with my clients and could not meet with them due to documentation
- Paperwork seemed to increase a lot from 2004-2013, the time period in which I worked it is nearly impossible to keep up.
- The paperwork requirements have increased significantly, and is different depending on the funding source.
- I think some of the paperwork is unnecessary and repetitive.
- Constant changes in recording requiring time for new system and delays in

- working out kinks lead to less time with clients.
- Way too many masters to serve no time for clients.
- State requirements continue to increase which diverts us from our primary responsibility, which is client centered care.
- With the STAR system there is more paperwork.
- Now on computer system. Faster but less efficient with information at times.
- The state requires more documentation as well as licensing bodies.
- Paperwork has been increasing over the years. It is leading to significant burnout.
- For an average client, 25 minutes are taken up doing paperwork now. When I started in 2001 it was 15 minutes.
- It is a real shame and problem that our system has us working on more paperwork, than truly helping our clients.
- The paperwork has become more cumbersome and redundant.
- More documentation than actually delivering services.
- But paperwork gets behind with some hope following switch to new electronic records.
- Decreasing streamlining simplifying paper is always helping to create more client time.
- I am a program specialist with multiple complex conditions. Clients are multicomplex. How does one not treat completely equally with less dollars plus 80% of writing equals less recovery towards helping.
- Paperwork demands are so excessive that it is difficult to keep qualified clinicians employed.
- Paperwork and repetition is overwhelming.
- data is useless to help clients but is collected to satisfy funders
- paperwork is often redundant and way too time consuming
- I spend a lot of time trying to "fix" welfare funding issues, phone calls, faxes and reapplications or clients face DC
- some of the forms are repeating if something is in the chart why continue to ask it over and over
- working in an agency was a nightmare in terms of paperwork it became the priority over client care
- It increases yearly I spend more time documenting than doing
- 50% increase in paperwork over the past 20 years makes me question why I do this work
- it seems that documentation is more important than treatment outcome
- way too much paperwork
- we are using paperless charts, expectations on paperwork are unrealistic
- way too much paperwork!
- Moved here from NY state, there was a marked increase in paperwork here in PA
- computer programs help
- Sigmund on line charting saves time
- The amount of paperwork required is preventing people from working in the field. It is overwhelming and continues to be a great barrier to keeping good clinicians in the field, even the clients complain! Clinicians who are licensed leave the treatment setting as it is too hard to balance paperwork and productivity
- We would like to spend more time with clients but documentation is critical for insurance reimbursement and reviews take up a lot of time
- I have learned to manage it better and to triage paperwork
- Not so much of less time with clients but I use all my free time doing documentation.
- SCA has increased documentation and it is redundant
- Paperwork demands just keep increasing, STAR is the worst program I have ever seen!!!
- The paperwork is impossible - no way to get it all done in a timely way
- paperwork demands are much greater for multiple sources. Paperwork maybe what causes me to quit the field.
- The required paperwork continues to be an enormous burden on clinicians. Over the years the paperwork has increased. It is very repetitive and some is unnecessary.
- appears to have tripled since I got in the field
- Again we are fee for service

- The amount of time wasted on paperwork, redoing treatment plans over and over again, wastes valuable clinical time with the client.
- The requirements that lead to the paperwork demands need to be restructured!
- documentation requirements have increased leaving the client with little therapeutic time in individual sessions. I have had several complaints.
- I am not a direct service provider
- Now that I'm in private practice I don't have nearly as much paperwork, but when I worked for an O/P facility, there was way too much and you didn't get the needed time to spend with the clients. Hate to think what the paperwork like now since I've been gone from that agency for 31/2 yrs. Documentation is necessary, but there is a lot of duplication for different funding sources. Where I work we take private insurance only, and I am grateful for less tracking. Prior position of supervisor (public non-profit) was spent as a "paper pusher" vs actually working with clients.
- Documentations take up the vast majority of my time, which prevents me at time from spending quality time with my client for better service.
- Difficult to coordinate all of the specific paperwork per county etc.
- I have been working in administration for the past 5 years which has its own high degree of documentation
- Funding sources require specific forms to be completed for their own use which do not enhance the treatment experiences of my clients.
- reason being is I've worked same place for over 5 years
- paperwork required much more extensive
- Everyone wants something different. Plus, standards have been more stringently reviewed. Waste, Fraud and Abuse audit possibilities are a constant stress.
- Not me specifically, but all of the counselors in our organization do, which leaves less time for the clients
- SCA paperwork has increased immensely. I now refused to take these clients because of the paperwork and time involved.
- Documentation is often time consuming; however, I understand the necessity.
- Every year, funding sources require more and more paper work
- Paperwork is constantly increasing as regulations change. Focus is beginning to turn to the paperwork needed to be in compliance rather than treating the clients.
- utilization and review are much more time consuming
- The degree of auditing for "complete and concise" answers on all of the mandatory questions has become subjective and more time consuming than clinically necessary.
- 3rd party billing has increased the paperwork.
- The paperwork has multiplied, but yet saying the same thing
- Forms are redundant, questions on form are redundant and there is always another for to fill out, they just keep coming.
- The DA / MH field continues to be more and more paperwork driven and less about the direct care as managed care / lawsuits happen in our fields
- In my prior position as a therapist/addiction counselor there were more paperwork demands at the cost of client care.
- many state regulations are not reflected to the serious complicated this of clients today
- Accepting pts. with no health insurance who are county funded has become extremely problematic with the STAR system
- Case management has increased exponentially over the course of the last 5 yrs. Subsequently therapist have less time to individual and group therapy.
- The paperwork has become so cumbersome, that several sessions become totally focused on getting paperwork completed. The SCA is never satisfied, from year to year and are constantly asking us to make changes to assessment forms and adding additional forms to their requirements. Some don't even make
- sense
- The shift is moving toward fixing the chart and not the client.

- Far too much of the mandated paperwork is really no more than busywork, and that is the information that the state licensure assessors seem to deem most important. (For example, listing strengths and preferences on a clinical assessment, and repeating all the intake information on a discharge summary.
- It seems that we have to placate the payors and some of the paperwork is repetitive and wastes time that could be spent with the clients and their families.
- I have moved from a long term halfway house setting to detox within the last 2 yrs so I cannot answer
- Not currently working but yes documentations requirements have definitely gotten more strict over the years. More time with paperwork than assisting clients.
- I've been a Social Worker for more than 20 years and the paperwork is getting more complicated and less service- appropriate in all the related services. The worst relate to funding and pleasing insurance agencies.
- It is an unfortunate experience when an agency follows its own source of treatment provision that does not specifically follow state and federal drug and alcohol treatment guidelines and the clinical staff is then required to follow those guidelines and correct considerable documentation in order to pass audits, thus
- requiring more attention to documentation and less time for appropriate therapy between clinician and consumer.
- it really depends on the setting, however
- D&A paperwork is redundant and excessive and hinders the quality of care providers offer. Additional each insurance company has their own requirements that are normally more time consuming than are state & federal regulations.
- The documentation requirements are tremendous and vary from the state level, between counties and based on various accreditation agencies - this becomes a challenge for clinicians to find a balance between providing quality service and spending the appropriate time engaging individuals in treatment opposed to focusing on documentation.
- There is too much documentation with not enough time allotted to complete it.
- Paperwork has taken over - the clients have gotten more complicated and we spend less time with them. It's a shame
- I previously worked outside of PA and find the paperwork requirements in PA to be more redundant and time consuming than other places I have worked
- Clearly, more and more paperwork to be done in a relatively short period of time. This prohibits time to build rapport and establish some kind of relationship with our clients at the front end when it is most important.
- Redundant and excessive paperwork takes time from working with resident and clients.
- Paperwork changes at what seems to be bureaucratic whim. failure to make the entry of paper work computer centric is a joke.
- Not sure as agencies don't remain consistent on expectations but overall paperwork exceeds client time
- Trying to meet DDAP requirements and CARF as well as SCA has increased the paperwork burden significantly
- Starr system is extremely time consuming and not always in working order
- We are moving toward electronic medical records which should help.
- State, county regulations and overlap of paperwork has become considerable forcing the therapist to spend more time meeting the regulations then working with the client
- Way more time with documentation and most of it is not useful.
- currently working as an administrator, my response applies to my clinical staff
- Documentation is increasing as funders continue to ask more information.
- licensing require more information related to clients charges then in the past.

Q8 Asked to provide unnecessary and personal information about your clients and their family histories beyond the PCPC

- As a supervisor I have had to intervene as a result of pressures from providers placed on staff.

- This applies more to private insurers.
- Presents an issue of confidentiality.
- Providers nearly ask for more information than allowed by law.
- This answer is for medical assistance clients.
- The managed care companies want more than simple yes/no to trauma issues and the like.
- CCBH and CBH require too much info.
- This happened more when I worked short-term residential than it does in outpatient.
- Yes, specifically when referring to a higher level of care.
- I don't do a lot of these as a supervisor.
- PCPC rarely seems to be enough. We have to fight even when there is imminent danger.
- We have an evaluator who does this versus the counselor.
- They are cutting our hours back due to medical insurance limitations.
- In the past when I worked with funding sources, I was always asked for more information about the client than legally allowed.
- Insurances don't want to pay - so if you don't give it, they STOP PAYMENT!
- Asked by decline to provide info; especially specifics for medical necessity for detox or rehab.
- We are asked, however, familiarity with laws, reqs, statutes gives us points to argue with those who request.
- Primarily by private insurances.
- Managed care such as CBH of Philadelphia demands this information or refuses authorization of services.
- I am not directly connected to insurance services. I am a therapist.
- Expectation is never make a mistake or insurances/sca's will take money back.
- At times, it appears the person is being judged as to their worthiness rather than clinical need.
- the questions are asked for private insurance companies
- The PCPC is not often required with the clients I see.
- Some funding providers WILL NOT authorize funds without info not in the PCPC regardless of confidentiality laws protecting the client.
- Publically funded definitely requires less info to fund.
- VBH prime offender
- Due to CBH and DBH state requirements too much is asked.
- VBH requires PCPC, ASAM and MMR forms. Mercer county BH Commission requires providers to fill out their own special forms
- sometimes clients get denied because of things like homelessness. (assuming that they just want shelter) they \get denied inpatient services
- MH Net and the SCA are the worst with this
- For MCO's, who threaten not to fund without the information (ie - family recovery status, head of household status)
- ALWAYS!
- However, length of stay has been shortened
- we are experiencing times when education and past employment has been a hindrance for getting people into short term / long term treatment
- again to gain authorizations to meet the needs of the patient his / her confidentiality is compromised
- Unsure
- I had a sense this was the case in 2009. After that can't say.
- Don't know what PCPC is
- This due to the star program.
- I primarily work with MH consumers, not much opportunity to work with referring consumers to D&A Tx. I sometimes wonder how unnecessary information is helpful in meeting clients needs.
- This would apply to managed care asking our case manager more and they do not, as an SCA we do not ask our providers for more than what we're entitled.

- The PCPC restrictions are never user friendly when referring clients to inpatient. We always need to exceed the PCPC.
- In order to get a few extra days funder requires more detailed info on clients.
- Always! PCPC is just one of many forms and info asked and required. Makes
- PCPC seem pointless just requiring PCPC would make our jobs more efficient
- It seems insurance reps want to obtain as much info as possible.
- We do not serve publicly funded persons. We use ASAM criteria but the insurance companies do ask for more.
- Our UR staff report that they are constantly asked to provide unnecessary and personal information or are threatened with denial of coverage
- Things like weight, physical health
- I only report ASAM criteria to our cert department.
- mostly asked too much information from insurance companies
- IOP and recovery takes longer than a few weeks. Ideally people need to be in IOP at least 1 year to work on life.
- Even the PCPC gives more info than the federal mandates
- During precerts with CCBH and private insurance, we are asked to give more information than permitted by confidentiality laws.
- Funders indicate they will deny services without detailed information despite reminders of PCPC criteria standards.
- We use the ASAM. Not sure what you mean by publically funded...MA if MA no, we do not have to provide more info.
- By employer's contracted insurance companies who want entire charts and if they do not get them withhold pay.
- dependent on the quality of the work done by intake
- Specific vital signs and medication names/doses. Additional details, beyond basic synopsis of presenting problem.
- I am now required to place info in Star system.
- And I do not give it if patients do get care, but usually an authorizations for 2-4 days in a dual facility.
- Several insurance companies will threaten to not cover services if information is not provided.
- Not sure what is appropriate for them to ask. Sometimes I felt unsure how to address the question.
- I am assuming that STAR data collection for CMRR is not collected to funding determinations.
- Review for funding for more intensive level of care requires data about the client to be reviewed to qualify them for higher level of care.
- MCO's want more information than they are entitled to as per confidentiality regulations.
- Our counselors were not asked to provide information other than the PCPC
- Not even for groups and individual sessions. Check Massella dissertation on managed care
- I am asked about family history (whether immediate family members are using). That is outside of PCPC criteria
- some insurance companies request additional info,. no other state has its own criteria. Get rid of the PCPC and use ASAM like the rest of us!
- I work with commercial insurance that always asks for too much information
- mostly from the county on low income federal funding
- EAP counselors are asked more questions than we need to answer
- SCA wants name of all Suboxone clients DC whether or not they funded
- I try to stay in the guidelines of 255.5 but the reviewers ask the questions anyway
- funding sources (county, state private) always require more information
- Custody cases, C&Y mostly.
- Ins. Comp. would often ask way more info. than was appropriate.
- CCBH and other insurances continually ask for more than we are allowed to give.
- Names of medications, education.

- I have been asked all the time for personal info that was not necessary or required.
- Funding streams pay no attention to PA 255.5 or any other documents for anonymity.
- When I was working in state and insurance based tx facilities.
- It depends on
- We don't use PCPC
- I don't deal with publicly funded clients
- Private Ins. asks for more information.
- Connected to funding and correspondence
- Funders will simply deny or sent to doctor review when info is denied due to 255.5 or CFR 42.
- If the client does not have insurance and the SCA does not have the money, the PCPC means nothing, often about money.
- The sad part is that if telling the funder give MC more days to help the client, then I'll do it.
- When I worked in IP and was dealing with funders I would have to provide personal info to get more time but don't have to deal with funders now.
- Living conditions and relationships particularly for FIR clients.
- When approval of referral to residential/detox, Medicaid (Magellan) often ask.
- Past experience, PCPC does not begin to give pertinent info.
- If info is not provided threats to deny coverage
- some insurance companies constantly ask for personal information and imply they will not approve if it is not given
- social security numbers
- Insurance companies might ask us to contact a persons doctors to get help or deny care because of prior Tx
- we are always asked for medications
- personal information is asked to justify inpatient care
- Now I am in Private Practice in the past I was asked all types of unnecessary information and I ended up being denied care when I stuck with 255.5
- When clients need to go to a higher level of care they ask for unnecessary paperwork
- About my degree, the aftercare plans and MH information
- medical information
- Magellan Behavioral Health often pressures me to provide this info and makes it clear that without it, service will be denied or shortened
- We do not take public clients
- I often have to cite 255.5 with managed care
- I do not give it to them
- from insurance companies
- Most care managers remain within the guidelines of PCPC & Confidentiality, some do not
- Again it is private insurance that is the culprit
- PCPC is all we are asked for with publicly funded clients
- It is for private funded clients and is not given - major struggle - public funded accepts PCPC usually with no question.
- I am not asked to do this by the SCA but some insurances are asking for more.
- I work in MH outpatient department
- some question are directly not related to criteria and seem to be data gathering and build a data base which will further add to the stigma that addicts already face.
- I know that our programs are asked to provide more than the PCPC to funders
- never for the public clients, but often for private insurance
- Insurances often ask for additional information. If the clinician does not give the patient information, funding is not available.
- almost feel the need to divulge in order to get necessary treatment time
- I am not currently or personally utilizing the PCPC in my position

- I am often asked for the client's vital signs
- My clients typically obtain their own placement through their private ins. payer.

Q9 Pressure to provide more information than is necessary and allowable

- Insurance gives an attitude when we mention 255.5.
- Sometimes Probation officers and SCA's ask for info that is not permissible under 42CFR
- confidentiality laws are necessary to protect clients as well as agencies
- It has become a game of "hypothetically"
- Not involved with this issue.
- I do not do a lot of PCPC referrals to higher level of care.
- Often I am but also I am clinically savvy and administratively savvy enough to chart to satisfy managed care without violating confidentiality, but my supervisory work tells me this is NOT the case with most providers MH or D/A. Unfortunately, supervision is not as valued as it should be.
- Some insurance companies still ask for info for clients to get reimbursed by their insurance company despite being out-of-network.
- Always need to be careful not to provide too much information.
- I only give out the information that I feel is appropriate to 255.5 confidentiality laws.
- Sometimes other services like CYS, probation, disability, they want way more info!
- I will always draw the line with confidentiality and the law.
- Many funding sources refused to provide funding without additional information. When you would push back and not give illegal information the staff would become rude, mean and difficult to work with.
- The clients need help - how else do they get it?
- HMOs are saying they need to know, or already have the information from other providers!
- Especially for emergency/crisis services
- Yes in regards to inpatient care.
- However I never comply; I respect my clients' confidentiality.
- At times, undue pressure to release information if you want approval. System at times is kidnapped by insurance entities who make unrealistic demands.
- CBH in Philadelphia County demands the information. If provider refuses CBH denies services, such as in patient treatment.
- At times we are torn between getting the person treatment or fighting for confidentiality.
- Private insurance companies often refuse to pay for more than 3 sessions at a time
- Unfortunately, I believe there is a gap between what an admission person may think is ok to ask about a publicly funded client and a privately funded one.
- we are getting the continued care for the clients but the authorizations are horrible . Long waits on phones to reach providers and long conversations with few days authorized. I dread calling for insurance coverage ,
- Yes, I have been told by funding sources that they cannot authorize funds without information requested that is not covered in PCPC. They will act as if they are providing their own money to pay for treatment. Especially CCBHO.
- Feel that proper level of care does not take the time to adequately assess needs of patient. Focus is on the paperwork vs. person.
- For private insurance companies.
- Confusion with funding sources regarding what we can release for HM versus AOD.
- we explain we cannot release based on the laws
- Some insurance companies will not cover the services unless more information is given. We get the patient's permission to give information that would be considered more than necessary. I will not break patients confidentiality regardless.

- Lawrence County SCA would have providers call them with the patient present and make the patient break their won confidentiality over the phone by telling them when their last positive drug screen was and what it was for
- MH Net and the SCA are the worst with this
- I have had companies threaten not to fund if information was not provided.
- Depends on agency
- I think this is because of the EHR
- Be real! Of course! If information was not provided; clients would not get TX
- across the board length of stay has been shortened, it is ridiculous
- but what insurers ask for is not unreasonable
- pressured to contact PO. OCY, etc
- again to gain authorizations to meet the needs of the patient his / her confidentiality is compromised
- Some info off limits but some areas are more gray areas, I give 'read between the lines' info. Less pressure than in the past though.
- With private insurances.
- For commercial patients.
- Medications
- I believe when therapists need to provide information, it reduces the immediate need clients can receive. Helpful information to live a more stable life.
- I am concerned about the providers inability to properly complete PCPC's for my case managers.
- Providing information is a strategy one acquires after 20 years, and requires some clever disclosure to get the appropriate LOC.
- If asked info is not provided, funders only give you few days at a time. The info requested has nothing to do with the PCPC.
- Explain what can be provided.
- funding would be rejected without the information being asked for
- Most companies we work with don't push the issue.
- when we refuse to release information that goes beyond the law insurance companies, including PA managed Medicaid companies state we MUST provide the info and they claim PA is misinterpreting the law
- SCA gets annoyed and argumentative when I don't tell them specific info that exceeds the law. Not a problem with CCBH
- But I always tell them due to confidentiality I cannot give them the information.
- 255.5 is not created to be a barrier with funding, but should be for collaboration for best interest of the client.
- This has always been an issue - which is why - regulations training is needed for all staff in a residential setting
- Depending on funding source.
- Some, but I can be pretty pushy.
- Funding sources are respectful when told we are not allowed to give information. I worry for new counselors that are not telling them now.
- Insurance companies routinely ask for information not permitted based on confidentiality standards.
- By private insurance companies if not Act 106 eligible.
- In my previous job, yes.
- In order to obtain authorizations from MCO's we have to give too much information to get authorizations
- Insurance companies challenge the laws.
- When do not provide, often get denial of continued stay, especially with Horizon for young adults who were previously non-compliant with aftercare.
- Won't do it.
- Never!
- Sometimes in order to get things authorized.

- In the past have felt this pressure. Currently does not apply.
- I feel physicians want more info than needed to justify care.
- Often feel like my professional and evaluations skills are being challenged.
- When the patient has private insurance this can often be the case.
- I have learned methods to cue reviewers that do not exceed the confidentiality laws.
- Sometimes threat or perceived threat of funding loss.
- Sometimes, depends on turnover carrier.
- question does not apply
- Just No!
- there was a time
- I do not believe that the questions impact the LOC
- Sometimes, but see it from the insurance company perspective, PA adds the unnecessary burden by using the PCPC, state 255.5 is stricter, understand why but it creates more barriers for care and to providers
- 25 years Exp allows me to know what is allowable
- at times, but I never do
- insurance companies ask too much.
- more details seems to result in more reason for time
- not a problem
- If I do not answer their questions the managed care providers can simply deny - although appeals are offered 90% of the time the denial is not overturned
- criteria set forth by the PCPC is not all inclusive to get a persons ; living environment. Sometimes you need to stretch the truth to get he or she what they need
- can't get payment without it
- I won't compromise my professionalism
- Clients need care and ins. comp. will only give authorization if their questions are answered, often is the case.
- Sometimes we have been refused payment from ins. because we refused to provide confidential information.
- I have said I cannot give this information and I feel like it determined the length of stay.
- Their arrogant and basically people who never worked with clients. Get rid of them all.
- Insurance companies tell primary counselors and your people if the information is not provided then they cannot approve continued stay.
- This is getting better, but still a problem with some funding sources.
- The confidentiality laws in PA are over 40 years old they are integrated at times, and at times prevent patients from having necessary information communicated to caregivers and other integral to their recovery.
- CBH requires answering all kinds of personal questions in order to have continued stay.
- At times info requested I believe does require counselors to possibly violate confidentiality.
- I feel pressure but refuse to give it.
- I don't go beyond the scope, but many places intimidate to get more information.
- I refuse due to not being willing to place myself/ facility license at risk. And clients suffer.
- This happens most often, or you don't get the days to help the client.
- In my prior jobs not in my present.
- Due to years of experience I challenge these requests however, I can see how someone less seasoned could fall into that trap/ manipulation.
- I know how to get needs met without answering areas that are confidential.
- I am often asked more details than necessary
- Almost always they want specific details that infringe upon HIPAA protection.
- Not so far.
- When I was working, yes definitely.
- sometimes I have to go above to get approval by insurance

- I let them know we cannot answer certain questions
- Most if not all the insurance companies want therapists to violate 255.5 some agencies condone this practice
- more so with commercial funders
- absolutely
- When I am asked I cite confidentiality laws
- At least for my agency, this has gotten better, it used to be problematic
- We are consistently fighting for our clients to get the time that they need to heal
- Unless managed care is very busy, there is always pressure to share more information to justify that the client is in the right level of care
- Unfortunately this is a delicate situation - our agency needs to be paid, Also please consider issues related to the electronic record. What indeed can be viewed by whom? If a client has a concurrent Psych condition I wonder if strict confidentiality requirements are so upheld?
- Insurance companies ask for more info beyond the five points we are permitted to release
- most of the time the funders will back off when I mention confidentiality
- Managed Care controls the funding dollars despite being employed by the counties that contract with them. They will OFTEN suggest that a claim will be denied or reviewed unless receiving the information they want.
- I always state that PA Code 255.5 will not allow me to provide what they are asking for
- Private Insurance Companies only
- with private insurance companies
- that is reason some insurance clients do not get extended IOP / or inpatient. They will not accept ASAM information and want more than this.
- Allow I get e-mails from utilization review at least 3 to 4 times a week asking for personal/confidential information about my clients I do not feel pressured to provide this information because I know what I as a professional counselor can and cannot release. They can ask, I don't have to tell.
- With reauthorizations to justify need for ongoing serves
- 255.5 must go! I am a professional. I know what should be released and I become concerned when I can't release what is in the best interest of the patient.
- I obtain direct releases from my clients to provide the personal information insurance companies ask for solely to obtain the funding they need.
- I am hearing that the programs are being pressured to provide more than allowed.
- Not as this time, with the work I do now.
- A few insurance companies such as (UBH) are horrible. They do everything they can to deny treatment or force clients into lower levels of care. Other companies such as UPMC and local b/c b/s seldom if ever use these pressure tactics
- All county-funded clients are required to share extremely personal information (ie. social security number) that have no bearing on their treatment needs. While I recognize the desire of the county/state to gather this information, it is for their own purposes and does not enhance the treatment of my clients.
- again not currently in the past yes
- always asked, sometimes unable to gain inpatient level of care or extend IOP as needed
- Especially in the private insurance area.
- Always...
- I don’t think it should take so much to get someone funding that really needs or wants treatment.
- I get comments on this often
- our assessments are within the laws
- I just remind those requesting additional information of the confidentiality laws.
- Wouldn't be able to secure the funding for the client and then they get nothing.
- However the limits are set and reminded therefore the funding sources generally stop but need reminding often
- However I have been in the field a long time, therefore do not feel pressured

- Escalating!
- It is either provide treatment and break the law or people don't get the services needed
- insurances often want more clinical information that HIPAA allows
- Threats of no authorization or the need to go to doc-to-doc reviews.
- There are instances where managed care is interested in knowing specifics about medication (i.e. names) and we have to work around that. Sometimes I feel as though they want to know more specifics as it's becoming harder and harder to get authorization for HWH
- I oftentimes feel pressured in providing information that is either ignored or overlooked to the consumer.
- Private insurance companies tend to bully and manipulate in an attempt to get
- information that is not allowed per confidentiality laws.
- insurance always asks more than they are allowed to have and acknowledge that they are aware as well
- I believe this is a major issue, particularly in residential treatment. Although I currently work in an outpatient setting, I have worked inpatient for many years and found this to be a consistent struggle.
- Funding agencies all ways want information related to medications in which they are aware of and will not fund if the information is not what they have in the system.
- I feel pressured to give information not only to get our clients more time, but to maintain a "good relationship" with funding sources.
- I have appealed denials. I will not violate the law; however it seems as if the intent is to deny services, to be frank.
- Again, this does not occur in outpatient, but I have had this experience when working in a 3C LOC
- Sometimes Children Youth and Families DHS, do not understand we can't divulge a person outcome of urine screens .
- Choice becomes violate confidentiality to get person into treatment or not give the information and risk not getting the person help.
- We are reminded by reviewers that others don't always follow the rules. Clients are denied extensions due to lack of information provided.
- Provide less covered days, frequent reviews, frequent Dr. Involvement.
- As the administrator I send the information to ensure it meets regulations on confidentiality, versus the clinician, even though it may equate to non-payments for services.
- SCA is notorious for refusing to authorize treatment until all of their questions are
- answered

Q10 Service level and duration

- not all the time but it is getting worse and happens more often.
- Our program does not place time limits on services for people it is done individually
- Again, depends on the client's insurance coverage.
- It depends and varies widely
- We work with medical assistance or self-pay. Others get referred to other agency programs.
- Commercial insurance covers OP, IOP and limited residential. No HWH.
- There is no money for IP bed-to-bed in our county and homelessness often discounts treatment gains within 24 - 72 hours after discharge.
- Depends on insurance or MCO
- Again, this depends on the individuals readiness and MCO's approval of level of care. Family-based and enhanced family based (COD).
- Most patients appear to get appropriate services to meet their needs.
- Most funders have been good at this LOC. Clients tent to not want the higher LOC.
- DVT setting - commercial insurance/ put pay
- Based on funding.
- Commercial and Medicaid insurance dictate level of care despite patient meeting diagnostic criteria.
- Again, anything to stop payment - not about client needs.

- Due to lack of funding.
- Although many times it's #3.
- We are a cash only facility.
- Most can afford what they need, but not all.
- When I have clients with addictions to xanax, heroin, meth, etc, they often struggle to get services they need when I refer to outside agencies.
- Work with adolescents. Copays an issue, especially IOP
- Also see clients getting a lower level of care than needed.
- Understaffed
- 28 days is never enough. Halfway houses are too expensive for self-pay and MA is not always available and/or timely.
- Many people being treated do not show internal motivation. Some people are poorly funded. Inpatient settings are not helpful or adaptable enough at times.
- For private insurances.
- It depends entirely on funding source. Huge variability.
- We are OP so most of our clients fall into this level or IOP however as I stated, struggles at times with getting higher level when clinically indicated.
- for the most part they receive the proper dose and duration
- At times publicly funded (county) clients are not able to get a higher level of care due to no funding.
- Patients often refuse the higher level so harm reduction warrants lower level care versus no care.
- Only for HWH services
- Many clients need a higher level of care and cannot receive it due to history of past treatment.
- Clients know how to get right level of care although some places shorten Tx to make client happy.
- Not all the time, it does happen.
- Many clients do not get the time they need to establish hope, consistency and the structure required for their recovery
- Funding source will build a case against treatment provider of how the client does not meet PCPC criteria.
- Sometimes private insurance will limit need but it seems to be not often.
- Due to budget cuts clinic is short-staffed the OP groups are full, they are put in lower LOC and placed on wait lists for higher LOC when beds become available
- Funding
- Most patients feel like they were discharged too soon.
- Deny them the services and wait for them to fail at lower levels of care
- when clients are limited to 14 days due to funding they rarely show up
- It appears that it is often difficult for persons I work with to get quality care.
- more often than not with county agencies clients get lower levels of
- I would like to know more about the engagement process of housing authority residents
- the county is out of $ and also does not fund a scant percentage of the persons who need this service
- clients go into rehab and are DC before they are ready and relapse quicker
- majority get appropriate LOC and adequate
- treatment is now, more so than ever cost effective
- It appears that funders would rather approve IOP rather than 3B / 3C long term TX
- I refer children to MH / DA Tx in Philly CBH is usually agreeable to LOC
- due to the program make up of community action
- many people I do assessments for cannot get funding for a higher level of care
- I only have private pay clients
- mostly they get only detox
- Very difficult to get rehab, also some insurances in particular more difficult than others.
- Effective at number one statement.
- Inpatient stays, when necessary, are usually not long enough.

- However, up through 2009 this was a continual struggle. Clients had to be half dead before inpatient would be approved.
- Money barrier
- Not enough time in Tx they relapse then no more time than death.
- This happens with certain commercial insurances that are located outside of PA
- I am currently working in a hospital ER room with consumers with MH some/many are dual. Focus is MH.
- If the client remains open minded and willing to receive level of TX provided
- Again lack of funding.
- For the most part prisoners are given a better opportunity for TX then the general public.
- Many insurances only pay for detox and/or short stays in IP. Standards insurance companies use to admit to IP are restrictive.
- Funders are dictating the length of stay regardless of clients needs.
- It depends on what the client has, 3rd party seems the worst for level and duration
- Clients are often placed in the wrong level of care.
- I.C. research dictates one year inpatient appropriate, in today's world we set 90 days as max.
- People are funded for shorter stays. I see more success the longer they are in treatment, especially inpatient treatment.
- Many clients are referred from us to detox or inpatient stays but their insurance doesn't cover it or they have no insurance.
- We are primarily private pay - not dictated by insurance only.
- Only private pay eligible patients get the 60 or 90 days which increases probability of sobriety. Need more funding!
- This is a funding issue
- Persons in recovery are presenting more frequently with co-occurring disorders that cannot be adequately treated in service provider time lines
- This is dictated by funding sources.
- Difficult to obtain continued stays at times.
- If the client needs PHP or IOP which is what we offer, yes. If the need to be referred inpatient, no.
- (Also checked "End up getting a lower level of care than the need") The insurance review and appeal process creates unnecessary stress on clients and their families and detracts from a client's ability to focus on the matter at hand.
- About 50% of our clients get the right service and duration, the others do not
- Some insurance companies will not provide additional sessions when appropriate (ie holidays, anniversaries, or continued cravings.
- A minority of clients I see have no insurance. In those cases they are referred to organizations where lower level of care only is available.
- Can only do so much as the only D/A person.
- Frequently clients are being discharged before they benefit from detox or IP care. Clients complain to counselors about this problem.
- Level that they require may not be available due to the amount of usage that LOC has had during a fiscal year.
- Most times.
- Cannot always get the LOC needed usually insurance issues
- I do get that a lot of people need a higher level of care, but this is due to their resistance
- center offers client oriented treatment and they are served as long as necessary
- due to budget restraints we have higher and higher caseloads and shorter TX stays
- although we refer for inpatient and right now no county funds for rehab or detox
- The agency is variable length up to 28 days - most folks are there an average of 14 days and most clients self pay for more time.
- In our county, there is no partial hospital and limited IOP services thus they receive outpatient Tx

- While this isn't always the case by any means I've seen it far too often or they get lower or no care funded.
- We often "settle"
- Sometimes
- Always pushing for a 3C when they never had any prior tx.
- No services available in our area.
- Insurance would not authorize
- Funding is
- insurance does not fund for extended care or HWH.
- Insurance issues
- Two weeks in rehab is not enough.
- If individuals got one good solid long term tx (dependent on severity) Then we could justify cutting future tx's that could help others.
- Frequent relapse is being stepped up from OP to intensive when pt is asking for inpatient.
- N/A but I do feel funded clients are often over treated underinsured clients undertreated.
- remaining in a recovery program beyond probation/parole.
- This may vary.
- Funding restrictions
- OP Tx seems good stricter tx levels are too short most of the time.
- Duration of care is almost always shorter than what the client actually needs.
- My recommendation advocate for more providers to invest bed dedicated for residential PHP when 3B PCPC is not met but they clearly still need additional IME. Also advocate for more HWH 2B LOC. There are only so many and it is very much need to begin work, get more practice using new going strategies.
- Residents always get right level and duration within their needs.
- Funding limits often cause excessive self pay or AMA's due to inability to pay. or inadequate with inadequate staff. A degree does not qualify staff dealing with addition.
- Too much MH or medical patients denied higher level.
- Clients are discharged from treatment relating to insurance requirements; LOC is sometimes not funded and treatment is shorter than needed.
- Opiate detox takes longer than 3-5 days and worst side effects occur 1 week after.
- I usually work with clients who are further along in their recovery, but when I referred I've had no problems.
- Provides needed level of care - no inpatient - therapeutic community and outpatient.
- when requesting 3C LOC clients are not getting the length of time needed to sustain recovery
- Often I am able to get people the right level of care but for a short period of time
- aftercare was not emphasized
- from detox
- average inpatient stay is 10 - 14
- Insurance companies do not want to reimburse for out of network so clients cannot afford it
- seems like once the client is no longer physically sick they are transferred to a lower level of care
- private
- long term care is almost nonexistent for adolescents
- Insurance pays 30 days most of our clients need and additional 90
- funding is very restrictive now
- I currently work PT in a residential facility
- not enough detox beds available
- sometimes with our dually diagnosed clients longer stays were needed but not available
- most of them get a lower level of care than they need but can \not get residential because of limitations on their insurance
- short detox more restricted admission criteria
- Usually I am able to refer to rehab after work in Lancaster

- depends on funding source
- Sometimes level of care is impacted by lousy insurance and aggressive "fail first" managed care
- Almost always less than they need. Yet again our local SCA runs out of money for rehab and Medicare clients cannot access IOP and must have other significant criteria - medical or Psych to get admitted to rehab. It can be quite frustrating
- clients who need inpatient are sometimes asked to do IOP first
- Most clients are given the appropriate duration of care. Some are denied despite medical necessity.
- For the most part, again Private insurance underfunds lengths of
- IOP clients have so many issues than in the past - they would have been inpatient first
- Insurances do not provide long enough time for level of care
- However, this depends on the funding source. there are times clients end up getting a lower level or shorter duration of services then they require to meet their needs.
- Client are limited to appropriate services
- Not easy to answer this because has so many levels and nuances to answer about.
- Many times they are sending clients who have been hospitalized to outpatient due to lack of services in the area
- funders as much let you know they do not fund "long term tx." as they want to set the days at the onset of tx.
- It isn't just that many individuals don't get the time that they need, it's that so many individuals get too much time and then are looked at poorly if they request to leave early because they are genuinely ready to go.
- Although the clients at my agency get what they need from us at Outpatient- I often hear about struggles with duration & service level of care in other settings/with other providers
- Our IOP duration is eight weeks in length, yet the insurance companies will only authorize a shorter amount of sessions which leaves me calling insurance companies during precious therapy time minimizing the clients time
- I get some clients as an aftercare provider or others just need O/P
- This varies person to person. The majority seem to get the right level of care for the right length of time.
- It depends on the insurance provider and company. A few are horrible but many are not.
- adolescents don't get what they need and sometimes length of stay is cut short
- Some clients may need additional time to stay for adequate treatment, but ends up leaving sooner.
- In my past experience working 4 years in an inpatient
- people with commercial insurance are more often in this category
- Lack of funding for inpatient treatment services.
- for the most part I can get time requested some of the area of difficulty comes with next level of care after our program if client loses coverage there can be difficulty in placing them in regards to our program most of the problem is client losing benefits who are on ALDA funding where that funding is limited we often
- risk running out therefore limits our ability to help if that funding was increased we could help SO many more people, we have an excellent program and we get good results (I'm not just saying that because I work here) it's the truth often they are at the correct level but less time than would be optimal All of the above would be the better response. It depends on the funding source we do not have in-patient, but otherwise they get the level they need. If the funding is available we can get the right level and duration, if not we don’t get what we need
- it really varies whether or no patients get the LOC they need. So much demand for long-term in-patient or HWH type services with limited providers available to refer too. Especially with patient who present with co-occurring disorders that require permanency, medication management and case management.
- Pts who have never been in treatment who are usually young adults are
- required to "fail" in an outpt setting before accessing rehab level of care
- People I serve get shorter time at the higher levels of care

- Many times the LOC is appropriate but the length of stay is not. At other times the service level that is required is not funded.
- All of the above could apply at different times depending on the clients needs at the time.
- In the case of our clients we are seeing the clients getting into the right level of care; however their services are getting cut short due to funding. Due to the economic climate it's hard to get a client working and have enough savings to move into their own place or into an expensive recovery house. Especially
- women consumers as they are less likely to get high paying or full time jobs.
- The referral to treatment can be authorized with some effort. It's the continued stay Managed Care cuts short with regularity.
- I have seen how treatment services are limited to minimal levels due to a limited funding from third party resources.
- Are required to get a higher level of care than they need.
- Most Clients do need longer in in-patient care so they can stabilize better and develop a stronger aftercare plan. Pushing them into IOP before they are ready hurts, and does not save funds in the long run as the chances are the person will relapse.
- However, County funding for individuals without insurance has been exhausted since February, 2013 and therefore, individuals are not able to access treatment
- 35+ years in the field and more and so many without insurance. Public funding funds a lesser level of care than I recommend routinely.
- OP no issues. Problems encountered with duration for our IP clients
- oftentimes inpatient is not funded
- The population I currently work with, outpatient, does not seem to have difficulty regarding length of stay. We are also routinely able to request (and have authorized) a higher level of care when outpatient treatment fails.
- I see a lot of clients who end up in 2B loc that meet 3C criteria
- Both End up getting the right level of care but shorter duration and sometimes end up getting a lower level of care than they need
- Sometimes even the right level of care is not provided though the LOS is most often LESS.
- Funders do not encourage us to go beyond 90 days.
- This agency consistently fights for longer time if the client displays the need. If they do not get authed, we pay.
- This varies by client person you are requesting LOC and funding status
- Duration.....
- Plus sometimes the incorrect level of care.
- Either placed in a facility which does not meet primary needs, moved to a lower level prior to readiness, attempt to provide outpatient as the first method of TX, despite a person's needs.
- There is pressure to move them before they are ready

Q11 Fit of service

- MAT is self referral who do not usually get court ordered, we do not get referrals from other agencies very much
- I work in an IP Psychiatric hosp. and more than 50% of our patients need rehab but because there is limited to no funding they are admitted to the hospital and may not get the proper counseling as in a rehab.
- Warren county has no IP or Long term residential settings. Op or IOP in extremely limited. We fill in the best we can offering referral services.
- Clients are often placed in treatment simply because of legal issues.
- Clients need more transportation and programs.
- As above, we work with medical assistance. If they have insurance, I direct them to other programs in local area.

- EMDR treatment for D/A clients is necessary. I provide EMDR on OP basis; in my area no other agency D/A or MHD offer this highly efficient and effective treatment - so I believe EMDR would greatly help the public funded client.
- I am in hospital setting that is focused on "flow" verses clinically appropriate level of care.
- We/I don't take referrals that are outside my identified scope of practice and competencies.
- Usually are a good fit but at times, not so much.
- Less restrictive than inpatient or residential, but not able to provide ongoing structure and support in OPT setting.
- State funded program that accepts Medicaid.
- Need more help with young opiate and heroin users.
- We offer the full continuum of care and also MH services.
- I have control to accept or decline.
- All are pre-screened/assesses
- They are referred elsewhere if needs cannot be met.
- Adolescents referred and then recommended to treatment resources. Often recourse does not meet need but copay an issue. In regards to commercial insurance. Those with commercial insurance receive less care and lower level of care.
- Persons are often referred to a lesser level of care because it is more cost effective. D&A professionals are often asked to do more with less.
- Outpatient is generally a "catch-all" entry point. Deter appropriate assessment/evaluation. We attempt to match appropriate treatment setting to patient's needs.
- (mostly yes)
- are in denial and won't get treatment.
- Dual diagnosis and adolescent treatment levels of care not available.
- Most clients served are a fit.
- Partial, IOP and OP we refer clients to inpatient when appropriate
- Deal with severe MH clients--byproducts of institutionalization. Dual diagnosis.
- the inmates need individual counseling as well as group this is never provided or offered to them while they are incarcerated
- Overall I feel it's a good match. Do not feel there is adequate training and providing for dual diagnosis at times. Do the best we can for them.
- Often lie about being suicidal so they can be admitted and get suboxone/subutex for withdraw.
- We have learned to work with more complex clients with less time and resources
- more of an issue of payment / insurance coverage than other issues
- IOP / MMT is a money maker so clients are forced against their will and they
- keep using because there is no motivation for change
- clients come to us because the appropriate facility was unavailable or no funding
- chronic heroin / opiate addict needs intensive case management and service coordination
- often the client is diagnosed and the LOC must be changed
- we get more co-occurring clients and MH is dumping clients
- not equipped to deal with the severity of MH problems we face
- many need residential services
- I refer all clients with D&A issues to the place I sold the D&A agency to.
- I did assessments for the county before I retired.
- Some require more of an MH focus. Then we regularly treat.
- Changing times!!!!
- There are a large # of clients who need a dual diagnosis outpatient program and Jun
- this type of program is limited therefore the service has to be split up.
- We offer OP, IOP and PHP which is a nice range of services for most clients, occasionally we are not able to get someone in IP and accommodate them in PHP until they fail that level of care, putting everyone at risk of relapse.

- Individuals with severe mental health are diverted to IP tx rather than to Psych hospital.
- depends on situation
- Clients meet some levels but don't meet others.
- program of the T.C., should be one year, not 90 days
- People get out of detox/rehab too soon. Also medication assisted clients sometimes need inpatient but no one will take them. Same is true for my people with extreme health problems.
- Hard to find supportive housing for clients on MAT - Berks SCA and HWH and recovery houses do not allow clients on MAT.
- Risk assessments usually identify those who may not be a fit for our program.
- MH needs are at times greater than the DA needs and then the patient needs to be referred to a higher level of care
- as funding decreases, many substance users begin using MH system – these agencies do the best they can but are not equipped to handle the DA client
- Usually a good match, although sometimes information seems to left out.
- I work in a 4A detox and we have no 3A so people need services and end up with and may not get approved but still need services
- Are often looking for something that is an alternative to the normal IOP or OP program.
- Generally meet criteria, however the issues they present with often require a multitude of services not available, usually because of waiting lists, insurance not covering
- We can and do refer to a high level of care if needed (inpatient My facility is secure and referrals are court committed. However increase funding for psychiatric care in D&A programs is desperately needed.
- If s/he is not appropriate for our setting, a referral is arranged. 65 If higher level of care is required, we refer.
- Referral sources are aware of the level of care offered. Occasionally clients will be referred that are on suboxone which we do not work with.
- In an EAP setting, members are employed with insurance benefits for the most part. Occasionally we have clients who have no insurance so, fit for a substance abuse program offering sliding scale fees.
- Not able to see frequently enough.
- Co-occurring clients with severe mental health issues and/or physical ailments are frequently asked to adhere to OP tx for D&A care only.
- In depth dual diagnosis care is rarely available. Most facilities advertise as such have few if any trained dual diagnosis therapists.
- Sometimes exceed due to co-occurring disorders.
- Depends, clients don't always want to go to the LOC - and try a lower LOC - some successful - some not so much.
- occasionally we get a referral that needs long term rehabilitation and none exists
- need more intensive outpatient (less rehab) and focus on treating co morbid disorders. More than 80% of our people have MH disorders let's stop ignoring this and train our therapists to be skilled at addressing!
- referrals like our program we are not licensed dual diagnosis program. Referrals don't seem to care that a psych program may be more effective at times
- we deal with a wide variety of referral sources - some match and some do not
- This question is too hard for me to generalize.
- If not a good match they are referred.
- Always jail people, get out of jail free card
- Difficulty with placement for those with co-occurring medical. Also high risk pregnancies due to location or skilled nursing staff.
- I am able to assess for clients needs and refer if needed.
- Some of the above, some of the time.
- Programs are designed to get funded not provide adequate services. A lot of people are being treated in IP when they really need long term residential.
- Pressure to take people because often funding is unavailable.

- Our county is attempting to work together to allow for collaboration across the systems to help clients and avoid of services.
- More often a good fit
- Severe MH is more and more common due to not having access to the proper LOC for co-occurring disorders
- NONE
- I work for CM for the chronically homeless that have either MH/or D&A diagnosis.
- Transitional age youth who have never failed in an OP level of care are denied tx based on PCPC criteria but cannot stop using in an IOP or OP LOC.
- Screening out the higher risk clients occurs daily PA needs MH residential TX facilities.
- I typically refer clients to group services if they are actually early in recovery they need more structure and educational support.
- clients ask for MAT but frequently do not meet criteria
- Clients may be approved for short term rehab with MMT - client may not be open to methadone and therefore do not follow aftercare
- I limit the number of recovering clients I work with due to impact of insurance requirements
- we often get clients with severe MH issues that have difficulty with our structure but there is really nothing appropriate for them
- We take anyone we can get
- capability is there, however length of time to reach ones capacity exceeds
- MH needs too high
- MH needs are not met
- There are inmates on benzos, methadone, etc who are placated in the treatment programs "to keep the numbers up" for fear they will lose the grant which is funding it.
- If they need other services I am able to refer them elsewhere with few gaps in services
- It is typically when the client refuses to engage in the proper treatment
- Those who are not are referred
- Almost always
- Clients are referred by Juvenile probation departments and interviewed prior to entry into treatment at our LOC
- Our SCA is good at matching their referrals to the services that the need
- Mental Health needs are usually are needing additional services that are now more limited in the community - longer wait lists to get psychiatric care.
- often a good match
- Since the state hospitals have closed down we have been forced to take in many, many individuals who require a higher level of care. They do not do well in these agencies because we cannot meet their needs and we have nowhere to discharge them to afterwards because their needs are so high.
- They often need medications and we have no resources to prescribe. What ever happened to the dual licensing?
- Client are more medically compromised and have co-occurring issues
- often funded under a lower level of care than they require
- In my experience in working 6 years in outpatient setting
- But we are understaffed and our groups are massive.
- we do sometimes take persons that don't make it in other programs
- Sometimes come into psychiatric settings when D & A setting is more appropriate
- Clients are coming in with higher mental health needs and case management needs and being serviced by our facility as it is a shorter wait time to access treatment.
- We are constantly getting level 4a clients and are only a 3a facility
- We are the cheapest alternative
- At times this does occur and I think that we tend to remember those times more because of the outcomes.

- the relapse rate is high, the patient's returning to detox more than twice is extremely high.
- We are the screen for our county. We keep what we can handle and refer out to others what we cannot.
- Clients with commercial insurance often have limited benefits. Once these benefits are exhausted they often do not qualify for publically funded services and cannot afford the actual length and/or level of service they need.
- Most of those referred are a good fit to match however, information is often omitted from the referral information where it leaves us finding out later that there are such issues as head traumas, significant learning barriers or cognitive deficits; active eating disorders is another area that is often minimized in the
- interview / referral information as programs for MA recipients with eating disorders is not readily available. It is a challenge then to transfer which leaves a community living environment at risk when one or two individuals needs are beyond what is able to be addressed at our level of care. After creative treatment planning and altering of phase move up criteria to meet the individualized needs of such participants in recovery a transfer to a lower level of care or a significant other/family members home is next step or even a shelter with OT or partial MAY BE an option according to the funder. When the needs of a PIR (Participant in Recovery) far exceed this level of care ...there are limited programs to meet the need and therefore, our agency can be perceived as a housing option which is not the purpose.
- Needs are global; vocational and medical are compromised by system inequities.
- our setting has evolved a set of skills to work with more complicated clients than probably would have been placed in this setting 5 or 10 years ago.
- need more 3C care before coming to 2B especially dual clients
- are definitely sicker than they were, necessitating more intervention and resources
- Our co-occurring population has increased significantly which requires an increase in skills and training but our reimbursement rate does not reflect this.
- Most are a good match for capability and structure.
- mental health, physical health, and criminality seem increasingly more challenging to address in treatment and are more profound in severity.
- also financial

Q12 Working in the drug and alcohol system five years

- Documentation requirements, STAR, PBPS, CMRR. Required to comply with state, county and agency mandates. Student loans far exceed income base.
- I expect to move up to administration.
- Working on a MSW, and plan to work with veterans.
- I have retired as a result of a work related injury
- As a clinical supervisor, I see my counselors with managing larger caseloads and more paperwork which results in burnout.
- I will be retiring soon
- The increased documentation and lack of funding leads to stress.
- Trying to get resources as funding sources decrease.
- Currently a school guidance counselor.
- The paperwork is outrageous and the company I work for unethical.
- I will volunteer as long as I am able to.
- Plan on retiring soon.
- Overworked and underpaid. Too much paperwork. I can't even see 5 years ahead.
- Providing the time for individual sessions or as opposed to the time spent on documentation and phone time with several case managers.
- Hopefully retired, however I cannot see many D/A clients because of high NO SHOW rate. I can't keep my practice running when clients fail to show and my clients are commercial insured.
- I am also practicing MH-OP for our organization, building programs with the hope that I will be given opportunity to expand D/A. Currently, they are not willing to fund more positions and trying to replace

me with less experience provider due to costs and wanting me to practice my level. We are not BDAP licensed and so I can bill for MH but not D/A. The plan is to add D/A in 1-3 years which I would like to return to because my passion.

- Insurance companies place criteria for inpatient treatment programs in order to pay for service. There are no such compliance criteria for outpatient services.
- Continuing education costs.
- Continue to have paperwork challenges - can't continue to compromise values or believes for financial gain.
- More caseload, less time
- I currently provide co-occurring in-home, family-based therapy. Not a D&A treatment facility.
- Balancing the business aspect with the therapeutic aspect. Demands to keep a high census and provide quality care.
- Not sure. I enjoy the field but also have some other interests.
- I hope to retire in two years and maybe do PT contract work.
- Counselor in recovery. The pressures are great at times. It is separately
- Layoffs in field despite need. Positions available at lower rate of pay.
- BDAP inspectors.
- Hope to retire in 2 years.
- Like counseling and supervision. Sick of management as practiced here.
- I hope to advance my career in the field and take on a role as a director. I would like to have a bigger role in advocating for this population.
- I have no plan to end working but I am 66 and work PT and the future is unknown.
- Case load sizes
- I have left direct care due to lack of adequate pay.
- But I have dual diagnosis capabilities - so will move more to MH.
- The D/A challenge is becoming more complex and expansive
- Looking for a position in D&A services
- Will be semi-retired.
- Am moving currently into private practice and some consulting/fee for service positions.
- Paperwork; high risk patients/clients; high volume
- Families not affording treatment.
- Documentation is a huge challenge with the state, MH, 3 CARF requirements all being different.
- To give clients all they need in 28 days with limited face to face time.
- Less full-time work; less benefits; paid as independent contractors.
- I have been promoted twice in five years. The pressures include excessive paperwork, strict guidelines and regulations and poor county, state, and federal funding for a growing problem.
- Retirement. After close to 41 years with the agency, I am retiring as CEO on 12/31/13.
- Pressure to meet hourly/weekly expectations and balance documentation and authorization effectively.
- The more experience I have the harder it seems to get a job. Providers do not want to pay.
- I hope not.
- Will retire in 6 years.
- This is my calling and will be my career I plan on getting my PhD in addictions counseling
- To keep pace with ever-expanding paperwork.
- Too much repetitive paperwork. Drug and alcohol has always done more paperwork than mental health.
- Paperwork/less time with clients, increased caseloads means meeting with patients for the minimum required per month rather than the actual needs which can vary from month to month or crisis to crisis.
- Retired from inpatient-IOP facility in 2010 after 9 years there. Prior to that I was a MH therapist.
- Pay for performance agencies tent to worry more about compliance from demands of managed care, licensure and less services for the client. Clients are not being held responsible for their actions.,
- I may be moving and unable to answer the question currently.
- Caregivers ought to be care takers. I will know when it is time to leave the field.

- Been 40 years. Time to step out. Field is very far from a helping profession.
- Essentially, the same as they have been for years. Over-exposure to emotionally draining material.
- You need a masters yet the pay is low
- I am driven to work in this setting but I see the effects the demands of the field can have. I started at my position 4 years ago and have seen eight people leave. And we are a small facility!
- I hope to eventually get into private practice but would still specialize in addiction.
- To work with clients even though they have reached a point where they need to be in a higher level of care
- I have worked in both residential and outpatient settings and find OP much more rewarding, will stay in that setting.
- trainings put on hold due to budget cuts seeing more people in shorter time frames and expected to keep up with documentation when no time is allotted for this
- I would like to return to being a counselor, Actually a psychiatric RN now but obviously use my counseling skills.
- Documentation, documentation, documentation. I work for the federal government.
- I would like to operate a business for support groups and referrals.
- I am very comfortable in working in a case coordinator and recovery role I will work as long as age allows
- the longer you are employed, the more patients you are given, up to 50 patients under a shady exception granted to Discovery House from BDAP years ago
- I plan on retiring
- impossible amounts of paperwork
- Retirement in the next 2 years.
- high case load leaves little time on my schedule for notes, TX plans talking to insurance companies
- paperwork, duration of hours worked w/ inadequate pay, I am in a non profit salary is low
- no time with clients, seeing the business side neglect clients. Not able to make a living between all the hours and the minimal pay
- I do not feel challenged clinically in this setting but know that I could with additional training
- I am due to hit the ceiling for my position pay rate
- I am moving more into MH because of DA paperwork
- documentation, burn out not enough clinical support and supervision not enough self development opportunities to maintain my ethical commitment to servicing clients without acknowledging costs
- I have been looking at retiring from management of TX settings and putting more effort into grant writing
- I work in an agency that is publicly funded, every year we get less money Once my youngest is out of school I will work in direct care
- Paperwork!
- ridiculous demands from employers and insurance companies rather than a focus on quality TX
- retiring
- predominantly MH
- retirement is not in my picture
- PA did not accept my license from another state. Unable to work as a counselor in the EAP system I come from
- budget cuts have closed some of our programs an unexpected transfer took place last year. Job security does not exist
- I am tired of paperwork but even more I am tired of hearing what people do to each other and I am tired of watching disease kill people
- each year more paperwork is required by the state of PA most of which is never viewed again
- paperwork, increased case management and less counseling with the patients I serve
- Fighting for time for clients and money to complete a higher level of care
- Retirement.
- I feel alone with no support.
- I will probably be retired in 5 years since I'll be 71.

- I'm letting my credentials expire due to bureaucracy and over-regulation.
- Effective Tx management.
- I all depends if I am in a financial capacity to retire, I will be working for the next 2 years in D&A trying to retire at 60 possibly work PT.
- Paperwork, counseling
- I would like to earn my LPC
- The amount of pressure or authority that is given to funders in dictating the direction of clients TX.
- Increased workload and higher expectations.
- I am not currently in a counseling setting. I am an SCA director
- I hope to work 5 more years to retire.
- Increase of funding sources.
- I no longer provide counseling. I have become a case manager who spent her time fighting with funders to get the time the clients require.
- Overworked, underfunded, want to focus more on client care but paperwork load and funding takes up our time
- I feel that I would like to advance my career in counseling
- I have left the DA field
- I have already moved out of service delivery into IT and I am likely to continue that course
- Supervisory or management position
- I plan to go to private practice - less stress/more money. The new DSM will add pressures.
- Helping clients receive adequate and appropriate services
- I left the drug and alcohol sector 10 years ago to enter the criminal justice. I am anticipating going back to D&A.
- Credentialing, re-certification are needed.
- Managed care - shorter lengths of stay with increased documentation.
- I am an administrator. Current job location is too far to travel.
- I am not sure that I can choose one answer for this question. The field is constantly evolving. Who knows what I'll be doing?
- Will retire full time, will work part time as a nurse.
- Paperwork!
- I plan on retiring from the DOC and I will look for work PT in the community
- Currently a pastor
- I am a senior counselor and plan to get a job as a clinical director
- Too much pressure
- Time constraints to get all paperwork done and "cookie cutter" treatments, not tailored to each client.
- I am beyond retirement age at this point
- Paperwork. Trying to learn too many protocols for clients, e.g. IMR, DBT, CBT, EMD rather than focus on treatment.
- Documentation - insurance is difficult. I enjoy my clients and want to be a positive influence to foster change
- I am leaving the field because there are more complex clients, less realistic expectations from service providers and inadequate funding
- Not really sure what myself or my agency may be doing 5 years from now.
- It depends on whether the paperwork continues to increase.
- Retirement
- More paperwork and less actual counseling.
- Pressure to bill, increasing documentation
- Paperwork! Time restraints caused by paperwork.
- I am retired and continue to work part-time.
- Balancing the true client needs with the demands of the MCO is a growing difficulty.
- Not involved in direct service treatment AHSS instructor now.

- Retire.
- To do more work with serious illnesses but at the pay stays the same. So you end up working 2 jobs to pay bills and tuition.
- Insurance not allowing enough treatment time especially with programs being deleted or changed.
- Pressure felt would just be to continue education which I am motivated for.
- EAP counseling comprises work with multiple types of people with multiple types of problems, SA included.
- I am in private practice doing both MH and SA counseling. I plan to continue for 20 years.
- Retirement. Currently 38 consecutive years.
- Current trends exclude the valuable innovative input into tx guidelines, agency policies, w regard to patient care and experiences that help shape tx goals and phases.
- I don't work in D&A currently
- I expect to retire in 5 years
- I will continue to work in a setting primarily identified as MH, while providing dual diagnosis care to my clients.
- the responsibilities for a counselor continue to increase and we are not keeping as many staff to share the load
- I have worked in a treatment setting (residential) prior to my current position as an assessor. I would like to return to a counseling position eventually.
- I am passionate about this field and the people I work with I hope to effect change on the burdens that keep counselors from burning out and leaving the field
- pressure to treat clients in a level of care that not quite right leads to burnout
- I will be retired in about 5 years but plan on continuing counseling
- I am presently in an MSW program and want to become more professional
- I would like to explore MH more
- only in this job, three weeks at this job, was laid off after 17 years as an EAP
- will retire in two years but will continue to work PT
- currently testing for my LCSW
- Their own denial
- I like my job and feel qualified. I need the pay check and benefits
- It is very difficult to practice best practices within current health care system
- turnover, recidivism, enabling field encouraging SSI/SSD on drug populations, diagnosing MH and not taking responsibility for self and recovery
- Tx is no longer effective, driven by insurance and politics. Clients do not get the help that they need.
- options / positions are limited - especially at age 55
- I plan on offering DA counseling in a private practice setting.
- the most significant pressure is to provide financial related treatment reviews which take a significant amount of time.
- Burnout!!! Dysfunctional administrations/management at some places unreasonable workloads, not enough resources and support.
- Looking for directorship.
- DDAP requires so much to serve our clients.
- As a supervisor the concern is we can't pay comprehensive rates for a 4 year degree, so the turnover is great.
- I am retiring in 4 years.
- I am in the D&A field with the same employer for 26 years now. I want to stay in this field but it looks bleak in this area and this field.
- I have recently retired and have enjoyed my years in the field
- Cost of education is not within my budget.
- Until I die.

- Primary care providers are asked to carry more workload, do more with less funds, and stress level is high heading to field losing good care givers.
- Insurance issues, issues with criminal justice system.
- Will retire.
- Lack of enough AOD counselors in area, support time resources for client, lack of communication between therapeutic providers.
- Working in a jail setting.
- To write tx plans that are in tune with insurance not the individual.
- Will be retiring.
- Too much paperwork, not enough patient care. Not paying for expertise, no funding for appropriate care.
- Best fit for me at current company. I'm the only CAC so I get spread thin at times.
- Retire if I must
- I enjoy my company. D&A and MH are exhausting though
- Documentation, clients issues are more severe, not enough time in the proper LOC
- Amount of documentation in the medical record.
- I like it
- I would like to be a director of a facility. I am more qualified than the current director I work with and this bothers me a lot.
- Retirement
- I anticipate to continue to deliver services until I retire.
- Balance work and self care nurturing family and friends.
- No
- as a clinical supervisor, maintaining counselors in positions is difficult; high staff turnover affects quality of care.
- As clinical supervisor maintaining counselors in positions is difficult; high staff turnover affects quality of care.
- Pay grade seems to be significantly lower in the D&A field as opposed to MH.
- No reward.
- hope to be able to retire in 5 1/2 years.
- I loved working with D&A clients and would love to return to counseling
- considering a change as I get my license
- TX is not working, lack of resources lack of proper
- concerned about
- we are expected to be co-occurring competent
- paperwork pressures! I feel that therapy is more important than paperwork
- I plan on retiring
- decreases in inpatient stay will lead to more outpatient and MAT
- The ACA
- too much paperwork, not enough therapy
- clients are sicker and need more not less
- providing quality treatment is more difficult to do when volume is stressed
- human behavior does not adhere to reimbursement schedule
- I love what I do
- too much paperwork
- excessive paperwork demands - low reimbursement for MA and public funded clients
- I enjoy my role as a clinical supervisor
- always short staffed, case loads between 9 and 14 clients
- Time pressure, lack of fair and consistent client TX lack of good food for the clients and lack of real concern for the welfare of other human beings
- I like what I do
- clients expectations are for intense therapy but they get little because of paperwork

- the pressure on me are appropriate as I am practicing and a licensed psychologist
- Not sure I am partially retired and working PT
- hard to answer background in DA currently working more in MH, pressured to see more clients in less time and do more precerts
- Possible getting back into the field in the next few years either PT or as a volunteer
- plan to work part time
- I will leave because of changing requirements that require licensure for all who Bill Insurance
- not sure when I am retiring
- I have almost completed my PHD and intend to continue this work and supervise others. Paperwork is the biggest struggle
- I would like to continue but have been thinking about private practice. It is very difficult to keep good staff due to paperwork requirements as a program director this is frustrating because my counselors are dedicated and hardworking
- I anticipate a promotion. Case management pressures takes away from therapy
- Probably will retire from this level as management positions do not interest me
- Retirement
- Unsure - May choose to stay at home and raise a family
- Insurance, financial access to TX that hopefully the ACA will address or diminish
- I will be retiring within five years
- The primary pressures of DA counselors is that DDAP inspectors demonstrate no consistency year to year in what regs are interpreted and enforced
- Too much paperwork, not enough time with clients. Pressure to keep numbers up and keep the sessions that are attended high
- moving
- The usual - see as many clients as possible but also get paperwork done on time. expectations is often just not doable in the hours worked
- Uncertain I want to stay may need to find a new agency. Paperwork deadlines, requirements to run too many groups and maintain too high a caseload, company focuses on money.
- I hope to retire in the next 4 years.
- I work in MH OP setting
- to do more w/less
- As an *i*nterventionist and case manager
- Everything already described. The system is broken. I am burned out.
- Retirement
- Budget responsibilities
- Inadequate supports, continually decrease in funding, client's with co-occurring disorders and inadequate funding for service.
- I am 58 and hope to retire or find a different position. Patients don't burn me out systems do.
- I know I make a difference in a portion of the clientele I work with.
- because of it being so money driven and the ethical boundaries are being pushed
- Excessive Funding Source paperwork.
- Retirement
- New recovering clients feel overwhelmed with all the changes they have to make in their lives, so between life, recovery meetings, even though you explain how important counseling is that seems to be the first thing they give up or if they have no insurance or limited insurance they just quit coming and ignore any contact you might try to make to reengage them.
- Unsure at this time.
- I love my work, my mission and that of my patients. I do not like or agree with the micro management of paper work.
- Probable LPC work - maybe own 'small counseling business'.
- I am an older person, I am vested in my retirement

- I'm 66 and my retirement plans are currently up in the air
- Paperwork is a primary "pressure cooker" for me in delivering services to my clients.
- I anticipate leaving the field within 5 years due to retirement. I plan to continue part time work for a while prior to full retirement.
- Our jobs are threatened ALL the time. We have lost hours and benefits over the last 5 years. There is absolutely NOTHING to look forward to it seems in this field any more. I have been certified (CADC) 22 years and in my agency for 26 years, I NEVER thought I would see the day when this field would be hurting so badly as well as the workers in it.
- I have left the field 4 years ago
- I may leave human services all together. There is little help and you are always fighting someone.
- Will be retiring this year
- My plan is to become a program supervisor with in the agency.
- Burned out
- Retiring and changing to part-time private practice
- Individualized treatment is no longer an option for a therapist. D&A Programs make more money in a group setting and therefore Partial and IOP therapy is a priority. This leads to large groups (I personally have run IOP groups with 35 – 40 people and Partial Hospitalization with 10 and no back up). I ran these groups simultaneously. Individual treatment is nonexistent for IOP group members with women and men and drug dealers are mixed together. If a women has suffered abuse issues, the core issues can never be dealt with. Drug dealers who have no addiction however said they did to avoid jail are in these groups and selling drugs to clients struggling with a real addiction. In PHP, individual treatment is built in however with only one therapist that means 9 group members are sitting by themselves. All treatment modalities should be explored for each person requesting treatment, not what makes the most money. Sadly, that is not happening. Having over 20 years, I was fortunate to have worked in the field when treatment was determined by the client, not the insurance company.
- simple I love what I do I have tremendous compassionate for the sick and suffering addict
- want to do more individual work than currently allowable within present system
- I have 14 years in my current position and have 11 more to do before I can retire.
- will be retiring
- I am retiring in three and a half years.
- Seeking work in corrections. Don't have to worry about pre-certs and auths for more treatment.
- To do the job of three people and I am only one person. To be able to handle a large case load when counselors come and go and still handle all other job functions. Also to be able and willing to do all of this and continue to receive low pay.
- Retirement is next
- It is getting exhausting with the amount of redundant paperwork
- I am an owner of a D&A business so will be working but would like to work more on the faith based level with clients so would like to develop track for the client who wants more of that kind of connection in his or her recovery
- I want to be a facilitator and a program developer.
- I have a diverse private practice with most clients seeking mental health services. I will continue to see both mental health and substance abuse clients.
- I hope to retire from a FT position and enter private practice on a PT basis utilizing my experience.
- May retire in less than 5 years.
- The real pressure is building and sustaining a treatment team that is able to respond to the needs of emerging populations. Also it's necessary to pay attention to the impact of services on the bottom line which means articulating patients present problems through the lens of "medical necessity" maintaining the integrity of the services that we provide.
- Will retire within the next 5 years

- The paperwork and inspections have become way to cumbersome. The amount of time and energy to document a program where there is no drawing of blood, no food made or served, no one spends the night, most clients are seen individually and one at a time, is outrageous. My staff is always changing
- because of it as well
- Because of funder refusal to grant adequate LOS, census increasingly drives workplace decisions. Faster pace, less personal attention, more (and sometimes frivolous) documentation, greater time spent on "getting them in and getting them out."
- Stress and pressure of paperwork, reporting and conformity. Very long hours for far too little pay.
- I always keep a part time situation in general MH to keep my degree and my skills in tune.
- Currently retired but plan to return to an outpatient setting. Completing all the necessary required paperwork/ documentation.
- Completing paperwork on top of insurance info while trying to help people with addiction. More political than it is serving our population which gets dicey.
- I hope that I will still be working in the D&A field but at a higher level (i.e. supervisor). My goal is to work with the VA and hopefully once I achieve my MSW (this spring) I will be able to do so.
- There is such need for service and growth. I expect to move to another position or location in that time.
- I am currently on personal medical leave of absence and have registered for disability benefits with no scheduled date to return to work.
- Retirement
- moving to teaching rather than direct service
- Pay, workload, paperwork, always fighting with insurance companies for additional days is burning me out. Also it is frustrating seeing people not make it all the time. The real success rate for at least a year sobriety is a lot lower then published because follow up is not really accurate.
- Retirement
- Will retire in 2-3 years. BUT, if I were to stay, would have to work in a large nationally known facility where people receive quality care and longer stays. What I am seeing as I audit records from the vast majority of rehabs is cookie cutter treatment, limited insight by counselors, and terrible documentation. My estimation, the field overall offers poor care. Saddens me!
- I am hoping to retire but if not I will
- No longer work in the field, but maintain my certification. Left the field a number of years ago
- Not sure but if I do leave the field it will because the paperwork & inspections require me to work many hours above and beyond what I get paid for.
- Low pay is a pressure in the field that is only exacerbated when paperwork requirements increase and payors make it more difficult for patients to access services. Counselors are often faced with neglecting self-care and keeping healthy boundaries or sacrificing patient care as the requirements of the field
- require well over 50 hours per week.
- Will retire within the next 5 years
- FINDING SUITABLE HOUSING FOR CLIENTS WITH PHYSICAL OR MENTAL DISABILITIES THAT ENABLE THEM TO WORK, MOST CAN NOT RECEIVE SSD/SSI UNTIL THEY ARE DISCHARGED FROM THE FACILITY WHICH IS A BARRIER TO OBTAINING HOUSING IN A TIMELY MATTER.
- Paperwork, Paperwork, Paperwork. If I could sit and see clients without all the stress of excessive paperwork it would be awesome. I did not get into this field to spend so much time on paperwork. It would be the only reason I would ever consider leaving the drug and alcohol field.
- paperwork
- I plan to continue to work for the agency where I currently work as I believe and support their mission statement. I hope to progress to an administrative position within the next 5 years.
- I will retire in 4 years
- The salary and expectations do not match in the drug and alcohol field. I would rather work with mental health counseling.
- redundant paperwork and fighting for funding. Also difficulty arranging medical or mental health services for persons with MA from other counties

- Who knows where any of us will be in 5 years, truly?
- At some point I will retire to part-time status but will continue advocacy and other less demanding responsibilities.
- All the added paper work
- No specific pressures, just plan to relocate to another state within 5 years. Obviously the pay in this field is less than ideal, but I plan to stay in drug and alcohol if I still find it to be rewarding in 5 years.
- The constant flow of redundant paperwork, funders pressuring me to complete a resident or becoming involved in the residents treatment.
- I love Gaudenzia and the mission. I hope to attend medical school and return as a staff physician. The pressures on myself as lead counselor are many; paperwork constraints, demands from legal involvement, managed care reviews every 14 days, timelines as well as diminished time for client care.
- Private
- Too much time consuming paperwork for poor pay
- Collaboration with others in a smooth, efficient way can be pressure filled
- The amount of paperwork is unmanageable and I plan to move to private practice to help decrease documentation and increase direct care with clients.
- Retirement
- I would love to retire someday, field has gone from helping people to meeting bureaucratic demands
- Stress level is up, incomes are down. I feel that insurance and governmental red tape has made the job unhelpful and less meaningful and I am looking for a way out so I can afford the basic things a person with a Master's degree should be able to get. I make today what I made back in 2004 in my 3rd year in the field. And the cost of living has skyrocketed. With a Master's degree in this field I sometimes wonder if I get a moderate illness or need a new car if I can remain financially afloat. My advice to students who ask me about going into the field is to stay away.
- It gets harder and harder to take care of yourself and the clients too. Needless stress. I anticipate more demands on me for case management, documentation of services under the umbrella of reduced time in treatment for clients.
- Sad to watch people not getting the appropriate help they need.
- There is too much liability associated with sicker clients who are high risks to OD not getting the proper level of care and in a timely manner

Q13 Greatest barrier that interferes with helping people you work with in obtaining long term recovery?

- Funding cuts, Medicare not acknowledging LPC's
- It can be hard getting them into a psychiatrist, it's almost a 2 month wait.
- Short lengths of stay and receiving IOP instead of the detox that they need.
- Lack of support systems and finances.
- limited funding for aftercare
- lack of insurance company approval for services
- Insurance funding being cut off, negative stereotypes in the community about methadone maintenance causing patients to feel pressured to leave when they are not ready.
- CBH and its out of touch responses
- lack of funding for aftercare services
- managed care / funding sources and lack of resources as well as clients with lack of motivation
- Ability to provide higher levels of care if needed for as long as needed
- Their own motivation to utilize coping skills, reach a twelve step community and stay sober utilizing their support system.
- Realizing that recovery is an ongoing long term disease.
- Funding sources.
- Lack of resources and supports in the community to help them in their recovery on a long term basis.
- Method of payment, confidentiality regulations.

- Access and willingness to participate in tx beyond 2 years abstinence.
- Housing
- Patient access to funding for Tx.
- Relapse and cost of care not funded.
- Too many are pressured to be in tx due to legal issues and the tx program constantly threatens to have them violated.
- The insurance companies.
- Need new methods to break down denial. Methods that let patients access their feelings.
- Multiple issues and lack of funds and resources.
- Lack of rehab centers and long term tx.
- Example: I have an LSW and CADC but local region of Blue Cross would not let me be a provider because I am not an LCSW.
- Old friends
- Seeing the "reintegrate" to mainstream source or stigma for addicts with legal history is a barrier.
- On OP basis, I can't get clients to try self help or 12 step groups. When I worked residential treatment, the agency put people in a van and drove them to meetings. Can't do that on OP basis. Got to meet clients "where they are."
- Additional 4/ social stressors—homelessness, environmental risk, lack of access to drug replacement therapy and psychiatric services to provide 30 - 90 day stabilization.
- Sub-standard inpatient services - Very poor.
- My client's own choices
- Motivation.
- Barrier to treatment is/and has been the clients motivation for change. Addiction non-compliance should not be supported or used to justify SSI or SSD applications. Addicts in active recover are not disabled or incapable of work.
- State budget cuts. Funding.
- Lack of longer-term residential to address barriers established during addiction.
- Funding - more times than not "others" do not have knowledge of needs for long term recovery or recover at all - money driven.
- Managed care.
- Funding.
- 1 Criminalizing drug policies. 2. One-size-fits-all treatment programs that don't reflect people's unique needs.
- People being ready (stages of change) for help and MCO's funding the appropriate length of stay.
- Funding can be problematic - catch 22 for some who obtain employment and then lose funding source like county or medical assistance.
- Insurance, funding
- Inappropriate step-down process interferes with longevity of care.
- Not enough money comes in so short on staff. Overworked.
- The clients own unwillingness to do the work needed to change.
- The truth.
- One stop shop - IE: Treatment with other social, financial, medical support services.
- Fear of going to 12-step meetings.
- More clients with co-occurring disorders and not enough well-informed medical professionals.
- The computer on my desk
- Qualified staff
- Insurance companies do not pay for the services they need. Also, my county does not receive enough funding to meet the needs for this population.
- Funding
- Not enough females in recovery to be sponsors. Long wait time to get into a psychiatrist.
- I cannot absorb the high rate of no-shows. Insurance should pay a limited amount for first no-show, etc.

- I work with dialysis patients - They have been refused services to their needs for treatments 4 hours per day, 3 days a week. There is one inpatient rehab that will accept these patients but if there has been a problem or long history I have had them refuse these patients. They then have nowhere else to go. If they do outpatient services - they are recommended for evening programs but then there is NO evening public transportation!
- The client them self - most are court stipulated and aren't internally ready, but we plant the seed.
- The amount of paperwork is now so extensive that a lot of activities are now not incorporated into treatment that helped people stay in recovery for a longer period of time.
- Returning to environments where they are continually exposed to crime, drugs, etc. No support from community.
- Funding uninsured and under-insured.
- Client follow through. I can make referrals and recommendations but it is up to the client to follow them.
- The standardization of addiction treatment and lack of counselor knowledge and willingness to deviate from 12-step philosophy for EVERY patient (not all are appropriate).
- Families.
- Insurances! And if they go back to work, can't afford copays. They need long, ongoing care to remain in sobriety and working.
- Obtaining primary supports due to how rural we are. Transportation is always an issue.
- The legal system viewing punishment over treatment.
- Funding. Length of stays.
- Funding and not being able to provide the appropriate LOC for the patients.
- Poor opportunities for people in recovery to become self-sufficient.
- Insurance coverage and authorization.
- Funding!!
- Lack of follow-through by families. Denial of problem.
- Funding for aftercare
- Funding.
- Continuity of care, copays- can't afford, drop out, not engaged in support (NA/AA), D&A partial hospitalization needed for teens.
- Client commitment.
- Length of stays decreased, state funding being cut, and documentation required that time would be better spent with the clients.
- Insurance reviewers and their lack of education on addiction.
- Qualified
- Lack of funding. Lack of service availability. Management focus on profits at expense of patient care.
- Medical doctors over prescribing narcotics! Medical doctors prescribing mental health meds!!
- Poor funding. Too much time dedicated to paperwork, audits, case management. Not enough time for direct care and professional development.
- Cost. Funding
- Diminished financial resources all around.
- Denial, lack of motivation, ego, pride, closed mindedness, euphoric recall, magical thinking, etc.
- Private insurances.
- Adequate healthcare coverage. Publicly funded persons have very few options. Those providers are usually overwhelmed by demand, resulting in inadequate resources to go around! Medicare patients have almost no option.
- INSURANCE COMPANIES!
- Funders rules!
- Temp service jobs, felony records that prohibit work and school choices, unfair laws for nonviolent crimes, the nature of addiction, the need for long term residential treatment or TC model for real change and better "step down" choices.
- Get Christians to go into NA/AA

- lack of availability for MA and opiate replacement therapy and lack of coordination with co-occurring
- Their unwillingness to work a thorough program of recovery outside of the treatment setting.
- Transportation, money, adolescent treatment is lacking. There needs to be money available to set up and staff an appropriate outpatient IOP for adolescents.
- I work in MA in the Suboxone prior Authorization Department many physicians are not adequately trained for this program
- Medicaid keeps patients fearful of legal employment. The requirements to keep Medicaid coverage is not realistic so people don't work or try to make disability claim or work illegally which does not coincide with recovery goals.
- Lack of funding for both D&A and MH treatment; treating D&A addiction as a crime vs. illness.
- funding / transportation
- Managed care tends to dictate treatment in Philadelphia, which they should not.
- funding - our county has run out of money for DA prior to the end of the fiscal year - no county clients are being funded at this time
- One of the barriers are education on relapse and the recidivism rate for ex-offenders (second chance stats).
- Financials are a huge barrier which effects the need to address families with addiction.
- Mountains and mountains of paperwork, stipulations, standards, bylaws, policies, managed care regulations. It's a juggling act.
- Untreated MH disorders / lack of available MH services
- Inability for trained and experienced therapist to make treatment decisions. County guidelines/mandates interfere.
- Multiple substance dependency, unmet health care needs - financial issues
- Funding!!
- Transportation to Tx. Access to longer term rehab.
- Ongoing access to consistent and cohesive treatment. Therapists in community based organizations constantly turn-over. Therapists such as myself can't work with public funded clients because of funding streams.
- Denial financial hopelessness refusal to go to 12 step
- Funding issues.
- FUNDING SOURCES!!
- Poor support system, returning to the same environment
- not enough staff to provide adequate TX for clients
- Not enough hands on support services
- Funding, Part of people's lifestyle, desire to have immediate fixes
- Employment opportunities for clients. Limited access to other holistic approaches, always using 12 step programs, need to offer more like acupuncture and activities for a healthy lifestyle.
- Multiple expectations too high case loads and high turnover because of these factors
- Overwhelming amount of drug trafficking; lack of supports—especially those coming out of prison - long term.
- Insurance, financial; and availability of needed LOC.
- Separation of church and state
- relapse occurs for a variety of individual reasons not committed to recovery, death divorce ptsd
- Willingness of the participants themselves.
- I work with teens who struggle with staying sober sometimes parents can be a barrier
- Stigma. Other comments: Red tape associated with Program Licensure prevents many providers from pursuing licensure.
- The aftercare they should have help with all the needs they face after they are discharged from Tx IOP alone is not doing the job.
- Staff turnover inconsistent providers for recovery relationships
- Money

- Financial, insurance issues.
- Acceptance of _____?
- engaging in treatment longer and follow through with bridge transitions no cash benefits or money for meds is a big problem
- Paperwork, takes away from clients needs. We don't have time to meet.
- funding restrictions
- Case loads too high
- our clients need to have more motivation need good support systems there tends to be prejudice against private practice
- professionals are underpaid in this field so the smartest and most competent people end up working in other fields
- Reports of recovery programs which are not helpful
- patient resistance to getting a sober support system outside of treatment, especially in IOP
- I work with impaired medical professionals who do not qualify for public funding.
- Insurance companies.
- financial backing
- barriers to funding
- No available outpatient appointments, constantly overbooked. general lack of mutual aid resources around the region and assistance for the additional needs, MH housing transportation
- poverty as a stressor and marijuana use is not a big deal in the cohort
- not enough research funding for medication assisted recovery
- do not go to AA / NA clients are sometimes given so many services that they do not have to work on their own recovery
- funding
- lack of proficient aftercare options
- available funding
- supportive services
- paperwork - I spend more than HALF of my time working on it!
- funding, lack of insurance, high co-pays and
- Insurance restrictions, higher deductibles and co pays
- funding requirements
- long term care options, lack of recovery houses in my area
- the funding source not approving for longer TX LOC or no TX at all. There has also been referrals to medication assisted TX / methadone for individuals with multiple TX stays
- lack of funding - difficult to find true MH / DA providers for
- competent, available psychiatric services
- TOO MUCH PAPERWORK!
- finances
- stays re short in most cases methadone maintenance also creates an impact on TX
- private insurance
- Insurance limits
- motivation
- Suboxone - appears to be another crutch and does not deal with recovery
- money
- Their willingness to remain in treatment
- funding and lack of Gov support lack of education / awareness programs
- lack of funding
- funding is the biggest problem clients lose at the end
- red tape, paperwork and understaffing
- lack of understanding that alcohol and prescriptions drugs are so addictive
- licensing and paperwork requirements

- denial and family issues
- funding and paperwork
- getting funding from the state
- Too much paperwork. Too much emphasis on accountability and not enough on service delivery. SCA in our county is unreasonable in some areas which limits the time left for direct service delivery.
- Not enough treatment for dual diagnosis.
- So much turnover in program staff, especially supervisors.
- Struggle with insurance companies to get treatment needs met. Supposedly universal ASAM criteria but seems subject to different interpretations.
- Decrease in amount of funding available.
- Consistent attendance and sincere commitment.
- The person in treatment is reluctant to participate in a source of community support such as AA, NA, faith-based groups, etc.
- Too few, too short and too over-regulated services and not enough funding.
- Funding and expertise I only refer to Caron and Mirmont.
- Money.
- Fear
- Patient compliance
- They are court ordered not motivated in recovery. Minimization of use
- Good assessments
- Feeling unwelcome and (not clean) at NA because they are being prescribed suboxone.
- Transportation in our area, and regulations so clients cannot get to Tx.
- Meeting the needs of the dual diagnosis population due to not having an integrated program that meets the needs of this population.
- Finding a facility with an available bed.
- lack of funding
- When clients focus on one addictive behavior but minimizes other addictions overseeing the overall behavior causing the problem.
- Clients have minimal to no motivation to make any long term lifestyle changes to improve their chances of success in their recovery.
- Lack of funding, concern over potential block granting of human services and elements ACT 152. I am a little concerned about some of the bias in these questions.
- Inmates return to the same unhealthy environment. They often priorities recovery. They don't make sobriety mean something, doesn't mean anything they throw it away at the first stressful or adverse situation.
- The IP setting has the most difficulty for getting the time needed for clients.
- Insurance limits level of care and duration for IP. Also, limited county funding/people are only receiving detox services.
- Finding adequate support systems for recovery.
- Funders.
- Limited funds.
- Consistent and dependable funding for TX and salaries for professionals to stay in the field
- I feel that the greatest barrier to long term treatment is the resources that clients receive after they leave.
- funding for good programs and bed space
- Insurance companies driven by money rather than treatment results.
- Limited resources resulting in reduced services and lower caliper staff (less trained as we cannot afford to pay for highly qualified staff).
- The lack of funding and understanding the seriousness of the disease from PCP's to insurance to legislators.
- Funding
- Lack of family involvement.

- Women - no childcare services so they can seek treatment. They lose the medical assistance when they work so they lose services. Basically they get punished for being more functional.
- Money for adequate treatment (lack of funding sources)
- Many if not all of the individuals who I serve have knowledge of the recovery process, but cannot take hold of or attain it.
- Housing, support systems other than 12 step, MANAGED CARE
- Generally speaking insurance and the current obstacles with managed care.
- Housing, getting MA, funding cuts
- Fee for service, reimbursement structure, doesn't allow for reimbursement of all services needed by our clients.
- Time and funding.
- Bias against people on methadone
- Being required to have an LPC to except insurance when for 15 years, doing the same work having a Master's and a CAC was acceptable. Although many insurances do not cover mental health or substance abuse.
- Funding!
- The DOC is not a treatment oriented organization. Nor do the view alcohol and drug addiction in a positive light, it is an afterthought to the organization
- funding to support treatment
- The insurance companies are getting tough to authorize the right level of care for the people I work with.
- Peer pressure
- Patients not adhering to their TX plan, contracts and clinical reviews – Patient may be terminated from MMT too quickly
- The disease
- Providers that hide behind 255.5 so they don't have to do more work
- MCO's and duplications of audits
- Lack of desire. Could care less. Methadone
- Funding restrictions and availability of funds.
- Funding for those without insurance - insurance companies "second guessing" assessment findings
- Think there are many barriers. I would like to see more focus on the family.
- The population I work with are incarcerated
- my own inability to reach the person, I choose not to blame the person
- Clients not staying in treatment long enough to maintain recovery. Even Medicare is very limited with clients paying $30 or more per session.
- service availability in our small community and funding being cut
- Inadequate funding and lack of programs or staff who have good knowledge of co-occurring disorders.
- Inadequate funding
- Willingness to follow suggestions (long-term
- Paperwork and strict audits.
- Everyone has their own individual issues. Mental and physical states sometimes plays a part. But everyone has a choice.
- Providing CBH with the clinician (Justification for long-term treatment and being denied. Moreover, BHSI care managers who constantly misplace faxed PCPC and refuses to pay for services rendered.
- Resources and housing.
- Unable to fund long-term treatment. i.e. Halfway houses.
- Documentation requirements increasing which take away from providing direct care.
- Returning to the same environment, and people quit drugs but get prescribed benzos by a doctor.
- Limited with length of stay, tough to stay in the field due to low salary, low rates for services.
- Obtaining and maintaining appropriate funding for services.
- The time paperwork takes away from direct care. Underfunded programs limit the amount of recreational activities clients can participate in and treatment services offered.

- limited resources and time to dedicate to clients
- Money
- Motivation to follow after-care recommendations.
- Insurance related issues.
- Partly due to the nature of this disease in and of itself. Secondly, prescription drug abuse epidemic—many young adults are progressing to IV heroin at extremely young ages, and this creates a systems-level need for treatment that is often what that individual (in that stage of change) is willing to engage in. And engaging the family in a beneficial, meaningful way, can be an immense challenge.
- poor aftercare programming and support
- Lack of funding and appropriate LT facilities.
- Addiction is a disease illness with no cure. Find a cure. Communities of recovering people and small pockets that are not easy for newly recovering people to find. Lots of 13th steppers easily found.
- Working in community.
- Obamacare!
- Flexibility of available programs. None on Saturday for clients who need to work!
- Not enough treatment time being allowed through their insurances.
- Greatest barriers would be both copays for therapy and clients willingness to attend 12-step programming.
- Ability to pay co-pays; time off work to attend treatment programs.
- Unrealistic expectations on the part of clients and society 2. Insufficient alternative recreational resources.
- Entry level staff. Poor wages. Few reasons to become seasoned.
- Chasing money for the payment of services.
- Financial means of client, clients state funded health care does not does not support the depth and intensity of care needed for most clients.
- Lack of family supports.
- Difficulty accessing psychiatric services for those with dual issues who are completing inpatient rehab and step down to IOP then relapse prior to getting MH option.
- Equality-there is none.
- Money
- Life presents itself, people, places and things. They feel they can't stay clean, not without the 12 twelve step fellowship, abstinent vs. sobriety.
- I work with adolescents who have little motivation for recovery
- People who are not in recovery do not understand what recovery is
- transportation, poverty, insurance, level of family
- If it is a higher level of care that is needed, it may be some / certain insurances. Next survey ask counselors what insurance companies are PRO Client. Thanks for caring
- services are unavailable
- not enough funds for families
- family conflicts
- Insurance requirements
- the archaic regulations that no longer make sense! Unskilled / under supervised counselors that are ill equipped to treat co-occurring disorders which is our systems problem not theirs
- excessive paperwork
- longer term TX
- getting on insurance panels and getting denied by Magellan who will not permit any new providers
- funding consistency for clients receiving treatment
- local DA services are low quality and most clients insurance do not want to pay for good quality treatment
- government regulations
- attitudes towards support services and lack of funding
- Too High caseloads lack of understanding about DA needs

- lack of funding, transportation issues, lack of outside support
- the regulations imposed by outside sources beyond what the therapeutic governing bodies expect
- MH issues
- no insurance - poorly funded treatment \most clients do not have the desire or willingness to do the work for recovery
- Insurance - PPL with insurance receive better care - if they are not MA eligible or have private insurance co pays are too much
- Insurance/ MCO providers are denying inpatient services for opiate dependency - they feel that ambulatory detox programs are good enough - they do not work!!!
- legal system
- clients are overmedicated, enabled by SSI/SSD housing, free transportation, etc. and not focused on the disease concept of addiction rather focused on MH diagnosis
- Insurance coverage, transportation issues
- client consistency in treatment
- lack of funding to remain in treatment, insurance denial, lack of family involvement, social supports
- the requirements to provide all the information funding sources want and when they want it. It takes away from client contact a lot!
- Time, money, and willingness.
- I truly do not know the answer to this, I wish I did.
- Access to
- Funding.
- Resources
- The area we live in.
- re-entry needs cuts in funding
- Catering to jail people who don't want, need to be more recovery D&A instead of Psych. groups.
- No resources, lack of counselors, programs + support meetings.
- 50% probably client feeling that can't give up 90 days feel like they are doing time. Often with those with insurance unable to even obtain residential at any length of stay.
- Their resistance to engaging 12 step program.
- Inadequate post treatment supports.
- Shorter duration of time, conflicts with obtaining and maintaining recovery.
- No consistency in messages.
- Cookie cutter care "One size fits all" timeframes in IP prohibit more than doing just triage type of care.
- Empowerment, stage of change.
- Therapists using old techniques and not willing to use medications if instructed.
- Community support, self help group availability-very rural, limited financial and transportation to services.
- Licensing, regulatory and confidentiality issues.
- Criminal justice system.
- Funding, availability of transportation to services (OP)
- Funding, motivation from patients.
- Insurance does not pay for the program I was working in.
- Family members enabling behavior.
- Understanding that this is a chronic disease that warrants long term care and that long term care is more cost effective that relapse tx.
- Politics and greed. Too many individuals making lots of money on people suffering from the disease.
- Lack of funding for long term tx.
- Funding.
- Their family not supporting.
- the system inclusive of PCPC are not geared to criminal justice clients.
- In our county, low intervention/ motivation, mostly external brought on as stipulation of court order.

- After our clients 3rd rehab finish here, finish 3 months one halfway after then must go back to an IOP as part of their probation and I believe they would be better off in our individual AA sponsorships.
- Funding for family members to aid in education and gaining insight to be part of the recovery process.
- Proper length of stay, individuals who dictate tx with accepting the therapists request or places unnecessary demands to obtain funding.
- Paperwork and multiple different opinions/not one way works for each person/ lack of proper money for agencies and housing.
- Time available for service, too few staff, greater number of clients, not enough time with clients due to number of documentation requirements.
- Finding stable employment and dealing with boredom and stress in their lives.
- Lack of supportive housing after TX.
- Fear of giving up old familiar habits/ lifestyles
- Primary cost of TX
- Funding
- Transportation to programs, and funding
- Youth and not ready to make life changes. Toxic environments, people/places/things.
- Finding the money.
- Family just recently working with adolescents, they were in tx for say 30 days and then sent right back home into the same environment.
- Finding employment and affordable housing.
- So many issues that people have to overcome their stressors are so severe legal, homeless, trauma, lack of self worth, extent of pain. They suffer and have only known to cope by using, and often defense mechanisms. All these issues substance dependence, mental health, medical concerns. Most people in early recovery have such severe pain that education isn't grasped fully, or partially their minds are cloudy, can't concentrate. I believe PAW is a major interference T.GORSK, MODEL is the best.
- Managed care, patient refusal of residential tx.
- Funding problems
- Stigma within 12 step community mainly NA against Methadone TX
- Doing well is a consequence they need to view continued tx and support for continued progress.
- Insurance restrictions
- Waits to get into program non admittance to detox too short lengths of stay, poor follow up, lower level of care.
- Finances clients and family members often lack resources needed to afford tx.
- Client status wantonness or not with stages of change. Definitely funding and inexperience with lack of passion.
- lack of MH TX
- Medical coverage, housing,
- Recovery environment, insurance does not cover
- Funding for programs; insurance companies
- Funding and resources.
- Continuous support and housing.
- Withdrawal symptoms, opiate dependency
- In the rural area, transportation, isolation, shame in close knit communities.
- Not applicable in corrections.
- Funding - lack of.
- insurance restrictions
- facilities for adolescent care
- funding
- their own resistance, no leverage
- more opportunity for varied approach to treatment more holistic care
- partners use, housing lack of change

- occurring issues addiction interactions leading to relapse
- lack of resources for becoming stable - jobs housing ability to move out of area, education / job training
- due to low compensation clinicians do not have proper experience to treat clients
- Polysub abuse / Dep, poor coping skills and not taking advantage of the services that are offered
- Insurance companies
- the people I work with are no longer eligible for GA and so they relapse once transferred to shelters
- getting necessary sessions authorized and paperwork demands
- Funding and LOS
- peer pressure, stigma, support not always available on a personal level
- need to integrate MH and DA
- themselves
- improve screening assessment some not ready, misdiagnosis which leads to improper meds, over medication and no holistic approaches such as school, job placement, sober supports etc
- family environment, people going back to the same triggers no money no job and expecting the to change!
- MH needs that are
- inadequate capacity to manage severe MH issues
- lack of insurance benefits to cover what they need
- Insurance issues
- high paperwork demands we have that preclude members from being able to get the help they need
- the amount of paperwork in the field
- Medication Maintenance programs
- there are too many demands for paperwork, long hours without pay
- trying to meet out client needs in a limited amount of time
- funding
- cultural diversity and sensitivity
- the lack of understanding about the field by MH professionals
- people not enjoying recovery because they do not want to change the lifestyle
- structure to support long term recovery is spotty
- Insurance (of course) lack of places where kids can go who do not have insurance
- short length of stay due to insurance
- funding for the proper level of care to meet the needs of clients
- finances and the availability of services
- Ease of access having to switch programs between MH and DA instead of blending both
- unnecessary documentation and paperwork which exceeds the quality of care I can provide in order to meet deadlines
- funding
- clients seem more resistant to 12 step programs than ever before
- lack of available dollars for all levels of care
- funding - need managed care companies to understand the needs of the client beyond medical necessity
- lack of needed referrals due to managed care networks
- financing
- the staff are underpaid, not educated and lack proper training to handle the complex problems of our clients
- The jail and the courts do not make decisions that support treatment in most instances
- corporate priorities are paperwork so aftercare planning is often rushed and can be set up for failure
- the uninsured
- Insurance coverage and denials
- The lack of family centered treatment ie mother's not having their children or partners involved in the recovery process
- duration of TX and funding issues

- Insurance and themselves (the clients)
- need more ACT resources
- limited insurance benefits
- Their commitment to their recovery high relapse rates and low patience for recovery
- Private insurance impedes length of stay by denying continued stay authorizations
- poverty, legal system
- Insurance companies!!!
- Some insurance companies are reluctant to pay for recovery
- County funding restrictions on inpatient stays
- funding issues and no money for extended care or for family services
- Getting clients to engage in the recovery community and the lack of good recovery programs and social activities
- Insurance companies cutting off patients and recommending a lower level of care before the patient is ready
- The greatest barrier that interferes with helping people is first that insurance barriers to getting them in and then sustaining their length of stay with the insurance company
- client resistance, insurance companies providing inadequate
- Funding Insurance denials
- Family systems that are undertreated
- poor recovery
- Money
- Money
- There are not enough after care support options!!
- Adolescents returning to same environment
- Intake Apt are difficult to obtain within a month. Clients need to stay in treatment as long as possible as we would do for any other chronic medical condition.
- Insurance companies dictating length of stay or level of care. They are not clinical and do not understand level of care necessity
- When people are granted SSD they are required to go on Medicare and then they lose their funding
- Funding for appropriate treatment
- Age of clients. Adolescents in TX are primarily hindered by lack of frontal lobe development and investment in TX.
- Our rural location means that resources are limited IE Ancillary services, mtgs, other self help groups resources, Etc
- Stigma and funding
- the volume of paperwork
- Time - Time required to develop rapport - know clients needs, establish trust, so much documentation that needs to be done presses into the ability to even be with client money - more difficult to gain funding for needed services, cut backs in all areas. Criminal Justice clients have even less resources regarding Mental Health Services
- not enough desire for recovery to be willing to do the personal work needed ie change
- relapse issues - short term DA inpatient stays
- Lack of sober living situations
- limitations of insurances,
- Insurance. And lack thereof: programming which does not prepare the client for step down, lack of follow through of clients going through LOCs
- demands of paper work decreases time with client and effects attitude toward services
- funding issues as the pressure to secure and keep it interfere with time for actual tx.
- Clients enter into outpatient services who would have been in inpatient services ten years ago. Many are experiencing post-acute withdrawal symptoms and are in the same environment in which they were previously using. This is so difficult to overcome.

- Funding, funding, funding.
- Finances
- The funding is being cut and the length of stay is becoming shorter all the time. It seems that we're being pushed into proving outpatient services.
- lack of following up with program activities after discharge. failure to work the 12 steps
- More time is spent on paper work than is spent working to meet client's needs.
- I am a good Counselor/ Teacher and work in the field for 23 year their no barrier that I could overcome.
- Lack of resources for individuals with chronic mental illness who need a state hospital but have nowhere to go since their closures.
- Lack of counselors education in drug and alcohol addiction.
- I work with mandated clients. legal vs internalized change
- When we refer to treatment, clients insurance limitations or lack of
- paperwork with insurances
- funding to provide prevention, intervention & follow up care
- feelings and emotions
- Chronic relapse, psychosocial stressors/lack of family structure and/or supports.
- Forensic populations generally externally motivated for recovery.
- While PA has pushed to have professionals treated in co-occurring disorders, the reality is that it is not happening. Few D&A professionals I talk to really understand mental health issues and even the dual facilities fall short in this regard. Having a psychiatrist on staff does not make a dual facility.
- ignorance
- Unnecessary paperwork that has its origins in times too far back and the lack of ability to address dual and physical needs.
- Funding without a doubt, and the difficulty in obtaining it.
- money and ppl working in the field that or only money driven not recovery based
- Too much paperwork - not enough therapy.
- Being engaged in a continuum of care long enough for recovery to take hold.
- Not enough evidenced based outpatient services at the local level to keep our folks at home and into the community
- Paperwork
- Life and them not understanding just how important it is that their recovery has to come first or they won't have a good quality of life.
- Insurance Companies dictating length of stay.
- Fewer staff but greater client needs
- Funding
- Treatment stay being too short is the biggest barrier.
- Lack of funds
- Funding.
- the greatest barrier is they themselves, developing strong social support networks
- funding
- funding, schedules, leniency
- Too much paperwork. Too little time with clients.
- Lack of mental health treatment
- financial ability to continue treatment
- Inability to make significant and consistent life changes.
- The gray area between self-disclosure and sharing experience, strength, and hope.
- Childcare, transportation and level of funding available
- funding
- Mandated clients with no internal motivation.
- Funding
- I had worked in New Jersey and there was limited detox beds available.

- people, places, things, enablers
- Funding - Long-term recovery is difficult to obtain. Affordable long-term care is needed for patients with chronic relapse.
- The differences in services from county to county; there are usually certain criteria that the client does not meet. This generally occurs if the client relocates to another county (aftercare referrals).
- Lack of right level of care due to funding restrictions
- Attitudes and perceptions of some of the people who have been in the field for a long period of time and who are set in their ways of thinking
- administration
- stigma of addiction, -attitude that recovery is boring lifestyle, fear of response from family/friends. Response to question on am I in recovery: too black and white. Many of us have used, abused and stopped on our own. I live by the 12 step program but am not actually in recovery because by the grace of God I am not alcoholic/addict. there are many of us in this field that should not be overlooked just because we don't meet criteria for dependence and don't currently use anything by choice.
- Lack of Insurance Coverage
- Failed histories of past treatment experiences.
- Client's individual commitment to treatment
- The greatest barrier include limited time afforded them instead of adequate time for their services.
- Major barriers: grinding poverty, intermittent homelessness, unemployment, lack of adequate social service supports.
- resources...funding
- Not getting the level of services they need for the proper length of time. The organization in which I work has to restructure due to financial strains and therefore does not always meet the needs of clients. Our organization focuses primarily on the drug and alcohol aspect of treatment and fails to see clients as
- individuals and meet their individual needs.
- transportation to aftercare treatment.
- lack of rehabs and outpatient services in our area.
- The client themselves
- the clients willingness to change their lifestyle - people, places and things.
- Insurance coverage, continued stay reviews.
- Frustration with all the nonsense of family, AA, NA, treatment courts
- mostly funding sources and not having the right services for people, so they get stuck in services they don't belong in and take money away from the people who could benefit from those services. The whole field is falling apart and I'm not sure if people are invested in really helping people anymore.
- They don't want to give up the substance or behavior. They just don't want to suffer the consequences any more. They also don't want to feel their feelings.
- Clients have serious difficulty in making the appropriate life style changes
- other staff members at times
- money
- Individuals have lack of family services and lack of the duration of treatment.
- Most programs do not have long term care. I do not consider a 90 day program
- long term.
- The bureaucrats and licensing gurus who don’t know the first thing about working in the trenches
- besides the client's motivation to seek treatment, I would say two things, first insurances that try to dictate standard of care, and second lack of communication from agency to agency.
- returning back to the environment they came from with little to no support from their family
- lack of motivation by the client.
- Not surrendering to the disease of addictions and surrendering to life on life's terms.
- Senior clinical managers underestimate the skill required to treat addictions. They are also bent on disintegrating treatment for co-occurring disorders, à la 1970's. You buy them books, but they never read them.

- Lack of support for the middle working class...insurance with high deductibles is not the answer nor are homeless long term facilities
- insurances
- Insurance Companies dictating treatment
- For the people with whom I work, the greatest barrier remains the dynamics of the addiction itself. The second would be members of the family (parents) refusing to acknowledge the problems their children have. (I practice two blocks from a state university)
- insurance companies dictate length and level of care
- Not enough appropriate educated providers
- Welfare system is difficult and often it's slow process interferes with helping others
- support in community for jobs, transportation, child care
- Not having a healthy support network upon release from prison and not find good employment.
- Lag time between the release from Prison and appointments for treatment.
- Transportation and funding.
- Funding constraints
- their own commitment
- Adequate number of outpatient treatment slots and the copays are sometimes too high.
- Less time with clients and more time with paperwork.
- funding
- Funding is the greatest barrier. The funders dictate the length of time a resident can and does receive care.
- Housing. Housing. Housing
- funding
- taking any and everybody and not being able to help the ones that really want treatment.
- Funding
- insurance benefits
- managed care
- Continuum of care.
- time of treatment, referral
- we need more funded long term care for some clients
- Denials- Even though there is clear documentation that an individual is in need of services or a longer stay more often than not they are denied further services
- Resources-housing and the lack of support from fellow peers/co-workers.
- Usually funding, and at times the commitment from the client.
- Lack of adequate programming, continuity of care is not available.
- Although many of the people I deal with receive the proper amount of care, there are times that increased funding and time would be beneficial.
- funding
- Lack of case management services to help with Mental health needs and housing.
- funding and employment opportunities for felons
- Funding
- Denial.
- Being able to afford needed length of stay in in-patient treatment.
- Caseload requirements when doing group therapies, degree of paperwork.
- lack of community resources
- funding, difficulty with coordinating with MH system.
- Funding challenges and referrals who accept methadone patients
- paperwork takes precedence over case management services to the client
- Length of Stay, resistance to
- Their unwillingness to go and the finding.
- environmental factors: Penn State Univ.

- A lack of public understanding of the disease of addiction.
- Insurance
- There is the distinct possibility that those without MA will not be able to continue receiving services in a program after their initial BHSI approval period.
- spend less funding on administration and more on treatment.
- Funding and insurances
- Funding
- Mental Health issues and the type of drug that they are addicted to such as crack. Also if they have never been functional and have no foundation to go back to.
- none
- level of denial and childhood issues
- lacking engagement in recovering community
- Insights , education and coping skills learned while patients are in treatment often times do not translate to the patient's life at the next LOC. I believe that if a patient eliminates or diminishes maladaptive behaviors or addictive thinking they must replace it with something that is healthy. This requires coaching and ongoing support which is difficult to engage outside of a treatment setting. This really holds true for "chronic recidivist."
- Too much paperwork
- paperwork
- funding and the court systems at times.
- Insurance/managed care although much easier than in a residential level of care
- No one want to pay. I serve the dual population and they have the highest no show rate. It is hard to keep staff trained in this area to help.
- Lack of understanding of the needs of patients
- Regulatory requirements that far exceed what is necessary and reasonable.
- Decreasing lengths of inpatient stay and funder insistence that patients first "fail at a lower level of care" which has the effect of overloading IOPs with floundering and non-abstinent patients thus diminishing that LOC's effectiveness for the 'committed' and "stepped-down" population.
- insurance coverage
- internal obstacles- lack of motivation, etc.
- clients' levels of resistance to the recovery process
- Treatment being dictated by the insurance companies
- Housing, mental health access for medications and/or evaluations/treatment and childcare.
- ability to access services they need
- Cost of treatment. Private insurance co-pays are now averaging $35-50 per session. Having to pay $100-150 per week in copays is very difficult for most people, and limits access. That, combined with the difficulty in getting authorizations is the biggest challenge.
- The different needs that each person may bring into treatment. Some will have good supports and some do not. Financial stress plays a large part and we cannot do anything about that.
- client's are court ordered to service and are not invested in outpatient services. Must have insurance or have CYS/JPO pay for service.
- Having the client fully understand that recovery is a lifetime process/journey. Ongoing spiritual involvement. AA/ NA etc
- PCB. Their requirements of licensure according to a very rigid criteria that doesn't take into account experience that lies outside their jurisdiction.
- Insurance
- Lack of resources in the community
- INSURANCE
- A lack of understanding on the part of funders regarding the cataclysmic effects of addiction on families and in, particular, women with children. This is not a 1,2,3 punch and you are "cured" after 6 months residential. You are looking a 20 -25 years of family dysfunction; domestic violence; abuse; health care

issues; social issues; lack of a decent education and job marketability; single-parenting; etc. YET, be "cured" in 6 months. It's unethical and frustrating.

- I would say one of the greatest barriers is financial. It is increasingly hard to help people get linked to other services or coordinate care due to certain insurances not covering people or county residency being a barrier since we have clients from all over the state who come and relocate. With women I would say we run into the issue of finding well pay jobs and the lack of well paying jobs and affordable housing causes stress and often can lead our women to move back to unsafe environments non conducive to their recovery.
- community support, jobs, housing
- Lack of supports outside of treatment. For example, limited access to jobs or childcare; limited help for people w/ legal backgrounds; limited peer support beyond AA meetings.
- Rigidity of systems.
- I have been a counselor in medically assisted outpatient treatment (methadone maintenance) programs for the past 15 years and have faced many persons who have complained how counseling or therapy is not needed (usually after a 3-5 year period) since there is no change in their personal lives however believe should they reduce or detox daily medication, relapse is expected since treatment services are overlooked and all is needed is the medication. Also, there are many who believe that medically assisted treatment is provided for opiate dependency which keeps the door open to other addictive behaviors that
- have not been addressed in their opinion.
- Willingness to follow direction
- Funding Mar 25,
- increasing demands of funding sources
- funding source
- Lack of resources to help persons start over. Many go back to the same people, places, and things, which act as a trigger to use again.
- Client cooperation
- Securing medical assistance for medical and behavioral health services. The County Assistance office delays, pro-longs and drags their feet to process applications. You are not able to talk with a specific worker at DPA - they are now using a "Wal-Mart greeter service" that essentially reduces access to a
- worker to insure that their paperwork is processed. The workers have returned to their "I have 30-days to process an application". Obtaining medications for medical needs is often a barrier if not impossible.
- Short lengths of stay. I refer to one large private program and clients stay on
- average 2-3 months and here I am seeing much much better outcome.
- Consistent support after they leave my level of care
- motivation and transportation
- No longer work in the
- caps on treatment and lack of funding for recovery houses
- Loss of or inadequate insurance
- Insurance and willingness of client
- funding insurance family system issues
- Family Dynamics
- Archaic mentalities in administration compounded by lack of education and counselors/supervisors being grandfathered into positions that now require more education.
- the fact that they must go back to live in the same area that they were purchasing and doing drugs
- Funding-insurance companies refuse to pay more often these days-very sad
- Everyone seems to be the expert. I work with adolescents and at times they are tricked to coming to our program by being told that the stay will be shorter then what they believe it to be. This leaves are program with the backlash of trying to convince the kid that he or she needs to stay in the program longer. We also run into parents at times not following are recommendation. Also the program is a outdated we have a new age addict who needs new age techniques and services. We can no longer think that what worked 50 yrs ago will work today.

- Lack of support from my supervisor. Lack of rules and follow thru. Lack of structure. We often get clients that are not appropriate for our program but we have to take them. Some are resistant to treatment and are only here for a home plan or to appease a PO/C&Y or other agency.
- Lack of halfway or recovery houses in our rural area. People end up going back into their old environments and have great difficulty staying clean and sober.
- funding and transportation
- resources
- Too much documentation; not enough time to care for and treat the consumers we serve due to redundant and very time-consuming paperwork. Also, very low success rates and low internal motivation for the population have made me question the amount of time and money that is spent on these programs.
- lack of money to pay for the help that they need and a lack of qualified and appropriately paid professionals
- Paper work process.
- The greatest barrier is that there is minimal continuum of care provided from highest to lowest with the appropriate duration for those that have long term use Also, medication assisted is so freely given, even to those with lower end use.
- Case load sizes are too large. Can't effectively do case management with anyone when you are spread so thin.
- As previously stated, the shortening duration of residential treatment is creating a barrier as it requires the "watering down" of programmatic functions in order to fit within the time constraints that funding is willing to authorize.
- The salary compensation that we receive is not where near enough to justify the continued education and cost of repaying student loans, making it difficult to remain in this field.
- Lack of transitional housing post residential treatment - stable housing is key to long term recovery
- Lack of funding for needed levels of treatment
- FUNDING
- The greatest barrier is that current supervisors are not interested in the person center model and often prevents clients from getting what they need to maintain sobriety.
- Difficulty in obtaining short level of care that could be used as a "check in" when urges intensify.
- Funding
- Career planning
- I believe the longer you can keep a person engaged in treatment on some level, the better their chances of long term recovery.
- lack of housing options and minimum wage hourly rates when they are used to making more doing the un-ideal.
- Incarceration for infractions that require treatment Using our tax dollars for incarceration when the same yearly amount could be used for schooling, treatment, housing, training, etc.
- length of stay reviews often yield less time than is needed to do a thorough job in a TC setting
- Professional people with good hearts have been systematically dis-empowered to responsibilities of system improvement and advocacy.
- Housing ,health insurance, medication
- ongoing public stigma and insurance company and employer discrimination.
- funding & resources, especially housing
- They are not given ample amount of time in treatment to work on themselves, find work, an find suitable housing
- Lack of funding.
- politics
- obtaining and maintaining benefits, paying for medications without any funds.
- not enough internal motivation-not enough time to internalize concepts of recovery
- Time and resources.

- Length of stay over load of paper work
- Funding and timeliness of resources.
- the length of stay that is permitted for those in need of long term recovery.
- Employment
- trauma issues that thwart openness to tx.
- Shorter duration in treatment
- Finding suitable housing programs that fit their needs; Changes to welfare making it more difficult to sustain medical benefits and limits to cash benefits for single individuals; Legal barriers to finding employment
- Childcare, not enough support for women,
- The lack of adequately monitored/managed recovery housing.
- Easy and available treatment on a timely basis. Attitudes of people regulating the funds
- Funding
- Paperwork taking away from face to face time and financial barriers of the patient.
- Insurance companies including Medicaid.
- LENGTH OF TIME IN TREATMENT; REFERRAL SOURCES
- Not enough sober supports once they leave treatment. Getting involved in romantic relationships in the first year. Struggle delaying instant gratification.
- ability to get the right level of care
- Length of stay....To transition people from treatment to recovery becomes harder as lengths get shorter. with clients that lack of drug-free living skills, employment , housing conducive to recovery, and an bad economy, they need more than funders allow.
- Drug an ETOH is a family disease process. Finances are always an issue. Dad often leaves txment because he must support his family. Mom cannot get the type of services that she needs because of child care issues. We should have more of a family friendly option - families in 1/2 homes, outpatient programs
- which offer childcare while mom or dad attends therapy. We almost have treat em' and street em' paradigm. You cannot just give someone 3 days of detox for opiates - they remain dope sick and cannot process information. You need to have LONG term care in order to assist with the cognitions (stinkin thinkin), attitudes and behaviors. in detox people feel like crap for the moment and then they leave and still feel sick so they go and purchase dope - this sets them up for an OD.
- funding for the correct duration of time needed to truly support individualized treatment.
- Lack of case management services/support outside the provider's doors. Being asked to do more with less.....
- Continuum of care for out of county clients relocating, lack of ICM services, wait time for services
- Not enough community support services to meet their needs.
- long term support systems outside of 6-12 weeks; care is not recovery oriented it is responsive only after a relapse or arrest has occurred
- funding and ease of accessing long term support