"Outcomes research" refers to research, usually medically-related, which investigates the outcomes of health care practices. It has been defined as the study of the end results of health services that take patients' experiences, preferences, and values into account, and is intended to provide scientific evidence relating to decisions made by all who participate in health care (Clancy & Eisenberg, 1998). The term "outcomes" describes many methodologies that include various research designs. The recognition that clients with similar diagnoses may be treated in many different ways underscores the need for clinicians to have best practice standards to inform their decisions.

In medically-related fields, outcomes have been the vehicle that informs practice while in addiction treatment outcomes have taken on many different meanings for clinicians. Addiction treatment providers must be educated concerning the relationship of outcome measures to practice and methods of incorporating theoretical approaches to treatment supported by credible data.

**The Tiers**

Treatment in the addiction field may be represented by a pyramid. At the bottom of the pyramid, Tier 4, one finds the majority of treatment programs providing care driven by constructs and belief systems supported by selected data, history and intuition. Tier 3 represents models supported by Substance Abuse and Mental Health Services Administration (SAMHSA), like evidence-based models, and Tier 2 is represented by care coordinated treatment where an advocacy relationship drives care. Treatment at the peak of the pyramid, Tier 1, is informed by research—both theory and practice come together to meet client needs (see figure 1).

Tier 4 represents a myriad of theoretical silos offering inpatient and outpatient treatment or a combination of both. Although there is some common language driven by the DSM-IV and the Alcoholics Anonymous (AA) fellowship, treatment may be dogmatic and based on intuition and minimal science. Volumes of information, often referred to as a biopsychosocial assessment, are often collected that fall into a deep dark hole never to be seen again. As an example, many of these programs have been completing the Addiction Severity Index (ASI) as part of their assessment procedure for more than twenty years. Nora D. Volkow's testimony to Congress implies that the ASI has contributed significantly in the development of best practices in treatment: "One well-known instrument is the Addiction Severity Index (ASI). The ASI, which has been developed and refined through NIH and Veterans Administration support over the past twenty years, is the most widely used and validated addiction assessment instrument in the world today. It provides the trained counselor with the tools he or she needs to conduct a structured forty-five to sixty minute interview that has been shown over the years to provide valuable information that not only captures critical baseline data, but sets the stage for improved treatment outcomes" (2004). The challenge is less with the instrument and more with the volumes of data that does not reach clinical practice. One would be hard pressed to find credible studies that clearly demonstrate ASI variables that predict outcomes. There is much less evidence that ASI data actually informs treatment.

In many treatment programs, assessments may take days and are almost
OUTCOMES REVISITED

always repeated as clients move from one program to another. Treatment is often routinized as clients learn to dance to the therapeutic music of the day. Tier 4 treatment may be episodic and acute. There is a strong belief that treatment causes change, and data is often collected and presented in a way that seems to demonstrate the same. As Alan E. Kazdin suggests, "demonstrating a causal relation does not necessarily provide the construct to explain why the relation was obtained. The treatment may have caused the change, but we do not know whether the change can be attributed to specific or conceptually hypothesized components of treatment (e.g., cognitive restructuring, habituation, stress reduction, mobilization of hope) and how the change came about" (2008).

Add to this reimbursement systems that promote stagnation and lack of accountability and the client becomes doubly victimized. The legacy gained from early Synanon-like therapeutic communities and AA-based Minnesota Models that at one time were a stepping stone to developing treatment systems have now in many cases become an anchor mired in dogma and politics (McElrath, 1987; Yablonsky, 1965).

Tier 3, the evidence-based models, may be arguably a significant step above care based on intuition and dogma. At the same time, questions of generalizability and lack of individualized attention to care plague this approach. Nevertheless, it may be of comfort to know that your surgeon is at least using procedures that have worked in another location that have withstood a level of scientific investigation. Conversely, one might assert that the reliance on evidence-based models actually widens the gap between research and treatment by championing models as opposed to advocating for client-driven care and ongoing outcomes research. These approaches, rather than result in best practice guidelines for treatment, run the risk of producing competing models. As Norman G. Hoffmann suggests, "Evidence-based treatments utilize a treatment model documented to be effective in controlled clinical research with no guarantee that it will work in clinical practice" (2012). Evidence-based models have been defined by the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Registry of Evidence-based Programs and Practices (NREPP) as interventions that meet a specific review process established by SAMHSA: "To have an intervention listed in NREPP, the intervention’s developer submits required information about the intervention for expert review. Experts then rate the intervention on the quality of research supporting specific intervention outcomes, and on the availability of implementation resources to translate the scientific findings into routine practice. All NREPP reviewers are recruited, selected, and approved by SAMHSA based on their experience and areas of expertise" (Substance Abuse and Mental Health Services Administration, 2007).

In addition, some treatment programs assert that they practice evidence-based treatment based on the inclusion of psychological theory and practice that has undergone scientific scrutiny. Often the inclusion of these therapies in the program has little relationship to outcomes or the overall treatment modality. Cognitive Behavioral Therapy (CBT), for example, is a very popular clinical practice in treatment programs. Since evidence is available that supports the use of this therapy for several disorders, some programs then take the quantum leap of asserting that they are a program that is evidence-based.

Tier 2, which is based on client advocacy and care management (also called care coordination), has strong theoretical underpinnings. The belief that advocating for a client across the care continuum will produce better outcomes represents a significant step forward. The theory is that if a client’s care plan is revised as needs change, clients will experience the treatment that matches their challenges. The slippery slope is that more often than not the care coordinator or client advocate is dipping into Tier 3 (evidence-based models) and Tier 4 (intuition-based) rather than reaching to Tier 1 (research-based) resources to provide treatment. The ASAM criteria has taken the field a giant step forward while at the same time has hit a glass ceiling based on the reliance on levels of care which is seen by some as tasting silos rather than a continuum of care. This is another very strong theoretical construct that may lose significance in practice. The ASAM criteria has provided the field with a clear direction for moving forward and care must be given to assure that treatment providers are well schooled in the use of the criteria (American Society of Addiction Medicine, 2001). NCADD New Jersey is one of the

Figure 1 - The Tiers
few care coordination agencies that have successfully slipped their sword into the chink in the treatment community’s armor. The foresight of Terry O’Connor, then Assistant Commissioner for the Division of Addiction Services of New Jersey, and the management of Wayne Wirta, Director and CEO of NCADD of New Jersey, supported initially by C4 Recovery Solutions, has created a system of care coordination that should serve as a compass for the field. Once Tier 1 research is added to this system true client advocacy and client-driven care can emerge. Care coordination may become the bridge that brings together research and practice. C4 Recovery Solutions has helped develop similar pilot projects around the world based on client advocacy, care coordination, and community empowerment.

Tier 1 is treatment based on research that informs the clinician in providing client-driven care, truly the holy grail of treatment. There has been no lack of scholarly research emanating from prestigious universities such as Rutgers, Brown, and Yale. As early as 1980, Dr. Norman Hoffmann developed the Comprehensive Assessment and Treatment Outcome Research (CATOR), the aggregate databases totaling over seventy-five thousand adults and eleven thousand adolescents.

The challenge has been in bridging the gap between research and practice. Scott Miller, for example, has successfully bridged the gap between theory and practice by presenting data that has strong implications for informing practice and is measurable. This is a beginning and a model that offers a glimmer of light at the end of the tunnel. Hopefully this type of research will lead to a system that promotes other research-based practices and does not become another broad brush to treat all clients.

Tier 1 treatment programs provide services that are outcome-based both on the program and client levels. These programs are represented by a professional staff that is able to provide individualized care supported by the client’s clinical presentation. Data is mined to develop best practice guidelines and client driven care. The ability to combine client presentation, aggregate program data and research in developing care plans is rarely seen in the addictions treatment community.

**Challenges**

There are many challenges facing the collection and utilization of outcomes in real time practice for addiction treatment. Some are:

- **Lack of a common language and definitions of outcomes.**

As an example, what is often called outcomes by some may in reality be self-promotion and marketing. It is interesting that research firms have emerged in this perceived marketplace and give the appearance of nonbiased independent study when often they are paid consultants of the treatment programs. Treatment programs eager to prove that they are doing a better job than everyone else employ agencies to present data to demonstrate the same. Rather than using data to evolve practice, some choose to bask in the perceived glory of success that this data advertises. Few programs are open to scholarly investigation and even those that are limit publication and, in many cases, identification of the program.

- **Failure to bridge the gap between scholarly research based on outcomes and treatment.**

There is no lack of quality research in the addictions field. Many dissertations and millions of dollars in SAMHSA, NIH, and NIDA grants have gone into funding scholarly research. Universities provide the field with an overwhelming plethora of valuable data. The challenge is bridging the gap between data and practice. It should not be surprising that the first road block does not exist in universities, but rather in treatment programs. So many programs collect tons of data only using the very small portion that supports their identified model and justifies their approach to treatment. Unlike teaching hospitals in the medical field, where real-time research drives practice, the addictions field has no such mechanism and even large medical institutions that house addiction treatment programs default to these models rather than research.

- **Reimbursement systems often have little relationship to outcomes.**

One might ask, why is it that reimbursement for drug addiction treatment has little to do with outcomes? The answer is multifaceted. First is the belief by many payers that treatment just does not work. Consequently, they want to limit the amount paid for treatment. The lack of recognition that addiction is a chronic illness leads some payers to reimburse for episodes of care rather than make long term commitments to patients such as in diabetes care. Others labor under unfounded beliefs such as “more is always better,” or “something is better than nothing,” and are therefore willing to pay to keep beds filled rather than focus on outcomes. More likely most payers are caught in the sociopolitical trap of feeling pressure to pay for treatment without the benefit of data that clearly support treatment choices. This is one area that is class-blind as treatment for the wealthy is often not based on better data than treatment for the poor, the major difference being designer treatment surrounded by tennis courts and swimming pools.

- **Credentials that are not based on research support the proliferation of an ideology that is frozen in time.**

This can best be seen by examining certifications and credentials which have little do with quality treatment while attesting to individual expertise and authority. While one can hardly assure the public that a credential will represent a level of quality of care, it should assure that the recipient has the knowledge...
represented by the best practice data. The same dogma that has become an anchor in the treatment community (Tier 4 intuition-driven care) is reflected by credentialing that supports these models. Both private and government issued credentials that attest to reflecting ones comprehension of a system often have limited basis in science.

- **The lack of universal assessment and referral procedures leads to much confusion in the field.**

In the United States, where treatment dollars are divorced from data, millions of dollars are spent on providing care often to the wrong people in the wrong settings. Andrea Barthwell, MD, reminds the field that treatment availability would be greatly increased if we were able to find the best treatment for the client as they present. People reach treatment often because of politics, geography, and lack of credible assessments rather than their clinical needs. The ASAM criteria have been a step forward in providing the underpinnings of a universal assessment instrument guided by David Mee-Lee, MD, and Gerald Shulman, MA. C4 Recovery Solutions, with the Guidance of Norman Hoffman and Walter Hillabrant to name a few, have developed universal assessment criteria that has yielded significant results (American Society of Addiction Medicine, 2001). The challenge is to encourage payers and treatment programs to adopt universal standards.

- **A greater focus is needed on recovery rather than pathology.**

Some spend more time in the identification of pathology rather than engaging clients in a path to recovery. Although it is necessary to sort out dependence from abuse in developing care plans, it may be counterproductive to search for other diagnostic labels at the beginning of client care. The focus on strength and developing resources may be more important than defining a client as depressed or borderline at the engagement level. Since the illness is chronic, it is likely that the client will move through several stages and diagnostic criteria. Overpathologizing may cause a clinician to become myopic in developing pathways to recovery, and subsequently utilize paradigms that force-fit clients into treatment systems. This may be seen in the current trend of diagnostic inflation supported by the DSM-V and the increased use of prescribed drugs in the treatment of addictions.

**Conclusion**

The victims are the clients. The phrase that “something is better than nothing” is a serious trap for desperate family members trying to find treatment for their loved ones. Often the wrong treatment can produce serious negative outcomes. In addition, uninfomed professionals in the medical and counseling field add fuel to what may become a spiral consisting of multiple failures, often leading to dire consequences.

Outcomes research focuses on the client's treatment process. When outcome data supports treatment and provides the evidence needed by clinicians to make informed decisions, everyone benefits. There must be an ongoing effort to utilize data to bridge the gap between outcomes research and practice.

Breaking down the silos first among providers of care, and next among researchers is a monumental task. Patrick J. Kennedy in One Mind For Research has taken a giant step forward in breaking down silos in the brain-bio realm. This is a brave new effort that should serve as a pathway for the rest of the treatment community.

**References**


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