



**Chestnut Health Systems**  
Lighthouse Training Institute

## **The Ethics of Competition \***

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# The Ethics of Competition

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## *I. Introduction*

It is a privilege and a pleasure to be here this morning. My research and consulting activities have been bringing me to Minnesota since 1978. The fact that the people and programs of this state have been instrumental to the development of my most seminal work always adds a special pressure when I come to speak here--a pressure born from the desire to repay a special gift. I was very excited when I received an invitation more than 18 months ago to speak on the subject of the ethics of competition in the CD field at last year's fall conference and I was quite disappointed when health problems prevented me from making that address. But as I was flying here last night I was struck by how different the address I will present today is from the one I would have presented just 12 months ago. Words I would have spoken tentatively last year I will speak with more boldness today. Last year I wanted to sound a warning of what could happen; today I wish to discuss what has happened and is happening.

I am speaking to you at a critical juncture in our history--a time that many are characterizing as crisis. We have entered a period in which a growing number of persons and organizations are suggesting that the treatment field itself may need treatment. And yet this crisis follows two decades of unfathomable success in our field. Who could have predicted 20 years ago that explosive growth within the field would bring hundreds of thousands of untreated clients and families into the recovery process? Who could have predicted president's wives on television talking openly about their addiction and recovery? Who could have predicted how far we would come in placing early intervention programs in our schools and work places? Who could have predicted the force and spread of the COA movement? Who could have predicted how far we could come in stigmatizing driving while intoxicated? Who would have predicted just a few years ago that we would go through a period where people proclaimed their

alcoholism publicly with great boldness but hesitated shamefully to admit that they smoked cigarettes? Who could have predicted that our prevention efforts would see a decrease in the number of illicit drug consumers in the United States? We have brought doctors and nurses and scientists and others back into what is now a legitimate component of our culture's health care system. What crisis could threaten such unprecedented success?

The crisis of which I will speak comes out of our success. It has come out of our growth. It comes out of the industrialization of the CD field. Signs of this crisis can be seen in many quarters. Following a period of explosive expansion, we are seeing programs close in unprecedented numbers. Occupancy rates are dropping in many CD programs/modalities across the country. The public as a whole and referral resources are looking at CD programs with a more critical eye. Talk of "treatment rip-offs" among active users fuels continued use and poses an obstacle to seeking services. Staff with history in the field grieve a loss of focus and loss of passion in the business; newcomers are overwhelmed by the sheer volume of paper. Morale has suffered during this decade of rapid change. Annual turnover of frontline workers in some portions of the U.S. has reached 40%. Much of the field seems to have lost control over its own destiny--reactors to market and regulatory forces. There is a growing sense that the forces shaping our identity and character are coming from outside rather than within the field. The integrity of the field is being increasingly challenged because of the abuses of some and the silence of many. We are experiencing an identity crisis now that will likely dictate the nature of the field for many years to come. While the crisis will be seen by many as a crisis of dollars, I would like to suggest that it is primarily a crisis of values and ethics.

Let me share a brief story that can perhaps serve as a metaphor of this crisis. You can tell a lot about a field by its storytelling. This is one of the most popular stories on the CD lecture circuit during the past year. It seems that two neophyte hunters had gone to the north country to hunt bear. Neither of them had hunted anything before, let alone bear. On the afternoon of their second day hunting, they were becoming quite tired from a prolonged trek up a mountain trail. Rounding a sharp bend, the two

hunters suddenly found themselves staring into the face of a bear whose size, close proximity and sudden ill-temper caught them so off guard that they dropped their guns and began tearing down the mountain trail for their very lives. Their terror was intensified by the sounds of breaking branches coming from behind them. Suddenly as if inspired one hunter threw himself on the ground, tore off his boots, reached frantically into his back pack and began tying on his tennis shoes. His standing partner screamed at him in disbelief: "Those shoes aren't going to help you outrun the bear!" Jumping from the ground into full stride, the tennis-shoed hunter shouted back, "I don't have to outrun the bear; I just have to outrun you!"

There are a lot of us in the CD field who have felt the breath of the bear and reached for our tennis shoes during the last decade. I believe there is nothing inherently unethical about competition. There are many areas within which the field has benefitted from increased competition of the past decade. This escalating competition within the field has, however, pushed many programs into practices that create ethical vulnerability. In the next hour I'm going to explore with you some of these areas of collective vulnerability and propose some broad strategies and directions to address ethical issues in our clinical and business practices.

The perspective I wish to speak from today is not that of the ethicist, but that of a clinician, manager and organizational consultant whose tenure in the CD field spans more than two decades. The perspective is based on assisting individual workers and programs respond to the growing number and complexity of ethical issues within our field. The areas of ethical vulnerability which I will review are those which are systemic across the country rather than those which are idiosyncratic to program or locality. Addressing the ethical vulnerability of the field is picking up momentum across the country in spite of the fact that these can be very painful issues to explore and resolve. There must be certain risks associated with raising such issues; I have noticed conference organizers always bring someone from out of state in to conduct this ethical inventory.

## ***II. Ethics in the Chemical Dependency Field***

There are a number of factors that make addressing ethical issues in the CD field qualitatively different than in sister professions.

- History:** The short history of the field as it exists today has not provided a well developed and well transmitted body of ethical values or models of ethical problem solving. We have no single set of codified standards that defines the boundaries of ethical and unethical conduct. We have no single casebook of ethics or model of ethical decision-making that spans geographical and modality boundaries. Our technology for articulating and transmitting ethical values is under-developed.
- Growth:** The rapid growth and industrialization of the field moved so quickly that standards related to the ethical conduct of our business practices have not yet evolved. The rapid growth has diluted the ability to transmit those historically shared values and ethics. We have operated historically as a guild system, with new members taught skills and values through mentor relationships. The explosive growth of the field led to a scarcity of mentors that overwhelmed this system.
- Diversity:** The enormous diversity of personal and professional backgrounds of persons within the field brings multiple perspectives on ethical questions. There is a richness and a depth to this diversity—an untapped resource—but there has been no process within the field to synthesize from this diversity shared values and standards that are of sufficient specificity to guide professional decision-making.
- Turnover:** The overall turbulence of the field is reflected in the instability of the workforce. High annual staff turnover regularly bleeds out our oral history making it very difficult to transmit core values to new generations of workers and managers.

These conditions have intensified our vulnerability to breaches in ethical and professional conduct. Our history of addressing ethical issues is not a notable one. What work we have done has focused primarily on the counselor role and has not been fully extending to all roles within the CD agency or to the agency as a whole.

We seem to have been afraid of dealing with ethical issues head-on. Ethical issues fester in the denial of silence until they detonate into humiliating exposes of our personal and institutional shortcomings. Those of us on the sidelines of these explosions react with self-righteous indignation seeing ourselves and our institutions as immune from such a fall. And yet the explosions continue, setting up the climate through which outside institutions paternalistically promulgate regulations to legislate our moral and professional conduct. The time for self-inventory is now. Now is the time to expose ourselves to the harsh light of reality and to identify and address our areas of ethical vulnerability.

### ***III. A Collective Inventory***

There are at least five broad areas within which the forces of competition have influenced our ethical vulnerability. These are areas of self-inventory being examined by CD programs across the country. Some represent areas under which we are already under attack from persons and institutions external to the CD treatment field. Some represent practices which have led to the restructuring of reimbursement for CD services, e.g., restrictions on coverage, pre-admission approvals, external utilization review, preferred provider arrangements, and managed care systems. The five areas include:

1. Planning and initiation of CD services,
2. Marketing of CD services,
3. Costing and billing of CD services,
4. CD assessment and treatment practices, and
5. Professional peer/agency relationships in the CD field.

My goal in this review is not to shame or demean persons or programs, but to stimulate a process of self-inventory that can protect and nurture our future. My goal is to elevate values and ethics to the same level of consideration as financial survival and to suggest that our values and ethics may well determine this survival.

#### ***IV. The Ethics of Planning***

We have seen across the United States a disregard or manipulation of planning bodies to oversaturate an area with substance abuse service providers. We have seen the initiation of services, not in response to unmet need, but to capture a portion of market share (profits) from an existing program. The long range needs for a coordinated continuum of care are sacrificed for short term profits. The number of institutions providing CD services with no roots in the field and only superficial commitments to the long range development of the field have increased. This veneer-thin commitment to the treatment of alcoholics and addicts is cast aside the minute more profitable services are discovered leaving in their wake severely weakened or closed agencies with a long historical commitment to this mission.

There is an emerging profile of the profiteers who spring up to drain our resources and then disappear in search of more profitable pastures. The characteristics often seen within this profile include:

- Weak ties to the local community.
- Skeleton staffing patterns.
- Excessive rates for services.
- Aggressive marketing via print and visual media.
- Extended lengths of stay (referred to internally as "maximizing the value of the admission").
- Treatment by "recipe."
- Propensity to frequently recycle chronically relapsing clients.

- Superficial links to local self-help groups.
- Propensity to abandon clients/community when profit levels fall below acceptable levels.

One can speak of "institutional predators" and "profiteers" in 1990, but the story I wish to unfold for you is not a story of good guys and bad guys. It would be easy to launch into Biblical rhetoric demanding that we drive the moneychangers out of the temples and reclaim our field--for the good guys. But such rhetoric is much too simplistic. The ethical issues catalogued here represent a much more pervasive problem than the practices of our most unconscionable and exploitive members. Much of our ethical vulnerability springs not from the blatant abuses of the few but the moral drift of the mainstream. I am not suggesting unethical decision-making by the mainstream as much as suggesting that the mainstream is making decisions without an awareness that they are even in ethical terrain. If we expelled the bad guys, there would still be a lot of good guys who have drifted into uncharted ethical terrain.

The pressure of competition can alter and contaminate the way we make decisions whether they be planning decisions or clinical decisions. We need to define ethical standards that should govern the process of planning, initiating and terminating CD services.

#### ***V. The Ethics of Marketing***

It has become fashionable this last decade to posit that CD agencies must become businesses, that we must apply business technologies in planning, marketing, public relations, financial management, personnel management, and service operations. Many have said this is the only way to save the field. I would suggest that the danger lies in saving the field but losing touch with our historical mission.

The competition of the last decade has spawned the aggressive application of marketing technology within the CD field. These programs are most often designed, implemented and evaluated without the input of direct service staff. The only criteria



for appropriateness and effectiveness is whether they fill beds. The marketing campaigns--marketing wars, in some communities--have pushed some programs to the brink of bad taste and unethical conduct. There are growing concerns about a number of marketing practices through which CD programs promote themselves through radio, television and print medias. These practices include:

- The misrepresentation of the scope, intensity or quality of services.
- Targeting of expanded client base through superficial specialization, e.g. women, adolescents, cocaine, dually diagnosed, etc.

*A traditional inpatient alcoholism unit, facing pressure from a deteriorating daily census, launches a media campaign announcing their new "specialized cocaine treatment track." Upon close examination, one would find only superficial changes in the program--a daily exercise period was added to the program schedule, a small amount of cocaine literature was purchased for patient education, etc. The medical and clinical protocol of this program has not been re-examined in light of the needs of the newly targeted clients nor have staff knowledge and skills been enhanced to address cocaine-specific treatment issues. The "success" of the new cocaine track will be measured in admissions and patient days of billable services, not in the impact of this program on the lives of these new clients.*

- Exaggerated and unsubstantiated claims of program success, conveying public perception that recovery is easy.

*Some of the inebriate asylums on the late 1800s proclaimed success rates of 95% based on the fact that only 5% of their clients returned for additional treatment; the assumption was "no news is good news." Some of our modern programs are claiming success rates of similar proportions using evaluation procedures about as sophisticated as the inebriate asylums of yesteryear.*

- Exploitive adds that seek to manipulate the shame and guilt of family members.

*The 30 second television spot for the newly opened substance abuse unit in a local hospital opens with a physician proclaiming that alcoholics and addicts are blinded by a disease of denial that makes it nearly impossible for them to initiate their recovery spontaneously. It is the family, the physician exhorts, not the alcoholic, that must initiate the change process. It is the family's responsibility! Panning through scenes of wrecked cars, then moving into a scene of a graveyard and finally a focused shot of an unnamed gravestone, the commercial ends with the words, "If you don't call us today, you may have no reason to tomorrow." Is this an effective tool to penetrate family denial or is it exploitive sensationalism? Is this good advertising or poor taste? Do such aggressive media campaigns unduly exploit and manipulate family guilt and emotional pain? What standards of ethics and taste should govern the design of marketing programs?*

- Aggressive adds that reflect poor taste and tarnish the professional image of the field.

*We have seen an aggressiveness in the marketing of CD programs that in my home town we usually reserve for the promotion of cars, carpet, replacement windows, and exotic kitchen gadgets. Are we on the verge of blue light specials, rebates, 2 for 1 sales, seasonal discounts?*

- Exploitive use of clients in program promotion.

*A growing number of programs are questioning the historical use of active clients to conduct facility tours and to participate in community/school speaking engagements (sometimes referred to internally as "dog and pony shows").*

- Misuse of information/entertainment forums for marketing purposes.

*How many times have you seen someone interviewed for their substance*

*abuse expertise exploit this opportunity to promote the special interests of their program?*

We need to define standards or principles that can guide the presentation of ourselves to the public.

#### **VI. *The Ethics of Service Costing and Billing***

There is increased ethical scrutiny of service costing and billing practices within the CD field. Areas in which we seem to be most vulnerable to attack include the following.

- Misrepresentation of costs or hidden costs, e.g., inflation of overhead to support other units of a hospital, "free assessments", "free aftercare", etc.
- Failure to provide comparative costs as part of the informed consent process.
- Fee-splitting--sharing portion of client fees to referral sources by agreement or coercion--creating conflicts of interest in contamination of objectivity in the referral process.
- Double billing--billing two or more parties for the same services.
- Setting service fees high with routine writing off of client copayment (accepting insurance portion as full payment) opening ourselves to charges of deception and fraud.
- Abandonment of client when insurance benefits or personal resources are exhausted.
- Violation of confidentiality via use of collection agencies without informed consent of client.

#### **VII. *The Impact of Competition on Assessment and Treatment Services***

The intensity of competition within the field and our growing preoccupation with occupancy rates, program income, bad debt write-offs, etc., can spill into the clinical

decision-making process. Major shifts in the structure of CD service reimbursement have grown out of abuses in this area. Areas of ethical vulnerability in this area include the following.

- **Providing free EAP/SAP services as a case-finding mechanism.**  
*Such practices violate the objectivity of the assessment and referral process through conflicts of interests that range from the subtle to the blatant.*
- **Conducting client screening as a recruitment (sales) process rather than an assessment process.**  
*Principle: Client pathology is in direct proportion to family resources; the greater the resources, the greater the pathology.*
- **Manipulation of diagnosis according to payor source; preference for "billable diagnoses."**  
*The current shift from CD diagnoses to psychiatric diagnoses--to escape limitations on reimbursement for CD services--offers a classic example of such manipulation.*
- **Placement of clients in treatment (particularly adolescents) without clinical data to justify a CD diagnosis.**  
*There is growing concern about "the ethics of diagnosis"--the labeling of both children and adults with a CD diagnosis without appropriate clinical justification and for the financial gain of the practitioner or the institution.*
- **Modality bias--admitting clients needing more or less restrictiveness.**  
*There is a well-documented tendency for programs to assess clients as appropriate for whichever modality they provide, e.g., residential programs consistently assess persons as needing residential services. The lack of independent judgement regarding modality placement and the bias toward more restrictive levels of care have tarnished the professionalism of the field.*

- **Misuse of treatment settings for purposes other than active treatment.**  
*There is a danger, for example, that locked units and long term treatment settings could become surrogate jails used as respite for families or as quarantine units (AIDS), losing their active treatment focus.*
- **Misdiagnosing and misplacing clients in treatment for financial gain raises risk of ineffective treatment and iatrogenic effects of treatment.**  
*Chronically relapsing clients, for example, may be recycled through precisely the same treatment structure and sequence of treatment activities that have failed repeatedly—until the client's financial resources are drained. We say, in essence, "you must go through this same program again because you didn't get it right the last time." Such shame-based treatment systems misapply treatment technology then blame the client for failure—leaving the clients original problem intact and adding iatrogenic effects of treatment failure: increased passivity, helplessness, hopelessness, and dependence.*
- **Making length of stay decisions based on insurance benefits rather than the clinical needs of the client.**

Our concern here is the integrity of the assessment and treatment process. This is true whether we have a system that financially profits from placing and keeping clients in treatment or an alternative system that profits by keeping clients out of treatment. Both systems can exclude the needs of the client and the voice of the client from the clinical decision-making process.

### ***VIII. Professional Peer Agency Relationships***

Our response to escalating competition has often been isolation and grandiosity. Competition has fueled professional arrogance. It forces us into self-aggrandizing statements when we should be asking questions. It forces us to close in when we

should be reaching out. It prevents us from seeing ourselves as part of a broader treatment community--part of a growing culture of recovery in the United States. Amid such isolation and animus have come such practices as gossip-mongering--the spreading of unsubstantiated rumors that detract from one's competitors--raids on the staff of one's competitors, and the open solicitation of clients already in treatment within other agencies.

#### ***IX. Where do We go from Here?***

I think there are three broad directions we need to go to contain our growing vulnerability. These directions include 1) developing internal standards of ethical conduct, 2) developing mechanisms of internal discipline and 3) refocusing our vision and our values.

#### ***X. Internal Standards Development***

There is a desperate need for us to come together to develop our own standards of professional practice. We are letting external agents define who we are, what we do, when we do it, to whom and for how long. We need to look internally rather than externally. We need client and community centered values and standards that decrease the need for our regulation by external agents. In the 1940's AA went through a turbulent period shaping the traditions that would govern its organizational life. Those traditions were heavily shaped by the belief that money, power, politics and property could destroy AA by diverting its attention from its primary mission--carrying the message of hope to still suffering alcoholics. Fifty years later, we may be learning the same lesson. In the same way that the traditions have governed the group life of 12 step programs, we need to develop codes of professional practice that govern the life of our organizations--both our clinical practices and our business practices. We must stop reacting and complying and shape our own identity and destiny.

I believe this standards development can occur at multiple levels. It can spring from professional organizations seeking to identify standards of ethical and professional conduct. It can spring from local service agencies who through the development of an agency code of professional practice seek to define the values and standards that will govern day-to-day business and clinical practices within their organizations. It can come also from persons sharing specialty roles whose functions fall outside the parameters of existing standards development. At all levels we need to define and say: These are the limits beyond which we will not be moved; these are the core values which will not be compromised.

### ***XI. Mechanisms of Internal Discipline***

We need to challenge programs and people who care more about profits than people, who care more about occupancy than recovery, and who are more concerned with private and institutional wealth than with public welfare. We need to explore mechanisms through which we can discipline ourselves so that the fate of the field is not shaped by the abuses of the few. We need to find forums from which to confront breaches in ethical conduct so that the fate of the field will not be shaped by the silence with which we have historically confronted our shortcomings.

### ***XII. Refocusing***

I think one of the most positive developments in the field is the growing number of programs, overwhelmed by rapid changes, who are taking an opportunity to step back and get themselves recentered and refocused. Whether in retreats or in staff meetings, this self-examination process is occurring across the country. Programs are re-examining their historical mission, refining or changing this mission when necessary, and providing for rituals of recommitment. Whether programs approach from a planning framework or a problem-solving (e.g., stress, team-functioning), they are collectively beginning to get back to fundamental issues of defining organizational values and organizational culture. Some of the major themes emerging from this self-examination process include the following.

- A. Vision and values - Many programs have observed the push from external forces to shift from a people-changing to a people-processing focus. In the former, responsiveness to client need--facilitating change in the client's quality of life--is the highest institutional value. With the latter, the highest value is procedural efficiency with the focus on process rather than outcome. How many times has a counselor confronted with overwhelming paperwork thought: "If I could just get rid of all these clients wanting to come in and tell me their problems, I could get my work done!?" Many of us have drifted into people-processing. We must redefine why we exist and recommit ourselves to those service values.**
- B. Defining Success - A growing number of programs are beginning to define success not in terms of profit but in terms of service accessibility, service affordability, responsiveness to client need. They are refocusing on the mission of service. They want communities and families to feel the agency has served them, not used them.**

The values that drive our business practices must be congruent with the values that drive our clinical practices. If not, there will be a war within the institutional identity that can compromise both service quality and financial viability.

- C. Stewardship of Resources - A growing number of programs are assessing their overall management of resources in light of their revisited mission and their newly clarified organizational values.**
- D. Networking - A growing number of programs are intensifying their relationships with other health and human service agencies and exploring innovative multi-agency, multi-disciplinary models of serving multiple problem client/families.**



- E. **Creativity** - There is a desperate need for creativity. Our obsession with regulatory compliance and financial survival or growth has numbed our imaginations and our ability to perceive and respond in original ways. A growing number of programs are exploring how to revive creativity as an organizational value.
  
- F. **Spirituality** - There is a spiritual component of this revitalization movement. Spirituality is being approached not as some ephemeral and mystical concept. It simply suggests that there are values and accountabilities that transcend personal and institutional self-interest. It is a concept that can temper our institutional appetite for power and profit. To cultivate spirituality within an organization is a recognition that there are external resources and relationships that can empower the organization. It is the experience of internal congruity and external connectedness. It is the experience of an ethically united professional community, full membership in the culture of recovery.

We need to tap our spiritual traditions to forge business ethics for our field. I fear most a future history where the driving motive will be profit—a field that saves itself but loses its soul—a field where once vibrant programs become empty carcasses changing identities through seasonal reorganizations, mergers and hostile takeovers. I don't think this future will come because we lack moral integrity, but it could come because of our passivity, our dependence on external institutions, and our failure to be morally assertive in the face of financial threat.

I am not proposing a retreat into the past, but I am suggesting that the best of our past can keep us grounded through what is likely to be a turbulent future. I am also suggesting that our ability to stay ethically grounded and to stay value focused may very well dictate our financial future.