Task Force on Substance Abuse Treatment Services

Findings and Recommendations

September 9, 2004

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Formation and Purpose:
Taskforce on Substance Abuse Treatment Services

On April 16, 2003, Senate Bill 974, Act 1457 of 2003 was passed and approved to be entitled "an act to create a taskforce on substance abuse treatment services; and for other purposes." The taskforce was originally comprised of twenty-eight members representing professionals with a broad based expertise in the treatment field of substance related disorders in the state of Arkansas.

The purpose of Senate Bill 974, Act 1457 of 2003 was designed to assess the state-wide delivery of substance abuse treatment services and strive to achieve the following:

(1) To assess substance abuse treatment needs and evaluate the current service delivery system and its capacity to responsd to those current and projected treatment needs.
(2) To examine interagency referral trends and continuity of care to include the identification of service duplication and service overlap.
(3) To determine accurate state-wide service costs and identify more cost effective means for the delivery of substance abuse treatment services and the identification of available revenue streams, underutilized revenue, and uncaptured revenue.
(4) To carry out a cost-benefit analysis of substance abuse treatment services to include outcome benefits for the development of policy and procedure reform; and
(5) To make recommendations for the strategic development and implementation of efficient and effective quality care measures.

Taskforce Process

In the process to carry out the aforementioned objectives, the taskforce met with legislators, Department of Human Services, Division of Behavioral Health representatives, Department of Community Corrections administrators, Medicaid administrators, Drug Court treatment providers, and other key agencies, personnel, and representatives with notable affiliation to the state's substance abuse treatment system.

The taskforce met monthly to hear testimony from agencies identified as working with populations diagnosed with substance related disorders or whose substance abuse contributed to their entrance into select agencies or institutions. The treatment providers also gave testimony on their assessment of current service delivery and projected needs. All parties were given the opportunity to question and discuss concerns.

The findings were collected and assigned to a five-member subcommittee appointed by Senator Jimmy Jeffress. The subcommittee met monthly to compile the findings and submit recommendations to all key participants and the Legislative Council, the Senate Interim Committee on Public Health, Welfare, and Labor.

Summary Findings and Recommendations

(1) To assess substance abuse treatment needs and evaluate the current service delivery system and its capacity to respond to those current and projected treatment needs.

In the state of Arkansas. there are seventy-five (75) counties divided into thirteen (13) catchment areas. Each area has a substance abuse treatment center licensed by the Arkansas Department of Human Services, Division of Behavioral Health Services Alcohol and Drug Abuse Prevention (ADAP). These include adolescent, specialized women's services, and residential treatment programs that provide therapeutic continuums of care as mandated by ADAP licensure standards. Total capacity of beds at these facilities is approximately 528. During the fiscal year 2003-04, some 15,000 persons received treatment at these facilities to include detoxification, residential treatment, intensive outpatient treatment, outpatient services, and transitional living programs. An additional 5,000 persons seeking services were placed on a waiting list and among this group, only 700, or 14-percent, received services.

The most recent household survey carried out by the Substance Abuse and Mental Health Services Administration (SAMHSA), labeled as "under reported", projected some 297,706 Arkansas residents admitted to alcohol and drug abuse during the prior twelve month period. Additional studies carried out by SAMHSA and other national agencies project some 15-18-percent of the U.S. population will become addicted to at least one drug during the course of their lifetime. Based on state-wide population estimates, these findings would suggest some 345,000 Arkansas residents will require some level of alcohol and drug treatment during the course of their lifetime.

At current, virtually all treatment facilities are unable to provide treatment services upon demand, primarily this service gap is directly related to the absence of sufficient revenue streams to expand, develop and enhance existing services. As a point, specialized women's services programs, for pregnant women and women with children, are not available in every catchment area.

A profile of the client population seeking services would identify those residents as underinsured, undereducated, and unemployed. Dually diagnosed clients, persons with substance abuse and mental illness, are rapidly rising. The most predominant drug of choice among all admissions is alcohol. At current, the most recognized population are those clients diagnosed with methamphetamine dependence. Dependent upon the region and sub-group, cocaine, crack cocaine, prescription drug, and cannabis abuse/dependence would follow. In select regions of the state there has been a notable increase in admission for opiate and methadone dependence.

Staffing these programs was identified by all respondents as critical. The recruitment and retention of qualified personnel is difficult with the latter correlated to pay and benefits packages when compared with other facilities (hospital, mental health, and private for-profit psychiatric) where substance abuse treatment counselors earnings are significantly lower. The salary range for counselors within the substance abuse treatment field rage

between $15,500.00 to $29,000.00 annually. These include licensed mental health professionals, certified alcohol and drug counselors, and certified alcohol and drug counselors in training.

The substance abuse service delivery system, treatment centers, have been in place with significant improvements in collaborative, referral, and support services. However, their capacity to respond to those current and projected treatment needs would be deemed in crisis.

(2) To examine state interagency referral trends and continuity of care to include the identification of service duplication and service overlap.

Interagency referral and continuity of care between ADAP treatment providers is assessed as good with provider agencies working collaboratively to place clients in facilities that best meet their presenting needs. However, referral from courts, probation and parole, Department of Human Services, medical and psychiatric hospitals, and other such facilities deemed poor to fair. This is especially true in regard to persons mandated into treatment facilities without any type payment source, the ability to first assess prior to admission for an individual's eligibility and appropriateness of admission. These actions serve to limit the number of state beds available for those self referrals. This is attributed in large part to the misperception that ADAP funded facilities are state operated and therefore must accept all referrals.

The most significant duplication and service overlap are identified as mental health referrals, Department of Community Corrections mandates to treatment, and Department of Community Correction Drug Court Programs mandating clients within their programs into ADAP funded treatment facilities absent of a payment source and/or Memorandum of Agreement.

The most seamless and cooperative referral trends within the regions served are with community agencies such as battered women's shelters, food banks, homeless shelters, educational counseling services, credit counseling agencies, free health and dental clinics, Salvation Army, and other such social service agencies that are incorporated into the case management needs of the treatment center clients.

Continuity of care found within ADAP funded agencies is deemed good as each agency must meet the minimum *Licensure Standards* and *Rules of Practice and Procedure* to remain licensed and funded. Each agency is audited annually and must each year submit a *Request for Proposal* to ADAP and present to the state Coordinating Council for approval of continuing funding. The ADAP is the single state agency responsible for developing and promulgating standards, rules and regulations for alcohol and other drug abuse prevention and treatment programs within the state, and operation of a comprehensive management evaluation and community research process for the allocation of resources. Therefore, adherence to these standards serve to ensure continuity of care across the state.

(3) To determine accurate statewide service costs and identify more cost effective means for the delivery of substance abuse treatment services and the identification of available revenue streams, underutilized revenue, and uncaptured revenue.

State wide service costs vary by agency dependent upon level(s) of care provided, type of program such as adolescent or specialized women's services, size of agency, programmatic services, and staffing of each agency. Statewide service costs ADAP funded beds are established by a fee scale as outlined under the ADAP *Rules of Practice and Procedure.* Treatment providers are allowed to collect payment for services over and beyond ADAP contracted rates developed and based on the Federal Minimum Hourly Wage Rate of $5.15 per hour or $10,712 annually. The fee allowed for billing is based on not only wage, but includes number in family to determine the percentage.

For persons falling below the minimum rate, less or equal to $10,712.00 or those that may exceed that rate, but have one or more family members that would place them in a 0-percent fee scale, the agency may only charge the ADAP allowance set at $52.00 a day and no more. For the majority of ADAP funded agencies, this group accounts for approximately 80-percent of all admissions. Thus, although cost effective for the client, it is deemed less that cost effective for each agency who must provide twenty-eight (28) days of treatment that includes housing, meals, individual counseling, and a minimum of twenty-eight hours group counseling weekly in addition to other service costs that may arise. For all ADAP funded agencies, the maximum fee collection schedule, service by episode are as follows:

- Regional Alcohol and Drug Detoxification (medical) $200.00 per episode or $75.00 per day for non-medical detoxification.
- Intake and Assessment $ 200.00 per episode
- Residential Treatment $1,500.00 per 30 days
- Partial Day Treatment $1,000.00 per 30 days
- Outpatient Treatment $ 200.00 per 30 days
- Specialized Women's Services $1,500.00 per 30 days

In comparison to other type medical, mental health, Medicaid, correctional costs or other such service providing treatment or treatment for substance related disorders within their respective facilities, these fees are deemed more than cost effective. Although highly cost effective for individual clients, the costs severely limit substance abuse treatment agencies to progressively enhance services and mirror best practice service delivery methods found throughout the country.

During the fiscal year 2003-04, $18,153,720.00 was split between alcohol and drug prevention and alcohol and drug treatment. The majority of these funds were from Federal Block Grant Awards, with only $4,022,083.00 coming from State Special and State General Revenue.

Available revenue streams identified by the taskforce were improved monitoring and aggressive application of federal grants related to substance abuse treatment and

increased State Special and State General Revenue for federal match. Shifting funds were identified as another means of potential increase in funding. The most notable and recent example of this has been the finding that treatment facilities could provide services to seven incarcerated persons for what it takes to incarcerate an individual annually. Upwards of 30-percent of the client population served in state-wide treatment facilities are persons on probation or parole with an equal number entering treatment prior to their court hearing. Drug Court programs are mandating and referring individuals at increasing rates into area treatment facilities without any revenues to cover those costs.

Within the ADAP and their respective funded programs, there are no underutilized revenues for treatment. The majority of facilities do not receive enough revenue to operate for a full fiscal year.

The most notable uncaptured revenue is identified as Medicaid. The state Medicaid program does not pay for any type alcohol or drug treatment services. One prime example would be in the area of detoxification where treatment providers could provide the same quality service at rates of a minimum 25-percent less the cost of private for profit hospital or mental health based facilities. Numerous states throughout country utilize Medicaid dollars for alcohol and drug treatment recognizing the high prevalence of dual diagnosed populations.

(4) To carry out a cost benefit analysis of substance abuse treatment services to include outcome benefits for the development of policy and procedure reform.

Although Arkansas does not have independent cost benefit analysis, numerous national studies and findings can be incorporated to analyze and compare services within the state. National studies and a most recent study carried out in California of drug treatment services showed that for every $1.00 committed to alcohol and drug treatment, a return of $7.00 is evident. Therefore, the $18,153,720.00 allocation for prevention and treatment would be projected to return $127,076,040.00. In the area of Specialized Women's Services, each $1.00 spent on addiction treatment result in savings ranging between $3.00 to $12.00 in health and social costs.

At this stage of the committee process, complete figures for Arkansas have not been adequately collected. However, areas identified as beneficial for directly related cost benefit analysis reflecting more accurate cost benefits for the state of Arkansas would be criminal justice to include county jail, state prison, and probation/parole costs, Department of Human Services and Department of Health savings: HIV/AIDS and STD, Medicaid costs, foster care costs, and child support to name potential areas of savings. Workman's Compensation, unemployment rates, homeless rates, crime and other such reduced costs associated with alcohol and drug abuse can be targeted and compiled as well.

Outcomes would be used to correlate such findings. However, there are current outcomes available that clearly demonstrate the effectiveness of treatment services in Arkansas.

(a) 63-percent of persons completing alcohol and drug treatment were employed six months post discharge. (Formulating the average annual salary in the state of Arkansas at $28,074.00 per person, the employment rate of 63-percent of the 15,000 served would result in $265,299,300.00 generated into the state economy annually).
(b) 91-percent of persons completing alcohol and drug treatment were in an independent living status six months post discharge.
(c) 55- percent of persons completing alcohol and drug treatment were abstinent of alcohol and drug use six months post discharge.

In a five-state Treatment Outcome and Pilot Prevention Study of alcohol and drug treatment programs carried out by the SAMHSA in which Arkansas participated, findings indicated:

(a) Participants improved their status in multiple problem areas over time and improvement was related to completion of treatment.
(b) Subsequent univariate analyses revealed admission to follow up improvement in six Addiction Severity Index problem areas to include employment, alcohol and drug, legal, family/social, and psychiatric. These tests revealed a significant difference in psychiatric severity related to treatment completion status with the "completed" group having lower psychiatric severity than the non-completed group at both points in time.

All of these indicators would strongly suggest that alcohol and drug treatment has been and can be even more effective. However, the system, policy, and procedure, is currently not outlined to benefit from these and other such findings.

(5) To make recommendations for the strategic development and implementation of efficient and effective quality care measures.

The primary purpose of the taskforce was to assess statewide delivery of substance abuse treatment services. It is believed at this stage, the taskforce thoroughly assessed service delivery and identified numerous areas of needs improvement and/or need for modification. However, the taskforce feels the overall strategic planning needs more in depth analysis. Thus, our recommendations would include:

(a) To extend the taskforce two more years taking the information and data obtained through the course of its work and translate these findings into a manner that would specify actions to improve the capacity to respond to projected state treatment needs, enhance interagency referral, develop means for identifying and implementing feasible revenue streams, and provide cost benefit analysis of service to outcomes as they relate to the state of Arkansas using data gained from state agencies.
(b) To use this information for the development and implementation of new policy and procedure as well as effective quality of care measures.

(c) The committee believes there is an urgent need for increased funding for treatment services to already strained treatment systems. This is based on the fact that there has been no state funding increase to ADAP and provider agencies since 1995. Without additional funding, provider agencies will find it increasingly more difficult to provide treatment on demand for adult, adolescent, and specialized women's services programs. This takes into consideration drug court clients, probation and parole clients, court ordered clients, and families. This point is compounded by the fact that 1990-2000 census figures show Arkansas growth rate to be 13.7-percent and upwards of twice that in select regions of the state.

(d) Finally, the committee would not recommend changing any current state commitment laws regarding alcohol and drug abuse until such aforementioned objectives can be completed.

Based upon its performance during the past year, the taskforce feels and strongly that these objectives can be completed in the requested time frame and provide the Arkansas State Legislature and state agencies with an efficient and effective plan of action.