Task Force on Substance Abuse Treatment Services

Findings and Recommendations

November 1, 2006

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Act 1457 of 2003

On April 16, 2003, Senate Bill 974 was passed by the Arkansas General Assembly. It became Act 1457 of 2003 entitled "an act to create a taskforce on substance abuse treatment services; and for other purposes."

The taskforce is comprised of six legislators and twelve non-legislative members representing a broad base of expertise in the treatment of substance related disorders in the state of Arkansas. The purpose of the Act is to assess the state-wide delivery of substance abuse treatment services and to achieve the following:

(1) To assess substance abuse treatment needs and elevate the current service delivery system and its capacity to respond 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 statewide service costs and identify more cost effective means for 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 treatment services to include outcome benefits for the development of policy and procedure reform; and

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

Taskforce Process

The taskforce met with legislators, alcohol and drug treatment providers, UAMS representatives, Department of Community Corrections representatives, Department of Health and Human Services representatives from Divisions of Medical Services (Medicaid), Children and Family Services, and Behavioral Health Services, State Board of Pharmacy representative, judges, and other key agencies, personnel and individuals with notable affiliations with 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 identified agencies. Providers, funders, and affected individuals also gave testimony on their assessment of current service delivery and projected needs. These individuals included licensed mental health professionals, nurses, physicians, certified alcohol and drug counselors, child welfare workers, courts, criminal justice workers, researchers, and individuals in recovery from addiction. Committee members and visitors were given the opportunity to question and discuss concerns.

Task Force Findings

Treatment Availability, Need, and Funding

Arkansas' seventy-five (75) counties are divided into thirteen catchment areas, each of which has a substance abuse treatment center licensed by the Arkansas Department of Health and Human Services, Division of Behavioral Health Services, Office of Alcohol and Drug Abuse Prevention (OADAP). These treatment centers provide detoxification, outpatient treatment, opioid maintenance, specialized women's services, and residential therapeutic continuums of care for adults and adolescents.

Treatment centers that accept publicly funded clients have 2,075 treatment slots of which the state, through OADAP, funds 970. Other institutions provide substance abuse treatment for approximately 1,000 clients per year. During State Fiscal Year 2006, 16,061 persons received treatment at these facilities. Approximately 5,800 persons seeking treatment services were placed on a waiting list and, from this group, only 814 (14 %), received services. Each catchment area also contains a Prevention Resource Center.

The most recent national household survey (often labeled as "under reporting") by the Substance Abuse and Mental Health Services Administration (SAMHSA) estimated that 269,578 Arkansas residents suffered from alcohol and/or drug abuse problems during the prior twelve month period. According to this SAMHSA estimate, approximately 6% of persons with alcohol or drug problems in Arkansas received any treatment.

Arkansas' treatment facilities are unable to provide treatment services upon demand because of the absence of sufficient revenue streams to expand, develop and enhance existing services. As a point of reference, although adolescent girls and women are abusing alcohol and other drugs at rates equal to boys and men, less than 30% of existing treatment slots are for women's treatment. Specialized services for pregnant women and women with children are available for many fewer women and are not available in every catchment area. The availability of adolescent treatment services is likewise inadequate to meet current demand and residential treatment for adolescents are not available in most of the state's catchment areas.

A profile of the population seeking treatment services shows those residents to be underinsured, undereducated, and unemployed. OADAP funded programs identified that 54% of those admitted for alcohol and drug problems had a co-occurring mental health disorder. For women, the percentage of clients with co-occurring substance abuse and mental health disorders is greater. More than 80% of substance abusing women have also been violence victims.

Cynthia Crone, Director of UAMS Arkansas CARES and representing the state's Specialized Women's Services, reported that >80% of substance abusing mothers have at least one parent with a substance abuse problem, and a vast majority of these mothers are victims of emotional, sexual or physical abuse. They often have poor parenting role models and limited social and economic support which further places their children at risk of health and development problems and exposure to crime, conflict and violence. Eighty five percent (85%) of Arkansas' incarcerated women have a substance abuse disorder and 80% of these women are mothers.

Combined, these risks increase the probability that children of addicted mothers will repeat the cycles of poverty, crime, abuse and dependence.

Pat Page with the Department of Health and Human Services' Division of Children and Family Services reported that an estimated 70% of Arkansas' child protective cases involve parental substance abuse. Further, 13% of children in foster care have used alcohol or other drugs. Karen Farst, MD, UAMS Department of Pediatrics and Arkansas Children's Hospital child abuse service, reported there is little if any evidence that prenatal use of *illicit* drugs causes birth defects, however there is a strong association between prenatal alcohol exposure and birth defects including mental deficits. She further reported there are documented associations between prenatal drug exposure and risk for subsequent poor parenting and child neglect.

During the first year of Garrett's Law implementation (Act 1176 of 2005), more than 90 newborns (33% of those with positive drug screens) and 33 of their siblings received out of home placements due to positive drug tests at the time of delivery. Less than 20% of the mothers reported under this law received any type of substance abuse treatment or parenting services. Although none of the newborns had health problems attributed to prenatal drug exposure and half of the newborns were returned to their mothers, mothers reported under this law are automatically placed on the state's child maltreatment register, limiting future employment opportunities in fields where low income women often work. Lack of meaningful employment is a risk factor for relapse to alcohol and other drug use. Mothers in recovery reported they would be likely to avoid prenatal care and hospital births in order to avoid consequences of this law.

Circuit Judge Teresa French discussed the appalling drug abuse in her Southeast Arkansas district and reported 90% of the juveniles in her court are addicted to controlled substances. Connie Hickman Tanner with Administrative Office of the Courts reported that 90% of Arkansas' juvenile dependency cases involve alcohol and drug abuse by parents.

The most predominant "drug of choice" named by treatment clients at admission is alcohol (32%). Methamphetamine abuse admissions to publicly funded treatment programs have grown by over 1,451% in the last 13 years. When methamphetamine admissions are combined with crack/cocaine admissions, they comprise 40% of all admissions to OADAP funded programs. Opiate addiction in the last 5 years has increased in the state to over 5% of all admissions. There is a steady rise in abuse of prescription medications and most current drug-related mortality from addiction is associated with misuse of prescription drugs.

In addition to adequate treatment capacity, a competent workforce is critical for positive outcomes in addiction treatment. The recruitment and retention of qualified personnel by state-funded treatment facilities is difficult when pay and benefits packages in those facilities compare poorly with other facilities (hospitals, mental health centers, and private for- profit psychiatric clinics) where substance abuse treatment counselors' earnings are significantly higher. The salary range for counselors within the state-funded substance abuse treatment facilities is $15,000 to $29,000 annually. These staff include licensed mental health professionals, certified alcohol and drug counselors, and alcohol and drug counselors in training.

OADAP funds approximately $10 million per year in treatment services. Treatment funding is primarily through the Substance Abuse Prevention and Treatment Block Grant ($6,930,000), State General Revenue ($2,687,114 for detoxification and court ordered treatment to those adjudicated to be homicidal, suicidal, and gravely disabled due to substance abuse under the substance abuse commitment law); Social Services Block Grant ($529,971 to provide treatment to indigent clients), and City of Little Rock funds ($250,000) for limited treatment services to Little Rock citizens.

In addition to OADAP treatment centers, the Department of Corrections provides treatment through 10 facilities, and the Department of Community Corrections administers 4 therapeutic community treatment programs, 21 education programs, treatment through 38 drug courts, and is piloting a program at two sites for early release and reunification of mothers with their children.
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The current substance abuse treatment system which is comprised mainly of local, non-profit treatment centers has been in place well over 25 years. Over those years significant improvements in collaboration, referral, and support services have been realized. However, the present system's lack of capacity to respond to current and projected treatment needs is deemed a crisis.

Does treatment work?
Addiction is a chronic disease that involves several transitions between treatment and recovery. Research shows that outcomes for addition treatment compare favorably to treatment for other chronic conditions such as diabetes, hypertension and asthma.

In testimony presented by Dr. Nicola Conners, UAMS Partners for Inclusive Communities, it was reported that multiple studies show 40% - 60% of substance abuse treatment clients report no alcohol or other drug (AOD) use in the year following treatment. This percentage is often higher for treatment graduates. An outcome study conducted in California showed 59% of clients receiving treatment were continually abstinent at 9 months after treatment. There was a greater than 50% reduction in cocaine use in all treatment modalities. A study of a specialized women's treatment program in Arkansas showed that 67% of graduates (including those addicted to methamphetamine) had not relapsed the year following treatment.

Most studies show a significant decrease in arrests and criminal activity after clients receive treatment. The Kentucky Treatment Outcome Study (KTOP) showed 51.9% reduction in arrests, compared to clients' records in the prior year. SAMHSA's National Treatment Improvement Evaluation Study (1997) reported that drug treatment reduces crime by 80% and reduces arrests up to 64%.

Other studies showed gains in employment in the range of 40-50%. For example in the state of California, 33% of clients were employed at admission to treatment, compared to 54% at 9 months after treatment. In Kentucky, there was a 48.6% increase in employment from intake to the 12-month follow-up.

The TOPPS II study of treatment outcomes in Arkansas was conducted with funds from the SAMHSA. The study of OADAP funded programs showed 55% of treated clients were abstinent and 63% were employed at a six-month follow-up.

Dr. Conners further reported that treatment outcomes show there is a significant improvement in physical and mental health and family functioning among persons completing AOD treatment. Studies also document changes in clients' beliefs and attitudes about raising children and beliefs associated with child abuse.

Intensive Family Services (IFS), where trained caseworkers provide in-home services to high risk families, paired with substance abuse treatment has been shown to improve outcomes for children and families with substance abuse problems. A University of Florida study (Wobie, et al, 1998) showed that foster care placement of newborns whose mothers were cocaine positive at delivery resulted in worse developmental outcomes for the infants at six months of age than for infants who remained with their cocaine positive biological mothers. What's been demonstrated to best help these families is family treatment *with children* to include quality prenatal care / childcare / education / developmental services and parenting support.

Of the 8,673 clients entering treatment through OADAP funded programs and identified as having a co-occurring substance abuse and mental health disorder, less than 10% received mental health services due to a lack of resources and coordination. Dr. Larry Miller, Medical Director of the state's Division of Behavioral Health Services, estimated relapse rates for this group not receiving integrated treatment for co-occurring disorders would approach 100%.

Another factor affecting treatment outcomes is length of treatment. Research has shown that client treatment duration of at least 3 months is associated with more positive outcomes. Continuing care—or care following an intensive treatment episode to prevent relapse and sustain gains made during intensive treatment—is the newest frontier in addiction treatment.

Is Treatment Cost-Effective?

Substance abuse treatment is not only successful but it is also cost effective. Cost-benefit ratios vary from study to study with a low-end ratio of $4.00 saved for every dollar spent on treatment to a high-end ratio of $25.00 saved for every dollar invested in treatment.

KTOPS focused on the total cost of state-funded services for 12 months, compared to costs charged in 3 areas:

- Arrests
- Jail time
- Unemployment.

The study estimated the state of Kentucky saved $4.52 in those 3 areas for every dollar spent on treatment. These cost savings did not include savings from other costs associated with addiction (health care, foster care cost, etc.). When adding savings from healthcare, every dollar spent on addiction treatment saves >$12.00. The Mid-America Addiction Technology Transfer Center reports that 40% of all inpatient hospital stays are related directly or indirectly to addiction and almost 20% of Medicaid hospital costs are for care associated with substance abuse.

The cost-offset from family treatment in Arkansas is estimated to range from $3 to $12 saved for every dollar spent. Cost savings afforded to the state by treating addicted pregnant and parenting women with their children are found in the following areas:

- Child welfare and foster care system
- Court costs
- Costs of incarceration
- Medical costs including mental health care costs – for mothers and children
- Costs of unemployment including lost tax revenue

Sacramento, California Dependency Drug Court reported that 86% of parents entered substance abuse treatment with 67% completing. The savings to the county was $3,000,000 in out of home placements over 2 years.

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While it is widely documented that substance abuse is associated with multiple health and social costs and that treatment is successful and cost effective, our state and nation continue to pay dearly for our failure to effectively prevent and treat alcohol and other drug problems. These substance abuse problems and associated costs cut across state agencies. In a recently released monograph titled "Blueprint for the States" (Join Together, 2006), the following table outlined states' *non-treatment* costs associated with substance abuse. Using these percentages, Arkansas state general revenue dollars spent for *non-treatment* services to persons with alcohol and drug problems exceed $500,000,000 annually.

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State Agency	Percent of State Agency Budget*	Positive Impact of Prevention and Treatment
Child Welfare	**70%**	**Children whose families receive appropriate drug and alcohol treatment are less likely to remain in foster care.**
Criminal Justice	**77%**	**Re-arrest rates dropped from 75% to 27% when inmates received addiction treatment.**
Juvenile Justice	**66%**	**Adolescent re-arrest rates decrease from 64.5% to 35.5% after one year of residential treatment.**
Health	**25%**	**Families receiving addiction treatment spent $353 less a month on regular medical care than untreated families.**
Mental Health	**51%**	**When mental health and drug and alcohol disorders are treated collaboratively, patients have better outcomes.**
Welfare	**16% - 37%**	**After completing treatment, there is a 19% increase in employment and an 11% decrease in the number of clients who receive welfare.**
Developmental Disabilities	**9%**	**Fetal Alcohol Syndrome affects an estimated 40,000 U. S. infants each year.**

*Percentage of state agency budget costs are from 1998 data due to lack of more current data, illustrating the importance of and need for stronger systems of measurement and accountability (Join Together, 2006).

Although addiction is a public health problem, and Arkansas Medicaid currently pays millions of dollars for physical and mental health care costs for persons with substance abuse disorders, the state Medicaid program has not exercised a state option to pay directly for substance abuse treatment. Roy Jeffus, Medicaid Director, and Pat Dahlgren, Director of Behavioral Health Services (both within the Arkansas Department of Health and Human Services), met with the task force and reported that a Medicaid state plan change would be needed for Medicaid to provide payment for substance abuse treatment. Issues to be considered would be state match

funding, cost controls, qualifications of providers, and how to meet "entitlement" and "statewide" provisions for the broad population.

Mike Feehan, legislative research staff, reported that only a small majority of Medicaid substance abuse treatment programs are created by statute. He presented strengths and weaknesses of statutory versus regulatory routes to state Medicaid coverage. Strengths of a statutory approach would include the legislative requirement for the Department of Health and Human Services to create a program, and weaknesses would include the requirement for the Center for Medicaid and Medicare Services (CMS) to approve any waiver sought. Further, if the program is legislatively mandated, the Department must find funds within its existing budgets, usually by cutting other programs. A statutory program cannot be changed except during a legislative session, however use of a "rules" approach would provide the ability to modify a program on a continuing basis. Weaknesses of a regulatory approach would include little legislative input to program design, and the possibility that the Department would set the program aside indefinitely.

Options for limiting Medicaid costs would include: pilot/demonstration projects; extra fees (i.e. drug courts); inclusion in Medicaid expansion under the Tobacco Settlement Act (would require 2/3 vote of both houses); limiting coverage to specific maximum dollars per recipient per year, specific drugs of abuse, specific diagnoses, age, funds available; administering under managed care program or making a stand-alone program requiring separate general revenue with specified eligibility.

G. Richard Smith, MD, Chairman of the UAMS Department of Psychiatry, reported on the difficulty of sustaining substance abuse treatment programs initiated through grants, and stressed the need for bridge funding for successful programs transitioning from grant funding to long-term sustainability.

Summary of Findings

Recurring themes emerged during the substance abuse treatment task force meetings:

1. Substance abuse treatment is successful in decreasing alcohol and other drug use and multiple other problems associated with substance abuse.
2. Substance abuse treatment services are cost effective through decreasing health, social, and criminal justice system costs.
3. The state does not have treatment capacity to meet its current or emerging treatment needs.
4. Women, mothers with children, adolescents and persons with co-occurring substance abuse and mental health disorders are particularly underserved groups.
5. Increased funding is needed to expand treatment capacity and to prepare and retain a competent treatment workforce.
6. Arkansas is spending millions of dollars now on services to addicted families, but not in ways with demonstrated positive outcomes.

Recommendations

1. Increase funding for alcohol and drug treatment services.

    - Consider Medicaid pilot program to cover substance abuse treatment services and medications for persons with co-occurring mental health disorders.

    - Establish a collaborative and comprehensive continuum of care that includes intensive family services and increased substance abuse treatment access for pregnant women and mothers with their children, particularly those impacted by Garrett's Law.

        - ❖ Establish a Medicaid pilot program for family treatment of pregnant and postpartum women and their children.
        - ❖ Pilot family dependency court(s).
        - ❖ Amend Garrett's Law and the Arkansas Child Maltreatment statute and regulations to:
            - o Insure Arkansas Child Abuse Hotline accepts reports of newborns testing positive for alcohol or other drugs of abuse;
            - o Require a home/environmental evaluation within 24 hours of a report of a newborn testing positive for drugs of abuse *and* an individualized health and safety plan to include Intensive Family Services and family treatment services as appropriate;
            - o Insure an investigation (not a positive drug test only) prior to a "true" finding of child neglect as for all other maltreatment reports/findings;
            - o Reserve placement on child maltreatment register for parents with "true finding" of abuse or neglect; and
            - o Assess need for out of home placements as for other infants/children at risk.

    - Increase general treatment services.

    - Increase treatment dollars for clients referred through drug courts.

2. Target efforts to develop and retain a competent treatment workforce.

3. Create a unified data system to track and report who is receiving substance abuse related prevention, treatment and support services, what agencies are providing services, costs of services, and outcomes related to health, social functioning and crime.

4. Funding to develop and provide an evidence-based, statewide substance abuse prevention program that includes high risk youth from substance abusing families.

5. Alcohol tax increase to fund recommendations #1 and #4 above. (Adequate treatment funding will have a positive effect on #2, and #3 is already in progress.)