Exhibit G.1

Final Report and Recommendations of the Arkansas Legislative Task Force on Substance Abuse Treatment Services

Submitted by the
Arkansas Legislative Task Force on
Substance Abuse Treatment Services

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Executive Summary

The Legislative Task Force on Substance Abuse Treatment Services was convened to evaluate substance abuse treatment services in Arkansas. Act 688 of 2007 includes five specific actions that the task force was commissioned to do:

- Identify the statewide services costs to find more stable revenue sources
- Use cost benefits analysis for studying outcomes
- Develop a strategic development and implementation program
- Determine the needs in the current system of delivery
- Review interagency referral and the continuity of care trends

According to the Substance Abuse Mental Health Administration (SAMHSA) only five (5%) percent of persons needing substance abuse treatment in Arkansas are receiving it. *(Substance Abuse and Mental Health Services Administration, Office of Applied Studies. 2006 National Survey on Drug Use & Health).* The consequences of untreated alcohol and drug abuse comprise the single greatest drain on Arkansas' state budgets.

State agencies are paying dearly for the lack of coordinated action to effectively treat alcohol and drug abuse problems. Yet, state agencies and the network of publicly funded community-based providers would be in an excellent position to help solve this problem through legislative action to increase and coordinate funding for treatment services.

Recommendations

Increase Resources

Expand state funding to increase treatment capacity. The following areas of expansion are encouraged:

- Make Medicaid coverage available for adolescents, pregnant and post partum women.
- Increase state treatment funding for non-Medicaid eligible populations.
- Direct state agencies to maximize treatment funding through collaborative, coordinated approaches to federal grants, block grants, categorical funding, state appropriations and additional revenue sources such as a wholesale liquor tax, tobacco settlement funds, or court fines.

Increase Accountability and Quality

- The Division of Behavioral Health Services shall adopt through its network of funded treatment providers evidence-based practices.
- The Division of Behavioral Health Services shall provide technical assistance and training to the substance abuse community-based providers thereby enhancing quality of care.

Establish Structure

- Create an interagency, interdepartmental mechanism through which DBHS will have authority as the lead agency to insure coordination and collaboration in addiction treatment funding and services delivery for families and individuals receiving services from more than one agency.

Support Advocacy

- Create a statewide advocacy and communications campaign to inform the public about the chronic health problem of substance abuse and the societal benefits of treatment.

CONSENSUS THAT GUIDES OUR RECOMMENDATIONS

The Costs of Not Treating Addiction are Tremendous

Arkansas pays dearly for the failure to effectively treat alcohol and drug abuse problems. Based on a survey of all states, a landmark publication *Blueprint for the States: Policies to Improve the Ways States Organize and Deliver Alcohol and Drug Prevention and Treatment* (Rosenbloom, Leis, Shah, & Ambrogi, 2006) reported the percentage of state agency budgets that were associated with untreated addiction. The following table shows those agency percentages applied to Arkansas state agency budgets with additional data on the impact of addiction in our state.

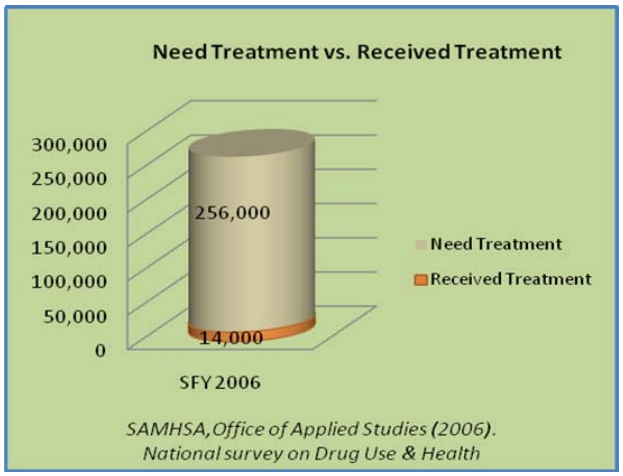
Estimated State Cost of Addiction to Arkansas Agencies

Arkansas Agencies	Estimated percent of State Agency Budget Spent on AOD Related Problems	State General Revenue Dollars applied to named percent of State Agency Budget	Impact of Addiction and Treatment in Arkansas
DCFS	70%	$34.44 million	According to DCFS (2007), **35% of new foster care cases were a result of parental substance abuse**. National data suggest this is an under-report. Children whose families receive treatment are less likely to enter and remain in foster care.
DOC and DCC	77%	$ 261.73 million	**85% - 90% of Arkansas' incarcerated women have a substance abuse disorder (DCC, 2006)**. An Arkansas study (Conners, 2001) of mothers receiving treatment showed arrest rates decreased from **85% to 19%** the year following treatment.
DYS	66%	$ 31.02 million	**66% of Youth Services cases showed an alcohol or drug problem (2007).** Following one year of residential treatment, adolescent re-arrest rates decrease from **64.5% to 35.5%.** Data show that **>80%** of persons with addiction have a parent with a substance abuse disorder, demonstrating the intergenerational impact of addiction.
Health	25%	$ 13.48 million	One in four deaths is attributable to substance abuse and addiction-related illness or accidents. Arkansas leads the nation in traffic fatalities: **40%** of traffic fatalities and **8%** of motor vehicle crashes involve alcohol.
Mental Health	51%	$ 2.4 million	There is a high co-occurrence of addiction and mental health disorders, especially among women and adolescents **(>60%).** When these co-occurring disorders are treated together, patients have better outcomes and mental health costs are reduced.
Workforce Services (TANF)	16% - 37%	$ 960,000	It is estimated that **12%** of TANF recipients need substance abuse treatment. A follow-up study of a women's treatment program in Arkansas (Conners, 2007) showed **66%** of women were employed a year following treatment compared to **10%** at intake.
DDS	9%	$ 5.3 million	Children affected by maternal alcohol and drug abuse are at increased risk for developmental disabilities. Fetal Alcohol Syndrome affects estimated **300 – 800** newborns in Arkansas annually. Estimated lifetime costs per person are **$2-$4 million**.
Total SGR only		$ 349.33 million	

Blueprint for the States: Policies to Improve the Ways States Organize and Deliver Alcohol and Drug Prevention and Treatment (Rosenbloom, Leis, Shah, & Ambrogi, 2006)

Addiction is a complex, costly problem that negatively impacts individuals, families, communities and state agencies. Although there is strong evidence that addiction treatment is effective in decreasing substance abuse and its negative health and social consequences, treatment has been historically underfunded in Arkansas. Different agencies have varying ideas about the nature of addiction and often focus on only one part of the puzzle. Each agency's narrow view prevents them from creating collaborative solutions to a problem that is bigger than any one agency can address alone. Lack of a coordinated funding and service response has resulted in a tremendous treatment gap. **In Arkansas, only approximately *one in twenty* people needing treatment are able to obtain it**. The costs of untreated addiction comprise the single greatest drain on our state's budget.

Until now, the federal government has been the major funder addressing the public health problem of alcohol and drug abuse. Arkansas' 2009 Substance Abuse Prevention and Treatment (SAPT) Block Grant provides over 73% of all public funding for alcohol and drug abuse treatment with a current allocation below the level received in SFY 2005. Further-- unlike in a majority of other states-- Medicaid in Arkansas does not cover substance abuse treatment.



- **State funding for substance abuse treatment has been at the same level since 1995 (thirteen years). Using current resources, our state falls far short of meeting our treatment needs.**

Statewide, on a daily basis, over 400 treatment referrals from private citizens, faith-based organizations, criminal justice and child welfare systems, and our courts are on waiting lists seeking public treatment. The publicly funded treatment system is straining to address the needs of citizens who cannot pay for treatment. Of particular concern is the chronic long-term shortage in family treatment capacity for adolescents, pregnant women, and women with children.

The lack of sufficient treatment resources overburdens our broader healthcare, child welfare, criminal justice, employment, and welfare systems. Because of the interconnections between addiction and other health and social problems, the DHS Division of Behavioral Health Services, Office of Alcohol and Drug Abuse Prevention cannot and should not *alone* meet the State's burgeoning demand for critical treatment services. With the upcoming 2009 General Assembly, Arkansas has an opportunity to lay a firm foundation for increasing the number of persons receiving quality addiction treatment by expanding and coordinating funding and our state's capacity to deliver evidence-based services.

The need for expanding substance abuse treatment services is based on the following three premises *(Scanlon, A. State Spending on Substance Abuse Treatment. Washington, D.C.: National Conference of State Legislatures, 2002)* which have been reinforced during testimonies presented to the Task Force:

- Untreated substance abuse results in extensive economic costs, as well as devastating individual, family, community and social consequences**;**
- Substantial evidence indicates the effectiveness of substance abuse treatment in reducing substance use, which produces significant improvements in the lives of individuals;
- Substance abuse treatment produces significant economic benefits from a public policy perspective.

Treatment is Effective. Evidence that treatment of alcohol and drug abuse is effective is extensive and compelling. Outcome studies, nationally and in Arkansas, indicate that treatment leads to a clinically significant reduction in substance use. It also results in statistically significant increased employment and income, improved parenting and decreased child maltreatment, decreased mental health symptoms, decreased victimization, decreased arrests and incarceration, and decreased overall healthcare costs.

Economic Benefit of Treatment. Multiple studies demonstrate that every $1 spent on treatment saves $3-$12, depending on the populations served and scope of outcomes studied. A Columbia University study conducted in 1998 reported that for every $1 spent on drug courts, $10 in savings was realized. A 2002 study in Arkansas showed the

cost benefit for specialized women's treatment to be $17,143 for each individual served *(Benefit-Cost Analysis of Addiction Treatment in Arkansas. French, et al., 2002).* Societal cost savings per person per year total $40,000 when drug addiction is treated, compared to when it is untreated (*Institute of Medicine. Pathways of Addiction: Opportunities in Drug Abuse Research. Washington, D.C: National Academy Press, 1996).*

Recommendations

The time is right for Arkansas to coordinate resources to enhance and sustain effective substance abuse treatment. Surveys have shown that 75% of the general public believes there should be more addiction treatment. Rationale for strategies recommended by the Legislative Task Force on Substance Abuse Treatment Services follows:

#1: Increase Resources

Increase state funding to (1) expand treatment capacity, (2) increase treatment availability to underserved populations, (3) enhance providers' ability to hire and retain quality staff, and (4) concentrate statewide efforts in substance abuse treatment in a single, coordinating state agency.

Enhanced treatment capacity will require money to increase the number of treatment slots and increase the number of skilled practitioners prepared to deliver quality treatment services. Currently, the Office of Alcohol and Drug Abuse Prevention funds treatment for 14,000 individuals annually with approximately $13 million, of which only $2.8 million is from state general revenue. Existing treatment dollars fund 339 residential treatment slots and a variable number of outpatient treatment slots statewide. Community providers could immediately expand to 559 residential treatment slots and also increase outpatient treatment capacity with $29 million annually, an increase of $16 million from the current $13 million. This would be an increase of $16 million in state funds. It is expected that most of those covered under this expansion would not be Medicaid eligible.

The Substance Abuse Treatment Task Force is also recommending adding addiction treatment coverage for adolescents, pregnant and post partum women under the state Medicaid program. Effective treatment of these vulnerable populations will pay for itself many times over and for generations to come. Importantly, for every state dollar used as Medicaid match, nearly $3.00 more will come to the state in federal Medicaid dollars. The proposed DHS budget requests $5 million in state general revenue to serve as Medicaid match for addiction treatment for adolescents and pregnant women until 60 days following the birth of their baby. This DHS proposal presents a strong start for expanding Arkansas Medicaid to cover this costly health problem and is supported by this Task Force.

Another strategy is to blend and coordinate funds from multiple agencies to increase addiction treatment for populations that are un- or underserved. Multiple agencies serving addicted clients would develop shared strategies for funding and delivering treatment services and then be held accountable for using funds in a manner consistent with identified strategies. Ideally, the DBHS-Office of Alcohol and Drug Abuse Prevention would be charged with providing leadership for such efforts. This will require infrastructure development within DBHS to support growth to include meaningful tracking and accountability for quality outcomes.

Finally, we recommend charging the Single State Authority for alcohol and drug abuse prevention and treatment (DBHS-Office of Alcohol and Drug Abuse Prevention) with providing leadership in working with other agencies serving individuals/families affected by addiction to maximize treatment funding through collaborative, coordinated approaches to federal grants, block grants, categorical funding, state appropriations and additional revenue sources such as a wholesale liquor tax, tobacco settlement funds, court fines, or other innovative strategies. These increased funds could be used to support care to Medicaid and non-Medicaid eligible populations.

Workforce instability is a major obstacle to effective treatment. An overburdened system and low pay contribute to unacceptable staff turnover rates and practices where the least prepared and lowest paid health care providers are asked to treat some of the most complex clients and families in our public systems. We believe the educational

requirements and pay for counselors must increase to attract and retain a substance abuse treatment workforce equipped to deliver evidence- based care. Continuous quality improvement efforts must include practitioner credentialing and performance monitoring to include peer review and outcomes monitoring.

#2: Increase Accountability and Quality

Require DHS/ DBHS-Office of Alcohol and Drug Abuse Prevention and its network of funded treatment providers to adopt evidence-based practices –-those that have been scientifically tested and can be readily disseminated --to prevent and reduce the incidence of substance abuse and its negative consequences.

SAMHSA's National Registry of Evidence-Based Programs and Practices (NREPP) identify practices that are evidence-based, best practices, or promising practices. These or other evidence-based practices must drive quality improvement for Arkansas' system of addiction treatment. The state's treatment provider network has embraced the transition to evidence-based practices and the need for national accreditation as treatment providers by such organizations as the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or the Commission on Accreditation of Rehabilitation Facilities (CARF).

It is recommended that Arkansas DBHS work with other state agencies serving addicted persons to determine common, shared outcomes targets (for example, decreased alcohol and drug use, increased family cohesion and decreased child maltreatment, increased employment, decreased arrests) and provide training and reinforcement for raising the standard of care toward achieving them. State agencies should collaboratively create a unified data system to track who is receiving services from multiple sources, the costs of those services, and related outcomes. In the future, treatment funding contracts will require outcomes measures that will financially reward or penalize agencies based on their outcomes.

Arkansas has implemented the ten National Outcomes Measures (NOMs) identified by SAMHSA *(Substance Abuse and Mental Health Services Administration National Outcome Measures (NOMs) 2008.)* as reflecting real-life outcomes for people trying to attain and sustain recovery: abstinence; employment/education; crime and criminal justice; stability in housing; access/capacity; retention; social connectedness; perception of care; cost effectiveness; and use of evidence-based practices. These provide a strong base for development of interagency outcomes that could be adjusted to include, for example, child welfare issues.

#3: Establish Structure

Create an interagency, interdepartmental mechanism through which DBHS will have authority to insure collaboration in addiction treatment funding and services delivery for families receiving services from more than one agency.

Arkansas still segregates the authority for health care financing, behavioral health services, and social services into separate agencies. For clients and families; however, these problems overlap. We believe that agencies must collaborate with a focus on the client/family's multiple needs. To accomplish this, state agencies must develop a common language to define services, outcomes and measures as reflected above. We also need cross training among agencies and a unified data system to track activity and outcomes across agencies.

#4: Support Advocacy

Support a statewide advocacy and communications campaign to inform the public about the chronic health problem of substance abuse and the societal benefits of treatment.

Coordinated, common messages from multiple sources should be created to inform the public and various constituencies of the health problem of addiction, how treatment is effective, the family and financial impact of shortfalls in treatment, and ways that savings can be afforded to multiple systems through effective, coordinated systems of care.

In order to advance the message and ongoing system improvements, it is recommended that the state ensures that the Alcohol and Drug Abuse Coordinating Council be empowered with the necessary resources, responsibility, and authority to design, monitor, evaluate, and continuously update state standards relative to coordinated alcohol and drug treatment. This Council, which is chaired by the State Drug Director, includes state agency leaders/decision-makers, providers, consumers, and community-based grass – roots coalitions is charged with coordinating the alcohol and other drug services of state departments, the criminal justice system, law enforcement, the legislature, and treatment/prevention programs.

CONCLUSION

The Legislative Task Force on Substance Abuse Treatment Services ends where it started. The "consequences" of alcohol misuse and legal and illegal drugs are the single greatest drain on Arkansas' state budgets. The negative impact of addiction on individuals, children, families and communities is beyond measure. Arkansas state government has the power to change all of this through executive, legislative, and agency leadership, realigned treatment structures, and effective use of fiscal and human resources to effect overall quality improvements and efficiencies in program operations. Strong systems of outcome measures and performance accountability will be needed to show the public subsequent results. We believe that the public will value the improvements and respond to our progress with added support for further improvements.

We issue this final report as a guide and framework for Arkansas to use in improving its substance abuse treatment infrastructure. The emphasis each state agency and the general public give to these recommendations will depend on many factors, but overall success will be driven by executive and legislative leadership. Not only will these recommendations result in immediate and long-term cost dividends, but they provide a critical path for improving the lives of families and individuals and improvement for our great state as a whole. The need is tremendous and we are poised like never before to make a real and lasting difference.

APPENDIX A. ARKANSAS LEGISLATIVE TASK FORCE ON SUBSTANCE ABUSE TREATMENT SERVICES MEMBERS

Legislative Members

Chair: Senator **Bill Pritchard**	Senator **Jimmy Jeffress**
Vice Chair: Representative **Clark Hall**	Senator **Kim Hendren**
	Senator **Gene Jeffress**
	Representative **Frank Glidewell**
	Representative **Tommy Lee Baker**
	Representative **Tracy Pennartz**

Non-Legislative Members

Diane Bynum	Associate Director	Western AR Counseling & Guidance Center, HATP
Jim Clark	Director	Health Resources of Arkansas
Mike Clark	Director of Treatment	Crowley's Ridge Development Council, NARRC
Rusty Cranford	Executive Director	Behavioral Health Assoc. of AR
Fran Flener	State Drug Director of AR	
Mitch Francis	Clinical Supervisor	Southwest AR Counseling & Mental Health Center
Reverend Terrance Fulce	Support Staff	Decision Point, Inc.
Joe M. Hill	Director	DBHS- Office of Alcohol and Drug Abuse Prevention
Anita Hudson-Meadows	Executive Director	Gateway House, Inc.
Gary Morgan	Regional Director	Dayspring Behavioral Health Services
Bob O'Dowd	Executive Director	Quapaw House, Inc.
Wes Robbins	CEO	Daysprings Behavioral Health Services
Reverend William H. Robinson	Executive Director	Black Community Developers, Hoover Center
David Slater	Deputy Sherriff	Texarkana Sherriff's Office

APPENDIX B. Acronyms Relevant to the Legislative Task Force on Substance Abuse Treatment Services

AOD	Alcohol and Other Drugs
DBHS	Division of Behavioral Health Services
DCC	Department of Community Corrections
DCFS	Division of Children and Family Services
DHS	Department of Human Services
DOC	Department of Corrections
DDS	Division of Developmental Disabilities Services
DYS	Division of Youth Services
NOMS	National Outcome Measures
NREPP	National Registry of Evidence-based Program and Practices
NSDUH	National Survey on Drug Use and Health
OADAP	Office of Alcohol and Drug Abuse Prevention
SAMHSA	Substance Abuse and Mental Health Services Administration

APPENDIX C. REFERENCES

Analysis of Issues in Preparation for the Use of Medicaid for Substance Abuse Treatment Services in AR, p. 3, citing Scanlon, 2002: *State Spending on Substance Abuse Treatment.* Washington, DC: National Conference of State Legislatures.

Analysis of Issues in Preparation for the Use of Medicaid for Substance Abuse Treatment Services in Arkansas: Revised Draft Prepared for Division of State and Community Assistance, Center for Substance Abuse Treatment, May 20, 2008, pp.2, 3.

Arkansas Department of Community Correction. *Women and Children Transitional Living Program concept paper* by Glenda Spratt (May 4, 2005), citing Bureau of Justice Statistics, Special Report, *Incarcerated Parents and Their Children*, August, 2000, NCJ 182335.

Arkansas Department of Human Services, Division of Behavioral Health Services, Office of Alcohol and Drug Abuse Prevention (DBHS, 2008). *Number of persons receiving alcohol and drug treatment SFY07 compared to SAMHSA estimated number of persons needing treatment in Arkansas. Provided by Jo Thompson, ADAP Data Manger.*

Arkansas Department of Human Services, Division of Children and Family Services, Data from personal communication with Mona Davis, December, 2007.

Arkansas Department of Human Services, Division of Youth Services *SFY'07 data of Youth with Substance Abuse*, presented by Jo Thompson of DHS-BHS-ADAP and based on DYS random sample report of 274 files (December, 2007).

Arkansas Legislative Council. State general revenue amounts for key state agencies for SFY 2008. Prepared by Kelvin Anderson 9/19/08.

CASAnet. *Stats on Child Abuse and Neglect, Foster Care, Adoption, and CASA Programs*. NCASAA February, 2000. http://www.casanet.org. (retrieved July 12, 2008).

Conners, N. A. *Arkansas CARES TANF Pilot Year-to-Date (2004 – 2006) Outcomes Report*. February, 2007.

Conners, Nicola. Unpublished data from two SAMSHA-funded projects at UAMS: Arkansas CARES Pregnant and Postpartum Women's Project and Adolescent Substance Abuse Treatment Project. Personal conversation July 10, 2008.

Conners, N.A., Bradley, R.H., Whiteside-Mansell, L. & Crone, C.C., (2001). *A comprehensive substance abuse treatment program for women and their children: An Initial Evaluation.* Journal of Substance Abuse Treatment. 21, pp. 67-75.

Dicker S. & Gordon, E. *Ensuring the Healthy Development of Infants in Foster Care: A Guide for Judges, Advocates and Child Welfare Professionals*. Zero to Three (January, 2004), p. 6.

Dickey, B. & Azeni, H. *Persons with dual diagnoses of substance abuse and major mental illness: Their excess costs of psychiatric care.* American Journal of Public Health (2006), 86 (7), pp. 973 – 977.

French, M., McCollister, K., Cacciola, J., Durell, J., & Stephens, R. *Benefit-Cost Analysis of Addiction Treatment in Arkansas: Specialty and Standard Residential Programs for Pregnant and Parenting Women*. Substance Abuse (2002), 23, pp. 31-51.

Government Accounting Office. Report to Chairman, Committee on Finance, U.S. Senate. *Agencies face Challenges Securing Stable Homes for Children of Substance Abusers*, September, 1998.

Klug, M.G. & Burd, L. (2003). *Fetal Alcohol Syndrome Prevention: Annual and Cumulative Cost Savings.* Neurotoxicology and Teratology, Vol 25 (6), pp. 763-765.

Institute of Medicine. *Pathways of Addiction: Opportunities in Drug Abuse Research.* Washington, D.C: National Academy Press, 1996.

National Center on Addiction and Substance Abuse (CASA). *Behind Bars: Substance Abuse and America's Prison Population.* New York, NY. CASA 1998).

Proposal to Expand Substance Abuse Treatment Services for Arkansas TEA Clients. Arkansas DHS-DBHS-ADAP, February, 2008.

Raaben, S. *Poll Finds Maryland Voters Likely to Support Alcohol and Drug Treatment*. Opinion Works (2006).

Rosenbloom, D.L., Leis, R.G., Shae, P. & Anbrogi, R. *Blueprint for the States: Policies to Improve the Ways States Organize and Deliver Alcohol and Drug Prevention and Treatment,* Join Together, 2006.

Substance Abuse and Mental Health Services Administration National Outcome Measures (NOMs) 2008.

Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Studies. 2006 National Survey on Drug Use & Health. http://www.oas.samhsa.gov/nsduhLatest.htm (accessed February 15, 2008)

Whiteside-Mansell, L., Crone, C.C., Conners, N.A**.** *The Development and Evaluation of an Alcohol and Drug Prevention and Treatment Program for Women and Childr*en. Journal of Substance Abuse Treatment (1999), 16, pp. *265-275.*

APPENDIX D. PRESENTERS

The following individuals presented the Task Force with oral testimony:

Carole Baxter, Executive Director, Recovery Centers of Arkansas

Dr. Rob Covington, Director, Horizon Adolescent Treatment Center

Cynthia C. Crone, Director, Family Treatment Consultation, University of Arkansas for Medical Sciences Partners for Inclusive Communities

Jim Clark, Vice President, Addiction Treatment Services, Health Resources of Arkansas/Wilbur Mills Center

Mike Feehan, Staff Attorney, Bureau of Legislative Research

Garland "Sonny" Ferguson, Director of Treatment, Office of Alcohol and Drug Abuse Prevention

Fran Flener, State Drug Director

David Guntharp, Director of Community Corrections

Janie Huddleston, Deputy Director, Department of Human Services

Anita Hudson-Meadows, Executive Director, Gateway House, Inc.

Dr. Laurence Miller, Medical Director, Division of Behavioral Health Services

Gary Morgan, Director, Co-Occurring Services, Alcohol Drug & Treatment Programs, Daysprings Behavioral Healthcare

Bob O'Dowd, Executive Director, Quapaw House, Inc.

Reverend William Robinson, Executive Director, Hoover Treatment Center

Terrell Rose, Program Coordinator, Office of Alcohol and Drug Abuse Prevention

Larry Santi, PhD, Senior Research Associate, Hornby Zeller Associates, Inc.

Jo Thompson, Director of Data Management, Office of Alcohol and Drug Abuse Prevention