

ADDICTION TREATMENT AND LONG-TERM RECOVERY IN ARKANSAS: “JUST SAY YES!”

A FOLLOW-UP REPORT



Support for this report was provided by the Open Society Institute with local support from the Winthrop Rockefeller Foundation and the Arkansas Community Foundation. We thank them for their support but acknowledge that the findings and conclusion presented in this report are those of the author alone, and do not necessarily reflect the opinion of these organizations.

Addiction treatment and long-term recovery in Arkansas: “Just Say Yes!”

A FOLLOW-UP REPORT

By Paul Kelly, Senior Policy Analyst

Introduction

In 2008, the national Closing the Addiction Treatment Gap (CATG) initiative was launched in Arkansas with support from the Open Society Foundation and with local support from the Winthrop Rockefeller Foundation and the Arkansas Community Foundation. The goal of the initiative was to mobilize public support for expanding addiction treatment by increasing public funding, broadening insurance coverage, and achieving greater program efficiency. In February 2010, Arkansas Advocates for Children and Families, which is a partner in the CATG program, released the report *Addiction Treatment and Long-Term Recovery in Arkansas: “Just Say Yes!”* which documented the addiction treatment gap in Arkansas.

Each year more than 200,000 Arkansans are identified as alcohol- or drug-dependent and almost 80 percent of those addicted to alcohol or drugs cannot get access to treatment or recovery services because their insurance doesn't cover it, they cannot afford it, or the state treatment system is overloaded. *“Just Say Yes!”* focused on the cost of untreated addiction; the need to consider addiction as a chronic disease that is treated and managed throughout a lifetime; the critical need for recovery services and support; the importance of reliable outcome measures for documenting successful recovery; and public support for addressing substance abuse. It also made recommendations for what the state could accomplish in the upcoming years.¹ This is the final report of the CATG project and takes a look at how far Arkansas has come during the past two years to address substance abuse treatment and long-term recovery in Arkansas.

Important steps have been taken to close this “addiction treatment gap” in that time. A follow-up analysis of state spending on the cost of addiction was updated, and the state launched a new service delivery initiative which included an innovative method of providing treatment and recovery services. Better outcome measures have been tested to capture the impact of treatment and recovery services.

At the same time, changes proposed in sentencing laws and prison reforms during the 2011 legislative session will likely create more need for services, and drug courts are being examined closely as they seek ongoing support during times of fiscal restraint. However, the demand for drug treatment and recovery services remains constant, and much more must be done to expand services and document the impacts of programs paid for by tax dollars to reduce the horrific consequences of untreated addiction in Arkansas.

“If substance use were its own budget category, it would rank third, behind higher education and elementary and secondary education.”

Shoveling Up: The Impact of Substance Use and Addiction on the Arkansas State Budget, 2008

The increasing financial drain of addiction on the state budget

In May 2009, the National Center on Addiction and Substance Abuse (CASA) at Columbia University released a nationwide study, *Shoveling Up II: The Impact of Substance Abuse on Federal, State and Local Budgets*, that included an analysis of Arkansas' use of state money in 2005 to address the problem. That report indicated that Arkansas spent \$887.5 million per year for items related to substance abuse, with only five percent of that (\$41.8 million) spent for substance abuse prevention, intervention, treatment, research, and regulation or compliance.²

In 2011, CASA conducted the same analysis on the 2008 state budget and came to similar conclusions:³

- In 2008 the Arkansas operating budget, excluding federal funds, was \$12.03 billion. The state spent \$1.15 billion on expenditures related to substance use and addiction, or 9.6 percent of the state budget. If substance use were its own budget category, it would rank third, behind higher education and elementary and secondary education.
- Of every dollar Arkansas spent on substance use and addiction:
 1. 93 cents went to pay for the burden of this problem on public programs such as prisons, public health, injuries, court costs, job loss, etc., (\$1.07 billion);
 2. three cents went to licensing and control of alcohol and tobacco and on collecting alcohol and tobacco taxes (\$30.09 million); and
 3. four cents went to prevention of and treatment for substance use disorders (\$50.54 million).
- For every dollar Arkansas spends to prevent and treat substance use and addiction, it spends \$21.17 on public programs shoveling up its wreckage (i.e. auto fatalities, job loss).

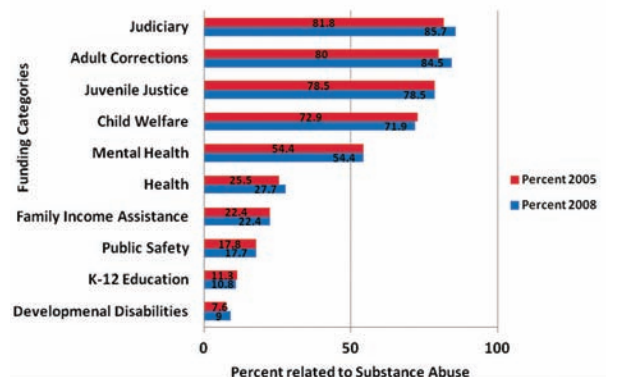
The largest areas of state spending directed at addressing the impacts of substance abuse and addiction are in justice programs to arrest, prosecute, defend, convict, jail, and to run and build prisons to house offenders or to supervise those on probation or parole (35 percent of total substance abuse and addiction spending, or \$372 million). The next biggest area of spending was for education to address the needs of children with emotional, learning, and behavior problems resulting from addicted family members (26 percent, \$277 million). Finally, the state spent \$259 million (24 percent) on health consequences of substance abuse, such as a lower levels of health in general and more frequent, longer, and more severe illnesses.

- For every dollar Arkansas spends on prevention or treatment for children, it spends \$443 on the consequences of substance use and addiction to them.

As a result of the failure to prevent and treat addiction, the burden of the problem has fallen on seven major areas of public spending: justice, education, health, child and family assistance, mental health and developmental disabilities, public safety, and the state workforce. As was the case in CASA's analysis of the state's 2005 budget, the judicial, adult corrections, and juvenile justice areas of the 2008 budget spent the largest percentages of their state funding allocations on addressing the consequences of substance abuse and addiction. In fact, the percentage of money spent on judicial and adult corrections related to untreated addiction increased over that three-year period. *See figure 1*

The Public Safety Improvement Act of 2011 is intended to reduce the cost

Fig. 1 The Percent of Category Spending Related to Substance Abuse, 2005 and 2008



Source: The National Center on Addiction and Substance Abuse at Columbia University

of adult corrections, expand the use of probation, and improve public safety by reducing recidivism. It was an acknowledgement of the unsustainable growth in the cost of prisons and the need to take a new approach to handling criminal behavior, much of it directly related to untreated drug and alcohol addiction. The criminalization of substance abuse and addiction, along with the lack of prevention, treatment, and recovery services to address the addiction, has created a crisis that appears almost impossible to overcome. The rise in the number of drug courts is just one indication that the relationship between crime and addiction is clearly understood by those in the criminal justice system. Unfortunately, it also contributes to public misconceptions that addiction is a criminal justice issue, something to be punished and not a public health problem to be addressed through treatment and long-term recovery before it results in criminal behavior.

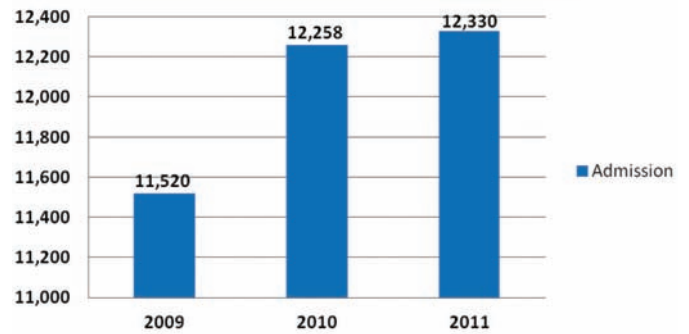
If properly used, drug courts can help address the underlying causes of criminal behavior. Drug courts are best suited to serve individuals with a high likelihood of substance abuse relapse or criminal recidivism. A recent survey of Arkansas adult drug courts⁴ shows that Arkansas drug courts tend to serve low-risk offenders with minor offenses and less severe substance abuse. Only two percent of the programs allow pre-adjudicated substance abusers admission without any court action regarding their guilt. More than half of the drug courts (54 percent) allow pre-adjudicated substance abusers admission to the program following court action, but prior to final disposition. The focus of drug courts has been on low-level offenders with minor substance abuse disorders. Most of the participants successfully completed these programs, but still had a criminal record that subsequently excluded them from holding many jobs, setting up additional barriers that make recovery even more difficult. Successful completion of substance abuse treatment and recovery services should allow those with minor offenses an opportunity to avoid criminal records. At the same time, adult drug courts should consider admission of more serious offenders to their programs. By successfully addressing the underlying causes of crimes committed by these serious offenders, public safety is improved, public costs are reduced, and the greatest benefits are realized.

Arkansas can no longer afford to ignore the consequences of untreated addiction to drugs and alcohol. The challenge is to take a long-term and rational approach to address addiction before it leads to crime, poor health, labor shortages, and loss of life and family. Despite the financial implications presented in this recent analysis of our state budget, moving public policy from a reactive to a pro-active approach has always been, and will continue to be, a challenge. The real tragedies of untreated addiction are not just in the loss of hundreds of millions of dollars in state tax revenue, but in the lives destroyed, the families torn apart, and the dashed dreams of the all those affected by untreated addiction each year. Arkansas can do much more to alleviate the impact of addiction and its financial burden on the state.

Publicly financed substance abuse treatment and recovery

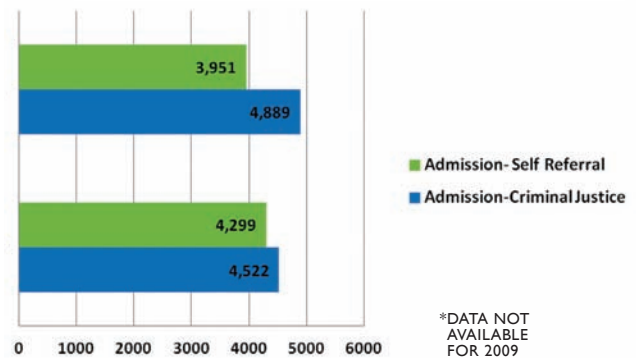
Total admission to publicly funded substance abuse treatment programs in Arkansas grew by only seven percent between State Fiscal Year (SFY) 2009 and SFY 2011. In each of those years, 83 percent or more of those entering treatment had no prior admissions, suggesting that less than 20 percent of those admitted had prior treatment.⁵ During this same three-year period, the number of state-funded treatment providers decreased from 44 to 42.⁶ See figure 2

Fig. 2 Substance Abuse Treatment Total Admissions SFY 2009-2011



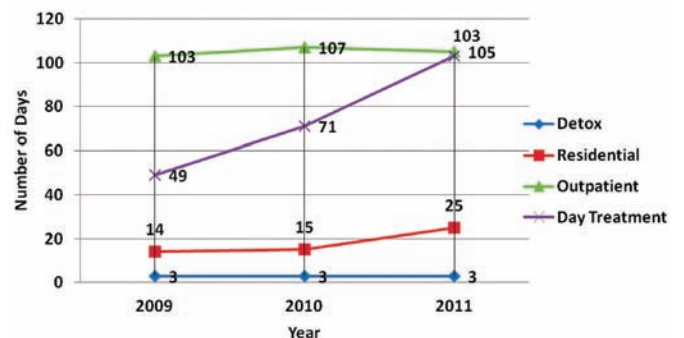
Source of data: Arkansas Drug Management Information System (ADMIS)

Fig. 3 Criminal Justice & Self Referral Admissions 2010-2011*



Source of data: Arkansas Drug Management Information System (ADMIS)

Fig. 4 Average Length of Stay in Each Treatment Modality SFY 2009-2011



Source of data: Arkansas Drug Management Information System (ADMIS)

It is instructive to look more closely at the two largest sources of referrals for admissions and discharges: self referrals and justice system referrals (prison/jail/corrections/criminal justice). This allows us to compare those entering treatment voluntarily (self referrals) with those who were non-voluntary. Justice system referrals represented 37 percent of all admissions in 2010, increasing to 40 percent in 2011. Self referrals represented 35 percent of admissions in 2010 and dropped to 32 percent in 2011. This indicates a growing connection between the judicial system and getting access to publicly funded substance abuse treatment services in Arkansas.⁷ See figure 3

Those entering treatment participate in a variety of treatment options depending on the severity of their addiction, their access to family and community support, and other factors that shape their treatment plan. Figure 4 illustrates the average number of days that clients participated in specific treatment modalities.⁸ Participants have the best chance of success after treatment if they have received at least 90 days of continued treatment (which may include various treatment modalities).⁹ There was a significant increase in the length of stay in day treatment programs during the past three years, a hopeful sign that the transition from acute care treatment to recovery services is improving. See figure 4

Perhaps the most basic measure of program success is tracking whether those entering treatment complete the program and/or transition to other needed services like those mentioned above. The percent of those completing treatment has remained constant throughout the past three years.¹⁰ See figure 5

Once again it is useful to look at those entering treatment through referrals from the justice system compared to those who were self referrals, since together they accounted for 72 percent of admissions in SFY 2011. It appears that those persons initially referred by the justice system are more likely to receive a favorable discharge (completed treatment or transferred to another facility) than those who enter treatment voluntarily. The most common “other discharge reasons” are “client left against professional advice” or “discharge for non-compliance.” See figure 6

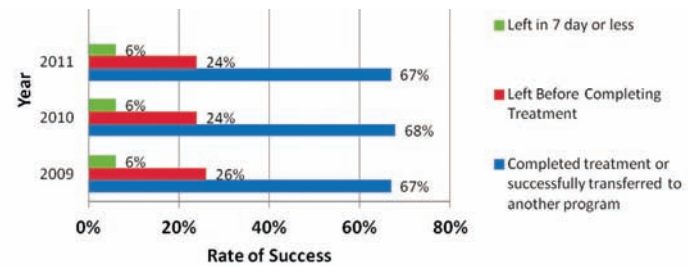
Measures of success after discharge include access to post-treatment services or supports that are critical to long-term recovery. Access to recovery services has long been a shortcoming in the state’s addiction treatment approach. Limited money for treatment has led to a focus on acute care treatment with few resources left for transitional programs or other recovery services. Employment remains a big challenge but improved access to housing and participation in support groups show signs of improvement.¹¹ See figure 7

Promising New Developments

THE ACCESS TO RECOVERY (ATR) PROJECT — This project is an initiative of the Substance Abuse and Mental Health Services Administration (SAMHSA), which awarded a four-year grant to the Arkansas Department of Human Services/Division of Behavioral Health Services (DBHS). This project, which began in October 2010, is being administered by DBHS with support from the University of Arkansas for Medical Sciences (UAMS) to help Arkansas shift the focus of care from acute treatment to an approach that builds on the strengths of those being served. Individuals with substance abuse problems are provided vouchers which they may use to pay for treatment and recovery support services that they believe best meet their needs. Individual choice has been found to strengthen the participant’s commitment to, and success in, recovery by honoring the familial, cultural, spiritual, economic, and logistical needs of each person.

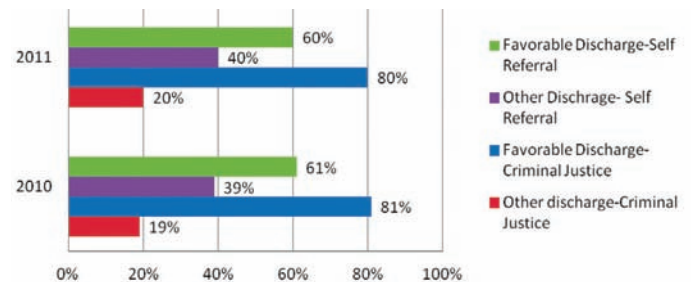
This approach has a history of success in other states and is being piloted in 13 counties in Arkansas: Benton, Washington, Crawford, Sebastian, Craighead, Garland, Saline, Pulaski, Lonoke, White, Faulkner, Jefferson

Fig. 5 Substance Abuse Treatment Admission: Success Vs. Discharge Rate



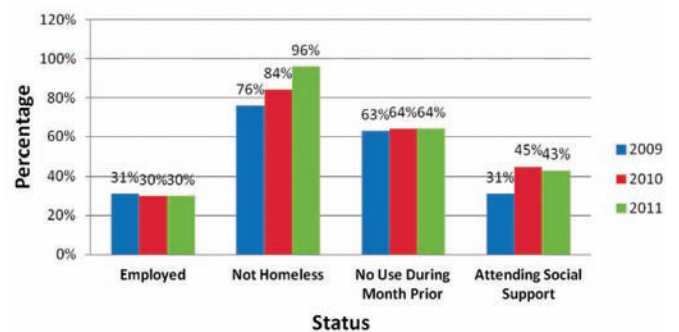
Source of data: Arkansas Drug Management Information System (ADMIS)

Fig. 6 Self and Justice Referrals Favorable vs. Other Discharge



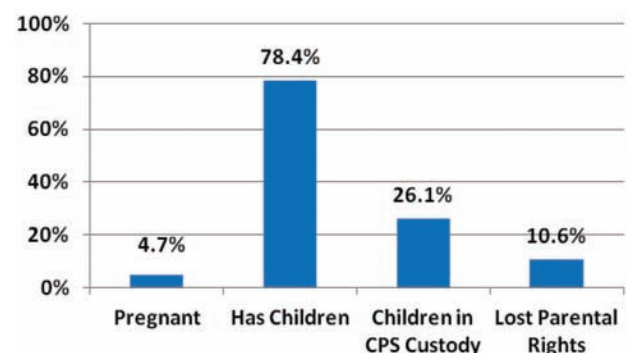
Source of data: Arkansas Drug Management Information System (ADMIS)

Fig. 7 Status At or Prior to Discharge SFY 2009-2011



Source of data: Arkansas Drug Management Information System (ADMIS)

Fig. 8 Percent of ATR Clients with Children



Source: UAMS Partners for Inclusive Communities

and Independence. To be eligible, one must be a resident of one of those counties, screen positive for or have documentation of a substance use disorder diagnosis, be at or below 200% of the federal poverty level, and be in one of the targeted service groups listed below:

- A member of the military/Arkansas National Guard and/or combat veteran (targeting veterans from Iraq and Afghanistan); family members may also receive services; or
- A pregnant woman or adult family member of child(ren) with Division of Children and Family Services or Youth Services involvement, or at risk for child welfare involvement; or
- Persons with a DUI/DWI conviction (targeting multi-offenders).

The initial phase-in of this project began in Washington, Benton, Pulaski, Saline, Garland, Faulkner and Jefferson counties where services were made available by ATR certified providers to more than 1,289 individuals who completed the ATR intake process during its first year.¹² A significant percentage (78.4 percent) of ATR participants has children. Of those, 26.1 percent have a child in Child Protective Services custody and 10.6 percent have lost parental rights. This data is not normally captured in other treatment programs and provides evidence of the considerable impact that substance abuse is having on Arkansas children. *See figure 8*

The ATR project has also served as a model for how to evaluate success by looking at various factors related to employment, housing, substance use, and legal involvement at the time of intake and then comparing the same numbers six months later. There were improvements in just about every category.¹³ Perhaps the most encouraging outcome measure was that 60 percent of ATR clients attended program self-help groups, 11 percent attended religious self-help groups, and 21 percent attended other ATOD groups six months after intake.¹⁴

Figures 9 and 10 illustrate the variety of recovery support services and clinical services that were chosen by the ATR recipients during the project's first year of operation. Both illustrate the variety of problems people with substance abuse face in trying to overcome their addiction and then re-enter the community in a way that improves the likelihood of a full recovery.

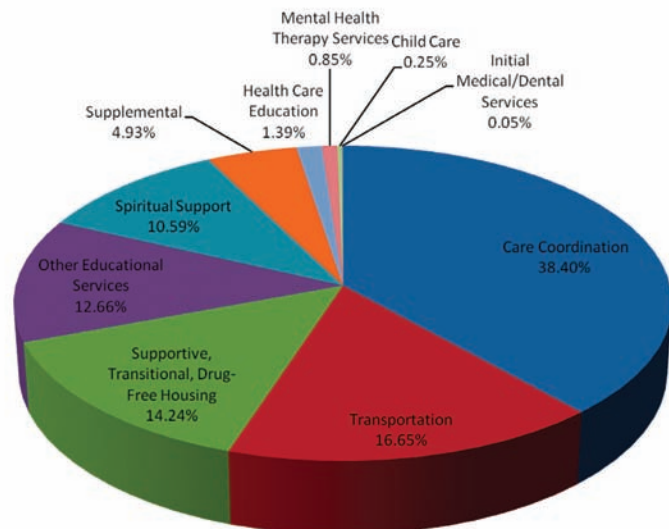
With the ATR project's flexible and holistic approach to drug treatment and long-term recovery, it has introduced a new and exciting model that could potentially transform how substance abuse treatment is provided in Arkansas. There is great anticipation that by the end of the ATR four-year grant period, resistance to changes in how to define services and how they are delivered will be minimized, and data will continue to confirm the program's effectiveness at reducing drug and alcohol addiction in Arkansas.

THE SUBSTANCE ABUSE TREATMENT SERVICES (SATS) PROGRAM

Administered by the Division of Behavioral Health (DBHS), the SATS program expands non-residential treatment options to women who are pregnant (and up to one month post-partum) and to youth eligible for Medicaid. A recent change in the state's Medicaid policy allows state money to be used for substance abuse treatment for this targeted population. With a match of three dollars in federal Medicaid for every dollar in state revenue, this policy will significantly increase money to serve pregnant women and children. The state has allocated \$5 million per year for this program. When matched with federal money, total annual funding could reach approximately \$18 million per year for direct services.

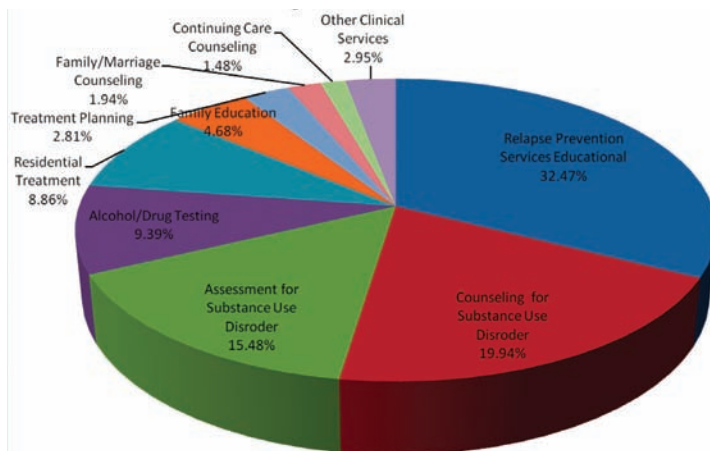
The SATS program, still in its early stage, is currently focused on certifying programs which must meet both DBHS and Medicaid requirements to

Figure 9 Percentage of ATR Recovery Support Services Accessed



Source: UAMS Partners for Inclusive Communities

Figure 10 Percentage of ATR Clinical Services Accessed



Source: UAMS Partners for Inclusive Communities

be eligible for funding. Of the 18 DBHS certified providers, 12 (66 percent) have also been Medicaid approved, two are pending Medicaid approval, and the remaining four programs are pending submission of an application for Medicaid approval. Unlike the aforementioned ATR program, the SATS billable services are more limited in scope and there is some concern that the reimbursement rates for those limited services are lower than the rates for similar mental health treatment services. The potential impact of SATS will not be understood until implementation is fully underway. Since this is the first time Arkansas has allowed substance abuse treatment under Medicaid there are likely to be growing pains and some adjustments during its first years of operation. This program, despite the policy changes needed to implement it, is a hopeful step towards reaching full parity for substance abuse treatment and recovery in the state's health care system. Given the anticipated increases on the overall cost of Medicaid in Arkansas, maintaining this program may present a real challenge in the years ahead.

The increasing role of drug courts in addressing substance abuse and addiction

Drug courts have been viewed as a hopeful way to increase treatment for those who have become caught up in the criminal justice system. Adult drug courts have enjoyed widespread public support, and criminal justice referrals now account for 40 percent of referrals to these publicly funded treatment programs. There are now 41 local adult drug courts in Arkansas that are structured in different ways, serve different populations, and operate differently. These local drug courts serve from 20 to 180 clients each year depending on the number of probation officers and counselors in each court.

The Closing the Addiction Treatment (CATG) project recently published a report, *Courting Success: Developing a Consistent Drug Court Model in Arkansas*, that outlines the 10 key components of effective drug courts. The report also summarized findings from multiple national drug court evaluations that define best practices. Based on a survey completed by local drug courts throughout Arkansas, this report outlines six opportunities for the implementation of best practices that would align Arkansas's local courts with established standards. These opportunities include

- Developing and supporting a consistent statewide model
- Improving the response time to positive drug screenings
- Reducing the use of jail time as a sanction
- Improving the use of external substance abuse treatment
- Expanding the eligibility of high-risk offenders
- Facilitating rapid program engagement

Given the important role these courts now play in the process of identifying and providing services to high-risk drug and alcohol addicts, it is critical they work to improve the efficiency of their programs and document their success. While the best approach to reducing the financial burden from addiction is to intervene before the person comes in contact with the courts, the oversight of treatment by a legal entity does have its place in the overall system of addiction treatment in Arkansas. If the adult drug courts in the state take advantage of these opportunities for program improvement and accountability, their role in reducing drug and alcohol addiction would be greatly enhanced and serve as model for reducing crime by addressing the root cause.

Where we go from here

The challenge moving forward is to develop a cohesive, coherent system of substance abuse treatment and recovery in which no population group is excluded, reimbursement rates are on par with those for other behavioral health services, and gaps in essential services are non-existent.

Currently, there are multiple sources of state and federal money used to provide treatment and recovery services for special populations, including pregnant women and adolescents, those in drug courts, and individuals involved with the Division of Youth Services, the Division of Children and Family Services, the Department of Community Corrections or the Department of Corrections. In addition, some sources of funding cover only certain types of treatment (e.g., outpatient only). These funding sources are not dove-tailed together well or coordinated, which leads to gaps in the services. Further, variations in the eligibility criteria bar entire population groups from accessing services.

The current system is driven by financially strapped providers trying to piece together what is possible given the current funding streams rather than the individual needs of the consumers – an approach that would result in a more holistic and effective approach to treatment and recovery. In order to create a truly effective system that provides comprehensive behavioral health care to Arkansans, the silos for substance abuse services and mental health services need to be broken down. To that end, the Division of Behavioral Health Services (DBHS) is undergoing internal reorganization. This includes dissolving the Office of Alcohol and Drug Abuse Prevention and the Offices of Children's and Adult Mental Health Services and combining the duties of those offices under one cohesive division. This is the first of many changes DBHS will need to make in order to achieve a holistic and comprehensive behavioral health care system in Arkansas.

The Access to Recovery Program offers a great opportunity to test a model of intervention that can alter the way treatment and recovery services are provided in the state. It should be replicated across the Arkansas if proven effective. Efforts should begin soon to develop a plan for sustaining this project beyond the federal funding period.

Adult drug courts should take advantage of the opportunities for improving their operation and outcomes that include developing a consistent statewide model based on best practices.

There are far too many Arkansans affected by substance abuse that cannot get treatment and recovery services because their insurance does not cover it, they cannot afford it, or because the current public system is overwhelmed. We must bring public attention and a sense of urgency to this crisis. It is a drain on our state economy and on the children and families impacted by this disease. Treatment and recovery does work. We can turn lives around when we take the elements that produce results, apply them in our communities, and just say yes.

References

- 1 Addiction Treatment and Long-term Recovery in Arkansas, Just Say Yes!, Arkansas Advocates for Children and Families, February 2010 <http://www.aradvocates.org/assets/PDFs/AACFjustsayeslow.pdf>
- 2 Shoveling Up II: The impact of Substance Abuse on Federal, State and Local Budgets, The National Center on Addiction and Substance Abuse (CASA) at Columbia University, May 2009 <http://www.casacolumbia.org/articlefiles/380-ShovelingUpII.pdf>
- 3 Shoveling Up: The Impact of Substance Use and Addiction on the Arkansas State Budget, 2008 Update. The National Center on Addiction and Substance Abuse at Columbia University, August 2011.
- 4 Courting Success Developing a Consistent Drug Court Model in Arkansas, Closing the Addiction Treatment Gap Team, 2011
- 5 Arkansas Department of Human Services, Division of Behavioral Health Services, Office of Alcohol and Drug Abuse Prevention, Referrals to Substance Abuse, Admission and Discharge State Fiscal Year (SF 2009, 2010, 2011
- 6 Ibid
- 7 Ibid
- 8 Arkansas Department of Human Services, Division of Behavioral Health Services, Office of Alcohol and Drug Abuse Prevention, Alcohol Drug Management Information System (ADMIS), Performance Measures for Substance Abuse Treatment Services, SFY 2009-11.
- 9 White, W. (2008). Recovery management and recovery-oriented systems of care: Scientific rationale and promising practices. Pittsburgh, PA: Northeast Addiction Technology Transfer Center, Great Lakes Addiction Technology Transfer Center, Philadelphia Department of Behavioral Health & Mental Retardation Services.
- 10 Alcohol Drug Management Information System (ADMIS),Arkansas Department of Human Services, Division of Behavioral Health Services, Performance Measures for Substance Abuse Services SFY 2009,2010, and 2011
- 11 Ibid
- 12 Arkansas Access to Recovery III, Year One Progress Report, October 1, 2010 to September 30, 2011, December 28, 2011 UAMS Partner for Inclusive Communities.
- 13 Ibid
- 14 Ibid
- 15 Service report with number clients 02.15.12 from WITS, Partners for Inclusive Communities
- 16 Report from the DHS Department of Behavioral Health, List of SATS Medicaid Delivery Sites status report. February, 2012
- 17 Courting Success: Developing a Consistent Drug Court Model in Arkansas, Closing the Addiction Treatment Gap Team, 2012

