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Testimony before the

House Committee on Government Reform,

Subcommittee on

Criminal Justice, Drug Policy and Human Resources

about Measuring the Effectiveness of Drug Addiction Treatment

March 30, 2004

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Introduction

Good afternoon, Mr. Chairman and members of the Subcommittee, with a special hello to Ranking Member Elijah Cummings, who represents the patients and families in Baltimore City whom my program, the Johns Hopkins Center for Addiction and Pregnancy, serves. Thank you for inviting me to testify about measuring the effectiveness of drug and alcohol treatment programs. I request that my written statement be submitted for the record, please.

I serve as the Director of Research for the Center for Addiction and Pregnancy at the Johns Hopkins University Bayview Campus and as a NIDA-funded researcher on drug treatment effectiveness. Additionally, my program is a member of the Maryland Addiction Directors' Council and the State Associations of Addiction Services, a national organization of state alcohol and drug abuse treatment and prevention provider associations whose mission is to ensure the availability and accessibility of quality drug and alcohol treatment, prevention, education, and related services. Improving the quality of services through evidence-based practice is one of the association's top priorities.

I have spent a significant amount of time thinking about how to expand and improve the drug and alcohol treatment system and maximize the effectiveness of drug treatment for my patients. Investing funding into the treatment system is critical, because the treatment gap looms large, both in my state and nationwide. In Maryland, there are approximately 250,000 individuals who need drug and alcohol treatment. According to the Substance Abuse and Mental Health Administration's 2002 National Survey on Drug Use and Health, in 2002 approximately 6 million persons with illicit drug dependence or abuse, and an estimated 17 million persons with alcohol dependence or abuse did not receive treatment. However, in addition to closing this treatment gap, we must ensure that we invest in the best treatment options and provide access to services that are evidence-based, ensuring that our wealth of science makes it to the street and becomes incorporated into everyday treatment practice

CAP's Outcomes Demonstrate that Alcohol and Drug Treatment Can Be Effective

Addiction is a serious and chronic health problem. We are all in agreement that something should be done to treat it. CAP and many other treatment centers for pregnant women and women with children throughout the nation are addressing this problem -- and I am here to tell you that we are succeeding. Let me please share some of our successes:

- **75%** of the women at CAP have drug free deliveries and are drug-free three months after treatment. This statistic is confirmed through urine drug screens, providing objective data about the status of drug use among our patients.

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- **81%** of the children born to CAP patients are born drug-free.
- **70%** of the women at CAP maintain custody of their children.
- **95%** of the women remain HIV negative while in treatment at CAP.
- **15%** of the women at CAP decrease their dependence on welfare.
- The average baby born to a CAP treated mother is born **at a normal time (38 weeks)**, at a **healthy birth weight (6+ pounds)** and with **normal alertness and health (Apgar scores of 8 and 9)** on a scale of 1-10).
- **\$12,000 in savings *per infant*** is generated by CAP care through a reduction in NICU stays.

CAP's successes are typical of women's treatment services across the country. According to the Center for Substance Abuse Treatment's (CSAT) 1995 evaluation of its Pregnant and Postpartum Women and Infants Program, which provides comprehensive services to substance abusing women and developmentally appropriate care for their infants and children at six months post-treatment:

- **95%** reported uncomplicated drug-free births.
- **75%** of women who successfully completed treatment were not using alcohol or other drugs.
- **65%** of children were returned to their mothers from foster care.

Additionally, results from NIDA's 1997 Drug Abuse Treatment Outcomes Study (DATOS) demonstrated that women who have at least 28 days of treatment (with at least 14 days in short-term residential) also can have sharp reductions in their use of illicit drugs, HIV risk behavior, and illegal activities. Women in short-term inpatient treatment showed significant reductions in illegal drug use one year after their treatment, with 86 percent admitting use at intake and 32 percent reporting use after one year. With long-term treatment, the results improve – at intake, 84 percent of the women admitted using illegal drugs every day or at least once a week. Twelve months after treatment, only 28 percent reported using drugs.

Treatment at CAP

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Pregnancy provides a window of opportunity for women with alcohol and drug problems. Every day at CAP we get phone calls from women who are pleading for help but who are afraid to come into treatment because they have heard from other women that they will lose custody of their children as a result of admitting that they have a problem. This fear of persecution results in some women sometimes not seeking or engaging in treatment despite the fact that they desperately want and need help. However, when women find out that they are pregnant, they want their babies to be healthy and often are highly motivated to enter treatment.

Founded in 1991, CAP is an outpatient and residential program that provides a comprehensive, coordinated and multi-disciplinary approach to treating drug-dependent mothers and their drug-affected babies. The program, which is housed entirely in the Johns Hopkins Bayview Medical Center, includes a broad spectrum of care, including mental health and substance abuse treatment, pediatrics, and obstetrics and gynecology. CAP also offers transportation, medication-assisted treatment if necessary, and a childcare center. By providing comprehensive health care and complementary services in one convenient location, CAP breaks down the barriers that often keep this high-risk population of women and children from receiving the care they need.

Clients at CAP spend 60-90 days in treatment, after having waited 2-4 days for a treatment slot to open. (The wait for treatment is so short because there is a mandate in Maryland that requires pregnant women to be treated within a certain period of time. When CAP is full, women are engaged in outpatient treatment to help them until an inpatient treatment slot is available.) Women enter CAP through referrals from the welfare, child welfare, criminal justice, mental health, and Medicaid managed care systems in Maryland. The program can accommodate 16 women at one time in residential treatment, 100 women in day treatment, and up to 130 women in medication-assisted treatment.

In addition to a treatment protocol that includes levels of inpatient and outpatient care that can increase or decrease in intensity depending on the patient's needs, CAP also has a range of support services that include on-site child care, transportation to and from treatment, and intensive outreach services for clients who miss one or more days of treatment. These services are critical to helping patients succeed during their treatment at CAP. Additionally, patients also receive exit planning, parenting training, and nutritional support. Children receive a host of services as well, including well and sick care, pediatric care during and after their mother's treatment is completed, case management, developmental assessment and tracking.

Including these types of services helps to improve the quality and success of the treatment at CAP and without these services CAP would not be able to achieve the types of outcomes that I have described to you today. Delivering quality drug and alcohol treatment is not limited to

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providing only clinical drug treatment, but also should include providing a range of aftercare and support services that help patients maintain their sobriety and succeed in becoming a participating member of our community. Important services that can enhance the success of drug and alcohol treatment include transitional housing, job training and education, child care, transportation, health care, and recovery support or mentoring. Without these additional services, for which there is difficulty getting funding or reimbursement if a treatment program attempts to provide them, simply providing clinical drug treatment may not be enough for many individuals and families.

Improving Treatment Quality

Measuring outcomes and conducting studies at the Center for Addiction and Pregnancy has taught us much about specific treatment strategies that work with the population whom we treat – pregnant and parenting women and their partners. We have been able to conduct studies, funded by NIDA, to determine the effectiveness of specific treatment techniques and that information has informed our protocols and improved our practice. And clearly, continuing to support funding increases for NIDA and NIAAA (the National Institute on Alcohol Abuse and Alcoholism), such as a 10% increase in each of their budgets to bring them to \$1.09 billion and \$472 million, respectively, so that they can continue to support the development of new science will help to improve the effectiveness of drug and alcohol treatment. However, once this science is complete, we need to continue to transfer this information to other providers through training and technical assistance in order to improve front line practice. Without science and technology transfer through vehicles such as NIDA’s Clinical Trial Networks and SAMHSA’s Addiction Technology Transfer Centers and Practice Improvement Collaborative, the addiction field will not be able transfer new scientific knowledge and practice to the front-line treatment provider. Additionally, better recruitment and retention of the addiction treatment workforce is key to the long-term improvement of treatment quality. Development of coursework in medical and nursing schools that trains and then encourages those practitioners to enter the addiction treatment field is critical. Many health care providers get fewer than three hours of addiction training or course work in school, thus making it difficult for health care professionals to recognize this common problem that underlies many other medical issues. Additionally, maintaining ties and improving training for the essential recovering community who has long served as front-line staff from many community-based drug and alcohol treatment programs is essential to developing a workforce that understands how to engage and retain clients in treatment and provide critical aftercare and support services.

I urge Congress and SAMHSA to place a high priority on developing the alcohol and drug treatment workforce. SAMHSA should work with stakeholders to address training, development of educational standards, diversity, recruitment and retention, and other workforce issues. Congress should develop loan forgiveness programs for addiction treatment providers that would

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help to relieve educational debt. These programs are critical to attracting and training qualified individuals for the addiction treatment workforce, since many practitioners cannot afford to accept the low salaries frequently offered by this underfunded field.

Increasing Funding for Treatment Will Help Improve Treatment Quality and Outcomes

Funding new treatment techniques, including emerging medications and incentives also will facilitate putting the best practice into place. Without additional treatment funding, providers are not able to put the most cutting-edge services into place. New medications are more expensive and new techniques, such as incentive vouchers, cost additional funding that was never previously budgeted and providers cannot afford to use this new practice technology without additional funding.

Access to the full continuum of treatment is also a problem – patients are not able to easily go from one level of care to the next because access to treatment is so limited. This problem can delay entrance into the next appropriate level of care for a patient, causing unnecessary expenditures at more expensive programs while a patient waits for a treatment slot to open at a more appropriate level of care. Additionally, patients from the CAP program often move into programs that cannot afford to continue the intensive support services that are needed to assist them in their parenting and recovery. For example, some third party payors fund detoxification but do not fund follow up treatment and care. This is clinically inappropriate and sets up the patient to fail. Detoxification is only the first step in the treatment of certain types of addiction. Follow up services are necessary to help make long-term recovery a reality. However, funding the full continuum of services is extremely difficult for many jurisdictions given the pressure on the limited amounts of funds that are available and the limitations that exist on some of the programs, such as Medicaid. (Specific Medicaid limitations and recommendations are described below.)

The Substance Abuse Prevention and Treatment (SAPT) Block Grant provides the lion's share of public funding for drug and alcohol treatment nationwide. However, despite this funding source, treatment remains scarce and difficult to obtain, with as many as 4 out of 5 individuals unable to access treatment. At CAP, women wait 6-8 weeks to access a another level of care once they are ready to transition out of the CAP program. This access problem is caused in part by the fact that private and public insurance frequently do not cover the cost of drug and alcohol treatment and States have faced unprecedented financial pressures over the last 2 years, thus making treatment funding even more scarce and increasing the importance of the SAPT Block Grant.

In FY 2004, the SAPT Block Grant will receive a \$25 million increase; while any increase is generous, this funding will not close the 80-85% nationwide treatment gap. While programs have made significant progress in expanding access to and improving the effectiveness of treatment, it is critical that funding be provided that will help to expand these services more

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widely throughout the 50 states. A \$125 million increase in FY 2005, to bring the SAPT Block Grant up to \$1.905 billion, will help provide the additional funding to continue to close the treatment gap and to meet the pressing need for treatment services nationwide.

In addition to adequate funding for the Substance Abuse Prevention and Treatment Block Grant, increased funding should be invested in the Targeted Capacity Expansion programs under the Centers for Substance Abuse Treatment to help meet the evolving needs of communities. These programs are targeted, gap filling services tailored to address specific and emerging drug epidemics and/or underserved populations, such as pregnant and parenting women – ensuring that these programs continue to receive support is critical, since many of these programs do not receive traditional Block Grant funding. Also, the President’s request for full funding at \$200 million for the Access to Recovery Program should be funded in order to help further expand access to services, especially since this program will permit the funding of aftercare and recovery support services that I have described as critical to the effectiveness of treatment.

Increasing Medicaid Coverage also would expand access to alcohol and drug treatment for low-income women and children and other eligible populations. Many low-income individuals, including all women on welfare and those in families involved in the child welfare system, are eligible for Medicaid. CAP receives approximately 90% of its funding from the Medicaid program. However, Medicaid coverage for alcohol and drug treatment services for these individuals and families is unnecessarily limited.

The national goal of reducing alcohol and drug use and their devastating consequences on individuals, families, and society requires better Medicaid coverage for treatment. Medicaid coverage for alcohol and drug treatment could be enhanced by:

- Making alcohol and drug treatment a required service under the Medicaid program.

Medicaid finances some drug and alcohol treatment, subject to state limits on amount, duration, and scope, but alcohol and drug treatment is not a required service under the program. Because it is an optional service, only about 25 States have opted to cover drug and alcohol treatment services under their Medicaid benefit. States providing treatment to Medicaid clients can receive reimbursement if the treatment is provided under a Medicaid service category that qualifies for Federal matching funds. The advantage of this policy change is that it would help establish a more stable source of funding for treatment that is not discretionary and subject to the annual appropriations process. Such stability would increase access to treatment for low-income individuals and families who presently rely on limited Substance Abuse Prevention and Treatment Block Grant and scarce discretionary funds to support treatment services.

- Lifting the “IMD exclusion.”

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One of the most serious roadblocks preventing low-income individuals from obtaining residential alcohol and drug treatment has been the “Institution for Mental Diseases (IMD) exclusion.” The IMD exclusion is a statutory provision that prohibits Medicaid from paying for institutional treatment for individuals between 22 and 64 who are diagnosed with mental diseases and receiving treatment in programs with more than 16 treatment beds. In order for CAP to receive Medicaid reimbursement for its patients in residential care, it must keep its residential program at 16 beds or less. Also, individuals who enter IMD’s lose their Medicaid eligibility for all Medicaid reimbursable services, including prenatal and HIV care – costly services which can drain scarce treatment funding if a program forgoes Medicaid funding by running a residential program larger than 16 beds or if it is located in one of the approximately 25 states that does not cover alcohol and drug treatment services under its Medicaid benefit.

While Congress never explicitly defined mental diseases to include alcoholism and drug dependence, the former Health Care Financing Administration (HCFA) interpreted mental diseases to include addiction. The simplest way to change the IMD exclusion would be to amend the regulations by removing “substance abuse” from the definition of “mental diseases.”

Legislative options for a fix also are available. For example, during the 105th Congress, Senator Daschle introduced legislation, S. 147,¹ which would have lifted the IMD exclusion for pregnant and postpartum women.² The Congressional Budget Office scored a previous version of this legislation as costing only \$145 million over five years.³

Moving Toward Standard Performance Outcome Measures: The Importance of Including the Provider Perspective

Since funding for drug and alcohol treatment is scarce, moving toward a system of uniform performance outcome measures across federal funding streams would be beneficial for providers

1 The "Medicaid Substance Abuse Treatment Act of 1997" is also co-sponsored by Senators Chafee, Kennedy, Johnson, and Reid.

2 The bill would prohibit reimbursement for facilities with more than 60 beds (unless waived by the state alcohol and drug agency) or licensed as a hospital. It would also set a ceiling on the number of beds covered at 1,080 in 1998 up to 6,000 in 2002. After 2002, the Secretary would determine the number of beds covered.

3 The provision had been included in the Senate version of the 1993 budget reconciliation act but was dropped in conference committee.

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in that this change would help to reduce the administrative burden that providers face in having to meet different outcome measurement requirements for different funders. The savings from reduced administrative expenditures, which have risen dramatically for some programs, would hopefully be invested back into treatment and provider training – things that would help to improve the overall quality of treatment, and as a result, its effectiveness.

However, when SAMHSA determines the selected performance outcomes measures, it is critical that it consult providers as well as States, since outcome data is generated first at the provider level. It is important to gain provider perspective about the challenges of collecting data for each of the selected measures, such as drug use, criminal justice involvement, employment, and family/community relationships, for the various types of providers who participate in the continuum of drug and alcohol treatment (residential, outpatient, medication-assisted, detoxification, intensive outpatient, office-based treatment, etc.) SAMHSA also would gain insight from providers about important issues, such as the ability to collect data during treatment as opposed to waiting only until after treatment has been completed, and individual issues it should take into consideration when collecting data from specific types of programs, such as programs serving pregnant and parenting women.

Conclusion

Drug and alcohol addiction is a significant public health problem, but we can do something about it by investing in our drug and alcohol treatment system and the other services that help support recovery. Thank you for your leadership today in holding this hearing and highlighting the importance of these critical, life-saving services – my patients and I applaud you.

Thank you for considering my testimony. I would be happy to take any questions.