Seven Policies Required to Conquer Addiction in our Lifetime

Testimony By
Johnny W. Allem
President
Johnson Institute

Before The
Institute of Medicine
April 26, 2004
Washington, DC

Advancing Help and Hope
The 40-year tradition of the Johnson Institute

Vernon Johnson, an Episcopal priest in recovery from alcoholism, founded the Johnson Institute in the 1960s to demonstrate that early intervention in the disease of addiction is successful. Dr. Johnson and his colleagues created and taught intervention technology to thousands of addiction counselors and related professionals throughout America and the world.

The Johnson Institute today identifies, nurtures, and supports initiatives that reach individuals andfamilies early in their difficulties with chemical dependency. Our initiatives include: Center for Education and Advocacy, Rush Center of the Johnson Institute - for congregational action, Center for Policy and Communications, and the Center for Resource Development.

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In 1999, the Institute of Medicine published "To Err Is Human," launching a major initiative to improve the quality of health care in America. The more detailed 2001 report, "Crossing the Quality Chasm," charted specific recommendations for improvements in the nation's health care system. The IOM received considerablepressure to include behavior health systems in their review. Hearings began on April 26, 2004, by a special IOM Committee on "Crossing the Quality Chasm – Adaptation to Mental Health and Addictive Disorders." Five lead-off witnesses representing the consumer communities within behavior health were heard. Mr. Allem was the only witness specific to addictive disorders.

Recovery from alcoholism and other drug addiction is happening for millions of Americans – rich and poor, old and young, Ph.D.s and high school drop-outs, women and men, black and white, country and city dwellers. Achieving a stable, productive and fulfilling life is, in fact, a normal expectation when proven solutions are applied. Appropriately diagnosed and treated cases of addiction illness yield many happy outcomes:

Recovery happens. Families heal. Money is saved. Life gets better. Recovering people give back. Everyone wins!

The frequent and consistent experiences of recovery demonstrate our growing understanding

of this disease and the tremendous advances of science. I believe we can say that the chronic illness of alcohol and drug addiction has been conquered. That is to say, we have proven solutions, and that when they are broadly applied, the illness can be reduced to a manageable health threat, and does not need to remain the on-going epidemic.

The fact is that when it comes to addiction, the solutions are not applied in proportion to disease prevalence. In the case of addiction to alcohol and drugs, the illness has been conquered, but the epidemic rolls on. The gap between what society knows about drug and alcohol problems and what society does with that knowledge is huge and fatal for millions.

The ground-breaking Institute of Medicine report, "Crossing the Quality Chasm," noted the importance of measurements that engage "everyone with a stake in health care." Identifying and mobilizing all available stakeholders is important to improved physical health. It is critical to improved outcomes in behavioral health and especially addictive disorders. I am grateful for this opportunity to add my voice to this effort. Thank you on behalf of myself and the millions of Americans who today enjoy recovery from this chronic, progressive and unnecessarily fatal illness.

The Johnson Institute (JI) believes recovery can become a normal and expected outcome for addictive disorders in America if and when responses are designed and applied when symptoms are presented. This appropriate application of responses in a timely manner has been a successful strategy in conquering other chronic disease. For this to occur in the early development of alcoholism and other drug addiction, significant new stakeholders must be mobilized, equipped and motivated.

Appropriate responses continue to be discovered in science and practice. New and on-going research will bring us newer and better responses. But today's challenge is to apply the responses currently available. That challenge requires new policies and practices more than it requires new science. Seven policies are required to bring the response to chemical dependency in line with other chronic illness. These policies have become cross cutting principles in all of JI's projects, publications and services.

1. Individuals and families who have survived their addiction experience must become visible and vocal stakeholders.

History teaches us that public responses to major illness are driven by the voices of survivors, their family members and allies. We are no exception. Our society's penchant for punishment instead of treatment has choked this voice. Our willingness to see value in "deterrent" strategies instead of healing practices costs everyone.

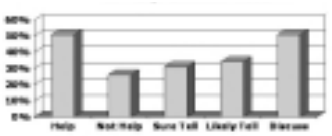
People long in recovery from addiction find themselves banned from access to Federal education grants, loans or work assistance for a year, two years or a lifetime if they have ever received a drug conviction. More than 124,000 students have been refused financial aid or stopped applying for aid as a result of a law enacted in 1998. Banning access to financial aid unfairly punishes people a second time and denies access to education for people who are trying to improve their lives and recover from addiction. Drug convictions are the only criminal act that can take away your right to student financial aid.

More than 80 percent of those in need of addiction recovery treatment are employed. If they have health insurance that includes coverage for addiction, they frequently face limits on the amount of care and must pay higher co-pays and deductibles. More than one in five people with employer-provided health insurance are afraid that seeking treatment will cause them problems at work, including being fired, losing a license, or missing promotions. This fear of discrimination causes many to pay for treatment out of their pocket in order to avoid a claim record that includes addiction.

The good news is that today we enjoy a generation of people in recovery that is ready and willing to speak out. The Johnson Institute was an early sponsor and funder of the Faces and Voices of Recovery Campaign, a national movement of people, families and allies in the recovery community. We must honor and support those who fight for better responses to our illness for our children and grandchildren.

In August of 2001, Peter D. Hart Research Associates conducted the first of its kind random-telephone national survey of people in recovery from drug and alcohol addiction, and family members of people in recovery. The survey showed that one in three (31%) people within the recovery community say that they definitely would be willing to speak out or write publicly about their experiences with addiction and recovery. Another third (34%) would probably be willing. Even more optimistic, half (51%) of the community felt very comfortable talking about the problems that they or their family member had with drugs and alcohol.

Eighty-seven percent of people in the recovery community say it is very important for the American public to know the basic facts about addiction and recovery. Eighty-eight percent believe it is very important for the American public to see that thousands get well each year. The recovery community strongly supports messages that explain results and the recovery process.



Degree that people in recovery are willing to help change America's attitudes about addiction (Peter Hart Associates, 2001)

2. Address symptoms of addictive disorders when they occur.

Early awareness and early intervention lead to early recovery. That's a bargain for individuals, families, employers and society. Johnson Institute is a leader in efforts to respond to alcohol and other drug problems early on and in a range of venues.

Our health system traditionally addresses addiction when a crisis occurs: car wrecks, criminal arrests, family violence, or firing from a job. We act as though entry into detox is the beginning of the disease. And institutionally, we lose interest within a few months of an initial treatment regimen. I call this tendency to react to addiction as an acute illness the "14-month wonder" of our health care system. Both the emerging symptoms of illness and the remarkable fact of recovery remain below the awareness level of

Society's knowledge and response to addiction is traditionally limited to the days before crisis until a few months after initial acute care treatment. This chart demonstrates the lack of interest or responses to either the emerging illness, or successful recovery.

society. Both aspects of this inattention breed the ignorance and misinformation that costs us all so much pain and money.

The seemingly radical idea that we should respond to symptoms of addiction when they present themselves is consistent with the fact that alcoholism and drug addiction is a chronic, progressive illness.

"Brief intervention" practices demonstrate tremendous efficacy, yet are seldom applied and rarely financed by insurance or public health finance. Over a period of 6-12 months, drinkers who receive a brief intervention are twice as likely to reduce their drinking as others. United Behavioral Healthcare, a managed care organization, found that 64 percent of the people who took advantage of counseling in an Employee Assistance Program did not need further treatment to address their problem drinking. For people with high levels of alcohol dependency or addiction, brief intervention is not a substitute for treatment. It can, however, motivate risky drinkers to seek help and significantly reduce the health and other risks related to drinking. Opportunities for clergy, school counselors, criminal justice officers and other social agents are tremendous. Simply raising the question and making conversation possible dramatically improves outcomes later in life. For instance, pastoral counselors participating in Johnson Institute's Faith Partners congregational team ministries are experiencing good results when asking this question during marriage

counseling: "What role does alcohol and drug use have in your relationship?"

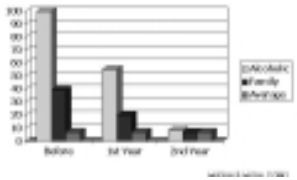
3. Promote healing strategies within the family and community.

Chemical dependency impacts everyone. Illness and the process of getting well have cascading impacts, moving from individuals to families, to communities, to society. Healing can, and must, include the entire family. We must carry this view into the world of healthcare reimbursement codes, workplace interventions, church ministries and schools.

Addiction is a family disease. Not only is there a significant genetic component that is passed from generation to generation, but the addiction of a single family member affects all other family members. The family environment and genetics can perpetuate a vicious and destructive cycle. Families also play a critical role in addiction recovery. They can be instrumental in encouraging a family member to seek treatment. Strong family support also increases the chances of successful recovery.

Children of addicted parents are at high risk for developing problems with alcohol and other drugs. They often do poorly at school, live with constant tension and stress, have high levels of anxiety and depression and experience coping problems.

Medical costs for the entire family decline dramatically after the first year of treatment for addiction. There are fewer missed days of work and school for the entire family once an individual is in recovery.

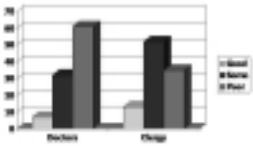


Scale for costs of all health care is based on $100 of care for alcoholic prior to first treatment. Costs for general health care not only drop significantly for the individual in treatment, but for the family as well. (Holdern & Hallan (1986).

4. Use existing institutions to intervene and promote healing.

Schools, faith-based institutions, primary care physicians, employers, the criminal justice system, and the health care system can and should recognize their stake and opportunity to identify difficulties related to substance use and developing addiction and apply appropriate educational, referral and support responses. According to research by the Peter Hart Associates for the Rush Recovery Institute (1998), American families in trouble still seek assistance and counsel from their general practice family doctor and their pastor or spiritual leader. Both of these professions report they are poorly prepared and lack knowledge or skills to appropriately respond to issues of drug use or addiction.

According to Columbia University's Center for Addiction and Substance Abuse (CASA), ninety four percent of clergy consider chemical dependency to be an important problem in their congregations. Yet, only twelve percent of clergy have received any training on chemical dependency issues. Usually, it is family members who bring their questions and cry for help. Too often, their questions go unanswered. The pastor simply doesn't know what to do. An understanding clergy supported by committed and trained members of a congregation have a tremendous opportunity to address addiction problems in very early stages of pain.



Doctors and clergy both report very little training that would adequately prepare them to respond appropriately to concerns of addiction, for individuals or families. (Rush Study, Hart Associates (1998).

After a decade of decline in treatment availability in America, capacity in residential and out patient settings is growing. This is a time of opportunity. As specialized addiction treatment expands, we need to recognize the significant role that traditional institutions can and must play in ending this epidemic. Enlisting and motivating these professions requires little new money, just new attitudes, training and commitment.

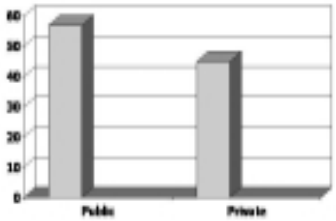
5. Restore responsibility for addiction recovery care within the nation's private health care finance system.

Prevention, treatment and recovery are health responsibilities. Eighty percent of people in need of treatment are employed, most with insurance benefits. Yet, most employee-based insurance hinders people from being treated successfully for addiction. Lifetime limits

are imposed on episodes of care even though addiction is a chronic disease, much like asthma, diabetes, and hypertension. Treatment is arbitrarily reduced or terminated for people with addiction disease, despite recommendations and standards of care providers. And by not fairly covering addiction treatment, like other chronic illnesses, insurance companies discourage people from seeking treatment by making them pay more out-of-pocket expenses.

Today, taxpayers are the single largest funder of addiction treatment services. Individuals pay almost eight percent of the cost of treatment out-of-pocket. Private health insurance only make up about 35% of the funding for addiction treatment. It's called discrimination! We must access the traditional health care dollar. That's why JI supports Members of Congress like Rep. Jim Ramstad (R-MN) and Rep. Patrick Kennedy (D-RI) and the work they are doing with the H.E.A.R.T. Act. The cost transfer of chemical dependence to the public sector delays appropriate care, costs much more, and reduces the chance for recovery. Access to the traditional, private health care dollar must be granted, if the addiction epidemic is to be overcome. The epidemic cannot be stopped with government money and self-pay treatment alone.

Studies have shown that the costs of chemical dependence treatment parity are minimal compared to the cost of untreated alcoholism and drug addiction. Treatment for alcoholism and drug addiction saves the healthcare system through lower primary health care and reduced accidents alone, not including the positive effects on lives, families, and communities.



Taxpayers are the single largest funder of alcoholism treatment. (DHHS, SAMHSA (1996)

A Minnesota report found that almost 80 percent of the costs of addiction treatment were offset in the first year following treatment due to decreased use of hospital, emergency room, and detoxification services and reduced arrests. In California, a study found that criminal activity declined by 66 percent, drug and alcohol use declined by 40 percent and hospitalizations declined by 33 percent following treatment.

Requiring health insurers to honor appropriate health claims is too often discussed as a cost issue rather than a discrimination issue. Cost is simply not the issue. Projected costs on data from states than have enacted parity for treatment have found the average premium increase due to full parity would be 0.2%-0.5%. The costs of addiction in America far exceed the minimal costs of enacting the HEART Act.

6. <u>Rebuild and reward a qualified, professional workforce for specialized treatment of addictive disorders.</u>

The professionals who staff specialized addiction treatment are highly motivated but under rewarded. Consequently, the turnover of staff is among the highest in the health industry. This workforce operates detoxification centers, intake and assessment clinics, residential treatment, intensive outpatient treatment, and specialized clinics and service centers. They include methadone clinics, collaborative services for people with co-occurring disorders and senior services. The field has experienced intensive pressure to upgrade education and technical credentials in recent years. The effort, however, is not met with increasing pay or opportunities for promotion. Individuals who obtain advanced degrees or credentials are drawn to other health fields for better income and professional growth.

According to estimates of the Association for Addiction Professionals, the majority of addiction recovery workforce is aged 40 to 55 years old. Most report spending less than half of their time counseling, often spending 60% of their time doing paperwork. Counselor turnover is more than 50% each year. In a March, 2004 survey, The Lewin Group reported that 5,000 new addiction professionals are needed each year just to replace those who are leaving the field.

The majority of people entering

the field are drawn by personal factors such as their own personal experience with addiction, a family member's experience with addiction, or the desire to help the community. Challenge, desire, community, family issues, and training are all listed as reasons for entering the field by professionals, well ahead of the opportunity for advancement and pay. We are grateful for the missionary aspect of people entering the field, but the career outlook is devastating and must improve.

Positions in the chemical dependency field must be appropriately paid and honored. Low salaries are cited by 84 percent of hiring managers as the reason they cannot fill these positions.

7. The spiritual gateway to change and healing works

The acknowledgement of the importance of faith practices is a door opening perspective, not a narrowing of the view. Trouble people and families turn to their institutions of faith for help. Too often, pastors and congregations lack the knowledge to help.

There is no conflict between science and spirituality, only misunderstanding and intolerance. Research continues to demonstrate the positive relationship between spiritual practices and values and evidence-based scientific practice. Pastors and spiritual leaders who study addiction disease and appropriate health responses dramatically increase possibilities of recovery.

The power of prayer to promote healing is well documented. In a Duke University study in 2001, a cardiac care group subject to off-site intercessory prayer had 50% better outcomes and fewer complications than those patients that were not subject to intercessory prayer. At the same time, a variety of paths and combinations of therapies and medication are effective and need support as appropriate responses for many individuals.

Civilization is blessed with a variety of physical specimens, personalities and states of mind. The universality of addiction disease is apparent. Just as apparent is the need, and the supply of varied and flexible recovery responses.

From the cross cutting principles I have outlined, let me address the three specific questions you have posed.

1. In what ways does substance use disorder health care diverge from these aims for quality health care (safe, effective, patient-centered, timely, efficient and equitable)?

As I have documented, the current system of health response to substance use disorder begins in crisis, applies acute care regimens, fails to provide long term support and blames the patient for relapse rates that are in fact lower than the rates for asthma, hypertension and diabetes. Though most professional, intensive treatment for the crisis phase of illness is adequate for this advanced state of illness, the health care response overall is not safe, effective, patient-centered, timely, efficient or equitable.

2. What strategies should be employed to improve these defects in health care quality?

The strategies we support are:

- Moving recognition and response to the earliest presentation of symptoms;
- Engaging ancillary professionals (such as clergy, school counselors, police, human resource, etc.) in knowledgeable responses – including intervention and referral;
- Honoring and engaging people who have survived their experience with addiction illness; and
- Restoring appropriate reimbursement for addiction treatment from traditional healthcare plans, where premiums have been paid with the expectation of appropriate care.

3. What roles should consumers play in improving the quality of substance use treatment services?

Consumers undergoing treatment for crisis symptoms are not likely to become a viable force for better treatment as long as early difficulties are ignored, crisis difficulties are punished and survivors discriminated against. We need to end discrimination, apply healing technologies where appropriate and honor and respect recovery.

May I add that this institution and this forum can significantly enhance America's view of this disease and advance the range of responses. As a person in recovery, I am grateful for your attention to behavioral health generally and addiction recovery specifically. I am honored to be part of this process. A prevailing view is that stigma is the primary barrier to appropriate attention and care. That may be true. But I suggest that fighting stigma is like packaging fog. What we can really work on is practices that end discrimination and policies that expand vocal and effective stakeholders. Your process has the hope of improving both.

Thank you for this opportunity to testify on behalf of Americans who suffer this disease and those who have recovered successfully.

Johnny Allem is a leading national advocate for addiction recovery issues and President of the Johnson Institute. The Johnson Institute has been a leading innovator in the campaign against addiction for more than 40 years.

Allem brings more than 45 years of experience in journalism, business, government, political consulting, and advocacy.

Beginning as a newspaper reporter in Knoxville, Tennessee, in 1956, he established a Florida public relations firm in the 1960s, a Washington political consulting firm in the 1970s, and a printing company in the 1980s. Sinceselling JONBAR PRINTING in 1991, Allem designed grass roots systems for the Clinton-Gore campaign in 1992, served as president of the Society of Americans For Recovery, was Director of Communications for the District Government, and served as Director of Operations of the Department of Mental Health Services.

With more than 23 years of recovery from alcoholism, Allem devotes considerable energy toward advocacy of recovery causes. He has a Master's Degree in Communications: Journalism and Public Affairs from American University and is a member of the National Press Club.

Allem is author of "Speaking Out for Addiction Recovery," a text used to train leaders in America's recovery community.

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