Substance Abuse Workgroup

(FY2007 Appropriation Bill - Public Act 330 of 2006)

May 31, 2007

Section 423: (1) The department shall work cooperatively with the departments of human services, corrections, education, state police, and military and veterans affairs to coordinate and improve the delivery of substance abuse prevention, education, and treatment programs within existing appropriations. (2) The department shall establish a workgroup composed of representatives of the department, the departments of human services, corrections, education, state police, and military and veterans affairs, coordinating agencies, CMHSPs, and any other persons considered appropriate to examine and review the source and expenditure of funds for substance abuse programs and services. The workgroup shall develop and recommend cost-effective measures for the expenditure of funds and delivery of substance abuse programs and services. The department shall submit the findings of the work group to the house of representatives and senate appropriations subcommittees on community health, the house and senate fiscal agencies, and the state budget director by May 31, 2007.

Michigan Department of Community Health

MDCH

Jennifer M. Granholm, Governor

Janet Olszewski, Director

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
OFFICE OF DRUG CONTROL POLICY
FY07 APPROPRIATIONS ACT SECTION 423 REPORT

EXECUTIVE SUMMARY

This report is submitted by the Department of Community Health (DCH) in compliance with FY07 Appropriations Act Boilerplate §423. This section requires DCH to work cooperatively with other state departments to coordinate and improve the delivery of substance abuse services within existing appropriations; to develop and recommend cost efficiencies for the expenditure of funds and delivery of programs and services; and to provide a report of findings.

In March 2007 the Office of Drug Control Policy (ODCP) within DCH established the Boilerplate Workgroup in response to the boilerplate. Participants urged that the report incorporate several concepts:

- The general sense of multiple state agencies all "doing the same thing in an inefficient way" was not supported by the expenditure data or the experience of workgroup participants.
- There are opportunities for efficiencies and cost avoidance as well as direct savings if sufficient treatment services were available and from a less time limited perspective, through effective prevention.
- That information about the nature, scope and impact of substance use disorders should be included in the report as well as examples of current coordination and collaboration

The workgroup recommended continuing interdepartmental discussions to examine opportunities in four areas: 1) efficiency and coordination in purchasing, 2) revision or streamlining current regulatory requirements in law, policy, procedure or mandate 3) better alignment between affected departments and treatment resources for individuals with substance use disorders in other social service systems, and 4) use of best practice and research. As an initial starting point, it was recommended that joint purchasing of drug testing be examined.

The summary conclusions drawn from workgroup discussions and the survey results are as follows:

- While Michigan has not invested in state-specific evaluation, national research has demonstrated the cost effectiveness of treatment and effective prevention programming and these research results are generally applicable to Michigan.
- The costs associated with the consequences of substance abuse occur in service systems that are not funded or staffed to treat or prevent substance use disorders. Better linkages between departments providing services to persons with substance use disorders and the substance abuse prevention and treatment systems would be worthwhile.
- Further examination to identify how collaboration could reduce costs through efficiencies in purchasing (such as drug testing services) and coordination by state purchasers (such as compatibility in contracting requirements) could reduce administrative and other business costs.
- Given the prevalence of substance use disorders and its impact, current funding levels do not meet the demands for substance abuse-related services. It was recommended that any savings associated with these efforts should be used to expand substance abuse services.

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

OFFICE OF DRUG CONTROL POLICY

FY07 APPROPRIATIONS ACT SECTION 423 REPORT

In March 2007 the Office of Drug Control Policy within DCH established the Boilerplate Workgroup (membership listed in Attachment 2). This group met on April 19, May 5 and May 22. Additionally, in March a survey to identify FY06 state department/office expenditures for substance abuse prevention, treatment and tobacco use was sent to selected state departments and agencies. The survey instrument and list of agencies receiving the survey is enclosed as Attachment 3).

SUMMARY CONCLUSIONS AND RECOMMENDATIONS

The general sense of multiple state agencies all "doing the same thing in an inefficient way" was not supported by the expenditure data or workgroup discussion. Furthermore, gross inefficiencies in the provider network or coordinating agencies were not identified. Generally, prevention, treatment and enforcement related expenditures are driven by specific needs or mandates such as federal funding, state legislation, department mission or service population. In relation to the consequences of substance abuse, there is opportunity for cost avoidance as well as direct savings if sufficient treatment services were available and from a broader less time limited perspective, additional costs could be avoided through effective prevention activities. Members stressed the recognition of ongoing coordination and collaboration as well as acknowledgement of efficiencies that have been achieved.

The primary source of funding for substance abuse prevention and treatment is the federal government. Most of these federal funds carry state match, maintenance of effort (MOE), non-supplantation or other restrictive requirements. The expenditure data submitted in response to the survey identified $243.0M in gross expenditures and $74.2M in state gf/gp related expenditures. Survey results are detailed in Attachment 1.

The workgroup recommended continuing interdepartmental discussions to identify and examine opportunities in four areas: 1) efficiency and coordination in purchasing, 2) revision or streamlining current regulatory requirements in law, policy, procedure or mandate 3) better alignment between affected departments and treatment resources for individuals with substance use disorders in other social service systems, and 4) use of best practice and research. As an initial starting point, it was recommended that joint purchasing of drug testing be examined.

The summary conclusions drawn from workgroup discussions and the survey results are as follows:

- National research has demonstrated the cost effectiveness of treatment for substance use disorders and effective prevention programming. The associated cost to comprehensively evaluate Michigan services would be extensive and require redirection from treatment and prevention services. However, review of the characteristics of Michigan's population and services, there is no evidence to suggest that Michigan is unique or so different from other

states that national data regarding best practice and effectiveness cannot be applied to Michigan. Also, there is no evidence that Michigan outcomes are below national standards. The federal Substance Abuse and Mental Health Services Administration (SAMHSA) has provided special recognition to Michigan for our early compliance with National Outcome Measures (NOMs) reporting requirements for treatment services.

- The costs associated with the consequences of substance abuse occur in service systems that are not funded or staffed to treat or prevent substance use disorders. Better linkages between departments providing services to persons with substance use disorders and the substance abuse prevention and treatment systems would be worthwhile. An increased investment, through improved coordination and increased treatment would provide benefits including cost avoidance in the affected service system.

- Further examination to identify how collaboration could reduce costs through efficiencies in purchasing (such as drug testing services) and coordination by state purchasers (such as compatibility in contracting requirements) could reduce administrative and other business costs.

- Given the prevalence of substance use disorders and its impact, current funding levels do not meet the demands for substance abuse-related services. It was recommended that any savings associated with these efforts should be used to expand substance abuse services.

Within the substance abuse services system, the average cost per person served was reduced from $1,655 in FY05 to $1,617 in FY06 while the number of persons receiving treatment for substance use disorders increased by 6,478 (10%). These savings were the cumulative result of various changes that included treatment practices, streamlining access system processes, revisions in authorization practices and other locally identified improvements. Among examples of recent efficiencies mentioned in the course of the workgroup meetings were the Department of Civil Service decision to carve out mental health and substance abuse services from the health care benefit; Department of Corrections internal consolidation of substance abuse treatment contracting and Michigan State Police re-organization of multi-jurisdictional drug teams.

WHAT IS SUBSTANCE ABUSE?

While most people have some experience with or knowledge about family members or friends with substance abuse related problems, there is lack of widespread understanding of the nature of this physiological and clinical disorder. Substance abuse is generally considered to be a moral choice, and "quitting" simply a matter of willingness within the individual. Considerable stigma as well as shame accompanies individuals with substance use disorders. The term "substance abuse" is defined by Article 6 of the Public Health Code as *"the taking of alcohol or other drugs at dosages that place an individual's social, economic, psychological, and physical welfare in potential hazard or to the extent that an individual loses the power of self-control as a result of the use of alcohol or drugs, or while habitually under the influence of alcohol or drugs, endangers public health, morals, safety, or welfare, or a combination thereof.* MCL 333.6107(3).

Substance use disorders involve a range of abuse, intensity and duration with definitions typically applied the past 12 months. The range of substance abuse can be described as **problem behavior**

(such as a brief period of binge drinking, a single lifetime DUI offense) to **abuse** which occurs when the recurrent use of alcohol or drugs creates 1) problems or failure to fulfill obligations at work/school, home/family or with friends; or 2) takes place in situations that are physically hazardous or 3) results in legal problems.

Dependence is characterized by compulsive drug craving, seeking and use that persists even with extreme, negative consequences and is usually accompanied by a wide range of dysfunctional behaviors resulting in family and parenting problems, job loss, crime, homelessness and other health problems. Dependence meets clinical criteria when it incorporates 3 or more of the following: 1) increased tolerance 2) withdrawal 3) consuming larger amounts over a longer period of use than originally intended; 4) unsuccessful efforts to reduce use; 5) a great deal of time to obtain, use, and recover; 6) giving up important social, occupational or recreational activities; 7) daily activities revolve around obtaining and using; or 8) continued use despite knowledge of the consequences.

Research has shown that long-term drug use results in significant long lasting or permanent changes in brain function. Recovery from alcohol/drug addiction is generally a long-term process with an expectation of relapse that often requires multiple episodes of acute treatment. In that regard, abuse and dependence are similar to other chronic diseases. Research has shown that substance abuse treatment has similar rates of success to that of other chronic diseases.

WHAT IS THE PREVALENCE OF SUBSTANCE USE DISORDERS?

Determining the prevalence, or magnitude, of substance use abuse and dependence is helpful both in identifying the need for treatment and the impact on service systems such as corrections and human services. The federal government conducts the National Surveys on Drug Use and Health (NSDUH). The 2002-2004 survey data for Michigan's age 12 and older population results in estimates that 315,000 are alcohol-dependent and 177,000 are dependent on an illicit drug. When abuse as well as dependence (using the above definitions) is considered, these estimates increase to 693,000 and 267,000 persons abusing alcohol and illicit drugs, respectively. This represents one out of every 9 individuals age 12 and over. (Summary data for Michigan is posted to www.michigan.gov/odcp under "reports and statistics").

In FY06, CAs funded treatment for 71,175 persons of which over 84% were diagnosed as dependent and about 6% were diagnosed as withdrawal and other diagnoses such as delirium. Less than 10% were diagnosed as abuse. Services were limited by availability of funding. Demand for treatment services has increased in most parts of the state. Since treatment for substance use disorders is not an entitlement, individuals do not receive services timely or are denied services. Typically, fees are increased and income-based eligibility criteria revised downward when the demand for services exceeds funding availability.

Of those with substance use disorders, the majority of individuals will not seek treatment due to denial of the abuse/dependence, shame, lack of knowledge about available services or providers and/or personal inability to seek services. A recent federal Department of Health and Human Services (HHS) National Institute of Health (NIH) survey identified that only 8% of people identified as drug abusers, and less than 40% of those diagnosed with drug dependence obtain

treatment. (www.drugabuse.gov) Of those seeking treatment, some will be denied access to treatment due to cost of care, availability of public funds and/or limitations in the number of providers.

For Michigan, the estimate from the NSDUH survey of persons who needed and did not receive treatment is 6% higher than national estimates. Use of alcohol and drugs by Michigan residents statewide is also generally somewhat higher (19% higher for marijuana use, 12% higher for non-medical use of pain relievers and 5% higher for alcohol) but slightly lower for some illicit drugs.

SAMHSA estimates that nationally, public funding covers 67% of all known substance abuse treatment admissions. Using this figure, the NUSDUH survey data and the number of persons served by CAs in FY06, **less than 1 in 5 persons who are dependent and less than 1 in 44 persons with substance abuse in Michigan received treatment services.**

For those that received treatment, the average time between the age of first use and treatment admission was 16 years. The FY06 primary drug at admission continued to be alcohol (42%), followed by marijuana (19%), cocaine/crack (16%), heroin (15%), and other opiates (such as oxycodone, codeine, morphine, and percodan) at 6%. Between FY2000 and FY2005, treatment admissions for heroin increased by 25% and for other opiates increased by 215%.

WHAT IS TREATMENT AND PREVENTION?

Substance abuse treatment is described by the American Society of Addiction Medicine (ASAM) as "*the application of planned procedures to identify and change patterns of substance use behavior that are maladaptive, destructive and/or injurious to health or to restore appropriate levels of physical, psychological and/or social functioning.*"

Current standards of practice for treatment and stable recovery emphasize 1) acknowledgement of abuse and dependence as a chronic illness with physiological implications 2) a strength-based approach focusing on building recovery and relapse prevention skills in the individual 3) an individualized treatment approach that incorporates using other supports within the community, 4) clinical practice models shown to be effective such as Motivational Interviewing, Cognitive Behavior Therapy and the Matrix model. 5) addressing the consequences of abuse and dependence—unemployment, homelessness, health needs, social dysfunction and family problems including referral and use of other social services by the client, There is also the continued recognition of the need for a range of detoxification services that include a direct link into continued treatment services and recognition of the benefits of medication assisted therapy.

Prevention is generally defined as interventions to prevent the occurrence of disease or disability. As defined by SAMHSA, substance use disorder-specific prevention is *a pro-active process that empowers individuals and systems to meet the challenges of life events and transitions by creating and reinforcing conditions that promote healthy behaviors and lifestyles. The goal of substance abuse prevention is the fostering of a climate in which (a) alcohol use is acceptable only for those of legal age and only when the risk of adverse consequences is minimal; (b) prescription and over-the-counter drugs are used only for the purposes for which they were intended; (c) other abusable substances, e.g., aerosols, are used only for their intended purposes; and (d) illegal drugs and tobacco are not used at all.*

Prevention services are directed to three population intervention types. 1) **Universal** populations that are the general public or identifiable groups of participants who have not been identified on the basis of risk. Services to this population type include information, media awareness campaigns, education sessions as well as parenting classes or general classroom based prevention curricula. 2) **Selective** representing individuals or a subgroup of a population whose risk of developing a substance use disorder is significantly higher than average; examples including children of persons with substance use disorders and students experiencing problems in school and 3) **Indicated** populations representing individuals at high risk of substance use disorders with detectable signs or symptoms, or involvement in events that foreshadow abuse or dependence. Such populations may also exhibit biological markers indicating predisposition but not yet meet diagnostic levels, individuals in high-risk environments or minors charged with possession of alcohol or drugs.

Current standards of practice in prevention as being implemented through Michigan's Strategic Prevention Framework State Infrastructure Grant (SPF-SIG) are intended to achieve population level change (the public health approach) and to be outcomes-based focusing on both consumption and the consequences of substance abuse. In this model, prevention services are intended to be more directly data driven while continuing to apply services and interventions that research has demonstrated to be effective.

Additionally, there is greater attention to the development and incorporation of community stakeholders in local prevention planning and to environmental factors that include the availability and promotion of substances, community and social norms regarding use and enforcement. An example would be a local coalition supporting a community wide effort to reduce the availability of alcohol to minors through local police involvement in under-age youth attempts to buy liquor paired with media articles on the scope and consequences of teen drinking and with parent's organization of alcohol free events. In combination, these are intended to reduce the availability of alcohol and drinking by minors with the results expected to be documented in NSDUH or similar local surveys as reductions in the number of underage youth drinking alcohol.

SUCCESSFUL MICHIGAN EFFORTS

The following initiatives are highlighted as examples of successful intervention to reduce substance abuse through a combination of efforts involving education, community mobilization, enforcement and treatment.

Impaired Driving. The Office of Highway Safety (OHSP) at the Michigan Department of State Police (MSP) funds a combination of enforcement, education, prevention and adjudication-related activities as part of a comprehensive approach to reducing impaired driving and increasing highway safety. These are complemented in some communities by drug treatment courts. Additionally, OHSP participates with ODCP in prevention activities. Twenty years ago, alcohol-involved crashes cost Michigan an estimated $8.2 Billion in economic losses; last year, these cost $2.9 Billion. This improvement comes as deaths fell by over 50%, injures by almost 75% and miles driven increased by more than a third. These cost estimates are from the University of Michigan Transportation Research Institute.

Methamphetamine. ODCP coordinates the activities of Michigan's multidisciplinary Methamphetamine Task Force whose efforts combined use of federal competitive grant resources, local community action (including awareness, education and prevention); legislation (including

restricting access to the main precursor ingredient --pseudophedrine in December 2005, treatment funding and attention to the consequences of methamphetamine abuse (such as development of the Drug Endangered Children Protocol through the DHS). In 1996, 2005 and 2006 respectively, Michigan State Police recorded meth lab seizures of six, 261 and 108. Methamphetamine related CA treatment admissions increased from 314 in FY00 to 1,628 in FY05 and declined to 1,366 in FY06.

Reducing Smoking. An example of a sustained, multi-pronged approach to reduce tobacco use is evidenced by Michigan's success in reducing the prevalence of cigarette smoking by persons aged 18 and over. The Michigan Behavior Risk Factor Survey identified 25.6% of Michigan's residents smoking in 1996 compared to 21.9% in 2005. As a condition of the award of the approximately $58M federal Substance Abuse Prevention and Treatment block grant, the state must limit the sale of tobacco to underage individuals to no more than 20%. Through collaborative efforts, the sales rate to underage individuals has been reduced from 41% in 1997 to 14.5% in 2006.

THE CONSEQUENCES AND COST OF SUBSTANCE USE DISORDERS

A study of 1998 expenditures (the latest available) by the Center on Addiction and Substance Abuse at Columbia University estimated that Michigan spent $2.7 billion on the consequences of substance abuse thereby ranking 12th highest in the nation. In contrast, at that time Michigan was 47th in spending on substance abuse prevention, treatment and research.

In addition to the personal and family effects, the public costs associated with the consequences of substance use disorder fall into five general categories: school success, social services, crime, primary health care and workforce productivity. Examples of each and current collaboration are summarized below:

School Success

Students who perform poorly in school are between two and six times more likely than their peers to use alcohol or drugs and to engage in violence and other high-risk behaviors. All CAs provide prevention services to youth with most providing early intervention services. Beginning with FY08, a statewide prevention data system will be available to provide statewide data about these services. ODCP administers federal Title IV Part A Safe and Drug Free Schools and Communities Act (SDFSCA) funding which supports youth violence and substance abuse prevention services within school districts as well as in community organizations for youth outside of the school setting. Also, schools using the Michigan model for health education are likely to incorporate substance abuse prevention in their curriculum. Finally, MDE participates with ODCP in various prevention initiatives such as implementation of the federal SPF-SIG prevention infrastructure grant.

Social Services

Abuse and Neglect: DHS reported 16,599 children in out-of-home care due to abuse or neglect as of March 2007. National estimates are that about 70% of substantiated cases involve substance abuse. In FY06, CAs reported 1,980 referrals from DHS to substance abuse treatment; while there is underreporting, this is a significant treatment gap. Ongoing collaboration between DHS, ODCP and other affected agencies has recently resulted in the development of a (draft) Screening, Assessment for Family Engagement and Retention Protocol, changes in the child welfare risk

assessment and joint training and education. Groups are currently working on data, training, protocol development and Native American issues.

Homelessness: According to the Michigan State Housing Development Authority (MSHDA) Baseline Data Report, 42% of the persons who were homeless in January 2006 were impacted by substance abuse. This represents 33,600 people. During FY06, CAs provided treatment services to 5,758 persons who were homeless at admission with homelessness resolved for 53% of these individuals at discharge. Stable housing is a key factor in maintaining recovery. ODCP is a participating member in various MSHDA initiatives.

Crime

Of the FY06 CA clients served, 58% have status with Michigan's correctional or judicial systems with 35% on probation. During FY06, CAs provided treatment to 2,179 drug court involved clients primarily with local funds such as the Facility and Conventions Tax revenue.

Enforcement. The number of narcotic offenses in Michigan increased by 26% from 1996 to 2005. About 40% of 2005 traffic fatalities involved alcohol or drug-impaired driving. And, during FY06, MSP drug teams arrested 3,383 persons for trafficking, seized 44,188 grams of cocaine, 10,485 grams of crack cocaine, 18,237 pounds of marijuana, and over 4,000 grams of heroin. The hometown security teams seized marijuana and other drugs with a street value of $1.5M.

Incarceration. More than two-thirds of Michigan's prisoners have been assessed as having a substance abuse problem. Recidivism (within two years) for those with substance abuse dependence was 2.6 times greater as noted in a 2004 Michigan Department of Corrections report. Between 1980 and 1999, the *"Report on Economic Effects of Michigan Drug Policies"* identified that prison commitments for drug offenses grew by 228%. Research on the Michigan DOC population suggests a 12% drop in the prison return rate for those offenders who complete treatment services. An evaluation carried out by the State Court Administrative Office (SCAO) of two Michigan drug treatment courts confirmed national research and demonstrated reductions in re-arrests and associated costs as well as dramatic reductions in substance use by participants.

Primary Health Care

Healthy babies. For 2005, DCH vital records reported drug use as a risk factor for 1,072 births and drinking alcohol while pregnant for 680 births that in combination represent 1.4% of all live births. For FY06 CAs reported 161 drug-free births for women receiving substance abuse treatment service and that of the 620 women pregnant at admission, 418 reported abstinence at discharge. ODCP has been collaborating with DCH Public Health staff on development of a substance use disorder screening tool to be used in maternal child health efforts.

Communicable disease. DCH reports that 60-90% of new hepatitis C cases are due to unsafe drug injection drug use. Health education and risk reduction for communicable disease is incorporated in the CA treatment system and was provided to 31,258 people either in treatment or through outreach services during FY06.

With regard to **mental health and substance use disorders as co-occurring conditions**, about 24,000 (34%) of persons admitted to CA funded treatment in FY06 were reported to have a co-

occurring mental health disorder mostly of mild/moderate severity. Current best practice identifies that both disorders must be treated in an integrated manner and that integrated treatment is more successful than parallel services or failure to treat the other condition(s). As CAs develop integrated treatment, staff qualifications and provider panels have changed but problems remain with access to psychiatric evaluations and medications. The client population served by the CA system is not typically eligible for CMH funded services or Medicaid. CMH systems, likewise, are implementing evidence-based practices to incorporate screening, assessment and treatment for substance use disorders into the mental health treatment system.

Older Adults: In the Substance Abuse and Mental Health Services Administration (SAMSHA) publication, *Substance Abuse Among Older Adults: A Guide for Social Service Providers*, 17% of older adults are reported to abuse alcohol and prescription medications. Forgetfulness, fatigue, loss of appetite, and confusion are often attributed to other illnesses, but may reflect substance use disorders. The Office of Services to the Aging and ODCP have begun discussions to identify ways in which the needs of this population could be addressed.

Workforce Productivity

The federal Department of Health and Human Services (HHS) Division of Workplace Programs reports that problems related to alcohol and drug abuse cost American businesses roughly $81 billion in lost productivity in just one year; that 77% of illicit drug users are employed and that up to 47% of industrial accidents can be linked to alcohol use. Furthermore, employees who use drugs cost their employers about twice as much in medical claims as non-drug using employees. As employer health care costs increase and revenues decline, Employee Assistance Programs (EAP) are frequently abandoned. Some CAs have contractual agreements with area businesses to provide these EAP services. However, most people receiving CA treatment services are no longer in the workforce. Of the FY06 CA treatment population in the labor force, 69% were unemployed at admission; and by discharge, 17% (3,000 individuals) had become employed.

STATE DEPARTMENT EXPENDITURES

In March 2007, the agencies and offices listed in Attachment 2 were requested to complete a survey identifying FY06 substance abuse prevention or treatment and tobacco-related expenditures. Respondents were asked to provide information about: the program area; the service category and type, providers, fund source, expenditure type, service eligibility and service volume. Information from all respondents as of May 29 was incorporated in this report. As of this date, information about Medicaid expenditures is incomplete and further supplemental information has been requested.

Each department and program area surveyed describes, identifies, tracks and reports substance abuse related services and expenditures differently, generally based on its mission and concerns, fund source requirements and operational needs. For example, DOC expenditures are in the context of the individual's criminality and OHSP expenditures are specific to the mission of highway safety. The expenditure survey identified three types of expenditures that include costs resulting from the consequences of substance abuse.

First, direct expenditures specifically for the purchase of substance use-related treatment and prevention are limited and primarily federally funded. The state agencies reporting substance abuse

treatment expenditures were DCH (including Medicaid, ODCP and Public Health administrations), DOC and the Office of the State Employer. Substance abuse specific prevention expenditures were reported by DCH (Public Health and ODCP), and OHSP with additional amounts expended by State Police posts.

The second type of reported expenditure is "embedded" in the department's programs and services. These may represent costs incidental to the operation of the program or incorporated in operations such as the provision of space for AA meetings and limited counseling in the two Homes for Veterans, or in post-level Michigan State Police activities such as drug awareness presentations in schools.

Although the survey was not constructed to obtain this information, the results identified a third type of expenditure that is reflective of the service population of the department. Individuals with substance use disorders are eligible for and represent a significant number of the service recipients in these departments, but treatment or prevention are not provided. Examples include MSHDA programs for persons who are homeless and DHS expenditures for substance abuse assessment and lab screenings in field operations.

NEXT STEPS

The formulation of the workgroup and review of the expenditure information has served to identify cross system opportunities. ODCP intends to reconfigure work group membership and continue to work collaboratively as described below:

- To identify and examine opportunities for efficiency and coordination in purchasing. For example, multiple state agencies and contractors purchase drug tests. Joint purchasing may offer opportunities to capture economy of scale and reduce prices and re-invest these savings in additional targeted services. With regard to treatment, MDCH-ODCP and DOC are the two primary purchasers. The extent to which contract requirements are identical or compatible; site reviews, audits and other administrative requirements are consolidated or combined; and, the 'same' services are purchased under the 'same' requirements can result in efficiencies. With regard to prevention, relatively little substance abuse prevention specific expenditures were reported. The extent to which prevention activities are coordinated across communities and state systems is suggested by the current research as the most effective use of resources.

- To examine the implications of state and federal law, administrative rules, federal regulations, local policy and procedures and other mandates that could be revised or streamlined. Further, to broaden use of best practice and research that would result in working "better and smarter".

- Better alignment between affected departments and treatment resources for individuals with substance use disorders in other social service systems. Among the barriers to be addressed in this regard is identifying ways to share relevant information while protecting client's privacy rights, lack of "involuntary" substance abuse treatment and limited resources to increase services in the current economic environment. Consequently, discussions need to address confidentiality, the voluntary nature of treatment, and resources.

Attachment 1

SUBSTANCE ABUSE EXPENDITURES, BY DEPARTMENT AND PROGRAM AREA AS REPORTED

Description (in millions)	Gross	Federal	Local, private, other	State Restricted	GF/GP
Total	**$243.0**	**$133.9**	**$28.3**	**$6.5**	**$74.2**
% Distribution by Fund Source	**100.0%**	**55.1%**	**11.6%**	**2.7%**	**30.5%**
Department of Community Health- Office of Drug Control Policy					
Health and Human Services (HHS)-SAMHSA competitive grants This includes expenditures from the SPF-SIG Prevention Infrastructure grant and the Methamphetamine prevention grant.	$0.9	$0.9			
Department Of Justice-OJP funds These expenditures are estimated and include funds not otherwise reported below.	$4.3	$4.3			
Federal Safe and Drug Free Schools and Communities Act (SDFSCA) FY06 state award This includes administrative costs at provider and state (ODCP) levels. Services are directed to violence or substance abuse prevention with the majority of projects directed toward prevention of violence. 20% of these funds are awarded to community organizations under the Governor's Discretionary Grant component of SDFSCA.	$12.8	$12.8			
Substance Abuse Coordinating Agency (CA) Expenditures					
CA-Substance Abuse Coordinating Agency expenditures**.** These services are administered under PA 368 (1978, as amended). Expenditures include all CA administered services including MCO functions. Federal funds include $1.2M in competitive grants; $1.9M in ABW and MICHILD and $62.9 in SAPT block grant funds of which $4.5M are one-time. The SAPT block grant requires a state Maintenance of Effort equivalent to the average of the previous two years of state expenditures. If the MOE is not met, a dollar for dollar reduction in federal funding is permitted. The full state $20.6M was utilized for MOE purposes. * local reported below Expenditures are reported in detail in the DCH appropriations boilerplate report for Section 408.	$113.1	$66.0	*	$1.8	18.8
CA- Other Local and PA 2 (1986) Convention Facility/Liquor Tax funds- Up to 50% of these funds are made available for substance abuse prevention and treatment under Section 24e(11) of the General Property Tax Act. These are commonly referred to as "PA 2" funds. These funds are the primary or only source for the 10% local match for substance abuse services for 15 of the 16 CAs. Funds are expended in the county from which the funds were received. Local funds include $2.8M in client fees; $3.8M in Detroit non-PA2 revenue and $19.9M in other local, primarily PA2 revenues.			$26.5		
FY06 Reported Medicaid--Substance Abuse Treatment **Specialty Services-Carve Out-**The substance abuse medicaid benefit consists of residential sub-acute detoxifcation, residential treatment(excluding room and board) outpatient services (including intensive outpatient) and methadone as an adjunct to treatment. The amount reported here is as submitted by CAs. Some PIHPs directly administer the substance abuse Medicaid benefit. In FY06, these included: Thumb Alliance and Venture Behavioral Health. Expenditures include treatment costs and Medicaid administrative functions	$29.0	$16.4			12.6

Description	Gross	Federal	Local, private, other	State Restricted	GF/GP
Survey Reported Expenditures The expenditures reported below are from the March surveys (see Attachment 3 for details) **Medicaid** **School based counseling and therapy** - substance abuse services	$4.4	$2.5			$1.9
Pharmaceuticals These include the cost of suboxone and methadone. Expenditures are based on payments	$0.3	$0.2			$0.1
Other Medicaid--other expenditures such as inpatient hospital based detoxification, or other costs based on a diagnoses of substance abuse or dependence are not included **Public Health** **Fetal Alcohol Spectrum Disorders Program** These expenditures include local diagnostic clinics and prevention services. About one in 100 births each year is affected by prenatal alcohol use and lifelong care will be required for associated brain defects. These are estimated program expenditures.	$0.7	$0.7			
Other Services that address substance use and tobacco include Child and Adolescent Health Centers, and the Adolescent Health-Michigan model. **Michigan Department of Corrections** **Office of Community Corrections.** P.A. 511 was created in an effort to control prison growth by creating cost-effective options for otherwise prison bound offenders. Within sentence guideline legislation, for those offenders for whom a prison sentence is not mandatory and the sentencing court has discretion to determine whether a prison or community supervision sentence is appropriate, these funds provide substance abuse treatment services. For prison-bound offenders, the community-based sentencing option is in lieu of a prison term and represents a diversion from a costly prison sentence. These expenditures represent treatment costs. Services are delivered via contracted providers.	$10.9			$1.4	$9.5
Prison-based treatment expenditures for direct therapy are funded and often delivered as a prerequisite to the granting of parole by the Parole Board. Treatment is supported in part by federal funds that include RSAT and Byrne-JAG. These expenditures represent direct costs but are embedded within prison operations	$3.5	$1.9			$1.6
Community Supervision Direct treatment services are delivered by contractual agencies to offenders that are under active MDOC community supervision. Services that focus primarily on the criminogenic needs of the offender have demonstrated an ability to reduce crime. Research on the MDOC population suggests a 12% drop in the prison return rate for those offenders who complete treatment services.	$11.6				$11.6
Drug Testing-enacted HB6275 requires that parolees under intensive or medium supervision must submit to a test for controlled substances at least twice per month. These community supervision treatment and drug testing expenditures represent provider payments.	$2.0				$2.0
Michigan State Police **MSP-Office of Highway Safety** addresses enforcement of impaired driving laws, supports adjudication, and provides education and prevention activities directed toward both underage drinking and impaired driving. This expenditure reflects the cost of services and OHSP administrative functions.	$6.1	$6.1			<.1M
Hometown Security These five teams were established in 2006 and perform traffic enforcement and drug interdiction activities.	$2.3				$2.3

Description	Gross	Federal	Local, private, other	State Restricted	GF/GP
Michigan State Police cont'd **Multi-jurisdictional Drug Teams** These 22 drug teams are supported by Byrne-JAG, state and local funding. Additionally Byrne-JAG supports positions in MSP, the Forensic Crime Lab and a follow-up team for the Methamphetamine Initiative. There are 110 MSP and 238 local officers assigned to the drug teams. Drug teams also deliver drug awareness presentations to schools, community/business groups and police departments Expenditures reflect state expenditures in MAIN for various fund sources and do not include local expenditures.	$10.5	$1.8	$1.7		$7.0
DARE and various other MSP post level programs provide prevention services including TEAM training, HEMP aviation, K-9 narcotics detection as well as the Michigan Youth Leadership Academy Expenditures are examples of post- level programs not identified at all work sites.	$0.9	$0.1	<.1	<.1	$0.8
Forensic Science Toxicology, Drug and Blood Alcohol Analysis	$4.6	$0.7		$0.5	$3.4
Department of Human Services The **Bureau of Juvenile Justice** (BJJ) provides institutionally based substance abuse treatment services for adjudicated state and court wards in BJJ treatment facilities. 50% of the cost is paid by the county or Native American tribe (not included in the expenditure). Additionally, US DOJ Juvenile Justice and Delinquency Prevention Title V funds (JJDPA) are awarded to three Michigan sites. Finally, Juvenile Accountability Block Grand US DOJ funds support 21 programs that are primarily substance abuse related	$2.1	$1.2			$0.9
Field Operations. DHS indicates that $1.8M is expended for substance abuse assessment and lab screenings. Of the total expenditures, 67% is federal and 33% state. Expenditures are estimated; DHS does not maintain expenditure program detail in a format that would enable full identification of SUD-related expenditures such as costs associated with children in out-of-home placement due to parental abuse/neglect, etc.	$1.8	$1.2			$0.6
State Court Administrative Office Drug treatment courts-A typical program provides close supervision by a judge supported by a team of agency representatives (including addiction treatment providers, prosecuting attorneys, public defenders, law enforcement and parole/probation officers) that operate outside of their traditional adversarial role to provide needed services to drug court participants. Expenditures represent state expenditures for local drug treatment court operations and may include some treatment costs. Byrne-JAG funding represents $1.3M	$3.6	$1.3	$0.0	$1.8	$0.5
Civil Service Coverage for substance abuse treatment, through a carve out of the State Health Plan benefit, is available for enrolled employees, retirees and their eligible dependents including exclusively represented employees through collective bargaining agreements. Expenditures are those of the PPO.	$1.0			$1.0	
Military and Veterans Affairs **Michigan Youth Challenge Academy**- Serves youth between the ages of 16-18 who fall into one of the highest risk categories for using drugs, alcohol and tobacco. The Academy is charged with helping these youth turn their lives around in a 22 week program and one year post graduation follow-up Expenditures are embedded within Academy operations including prevention skills building, drug testing and education within a drug and smoke free environment.	$1.6	$0.8	$0.1	$0.0	$0.6
Michigan's two **Homes for Veterans** provide some support for Alcoholics Anonymous and Alcohol Cessation within the homes as well as smoking cessation and tobacco abuse counseling. The combined estimated expenditures are under $15,000/year					

Description	Gross	Federal	Local, private, other	State Restricted	GF/GP
Other Federal Funding Awarded to Michigan Agencies:					
Federal Grants to Local Agencies					
Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) Grants in Michigan--Substance Abuse Prevention and Treatment only	7.4	7.4			
The amount reported excludes SAMHSA competitive grants awarded to CAs or ODCP-- these funds are included in the expenditure data provided above. These awards are made to tribal governments, universities, health departments and community level agencies. These are federal grant award amounts, not expenditures					
Department Of Justice (DOJ) --Office of Justice Programs (OJP) grant awards not otherwise reported	**$7.6**	**$7.6**			
These are funds awarded to local units of government and exclude DOJ funds awarded to the Michigan Department of Community Health Office of Drug Control Policy					
Notes: The Michigan Department of Education reported no substance abuse prevention/treatment expenditures. The Michigan State Housing Development Authority (MSHDA) reported no expenditures although individuals with histories of substance use disorders are eligible for some services for persons who are homeless					
Tobacco-related --Not Included with Above Substance Abuse Expenditures					
The March survey also requested information about tobacco-related expenditures. In response, the following was provided.					
MSP -Tobacco Tax Enforcement	$0.6			$0.6	
DCH-Public Health Tobacco Related	$6.1	$1.7		$0.5	$3.9
Medicaid- tobacco cessation pharmaceuticals	$0.9	$0.5			$0.4
Total	$7.6	$2.2	$0.0	$1.1	$4.3

Attachment 2

MICHIGAN DEPARTMENT OF COMMUNITY HEALTH
OFFICE OF DRUG CONTROL POLICY
DCH BOILERPLATE WORKGROUP

The following represents the list of organizations and individuals that participated in the boilerplate work group.

Clinton, Eaton & Ingham Community Mental Health	Bob Sheehan
DCH Budget Office	Julie Mullins
Department of Civil Service	Susan Kant
Department of Corrections	Tom Combs, Michael Draschil, Lia Gulick
Department of Education	Robert Higgins, Jim Constandt
Department of Human Services	Jocelyn Vanda
Executive Office	Pam Yager
MDCH - Office of Drug Control Policy	Donald Allen
MDCH - Office of Drug Control Policy	Doris Gellert
MDCH - Office of Drug Control Policy	Deborah Hollis
MDCH - Office of Services for the Aging	Sally Steiner
MDCH - Operations Administration	Nick Lyon
MDCH - Public Health Administration	Betsy Pash
Mich. Assn. of Community Mental Health Boards	David LaLumia
Mich. Assn. of Substance Abuse Coordinating Agencies	Randy O'Brien
Michigan State Housing Development Authority (MSHDA)	Connie Hackney
Michigan State Police	Kathleen Fay
Military and Veteran Affairs	Joel Wortley, Eric Alderman
MSP - Office of Highway Safety Planning	Dianne Perukel/Michael Prince
Northern Michigan Substance Abuse Services	Dennis Priess
State Court Administrator Office	Phyllis Zold-Kilbourn

STATE OF MICHIGAN
DEPARTMENT OF COMMUNITY HEALTH
LANSING

JENNIFER M. GRANHOLM
GOVERNOR

JANET OLSZEWSKI
DIRECTOR

MEMORANDUM

Date: March 9, 2007

To: State Department and Agency Contact

From: Donald L. Allen, Jr., Director
Office of Drug Control Policy

Subject: Survey – Expenditures Associated with Substance Use Disorder

As you may be aware, the Michigan Legislature has mandated that the Michigan Department of Community Health ("Department") convene a workgroup to examine and review the source and expenditure of funds for substance abuse programs and services. This requirement is found in §423 of the appropriations boilerplate for 2006. The responsibility for convening the workgroup has been delegated to the Office of Drug Control Policy (ODCP) and we have decided to conduct a survey as an initial measure to meet the legislature's mandate. We have identified as a necessary source of information, your agency or department. ODCP is the lead agency in this effort and questions or concerns should be addressed to our attention.

Following, you will find the initial request for information, which I request that you complete and return to my attention by March 28, 2007. Please e-mail the information to Doris Gellert at gellert@michigan.gov and copy Marlene Simon at simonma@michigan.gov. Once the information is compiled, a workgroup will be convened to review the preliminary findings, prepare a report of our findings and to develop and recommend cost-effective measures for the expenditure of funds and delivery of substance abuse programs and services. At the conclusion of our efforts, the report will be submitted to policymakers pursuant to §423(2) of the appropriations boilerplate.

cc: Janet Olszewski
Teresa Bingman

Attachment 3
State Department/Agency Survey-Expenditures Associated with Substance Use Disorders

General Instructions: The survey is intended to obtain information about substance abuse prevention and treatment related expenditures by your department/agency. The survey format attempts to accommodate various fund sources, program arrangements and recognizes that expenditures may not be solely or directly attributable to substance abuse prevention or treatment. For example, hospital emergency rooms provide services to persons with a substance use diagnoses but are not generally considered to be 'in the business of' substance use disorder treatment. Respondents are requested to provide brief explanatory notes as necessary to explain the information provided, limitations of the data, concerns about its reporting or similar comments.

Substance Abuse prevention is any organized program or other strategy that enhances individuals' or communities' abilities to avoid or reduce the use or abuse of tobacco, alcohol and other drugs, regardless of whether substance abuse prevention is its primary goal. Key to substance abuse prevention are efforts targeted to prevent substance abuse, support recovery and prevent relapse from substance use disorders. To help you determine if your department or agency is supporting or administering such programs, the following non-exhaustive list of examples is offered:

- Health Education programs including alcohol, tobacco, and other drug information
- Youth groups, after school and summer programs, mentoring/tutoring programs (i.e. programs/activities that serve as alternatives to substance use.
- Enforcement of laws that reduce the harmful impact of alcohol, tobacco, and other drug use.
- Advocacy for laws/policies to reduce the harmful impact of alcohol, tobacco, and other drug use.
- Inpatient or outpatient substance abuse treatment that includes relapse prevention training.
- Drug-free school, neighborhood, and/or workplace initiatives.
- Mental health treatment particularly that which addresses dual diagnosis (i.e. mental illness and addiction) issues
- Youth violence, school drop-out, pregnancy and/or suicide prevention programs (risk factors for these problems overlap significantly with risk factors for substance use/abuse).
- Domestic and other violence prevention or counseling programs.
- Employee/student assistance programs with referrals to substance abuse and mental health services.

Substance Abuse treatment is described as: the application of planned procedures to identify and change patterns of substance use behavior that are maladaptive, destructive and/or injurious to health; or to restore appropriate levels of physical, psychological and/or social functioning

It is requested that your response be provided in an excel spreadsheet using the following columns and explanatory footnotes as appropriate:

Department/Agency: _____
Bureau/Division or Unit: _____
Contact Person-name, e-mail, phone: _____

Time period for the report: State Fiscal Year October 1, 2005 through September 30, 2006 or alternate state fiscal year if FY06 is not available. If an alternate year is provided identify here: _____

1. Please note that substance abuse services which concern tobacco use should be addressed in response #2.

Your Program Area	Service Category	Service Type	Provider Description	Fund Source	Expenditures	Expenditure Type	Service Eligibility	Service Volume	Comments

2. Please answer the follow inquiries with respect to tobacco services administered by your department/agency.

Your Program Area	Service Category	Service Type	Provider Description	Fund Source	Expenditures	Expenditure Type	Service Eligibility	Service Volume	Comments

Supplementary Information: For purposes of this survey and activities of the work group, it would be helpful if respondents also addressed:

1. Plans for FY07 that will significantly affect the expenditure information provided for FY06.

2. If there are program areas or costs that have been identified that are impacted by untreated substance use disorders. For example, national estimates are that a significant proportion of child neglect and abuse is associated with caretakers with substance use disorders. If reports or data are available, please identify the source/availability.

3. Any other information you would like to share that a work group addressing cost effective measures for the expenditure and delivery of substance abuse services should address.

General descriptions/definitions for each of the columns are provided as follows:

Your program area: Identify the "name" or category your agency uses to describe the program area

Service Category: Specify if this is prevention, treatment or other type of substance abuse program and provide a brief description by footnote.

Service Type: Specify if this service is embedded within another program or service or is "stand alone". For instance, if your agency funds a general prevention curriculum, and within that, a module addresses substance abuse, this would be an example of an embedded program. If substance use disorder treatment is provided as an activity, but not a stand-alone program/service, the service would be considered embedded. Please provide a brief description as appropriate via footnote or w/in the cell**.**

Provider Description: Please indicate the service provider. Examples include, if funds are allocated to a local or regional authority such as a county office, or a regional network, or based on rfp to providers or expended directly by the department.

Fund Source: Please identify the fund source as state restricted (describe source), state gf/gp; federal block grant (please identify the source/name), competitive grant (if so, the source), and if an IDG, identify the source department.

Expenditures: Please provide FY06 expenditures and identify if these are estimated or actual

Expenditure type: If expenditures have been estimated, please describe how the estimate was made

Service Eligibility: Please briefly identify eligibility criteria for services

Service Volume: Please provide an indication of service volume such as cases served, hours of service, or similar if available.

Comments: Use this space for any general comments regarding the information submitted.