

## **Blueprint for the States:**

### **Policies to Improve the Ways States Organize and Deliver Alcohol and Drug Prevention and Treatment**

*A briefing paper prepared for the Join Together national policy panel on state systems for substance use disorders*

People with substance use disorders (SUDs) rely on public sources of financing for treatment and other services to a significantly greater extent than for any other disease. In 2001 – the most recent year for which comprehensive figures are available – 76 percent of all spending on substance use programs came from government sources.

The major share of this spending is managed by state governments. Taking into account all Medicaid, state and local revenue, states managed 57 percent of all public spending on substance use in 2001. In addition, they managed a substantial portion of the federal Substance Abuse Prevention and Treatment (SAPT) block grant. State and local government funding constituted the largest source of support, making up almost half of all public substance use funding and 38 percent of total substance use funding.

Even as states and communities continue to deepen their understanding of the important social and economic benefits of effective substance-use treatment and prevention programs, they nevertheless wrestle with fiscal belt-tightening and competition within government for resources and recognition. States vary in the priorities they attach to substance use programs, but even in states whose policies make it a high priority, there is often disagreement as to how best to structure and fund substance use agencies and programs within state government. With 50 different states, there almost as many variations in state systems for SUD treatment and prevention.

What state organizational and financial structures would be most effective in enabling states to prevent and treat SUDs? If states are to achieve their optimal effectiveness in preventing and treating substance use disorders, how should they structure and finance relevant services?

These are among the questions for the Join Together policy panel on state systems. In the process of seeking the answers, the panel will be asked to consider several subsidiary issues. They include:

- How should states structure their prevention and treatment agencies?
- How should the costs be allocated for treatment and prevention in the states?
- What level of collaboration and coordination should there be among state entities involved in substance use disorders and treatment issues and how might that be achieved?
- What changes in policy and structure would encourage best practices for treatment of SUDs in the states and encourage integration of SUDs treatment with primary health care?
- How should prevention programs best be organized and managed within a state to ensure optimal effectiveness?
- Should state organizational reforms be coupled with requirements that private insurers provide equal coverage for substance use disorders?

- What changes could be made in state systems to encourage greater collaboration between substance-use treatment agencies and the criminal justice system?
- How should states structure financing, facilities regulation and professional licensing to ensure quality and integrity of treatment programs?

This briefing paper briefly lays out these key issues and offers some background for the panel's consideration.

## **I. STRUCTURE.**

Where in state government should prevention and treatment efforts be located? Fewer than five states have a cabinet-level agency. Most states house these activities under the umbrella of mental health, public health or social services agencies. What are the implications of various state structures for access, quality and funding?

### *Single State Authorities*

Within each of the 50 states is a "single state authority" (SSA) with oversight of alcohol and drug programs and spending. Each SSA is responsible for overseeing the planning, funding and regulation of public SUD prevention and treatment services. Their functions typically include finance, quality control, facility regulation and licensing and individual licensing.

SSAs first developed as state alcohol authorities for prevention and treatment supported by the Uniform Alcoholism and Intoxication Treatment Act of 1971. In 1981, the Omnibus Budget and Reconciliation Act formally established SSAs encompassing both alcohol and other drug abuse treatment. The act designated SSAs as the entities to receive federal prevention and treatment funding under the Substance Abuse Prevention and Treatment (SAPT) block grant. SSAs also receive and manage the bulk of federal discretionary grant funds and state funds for SUD treatment.

Although each state has an SSA, their structures and placements within the government hierarchy vary widely. And as states further restructure the organization of their governments to accommodate tighter budgets and meet greater demand for public services, SSAs are often the stepchildren of restructuring.

Continuing pressure to increase the efficiency and effectiveness of public agencies leads states to merge systems and agencies in order to eliminate duplication of effort and enhance administrative efficiencies. But consolidation can weaken or bury a substance-use agency, and centralization of an SSA's specialized budget and fiscal functions can result in loss of expertise, focus and priority in substance-use budgeting.

In 2004, four of the 50 SSAs, were independent, cabinet-level agencies. Twenty-five SSAs were aligned with mental health – 14 as combined agencies responsible for substance use and mental health and 11 nested within a larger organizational structure responsible for substance use and mental health. In 19 states, SSAs are aligned with public health agencies. Two are aligned with agencies responsible for children and/or families.

Wherever they are in state government, SSA staff report increasing pressure to do more with less. State agencies of any type face tight funding and fierce competition for resources. This has led to a rise in attrition among senior and mid-level staff. It is an environment that makes it difficult for directors to maintain or begin innovative programs, concluded a November 2005 study of state substance use agencies by The Avisia Group.

### *Importance of Placement*

In the competition among state agencies for funding, influence and visibility, placement within the government structure is important. The Avisia Group study found that organizational placement and positioning of a state substance use agency within state government helped to determine its degree of decision-making and policy authority, its visibility, its funding and its collaborative ability, as well as its ability to attract and retain talented staff.

The Avisia study found that SSAs that are relegated to lower levels within larger agencies have difficulty in achieving their missions. Agencies that were merged or submerged too far down within another agency had problems in staff retention and recruitment, funding, collaboration, productivity and compliance with legal obligations imposed under the block grant. Substance use agencies in the lower echelons of state bureaucracy lose their visibility and influence, the study found, leaving them unable to advance significant substance use education, prevention, treatment and policy objectives.

In contrast, SSAs that enjoy autonomy because they are at cabinet level or are led by gubernatorial appointees are better able to carry on policy initiatives from year to year. Whether the SSA director is appointed or approved by the governor is an important determinant of agency autonomy, the Avisia study found. Approval by the governor confers authority, credibility, influence and status on the agency.

The importance of placement within the government hierarchy has to do with visibility – state agencies with high visibility are better able to promote effective substance-use policies, the Avisia study found. The SSA must be visible within the government structure and sufficiently autonomous to carry out its legal and social mission adequately.

Others corroborate this. In a January 2000 article, "Behavioral Health Expenditures and State Organization Structure," authors Elaine Fleming, Ching-to Albert Ma and Thomas G. McGuire found that, among mental health, substance use and developmental disability agencies at the state level, there are strong relationships between the agencies' organizational structures and their spending levels. This is because an agency's position in the state bureaucracy determines its bargaining power and competitive advantage over other agencies, they concluded.

### *Role of Leadership*

Leadership is an important determinant of an SSA's success, the Avisia Group study concluded. The study looked at several states that have adopted behavioral health systems in which substance use is nested or merged within a larger division. In states where experienced

substance-use directors became heads of these divisions, the functioning of the substance-use office was protected within the new structure. But in states where substance-use agencies were merged into departments led by directors lacking substance-use experience, the substance-use agency suffered in its functions and staff retention.

The Avisa study found that leadership is important to the success of an SSA, regardless of its organizational position within state government. However, it further found that ineffective structure hampers leadership at any level and that, in the long run, an agency's structural autonomy is more important than its leadership.

One reason leadership is not a consistent determinant of agency success is that it is subject to turnover and retirement, the Avisa study noted. Continuity of an agency's leadership is closely tied to its performance.

Turnover of leadership is frequent at SSAs. CSAT reported that in 2002, 23 of 60 SSA directors were new to the position. In 2003, 19 were new. Every year, 11 states had new SSA directors. Of 60 SSAs (including U.S. territories and possessions), 38 had at least one change in leadership in the three years ending in 2004.

#### *Governor and Legislative Leaders*

Of course, leadership on issues relating to SUDs is most critical at the highest tiers of state government – the governor and the state's legislative leaders. In addition to their executive authority, governors and legislatures have available to them a variety of tools to advance their SUDs priorities, including coordinating councils, proclamations, social marketing, evidence-based prevention programs, parity laws, Medicaid optional services and waivers, TANF programs, drug courts and offender treatment in lieu of incarceration.<sup>1</sup> Seven or eight states have a governor's-level office of drug control policy – often referred to as a "drug czar." While this often typically focuses on law enforcement and demand reduction, in some states, such as Florida, its responsibility also extends to prevention and treatment.

The National Governors Association recommends six actions state leaders can take to promote SUDs prevention and treatment:<sup>2</sup>

- Coordinate stakeholder resources to create and sustain effective substance-use policies.
- Build public awareness about the chronic nature of chemical dependency and the societal benefits of treatment.
- Implement cost-effective programs to prevent, reduce or minimize the incidence of drug use and its negative consequences.
- Encourage private insurers and businesses who purchase benefits for their employees to offer adequate coverage for treatment of chemical dependency.
- Leverage federal funds to expand coverage for SUDs treatment services.

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<sup>1</sup> *Issue Brief: Substance Abuse: State Actions to Aid Recovery*, National Governors Association Center for Best Practices (2002).

<sup>2</sup> *Id.*

- Require effective and sustainable treatment alternatives as part of sentencing for chemically dependent offenders.

*Questions for the Panel*

- What differences do organization and structure make for access, quality and funding in the states?
- Where and at what level in state government should the substance use agency be placed?
- How is an agency's performance affected by intergovernmental differences in position, visibility and other factors?
- What strategies should states adopt to ensure that their substance use agencies continue to function effectively?
- How do autonomous substance use agencies compare with nested or merged agencies in their effectiveness?
- What advantages and disadvantages do different SSA structures provide?
- What is the role of leadership in a substance use agency's effectiveness?
- Should any of the functions typically performed by an SSA be assigned elsewhere within state government?

## **II. PAYMENT.**

To what extent and under what circumstances should states foot the bill for treatment and prevention services?

*The Public Bears the Cost*

Unprevented and untreated SUDs impose significant costs on health care and other components of the state and its communities, the Avisa Group study found. Treating SUDs lowers expenditures for health care, public safety, child welfare, criminal justice, public housing, education and mental health.

As noted earlier, the public pays the bulk of the cost of SUDs treatment and prevention in the United States. In 2001, \$18.3 billion was spent on substance use programs, an amount that represented 1.3 percent of all health care spending. Of that total spent for substance use, 76 percent came from government sources – federal, state, county and other public funds. Just five years earlier, the public paid only 62 percent of the tab.

Private insurance paid for 13 percent of total SUDs expenditures, down from 24 percent in 1997. By comparison, private insurance paid for 36 percent of total health care expenditures. Out of pocket payments by individuals for SUDs treatment made up 8 percent of total substance use expenditures.

The public's share of spending is going up, while that of the private sector is declining. From 1991 to 2001, public substance-use spending increased 6.8 percent each year, while private sector expenditures fell by 1.1 percent each year. The Avisa study concluded that there is a

strong correlation between the decline in private SUDs treatment spending and the growth of public spending.

According to a report released earlier this year,<sup>3</sup> the major share of public spending is managed by state governments. Taking into account all Medicaid, state and local revenue, states managed 57 percent of all public spending on substance use in 2001. In addition, they managed a substantial portion of the federal SAPT block grant. State and local government funding constituted the largest source of support, making up almost half of all public substance use funding and 38 percent of total substance use funding.

Among public payers, state and local government funding constituted the largest source of support, making up almost half of all public substance use funding and 38 percent of total substance use funding. Medicaid contributed 25 percent of all public dollars spent on SUDs treatment and 19 percent of total expenditures. Other federal government spending on SUDs treatment, including block grants, accounted for 19 percent of public spending. Federal block grant dollars that go to SUDs treatment were estimated to be 8 percent of public spending. Medicare constitutes 7 percent of public spending on SUDs.

The vast majority of these expenditures – 84 percent – went to specialty providers (i.e., general hospital specialty units, specialty hospitals, psychiatrists, other mental health and substance use professionals, multi-service mental health organizations, and specialty substance-use centers).

In many states, the SAPT block grant accounts for almost half of all public substance use spending. As of 2002, more than 10,500 community-based organizations received SAPT block grant funds from the states, according to SAMHSA. The block grant provides states flexibility to plan, carry out and evaluate SUDs prevention and treatment services. The grant provides a 20 percent set-aside for SA prevention. It also stipulates that 2 percent to 5 percent be spent on AIDS-related drug use programs in states with an AIDS case rate of 10 per 100,000 population. The grant mandates spending of an amount "equal to fiscal year 1994 spending levels" on programs for pregnant women and women with dependent children, and up to 5 percent may be used for administration.

Block grant funds are distributed to states through a formula prescribed by the authorizing legislation. Factors used to calculate the allotment include total personal income, state population by age groups, total taxable resources and a cost-of-services index factor.

In recent years, SAMHSA began planning to replace block grants with Performance Partnership Grants. These would change the thrust of the block grants from state expenditure reports and accountability based on documentation of compliance to reliance on evidence of performance. States would gain more flexibility to use block grant funds to address their specific needs. State and federal government would work together to identify the strengths of a state's service system and areas where it could be improved. The goal would be to promote an atmosphere where best

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<sup>3</sup> Mark, T., et al. *National Expenditures for Mental Health Services and Substance Abuse Treatment 1991-2001*, SAMHSA (2005).

practices are integrated into state programs as part of a continuing cycle of quality improvement. More recently, SAMHSA has turned its focus to National Outcome Measures.

The SAPT block grant carries a maintenance-of-effort (MOE) requirement. This requires that the SSA maintain aggregate state expenditures for authorized activities at a level that is not less than the average level of such expenditures for the preceding two-year period. If a state fails to meet this requirement, its block grant allotment may be reduced. In states where block grant funding is a major source of revenue, this can be serious.

State spending for SUDs is much lower than mental health spending and the sources for each are much different. Of total state and local spending for mental health and SUDs in 2001, 78 percent was for mental health. Federal funding other than Medicaid and Medicare provides 14 percent of funds for substance use but only 5 percent for mental health. Medicaid provides substantially greater support for mental health services than for SUDs treatment, in part due to the federal stipulation that people who are disabled due to drug addiction or alcoholism are ineligible for SSDI and SSI benefits. SSDI and SSI are important sources of support for people with mental disabilities. Under Medicaid, SUDs treatment falls under the optional services that states can elect whether to cover.

#### *Questions for the Panel*

- Should state and federal funding streams for SUDs treatment be combined into one program with one set of standards at the state level?
- Should eligibility for services be based on clinical need, status or income?
- What can be done about private insurers denying addiction coverage to working individuals in need of treatment, thus making the beneficiary seeking treatment "functionally indigent"?

### **III. COLLABORATION.**

People with serious addictions often have multiple problems that require resources from multiple public entities. Can organizational and policy changes at the state level encourage and facilitate the coordination of services for those with multiple needs?

#### *The Need for Collaboration*

Effective collaboration between the substance use agency and multiple other state and community agencies affected by addiction and addicted persons is a key requirement for establishing and maintaining effective substance use services and policy, the Avisa study concluded. The need for interagency collaboration is greater for substance use agencies than for almost any other health or human services agency because virtually every government agency has clients with overt or hidden SUDs.

Collaboration is not possible unless state substance use agencies are sufficiently visible within the government structure that other agencies see them as important to work with them, the Avisa

study found. It is also necessary that substance-use agencies have directors and staff who are capable and available to work with peers in other agencies and organizations.

Structure plays a role in collaboration. If the director of the substance-use agency is directly appointed by the governor, the director is likely to be perceived by other agencies and staff to have sufficient importance for them to be willing to spend scarce time, staff and effort in effective collaboration, the Avisa study reported. When agencies are on a par structurally, they are better able to collaborate. SSAs that lacked gubernatorial appointment status and were in lower levels of the bureaucracy were less able to engage in successful collaboration with other agencies.

When government reorganizations move substance-use agencies to nested positions within a larger "super agency," the resulting loss of higher level managers, administration and finance staff hinders collaboration by removing the very staff who are most useful and necessary to support interagency efforts, the Avisa study found.

### *Mental Health*

In the mental health arena, 23.2 percent of public mental health clients with severe mental illness also have a SUDs, and about 29 percent of clients report use of an illicit drug within the prior year. And of adults with substance dependence or use problems, 20.4 percent had severe mental illness.

For state mental health agencies, collaboration with the state SSA is of critical importance. But for SSAs, the mental health agency is one of only many with which collaboration is needed. Surveys find that many SSA directors report a greater need to collaborate with criminal justice agencies than with mental health agencies. This disequilibrium in perspectives is a potential source of tension between mental health and substance use agencies, suggested the Avisa Group.

### *Child Welfare*

Within the child welfare and protection system, many parents who come to the attention of the system are identified as having SUDs that may contribute to their inability to care for their children and that may result in their children being removed from their home, according to a July 2004 report, "A Policy Guide on Collaborative Models for State Alcohol and Other Drug Directors and Child Welfare Administrators," written by Kathleen M. Nardini of The National Association of State Alcohol and Drug Abuse Directors. Once a parent is identified as having a substance-use problem, it is critical that the parent be referred for treatment, that treatment status be monitored, and that treatment providers inform child welfare officials of progress, she said. This means it is important for those within the child welfare and SA systems to collaborate with each other as well as with related systems such as mental health, social services, primary health care and the courts.

Broadly speaking, although substance use related problems is prevalent in most schools, primary care practices, mental health clinics and criminal justice agencies, there is insufficient training, organization or reimbursement to screen, assess and refer those with dependence or use disorders

to appropriate services. As a result, a large group of adults and particularly adolescents who use, abuse or are dependent on substances are not being appropriately identified or referred for care, according to A. Thomas McLellan and Kathleen Meyers in their 2004 article, "Contemporary Addiction Treatment: A Review of Systems Problems for Adults and Adolescents."

### *Encouraging Collaboration*

A just-published Institute of Medicine report, "Improving the Quality of Health Care for Mental and Substance-Use Conditions,"<sup>4</sup> proposes policy initiatives states should adopt to encourage collaboration. IOM suggests:

- Government agencies, purchasers, health plans and accreditation organizations should implement policies and incentives to continually increase collaboration among providers of primary care, mental health and substance-use services to achieve evidence-based screening and care of patients with general, mental or substance use problems.
- Federal and state governments should revise laws, regulations and administrative practices that create inappropriate barriers to the communication of information between providers of health care for mental and substance use conditions and between those providers and providers of general care.
- Substance-use treatment providers should coordinate their services with those of other human-services and education agencies, such as schools, housing and vocational rehabilitation agencies, and providers of services for older adults.
- Providers of services to high-risk populations – child welfare agencies, criminal and juvenile justice agencies and long-term care facilities for older adults – should use valid, age-appropriate and culturally appropriate techniques to screen all entrants into their systems to detect substance use problems and illnesses.
- State governments should create linkages across state agencies to improve collaboration and coordination among their mental, substance-use and general health care agencies.
- State governments should encourage the widespread adoption of electronic health records, computer-based clinical decision-support systems, computerized provider order entry, and other forms of information technology for substance-use health conditions.

In her study of the need for collaboration between child-welfare and substance use agencies, Kathleen Nardini suggested that different state and local entities involved in substance use issues should enter into memoranda of understanding or memoranda of agreement that describe joint statements of purpose and commitment to specific roles and responsibilities. Such agreements can lay the groundwork for collaboration to occur and proceed among various systems. These agreements could be prepared at the state level and serve as templates that could be distributed and used at lower levels, she suggested.

Other of Nardini's suggestions for encouraging collaboration include:

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<sup>4</sup> IOM (Institute of Medicine). 2006. Improving the Quality of Health Care and Mental and Substance-Use Conditions: Quality Chasm Series (Executive Summary). Washington D.C: National Academy Press.

- Development of communication protocols among agencies for exchanging information and for capturing and sharing information to the extent appropriate.
- Development of cross-training programs among agencies.
- Collaboration among agencies on budget and funding requests.

New Mexico is considered to have taken an innovative approach to collaboration by creating the Interdepartmental Behavioral Health Purchasing Collaborative. This initiative streamlines behavioral health services offered by nine different agencies to create one oversight agency. The legislation authorizes the IBHPC to design and purchase a common set of services with common expectations and outcomes across multiple departments.

#### *Questions for the Panel*

- Can certain organization and policy changes at the state level create an environment that encourages the collaboration needed to address the needs of SUD patients?
- Where should be the locus of responsibility for integrating care?
- What is the purchaser's responsibility with regard to collaboration?
- What are the implications for how the state merges revenue streams?
- What are the barriers to collaboration?
- What forms of collaborative models are most effective within states?
- To what extent should other state programs incorporate linkages to screening and treatment services?

#### **IV. TREATMENT.**

Alcohol or drug dependence is a chronic disease requiring screening, brief interventions, referral to treatment and quality treatment and recovery. Most states, however, provide only short-term, acute care. What changes can be made in state systems to encourage longer-term treatment?

#### *Acute Treatment of a Chronic Disease*

In terms of vulnerability, onset and course, alcohol and drug dependence is similar to other chronic illnesses, such as type 2 diabetes, hypertension and asthma. However, while SUD shares many features with other chronic illnesses, many SUDs treatments are delivered in a manner more appropriate for acute care disorders. As with other chronic illnesses, the effects of SUDs treatment are optimized when patients remain in continuing care and monitoring without limits or restrictions on the number of days or visits covered.<sup>5</sup>

While mental health treatment is an entitlement for many with severe mental illness, SUDs treatment is made available to only about 20 percent of those who are substance dependent. Of those who do obtain SUDs treatment, clients typically bring with them a complex and generally

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<sup>5</sup> McLellan, A., Lewis, D., O'Brien, C., Kleber, H. (2000). Drug Dependence, a Chronic Medical Illness. *JAMA*, 284(13), 1689-1695.

serious set of problems required experienced professionals and a range of medical and social service options.

In 1990, there were more than 16,000 treatment facilities in the United States, 55 percent of which were residential or inpatient. By 2002, there were fewer than 14,000 programs, 78 percent of which were abstinence-oriented outpatient programs.

Generally speaking, treatment programs suffer from unstable organizational and administrative infrastructures and unstable workforces. Many are choking on data collection requirements. This instability raises questions about the ability of the national treatment infrastructure to adopt or support many potentially effective new therapies, interventions and medications that are emerging.

### *Integration with Primary Care*

While the prevalence of medical and psychiatric conditions is high among individuals with alcohol and other drug disorders, medical care or screening are seldom provided as part of SUDs treatment, and medical and SUDs services are most often separate and uncoordinated.

Several studies indicate that the answer is better linkage and integration between primary medical care and substance-use treatment services. The IOM report's overarching recommendation is, "Health care for general, mental and substance-use problems and illnesses must be delivered with an understanding of the inherent interactions between the mind/brain and the rest of the body." One recent study examining costs and outcomes of integrating medical and drug treatment for patients with substance use-related medical conditions found that patients had higher abstinence rates and longer periods of abstinence and their costs were not significantly higher relative to other patients.<sup>6</sup> The findings suggested that patients with physiologic or behavioral conditions related to substance use would benefit from having medical and addiction treatment integrated.

Another study<sup>7</sup> found that linkage would benefit individuals in the following scenarios: (1) when SUDs issues are not addressed in primary care and mental health settings, (2) when medical and mental health issues are not addressed in SUDs treatment, and (3) when the patient is seen in two or more of these settings but no effective communication occurs between the systems.

### *Focus on Recovery*

Following the lead of studies that show that alcohol and drug addiction is a chronic disease, states such as Connecticut and Vermont are increasingly placing their emphasis on recovery. At Connecticut's Department of Mental Health and Addiction Services, for example, recovery is described as the overarching theme that guides everything it does. Its Recovery Initiative is focused on five key ideas:

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<sup>6</sup> Weisner, C., Mertens, J., Parthasarathy, S., Moore, C., Lu, Yun (2001). Integrating Primary Medical Care With Addiction Treatment. *JAMA*, 286(14), 1715-1723.

<sup>7</sup> Samet, J., Friedmann, P., Saitz, R., 2001. Benefits of Linking Primary Medical Care and Substance Abuse Services. *Arch Intern Med*, 161, 85-91.

- Empowerment. The goal is empowering people in recovery at all levels within the system and offering hope that they can lead self-determined and fulfilling lives.
- Individualized and person-centered. The goal is to provide culturally competent and individualized care and support chosen by the person in recovery to meet his/her unique needs.
- Built on cornerstones. It builds on work that has been occurring in the behavioral health community over the past several decades, but also expands that work into new areas, such as use of peer supports.
- Systematic emphasis. Using recovery-oriented standards, practice guidelines, performance monitoring and contracting language, it systematizes how the state conceptualizes, implements and operates services and supports.
- Quality and outcome-oriented. It emphasizes outcomes and incorporates best practices from scientific literature, informed by experiences of people in recovery.

#### *Questions for the Panel*

- Do state agency structures and contracting procedures contribute to the emphasis on acute care for what is recognized as a chronic disease?
- What changes would move policy and treatment closer to the best clinical practice models?
- How can states encourage linkage between primary medical care and substance-use treatment or possible integration with primary medical care?

## **V. PREVENTION.**

At the state level, prevention spending is often split among school programs funded through the U.S. Department of Education, highway safety programs funded through the National Highway Traffic Safety Administration and the National Association of Governor's Highway Safety Program, and state and community substance-use programs. According to the most recent figures available from SAMHSA, SSAs spend an average of 10.17 percent of their total substance use funds on prevention programs.

#### *Funding for Prevention*

The SAPT block grant imposes a 20 percent set-aside to be spent on prevention. States are required to expend these prevention funds using six specific strategies: community-based processes, information dissemination, education, alternative activities, problem identification and referral and environmental strategies. A 2002 SAMHSA report said that state block grant spending on prevention broke down as follows:

- Community-based processes made up 17 percent of total prevention expenditures. This included working with communities to address alcohol treatment outcome data prevention efforts. Examples were training of volunteers, development of community coalitions and neighborhood action training.

- States spent 18 percent of the total for information dissemination activities. This included development of educational brochures, pamphlets and other media materials for dissemination to youth, parents, teachers and the general public.
- States spent 34 percent of their prevention funding applying educational strategies. Examples included education and training in life skills, problem solving and developing peer resistance skills.
- States spent 10 percent for alternative activities. These included activities such as drug-free dances, leadership activities and drop-in centers.
- Thirteen percent was spent for problem identification and referral. This included the identification of individuals at risk for SUDs and referring those individuals to appropriate services and counseling.
- Six percent was spent in the "other" category, which may have included initiatives such as HIV prevention efforts.
- Environmental strategies were 2 percent of the total. These included maximizing enforcement of tobacco and alcohol access laws and modifying alcohol and tobacco advertising practices.

Another source of prevention funding comes through State Incentive Grants awarded through The Center for Substance Abuse Prevention. The SIG program is intended to help states and communities implement effective prevention program models. Eighty-five percent of program funds are channeled through the states to local recipients, which include community-based organizations, coalitions, partnerships, local governments, schools and school districts.

CSAP has 37 SIGs in place with more than 600 sub-recipients. The SIG program is a state-coordinated, community-based approach that aims to bring the issue of teenage substance use to the level of the individual teen. SIG has two overarching goals:

- Coordinate all substance use prevention funding streams within the state that are directed at communities, families, schools and workplaces. In particular, governors ensure that state strategies account for all federal and state substance use prevention efforts in the state, and propose how these funds will be used to identify and fill gaps with effective and promising prevention approaches.
- Develop a comprehensive statewide strategy aimed at reducing drug use by youth. The proposed statewide prevention strategy incorporates a range of effective substance use community-based prevention efforts that are derived from sound scientific research findings

The SIG program calls on governors to create comprehensive state prevention plans. States receive funding for three years and are to use at least 85 percent to support community-based programs and implement sound, science-based local prevention efforts. A total of 21 States have received SIG grants to date.

As an example of how SIG funding can be used, CSAP cites an initiative undertaken by the state of Vermont, one of the first states to participate in the program. Through its New Directions Program, the Vermont Department of Health is using the bulk of its grant to establish cooperative agreements with up to 30 communities to implement and evaluate programs and services based on models that have been shown to be effective in preventing teen alcohol and

drug use. All New Directions grantees are required to be part of a coalition that represents all the stakeholders in the community, including prevention service providers, community leaders, and teens and their families. At the end of the grant period, Vermont will use what it has learned from these projects to increase research-based programming and improve the cost-effectiveness of prevention efforts statewide.

### *Other Prevention Programs*

Not all federal money spent on substance use prevention in the states is funneled through the state substance use agency. No figures are available showing the total amount spent on prevention from all sources. While it is estimated that most prevention spending is through the state substance-use agency, other federal sources of prevention funds include:

- Safe and Drug Free Schools Program, U.S. Department of Education, [www.ed.gov/offices/OESE/SDFS](http://www.ed.gov/offices/OESE/SDFS). The Safe and Drug-Free Schools Program is the federal government's primary vehicle for reducing drug, alcohol and tobacco use and violence through education and prevention activities in the nation's schools. The program supports initiatives to prevent violence in and around schools and strengthen programs that prevent the illegal use of alcohol, tobacco and drugs.
- Centers for Disease Control, Division of Adolescent and School Health, [www.cdc.gov/HealthyYouth/index.htm](http://www.cdc.gov/HealthyYouth/index.htm). The division oversees the Youth Risk Behavior Surveillance System (YRBSS) and the School Health Policies & Programs Study which provide information on the prevalence and trends in health risk behaviors among U.S. high school students and on school health policies and programs addressing the prevention of health risk behaviors. The division funds state and local programs in every state.
- U.S. Department of Justice, Office of Juvenile Justice and Delinquency Prevention, [www.ojjdp.ncjrs.org](http://www.ojjdp.ncjrs.org). The mission of OJJDP is to provide national leadership, coordination and resources to prevent juvenile victimization and respond appropriately to juvenile delinquency. This is accomplished through developing and implementing prevention programs and a juvenile justice system that protects the public safety, holds juvenile offenders accountable, and provides treatment and rehabilitative services based on the needs of each individual juvenile. OJJDP also conducts the Enforcing Underage Drinking Laws program.
- National Highway Traffic Safety Administration, Impaired Driving Division, [www.nhtsa.gov](http://www.nhtsa.gov). NHTSA is responsible for reducing deaths, injuries and economic losses resulting from motor vehicle crashes. It accomplishes this in part through programs and partnerships designed to save lives, prevent injuries and reduce traffic-related health care and economic costs resulting from impaired driving due to alcohol and other drugs.

### *A Priority for Governors*

The National Governors Association says that, given the states' difficult budget climates, policymakers should pay even greater attention to ensuring that investments are being made in

cost-effective prevention programs with demonstrable records of success. Governors can use their executive authority to cultivate effective evidence-based prevention programs within state government and throughout local communities, the NGA recommends.

A critical element of prevention is building public understanding of the chronic nature of chemical dependency and the societal benefits of treatment, the NGA says. Governors can issue proclamations and use the bully pulpit to mobilize stakeholders and to elevate substance use related problems as a public policy issue, it recommends.

Examples of state measures to promote prevention include:

- In Kansas, the Governor's Substance Abuse Prevention Council was established by executive order to develop a comprehensive coordinated system of prevention throughout the state.
- South Carolina created the Governor's Cooperative Agreement on Prevention to manage a three-year, \$9 million federal State Incentive Grant administered by the cabinet-level Department of Alcohol and Other Drug Abuse Services.
- Colorado created a new division within the Department of Public Health and Environment with the authority to consolidate a number of state prevention-oriented substance use programs for children and youth.
- In several states, governors' spouses have created Governors' Spouses' Program Leadership to Keep Children Alcohol free. Participating spouses are active at both state and national levels.
- The IOM report, "Reducing Underage Drinking, A Collective Responsibility," has national and state recommendations ([www.nap.edu](http://www.nap.edu)).

#### *Questions for the Panel*

- Would prevention programs be more effective if they were organized under a single entity?
- If so, where should that entity be located and what should be the scope of its authority?

## **VI. COVERAGE.**

Public and private medical insurance programs discriminate against individuals with SUDs. Should state structural reforms be coupled with requirements that public and private insurers provide equal coverage for SUDs?

#### *Barriers to Care*

A major reason for poor access to SUDs treatment and inadequate treatment capacity is the funding system. There is a need for removal of insurance barriers to proper care and for the creation of financial incentives to ensure that private and public health plans identify, refer and reimburse treatment for SUDs.

Historically, health plans have been reluctant to provide coverage for treatment for alcohol and drug disorders. Beginning with Wisconsin in 1972, states began to pass legislation requiring that

group health plans include coverage for alcoholism treatment. Eventually, 45 states either required a specific treatment benefit or required health plans to offer a treatment benefit. The typical benefit was 30 days of inpatient treatment and \$500 for outpatient services. This benefit structure led to a proliferation of private 28-day inpatient treatment programs.

In the 1980s, dramatic increases in treatment and health care costs led employers to shift to self-insurance plans and to rely on managed care plans to better control costs. This led to limits on the use of inpatient treatment services. In 1980, 20 percent of treatment services were provided through private detoxification and residential treatment facilities. By 1995, less than 8 percent of treatment services were provided in such facilities.

### *Medicaid*

Medicaid is a federal-state partnership that provides required and optional health care services to millions of low-income Americans. The federal government provides a minimum 50 percent share in the cost of medical services covered and part of the administrative costs.

Medicaid reimbursement accounts for 19 percent of expenditures for alcohol- and drug-use treatment. Medicaid regulations define alcohol and drug dependence as mental diseases and prohibit reimbursement for any service if the recipient is between the ages of 21 and 65 and a resident of an "Institution for Mental Disease" – a residential program of more than 16 beds. This effectively denies Medicaid funding to residential, community-based SUDs treatment services. Therefore, treatment is reimbursed most frequently if provided under a service category that qualifies for federal matching funds, such as inpatient or outpatient hospital services.

Medicaid spending on alcohol and other SUDs rose at an inflation-adjusted rate of 9.8 percent yearly between 1987 and 1992. From 1992 to 1997, Medicaid spending on SA programs slowed to an annual 5.7 percent increase.

Medicaid guidelines allow states discretion over whether and to what extent to cover SUDs treatment programs. As a result, coverage for SUDs treatment varies substantially from state to state. Some states have turned to managed care to control Medicaid costs. Others have responded to projected deficits by cutting Medicaid coverage for SUDs treatment altogether. Oregon in 2003 eliminated outpatient coverage for mental health, substance use and dental treatment for individuals who did not meet federal eligibility standards. Massachusetts changed eligibility requirements for state assistance and closed about half of the state's detoxification beds.

### *Promoting Parity*

Historically, insurers have not maintained parity between general health coverage and coverage for SUDs. Many see mandating parity as a way of improving access to and availability of SUDs treatment. Parity also serves to shift the cost of treatment from the public system to the private sector.

On the federal level, President Clinton in 1999 announced a plan to extend parity coverage to federal employees, retirees and their dependents who are part of the Federal Employees Health

Benefit program. As of January 2001, all 9 million participants in the FEHB program who receive treatment from plan-specified providers have parity coverage for all mental and addictive disorders. More recently, Congress has been debating expanding a limited federal parity law.

In the states, parity for mental health insurance has gained momentum in recent years – 21 states now require full parity for the treatment of mental illness. Of those 21, nine – Connecticut, Delaware, Maine, Minnesota, North Carolina, South Carolina, Vermont, Virginia and West Virginia – include treatment for alcohol and other SUDs.

The recent IOM report recommended that state legislatures enact parity for SUDs treatment. Join Together's Discrimination Report recommends parity

#### *Other Coverage Sources*

- Employee assistance programs. Of the estimated 11.8 million adults who used illicit drugs in 2000, 9.1 million were employed. Employers who oppose parity for treatment of drug and alcohol disorders often instead rely on EAPs as their primary strategy for addressing substance use problems among employees. Over time, EAPs have shown a sharp decline in referrals to treatment programs, focusing instead on less stigmatized issues within the workplace.
- SSI/SSDI. In 1996, the U.S. eliminated addictions as a qualified disability covered by Supplemental Security Income and Social Security Disability Insurance (SSDI). As a result, SSI is generally not available for those with addictions. Join Together's Discrimination Policy Panel Report recommends under *Public Benefits that "people who are disabled as a result of their alcohol or other drug disease should be eligible for SSDI and SSI."*
- TANF funds. The Temporary Assistance to Needy Families block grant allows states to allocate some funds to substance use services. At least 40 percent of the states have allocated some TANF funds for this purpose. Examples include integrating substance use education into job readiness programs, providing screening services and treatment for welfare clients through mental health programs, providing counseling services, and developing pilot programs that provide financial incentives to business that hire welfare recipients.
- Medicare. Like Medicaid, Medicare includes SUDs as mental disorders. Substance use among the elderly is said to be one of the fastest growing problems in the U.S.

#### *Questions for the Panel*

- Should state organizational reforms be coupled with the requirement that public and private insurance plans provide equal coverage for SUDs?

## **VII. CRIMINAL JUSTICE.**

People with SUDs often come under the control of the criminal justice system. Fortunately, collaboration between treatment agencies and the criminal justice system is improving. What changes in state structures would further strengthen and encourage this collaboration and further enhance early detection and treatment?

### *A Population at Risk*

In 2001, the criminal justice system accounted for 55 percent of all patients referred to SUDs treatment. Men and women arrested for crimes consistently report high levels of drug use. Data indicates that 64 percent of individuals arrested for any crime test positive for drugs; 21 percent test positive for two or more drugs. More than one third of arrestees are at risk for drug dependence, yet the number who report participation in drug use treatment within a year of their arrest is less than 10 percent.

In prisons, 70 percent of inmates in state prisons and 80 percent in federal institutions are there on charges related to drug trafficking and possession. Inmates released back into the community are likely to resume drug use. However, intensive treatment during incarceration leads to reduced levels of drug use among those who return to the community and lower rates of rearrest and reincarceration.

The National Association of State Alcohol and Drug Abuse Directors recommended that federal initiatives for people coming out of the prison system into the community should be coordinated with the state SSA director. Treating SUDs is an effective tool in stopping the revolving door of recidivism, it said.

The Second Chance Act of 2005 (H.R. 1704), introduced last April, includes language that would require coordination with SSAs. Under the program, applicants would have to show "extensive evidence of collaboration with state and local government agencies overseeing health, housing, child welfare, education, substance use, and employment services, and local law enforcement."

Treatment alternatives can help reduce drug-related crime and relieve the financial burden of substance use on the criminal justice system. Many states are using diversion programs and probation-based drug courts to push offenders into treatment. Nearly 1600 drug courts are in operation in the U.S. today (American University, Drug Court Clearing House, BJA) with hundreds more planned. Drug courts give judges flexibility to order treatment, frequent testing and close monitoring of drug offenders in lieu of incarceration.

Examples of state programs:

- In Connecticut, a program empowers judges to order a full continuum of treatment alternatives for low-risk, first-time offenders. A study of the program found that non-participants were re-arrested at three times the rate of program participants.
- Washington reduced by six months, from 24 to 18, the mandatory minimum sentences for several offenses related to selling heroin or cocaine. Roughly 75 percent of the savings

derived from reduced prison rolls goes to counties for court-supervised treatment programs. The remainder is spent on treatment programs run by the state prison system.

- Delaware funds a program that provides drug-addicted inmates access to treatment in the last 12-18 months of their incarceration followed by work release and intensive aftercare services in the community. A study found that 18 months after release, 71 percent of program participants remained arrest-free and 76 percent were drug-free, compared to 30 percent and 19 percent of non-participants.

#### *Questions for the Panel*

- What policy and organizational changes would further promote collaboration between the criminal justice system and state substance use programs?
- Should states expand the use of drug courts?
- Should community treatment services replace incarceration for nonviolent drug offenders?

### **VIII. OVERSIGHT.**

Some states assign financing, facilities regulation and professional licensing to a single state agency. Others delegate these functions to distinct departments. What are the consequences of these different arrangements? What is the optimal structure for ensuring the effectiveness and quality of substance use prevention and treatment programs?

#### *Ensuring Accountability*

On the federal level, SAMHSA had moved to transform the SAPT block grant into a Performance Partnership Grant. States would be required to identify expected levels of system performance and report measures that assess their ability to meet the performance expectations. The goal would be to promote attention to outcomes at all levels of the drug and alcohol treatment system.

On the state level, each state SSA is responsible for effective allocation and utilization of federal and state sources that are specifically targeted for alcohol and other SUDs treatment services. Increasingly, state governments are implementing contracts that require demonstrations of specified levels of outcomes rather than just purchasing the delivery of services.

The recent IOM report makes the following recommendations:

- Licensing boards, accrediting bodies and purchasers should incorporate the competencies and national standards established by the Council on the Mental and Substance-Use Health Care Workforce in discharging their regulatory and contracting responsibilities.
- State and local governments should reduce the emphasis on the grant-based systems of financing that currently dominate public SUDs treatment systems and should increase the use of funding mechanisms that link some funds to measures of quality.
- State government procurement processes should be reoriented to give the most weight to the quality of care to be provided by vendors.

- Government purchasers should use substance-use health care quality measures in procurement and accountability processes.

*Questions for the Panel*

- How should states monitor and measure performance and outcomes?
- What are the consequences of different structures for overseeing facilities regulation and professional licensing?
- Should regulatory and licensing functions be separated from financing treatment providers?