

M00K
Alcohol and Drug Abuse Administration
 Department of Health and Mental Hygiene

Operating Budget Data

(\$ in Thousands)

	<u>FY 09</u> <u>Actual</u>	<u>FY 10</u> <u>Working</u>	<u>FY 11</u> <u>Allowance</u>	<u>FY 10-11</u> <u>Change</u>	<u>% Change</u> <u>Prior Year</u>
General Fund	\$93,478	\$89,809	\$87,527	-\$2,282	-2.5%
Contingent & Back of Bill Reductions	0	0	-108	-108	
Adjusted General Fund	\$93,478	\$89,809	\$87,419	-\$2,389	-2.7%
Special Fund	17,700	17,914	20,825	2,912	16.3%
Contingent & Back of Bill Reductions	0	0	-5	-5	
Adjusted Special Fund	\$17,700	\$17,914	\$20,820	\$2,907	16.2%
Federal Fund	31,836	31,937	33,990	2,052	6.4%
Contingent & Back of Bill Reductions	0	0	-46	-46	
Adjusted Federal Fund	\$31,836	\$31,937	\$33,944	\$2,006	6.3%
Reimbursable Fund	4,801	4,937	5,713	776	15.7%
Adjusted Reimbursable Fund	\$4,801	\$4,937	\$5,713	\$776	15.7%
Adjusted Grand Total	\$147,815	\$144,597	\$147,897	\$3,300	2.3%

Note: For purposes of illustration, the Department of Legislative Services has estimated the distribution of selected across-the-board reductions. The actual allocations are to be developed by the Administration.

- The fiscal 2011 allowance including contingent reductions is \$3.3 million, or 2.3%, more than the working appropriation.
- Special and federal funds are driving the increase, increasing by \$2.9 and \$2.0 million, respectively.

Note: Numbers may not sum to total due to rounding.

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Personnel Data

	<u>FY 09 Actual</u>	<u>FY 10 Working</u>	<u>FY 11 Allowance</u>	<u>FY 10-11 Change</u>
Regular Positions	60.00	62.50	62.50	0.00
Contractual FTEs	<u>2.44</u>	<u>5.00</u>	<u>4.50</u>	<u>-0.50</u>
Total Personnel	62.44	67.50	67.00	-0.50

Vacancy Data: Regular Positions

Turnover and Necessary Vacancies, Excluding New Positions	3.00	4.80%
Positions and Percentage Vacant as of 12/31/09	6.00	9.60%

- The fiscal 2011 allowance includes the same number of regular positions and 0.5 fewer contractual full-time equivalents.
- The agency currently has 6.0 vacancies; 5.0 have been vacant less than eight months.

Analysis in Brief

Major Trends

Prevention: Changes in the strategy in Baltimore City lead to a decline in the reported exposure to prevention activities. The Baltimore City Substance Abuse Systems (BSAS), in conjunction with the Baltimore City school system, created an initiative which utilizes the “Why Try” curriculum targeting youth. The curriculum is being implemented in 30 schools. BSAS has redirected funds to support this prevention activity. Participants are not included in the prevention numbers presented in the annual prevention report.

Treatment: The full-range of treatment outcomes from fiscal 2009 were not available at the time of writing. Admissions in ADAA-funded treatment programs decline slightly in fiscal 2009; however, completion rates increase. In national comparative data, Maryland’s treatment outcomes are generally better than the national average.

Court-involved Processing: Clearance to admission times show improvement following the addition of funding in the fiscal 2009 budget for more residential beds.

Recommended Actions

1. Concur with Governor’s allowance.

Updates

Development of a Substance Abuse Strategic Plan: In July 2008, the Governor issued an executive order to reestablish the Maryland State Drug and Alcohol Abuse Council and directed the Council to develop a comprehensive, coordinated, and strategic approach to the use of State and local resources for prevention, intervention, and treatment of drug and alcohol abuse among citizens of the State.

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M00K
Alcohol and Drug Abuse Administration
Department of Health and Mental Hygiene

Operating Budget Analysis

Program Description

The Alcohol and Drug Abuse Administration (ADAA) develops and operates unified programs for substance abuse research, training, prevention, and rehabilitation in cooperation with federal, State, local, and private agencies. ADAA's mission is to provide access to a quality and effective substance abuse prevention, intervention, and treatment service system for the citizens of Maryland.

ADAA maintains an integrated statewide service delivery system through a variety of treatment and prevention modalities that provide financial and geographic access to Marylanders who need help with drug and alcohol addiction. Treatment is funded through grants to private and nonprofit providers and local health departments. Maryland's community-based addictions treatment programs include primary and emergency care; intermediate care facilities; halfway houses; long-term programs; and outpatient care. The State also funds prevention programs.

Chapters 237 and 238 of 2004 formalized a local planning role for drug and alcohol abuse services. That legislation requires each county to have a local drug and alcohol abuse council and for each council to develop a local plan that includes the plans, strategies, and priorities of the county in meeting identified needs of both the general public and the criminal justice system for alcohol and drug abuse evaluation, prevention, and treatment services. ADAA has indicated that these local plans will be key in determining specific program activities in each jurisdiction.

Performance Analysis: Managing for Results

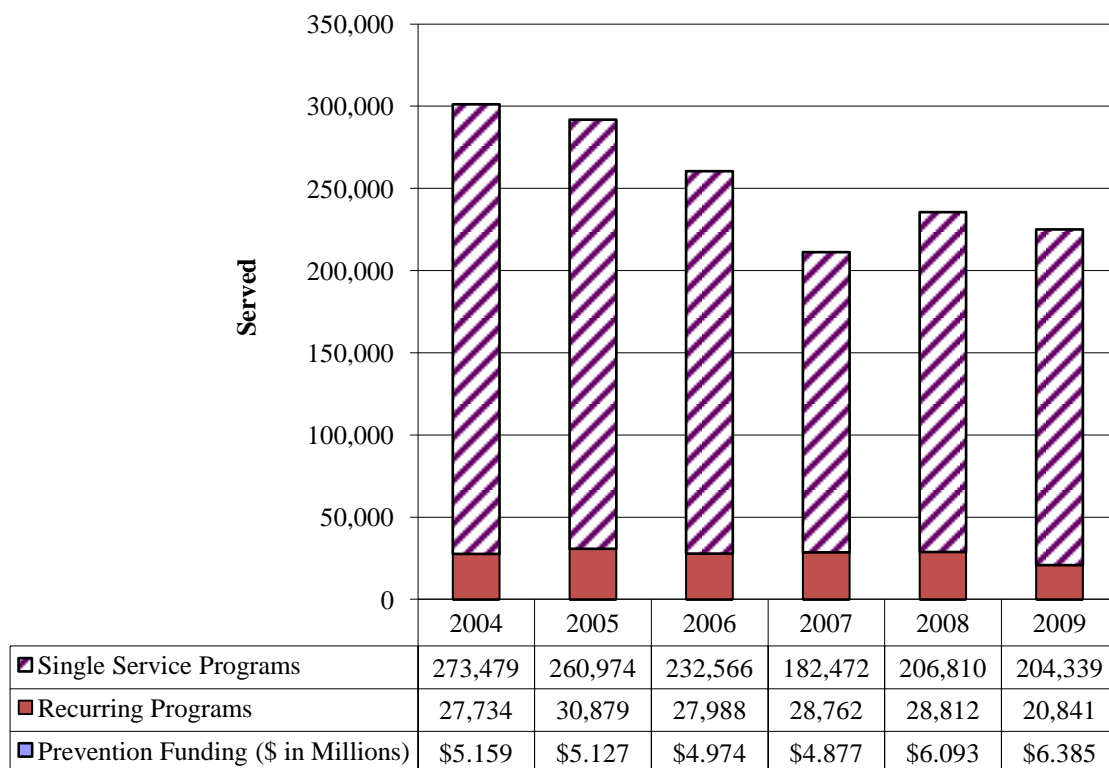
Prevention

ADAA prevention services are provided through two types of programming:

- Recurring prevention programming, *i.e.*, with the same group of individuals for a minimum of six separate occasions and with programming that is an approved Substance Abuse and Mental Health Services Administration (SAMHSA) model. In fiscal 2009, a total of 436 recurring prevention programs were offered across the State.
- Single service programs such as presentations, speaking engagements, training, etc., that are provided to the same group on less than six separate occasions. Participant numbers are either known or estimated. In fiscal 2009, 1,364 single service prevention activities were offered in Maryland.

As shown in **Exhibit 1**, ADAA prevention programming served 225,180 clients in fiscal 2009. This is lower than the approximately 235,000 served in fiscal 2008. The number of recurring programs declined by almost 8,000 served while the number served in single services programs declined by almost 2,500. Recurring activities have more sophisticated programming requirements (*i.e.*, programming consistent with SAMHSA evidence-based practice models).

Exhibit 1
ADAA-funded Prevention Programs: Numbers Served by Program
Fiscal 2004-2009



ADAA: Alcohol and Drug Abuse Administration

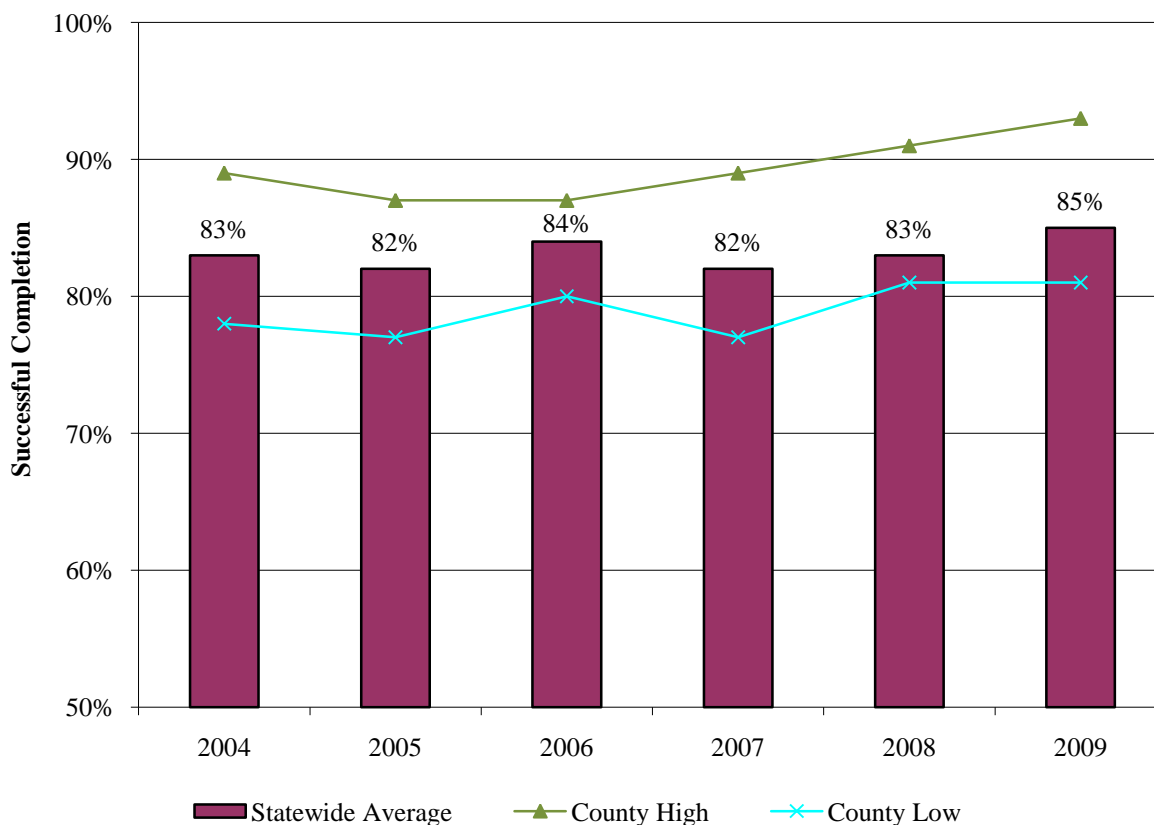
Source: Alcohol and Drug Abuse Administration

The agency attributes this decline to a change in strategy in Baltimore City. The Baltimore City Substance Abuse Systems (BSAS), the coordinator of substance abuse services in the City, has partnered with the Baltimore City Public School System and Baltimore Mental Health Systems to implement a behavioral health initiative aimed at potential drop outs. The initiative utilizes the “Why Try” curriculum which targets youth. The curriculum is being implemented in 37 schools. BSAS has redirected funds to support this prevention activity. Participants are not included in the prevention

numbers presented above. In fiscal 2009, BSAS spent \$410,000 on the program and served 772 clients.

As shown in **Exhibit 2**, ADAA reports that in fiscal 2009, 85% of participants in recurring prevention programs successfully completed the program, slightly higher than in fiscal 2008. As also shown in this exhibit, there is variation by county among programs in terms of successful completion. In fiscal 2009, for example, the successful completion rate varied from 93% in Prince George’s County to 81% in Garrett County. But across all of the programs, the general trend is one of higher levels of completion. It should be noted that since programming varies from one jurisdiction to the next, there is no universal definition of what is considered a “successful completion.”

Exhibit 2
ADAA-funded Recurring Prevention Programs: Successful Completion Rates (%)
Fiscal 2004-2009

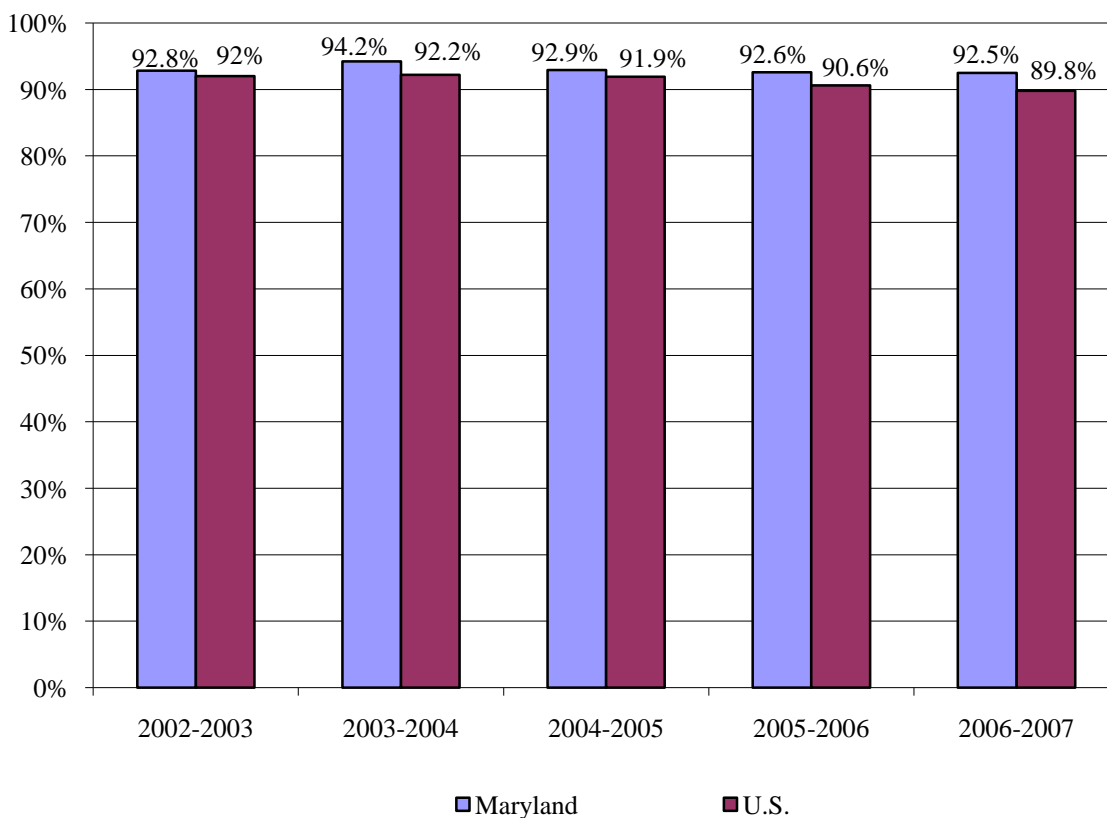


ADAA: Alcohol and Drug Abuse Administration

Source: Alcohol and Drug Abuse Administration

At the national level, the federal SAMHSA through its National Outcomes Measures (NOMS) initiative compiles a variety of state-by-state data around a series of domains concerning the treatment and prevention of substance abuse and the treatment of mental illness. Picking just two of the measures relating to prevention of substance abuse, **Exhibit 3** shows that, based on survey data, 92.5% of Maryland youth (aged 12 to 17) indicate exposure to prevention messages. While the trend among Maryland youth is actually downwards in terms of exposure, it is still slightly higher than the national average.

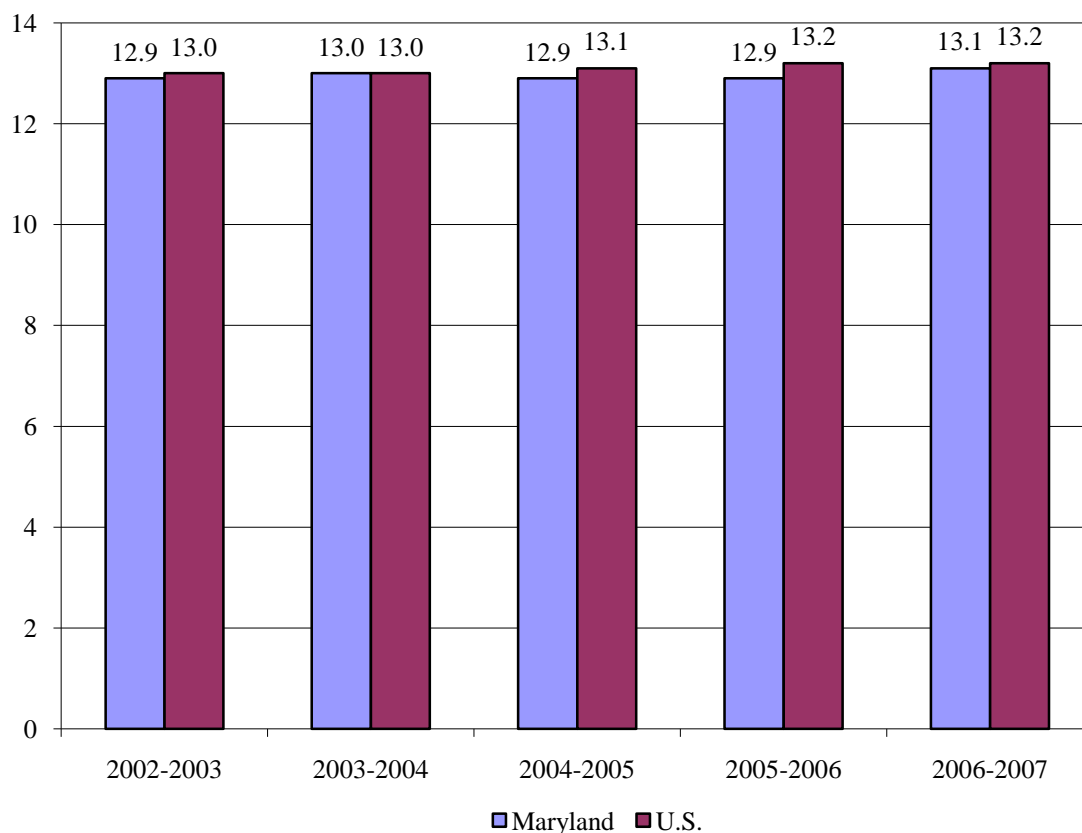
Exhibit 3
Youth Exposure to Prevention Messages
Fiscal 2002-2007



Source: Substance Abuse and Mental Health Services Administration; National Outcomes Measures

Exhibit 4 presents data on the average age of first use of alcohol. Again, this data is drawn from self-reported survey data of youth 12 to 17 years old, and again the Maryland data closely tracks the national average. However, Maryland youth surveyed report first use of alcohol at a slightly younger age than the national average, and that age has remained relatively unchanged over the period shown, while the national average shows evidence of a slight deferment of first alcohol use.

Exhibit 4
Reported First Use of Alcohol
Fiscal 2002-2007

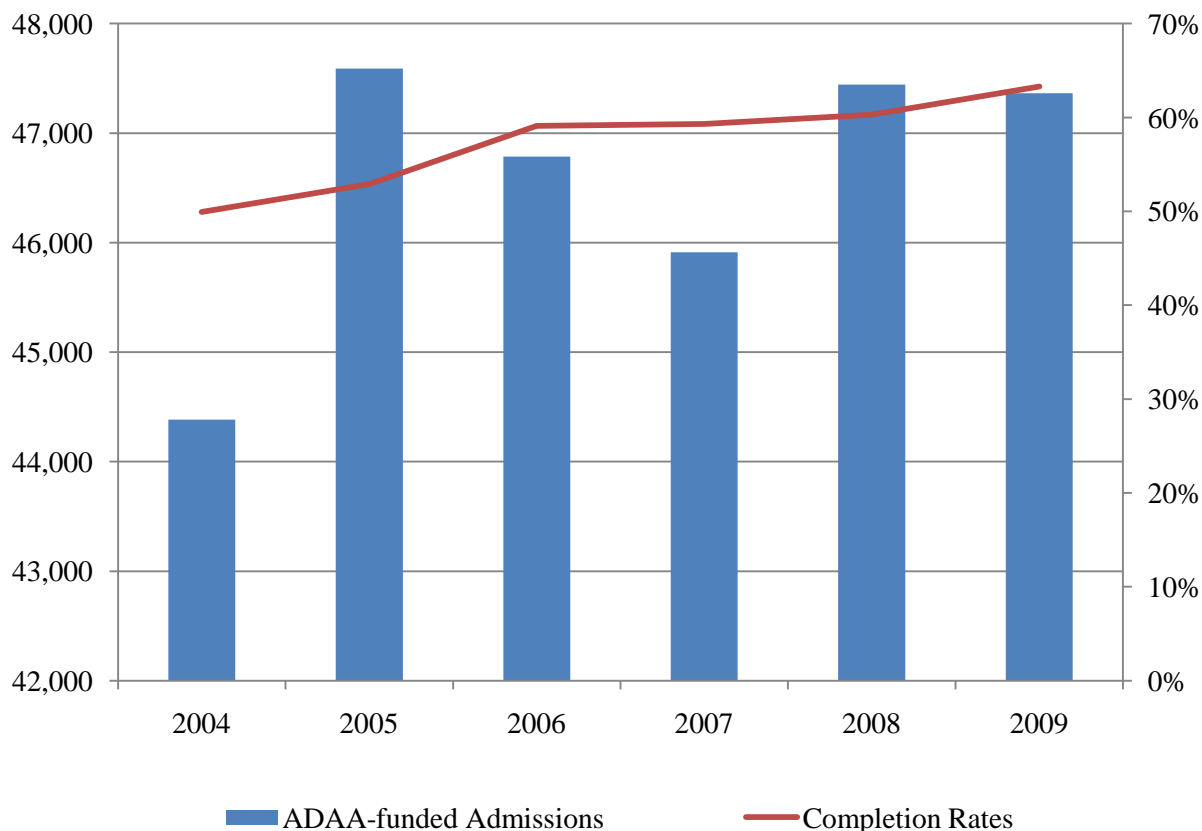


Source: Substance Abuse and Mental Health Services Administration; National Outcomes Measures

Treatment

As shown in **Exhibit 5**, after falling between fiscal 2006 and 2007, admissions to ADA-funded treatment services increased by 3% between fiscal 2007 and 2008 only to fall slightly in fiscal 2009. The agency is utilizing a new data tracking system, the State of Maryland Automated Record Tracking (SMART) system. This is allowing for more accurate data tracking and the elimination of duplicates. The agency believes once the data is completely cleaned, fiscal 2009 will have more admissions than 2008. Completion rates (program completion and discharge without the need for further treatment or program completion with appropriate referral to the next level of treatment) continued the steady rise seen in prior years.

**Exhibit 5
Admissions to ADAA-funded Treatment Programs and Completion Rates
Fiscal 2004-2009**



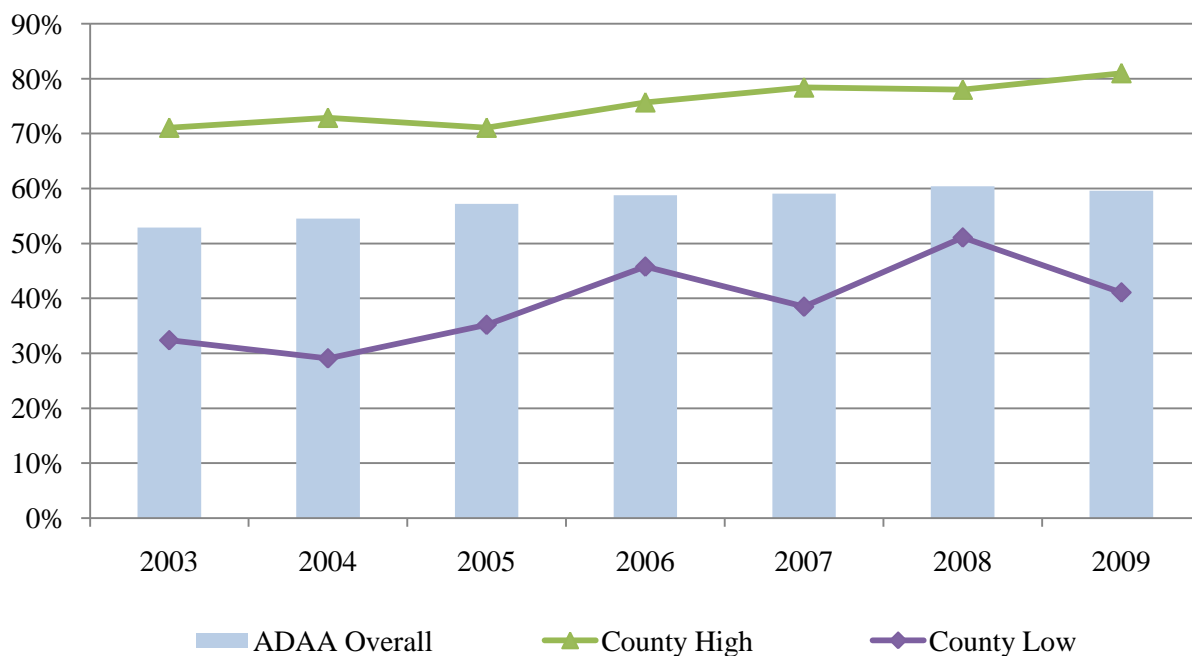
ADAA: Alcohol and Drug Abuse Administration

Source: Alcohol and Drug Abuse Administration

In terms of outcomes, a key outcome measure is retention rate within a program. Research, as well as Maryland experience, demonstrates a strong relationship between retention rates and successful outcomes. In outpatient treatment, for example, keeping a person in a program for longer than 90 days is considered an important benchmark. As shown in **Exhibit 6**, the gradual improvement in the retention rate beyond 90 days in ADAA-funded Level I (outpatient) programs continued to slow in fiscal 2009.

At the same time, there was greater variation between programs in fiscal 2009 than in the prior year. For fiscal 2009, the highest retention rate for ADAA-funded programs is 81% (Somerset County), while the lowest retention rate is just above 41.1% (Queen Anne’s County). **The agency should discuss the variation in retention rates among the counties.**

Exhibit 6
Level I Retention Rates
Retained More than 90 Days
Fiscal 2003-2009



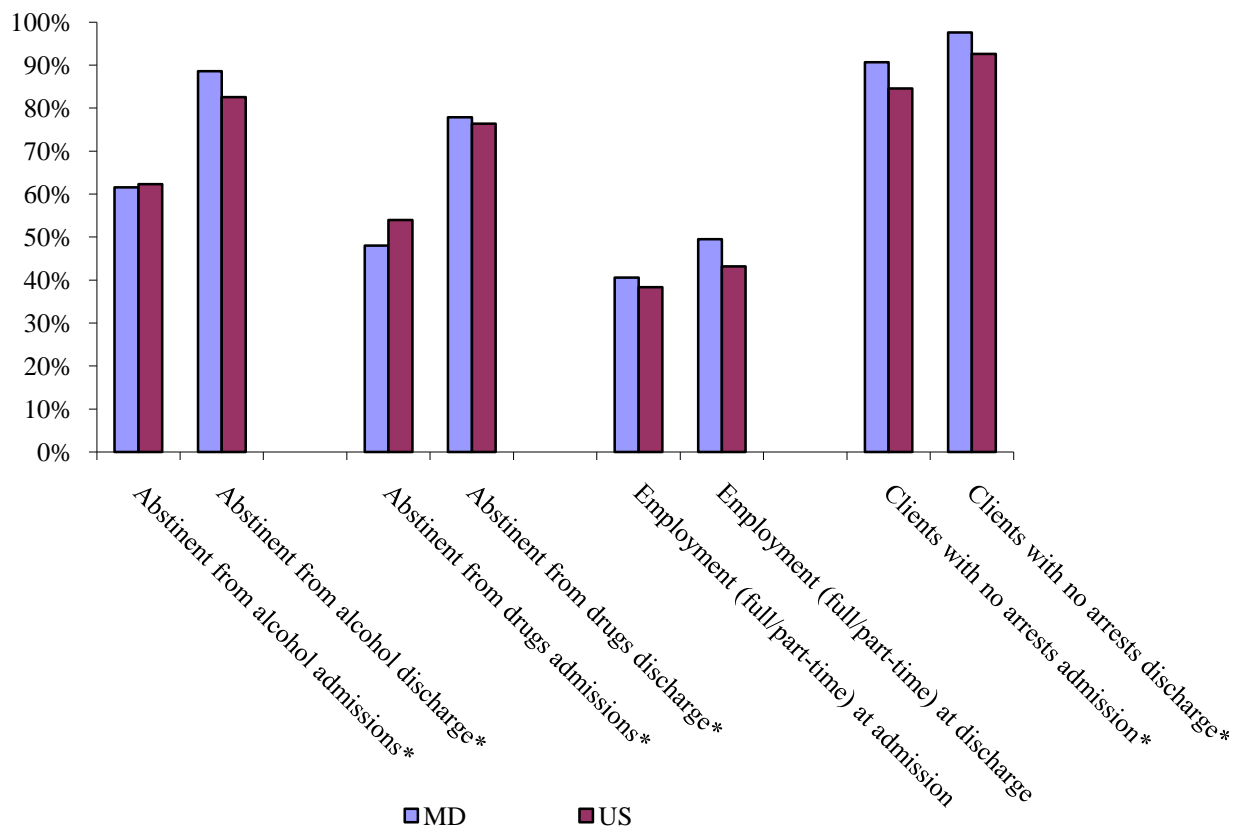
ADA A: Alcohol and Drug Abuse Administration

Source: Alcohol and Drug Abuse Administration

Comparative treatment data is available through the NOMS program. The data shown in **Exhibit 7** illustrates that Maryland generally outperforms the national average:

- clients in Maryland have higher levels of abstinence from alcohol and drugs at program discharge and a greater level of improvement;
- clients in Maryland show higher levels of employment at discharge, and the increase in employment levels are greater than the national average; and
- clients in Maryland have fewer arrests 30 days prior to discharge compared to the national average although improvement between admission and discharge among Maryland clients is lower. However, this is perhaps more a reflection of the higher overall criminal justice involvement of clients at admission nationally rather than any issue with Maryland programming.

Exhibit 7
National Outcomes Measures
Various Treatment Outcomes for all Treatment Types
Most Available Data (2007)



*30 days prior

Source: National Outcomes Measures

Court-involved Processing

Under current law, the courts may order the Department of Health and Mental Hygiene (DHMH) to conduct evaluations of criminal defendants to determine if they are in need of, and could benefit from, treatment. Additionally, the courts may commit a defendant to DHMH for treatment (in outpatient or residential settings) if the defendant agrees to that treatment as a condition of release, after conviction, or at another time (Sections 8-505 and 8-507 of the Health-General article).

Although the statute notes that the department shall provide the services required, it is generally considered that this service provision is subject to the availability of funds provided for in the budget. Certainly, a review of the legislative history associated with these provisions would indicate that. In other

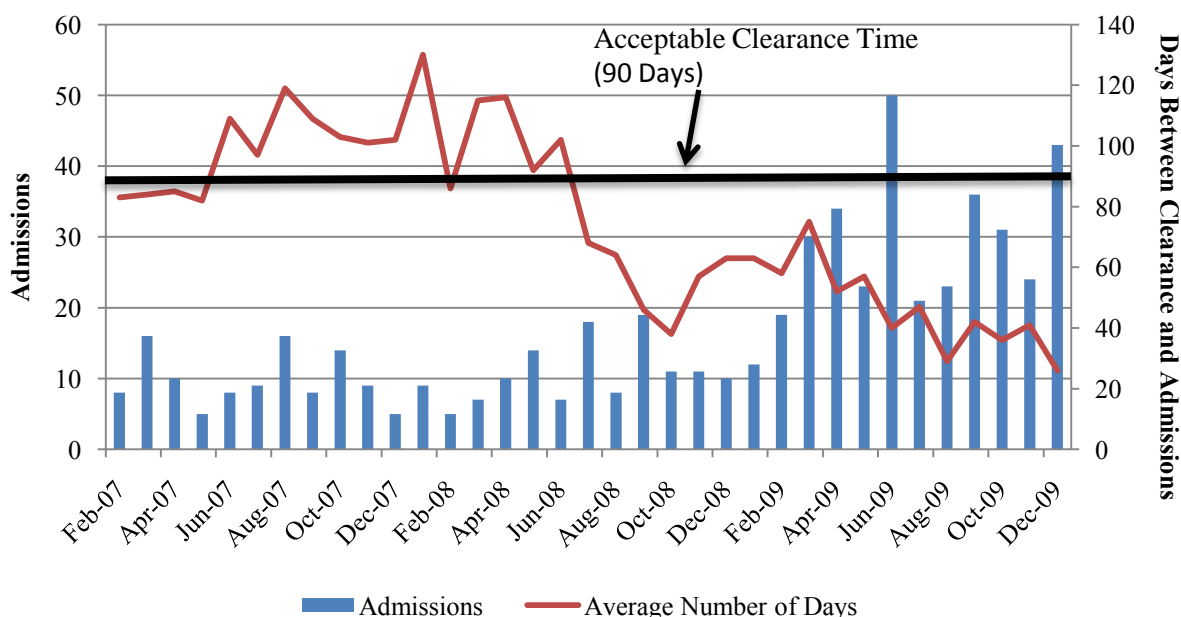
words, this section is not “treatment on demand” for all individuals that the courts find have an alcohol and drug dependency and are suitable for, and agree to, commitment to the department.

In recent years, there have been various times when ADAA has found itself in contempt of court for another provision of the same statute, namely the facilitation of “prompt treatment of a defendant,” which the courts have generally considered to be 90 days from clearance to admission. In particular, the courts have been frustrated by the lack of residential treatment slots for individuals under Section 8-507.

ADAA rebid its three statewide residential contracts in calendar 2009. The existing contracts for women and children (46 beds) and co-occurring disorders (80 beds) are not exclusively for court-involved individuals although generally serve such clients. The third, and largest, contract is exclusively for court-ordered individuals (110 beds).

At the beginning of calendar 2008, delays in the placement of individuals under Section 8-507 were noted, and additional funding for co-occurring residential slots was included in the fiscal 2009 budget. As shown in **Exhibit 8**, which presents data only for individuals with co-occurring disorders who require level III.3 (residential) treatment, the time taken from a defendant being cleared for service under Section 8-507 and admission to the program has fallen considerably.

Exhibit 8
Clearance to Admission Times for
Co-occurring Level III.3 Treatment
February 2007 through December 2009



*February 2009 data and beyond includes co-occurring Level III.3 and III.5 data.

Source: Alcohol and Drug Abuse Administration

Fiscal 2010 Actions

Impact of Cost Containment

The fiscal 2010 budget has been reduced by \$5.0 million by the Board of Public Works (BPW) during three rounds of cost containment, with \$4.8 million reduced from the grants provided to the counties for prevention and treatment services. In July, the 0.9% inflationary adjustment for community providers was eliminated, resulting in a \$1.2 million reduction to the grants. During the August round of cost containment, \$1.7 million was reduced (equal to an annualized 2.0% reduction in the estimated salary portion of local treatment grants), and, in November, a 1.5% across-the-board reduction to the county grant program was implemented resulting in a \$1.9 million total reduction. The remaining \$200,000 reduction includes a furlough for State employees and across-the-board reductions to operating expenses in various DHMH administrations.

Treatment Expansion to Primary Adult Care Program Recipients

Chapter 332 of 2009 expanded limited substance abuse benefits to Primary Adult Care (PAC) recipients and increased rates for Medicaid-funded substance abuse services. This is part of a wider effort being undertaken by the department to improve access to substance abuse services within Medicaid. Prior to this, Medicaid delivered most substance abuse treatment via the managed care organizations. However, this only covered regular Medicaid recipients and not those covered under the PAC program. The rate increases affect community-based Office of Health Care Quality certified addiction programs. Rates were increased for the following services: substance abuse assessments; individual and group counseling; intensive out-patient services, and methadone maintenance programs.

PAC substance abuse expansion and rate increases were implemented on January 1, 2010. In order to fund the expansion, the fiscal 2010 budget bill included language restricting \$3.3 million from the grant program in ADAA to be used to reimburse the Medicaid program. The services would be provided on a fee-for-service basis rather than the slots provided in the grant program. This would also allow the providers to access matching federal funds. **Exhibit 9** shows the cumulative effect of the cost containment reductions and the PAC expansion/Medicaid rate increase on the grants provided for treatment and prevention.

Early indications from the department and provider groups suggest that the implementation of the PAC expansion/Medicaid rate increase has been relatively smooth. Among the issues reported include:

- providers are reporting failure on the part of Managed Care Organizations (MCOs) to reimburse at the new higher rates;
- the difficulty of some providers, predominantly those used to providing services exclusively under the ADAA grant system, to learn the basics of eligibility, service coverage, and billing; and

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- the necessity to at least develop relationships (although not contractual relationships) with MCOs in order to deal with problems that have arisen.

Proposed Budget

As shown in **Exhibit 10**, the fiscal 2011 allowance increases by \$3.3 million or 2.3%. Special and federal fund changes are driving this, increasing by \$2.9 million and \$2.0 million, respectively. Reimbursable funds increase by \$776,000.

Impact of Cost Containment

The fiscal 2011 budget reflects several across-the-board actions to be allocated by the Administration. This includes a combination of employee furloughs and government shut-down days similar to the plan adopted in fiscal 2010; a reduction in overtime based on accident leave management; streamlining of State operations; hiring freeze and attrition savings; a change in the injured workers' settlement policy and administrative costs; and a savings in health insurance to reflect a balance in that account. For purposes of illustration, the Department of Legislative Services has estimated the distribution of selected actions relating to employee furloughs, health insurance, and the Injured Workers' Insurance Fund cost savings.

Personnel

Personnel expenditures increase by \$218,000. Employee and retiree health insurance and payments to the employee retirement system increase by \$79,000 and \$76,000, respectively, due to higher rates for all state agencies. Total salary expenditures, including the proposed fiscal 2011 furlough, increase by \$76,000 due to positions being filled at higher steps.

Exhibit 9
Impact of Fiscal 2010 Budget Actions and Primary Adult Care Expansion on
Local Prevention and Treatment Grants

	Grant \$	Redirected to				
	2010	PAC Expansion/	July	August	November	2010
	Start	Medicaid Rate	BPW	BPW	BPW	Working
		Increase and Rate				
		Increase				
Allegany	\$5,678,752	-\$82,123	-\$56,348	-\$75,905	-\$85,477	\$5,378,899
Anne Arundel	5,497,444	-118,657	-55,774	-75,132	-84,693	5,163,188
Baltimore City	51,509,733	-1,977,446	-488,931	-658,628	-741,652	47,643,076
Baltimore	7,910,021	-311,923	-79,229	-106,727	-120,478	7,291,665
Calvert	990,752	-10,418	-10,260	-13,822	-15,560	940,691
Caroline	653,415	-10,244	-6,996	-9,424	-10,529	616,222
Carroll	3,834,277	-22,199	-39,178	-52,776	-59,412	3,660,712
Cecil	1,518,559	-29,190	-15,052	-20,276	-22,879	1,431,163
Charles	2,419,671	-22,358	-24,458	-32,947	-37,100	2,302,809
Dorchester	2,055,442	-25,532	-20,706	-27,892	-31,408	1,949,904
Frederick	2,514,323	-46,075	-27,384	-36,888	-41,542	2,362,435
Garrett	838,615	-16,630	-10,268	-13,832	-15,642	782,242
Harford	2,257,732	-63,037	-23,596	-31,786	-36,122	2,103,191
Howard	1,864,812	-23,681	-18,579	-25,028	-28,252	1,769,272
Kent	2,082,770	-10,822	-21,013	-28,305	-31,874	1,990,757
Montgomery	4,701,432	-120,177	-49,823	-67,116	-75,689	4,388,627
Prince George's	11,779,211	-108,637	-117,675	-158,517	-178,470	11,215,913
Queen Anne's	792,387	-10,795	-8,259	-11,126	-12,722	749,485
Somerset	1,139,671	-13,333	-11,783	-15,873	-17,874	1,080,807
St. Mary's	3,419,274	-14,946	-33,806	-45,540	-51,365	3,273,617
Talbot	947,279	-12,575	-10,088	-13,590	-15,184	895,842
Washington	3,839,029	-207,798	-37,448	-50,445	-56,804	3,486,534
Wicomico	2,163,925	-34,651	-24,899	-33,540	-38,083	2,032,753
Worcester	3,313,300	-50,172	-33,321	-44,886	-50,501	3,134,419
Total	\$123,721,828	-\$3,343,418	-\$1,224,874	-\$1,650,001	-\$1,859,312	\$115,644,223

BPW: Board of Public Works

PAC: Primary Adult Care

Note: Grants include Prevention.

Source: Alcohol and Drug Abuse Administration

Exhibit 10
Proposed Budget
DHMH – Alcohol and Drug Abuse Administration
(\$ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
2010 Working Appropriation	\$89,809	\$17,914	\$31,937	\$4,937	\$144,597
2011 Allowance	<u>87,527</u>	<u>20,825</u>	<u>33,990</u>	<u>5,713</u>	<u>148,055</u>
Amount Change	-\$2,282	\$2,912	\$2,052	\$776	\$3,458
Percent Change	-2.5%	16.3%	6.4%	15.7%	2.4%
 Contingent Reduction	 -\$108	 -\$5	 -\$46	 \$0	 -\$158
Adjusted Change	-\$2,389	\$2,907	\$2,006	\$776	\$3,300
Adjusted Percent Change	-2.7%	16.2%	6.3%	15.7%	2.3%

Where It Goes:

Personnel Expenses

Employee and retiree health insurance including Section 19	\$79
Salary including Section 18.....	76
Employee Retirement System.....	76
Workers' compensation premium assessment including Section 21 & 23.....	14
Social Security contribution	10
Turnover adjustments	-42
Other fringe benefit adjustments	5

Other Changes

Maryland Strategic Prevention Framework (Federal Funds)	1,884
Whitsitt Center Funding to accommodate patients from the Upper Shore Community Mental Health Center (Reimbursable Funds).....	1,434
Problem Gambling Study (Special Funds)	500
State of MD Automated Record Tracking (SMART)	198
In-state travel	19
Office supplies.....	9
Substance Abuse Treatment Grants.....	-1,125
Other adjustments	163

Total **\$3,300**

Note: Numbers may not sum to total due to rounding.

Substance Abuse Treatment Grants

The fiscal 2011 allowance includes a total of \$129.7 million for treatment including PAC expansion/Medicaid rate increase, treatment grants, drug court treatment, and Buprenorphine funding. This is \$1.125 less than the fiscal 2010 working appropriation and \$5.0 million less than the fiscal 2009 actual spending.

Fund types also vary from fiscal 2010. General funds decrease by \$2.7 million. Reimbursable funds from the Office of Problem Solving Courts (OPSC) decline by \$728,728. Additionally, \$197,760 in funds for Buprenorphine treatment was reallocated within the agency. These decreases are offset by a \$2.39 million increase in the Cigarette Restitution Fund and \$111,905 in additional funds from the Department of Human Resources.

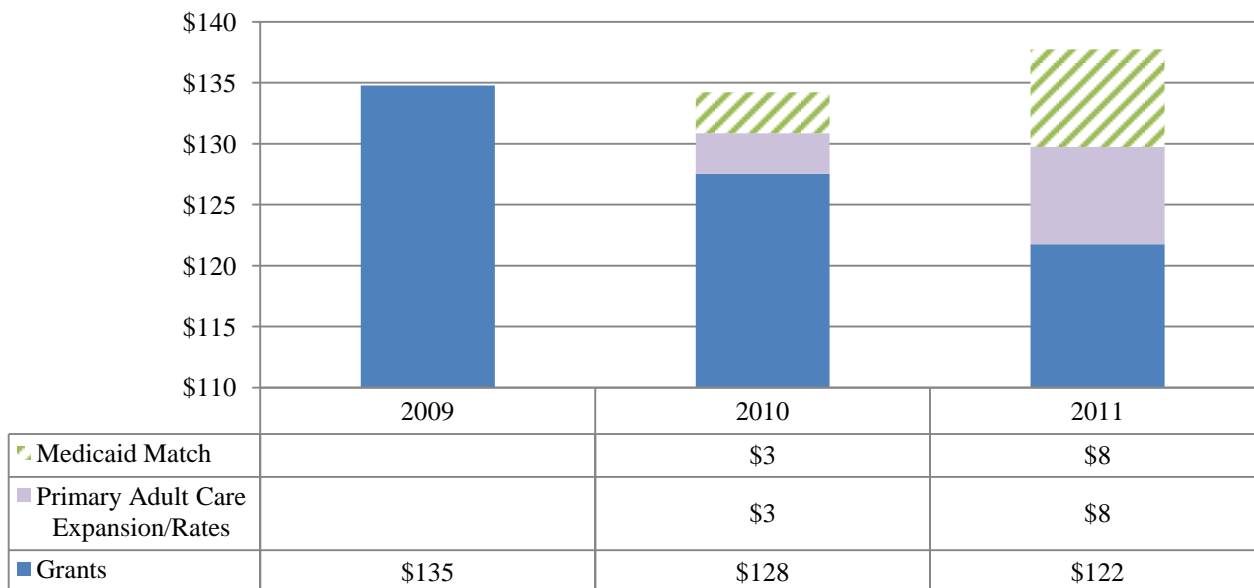
PAC expansion/Medicaid rate increase, for half of fiscal 2010 and 2011, further reduces the funds available to the traditional ADAA grant system. Under this system, grants are provided to local jurisdictions that in turn contract for services or, in some cases, deliver services directly. These local grants are supplemented by statewide contracts for certain residential services, and services primarily directed to court-involved individuals.

As stated earlier, Chapter 332 of 2009 expanded limited substance abuse benefits to PAC recipients and increased rates for other Medicaid-funded substance abuse services. This began in January 2010 with \$3.3 million in funds included in the allowance for the grant program, which would be used to fund PAC expansion/Medicaid rate increase instead. However, due to the economic downturn, PAC enrollment has exceeded estimates available during the 2009 legislative session, when the full-year cost was estimated at \$6.7 million. The fiscal 2011 allowance includes \$8.0 million in the grant program that will be transferred to the medical care programs for the PAC substance abuse expansion. This leaves \$121.7 million for ADAA funded grant programs. Available funding for the traditional treatment grant program declines from the fiscal 2009 level of \$135.0 million to \$128.0 million in fiscal 2010 and \$122 million in fiscal 2011.

To implement the reductions to the grants, ADAA used Medicaid Substance Abuse and PAC enrollment data by jurisdiction from the Medical Care Programs Administration. Based on these data, ADAA allocated the reduction by jurisdiction to each county grant. ADAA, at the time of writing, has not decided on the process for the funding reduction in fiscal 2011.

However, due to federal Medicaid matching funds available through PAC expansion/Medicaid rate increase, funding in the system actually grows between fiscal 2009 and 2011. A substantial portion of the population served by the ADAA grant program is PAC eligible. In the past, by using grant awards to cover substance abuse treatment for individuals in PAC, the State missed an opportunity to maximize federal funds. The \$8 million reduction to the grant program to fund the increased services in fiscal 2011 for PAC should generate \$16 million in additional funds for the treatment system. **Exhibit 11** shows the impact the use of ADAA grant funds for PCA expansion/Medicaid rate increase will have on the system.

Exhibit 11
Impact of PAC Expansion/Medicaid Rate Enhancement
On the Substance Abuse System
Fiscal 2009-2011
(\$ in Millions)



Source: Alcohol and Drug Abuse Administration; Department of Legislative Services

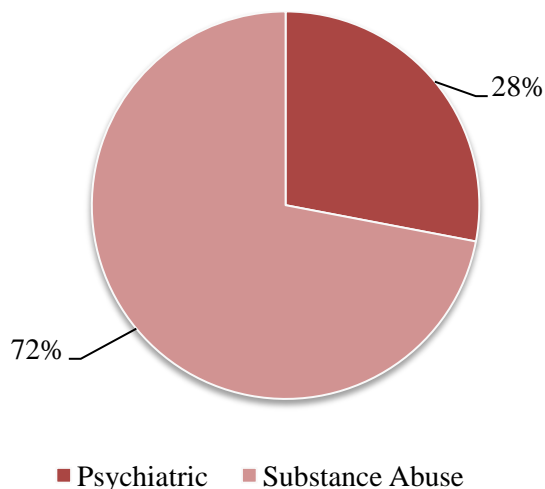
ADAA should update the committees on the expansion to the PAC program and the providers’ ability to bill under the fee-for-service program, and the allocation of treatment grants for fiscal 2011. ADAA should also comment on the effect the reduction in funds to the grant program has on the number of available slots and the total number of clients served.

Effect of the Closure of the Upper Shore Community Mental Health Center

The Upper Shore Community Mental Health Center (USCMHC) was a psychiatric hospital in Chestertown, Kent County which operated 40 beds (licensed capacity is 64). The center also housed tenants: the Whitsitt Center, a residential treatment facility for substance abusers operated by the Kent County Health Department; and the J. DeWeese Carter Center, a juvenile detention facility operated by the Department of Juvenile Services. After deliberation, it was decided that the USCMHC would be closed, consistent with the policy direction DHMH has been moving toward in recent years by closing other State-run psychiatric hospitals.

USCMHC served a preponderance of individuals with co-occurring mental illness and substance abuse issues. For many patients the primary diagnosis was substance abuse issues. As shown in **Exhibit 12**, in fiscal 2009, 72% of the admissions to USCMHC are for individuals with a primary diagnosis of substance abuse. In other parts of the State, these individuals would receive treatment either in a residential substance abuse or ambulatory setting.

Exhibit 12
Upper Shore Community Health Center
Fiscal 2009 Admissions by Primary Diagnosis



Source: Department of Health and Mental Hygiene

The plan to close USCMHC included expanding residential substance abuse treatment capacity through the Kent County Health Department, accommodating 200 additional admissions annually. \$1.4 million in reimbursable funds (funds are currently budgeted in DHMH) is included in the fiscal 2011 ADAA allowance to provide 16 residential substance abuse treatment beds and four crisis beds for individuals with co-occurring substance abuse and mental health disorders at the Whitsitt Center. The DHMH plan calls for integrating appropriate mental health services for these patients who might otherwise be placed at USCMHC.

Other Changes

Maryland Strategic Prevention Framework

SAMHSA’s Center for Substance Abuse Prevention awarded ADAA a five-year grant to establish the Maryland Strategic Prevention Framework. ADAA plans to use the funds to implement a cross-system statewide strategic prevention planning and services system. Maryland will receive \$2.1 million each year for five years.

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The grant requires that a minimum of 85% of the total award must be allocated directly to community-level organizations to target need and fill gaps to implement and sustain evidence-based prevention services. ADAA will award \$1.9 million in fiscal 2011 in the form of grants to local health departments and other providers on a competitive basis. The awards will be made only after a plan has been developed and submitted to SAMHSA by the local jurisdiction.

Problem Gambling Study

Chapter 4 of the 2007 special session established the Problem Gambling Fund. The fund receives revenue from video lottery licensee fees. Each slot licensee must pay \$425 annually for each slot machine operated that year. Funds may only be spent by DHMH to establish a 24-hour hotline for compulsive gamblers and to provide counseling and other support services to problem gamblers and to develop and implement program gambling treatment and prevention. After satisfying these requirements, funds may be spent on other addiction services. The fiscal 2011 allowance includes \$500,000 for ADAA to conduct a study of problem gambling in the State. The legislation also requires that this study be replicated every five years.

State of Maryland Automated Record Tracking System

Funding for the SMART system increases by \$197,760. The increase in funds is committed from the Buprenorphine initiative, which decreases by a corresponding amount, and is not an actual increase in general fund support for the agency. The funds will be used to increase the capacity of the SMART system to collect data and track outcomes and program services for Buprenorphine patients in various levels of care.

Recommended Actions

1. Concur with Governor's allowance.

Updates

1. Development of Substance Abuse Strategic Plan

In July 2008, the Governor issued an executive order to reestablish the Maryland State Drug and Alcohol Abuse Council and directed the Council to develop a comprehensive, coordinated, and strategic approach to the use of State and local resources for prevention, intervention, and treatment of drug and alcohol abuse among citizens of the State. The council included the head from 12 executive agencies, representatives from the Maryland General Assembly, the Circuit Court, and seven gubernatorial appointees. The Council developed a two-year Strategic Plan and presented it to the Governor on August 1, 2009.

The Council established several principles to guide and inform the organization and delivery of all substance abuse services in the State and all outcomes related to the strategic plan. These included pursuing quality health care and establishing a network of providers with cultural and linguistic competency. Also, the Council envisioned “no wrong door” for entry to the system or its services and seamless access to a wide range of services available by diverse providers.

The Strategic Plan included four goals:

1. Facilitate the establishment and maintenance of a statewide structure that shares resources and accountability in the coordination of, and access to, comprehensive recovery-oriented services.
2. Improve the quality of services provided to individuals (youth and adults) in the criminal justice and juvenile justice systems who present with substance use conditions.
3. Improve the quality of services provided to individuals with co-occurring substance abuse and mental health problems.
4. Codify the State Drug and Alcohol Abuse Council to assure a sustained focus on the impact of substance abuse.

The plan outlined objectives for each goal with action items for each of the responsible agencies. These action items included end dates for deliverables. The Council will provide an annual report to the Governor on the progress in implementing the Strategic Plan.

Current and Prior Year Budgets

Current and Prior Year Budgets DHMH – Alcohol and Drug Abuse Administration (\$ in Thousands)

	<u>General Fund</u>	<u>Special Fund</u>	<u>Federal Fund</u>	<u>Reimb. Fund</u>	<u>Total</u>
Fiscal 2009					
Legislative Appropriation	\$93,811	\$17,950	\$32,321	\$4,108	\$148,190
Deficiency Appropriation	0	0	0	0	0
Budget Amendments	765	-99	0	783	1,450
Cost Containment	-1,099	-2	-8	0	-1,108
Reversions and Cancellations	0	-150	-477	-91	-717
Actual Expenditures	\$93,478	\$17,700	\$31,836	\$4,801	\$147,815
Fiscal 2010					
Legislative Appropriation	\$94,846	\$17,918	\$31,937	\$4,937	\$149,638
Cost Containment	-5,037	-5	0	0	-5,042
Budget Amendments	0	0	0	0	0
Working Appropriation	\$89,809	\$17,914	\$31,937	\$4,937	\$144,597

Note: Numbers may not sum to total due to rounding.

Fiscal 2009

The fiscal 2009 legislative appropriation for ADAA declined by \$375,000 compared to the fiscal 2009 actual. The reduction was derived as follows:

- Budget amendments increased the legislative appropriation by just over \$1.4 million. This increase consisted of:
 - an increase of \$765,000 in general funds. This change was primarily comprised of an increase of over \$1.5 million added for a provider rate adjustment derived from fiscal 2008 lottery overattainment (Chapter 335 and 589 of 2008 directed these overattainment funds to provide the rate adjustment) and a smaller increase of \$53,000 that represented ADAA’s share of the fiscal 2009 cost-of-living adjustment originally budgeted in the Department of Budget and Management. This increase was partially offset by almost \$795,000 transferred out of ADAA into other programs in DHMH as part of fiscal 2008 close-out;
 - a small reduction of \$99,000 in special funds; and
 - a \$783,000 increase in reimbursable funds received from the Judiciary for treatment of drug court participants. This treatment will be provided through the local health departments.
- Fiscal 2009 cost containment actions by the BPW reduced ADAA’s appropriation by just over \$1.1 million including reducing community provider rate increases, hiring delays, and other operating expense reductions.
- Cancellations further reduced the legislative appropriation by \$717,000.

Fiscal 2010

The fiscal 2010 budget has been reduced by \$5.0 million during three rounds of cost containment, with \$4.8 million from the grants provided to the counties for treatment services. The remaining \$200,000 reduction includes a furlough for State employees and across-the-board reductions to operating expenses in various DHMH administrations.

**Object/Fund Difference Report
DHMH – Alcohol and Drug Abuse Administration**

<u>Object/Fund</u>	<u>FY09 Actual</u>	<u>FY10 Working Appropriation</u>	<u>FY11 Allowance</u>	<u>FY10 - FY11 Amount Change</u>	<u>Percent Change</u>
Positions					
01 Regular	60.00	62.50	62.50	0	0%
02 Contractual	2.44	5.00	4.50	-0.50	-10.0%
Total Positions	62.44	67.50	67.00	-0.50	-0.7%
Objects					
01 Salaries and Wages	\$ 4,270,967	\$ 2,518,720	\$ 4,941,325	\$ 2,422,605	96.2%
02 Technical and Spec. Fees	73,654	119,172	110,569	-8,603	-7.2%
03 Communication	18,447	26,799	26,212	-587	-2.2%
04 Travel	80,722	91,751	99,355	7,604	8.3%
07 Motor Vehicles	2,250	4,858	5,186	328	6.8%
08 Contractual Services	143,245,999	141,763,343	142,800,650	1,037,307	0.7%
09 Supplies and Materials	46,441	42,872	51,632	8,760	20.4%
10 Equipment – Replacement	30,258	0	0	0	0.0%
13 Fixed Charges	45,837	29,087	20,135	-8,952	-30.8%
Total Objects	\$ 147,814,575	\$ 144,596,602	\$ 148,055,064	\$ 3,458,462	2.4%
Funds					
01 General Fund	\$ 93,477,994	\$ 89,808,885	\$ 87,526,996	-\$ 2,281,889	-2.5%
03 Special Fund	17,699,754	17,913,642	20,825,195	2,911,553	16.3%
05 Federal Fund	31,835,860	31,937,351	33,989,658	2,052,307	6.4%
09 Reimbursable Fund	4,800,967	4,936,724	5,713,215	776,491	15.7%
Total Funds	\$ 147,814,575	\$ 144,596,602	\$ 148,055,064	\$ 3,458,462	2.4%

Note: The fiscal 2010 appropriation does not include deficiencies.