

STATE SUBSTANCE ABUSE AGENCIES AND THEIR
PLACEMENT WITHIN GOVERNMENT:
IMPACT ON ORGANIZATIONAL PERFORMANCE AND
COLLABORATION IN 12 STATES

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States were given an opportunity to review their own State descriptions and make comments and suggestions, many of which are incorporated here. In addition, four expert reviewers made comments and suggestions that are incorporated into this document. Remaining errors are the responsibility of the Avisa Group.

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EXECUTIVE SUMMARY

State substance abuse agencies are critical components of State government. They directly serve a population of usually low income individuals afflicted with what are often chronic, stigmatized disorders that can impact every area of society, family and government but that can be successfully treated in many cases. They also provide substance abuse education and prevention services to a wide spectrum of the population and are involved with the development and implementation of State substance abuse policy, which has a broad impact throughout society. Currently, many of the State substance abuse agencies are involved in ongoing State government efforts to reform, to reshape and to save money by reorganizing and changing the placement of existing agencies within government.

Undetected, untreated, under-treated and poorly treated substance abuse and dependence impose significant avoidable costs on a State's public health, public safety, adult and juvenile criminal justice, social services/child welfare, education, labor and other State functions, as well as on families, households, businesses, community institutions and peers. Our study indicates that with proper understanding of their mission and function, adequate resources, a supportive place within the government structure, positive and stable leadership and positioning within government, the State substance abuse agencies can play a key role not only in planning and providing effective public substance abuse prevention and treatment programs but in working collaboratively with other State agencies and key stakeholders to ensure that quality public substance abuse services contribute positively to the State's overall health, welfare, public safety and budget. Without these necessary factors, the agencies are uncertain about their own ability to function appropriately and proactively and key stakeholders who matter when reorganization and competition become keen tend to deal with them primarily as an afterthought.

Effective collaboration between the substance abuse agency and multiple other State and community agencies affected by addiction and addicted persons is a key requirement for establishing and maintaining effective substance abuse services and policy. Stakeholders and agency executives said that substance abuse collaboration was not possible unless State substance abuse agencies were sufficiently visible in terms of their governmental status so that other agencies felt it was important to be seen to work with them actively on projects of joint interest.

Stakeholders were particularly clear also about the substance abuse agency needing not just a director but staff who were capable and available to work with peers in other agencies and with Federal and state/count/other payers and decisionmakers. Shortages of experienced staff and time to invest in collaboration weaken the state agency's ability to interact collaboratively. In many respects, the loss of higher level managers, administration and finance staff to a "superagency" or a parent agency such as a health and human services agency removes the very staff who are most useful and necessary to support interagency collaboration. That is also the reason, of course, why such staff are most likely to be lost in any kind of agency merger or reorganization. The results of such a loss to the substance abuse agency can paralyze what had been effective collaboration. In addition, the specialized expertise of substance abuse fiscal staff, who understand and have been party to such important issues as maintenance of effort under the SAPT block grant can push a state into a penalty situation with SAMHSA or other agencies and can result in a net reduction or even complete loss of block grant funds to the state. In this type of situation, stakeholders explained, even if the loss of funds is not major, the time and effort alone incurred to "repair" maintenance of effort issue before it reaches a crisis may be very substantial. General finance staff who do not understand block grant requirements can plunge the state agency and the state into a situation of substantial non-compliance that can negatively impact scarce state resources and preoccupy staff who are badly needed for other high priority tasks.

This finding about collaboration and the specialized resources needed to make it work is consistent with accepted organization-environment theory in government and business, which posits that in a turbulent and competitive environment, interorganizational relationships and exchanges become essential ways to defend, sustain and promote agencies and to optimize their performance.

This need for interagency collaboration is greater for substance abuse agencies than for almost any other health or human services agency because virtually every government agency has clients with overt or hidden substance abuse disorders that complicate their lives and hence affect the other services' use, costs and effectiveness.

According to respondents at twelve State agencies and their key stakeholders, the substance abuse agency must be not just visible, but sufficiently autonomous to carry out its very particular legal and social mission adequately. State agencies that were merged (or submerged) too far down within another State agency reported problems in staff retention/recruitment, funding, collaboration, productivity and compliance with legal obligations imposed under the block grant. Respondents from Massachusetts and Florida reported that State substance abuse agencies had managed to emerge from such situations. (See the State reports for details).

Several states (e.g. Texas and North Carolina) have adopted behavioral health systems in which substance abuse is nested or merged within a behavioral health division. In these states, the experienced State substance abuse directors, both of whom have extensive mental health experience as well as substance abuse expertise, have become heads of these new divisions after a competitive selection process. They report, and most of their stakeholders concur, that their substance abuse offices function within the merger framework. Stakeholders reported that these directors were using their personal experience in and commitment to substance abuse as well as mental health to protect the offices' unique mission. Both directors have managed to retain some key substance abuse staffers during the reorganization process and they and their stakeholders report that they are still able to support collaborative activities and to retain stakeholder interest and relationships during periods of intense change. Stakeholders are waiting to see if this productivity can be maintained in the longer term, since both reorganizations are relatively new.

In other states with substance abuse agencies merged into other departments led by non-substance abuse directors and with fewer substance abuse staff retained in that specialty office, substance abuse and agency independence has not necessarily been a priority of the overall department leader. State agency respondents reported that they lost essential staff and visibility they once had and provider organizations reported difficulty in maintaining professional relationships and initiatives with the substance abuse offices. In one State, (Maine) the State's Advisory Commission on Substance Abuse requested that the performance effects of the State substance abuse office's placement within a behavioral health division in a relatively newly merged health, human services and disability agency, be evaluated by an outside entity during October 2005-January 2006.

Organizational placement and positioning of a State substance agency within State government helps to determine the degree of decisionmaking and policy authority, agency visibility, funding and collaborative ability of the agency or office, as well as its ability to attract and retain talented staff. Leadership and the personal expertise, track record, charisma and connections of the Directors and key staff, as well as good data on achievements and performance, play important roles in agency recruiting and performance. According to informants, however, leadership, even of high quality, can be hampered if the structure chosen by policymakers and executives does not permit significant key staff retention, rewards for expertise or sustained collaborative initiatives that have the Governor's or legislature's approval and that are increasingly required by Federal funders.

Continuity of agency leaders and leadership teams at the State level appears to be closely related to enhanced State substance abuse agency visibility, funding,

collaboration and other key organizational characteristics that reportedly positively affect agency or office performance and outcomes. Continuous leaders and leadership teams forge relationships that can sustain these substance abuse agencies and offices through administration and legislative changes, as well as Federal agency and legislative changes. Many key stakeholders and agency leaders report that they retain relationships for years as they continue to work in various government positions. They then bring those relationships with them to support the substance abuse agency, especially when it is threatened. Historically, positive executive and organizational relationships build trust, expertise and successful initiatives that survive turbulent environmental changes and help sustain and increase agency funding and effectiveness (Washington State).

An often neglected but reportedly important determinant of relative agency autonomy, and one that is highly correlated with organizational placement, is whether or not the State agency Director, Commissioner or "Drug Czar" is appointed or approved by the Governor, as s/he is in California, Ohio, Michigan, Florida, North Carolina, Texas and New York. Appointment or approval of the State agency Director, Commissioner or Drug Czar by the Governor reportedly confers a degree of authority, credibility, influence and status on the agency within the government, as well as clearly indicating the priority substance abuse issues have within that State government.

If agency leaders themselves do not have cabinet or subcabinet status – and they do not in most states – they can still retain and increase agency effectiveness by working closely with the Governor's drug Czar, substance abuse policy person, or the legislature or by remaining in a leadership position for a long time with continuing initiatives that stakeholders can support over time.

Substance abuse agencies that are in the lower echelons of a State bureaucracy or another department lose their visibility and influence. They reported that they were simply unable to advance significant substance abuse education, prevention, treatment and policy objectives, particularly those objectives that are held jointly with other agencies including mental health, criminal justice, Medicaid and public health and that Federal funders increasingly mandate. Such agencies and their stakeholders said that they focused only on complying with Federal block grant funding requirements, that sometimes they cannot meet those requirements, and that their states stand to lose substantial Federal funds they could have added to State coffers. The states may incur fiscal penalties in the form of Federal "give backs" that also exacerbate State deficits.

Several State agencies with high visibility in the State system (and a corresponding allocation of resources) reported being able to promote effective substance abuse policy through the agency's intergovernmental credibility,

status, visibility, and leadership team, using a combined strategy of interagency collaboration and substantial data documentation (Washington State, Texas, North Carolina, New York). These agencies also report being better able, compared to their peer agencies in some states, to devote internal resources to the effort required to obtain discretionary Federal and even foundation grants to attract and support new staff and initiatives because of their data systems. Key stakeholders in Phase II generally supported this Phase I finding but sometimes felt that State agencies that were prominent may have done even better in making positive use of their information to support more challenging initiatives.

SSA's that are directly supported either by a drug Czar responsible for demand reduction, to a key staffer in the Governor's office, or where the SSA Director and staff have direct experience with and positive relationships with the criminal justice/corrections system through early and continued working relationships reported that they were able to recruit and retain management staff, to defend funding and to function efficiently (North Carolina, Florida, California). Such agencies typically had organized groups of key stakeholders such as statewide provider organizations that supported their policies and initiatives over time, even as administrations and priorities changed repeatedly at the State and Federal levels. Florida and its key stakeholders, including the former director of mental health to whom the SSA had once reported, explained that when they were less independent and visible for a period of several years within the Children and Families' Services agency, they had had considerable problems in fulfilling their legal, regulatory and quality of care missions, as well as supporting collaborative interagency projects and financing objectives that were of benefit to the agency and the State government.

Agency leadership alone, according to most key stakeholders, was critical to SSA performance but was not on its own able to sustain substance abuse agencies that were structurally submerged and subordinated within other organizations that moved their specialized administrative and financial staff to super-agency functions. Statewide substance abuse provider organizations reported that they were unable to reach substance abuse agencies easily when they were embedded far within other bureaucracies. They felt strongly that special substance abuse agency missions were possibly at risk when what they called "submersers" occurred. Several State provider organizations intervened at the State legislative level and with Governors to try to remedy such circumstances by recommending or even demanding a different placement of the substance abuse agency. Florida is an example of such an instance in the past, remedied several years ago by the combined addition of a well known "drug czar" supportive of the agency and greater autonomy for the single State agency within the Department of Children and Families.

Substance use and abuse is an important issue in the treatment of those with severe mental illness (SMI) or severe emotional disorders (SED). Collaboration with the State substance abuse agency is of critical importance for State mental health agencies that primarily serve children and adults with serious and persistent mental illnesses because so many of these individuals, as opposed to persons with more routine diagnoses, have serious substance abuse problems in the community.

Most informants agreed that collaboration with the State mental health agency is one key function for State substance abuse agencies and that mutual respect is enhanced when the substance abuse and mental health agencies are on a par structurally. Key stakeholders and Directors reported that the effect of a total merger or reorganization with loss of key substance abuse staff – sometimes to mental health, public health, health and human services or children and families' agencies - was to make the SSA's efforts to address co-occurring mental health and substance abuse or substance abuse and medical disorders assume secondary importance. Agencies' staff members become preoccupied during times of uncertainty such as in the course of the merger planning and implementation with its effect on their jobs, salaries, tenure, benefits, peers and supervision, rather than with the actual work or funding of the agency or with challenging clinical initiatives such as collaboration around co-occurring disorders with mental health or public health.

INTRODUCTION AND METHODOLOGY

INTRODUCTION

Many states have involved their substance abuse agencies in reorganization, either because of changes in State administration, legislature and governing philosophy or to deal with continuing deficits and rising Medicaid costs. This trend has increased interagency competition for scarce resources and the need for State officials and policymakers to understand and be supportive of the unique mission as well as the legal and financial requirements placed on these key State agencies by Federal and State stakeholders. A number of states have reported that the reorganizations and interagency competition for shrinking dollars have made it difficult for them to be proactive about substance abuse prevention and treatment. The demands of reorganization and competition can be a major distraction for agencies with a challenging agenda to begin with; they may also reveal in discussions and the plans to reorganize and position each agency how little their mission is understood and supported at the State level. Even State agencies that do not have ongoing reorganizations and that may have more stable budgets report being concerned that the intense activity and discussions reorganization and competition provoke are never far from their doors and make it difficult to focus on new initiatives such as promoting evidence-based care and prevention or addressing co-occurring disorders appropriately.

Because of this trend, we contacted and interviewed the State substance abuse agencies in 12 states in varied geographic regions in the U.S. in 2004 and 2005 to test some ideas about what helps agencies to perform better and better understand how ongoing discussions and decisions or earlier agreements about the placement of State substance abuse agencies appear to be having an impact on their performance as government agencies.

The study proceeded in two phases: Phase I consisted of interviews with Director and staff of the substance abuse agency in nine States; Phase II expanded the study to three additional states and included external stakeholders from all twelve study States.

Given the great variation amongst the states, it is no surprise that we found variation both in the extent of their substance abuse problems and in the size, prominence and perceived effectiveness of their State substance abuse agencies within the State government. Some State substance abuse agencies are autonomous Cabinet or subcabinet agencies, while others are subsumed or

nested within super-agencies that have related or different missions. Regardless of the agencies position, they share the issue that their states are facing either deficits or very tight public funding and fierce competition for resources. Simultaneously, more individuals are seeking public sector substance abuse treatment services managed by these agencies, seeking them in part due to declining funding from health and substance abuse treatment benefits in the private sector.

Our report indicates that State substance abuse agencies, often smaller than their peer agencies and not well understood, have sometimes been the stepchildren of organizational restructuring in which they may or may be given much voice. Disparities in funding and visibility that lead to problems with clients' ability to access treatment – a major social concern - can result from uninformed restructuring. Sometimes the existing or new placement of a given State substance abuse agency within the confines of another organization can be the product of preoccupations with, for example, Medicaid fraud and reform that precipitated the reorganization in the first place. In states that have not reorganized health and human services or moved their substance abuse agencies recently, there is still often reported to be a legacy left by earlier reorganization that convinced the states either not to submerge or move the substance abuse agencies or, conversely, to limit the agency's autonomy.

If State agency submersion or nesting within another or a larger department is felt to be unavoidable or preferable, certain states manage to do so with structural protections and committed leaders in place that help maintain a continued focus on substance abuse and that preserve aspects of the agencies' independence, visibility, ability to collaborate within government and ability to comply with authorizing legislation for the SSA's.

This report examines the experience of the 12 SSA's we studied in managing or avoiding these issues of agency placement, organizational autonomy and reorganization, "nesting" or complete merger with other agencies under conditions of intense interorganizational competition for scarce public dollars.

IMPORTANCE AND FUNCTIONS OF THE SINGLE STATE AUTHORITIES (SSA'S)

State government substance abuse agencies today have a role that rivals that of SAMHSA/CSAT and other Federal agencies that provide the majority of substance abuse prevention and treatment dollars. The 50 State substance abuse agencies were formed in two phases – first they developed as State alcohol authorities for prevention and treatment supported by the Uniform Alcoholism and Intoxication

Treatment Act of 1971 and separate State drug agencies¹. In 1981, the Omnibus Budget and Reconciliation Act established “single State authorities” (SSAs) encompassing both alcohol and other drug abuse treatment². These State agencies were the entities designated to receive Federal prevention and treatment funding under the Substance Abuse Prevention and Treatment Block Grant (SAPTBG). They also receive and manage State substance abuse treatment revenues.

Today, Federal ongoing funding (e.g. Medicaid, substance abuse, mental health, and community development block grants) and much of the discretionary (targeted, limited-term grants) funding flows through the States. State and local revenues are an important source of public sector treatment funding³. The single State substance abuse agencies manage the majority of the publicly supported substance abuse prevention and treatment dollars, sometimes delegating a portion of that responsibility to substate entities such as the counties.

Despite this considerable responsibility, our study finds that certain State substance abuse offices remain at lower levels within other larger State departments. However, a number of the states studied here moved their substance abuse offices up in the state hierarchy, often combined with mental health, after Phase I of this report was completed. In several states (Florida, Texas, Washington State, North Carolina, and Oregon) post Phase I of our report (2004) the state substance abuse directors were promoted to become either heads of combined state behavioral health agencies that had fairly high level substance abuse offices comparable to mental health office stature or were actually made commissioners or heads of behavioral or community divisions of superagencies or departments. In other states the substance abuse offices received new directors. In one state the state drug czar’s position is now open (Michigan). In Florida the substance abuse agency director, who once reported to the mental health director, is now in charge of the combined function within the Department of Children and Families. The agency is very closely linked to the state’s comprehensive drug strategy effort, led by Florida’s drug czar, whose office is located within and literally next to the Governor’s Office in that state.

¹ McCarty et. al., “State and Federal Policy Influences on Alcohol Treatment Services,” in Mignon, S. et al, Substance Use and Abuse: Exploring Alcohol and Drug Problems, Boulder, CO, in press

² D. McCarty and H. Goldman, “Treatment for Alcohol and Drug Dependence: History, workforce, Organization, Financing and Emerging Policies,” in Lewinson et. al., Substance Abuse: A Comprehensive Textbook, Fourth Edition, Lippincott, Williams and Wilkins, Philadelphia 2005 pp. 1346-1360

³ SAMHSA Expenditure Estimates report, 2005

Moreover, in Florida, the authority of the drug czar position extends beyond law enforcement to prevention and treatment, which provides for a more coordinated approach to substance abuse. In another state, Oregon, the state substance abuse agency director is now director of all of behavioral health and the office has been moved upwards to Cabinet level once again, after the function had been moved down significantly previously.

Part of the reason for this degree of change is that the State substance abuse agencies are small in staff size, if not in dollars, and often caught up in reorganization efforts frequently undertaken for reasons having little to do with them, both at the overall system level and the departmental level. Because of the ongoing changes and positioning of substance abuse and healthcare in general at the County, State and Federal levels of government, such reorganization and interorganizational "competition", as well as new or renewed enthusiasm for managed care to allocate public dollars, are now typical rather than unusual. State substance abuse agencies are obviously affected by these initiatives and are subject to being moved from one position and agency within a governmental department to another within that department or as part of a new, often larger entity.

However, because of their key role in the complex issues of substance abuse prevention, treatment and demand reduction that cut across all agencies and require significant collaboration, where and at what level these particular agencies are placed in government has as significant an impact on their perceived effectiveness as does their funding, mission, leadership and productivity.

In this second of two reports we looked at widely differing geographic regions of the US, including both urban and rural states, large and small states, and at states representing different positioning of substance abuse agencies within their State governments. We aimed to understand how key aspects of the agencies' performance are affected by intergovernmental differences in position, visibility and other factors.

Each Single State Authority (SSA), usually a Department, Bureau or Office of Substance Abuse Services, is designated to oversee the planning, funding and regulation of public substance abuse prevention and treatment services. The SSA's not only receive, allocate and manage Federal Substance Abuse Prevention and Treatment Block Grant (SAPTBG) funds but also receive and oversee the bulk of Federal discretionary grant funds and State funds for substance abuse as well. Quality management and outcomes evaluation in prevention and treatment are additional roles for the SSA's that are as important as their fiduciary role. In states that have offices of drug control, such as Florida, the

State's drug czar coordinates all drug policy efforts at a high level, usually out of the Governor's Office.

We examined performance factors that influence and are influenced by agency placement including the following:

- Substance abuse policy leadership, as perceived by the agencies themselves and their key stakeholders;
- Organizational and executive management team stability despite change in administration and legislature;
- Ability to attract stable funding;
- Entrepreneurialism in seeking new funding and programming under conditions of inter- and intra- agency competition
- Ability to lead, manage, recruit and retain key staff for the agency;
- Sponsorship of longer-term strategic initiatives and performance management supported by data systems that produce credible evidence for stakeholders and policymakers;
- Articulating and disseminating an explicit mission and purpose for the SSA to key stakeholders and funders;
- Ability to maintain close and enduring connections with key stakeholders such as other agency leadership teams, the Governor's Office, policymakers, funders, provider associations, community and client/family stakeholders, even under conditions of change;
- Maintenance of positive relationships with key payers, regulators and providers at the county, State and Federal levels;
- Organizational productivity and stable performance under turbulent conditions

The fiscal environment at both State and Federal levels today is characterized by concerns about the level of spending and increasing interest from the legislative and executive branches alike in the value that State agencies, including substance abuse agencies, provide. Accompanying this interest in value is a renewed focus on outcomes and on performance measurement and management in the public sector. For example, there have been efforts among both public and private payers to more explicitly connect the funding of substance abuse services to demonstration that services are based on scientific evidence of effectiveness. Substance abuse agencies are being asked to provide measures of agency performance and to demonstrate compliance with legal and fiscal requirements.

These challenges are magnified by continuing reorganizations in State government, whether prompted by deficits or by changes of administration or both. Reorganizations respond to and enhance interorganizational competition at

the State level for scarce public resources, visibility and credibility. These can be a major distraction from mission and from promising initiatives such as co-occurring disorders. Under these circumstances, State substance abuse agencies must compete when they can for credibility and visibility in order to maintain funding and staff that may otherwise be lost entirely or lost to other agencies.

Some SSA's have seen these developments emerging and have acted to reform their agencies or to institute strong infrastructure and databases to promote themselves and their mission. Others have not done so or have not been able to do so, often due to constant leadership changes that reflect the turbulent environment. SSA's have adopted or have been forced to adopt differing strategies to maintain or improve their organizational position sufficiently within government and the policy environment to preserve their mission. Leaders and executive staff of the SSA's in the 12 states, as well as others interviewed for this analysis, uniformly reported feeling increasingly pressured by the "do more with less" environment. Senior and mid-level staff attrition has reportedly increased; numerous experienced staff have taken early retirement, Directors or Commissioners have been removed or have moved on or out of the field; many states are talking about current or recent penalties for non-compliance with block grant maintenance of effort requirements; and initiatives painstakingly begun have sometimes had to be put on hold.

In the current environment, it is reported to be increasingly difficult for Directors to maintain or to begin innovative programs because they cannot attract or retain appropriate staff, maintain level or increased funding and infrastructure and a positive organizational position from which to work with funders or other State agencies and stakeholders. It is perceived by key stakeholders to be affecting agencies throughout the states. While some State agencies in our study have persevered and a few have even thrived (through leadership and strategic use of data to defend themselves and support initiatives and collaboration), others have had a far more difficult time. Some remain subsumed several layers down in super-agencies with other priorities and a lack of interest in substance abuse treatment.

This analysis of substance abuse agencies in 12 key states was launched to examine State agency performance because so many State substance abuse offices and agencies have found themselves enmeshed in or barely avoiding State government reorganization efforts, while competing for resources at the same time. Many questions have arisen from the State agencies and stakeholders as to what strategies to adopt to continue to function appropriately. In Phase I, we found as expected that both reorganization and organizational competition, fortunately or unfortunately, clearly affect one another and not always positively. Recent governmental and leadership change events in states in

our study, such as Ohio, New York, California, Texas, North Carolina, Massachusetts and Maine, have only added to the more complex picture drawn here in Phase II.

The recently released SAMHSA report prepared by Tami Mark et. al, "National Estimates of Expenditures for Mental Health Services and Substance Abuse Treatment, 1991-2001", undertaken for the Center for Substance Abuse Treatment, makes it very clear that Federal, State, county and other public funds are now the major driver of all estimated substance abuse treatment expenditures in the U.S., accounting for an estimated 76% of total substance abuse expenditures of \$13.8B in 2001. Substance abuse spending by all public payers is estimated to have increased 6.8 % annually over the decade, 1991-2001. During that same period, private sector expenditures by employers fell by 1.1% annually while consumer out-of-pocket spending grew by 3.2% annually. Many individuals, who exhaust their limited private insurance coverage for substance abuse treatment and/or their own funds, now turn to public sector treatment or to public emergency rooms to find help. Therefore, the State agencies, as both funders and managers of the public substance abuse dollar, have a more central role than ever before – just at the time when State budgets are tight and voters, legislators and policymakers are reluctant to increase taxes to provide more revenue at the Federal and State levels.

State and substate units such as counties continue to be managers of much of the country's investment in public sector substance abuse prevention and treatment. Specifically, states managed 57% of all public spending on substance abuse treatment in 2001, as well as managing the expenditure of a substantial proportion of Federal SAPT block grant funds. Rising Medicaid and other entitlement costs also occurred during the 1991-2001 decade in most states, along with the increased deficits in many. Right now State leaders are focused on Medicaid reform to cut back any spending that they decide is unnecessary, tighten eligibility rules, pare back many optional or other Medicaid services such as the rehabilitation option and case management, as well as certain types of Medicaid optional substance abuse treatment.

Although Medicaid is a smaller contributor to State substance abuse agencies' funding than other funding sources (19% of the total for substance abuse), the highly visible concern about states and Medicaid has exacerbated an already turbulent environment politically and fiscally. This turbulence and uncertainty has encouraged State and Federal legislators, regulators, and administrators to demand that State agencies improve their organization and performance and to expect that State government should be organized so as to produce greater efficiency and effectiveness. Mental health and substance abuse offices and agencies have frequently been a focus of such interest. Along with Medicaid, developmental disabilities, and adult and juvenile criminal justice, they have

become preoccupations of policymakers who are looking for sources of greater efficiency and potential savings.

State substance abuse agencies are perhaps particularly vulnerable to such efforts, even though their State budgets are relatively small and would not seem to be typical targets, because of the stigmatized populations of juveniles and adults that they serve. The relatively small agency budgets and staffs may actually make it easier to envision the agencies becoming part of other entities. Lack of understanding or support of the role of the SSA and the mission of the agencies makes it even easier to move the agencies and their staffs around. This placement may enhance, make no difference or, quite often, actually conflict with the substance abuse agency's necessary close relationship to other State social services, economic, criminal justice and health agencies.

METHODS

This qualitative study is based on a series of interviews with 12 State substance abuse agency leaders and their executive staff, as well as their key stakeholders. We used findings from policy and organizational studies of governmental systems and organizational effectiveness theory to create semi-structured questionnaires for the interviews. Nine States were initially selected for inclusion for the Phase I. The Phase I study examined State substance abuse agencies, their leadership teams and a few policymakers' views of the agencies' performance; for Phase II three additional states were added to the original nine and additional separate, stakeholder groups in each State were interviewed using a second set semi-structured questionnaires. (See attachments for sample interview instruments).

We chose the twelve states so that they constitute as representative as possible a focused sample of differing governmental placement of the substance abuse agencies and differing geopolitical regions. We sought out key stakeholder perceptions of agency performance on factors identified above. The key stakeholders interviewed in Phase II included states' political, regulatory and policy leaders who work with the State substance abuse agencies or offices, as well as key statewide provider and community representatives.

Interviews and extensive follow-up discussions occurred with State Directors, their key executive staff members, and influential stakeholders for each State. Interviews were conducted by two researchers on site in eight States: New York, Texas, Washington State, Florida, California, Oregon, and Maine. In the remaining four States, (Massachusetts, Ohio, Georgia and North Carolina) extensive interviews with Directors, key staff and influential State agency stakeholders were conducted in Phases I and II by telephone. Additional information related to substance abuse expenditures was received from each

Phase I State. Because each State's data and data definitions differed significantly and analyzing them comparatively would have been beyond the funding available for this study, the funding data for each of the original 9 states are presented separately. Data from SAMHSA and the US Census are presented for each of the twelve States in the study. Examining these data in terms of the agency's placement within State government appears to show an association we predicted between greater autonomy and visibility and higher levels of funding and functioning but this hypothesis would need to be verified with a larger study. A more exhaustive analysis of State substance abuse agencies' performance would be required to examine any causal relationships suggested here.

Prior to determining who to interview as key stakeholders, discussions were held with the various State directors, their key staff members and individuals knowledgeable in the field of substance abuse policy to identify and then recruit those stakeholders. Recruitment was the job of the principal investigators, who also did the interviewing and data collection. Only one stakeholder identified by a State could not be reached for an interview.

An initial letter from CSAT's State Division Director, Anne Herron, on behalf of CSAT went to 13 State substance abuse agencies, inviting and encouraging them to participate. One State agency that initially agreed to participate did not do so and was replaced with a different State agency. One State agency declined the invitation to participate and was not replaced, yielding a total of 12 states for this Phase II Final Report. The interview response rate for the 12 State agencies that agreed to participate in interviews was 100%.

Limitations and Uses of this Report

Key participant interviewing either on-site or via telephone with semi-structured questionnaires is the key method used in this series of reports. The approach was dictated by the budget available for this exploratory, non-random analysis. The ability for us to generalize to the 50-State level and to all key stakeholders or stakeholder groups is restricted by this quasi-experimental approach but the pattern of responses here is so consistent that it is clear that hypothesis testing based on the predictions of organization theory and experience is now possible. This study and a study of all states and territories can assist agencies and State government policymakers by indicating what factors optimize and what may minimize state substance abuse agency performance in this policy environment.

The selection of both large states and smaller states, as well as urbanized and more rural or suburbanized states in different geographic regions, resulted in a purposive sample of states that is reasonably representative of the total population of US states and their substance abuse agencies. The study results

make it clear that the key informant approach used here, combined with data analysis, can be useful as the beginning of a more formal study of State agency effectiveness.

STATE SUBSTANCE ABUSE AGENCIES IN CONTEXT

In 2001, an estimated total of \$18.3 billion of public and private sectors funds were estimated to have been spent in the U.S. on prevention and treatment of substance use disorders. Although that sum is substantial, it totaled only 1.3% of all US health care spending in 2001. This 1.3% of total spending compared to the 9.4% of the U.S. population classified as having a substance use disorder in any one year (OAS, 2003) and the \$1.372.5 billion spent on all health care in 2001. More than 76% of total estimated U.S. substance abuse spending in 2001 came from all government sources, although only 19% of spending on substance abuse in 2001 was attributed to Medicaid⁴.

State and local governments managed Medicaid, State, local and SAPTBG (block grant) substance abuse expenditures in 2001, 57% percent of all estimated expenditures on SA in that year. At the same time, private sources continued to decline from 1991-2001 as a source of substance abuse treatment expenditures, falling by an average rate of 1.1 percent annually between 1991 and 2001, according to the latest SAMHSA study. There is strong correlation between the decline in private SA treatment spending and the growing amount of public spending. State substance abuse agencies' roles as managers and stewards of the funds devoted to substance abuse treatment grew as public spending increased.

The spending trends enhanced the responsibility, the position, and the significance of State substance abuse agencies and magnified their need to manage and lead the public substance abuse policy agenda in each State. At the same time, however, an increasing number of States considered reorganizations of the executive branch. Both large and small states discussed the usefulness of merging SA agencies under public health departments or mental health/behavioral health departments of State divisions of health and human services or public health services. This issue has not retreated.

In a number of states, such reorganizations have recently occurred, often recommended by external consultants to administrations or policymakers. These consultants typically believe that merging systems and agencies is a rational means to enhance the efficiency and effectiveness of public agencies, eliminating

⁴ SAMHSA/CSAT/2005

duplicative capabilities and creating State human services or health “superagencies” that share administrative capabilities and staff. This idea, while not new, has some face validity but rigorous effectiveness studies have not been completed and data problems are making such analysis difficult. Key stakeholders vary in their estimation of how successful these initiatives have been or could be. Estimates from consulting firms of how many dollars can be saved through reorganization have been reported by some stakeholders to have been greatly inflated.

Phase I of this report examined the State substance abuse agency placement in State government of 9 large states and found that agency staff believed that was important to provide the State substance abuse agency a high level of visibility and authority in its administrative, clinical and financial functioning in order to perform the required specialized financial and clinical management of public funds (Federal and State). State substance abuse agency staff also reported that it was necessary to be visible and autonomous in order to create and sustain strong inter-agency and State legislative awareness and relationships that allow the substance abuse agency to optimize the attention and resources devoted to effective, evidence-based use of substance abuse treatment and to compete for scarce resources and alliances in the within-State-government competition. These observations have been expanded in Phase II of the study.

Phase II of this report extends our original analysis to three more states with varying placements of their State substance abuse agencies (California, Oregon and Maine). We updated our earlier analysis with current information from all states, and added the perspectives of key stakeholders on the substance abuse agencies in all 12 states to the analysis previously provided. Phase II examines ways in which some states have more successfully or less successfully managed either substance abuse agency full autonomy, nested divisions/offices or merged behavioral health divisions, looking to see if they have been able to make provisions to preserve sufficient visibility and independence for the substance abuse agency to function effectively, as far as key stakeholders are concerned. The Phase II report looks at the issue from both the agencies’ and their key stakeholders’ perspectives. Attention is paid to what happens to management, how SSA’s fare and how they manage their responsibilities when and if State substance abuse agencies’ functions/organizations are subsumed in a merger undertaken for reasons separate from mental health or substance abuse imperatives and requirements.

The theory of organizations is one basis for this study. Under conditions of environmental turbulence, the relevant organizational theory and findings are those found in contemporary organization-environment theory.

Contemporary organization-environment theory⁵ predicts that when organizational and environmental aims vary and sometimes conflict, as do those of State health or human services superagencies that try to restrain demand for treatment and scarce funding while presumably providing the public access to all necessary care, organizations that are “loosely coupled” systems with subunits (such as SSA’s) having high autonomy may be most effective in dealing with great uncertainty and change, such as the current State environments described in our Phase I report. However, it may also be possible that skillful administrators mindful of the special mission and funding requirements of State substance abuse agencies can find alternative ways to make nested or merged State agency arrangements work well enough to suit some stakeholders, while keeping others from pursuing their policy agendas by intervening aggressively to change the status of the agencies.

⁵ James Thompson, *Organizations in Action*, (2004) and W. Richard Scott, *Organizations: Rational, Natural, and Open Systems* (2003) are two examples of such arguments.

FINDINGS

IMPORTANCE OF STATE SUBSTANCE ABUSE SERVICES AND POLICY

State substance abuse services and policy are critical components of State government functions. This is true despite the relatively small portion of State health or human services budgets devoted to substance abuse. Sectors that are affected by substance abuse-related issues that include accidents and violence are health care, public welfare and social services, public safety, housing, education, adult and juvenile criminal justice and corrections, vocational rehabilitation, commerce/labor and economic development. Two clusters of issues explain the disparity between the critical importance of the issue of substance abuse to the States and the amount of direct spending by States on substance abuse education, prevention and treatment services.

We argue that unprevented and untreated substance abuse problems impose significant costs on health care and other components of the community⁶, including the very sectors or areas of State spending noted above. Excess and avoidable expenditures that could be lower if substance abuse were treated include the following according to key stakeholder interviews:

1. Primary and specialty health care services and systems, especially including infectious disease, obstetrics and emergency medicine
2. Public safety, rates of domestic violence and vehicular accidents
3. Child welfare, including foster care and mental health care of wards of the State
4. Criminal justice expenditures including
 - a. Law enforcement and the court system
 - b. Jails, prisons and parole systems
 - c. Juvenile justice
 - d. Incarceration alternatives
5. Housing, especially public or subsidized housing
6. Education and Vocational Rehabilitation efforts
7. Mental health, particularly amongst those who are seriously mentally ill and have co-occurring substance abuse disorders

⁶ Office of National Drug Control Policy (2001). *The Economic Costs of Drug Abuse in the United States, 1992-1998*. Washington, DC: Executive Office of the President (Publication No. NCJ-190636).

Second, stakeholders report that funding changes for SA, related to budget deficits or surpluses, may be accompanied by corresponding changes in Federal support, causing a multiplier effect on State spending for substance abuse services. Federal Maintenance of Effort (MOE) requirements associated with the Substance Abuse Prevention and Treatment (SAPT) Block Grant stipulate that the single state authority must maintain aggregate state expenditures for authorized activities under the grant at a level that is not less than the average of such spending for the previous two years. States that do not meet their MOE requirement in any given year can see the amount of their SAPT block grant award reduced dollar-for-dollar for the shortfall, unless they can show material compliance with the MOE requirement or receive a waiver of the requirement from the federal agency.

States failing to maintain their specified substance abuse State-funding levels are subject to a proportionate reduction in Federal funding under the SAPT Maintenance of Effort Requirements. Several states have either been cited for MOE problems already or fear that they will be cited, causing fiscal uncertainty that affects planning, operations and interagency collaboration. Thus, reductions in State spending that do not meet the MOE waiver requirements and that drop the single state authority expenditures below its MOE requirement can create a substantial reduction in Federal funding. In states where SAPT block Grant funding is a major source of revenue, this is a serious matter.

Under Medicaid rules, some benefits are optional, including substance abuse treatment. Many States provide some substance abuse treatment services as an optional benefit under their Medicaid programs. State dollars spent for services covered by Medicaid are also matched according to a formula by Federal dollars, providing for a second multiplier effect that works in both directions also.

Several stakeholders interviewed in Phase II noted that spending by States for substance abuse education, prevention and treatment has an impact on health and welfare disproportionate to its size due both to the mechanisms of Federal support and to the corresponding impact of changes in spending on the direct and indirect economic and social costs of substance abuse and dependence. It is of note that both mechanisms of Federal support work to reduce Federal spending when State spending declines, but only Federal Medicaid support increases when State Medicaid expenditures increase.

CRITICAL ROLE OF INTERAGENCY COLLABORATION AND LEADERSHIP IN IMPLEMENTING EFFECTIVE PUBLIC SUBSTANCE ABUSE POLICY AND SERVICES

In order to implement public substance abuse policy and services that reduce direct and indirect costs of substance abuse, effective collaboration between the substance abuse agency and multiple other State and community agencies is required, according to all of the respondents interviewed in both phases of this study. Stakeholders asserted repeatedly that this is more significant for substance abuse than for other health or human services or family services agencies because so many clients of other State agencies have diagnosed or hidden substance abuse problems that diminish the effectiveness of other State services.

Being relegated to a low level in a host agency that does not comprehend its requirements, mission or Federal obligations makes it very difficult for the substance abuse agency to function, according to key stakeholder interviewees and State agencies themselves in each of the 12 states. State agency directors often commented if they had experienced being in a completely subordinate position within another agency that they could not get their work done properly. Key stakeholders in states where the substance abuse agency had not been able to remain visible, either historically (NY and FLA) or currently (Maine) indicated that they were dissatisfied with what the State agency was able to accomplish, even in terms of fulfilling its basic functions related to disbursing funds for treatment. In contrast, State agencies such as the ones in California, Ohio, Washington State and NY report – and their stakeholders confirm – that they enjoy sufficient autonomy because of being Cabinet level or gubernatorial appointees at a secondary level to carry on policy initiatives from one year to the next. For example, Ohio and Washington State have been able to carry out longstanding initiatives in performance and outcomes measurement that have also helped the agencies maintain their visibility and their independence, according to State directors and key stakeholders. California has been able to continue to manage its Proposition 36 program to provide offenders charged with possession with three chances to try substance abuse treatment, despite changes in administration. NY State is known for a number of outcomes' evaluation initiatives, using its information system to work with and refine providers' offerings and this emphasis has continued despite political changes and departures of department directors.

According to all of this study's informants if the State agency director is directly appointed by the Governor, the Director is likely to be perceived by other

agencies and staff to have sufficient importance, status and clout within State government in order for them to be willing to spend scarce time, staff and effort at a time of competing priorities in effective collaboration. Influence enables agencies to mount and maintain initiatives to improve SA clinical service integrity and quality, while providing services to SA clients of other State departments. Attracting additional resources through active collaboration also provides the ability to devote resources to the effort required to obtain additional discretionary grant funds from Federal agencies that provide funding for substance abuse services, which in turn confers credibility with other State departments, the Governor and the legislature.

This review of substance abuse agencies in 12 States indicated that SA agencies that lacked Gubernatorial appointment status, were in the lower levels of the State bureaucracy and did not have sufficient visibility, adequate staff or other resources, were simply unable to advance significant substance abuse education, prevention, treatment and policy objectives that are held jointly with other agencies, including criminal justice.

One result was that these State substance abuse agencies appeared to be dominated by external constituencies that had more power, such as providers. Some responded primarily to the concerns and interests of these constituents rather than being able to focus more on the needs of the substance abuse clients and others negatively affected by substance abuse. The organizational placement of a State substance agency is one major variable explaining the visibility and performance of substance abuse agencies. Agency leadership and personal expertise and connections of the Directors and key staff also play important roles but they can be stymied if structure does not permit them to exercise that expertise or participate in and initiate collaborative efforts easily.

However, things can change, even when an agency has been completely subordinate for a long time. During Phase II, in Massachusetts, a State in which the substance abuse agency had been subsumed within the State's Public Health Department, the substance abuse agency was permitted to engage in strategic planning for its future. This effort has revitalized the agency's leadership, its position in government, and its prominence amongst the many policy priorities competing for the Governor's attention. It is clear that this effort has greatly strengthened the Director's position and has made the agency a far more significant and, perhaps, more effective player in State government. It is too early, according to key stakeholders and the Director, to discern the impact of this very significant change on outcomes for clients but the early indicators are positive according to interviewees.

ORGANIZATIONAL PERFORMANCE OF STATE SUBSTANCE ABUSE AGENCIES

This study indicates that State substance abuse agencies with high visibility in the State system and corresponding allocation of funds report being able to promote effective substance abuse policy. This is accomplished through the agency's status, credibility and strategy of collaboration with other agencies throughout State government that enables the SSA to serve clients with substance abuse disorders who are often clients of other State systems. During Phase II we asked key stakeholders if they agreed that the high visibility agencies were effective in mounting and maintaining policy priorities. In most cases, the respondents, including legislators and former legislators and provider agency heads, agreed that the agencies were effective even when the informants disagreed with the agencies' priorities and initiatives.

SSA's that were directly supported either by a cabinet-level drug Czar or where the SSA Director or staff reported having rapport with the criminal justice/corrections system through mechanisms such as the SSA Director sitting on the State's drug demand reduction council or having professional experience in the criminal justice agency also reported that they were better able to function efficiently and effectively. A summary of these perceived organizational performance measures appears in Table I below.

TABLE I

PERCEIVED ORGANIZATIONAL PERFORMANCE

STATE	SSA DIRECTOR APPOINTED or APPROVED BY GOVERNOR	SUCCESS IN MOE	EXTENT OF COLLABORATION WITH OTHER AGENCIES	ABILITY TO MOUNT SA POLICY INITIATIVES
California	Y	Y	M	H
Florida	Y*	Y	H	H
Georgia	N	Y	L	L
Maine	N	Y	M	LM
Massachusetts ⁷	N	Y	M	H
Michigan	Y	Y ⁸	H	H
New York	Y	Y	H	H
North Carolina	Y	Y	H	H

⁷ Massachusetts – Extensive collaboration and policy development within Department of Public Health, focused on prevention mission

⁸ Michigan – Problems with MOE requirement prior to reorganization

STATE	SSA DIRECTOR APPOINTED or APPROVED BY GOVERNOR	SUCCESS IN MOE	EXTENT OF COLLABORATION WITH OTHER AGENCIES	ABILITY TO MOUNT SA POLICY INITIATIVES
Ohio	Y	Y	H	H
Oregon	N	N	M	M
Texas ⁹	N	Y	M	M
Washington State	Y	Y	H	H

N, Y No, Yes
H, M, L High, Medium, Low

* Director of Florida Office of Drug Control (ODC) is appointed by the Governor. Director of SSA is dually appointed to ODC and the State SA/MH Agency within the Department of Children and Families.

In Phase II the three states that were added had varied dimensions on these factors. California, with a State Department nested within a Cabinet-Level Health and Human Services Agency, has its ADP Alcohol and Drug Programs Director appointed by the Governor. It does not currently have an MOE issue, although that could happen if its State funding is cut significantly. ADP, according to stakeholders, does not collaborate significantly with other agencies, although its relationship with the large State Department of Mental Health was not aided by a recent effort by that Department to subsume ADP, per a preliminary recommendation from the Governor's reorganization committee. The committee eventually changed its opinion and rejected the proposal to merge ADP within DMH, after virtually all public testimony to the Commission on Performance Review rejected the initial proposal. More recently, however, the two Departments have been able to set aside their differences and work collaboratively on a coordinating initiative for co-occurring disorders at the clinical level. Key stakeholders of ADP commented that surviving this conflict and remaining independent had increased ADP's governmental influence and ability to carry out significant initiatives. Maine's story is explained in detail in this report. Oregon has a merged Department of Behavioral Health, headed by an individual with a mental health and substance abuse background who is not a direct appointee of the Governor. Nevertheless, Oregon has been able to exert sufficient influence to mount and maintain a significant "best practices" initiative that preceded the Federal effort at CSAT and that has brought the Department considerable publicity and prestige. Recently the position of substance abuse staff within the Department has been strengthened by the director with the addition of substance abuse staff with significant experience and credentials to

⁹ Texas - Planning for reorganization of State agencies has disrupted collaboration and SA policy development

lead collaborative initiatives such as this one, even in the face of a very difficult State deficit situation.

In several of the other states with merged mental health and substance abuse departments, including Texas and North Carolina, the directors selected have had both substantial mental health and substance abuse experience. In both cases they have been able to use data strategies to protect and enhance substance abuse capabilities, even though they are merged within large behavioral health divisions of other departments. Part of the strength in these two agencies, according to their key stakeholders, stems from having dual and equal experience in both fields and from using data and policy constancy to defend and expand their interagency collaborative efforts, even in the case of very substantial deficits and changes in State administration. Whether or not the equality of substance abuse and mental health initially created despite these mergers can be maintained along with the concomitant policy advances in these two states remains to be seen.

SIGNIFICANT SUBSTANCE ABUSE POLICY AND PERFORMANCE ISSUES

State Directors, key staff and stakeholders raised substance abuse policy issues that were broadly relevant beyond the borders of their individual States. In addition to the specific organizational issues discussed in more detail in State sections of this report, the following significant substance abuse policy issues were emphasized by State Directors and also mentioned continually by key stakeholders.

Stable and Consistent Substance Abuse Leadership

Several respondents emphasized the key role of leadership in the success of their SA agency, regardless of its organizational position within State government. This was true for states with and without an office of drug control policy at the Governor's level (drug czar). This attribution of the success of their agencies to the exercise of leadership by the Director, in concert with the Drug Czar and his/her key staff, who were part of teams that had stayed in place for long periods of time, was upheld by key stakeholders in answer to a question in the Phase II interviews. All key stakeholders, with the exception of one, agreed with the Directors'/staff members assertions about the importance of recognized and continued leadership. Stakeholders had often heard about other State agency directors/executive staff who were said to be leaders and usually agreed that those agencies had effective leadership that helped sustain the agency through hard times and administrative changes.

The exercise and retention of any type of consistent leadership requires resources. A Director and senior staff in an agency with severe resource constraints and very few staff members will be unable to devote the resources of the agency to leadership and interagency, intergovernmental activities. Even though such an agency provides services to other departments, it will, instead, be forced to devote most resources toward fulfillment of the agency's Federal and State required missions alone because of resource constraints. Although some of these missions require providing services to clients, the minimum required number of tasks can be accomplished. As noted earlier, this situation can be changed through strategic planning, the exercise of influence by a drug czar or similar mechanism at the Governor's office, or by freeing the agency from its wholly subordinate position, according to the State cases examined here. One of these developments frequently leads to another.

The ability to exert leadership is also fostered by funding stability and continuity. Agencies with continuity in funding and leadership and key staff, reported they had more ability to lead at the State level in combating substance abuse. Stakeholders, even those who had not always supported particular Directors or the agencies' initiatives, said that continuous leadership and policy had helped the agencies remain substantial in policy terms, within the highly competitive market for priority and resources in State government.

Policy leadership requires agency and staff collaboration with other entities, especially because substance abuse agencies treat clients of other departments; effective inter-agency collaboration based on shared utilization and outcomes data is perhaps the most effective strategy to accomplish SA policy goals. However, sustaining collaboration over time and periods of change or financial stress requires clear policy and strategy, as well as respected leadership in order for other State agencies to feel it is worthwhile to spend time and effort on collaboration that leads to policy preeminence.

Some respondents felt that reliance on personal leadership instead of organizational structure provided only a temporary solution to substance abuse policy imperatives, when longer term structural autonomy was needed to assure effective State-funded substance abuse services. Political stakeholders were especially likely to agree with this Phase I finding, often citing their own experience in being "termed out" and how that experience had limited their policy initiatives and influence. They agreed that structural autonomy aided State substance abuse agencies, while even good leadership tended to be subject to turnover, retirement and other reasons for departure of key substance abuse leaders.

Relationship to Mental Health Agency

There are important differences between the substance abuse and mental health policy environments that can make it difficult for the agencies to merge, to coordinate or to collaborate. Stakeholders and State directors reported the following:

- Mental health treatment is an entitlement for many individuals with severe mental illness. Departments of Mental Health often provide services to as many of these persons as possible, primarily orienting their services towards those with serious mental illnesses. Departments seek to serve all of the individuals eligible in the target population as part of their policy mandate.
- In comparison, substance abuse treatment services are made available only to about twenty percent of those who are members of the substance dependent population, rather than to the entire target population.

Substance abuse agencies and mental health agencies may be organizationally close to or distant from one another in State government. However, substance abuse spending in States is much lower than mental health spending, which generally implies that substance abuse agencies are smaller. The sources of funding for mental health and substance abuse are quite different from one another.

- Federal funding other than Medicaid and Medicare provides 14% of the funds for substance abuse but only 5% for mental health¹⁰. These funds are primarily from the Federal Block Grant Programs for substance abuse and for mental health.
- Medicaid, a joint State-Federal program, provides substantially greater support of mental health services than of substance abuse treatment services, in part due to the Federal stipulation that people who are disabled due to drug addiction or alcoholism are ineligible for Social Security Disability Income (SSDI) and Supplemental Security Income (SSI) benefits and, therefore, Medicaid coverage linked to these programs. SSDI and SSI remain important sources of support for individuals (children, adolescents and adults) with a mental disability.

¹⁰ SAMHSA *National Expenditures for Mental Health and Substance Abuse Treatment 1991 - 2001*
DHHS Publication No. SMA 05-3999 2005

- Substance abuse treatment services fall under the optional services that States can elect to cover or not cover under Medicaid. Stakeholders and directors in several states with deficits indicated either that this optional Medicaid coverage had been eliminated (Oregon) or that it was endangered.
 - For the nation as a whole, total State and Federal public expenditures for mental health are 3.9 times the public expenditures for substance abuse, and State expenditures for mental health are 3.6 times those of State expenditures for substance abuse¹¹. In comparing State spending for mental health and substance abuse, the majority goes to mental health.
 - 78% of total State and local spending for mental health and substance abuse went for mental health in 2001¹².
- Respondents from States where services are provided by some entities that combine substance abuse and mental health services and others that provide specialty substance abuse treatment services reported that combined or integrated services had the following characteristics:
 - The definition of co-occurring disorders broadened so that a much larger proportion of substance abuse patients were diagnosed and treated for a mental disorder than previously.
 - Mental health practitioners and substance abuse practitioners had different evidence-based best practices and little or no cross training. Combining services or departments did not necessarily address this issue unless serious training issues were undertaken.
 - Practitioners with a mental health background were reported to diagnose substance abuse patients as having mental health disorders rather than substance abuse disorders, similar to the literature on primary care physicians' propensity to diagnose some mental health disorders but to miss substance abuse disorders.

¹¹ SAMHSA *National Expenditures for Mental Health and Substance Abuse Treatment 1991 - 2001*
DHHS Publication No. SMA 05-3999 2005

¹² SAMHSA *National Expenditures for Mental Health and Substance Abuse Treatment 1991 - 2001*
DHHS Publication No. SMA 05-3999 2005

Agency Mergers

Centralizing specialized budget and fiscal functions that were formerly within the State substance abuse agency has been a component of consolidation efforts in several States, including Texas, Oregon, and Maine. This centralization at the superagency level can result in loss of expertise, focus and priority in the substance abuse budgetary function unless specific steps are taken to counteract this tendency. The centralization in some states, including an effort at one time in New York, reportedly led to state inability to fully understand or model the policy implications of proposed changes in substance abuse budgets and finances because the staff given up to superagencies by merged substance abuse agencies led to those staff having other duties and priorities. Further, the generalist staff from superagencies were sometimes reported to be unfamiliar with specialized substance abuse reporting, performance, maintenance of effort and confidentiality requirements and, at a minimum, required remaining specialty substance abuse staff to spend hours explain many detailed fiscal SA issues to them. Lacking such explanation, they were reportedly likely to misunderstand or overlook requirements, sometimes incurring MOE issues for the State as one result, along with sometimes failing to obtain discretionary funds that would otherwise have come to the State agency. This issue did not occur as often in merged agencies with Directors who had substantial substance abuse expertise at the State level before the agencies were merged. Nevertheless, Substance abuse financing/reporting required under the Federal Block Grant was believed by these individuals to have been negatively affected when the fiscal functions were lost to the superagency.

Clients with co-occurring mental health and substance abuse disorders benefit both from mental health and substance abuse treatment services. According to the Federal Drug and Alcohol Services Information System, 16% of substance abuse treatment admissions in 2001 were for clients with a co-occurring mental health disorder¹³, which was not necessarily a serious mental illness. Although this is probably a significant underestimate, since many of the programs that are funded by the SAPT block grant and supply the data for this observation do not have mental health professionals qualified to make a diagnosis of a mental health disorder, the point is that most clients treated for substance abuse are not found to have a serious mental disorder.

Turning to the epidemiologic perspective, 23.2% of the members of the targeted public mental health population, clients with severe mental illness (SMI), also

¹³ SAMHSA, Office of Applied Studies, *The DASIS Report, "Admissions with Co-occurring Disorders: 1995 and 2001"* April 9, 2004

have a substance use disorder¹⁴. Moreover, about 29% report use of an illicit drug in the past year. Among adults with substance dependence or abuse, 20.4% had SMI, according to the National Survey on Drug Use and Health. The great majority of SA clients do not meet the public sector criteria for SMI necessary for entitlement to State-provided mental health services, which makes it all the more important, according to stakeholders and State directors, for substance abuse agencies to be able to retain vital Federal block grant funds and discretionary grants. Lack of autonomy makes it difficult for substance abuse agencies to maintain or increase various types of Federal funding to which clients are theoretically entitled. Directors of merged behavioral health agencies were more likely to be able to retain such funding if the agency directors had both mental health and substance abuse experience, as well as fiscal staff devoted to these issues.

TABLE II

PERSONS AGED 18 OR OLDER WITH SERIOUS MENTAL ILLNESS (SMI) AND
SUBSTANCE USE DISORDER (SUD)
2002¹⁵
(Thousands)

		SUBSTANCE DEPENDENCE/ABUSE		TOTAL
		YES	NO	
SMI	YES	4,048	13,435	17,483
	NO	15,749	159,674	175,423
TOTAL		19,797	173,109	192,906

Because the intersection of the target populations for the two conditions in the general population – those who report serious mental illness and substance dependence/abuse – is a small proportion of the total of the two populations (12.2%), treating co-occurring disorders may be described as a clinical issue, not as a reason for merging the two types of departments. One leading “system integrator” consultant maintained that mixing mergers of agencies with co-occurring disorders initiatives distracted from those initiatives and limited their success. Regardless, it is clear from data and interviews that abuse is an

¹⁴ Epstein J., Barker, P., Vorburger, M., & Murtha, C. (2004). *Serious mental illness and its co-occurrence with substance use disorders, 2002* (DHHS Publication No. SMA 04–3905, Analytic Series A-24). Rockville, MD: Substance Abuse and Mental Health Services Administration, Office of Applied Studies.

¹⁵ *ibid*

important issue in the treatment of those with SMI. Not only do a significant portion of the clients in the public mental health population with SMI have a substance use disorder (SUD), but substance use by these clients, even in those without SUD, can significantly undermine behavioral stability. In addition SUD in the SMI population is higher in urban areas, higher for adolescents than for adults and may be higher among public sector clients than in the population treated elsewhere. Therefore, collaboration with the State substance abuse agency is of critical importance for State mental health agencies. State substance abuse agencies may see the mental health agency as only one of many agencies with which collaboration is needed. This disequilibrium in perspectives is a potential source of tension between the two agencies.

Several substance abuse agency Directors indicated that they felt more need to collaborate with criminal justice agencies than with mental health agencies. Stakeholders were very likely to point out that both the State substance abuse directors and the State mental health directors, if they were in separate departments or if they were merged in behavioral health departments, lacked sufficient skills and/or willingness to engage in the sustained collaboration necessary for both mental health and substance abuse agencies to advance and improve. Stakeholders strongly supported training both types of agencies' top, middle and line staff in clinical collaboration along continuous quality improvement lines that would engage them equally.

The significant proportion of clients of a State mental health agency who have substance use and abuse issues may imply to the mental health agency that its ability to fulfill its organizational mission would be improved if it could simply subsume the substance abuse agency into its operations so as to be able to exert greater control on behalf of its clients. However, the evidence developed to date in this 12 State study clearly indicates that this merger would or actually has significantly degraded the ability of the State substance abuse agency to fulfill its mission, which requires dealing with clients from many other State agencies through extensive collaborative efforts, especially involving criminal justice, in addition to collaborating with the mental health agency. It is not clear whether or not the State mental health agencies improve their operations and fiscal performance post-merger. The question awaits a more focused evaluation.

Other Significant Policy Issues Raised by Respondents

- Political attitudes towards and sympathy or lack of support for substance abuse treatment have importance beyond structure and leadership:

- One strong Director in a “nested” department mentioned that over the past five years there had been four individuals in positions superior to his in the Department: two “sympathetic” to substance abuse issues and two “not sympathetic” to substance abuse issues. The differences had an important impact on this long term Director’s ability to obtain resources for key strategic initiatives to improve substance abuse treatment, despite the Director’s own personal charisma and experience. Stakeholders interviewed from various political orientations echoed this theme that support for substance abuse waxed or waned according to the policy priorities of each administration or legislative majority.
- Substance abuse policy has a fundamental relationship with Federal policy – the Substance Abuse Prevention and Treatment (SAPT) Block Grant accounts for almost half of all public SA spending in many States. The mental health block grant is smaller than the substance abuse block grant – about 24% as large. Thus the Center for Mental Health Services Block Grant is a much smaller proportion of total State spending on mental health services than the SAPT Block Grant is on State Substance Abuse Agency spending, tipping the substance abuse agencies’ orientation more towards their primary Federal funder.
- State level accountability and oversight mechanisms are a fundamental component of a well managed, effective and high quality public substance abuse prevention and treatment system. Licensing, certification and accreditation requirements alone are insufficient for this purpose. Monitoring, operating and evaluating the results of these mechanisms are State-level functions that require sufficient agency independence, staff and other resources to accomplish successfully. Data leadership at the substance abuse agency level is closely connected to strong agency directors and staff who can cobble together sufficient resources to evaluate operations and providers in order to improve quality of care and fiscal accountability. In merged and subsumed agencies, this level of monitoring and improvement of substance abuse functions was reported by stakeholders and agency leaders to be harder to maintain.
- Despite the reported need for reform and reorganization, the impact of recent and continuing structural changes within State substance abuse agencies and in State government are taking considerable time to evolve and for the impact of reorganization and/or the promised level of savings to be apparent. The fact that states face funding crises means that most have not set aside funds to evaluate the impact of

reorganizations or mergers. In the case of one State agency, the statewide provider association is calling for such an evaluation of a merger but the State has not funded an effort and the evaluation may not occur without Federal funding intervention that may or may not be forthcoming. In the absence of an evaluation, say stakeholders, political intrigue around the merger continues to preoccupy the State government.

ORGANIZATIONAL PLACEMENT OF STATE SUBSTANCE ABUSE AGENCIES

The organizational placement of State substance abuse agencies is a key dimension affecting organizational performance through its impact on visibility and power. Autonomy, whether achieved through structure or leadership, substantially affects the capacity of a State substance abuse agency to develop and implement policy initiatives that are responsive to the needs of its vulnerable clients and inter-agency stakeholders. One of the most important determinants of autonomy, and one that is highly correlated with organizational placement, is whether or not the SSA Director is appointed by the Governor. Appointment of the State agency Director by the Governor confers authority, credibility and status, as well as indicating the priority of substance abuse issues within State government. Organizational placement of the State substance abuse agency within a State government structure affects the influence and thus the ability of an agency to promote and actually implement policy initiatives that depend upon power derived from a tight relationship to the Governor. Influence may be achieved through a variety of mechanisms, some direct and some subtle, but advantageous organizational placement or the ability to maintain a high level of autonomy within a nested or merged structure appears to be key.

Types of agency placement found in the 12 States included in this Phase II Report are in Table III below:

TABLE III

STATE CLASSIFICATION MATRIX

STATES WITH CABINET LEVEL SUBSTANCE ABUSE AGENCIES	STATES WITH MERGED SA/MH/OTHER AGENCIES WITH DESIGNATED OR SEPARATE SA OFFICES OR STAFF	STATES WITH NESTED SUBSTANCE ABUSE AGENCIES SEPARATE FROM A MENTAL HEALTH/OTHER AGENCY	STATES WITH NESTED SUBSTANCE ABUSE AGENCIES WITHIN A BEHAVIORAL HEALTH OR DRUG CONTROL AGENCY THAT IS WITHIN A SUPERAGENCY
New York	North Carolina	Massachusetts	Georgia
Ohio	Texas	Washington State	Michigan
Oregon		California	Maine
		Florida	

Notes on Classifications:

- New York: The SA Commissioner’s position is open and agency is being led by four Associate Commissioners; in Ohio the Director’s Office has a new leader appointed when the original Director left; in Oregon the SA Agency head now also heads mental health/behavioral health and the position has been recently moved up to cabinet level
- In North Carolina the former SA agency director has become head of Community Services, including SA/MH/DD for the state and there are separate substance abuse staff within this division
- In Maine the Office of Substance Abuse was moved several notches down within DHHS, now reporting to a Deputy for Behavioral Health, formerly head of mental health.
- Florida: Courtesy double appointment of SSA within cabinet-level office of “Drug Czar” provides visibility despite SSA being component of larger state Child and Family Services agency. Authority of “Drug Czar” extends beyond law enforcement to prevention and treatment.
- Massachusetts: Substance abuse agency was originally at a lower level than the mental health agency until a strategic initiative led to Gubernatorial support; in Washington State the substance abuse agency is equivalent to mental health and the former SA Director is in charge of both
- Michigan SSA combines Office of Drug Control Policy (“Drug Czar”) with substance abuse agency

States in this study with “highest autonomy” substance abuse agencies had agencies with a close formal organizational relationship to the Governor’s Office and two were actual cabinet level agencies (Ohio and New York). California’s

ADP Director is placed within the State's DHHS but the Director is appointed by the Governor.

States with a substance abuse agency fully merged (rather than nested as an independent entity) with a mental health agency have the potential for having the least autonomy of any of the placement models examined here. Maine has recently joined this group. In North Carolina, however, specialized substance abuse staff are still in place and continue to provide substance abuse leadership.

States with "nested" substance abuse agencies have the substance abuse agency reporting to a larger organization (generally Health Services or DHHS) and are thus at least one organizational level removed from the Governor. The number of organizational levels between the SSA and the Governor is an indicator of the degree of influence of a State substance abuse agency.

KEY FINDINGS FROM STATE INTERVIEWS

CALIFORNIA

- The Department of Alcohol and Drug Programs (ADP) is one of twelve departments and one Board within California's Health and Human Services Agency.
- The ADP Director was appointed by the Governor in November 2000. Prior to her appointment, there had been a two year period during which the Department did not have a director.
- The Department also administers funds provided by the Substance Abuse Treatment Trust Fund, or Proposition 36. This is a program that offers certain eligible low level drug possession offenders the opportunity to choose treatment and probation in lieu of incarceration. This program is State funded at an annual level of \$120 million until June, 2006, when funding is scheduled to sunset. Like other funding received by ADP, the great majority (97%) is designated for local assistance, under which provisions funds are transferred to Counties.
- Services are provided through California's 58 Counties; 93% of the ADP budget is designated for local assistance, the majority of which provides funds to be administered by the Counties, under the guidance of ADP.

FLORIDA

- The Florida Office of Drug Control was established by the Governor and is now incorporated into Florida statute; the Director of the Florida Office of Drug Control is appointed by the Governor and confirmed by the Florida Senate; the individual who currently holds this position, popularly known as the Florida “drug czar”, previously worked at the Federal Office of National Drug Control Policy (ONDCP).
- State Director for Substance Abuse is also Deputy Director for Treatment of the Office of Drug Control (ODC).
- The position of the Director of the Office of Drug Control resides in the Office of the Governor with the authority to coordinate all state efforts concerned with drug control, to include treatment, prevention, law enforcement, budget, legislation, grass roots coordination, and liaison with local, county, state, and federal policies and officials. The added advantage of the chief state agency official for treatment and prevention (the Department of Children and Families) being the Deputy to the Director of the Office of Drug Control further enhances the reach and effectiveness of substance abuse treatment and prevention efforts. The budgetary totals from the state of Florida for the latter two drug control efforts alone are now almost \$300 million.
- The Director of the ODC has direct access to Governor; the Director of Substance Abuse obtains access via the ODC and Secretary of Department of Children and Families.
- The Director of the State substance abuse agency (SSA) is also the Deputy Director for Treatment of the Florida Office of Drug Control (ODC). The close relationship of the Office of Drug Control to the Governor has facilitated recent promotion of a strong substance abuse policy agenda in the State. Thus although the SSA remains formally within the Child and Family Services Agency, the existence of the ODC within the Office of the Governor has facilitated creation of a strong substance abuse policy and services agenda.
- Separation of the SSA from the Department of Mental Health in 1997 significantly enhanced the visibility and ability of the Director of Substance Abuse to advance key SA policy objectives in concert with ODC, in the opinions of the SSA Director and the Director of Mental Health. Substance abuse providers had been very disturbed about the SSA's lack of influence and resources when it was reporting to mental health in the Department of Children and Families. The State's mental health Director, the person to whom the SSA formerly reported, strongly concurred with the opinion of the SSA Director on this point.

- External stakeholders confirmed the significance and impact of the elevation in status of the SSA as well as the importance of the dual responsibility of the Director in both the SSA and in the ODC.
- External stakeholders observed that the separation of the SSA from mental health had increased the focus on substance abuse but had diminished the collaboration between the two agencies.

GEORGIA

- The functions of the Office of Substance Abuse have been almost completely regionalized and decentralized and the Office is now within the Division of Mental Health, Developmental Disabilities and Addictive Diseases, within the Department of Human Resources. The Office of Substance Abuse has a Chief and three staff; the (Acting) State Methadone Authority (SMA) officer is a physician at a regional psychiatric hospital, not an SA agency staff member.
- Lack of agency personnel at the State level and subordination within DMHDDAD have made engagement in collaborative efforts with other entities and agencies very challenging, if not impossible, for the Georgia State agency.
- As another consequence of limited staffing, State-level accountability mechanisms or oversight of substance abuse treatment services are minimal as is the ability of the SSA to track outcomes and produce reports needed by Federal or other agencies and funders.
- The current public SA treatment system is highly responsive to local and regional provider needs and demands, rather than to those of consumers and other stakeholders because State-level resources are lacking.
- The Director and his four staff find it difficult to be collaborative and fully responsive to Federal and State requirements
- Following the release of the Phase I report, the Division Director announced that the substance abuse agency was to be elevated in status so that it will stand on its own.

MAINE

- During 2004-05 Maine's new Commissioner for the Department of Health and Human Services, a former budget director for the Governor, undertook a complete reorganization of DHHS due to major issues involving social services and mental health, including the creation of the new Department of Behavioral and Developmental Services, to which OSA now reports through a

Deputy Commissioner for Programs. At one point, all OSA functions and staff were recommended by the Implementation Taskforce to be distributed throughout the Department of Behavioral and Developmental Services, effectively merging all staff. A later iteration of the reorganization, developed after much public discussion and resistance to disbanding the function, retained the OSA Office and its Director and program personnel in one unit within BDS but OSA reports through a Deputy Commissioner for Programs to the DHHS Commissioner.

- While program staff currently remains with OSA, the former OSA specialized financial, IT and HR staff who are still with the Department have been moved to the DHHS Departmental level and no longer report to OSA.
- External stakeholders expressed significant concerns about the reduction in visibility and status of the substance abuse agency caused by the recent reorganization.

MASSACHUSETTS

- The SSA in Massachusetts is a Bureau led by an Assistant Commissioner within the Department of Public Health, within the Office of Health Services, within the Executive Office of Health and Human Services.
- Placement of the SSA within the Department of Public Health has meant that a strong public health emphasis and focus on prevention has developed but that other substance abuse emphases and priorities have not been equally prominent.
- The Assistant Commissioner for Substance Abuse Services initiated a strategic planning process in an effort to raise the visibility of substance abuse issues within State government. In May 2005, as a part of that strategic planning process, the Governor issued an Executive Order that established the Interagency Council on Substance Use Prevention and Treatment. The goal of the Council, which is chaired by the Lieutenant Governor, calls for senior level representation by all of the major government entities and greater cross-agency collaboration and accountability for how they are dealing with substance use issues as they affect their clients and services.
- As a result of the Executive Order, agencies have to account to the Council (and the Bureau of Substance Abuse) for better service coordination and to make sure that all agencies are moving in the same direction. The Substance Abuse agency meets monthly with all other agencies affected by the Executive Order and the Assistant Commissioner meets with the Lieutenant Governor regularly and works with her office almost daily.

- The agency has been able to avert recently threatened MOE penalties through a negotiated arrangement with SAMHSA. Additional funds have been appropriated for the agency and they have been able to restore some services lost over the past several years and are in the process of hiring some key staff to enhance the organizational capacity of the Bureau. They are establishing an Office of Youth and Young Adult Treatment Services, hiring a Coordinator of Housing and Homeless Services, Coordinator of Workforce Development, an individual who will coordinate the development of a Consumer Office and a Grants Development Coordinator.

MICHIGAN

- The Office of Drug Control Policy has been in existence since 1991, and was transferred to the Department of Community Health in 1996.
- In 2003, the Division of Substance Abuse and Gambling Services (DSAGS) was transferred into the Office of Drug Control Policy (ODCP).
- The goal of ODCP/SA merger was to eliminate fragmentation between law enforcement and the treatment and prevention of substance abuse and to improve the coordination and collaboration between enforcement, education and substance abuse programs.
- The MH and SA Directors are in close physical proximity and have informal conversations daily. The staff of the divisions are in similarly close physical proximity, which facilitates collaboration.
- The reorganized ODCP under one Director has created a visible position in State Government.

NEW YORK

- New York State's Office of Alcoholism and Substance Abuse Services (OASAS) is one of four States in 2004 with a cabinet-level SSA.
- OASAS utilizes an Executive Team approach to manage the agency; the full team currently includes the Acting Commissioner, four Associate Commissioners, Chief Counsel, Medical Director, Director of Addiction Treatment Centers, Public Information Officer, Director of Inter-Governmental Affairs and a Special Assistant.

- OASAS is the largest chemical dependence service system in the U.S., serving approximately 265,000 unique individuals annually in treatment. OASAS also funds approximately 300 prevention providers that deliver science-based program services throughout the State.
- OASAS is itself a treatment provider, offering inpatient rehabilitation services through 13 State-operated Addiction Treatment Centers (ATCs); many innovative programs are offered through the ATCs including: a program for the deaf and hard of hearing at Norris ATC in Rochester, one of only five such programs in the country; the integrated dual recovery program at McPike ATC and Mohawk Valley Psychiatric Center in Utica; services to mothers and their pre-school children, offered at Stutzman ATC in Buffalo and Ward ATC in Middletown; and a mono-lingual (Spanish) track at the Manhattan ATC.
- Data and information systems are a core strength in OASAS and a foundation of its strategy to demonstrate the continuing positive impact of its services and initiatives. According to stakeholders, the data systems and reliance on information are thought to distinguish OASAS amongst State addiction agencies.
- Heavy inter-agency and inter-organizational collaboration is emphasized and strongly supported by the agency and the Governor.
- As part of the current organizational structure, OASAS has initiated a specific Performance Improvement Unit, charged with identifying and implementing evidence-based practices systematically. This unit is focused on the dissemination and adoption of best practices. Early work will focus on establishing a culture of continuous performance improvement internally within OASAS and externally throughout the field.
- There is also a Bureau of Enforcement to address waste, fraud and abuse within the provider system.
- OASAS field office staff play key roles in the development and delivery of services; they are key in the adoption of EBPs, linking performance and budgeting and working with providers to achieve continuous performance improvement.

NORTH CAROLINA

- SA, MH and DD were combined at the State and community levels in North Carolina in an ongoing statewide “mental health reform” that includes substance abuse. This reform has conceptualized the new Agency as having two divisions: State operated institutional treatment and community policy/treatment.

- The North Carolina Chief of Community Policy Management, who was formerly the State Director for Substance Abuse, is now the official Single State Agency (SSA) Executive with management responsibility for substance abuse, mental health and developmental disabilities. There is not a separate State substance abuse office in the North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services but there are dedicated substance abuse-specific staff members.
- The Department head, who is appointed by the Governor and has served both in Republican and Democratic administrations, has an extremely close and longstanding relationship with the Departments of Corrections and Juvenile Justice on substance abuse issues.
- Development of an effective State data infrastructure over the past ten years has facilitated mental health reform and substance abuse system reform by providing information allowing modeling the financial impacts of this reform and permitting the new mechanisms of contracting and payment that are the heart of this reform. This accomplishment was made possible by some continuity at the top in the key leadership positions during this period.
- The Chief of Community Policy Management is a gubernatorial appointee who has strong independent relationships with the Governor's Office and legislators to help promote substance abuse and other policy initiatives. She chaired the design committee of the reform initiative.
- The Chief of Community Policy Management is a nationally recognized substance abuse policy expert and the former State substance abuse Director, so that the visibility of substance abuse policy has been able to be maintained despite the lack of a specifically designated substance abuse policy office. Additionally, the Governor's wife is a noted alcohol treatment advocate who has worked closely with the substance abuse agency.

OHIO

- The Ohio Department of Alcohol and Drug Addiction Services (ODADAS) is an autonomous cabinet-level agency, one of four States with a cabinet-level substance abuse agency in 2004.
- The executive team at ODADAS considers Cabinet-level status crucial for the launch and success of its numerous intra-governmental collaborative initiatives, for which there are otherwise competing priorities.

- ODADAS contracts with 43 combined Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards and 7 specialty Alcohol and Drug Addiction Services (ADAS) Boards in more urbanized areas to deliver prevention and treatment services specifically for substance abuse.
- ODADAS perceives that the 7 ADAS Boards that work specifically on substance abuse services have a much greater focus on substance abuse services than do the 43 ADAMHS boards that combine the delivery of both substance abuse and mental health services.
- External stakeholders observed that the change of leadership at the agency in 2003 has had a significant impact. The new Director is perceived as having a very different leadership style than his predecessor. Several external stakeholders observed that the new Director spends more time reaching out to external stakeholders than did his predecessor, is more engaged with the provider community, and is making progress in improving access to methadone treatment.

OREGON

- Oregon combined its community treatment systems for mental health and alcohol and other drugs in 2001, a transformation that required a lot of coordination, according to interviewees and external stakeholders. The merger includes blended disaster response services. AOD lost its independent status under the merger, but the position of director of the combined agency, the Assistant Director for DHS Health Services, Office of Mental Health and Addiction Services, is now a DHS cabinet-level position.
- Interviewees reported that the most significant internal changes in the AOD agency, formerly separate, have included a leadership role broadened to encompass mental health, broader program areas and budget issues, new methods becoming necessary to resolve internal disputes and grievances related to the reorganization, and enhanced measures needed for efficiency and accountability. External stakeholders who were from the substance abuse community said they felt that the department was more efficient but had much less focus on substance abuse than before. External legislative stakeholders were supportive of the combined department and its management.
- Initially the focus on AOD services was diminished but as state revenues improved the combined agency leaders were able to restore a number of AOD positions and enhance the AOD focus. A new emphasis on evidence-

based practices has actually pushed the merged department to a position of greater prominence than either department had separately, according to administrators. External stakeholders said that the impact was not yet possible to evaluate, since the combined focus was too new.

TEXAS

- Following a recent reorganization of State government in Texas, the former Director of Substance Abuse was designated in May 2004 as the new Deputy Commissioner for Behavioral and Community Health for the Department of State Health Services (DSHS), to take office in September 2004. The impact of this organizational change on substance abuse agency performance, services and policy will only become evident over time.
- The impetus for this reorganization was change in the political composition of the Texas State Legislature and the election of a new Governor; the substance abuse agency has been greatly affected by the reorganization, along with the rest of the State government, but SA issues were not a cause of the reorganization.
- The ability of SA to maintain independent policymaking initiatives and meet Federal requirements now rests with the individual who will have integrated mental health and substance abuse authority, and with the two separate divisions (Mental Health and Substance Abuse Division and the Community and Family Health Division (M&CH, Title V, WIC, etc.) that report to that individual.

WASHINGTON STATE

- The Division of Alcohol and Substance Abuse (DASA) is within the Health and Rehabilitative Services Administration, within the Department of Social and Health Services.
- Data and information systems are the core strength of DASA and the foundation of its strategy to demonstrate impact of services, document accountability and achieve credibility within its Department, with other agencies and within the State and U.S.
- Ongoing cost-offset studies produced by DASA have been a key strategy to document outcomes of substance abuse treatment in Washington State. Such offsets include avoiding crime and incarceration, limiting utilization of

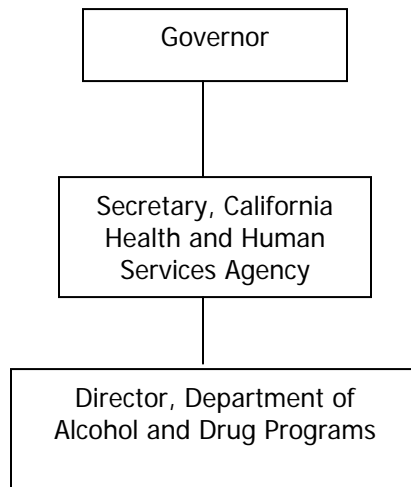
acute health care and psychiatric services, and reducing reliance on public assistance and getting people back to work, that is, employment.

- The stability of DASA's leadership group and the strength of the DASA data system have facilitated productive connections with the Governor's Office, other State/public agencies, and the Legislature.
- Collaboration with other entities is the most important tactic used by DASA to accomplish its strategic objectives. Staff is encouraged to collaborate with other public and private entities and is allocated significant time to do so. The expectation is that effective collaboration requires the assumption of increased workload by DASA staff.

SPECIFIC STATE INFORMATION

CALIFORNIA

Organizational Placement of AOD Agency



Organization of California Department of Alcohol and Drug Programs

- The Department of Alcohol and Drug Programs is one of twelve departments and one Board within California's Health and Human Services Agency.
- For Fiscal Year 2004-2005, the Department of Alcohol and Drug Programs (ADP), is budgeted for 324 positions to administer approximately \$596 million in total funds.
- The Director was appointed by the Governor in November 2000.

Organization and Funding of Services

- Services are provided through California's 58 Counties; 93% of the ADP budget is designated for local assistance, which provides funds to be administered by the Counties, under the guidance of ADP.

- Federal funds from the Substance Abuse Prevention and Treatment Block Grant account for 44% of ADP revenues.
- One of the principal programs funded by ADP is Drug Medi-Cal, which provides substance abuse treatment services for eligible Medi-Cal (California's implementation of Medicaid) beneficiaries. Services include outpatient drug free, narcotic treatment program, day care rehabilitative, Naltrexone, and residential services for pregnant and parenting women.
- The Department also administers funds provided by the Substance Abuse Treatment Trust Fund, or Proposition 36. This is a program that offers certain eligible low level drug possession offenders the opportunity to choose treatment in lieu of incarceration. This program is funded at an annual level of \$120 million until 2006, when funding is scheduled to sunset. Like other funding received by ADP, the great majority (97%) is designated for local assistance, under which provisions funds are transferred to Counties.

Access to Office of Governor and Legislature

- Governor determines amount of contact with Department.
- The ADP Director meets regularly with HHS Agency Secretary.
- ADP staff meets regularly with HHS Agency staff
- ADP has direct access to legislature and management staff meet regularly with legislators.

Commission on Performance Review

- Shortly after assuming office, Governor Schwarzenegger issued an Executive Order that established the California Performance Review (CPR) with the objective of making recommendations for making government more effective, efficient and responsive. On August 3, 2004, the CPR presented its report to the Governor.
- The CPR Report recommended that the Health and Human Services Agency should consolidate the administration of the state's substance abuse and mental health programs. The recommendation further proposed that savings be achieved through elimination of the following positions: one director, one chief deputy director, one chief counsel, one public information officer, one

deputy director/chief of legislation, one deputy director for administration, one deputy director/chief of information technology. The Department from which the positions would be eliminated was not specified. ADP is budgeted for 324 positions to administer approximately \$596 million in total funds; DMH is budgeted for 9,183 positions to administer approximately \$2.5 billion.

- Extensive public comment by substance abuse treatment stakeholders caused the Commission to reconsider this recommendation. In November 2004, the Commission recommended that reorganization within the Health and Human Services Agency be postponed and that instead of a consolidation of mental health and substance abuse, “the Governor should direct the Department of Mental Health and the department of Alcohol and Drug Programs to coordinate their services and activities to better serve their shared client population. This latter point should be accomplished through a written memorandum of understanding”. In January 2005, the Governor submitted a set of recommendations for governmental reform based on the CPR Report; consolidation of the Departments of ADP and Mental Health was not among them.

Selected State Data from SAMHSA¹

STATE	2003 SAPT PER CAPITA BLOCK GRANT ALLOCATION ²	2002 - 2003 RATE OF ALCOHOL OR ILLICIT DRUG DEPENDENCE OR ABUSE ³	2002 - 2003 ILLICIT DRUG TREATMENT GAP ³	2002 PER 1000 SA TREATMENT ADMISSIONS ⁴	BLOCK GRANT LEVERAGE: SA ADMISSIONS PER 1000 BLOCK GRANT \$	RATIO OF ADMISSION RATE / DEPENDENCE RATE
UNITED STATES	\$7.04	9.22	2.66	8.1	1.15	0.88
CALIFORNIA	\$9.01	9.00	2.81	7.5	0.83	0.83

1 The data used in this and other State tables do not constitute all SAMHSA state data, nor do they represent all of the data that states use in their operational analyses and planning efforts. These statistics should be interpreted with caution because there are a great variety of factors which affect their magnitude and implication.

2 The population denominator used here to calculate the per capita block grant for CA is 2003 Civilian Population Over Age 13, from US Bureau of the Census; this denominator is used in other SAMHSA calculations and is used for all other states in this report. However, it is used here illustratively only, not as the calculation factor for the SAPTBG itself. Further, it is not a representation of the denominator used by SAMHSA to actually allocate the SAPT Block Grant for each State, which is based on a complex formula that incorporates multiple factors, and uses as its denominator the population of persons aged 18-65.

3 SAMHSA (OAS) State Estimates of Substance Abuse From the 2002 - 2003 National Household Survey on Drug Abuse

4 SAMHSA, Substance Abuse Treatment Admissions by State, 2002

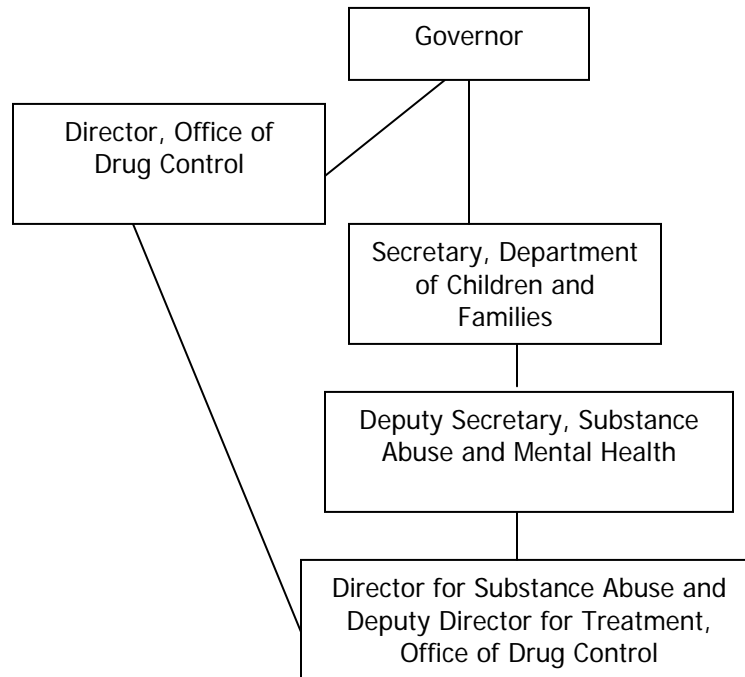
- California receives more per capita from the SAPT block grant than the US average (2003).
- The rate of alcohol or illicit drug dependence or abuse in California is slightly less than the US average (2002 - 2003).
- The rate of admissions to substance abuse treatment in California is 7% less than the US average (2002). Correspondingly, the SAMHSA-defined illicit drug treatment gap is 6% above the national average.

California Budget and Expenditure Data

- In January 2005, the Governor proposed that the budget for the Department of Alcohol and Drug Programs' (ADP) for Fiscal Year (FY) 2005-06 be \$613.7 million. This represents a total increase of \$17.4 million (2.9%), as compared to the FY 2004-05 Budget Act appropriation of \$596.3 million. Of the total \$613.7 million, \$570.3 million (92.9%) is for local governments and communities to provide treatment, recovery, and prevention services; and \$43.4 million (7.1%) is for State Support.
- The number of positions funded remained the same as those funded in the appropriation for 2004-2005; a 9% reduction from 2003-2004.

FLORIDA

Organizational Placement of AOD Agency



Organization of Office of Substance Abuse

- Florida has a strong Office of Drug Control established by the current Governor and now incorporated into Florida statute. The Director of the Florida Office of Drug Control is appointed by the Governor and confirmed by the Florida Senate; this individual sets the drug strategy for the state and is popularly known as the Florida “drug czar”. The Director of the ODC previously worked at the White House Office of National Drug Control Policy (ONDCP).
- State Director for Substance Abuse holds an additional appointment with the approval of the Director of ODC as a Deputy Director for Treatment of the Office of Drug Control (ODC).
- The position of the Director of the Office of Drug Control resides in the Office of the Governor with the authority to coordinate all state

efforts concerned with drug control, including treatment, prevention, law enforcement, budget, legislation, grass roots coordination, and frequent, high level liaison with local, county, state, and federal policymakers and officials. The advantage of the chief state agency official for drug abuse treatment and prevention (within the Department of Children and Families) being additionally named as a Deputy to the Director of the Office of Drug Control enhances the reach and effectiveness of the associated substance dependence treatment and prevention efforts. The budgetary total from the State of Florida for the latter two drug control efforts alone is now almost \$300 million.

- The Director of the ODC has direct access to Governor and the Director has the office literally next to the Governor's Office; the Director of Substance Abuse and Mental Health obtains access to the Governor's Office via the ODC and the Secretary of the Department of Children and Families.
 - The initiation of the ODC has raised issues of substance abuse control, prevention and treatment policy and related activities to the forefront in Florida. For example, the ODC convenes an annual statewide Drug Control Summit hosted by Governor in which the SA/MH organization participates.
 - A new non-profit behavioral health corporation, the Florida Substance Abuse and Mental Health Corporation, was created in 2003 to provide external oversight both of the mental health and of the substance abuse systems, and to make policy and resource recommendations to improve coordination, quality and efficiency (bill signed by the Governor 7/11/2003).
 - The district DCF offices have combined mental health and substance abuse program offices. These functions include local planning and the purchase of services in a coordinated manner.
- **History of Florida Substance Abuse Agency: Subordination to and then Separation from Mental Health**
 - In the mid 1990's, providers and consumers, reportedly greatly dissatisfied with access to and management of substance abuse services which were subordinated to mental health at that time within the Department of Children and Families, instigated reform and a new focus on substance abuse treatment services at the State level.

- In the fall of 1997, substance abuse was separated from mental health, to which it had reported, in order to elevate SA to a separate Office within the Department of Children and Families (DCF). The SA Director, who has reportedly recently been promoted and is now in charge of both functions within DCF, stated that “more was accomplished in SA in the five (now six) years after separation from MH than in the ten years prior to separation” due to the increased ability of the Office to convey substance abuse policy priorities to State policy leadership, particularly with the assistance of and linkage to ODC.
- The Florida Office of Drug Control was established in 1999 with a Director who came from the White House Office of National Drug Control Policy. The Director is appointed by Governor and confirmed by the Florida Senate; this post is the key overall substance abuse policy role in the State and is within the Governor’s Office itself.
- Since 2001, the Director of Substance Abuse has, with the approval of the ODC Director, had a dual appointment as an ODC Deputy Director for Treatment, allowing the SA Director to work more directly with the Drug Czar and key state stakeholders.
- The Director of Substance Abuse feels that the original separation from mental health and the approved linkage with ODC has facilitated a unique focus on substance abuse issues within the State of Florida. Prior to this separation of SA from mental health and the initiation of ODC, the top three to four priorities of the then combined substance abuse and mental health department were always exclusively mental health issues. The mental health director concurs with this assessment. Any upward or outward communication of departmental priorities when SA was subordinate to MH showed that the top 3-4 out of top five priorities were always mental health-related. Now, mental health and substance abuse are always at the table as peers. Mental health and substance abuse issues are discussed together and with equal emphasis. The SA Director also values the linkage to and appointment with ODC and is still within the Department of Children and Families, where the Director reportedly now supervises both SA prevention and treatment services and mental health.

Organization of Treatment and Prevention Functions and Services

- Local service provider programs tend to have both mental health and substance abuse components within one agency, but they are not necessarily organizationally integrated even if clinically related. This mirrors the organizational arrangement on the state level.
- Key State-level mental health and substance abuse functions have been separate and equal within the Department of Children and Families since 1997.
- Mental health and substance abuse prevention and treatment do combine certain similar functions at the State level:
 - Data System
 - Planning
 - Contracting with Providers
 - TANF-related Programs

Data and Information

- Mental health and substance abuse prevention and treatment have their own shared data system within DCF. This independence from other DCF systems has permitted focus on needs of substance abusers, which otherwise risked being accorded secondary status in terms of IT priorities. The SA Director believes that a strong, independent information system has been critical to the success of Division of Substance Abuse. This belief was seconded by the MH Director, who had supervised SA in its prior organizational position reporting to mental health.

Access to Office of Governor and Legislature

- Departmental re-organization within DCF in 2003 transferred an SA budget position from the DCF Secretary's Office to the Substance

Abuse Office instead. This provided the SA Director with direct line authority over the SA prevention and treatment budget, a key symbol of and tool for control over SA agency priorities and operations that can be exercised by the Director. DCF still exercises overall decision making authority over the SA budget, but the Substance Abuse Office has increased authority over the preparation and ongoing management of its own budget. This provides for substantially greater management control for SA than did the prior arrangements, according to stakeholders.

- o The approved linkage of SA with ODC also provides increased access to the Governor’s Office, an important mechanism for the Director of SA to better achieve SA prevention and treatment policy initiatives and to call attention to SA priorities with the assistance of ODC.

Selected State Data from SAMHSA¹

STATE	2003 SAPT PER CAPITA BLOCK GRANT ALLOCATION ²	2002 - 2003 RATE OF ALCOHOL OR ILLICIT DRUG DEPENDENCE OR ABUSE ³	2002 - 2003 ILLICIT DRUG TREATMENT GAP ³	2002 PER 1000 SA TREATMENT ADMISSIONS ⁴	BLOCK GRANT LEVERAGE: SA ADMISSIONS PER 1000 BLOCK GRANT \$	RATIO OF ADMISSION RATE / DEPENDENCE RATE
UNITED STATES	\$7.04	9.22	2.66	8.1	1.15	0.88
FLORIDA	\$6.83	8.80	2.83	6.3	0.92	0.72

1 The data used in this and other State tables do not constitute all SAMHSA state data, nor do they represent all of the data that states use in their operational analyses and planning efforts. These statistics should be interpreted with caution because there are a great variety of factors which affect their magnitude and implication.

2 The population denominator used here to calculate the per capita block grant for CA is 2003 Civilian Population Over Age 13, from US Bureau of the Census; this denominator is used in other SAMHSA calculations and is used for all other states in this report. However, it is used here illustratively only, not as the calculation factor for the SAPTBG itself. Further, it is not a representation of the denominator used by SAMHSA to actually allocate the SAPT Block Grant for each State, which is based on a complex formula that incorporates multiple factors, and uses as its denominator the population of persons aged 18-65.

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4 SAMHSA, Substance Abuse Treatment Admissions by State, 2002

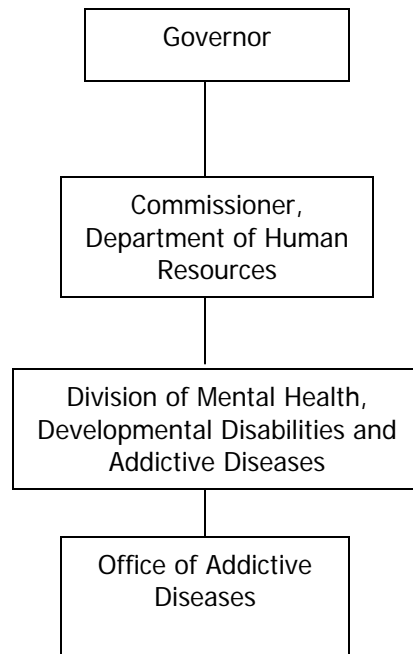
- Florida receives slightly less per-capita from the SAPT block grant than the US average (2003).
- The rate of alcohol or illicit drug dependence or abuse in Florida is slightly less than the US average (2001).
- The rate of admissions to substance abuse treatment in Florida is about 20% less than the US average (2002) but nevertheless the SAMHSA-defined illicit drug "treatment gap" is also 16% below the national average.
- In 2005 Florida ODC reports that virtually every indicator of substance abuse prevalence in the State is declining, part of a six-year trend.

Florida Budget and Expenditure Data

- Information obtained from Florida indicates a \$277 million to \$295 million or 6.4% increase in substance abuse funding from the 2003/2004 budget year to the 2004/2005 budget year. The 2004/2005 budget includes \$258 million for prevention and treatment and \$37 million for law enforcement, prosecution and other services related to substance abuse in the criminal justice system. This is a substantially greater increase than the 2.6% increase in the entire Florida State expenditure budget. Funding from Florida general revenues also increased substantially in the 2004/2005 budget year.
- Public funding for substance abuse prevention and treatment in Florida has increased in every year but one since the 1998/1999 budget year in which the ODC was created. In the 2001/2002 budget year, funding decreased by 1%, a decrease that was reversed by a 4% increase in the following year.
- Funding for substance abuse prevention and treatment in Florida is \$18.53 per capita in 2004/2005.

GEORGIA

Organizational Placement of AOD Agency



Organization of Office of Substance Abuse

- The Division of MHDDAD is one of seven divisions within Georgia's Department of Human Resources.
- The Office of Addictive Diseases has a Director of Addictive Diseases and four staff and it is at an equivalent level with mental health and developmental disabilities. There is a new Director of the Office and a Chief, an experienced staff person, who continues in that role.
- The State Methadone Authority (SMA) is currently a physician at a regional public psychiatric hospital who has taken on the SMA tasks in addition to the regular psychiatric position
- There are no separate budget, fiscal or planning functions for substance abuse; all are centralized and report directly to the Division Director and then to Commissioner of Human Resources.

Organization of Services

- Many of the Division's functions were decentralized to regional boards in 1993. Each regional board is responsible for MH, SA and DD. Regional boards hold all SA/MH provider contracts themselves.
- The number of regional boards was consolidated to seven in 2003.
- Medicaid funds some substance abuse services through TANF; a relatively comprehensive set of services is available through Medicaid for this largely female population.

Impact of Nested State-Level Substance Abuse Function in Division of MH/SA/DD

- Relative to other States, there is still limited State SA staffing (four positions) for a State of Georgia's size, according to key stakeholders and staff. This limits State-level substance abuse oversight of substance abuse treatment services, as well as possibilities for collaboration with other agencies at State level or State level SA system accountability.
- There is limited visibility or possibility for State-level substance abuse policymaking. The State is heavily dependent on regional MH/DD/SA boards. State-level SA reporting is diffuse and difficult because much data is kept at the county level.
- The very small staff size, while slightly augmented in the last year, for the Office of Substance Abuse still prevents more effective collaboration with other State and Federal agencies and departments due to personnel/resource constraints.
- The Atlanta Journal-Constitution (9/14/03) reported that at almost any time in the past decade, one or more of the State's regional boards have been under some kind of criminal, financial or administrative review. Limited State oversight was reported to have been a significant source of these problems.
- The substance abuse treatment system is highly responsive to regional and provider needs and demands, rather than to State oversight, because State-level resources are so limited.

Access to Office of Governor and Legislature

- The AOD budget is controlled by the Office of Planning and Budget Services in DHR, not by Addictions unit.

- The AOD Director never meets with Governor or Governor's Office staff.
- The AOD Director meets with legislators only by special request, once every two years or so. The Director did not meet with any legislators during the last session.

Selected State Data from SAMHSA¹

STATE	2003 SAPT PER CAPITA BLOCK GRANT ALLOCATION ²	2002 - 2003 RATE OF ALCOHOL OR ILLICIT DRUG DEPENDENCE OR ABUSE ³	2002 - 2003 ILLICIT DRUG TREATMENT GAP ³	2002 PER 1000 SA TREATMENT ADMISSIONS ⁴	BLOCK GRANT LEVERAGE: SA ADMISSIONS PER 1000 BLOCK GRANT \$	RATIO OF ADMISSION RATE / DEPENDENCE RATE
UNITED STATES	\$7.04	9.22	2.66	8.1	1.15	0.88
GEORGIA	\$6.97	9.11	2.55	5.0	0.72	0.55

1 The data used in this and other State tables do not constitute all SAMHSA state data, nor do they represent all of the data that states use in their operational analyses and planning efforts. These statistics should be interpreted with caution because there are a great variety of factors which affect their magnitude and implication.

2 The population denominator used here to calculate the per capita block grant for CA is 2003 Civilian Population Over Age 13, from US Bureau of the Census; this denominator is used in other SAMHSA calculations and is used for all other states in this report. However, it is used here illustratively only, not as the calculation factor for the SAPTBG itself. Further, it is not a representation of the denominator used by SAMHSA to actually allocate the SAPT Block Grant for each State, which is based on a complex formula that incorporates multiple factors, and uses as its denominator the population of persons aged 18-65.

3 SAMHSA (OAS) State Estimates of Substance Abuse From the 2002 - 2003 National Household Survey on Drug Abuse

4 SAMHSA, Substance Abuse Treatment Admissions by State, 2002

- Georgia receives very slightly less per capita from the SAPT block grant than the US average (2003).
- The rate of alcohol or illicit drug dependence or abuse in Georgia is 14% less than the US average (2001).
- The rate of admissions to substance abuse treatment in Georgia is 38% less than the US average (2002). Nevertheless, the SAMHSA-defined illicit drug treatment gap is 12% below the national average.

Georgia Budget and Expenditure Data

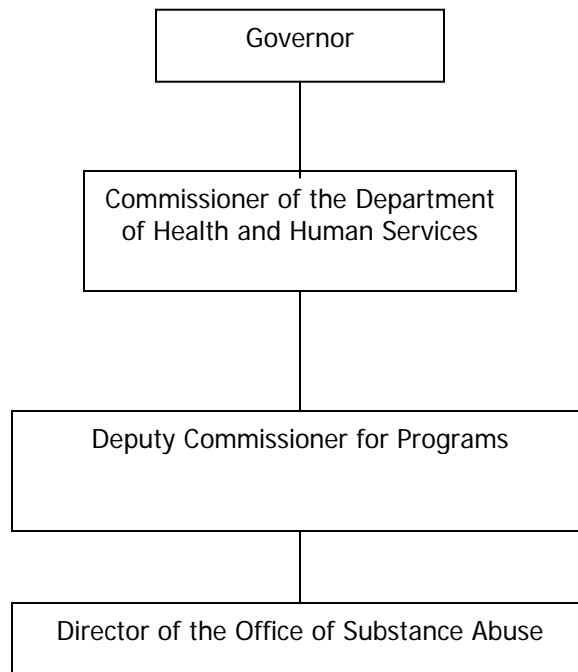
- Information obtained from Georgia indicated a 17% increase in State-funded substance abuse services from State fiscal year 2000 to State fiscal year 2001. This was followed by a 1% decline for State fiscal year 2002, a period that also saw an increase in Federal funds that more than offset the decline

in State funds.

- Total funds for substance abuse prevention and treatment services in State Fiscal year 2002 were \$91.7 million or \$13.46 per capita.

MAINE

Organizational Placement of AOD Agency



- Maine's Office of Substance Abuse (OSA) reports to a recently established Department of Health and Human Services formed by the combination of the Department of Behavioral and Developmental Services and the Department of Human Services.
- The current Director of the Substance Abuse Office reports to the Deputy Commissioner for Programs, rather than to the Commissioner.
- Maine has an external Substance Abuse Services Commission with an advisory role to the Governor and to the Office of Substance Abuse. The Commission has requested an external evaluation of the organizational placement of the Office, including the impact of the placement on the State Substance Abuse authority.

History and Organization of Services

- Maine's Office of Substance Abuse Services has a complex organizational placement history of a) reporting directly to the Governor's Office; b) reporting directly to the Commissioner of Behavioral and Developmental Services on a higher level than mental health; c) currently reporting to the Deputy Commissioner for Programs, a recently created component of the Department of Health and Human Services. The Office has always had strong provider support and continues to do so.
- During 2004-05 Maine's new Commissioner for the Department of Health and Human Services, a former budget director for the Governor, undertook a complete reorganization of DHHS due to major issues principally involving social services and mental health.
- At one point, all OSA functions and staff were addressed by the Reorganization Implementation Taskforce with a recommendation to be disbanded as a specialty office and distributed throughout the Department of Health and Human Services, effectively merging all SA staff, including the Director. A later iteration of this proposed reorganization, developed after much public discussion and resistance to disbanding the SA Office and function, discussed below, retained the OSA Office and its Director and program personnel in one unit within DHHS but OSA reports through a Deputy Commissioner for Programs to the DHHS Commissioner, effectively two levels down from its previous position. Financial analysts and other administrative staff who originally worked with OSA now work for the larger department.
- In the larger Departmental reorganization, which involved outside consultants from Price WaterHouse Coopers and an internal/external Commissioner's Implementation Taskforce with several workgroups, OSA was moved to a subordinate position reporting to the Deputy Commissioner, despite a fair amount of resistance from providers, some legislators and OSA itself. OSA was reduced two levels in the bureaucracy and the Director of OSA, who once reported directly to the Governor and subsequently to the Commissioner, no longer reports to the Commissioner directly. There is no clear relationship of SA to mental health, which is currently headed by an acting director.
- OSA has had a history of collaborating in the past with other State agencies, including but not limited to criminal justice and education. Its relationship to the mental health department has been alternately close

and distant in terms of collaboration. One of the subjects of the planned evaluation requested by the Substance Abuse Commission is an assessment of how its organizational placement has affected the Office of Substance Abuse's ability to relate to other State agencies and to other functions within its own department.

- Maine's OSA, which is the SSA for the State, has most of its functions centralized in Augusta, although there was a proposal from DHHS to regionalize some of its services and co-locate them with other regional DHHS services. While program professional staff currently remains with OSA, the former OSA specialized financial, IT and HR staff who are still with the Department have been moved to the DHHS Departmental level and no longer report to OSA. No replacements for these staff have been authorized.

Collaboration with other State and National Agencies

OSA has worked collaboratively with a number of states in New England and nationally and is active in NASADAD, as well as working closely with CSAT, as do many of the other states discussed here. The Director has been with OSA for four years and has a strong mid-management program team, although the departures noted above have diminished her focused resources substantially. The Director works very closely with the Legislature and with Maine's substance provider association but she now has only mediated interaction with the Commissioner of DHHS since she reports to a Deputy Commissioner for Programs.

Access to Office of Governor and Legislature

Maine's Legislature has been very active in substance abuse issues and policy because Maine has been beset with an upsurge of substance dependence, including prescription drug abuse and heroin dependence, particularly in rural areas that lack a sufficient number of public sector treatment providers. Several key legislators are very positive about OSA and have worked with the Director for many years. They were instrumental in keeping the Office of Substance Abuse together during the reorganization, with substantial support from the provider community, which thinks well of OSA and its Director. Despite being several levels down from her previous position, the Director was called directly to testify on her own about her office during recent legislative budget hearings, allowing OSA to maintain some direct relationship to the legislature. However, access to the Governor's Office and other agencies appears to have been diminished somewhat in the reorganization.

Selected State Data from SAMHSA¹

STATE	2003 SAPT PER CAPITA BLOCK GRANT ALLOCATION ²	2002 - 2003 RATE OF ALCOHOL OR ILLICIT DRUG DEPENDENCE OR ABUSE ³	2002 - 2003 ILLICIT DRUG TREATMENT GAP ³	2002 PER 1000 SA TREATMENT ADMISSIONS ⁴	BLOCK GRANT LEVERAGE: SA ADMISSIONS PER 1000 BLOCK GRANT \$	RATIO OF ADMISSION RATE / DEPENDENCE RATE
UNITED STATES	\$7.04	9.22	2.66	8.1	1.15	0.88
MAINE	\$6.04	8.81	2.84	10.9	1.80	1.23

1 The data used in this and other State tables do not constitute all SAMHSA state data, nor do they represent all of the data that states use in their operational analyses and planning efforts. These statistics should be interpreted with caution because there are a great variety of factors which affect their magnitude and implication.

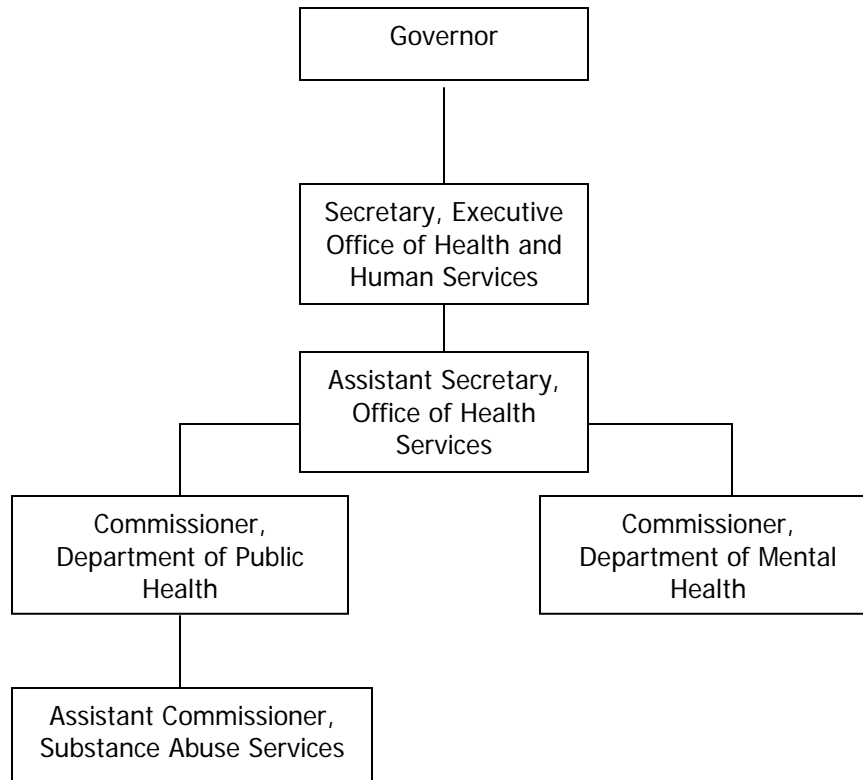
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3 SAMHSA (OAS) State Estimates of Substance Abuse From the 2002 - 2003 National Household Survey on Drug Abuse

4 SAMHSA, Substance Abuse Treatment Admissions by State, 2002

MASSACHUSETTS

Organizational Placement of AOD Agency



Organization of Services

- A major State government reorganization occurred in July 2003, following election of a new Governor. Seventeen separate agencies within the Executive Office of Health and Human Services (EOHHS) were grouped into five offices, one of which is the Office of Health Services. The Office of Health Services has four Departments or Divisions:

- Medicaid
 - Department of Public Health
 - Department of Mental Health
 - Division of Health Care Finance and Policy
- The reorganization resulted in the consolidation and centralization of many functions within EOHHS. Contact with the legislature was coordinated through EOHHS and many other functions where both the Bureau and the Department had direct access are now required to go through EOHHS. Budget and fiscal responsibility shifted from the Bureau of Substance Abuse to the Department of Public Health. Budget and fiscal staff is no longer as easily available to model precise SA-specific programmatic and policy impact of proposed changes in the substance abuse budget or fiscal policy.

Developments in 2005

- The Assistant Commissioner for Substance Abuse Services initiated a strategic planning process in an effort to raise the visibility of substance abuse issues within State government. In May 2005, as a part of that strategic planning process, the Governor issued an Executive Order that established the Interagency Council on Substance Use Prevention and Treatment. The goal of the Council, which is chaired by the Lieutenant Governor, calls for senior level representation by all of the major government entities and greater cross-agency collaboration and accountability for how they are dealing with substance use issues as they effect there clients and services.
- As a result of the Executive Order, agencies have to account to the Council (and the Bureau of Substance Abuse) for better service coordination and to make sure that all agencies are moving in the same direction. The Substance Abuse agency meets monthly with all other agencies affected by the Executive Order and the Assistant Commissioner meets with the Lieutenant Governor regularly and works with her office almost daily.
- The agency was able to avert any MOE penalties through a negotiated arrangement with SAMHSA. Additional funds have been appropriated for the agency and they have been able to restore some services lost over the past several years and are in the process of hiring some key staff to enhance the organizational capacity of the Bureau. They are establishing an Office of Youth and Young Adult Treatment Services, hiring a Coordinator of Housing and Homeless Services, Coordinator of

Workforce Development, an individual who will coordinate the development of the Consumer Office and a Grants Development Coordinator.

Relationship of Substance Abuse Services to Department of Mental Health

- The Directors are at different levels; Mental Health is headed by a Commissioner and Substance Abuse is headed by an Assistant Commissioner but the Office of Substance Abuse has just received much attention from the Governor's office and the field due to its new Strategic Plan, endorsed by and announced by the Governor.
- Like many states, Massachusetts has mental health parity but not substance abuse parity as yet. Mental health parity in Massachusetts requires that State-regulated health insurance plans (primarily plans provided by small employers that are not regulated under ERISA) and plans for State and local employees to provide mental health benefits for certain mental disorders at the same level of coverage provided for other health conditions.
- Mental Health has its own budget line; Substance Abuse is one of many functions within the Department of Public Health that does not have its own budget line.
- The Director of Substance Abuse did not meet with the Commissioner of Mental Health until the SA Strategic Plan was introduced; contact is at the staff level; collaboration exists, but substantial budget cuts reduced the ability of SA to collaborate until its Strategic Plan was endorsed by the Governor.

Core Strategic Initiative: Prevention

- Placement of Bureau of Substance Abuse in Department of Public Health has meant that the Bureau has a strong prevention function. The focus of the Bureau is both on prevention and treatment, with the introduction of its Strategic Plan.

Collaboration with other Entities

- The focus of collaborative efforts with other agencies within Department of Public Health quite naturally has a public health focus, including:
 - HIV / AIDS;
 - Hepatitis C;
 - Domestic Violence; and
 - Homelessness.
- Other important collaborative efforts include the
 - Department of Mental Health;
 - Department of Transitional Assistance;
 - Department of Social Services;
 - Department of Mental Retardation;
 - Executive of Public Safety, including Department of Corrections;
 - Deaf and Hard of Hearing;
 - County Houses of Corrections; and
 - Tobacco Control Program.

Access to Office of Governor and Legislature

- The Assistant Commissioner for Substance Abuse met with the Governor and governor's staff a dozen or so times during 2003 and 2004 year because of the sudden emergence of substance abuse budget issues and publicity concerning public safety issues related to substance abuse. This was a precursor to approval of the agency's new Strategic Plan, which revitalized the agency and gave it substantial legislative and gubernatorial support it had not previously enjoyed.
- In 2004, the Legislature established the Joint Committee on Mental Health and Substance Abuse. As a result, there was a renewed working relationship between the Bureau and members of this Legislative Committee.

Relationships to Providers

- Introduction of managed care through the Massachusetts Behavioral Health Partnership was the impetus for merging the substance abuse provider and mental health provider trade associations.

- The combined association has focused primarily on mental health issues and but is now turning to substance abuse issues – a gap still remains among specialty substance abuse providers, those with a substance abuse focus, and multi-service providers whose focus is on mental health and other services but the gap is closing due to the Strategic Plan.
- Residential substance abuse treatment providers have their own trade association.
- The Bureau of Substance Abuse licenses all providers of substance abuse treatment services and contracts with providers for services to publicly funded clients, rather than operating the centers itself.

Selected State Data from SAMHSA¹

STATE	2003 SAPT PER CAPITA BLOCK GRANT ALLOCATION ²	2002 - 2003 RATE OF ALCOHOL OR ILLICIT DRUG DEPENDENCE OR ABUSE ³	2002 - 2003 ILLICIT DRUG TREATMENT GAP ³	2002 PER 1000 SA TREATMENT ADMISSIONS ⁴	BLOCK GRANT LEVERAGE: SA ADMISSIONS PER 1000 BLOCK GRANT \$	RATIO OF ADMISSION RATE / DEPENDENCE RATE
UNITED STATES	\$7.04	9.22	2.66	8.1	1.15	0.88
MASSACHUSETTS	\$6.47	10.71	3.12	12.8	1.98	1.19

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4 SAMHSA, Substance Abuse Treatment Admissions by State, 2002

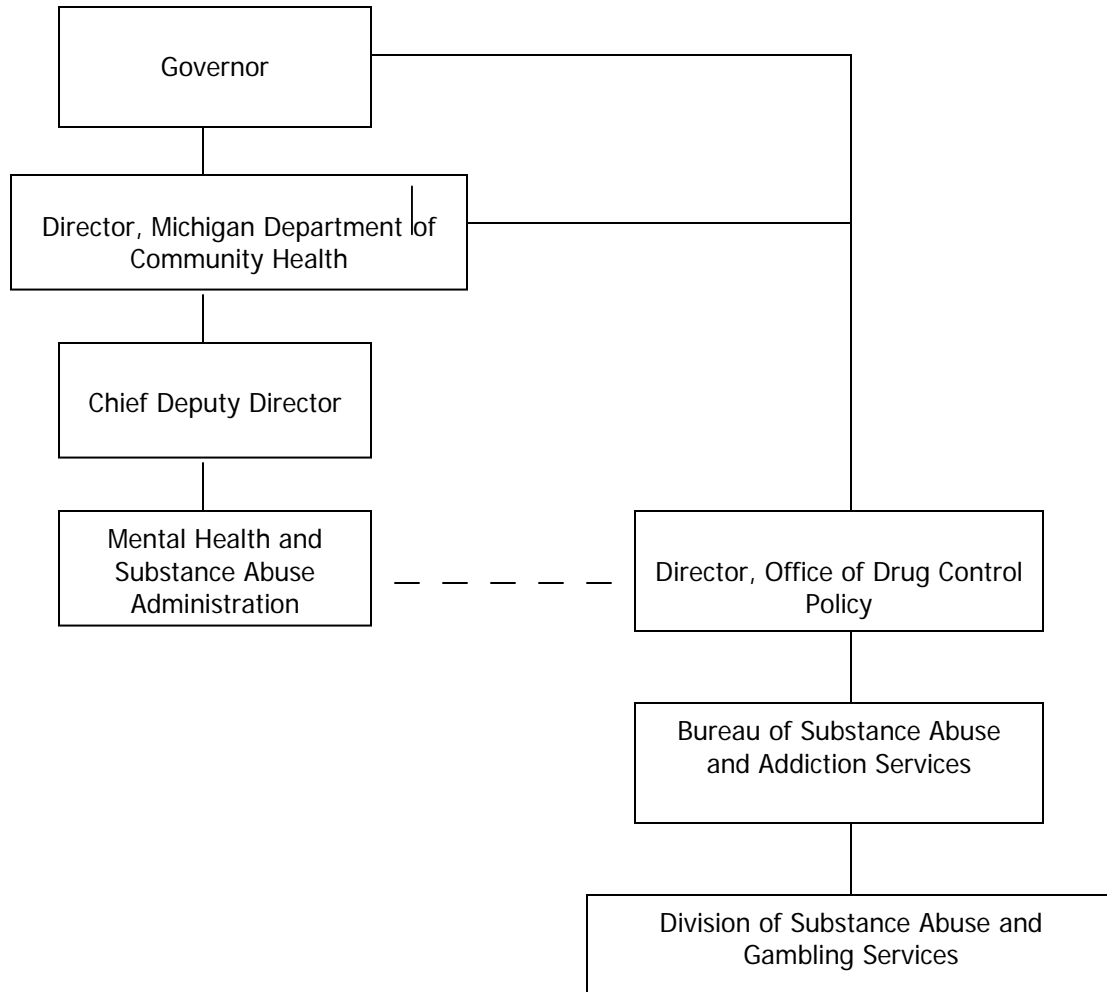
- Massachusetts receives 8% less per-capita from the SAPT block grant than the US average (2003).
- The rate of alcohol or illicit drug dependence or abuse in Massachusetts is 31% higher than the US average (2001).
- The rate of admissions to substance abuse treatment in Massachusetts is 58% higher than the US average (2002). Nevertheless, the SAMHSA-defined illicit drug treatment gap is 25% above the national average.

Massachusetts Budget and Expenditure Data

- Information obtained from Massachusetts indicates that total appropriations for substance abuse have declined each year since budget fiscal year 2001, and in 2004 were 21% below the level in 2001. An increase in expenditures is approved and was a reason for its new Strategic Plan.
- Massachusetts faced threatened reductions in Federal block grant funds because of failure to meet SAPTBG maintenance of effort (MOE) requirements due to reductions in State substance abuse spending.
- The agency was able to avert any MOE penalties through an arrangement negotiated with SAMHSA in early 2005. Additional funds were appropriated by the legislature for the agency and they have been able to restore some services lost over the past several years.

MICHIGAN

Organizational Placement of AOD Agency



Organization of Office of Drug Control Policy and Division of Substance Abuse and Gambling Services

- The Office of Drug Control Policy has been in existence since 1991, and was transferred to the Department of Community Health in 1996.
- In 2003, the Division of Substance Abuse and Gambling Services (DSAGS) was transferred into the Office of Drug Control Policy (ODCP).

- The goal of ODCP/SA merger was to eliminate fragmentation between law enforcement and the treatment and prevention of substance abuse and to improve the coordination and collaboration between enforcement, education and substance abuse programs.

Organization of Services

- The 2003 restructured ODCP has four principal functions, including:
 - Prevention;
 - Education;
 - Law Enforcement; and
 - Treatment.
- Funds administered by ODCP include:
 - The SAPT Block Grant;
 - Byrne Grant Program Funds;
 - Local law Enforcement Block Grant Funds; and
 - The Safe and Drug Free Schools and Communities Funds.
- Substance abuse treatment services are provided through the 16 Regional Coordinating Agencies, which directly hold all substance abuse provider contracts. The regional Coordinating Agencies may be components of local health departments, integrated MHSA entities, or 501(C3) agencies. Services are provided by a large number of providers, including specialty substance abuse providers and multi-service agencies.
- The reorganization of DCH/ODCP has facilitated collaboration between substance abuse treatment / prevention / education and criminal justice/law enforcement.
 - There are 63 drug courts in various stages of implementation, from planning to fully operational.

Relationship to Mental Health

- MH and SA both attend regular monthly DCH senior staff meetings.
- The MH and SA Directors are in close physical proximity and have informal conversations daily. The staff of the divisions are in similarly close physical proximity, which facilitates collaboration.

- MH and SA jointly conduct coordinated quality assurance site visits.
- Mental Health – Substance Abuse management team is active with twice monthly formal meetings and additional joint projects and meetings.
- Current collaborative efforts focus on various topics, including:
 - Co-occurring disorders;
 - MHSA managed care; and
 - Best Practice Initiative(s).

Access to Office of Governor and Legislature

- All formal relationships with the Governor and Legislature are managed through the DCH liaison office; the ODCP Director has informal contacts with both.
- The Budget function is centralized in the DCH office of Budget and Finance.
- The reorganized ODCP under one Director has created a highly visible position in State government.

Selected State Data from SAMHSA¹

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UNITED STATES	\$7.04	9.22	2.66	8.1	1.15	0.88
MICHIGAN	\$7.15	10.05	2.60	7.8	1.09	0.78

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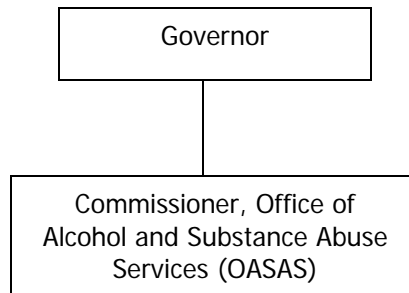
- Michigan receives slightly more per capita from the SAPT block grant than the US average (2003).
- The rate of alcohol or illicit drug dependence or abuse in Michigan is slightly greater than the US average (2001).
- The rate of admissions to substance abuse treatment in Michigan is slightly less than the US average (2002). The SAMHSA-defined illicit drug treatment gap is very slightly less than the national average.

Michigan Budget and Expenditure Data

- Total spending for substance abuse prevention and treatment remained essentially constant from State fiscal year 2000 to 2002. However, the components changed slightly, with Medicaid funds increasing by 18% and non-Medicaid State funds decreasing by 6%.
- Total spending for substance abuse prevention and treatment was \$111.9 million in State fiscal year 2002, or \$13.76 per capita. This figure includes Medicaid spending for substance abuse treatment.

NEW YORK

Organizational Placement of the AOD Agency: Autonomous, Cabinet-Level Agency



- OASAS has a Cabinet-level Commissioner (currently filled with an Acting Commissioner), who is appointed by the Governor and confirmed by the State Senate. OASAS uses an Executive Team approach to manage the agency; the full team currently includes the Acting Commissioner, four Associate Commissioners, Chief Counsel, Medical Director, Director of Addiction Treatment Centers, Public Information Officer, Director of Inter-Governmental Affairs and a Special Assistant. The Executive Deputy Commissioner position, to which the Associate Commissioners report, is currently vacant.
- Prior to 1992, there were two separate State agencies (the Division of Alcoholism and Alcohol Abuse and the Division of Substance Abuse Services), each led by a Director who reported directly to the Governor; these two divisions, together with the New York State Office of Mental Health and the Office of Mental Retardation and Developmental Disabilities together comprise New York's Department of Mental Hygiene. DAAA and DSAS were consolidated as OASAS under State legislation enacted in 1992, under the leadership of a single commissioner.
- While the two separate State agencies were consolidated under the 1992 enactment, statutory changes required for certification of chemical dependence treatment services and related OASAS funding were not enacted until 1999. Regulations governing the integration of treatment services and OASAS reimbursement were completed by 2004.
- While many services to prevent and, where indicated, treat those with chemical dependence have been merged, New York continues to plan for and provide services that:

1. Reach a geographically, ethnically and culturally diverse population throughout the State.
2. Use science-based prevention services to reach youth, the elderly, pregnant women and others at higher risk.
3. Employ, wherever appropriate, pharmacological approaches, including methadone treatment therapies, to foster recovery for those addicted to opioids.
4. Address the multiple needs of patients, including those who are homeless, mentally ill, and those whose health is compromised by HIV infection, tuberculosis, hepatitis and/or sexually transmitted diseases.
5. Use expertise in preventing and treating chemical dependence to, effective with legislation enacted in 2004, address compulsive gambling.
6. Disseminate information and advocate to combat the widespread and enduring stigma that may attach to addiction.
7. Work collaboratively with a variety of other NY state services' systems, such as the welfare system, health, criminal justice, juvenile justice, mental health and education/vocational rehabilitation, to better serve New Yorkers and those in need of treatment.

OASAS' position as a stand alone, cabinet level agency advances New York's ability to prevent and treat those with chemical dependence and/or compulsive gambling disorders. The agency's strong emphasis on the use of data and information systems for management, its commitment to specialized evidence-based practices and prevention, and its independent policy voice better address New York's needs than if OASAS were merged into a larger agency, where our core mission would compete with other priorities.

Funding

- According to SAMHSA data, OASAS' budget for 2004-05 is over \$500 million for agency and community operations. (Not included are additional funds appropriated to OASAS for Capital Projects of the State operated ATCs and nonprofit providers.) OASAS funding is supplemented by patient revenue, including Medicaid, State and local public health coverage for the poor and State welfare, local government tax, and non-SAMHSA Federal agencies. OASAS continues to provide direct treatment services through 13 State-operated Addiction Treatment Centers (ATCs), to regulate both public and voluntary (not-for-profit) and for-profit chemical dependency treatment programs, and to oversee community and school based prevention program services throughout the State.

- NY OASAS is the largest chemical dependence service system in the U.S., serving approximately 265,000 patients annually in treatment; OASAS itself operates 13 ATCs that provide inpatient treatment to those in need of this level of care. OASAS also funds approximately 300 prevention programs that are science-based.

Core Strategic Initiatives: Data and Information, Collaboration, Evidence-Based Practices, Financial Strategy

- Data and information systems are one core strength of OASAS and a foundation of its strategy to demonstrate the continuing positive impact of its services and initiatives. According to stakeholders, the data systems and reliance on information are thought to distinguish OASAS amongst State addiction agencies.
- Heavy inter-agency and inter-organizational collaboration is emphasized and strongly supported by the agency and the Governor.
- OASAS participates as an autonomous agency in the Executive Budget process, one which involves heavy collaboration with the Governor's Division of the Budget.

Current Organizational Structure

- OASAS currently has five divisions:
 - Treatment and Prevention Services
 - Systems/Program Performance and Analysis
 - Management Services and Quality Assurance
 - Financial, Capital, and Information Technology Management
 - Legal Affairs
- As part of the current organizational structure, OASAS has initiated a specific Performance Improvement Unit, charged with identifying and implementing evidence-based practices systematically. This unit is focused on the dissemination and adoption of best practices. Early work will focus on establishing a culture of continuous performance improvement internally within OASAS and externally throughout the field.
- There is also a Bureau of Enforcement to address waste, fraud and abuse within the provider system.

- In addition to inpatient treatment services, the State operated ATCs afford OASAS a venue for testing of promising new approaches. Current innovative programs being developed at the ATCs include: integrated treatment of tobacco dependence; specialized services at the Manhattan ATC to respond to methamphetamine use in the lesbian, gay, bisexual and transgender population; services for those with traumatic brain injuries at the Blaisdell ATC in Rockland County; and community-based, inpatient detoxification services at the Kingsboro ATC in New York City.
- OASAS field office staffs play key roles in the development and delivery of services, fostering the adoption of EBPs by community and school based providers, linking performance and budgeting and addressing continuous performance improvement.

Key AOD Issues

Collaboration with other Entities

- Being a separate, cabinet level agency has facilitated visibility of OASAS policy priorities, entrée to other agency, community and provider leaders and continuing interagency collaboration and contacts for OASAS. According to its leaders and stakeholders, OASAS has also taken pains not to let autonomy lead to a silo mentality and it avoids this pitfall through frequent interagency collaboration.
- The OASAS Executive Team feels it is critical for the interagency efforts for OASAS to be seen as equal to other Cabinet-level agencies, even those such as mental health and health that may have larger budgets and more staff members.
- OASAS works with the Department of Health regarding infectious and chronic diseases that affect chemically dependent persons and also collaborates extensively with the adult criminal justice system and the Department of Corrections, especially on diversion and re-entry programs. OASAS also works with the Office of Court Administration and a statewide system of more than 100 drug courts located in every county.
- There are policy and program connections with the State Office for the Prevention of Domestic Violence, the Office of Children and Family Services (including Juvenile Justice), the Office of Temporary and Disability Assistance, the State Office for Aging and the Department of Education, amongst others.

Access to Office of Governor and Legislature

The Governor has a Chief of Staff who is Secretary to the Governor. There are Executive Office staff members who are assigned to monitor health and human services, including substance dependence. The Acting Commissioner of OASAS reports directly to the Deputy Secretary for Health and Human Services. She attends meetings convened by the Governor and his staff and has virtually daily contact with the Deputy Secretary. OASAS' legal counsel reports to the Acting Commissioner of OASAS and reviews legislation for the agency.

- The NYS Assembly has a standing alcohol and substance abuse committee and the Senate committee on health covers alcohol and substance abuse issues; OASAS provides reports and analyses to the Legislature. New York is not a term-limit State; many of the committee members have considerable tenure. Each State agency in NY relates to legislative committees in each branch of the legislature. OASAS interacts frequently with the Senate Finance Committee and the Assembly Ways and Means Committee, in addition to the two separate committees that have purview over chemical dependence. The Commissioner may meet with the Chairs of various legislative program committees as well.
- The NY Senate's Majority leader has staff members who specialize in health and human services issues and who meet with the Acting Commissioner and key OASAS staff as well.

Counties and Other Key Stakeholders

New York State's counties and the City of New York are key players in the planning, development and management of chemical dependence prevention and treatment services. Under the State's Mental Hygiene Law, local governments are responsible for developing annual plans under OASAS aegis; the process includes county, provider and consumer stakeholders. Counties also participate in funding through a local Medicaid contribution and local tax levies to support addiction prevention and treatment services. The OASAS field office structure relates to the counties and the City of New York and works with them on an ongoing basis. There is a strong "Home Rule" tradition in the State and heavy reliance on partnership with local government. OASAS also collaborates with statewide and local chemical dependence provider organizations such as the Alcoholism and Substance Abuse Providers of New York State, specialty provider associations such as the New York State Committee of Methadone Program Administrators, Inc., as well as regional provider organizations throughout the State and other stakeholders. For example, OASAS works with the Governor's Advisory Council to review proposed program establishment, regulatory changes, planning strategies and policy issues.

Selected State Data from SAMHSA¹

STATE	2003 SAPT PER CAPITA BLOCK GRANT ALLOCATION ²	2002 - 2003 RATE OF ALCOHOL OR ILLICIT DRUG DEPENDENCE OR ABUSE ³	2002 - 2003 ILLICIT DRUG TREATMENT GAP ³	2002 PER 1000 SA TREATMENT ADMISSIONS ⁴	BLOCK GRANT LEVERAGE: SA ADMISSIONS PER 1000 BLOCK GRANT \$	RATIO OF ADMISSION RATE / DEPENDENCE RATE
UNITED STATES	\$7.04	9.22	2.66	8.1	1.15	0.88
NEW YORK	\$7.41	8.88	2.74	20.0	2.70	2.25

1 The data used in this and other State tables do not constitute all SAMHSA state data, nor do they represent all of the data that states use in their operational analyses and planning efforts. These statistics should be interpreted with caution because there are a great variety of factors which affect their magnitude and implication.

2 The population denominator used here to calculate the per capita block grant for CA is 2003 Civilian Population Over Age 13, from US Bureau of the Census; this denominator is used in other SAMHSA calculations and is used for all other states in this report. However, it is used here illustratively only, not as the calculation factor for the SAPTBG itself. Further, it is not a representation of the denominator used by SAMHSA to actually allocate the SAPT Block Grant for each State, which is based on a complex formula that incorporates multiple factors, and uses as its denominator the population of persons aged 18-65.

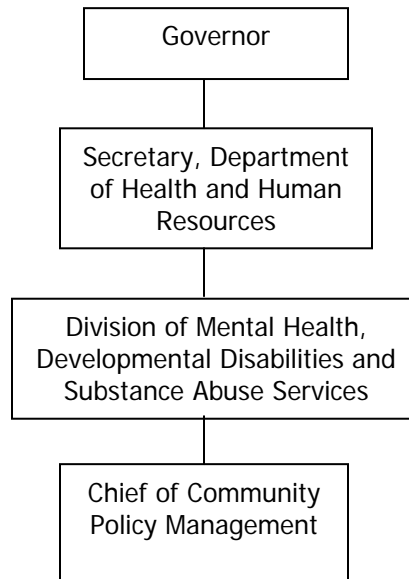
3 SAMHSA (OAS) State Estimates of Substance Abuse From the 2002 - 2003 National Household Survey on Drug Abuse

4 SAMHSA, Substance Abuse Treatment Admissions by State, 2002

- According to SAMHSA data, New York received 5% more per capita from the SAPT block grant than the US average (2003).
- While the rates of binge drinking and illicit drug use were higher than the national average, the reported rate of alcohol or illicit drug dependence or abuse in New York was slightly less than the US average (SAMHSA, 2002).
- The rate of admissions to substance abuse treatment in New York is more than double the US average (SAMHSA, 2002). Nevertheless, the SAMHSA-defined illicit drug treatment gap was 12% above the national average in 2002-2003.
- New York's performance measures for 2002, as reported to NASADAD and found at SAMHSA's web site, demonstrated positive outcomes: patient employment and abstinence increased (+20.5 for abstinence from alcohol), while patient arrests and homelessness decreased between admission to and discharge from treatment.

NORTH CAROLINA

Organizational Placement of AOD Agency



Organization of Office of Substance Abuse

- The NC Chief of Community Policy Management (CPM) is the SSA for substance abuse and has responsibility for mental health and developmental disabilities. The CPM chief has an extensive substance abuse and mental health background. She chaired the Design Committee for ongoing mental health reform.
- There are no separate State substance abuse functions in Division of MHDDSAS.
- There are three specialty substance abuse treatment institutions still managed by a separate Chief of State Operated Services in MHDDSAS.
- There has been stability in the senior staff of the Office of Community Services.

Organization of Services

- Since the end of the 1990's, the MHDDSAS system in North Carolina has been undergoing a complex and carefully planned reform that

resulted from a multi-year legislative study of the mental health, developmental disabilities and substance abuse systems. The impetus for system reform came from press and advocates concerned about symptoms of system failure resulting in client deaths in early 1990's. Reform is ongoing. As of 7/1/2004, clinical and management services will be provided through Local Management Entities (LME's), the successor to Community Mental Health Centers. LME's are local bodies responsible for approving, coordinating, and managing services. The three institutions providing substance abuse treatment services will remain State-owned and managed; these are perceived as regional resources of particular importance to the resource-poor Eastern portion of State.

- State and block grant-funded community-based substance abuse services are delivered predominantly by non-profits and CBO's.

Impact of Merged Specialty Substance Abuse Function

- Prior to the reorganization of MHDDSAS, there were 35 – 40 FTE staff exclusively focused on substance abuse issues; currently there are 12 FTE staff, each of whom has a partial focus on substance abuse, along with MH and DD functions.
- Staff reductions have greatly increased reliance on contractors, consultants, and other sources of external support.
- Outsourcing of many functions has increased focus on procurement and performance management of external resources.
- One result of reductions in State staff and reliance on external resources has been empowerment of providers.
- Performance and outcomes management of substance abuse services has become crucial.
- State and LME staff have had to learn new contract management skills.
- The Chief of Community Policy Management believes that merger promotes alignment of approach to service delivery among SA, MH, and DD, while specific elements of policy and operations may differ. She believes this unified approach among services facilitates collaboration with other departments and entities.

Data and Information

- NC has built an effective data infrastructure over a period of ten years, with Federal and State support. This accomplishment has facilitated system reform. Consistency of State substance abuse leadership in NC is thought to be an important factor in the development of this capability.
- NC also has developed a large human services data warehouse to facilitate data collaboration among various functions.

Access to Office of Governor and Legislature

- The system-reform is effort overseen by a 16 member legislative oversight committee, with equal number of members from House and Senate. The Chief of Community Policy Management works closely with the legislative oversight committee through monthly meetings and frequent conversations. Chief of Community Policy Management also meets with legislative appropriations committees 10-12 times during session.
- The reform efforts were initiated by the legislature, which has a history of strong mental health advocacy, and substance abuse has followed in its path.
- The Governor's wife is leader of Child Alcohol Use Initiative.
- The Governor maintains a MH/ SA/ DD planning office as part of Executive Branch.
- The Chief of Community Policy Management has access to Governor through an informal network.
- NC has a separate Governor's Institute on Alcohol and Substance Abuse, a private corporation. The Institute has a focus on research, practice improvement and education and training.
- The Chief of Community Policy Management works closely with the State budget office. She believes that relationships with State and

legislative budget authorities are crucial to successful substance abuse policy.

- The Chief of Community Policy Management has been entrepreneurial in securing funds from discretionary Federal grants and contracts, the Robert Wood Johnson Foundation, and other foundations to support continued policy initiatives.

Selected State Data from SAMHSA¹

STATE	2003 SAPT PER CAPITA BLOCK GRANT ALLOCATION ²	2002 - 2003 RATE OF ALCOHOL OR ILLICIT DRUG DEPENDENCE OR ABUSE ³	2002 - 2003 ILLICIT DRUG TREATMENT GAP ³	2002 PER 1000 SA TREATMENT ADMISSIONS ⁴	BLOCK GRANT LEVERAGE: SA ADMISSIONS PER 1000 BLOCK GRANT \$	RATIO OF ADMISSION RATE / DEPENDENCE RATE
UNITED STATES	\$7.04	9.22	2.66	8.1	1.15	0.88
NORTH CAROLINA	\$5.72	8.31	2.62	4.4	0.77	0.53

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3 SAMHSA (OAS) State Estimates of Substance Abuse From the 2002 - 2003 National Household Survey on Drug Abuse

4 SAMHSA, Substance Abuse Treatment Admissions by State, 2002

- North Carolina receives 19% less per capita from the SAPT block grant than the US average (2003).
- The rate of alcohol or illicit drug dependence or abuse in North Carolina is 26% less than the US average (2001).
- The rate of admissions to substance abuse treatment in North Carolina is substantially less than the US average (2002). Nevertheless, the SAMHSA-defined illicit drug treatment gap is 14% below the national average.

North Carolina Budget and Expenditure Data

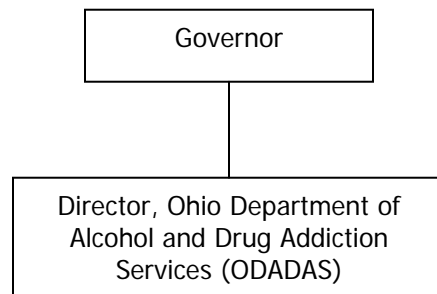
- Substance abuse funds reported by North Carolina were fairly similar from year to year between State fiscal years 1998 and 2003, except for a significant jump in funding in the years 2001 and 2002. Substance abuse

funds in State fiscal year 2003 were 3.5% below those in 2000 and the lowest in six years.

- North Carolina reported a budget allocation of \$100.9 million for substance abuse services, including some services provided through Medicaid (\$12.7 million), in State fiscal year 2002 – 2003, or \$15.13 per capita.

OHIO

Organizational Placement of AOD Agency



- The Ohio Department of Alcohol and Drug Addiction Services (ODADAS) is an autonomous cabinet-level agency. Its director recently left the agency. A new director was recently appointed.
- The departed Director, who previously headed prevention for ODADAS, was appointed 7/12/2003. The new director was appointed in July 2005.
- There is a Governor's Advisory Council on Alcohol and Drug Addiction Services, which has recently been strengthened and is moving towards having more of a substance abuse policy recommendation role.

Organization of Services

- Ohio's public substance abuse system is State-administered and locally-operated.
- ODADAS contracts with 43 Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards and 7 specialty Alcohol and Drug Addiction Services (ADAS) Boards in more urbanized areas to deliver prevention and treatment services.
- ODADAS perceives that the 7 ADAS Boards that work specifically on substance abuse services have a much greater focus on substance abuse

services than do the 43 ADAMHS boards that combine the delivery of both substance abuse and mental health services.

- The local Boards receive funds from ODADAS and also raise some local revenue.
- The majority of funding from ODADAS to the local boards is provided on a per-capita formula basis; a portion – perhaps 15% or so - is provided on a competitive discretionary grant basis.
- ODADAS has a specific number of designated slots on the local boards for which it, through the Governor's office, appoints members.
- Medicaid managed care in Ohio is strictly for physical health. There is no Medicaid managed care for substance abuse or mental health care.

Data and Information

- Since 2000, ODADAS has shared an integrated claims system with the Department of Mental Health.

Key AOD Issues in Ohio

- There is close collaboration with the Department of Mental Health on substance abuse treatment issues for clients under the jurisdiction of Ohio's new mental health courts, which were modeled on the drug courts.
- ODADAS sponsors a fetal alcohol syndrome initiative.
- ODADAS shares prevention initiatives with multiple State agencies.
- ODADAS is planning for possible reduction in State funding due to Ohio's budget deficit.

Collaboration with other State Agencies

- The ODADAS executive team considers that Cabinet-level status is crucial for the launch and success of its many intragovernmental collaborative initiatives, for which there are other competing priorities.

- ODADAS has numerous ongoing collaborative initiatives with multiple entities, including:
 - Health;
 - Rehabilitation;
 - MR/DD;
 - Aging;
 - Housing;
 - The Lottery;
 - Public Safety;
 - Commerce;
 - Education;
 - Criminal Justice;
 - Economic Development; and
 - Mental Health.

- There are daily communications between ODADAS and DMH.

- The new Director of ODADAS emphasizes the importance and value of collaboration with other agencies and has positive relationship with DMH, whose current DMH Director previously worked in ODADAS.

- ODADAS is active in collaborating with the State's public and private universities in putting together collaborative research projects. Projects are currently in place with Ohio State and Case Western Reserve universities.

Access to Office of Governor and Legislature

- The ODADAS Director attends approximately quarterly Cabinet meetings with the Governor.

- The Director meets with the Governor on ad-hoc basis for briefings and other purposes.

- The Director talks at least weekly to staff in the Governor's office.

- The Director talks weekly with First Lady regarding her advocacy role for alcohol abuse issues.

- The ODADAS legislative liaison meets weekly with counterparts from other Cabinet-level Departments in the Governor's office.

- The Director meets with key legislators at least monthly.
- The new Director has emphasized importance of closer communication with Governor and Legislature.

Internal Departmental Restructuring

- ODADAS has recently restructured to enhance efficiency and effectiveness. The following Divisions have been created:
 - Quality Improvement
 - Planning, Outcomes and Research
 - Treatment and Recovery
 - Prevention Services
 - Fiscal Services
 - Management Information Services
 - Fiscal Services

Additionally, the Director has the following functions reporting to his office:

- Communications and Training (moved in house from contractors)
- Assistant Director
- Legislative Liaison
- Administration
- Chief Counsel

Entrepreneurial Attitude

- Ohio describes itself as having an assertive, entrepreneurial attitude towards finding new sources of funding for substance abuse prevention and treatment, often obtained through collaboration with other departments and universities.
- Ohio is also actively pursuing every Federal grant it can find to help provide substance abuse funding.
- Ohio has a substance abuse benefit under Medicaid and has TANF-funded programs for substance abusing mothers who

are trying to find paid employment. Services covered include inpatient detoxification, general hospital outpatient AOD services, IOP, counseling, methadone, and case management services.

Selected State Data from SAMHSA¹

STATE	2003 SAPT PER CAPITA BLOCK GRANT ALLOCATION ²	2002 - 2003 RATE OF ALCOHOL OR ILLICIT DRUG DEPENDENCE OR ABUSE ³	2002 - 2003 ILLICIT DRUG TREATMENT GAP ³	2002 PER 1000 SA TREATMENT ADMISSIONS ⁴	BLOCK GRANT LEVERAGE: SA ADMISSIONS PER 1000 BLOCK GRANT \$	RATIO OF ADMISSION RATE / DEPENDENCE RATE
UNITED STATES	\$7.04	9.22	2.66	8.1	1.15	0.88
OHIO	\$7.22	9.56	2.61	4.9	0.67	0.51

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4 SAMHSA, Substance Abuse Treatment Admissions by State, 2002

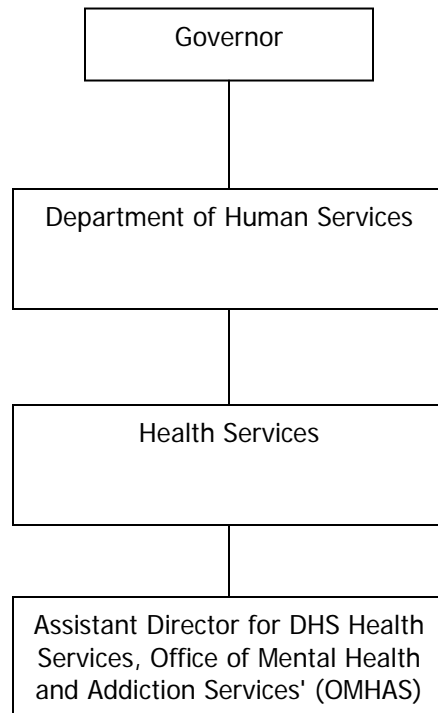
- Ohio receives slightly more per capita from the SAPT block grant than the US average (2003).
- The rate of alcohol or illicit drug dependence or abuse in Ohio is 10% lower than the US average (2001).
- The rate of admissions to substance abuse treatment in Ohio is about 37% lower than the US average (2002). Nevertheless, the SAMHSA-defined illicit drug treatment gap is 16% below the national average (2001).

Ohio Budget and Expenditure Data

- Expenditures for substance abuse services in Ohio increased from \$281.6 million in State fiscal year 2000 to \$305.2 million in 2002, an increase of 8.4%.
- Ohio spent \$33.47 per capita on substance abuse services in State fiscal year 2002. This figure includes Medicaid, which accounts for one-third of the ODADAS budget.

OREGON

Organizational Placement of AOD Agency



Structure

- Oregon's combined Office of Mental Health and Addiction Services is part of the Health Services cluster of program areas within the State's Department of Human Services, begun in 2001 and completed in 2003. The Health Services group also includes Medicaid and Public Health, which are on the same departmental level as MHAS, with leaders at a similar bureaucratic level, reporting to the Deputy Director of Health Services.

Combined Systems of Mental Health and AOD

- Oregon combined its community treatment systems for mental health and alcohol and other drugs in 2001, a transformation that required a lot of coordination, according to interviewees and external stakeholders. The merger includes blended disaster response services. AOD lost its independent status under the merger, but the position of director of the combined agency, the Assistant Director for DHS Health Services, Office of Mental Health and Addiction Services, is now a DHS cabinet-level position.

Most Significant Internal Changes

- Interviewees reported that the most significant internal changes in the AOD agency, formerly separate, have included a leadership role broadened to encompass mental health, broader program areas and budget issues, new methods becoming necessary to resolve internal disputes and grievances related to the reorganization, and enhanced measures needed for efficiency and accountability. External stakeholders who were from the substance abuse community said they felt that the department was more efficient but had much less focus on substance abuse than before. External legislative stakeholders were supportive of the combined department and its management.

Interorganizational Relationships

- The Assistant Director who runs the merged department meets with his program peers (Medicaid and Public Health) and sometimes with the Department's external task force. The Director and his deputy do not meet with the Governor or with his executive staff, unless there is an emergency related to SA or MH. Previously, AOD was a separate agency and had reported directly to the Department Director. The Office of Alcohol and Drug programs was eliminated during the merger. MH and SA therapists have been cross-trained as part of the co-occurring disorders effort and the new emphasis on evidence-based practices. However, the relationship of the combined agency to Child Welfare has not yet been worked out. MH and AOD have 4 joint committees internally. The merged agency meets collaboratively with the 15 area field offices for social services. It also works extensively with adult and juvenile corrections. Oregon has an interagency steering committee. Department administrators felt that their ability to meet with other departments had significantly improved since the merger and the overall reorganization of the parent DHS.

Relationship to Legislature

- The Department's Relationship to the Legislature did not change due to the merger, according to the administrators. The two MHAOD leaders still testify in front of legislative committees, provide substantive input to them, and administer their component of the agency budget, although they do not determine the overall context of the budget within DHS. The leaders work with the Ways and Means committee and with its staff, as well as with the Judiciary and MH/Corrections committees.

Relationship to Mental Health

- The two functions are now combined but administrators have hired/rehired AOD staff and feel that the merger did not obliterate the core AOD focus. Some AOD staff commented that they feel they are now getting a lot more agency support. Others felt that the AOD focus was weakened somewhat. The AOD function lost 8 positions in the merger, about half from AOD and half from mental health. One staff member still in AOD said that it wasn't well protected and was easily consumed. Others pointed out not only greater support from the DHS but the ability to blend research and analytical tasks, including a restored AOD research position.

Relationship to the Executive Office of the Budget

- During the year, the agency leaders meet once or twice with the Governor's budget staff and they have a commitment to keeping AOD visible in the budget cycle, as well as maintaining strong provider relationships to support budgeting and a strong relationship to the Governor's Substance Abuse Council. The fact that both merged agency leaders have both an AOD and an MH background has led to the restoration of some AOD staff who had been lost during the merger.

Impact on Clients

- Stakeholders reported that the agency merger had a significant impact on client access due to staffing cuts and budget cuts. The agency has been able to argue for some restoration of funds but some stakeholders felt that AOD clients had absorbed more of the impact of the deficit than mental health clients had absorbed. Access was more limited to AOD services, although stakeholders could not untangle the unique contributions to that of the merger and the large state deficit. To some extent, on the other hand, clients with co-occurring disorders were receiving a benefit from the new emphasis on these disorders and on evidence-based practices in general.

The merger affected clients whose counselors were defunded. A number of senior staff left at the agency and community provider levels due to budget cuts and the merger.

Rationale for the Merger

- The impetus for the combination of MH and AOD was in part the regional structure of the parent department, as well as AOD. The change was reportedly primarily one that was philosophical, not pushed by IT or budget issues but by a rethinking of the role of AOD services within the state. Departmental consolidation and reorganization involved more than the MH/AOD functions and the state is still facing a large deficit so that consolidation was partly motivated by the need to save on administrative costs and staffing.

Impact

- Initially the focus on AOD services was diminished but as state revenues improved the combined agency leaders were able to restore a number of AOD positions and enhance the AOD focus. A new emphasis on evidence-based practices has actually pushed the merged department to a position of greater prominence than either department had separately, according to administrators. External stakeholders said that the impact was not yet possible to evaluate, since the combined focus was too new.
- The combined department has a new taskforce on adult and children's co-occurring disorders and has had external trainers come in to the state to assist with its efforts.

Maintenance Of Effort

- Oregon had MOE difficulties with its SAPTBG obligations in 2004 and was waiting to hear about its appeal in January 2005.

Counties

- Oregon has a strong county system. The combined agency now makes dual MH/SA site visits to agencies. In smaller counties, most state AOD services are housed within the community mental health centers.

Oregon Health Plan

Oregon has its own Medicaid Health Plans, with a separate mental health staff. Providers have complained that there are fewer MH and SA resources available to them via Medicaid, both for mental health and for AOD. Medicaid reimburses methadone detoxification in Oregon. However, the state no longer provides reimbursement for methadone maintenance services for persons who are in a special category of financial eligibility for Medicaid, a pool of 24,000 persons whose care is financed by a provider tax on hospitals.

Selected State Data from SAMHSA¹

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UNITED STATES	\$7.04	9.22	2.66	8.1	1.15	0.88
OREGON	\$5.54	9.25	2.88	19.3	3.49	2.09

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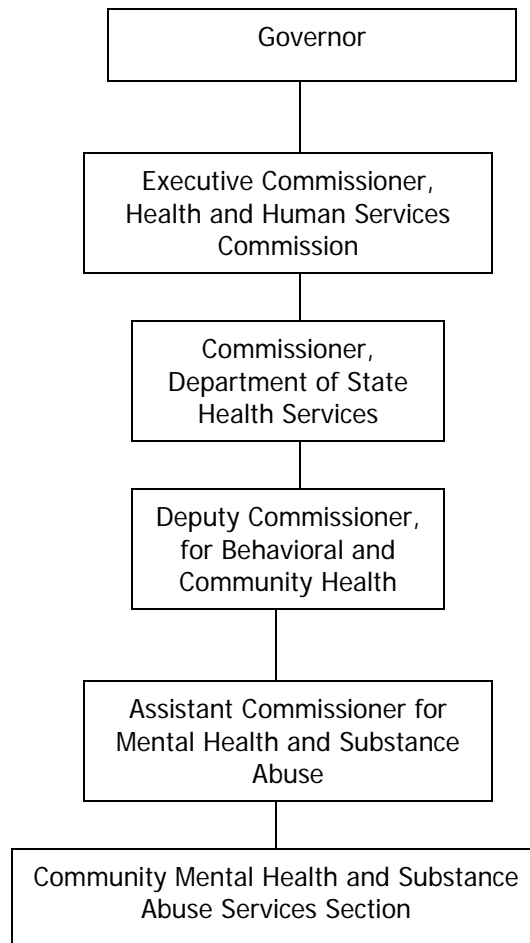
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4 SAMHSA, Substance Abuse Treatment Admissions by State, 2002

TEXAS

Organizational Placement of AOD Agency



Organizational Placement of Substance Abuse After 2003 - 2004 Reorganization

- The current Executive Director of the Texas Commission on Alcohol and Drug Abuse (TCADA), who also served 14 years in the State MH department, was promoted in May 2004 to be new Deputy Commissioner for Behavioral and Community Health for the Department of State Health Services (DSHS).

- Historically, TCADA had its own Board of Directors appointed by the Governor. This Board and 12 other agency-specific boards will be discontinued in September 2004 as part of the Texas State government health and human services reorganization. There will now be a 9-member advisory committee for the whole HHSC and one for each of the four agencies reporting to it, including the Department of State Health Services (which houses mental health and substance abuse), the Department of Aging and Disability Services, the Department of Assistive and Rehabilitative Services, and the Department of Family and Protective Services.
- The TCADA Director reported to the TCADA Board and to the Commissioner of Health and Human Services. In the new structure, the Division and the Director will report to the new Deputy Commissioner for Behavioral and Community Health and through that person to the Commissioner of the Department of State Health Services (DSHS), who in turn reports to the newly elevated and appointed Executive Commissioner of Health and Human Services.
- In the recent reorganization, which began in June 2003 and will be fully implemented on September 1 2004, 12 Health and Human services-related agencies were consolidated into the 4 Departments noted above.
- The Department of State Health Services, headed by a Commissioner, who is a physician specializing in family practice and public health, is the new home for both mental health and substance abuse. DSHS will have four divisions (Division of Mental Health and Substance Abuse, Division for Family and Community Services, Division for Prevention and Preparedness, and the Division for Regulatory Services).
- The impetus for the change coincided with the changes in the political composition and direction of the Texas Legislature and the election of a new Governor. External consultants from at least two consulting firms were involved, but much of the analytical work is being done by State employees who are appointed to a special reorganization task force.

Organization of Substance Abuse Services

- The new Substance Abuse Services office will be part of the Community Mental Health and Substance Abuse Services Section,

reporting to the consolidated Division Director, whose title is Assistant Commissioner for Mental Health and Substance Abuse. Functions for the section include contract management, quality management and programs.

- SA services office will be nested lower than before, but is at an equivalent level with the Mental Health office (Mental Retardation Services were moved out of Mental Health and placed in the Department of Aging and Disability Services), the consolidated MH/SA Contract Management Unit and the consolidated MH/SA Quality Management Unit. Psychiatric hospitals are separate from these units and are part of the new State Hospitals Section that reports to the Division Director.

Relationship to Mental Health Unit

- Mental health and substance abuse are now equivalent, lower ranking offices with lower ranking Directors, both reporting to the Director of the Community Mental Health and Substance Abuse Services Section, which, like the new Hospitals Section, reports to the Director of the newly consolidated Division for Mental Health and Substance Abuse.

Access to Office of Governor and Legislature

- The TCADA Director is by statute also the chair of the State's Drug Demand Reduction Advisory Council. The Drug Demand Reduction Council was created by the Legislature in 2001 and is directed to serve as a single source of information for the governor, the legislature, and the public about issues relating to reducing drug demand, including available prevention programs and services. It is also charged with developing a statewide strategy to reduce drug demand.
- TCADA formerly worked closely with the Legislative Budget Board and, because of its close management and its contemporary web-based clinical records and billing system, has been recently regarded within TX State government as having been far more efficient and accountable since 2001 than it was previously. A number of the other State agencies are either assessing or considering using this TCADA information system, an adjusted version of which has migrated nationally to SAMHSA and other States in the form of the Web Infrastructure for Treatment Services (WITS) system.

- The TCADA Director, soon to be the new Deputy Commissioner for Behavioral and Community Health, works frequently with the House Appropriations Committee, the Senate Finance Committee and other legislative committees.
- However, since 90% of TCADA's funding is Federal, there is concern that the State, like all the other States, must continue to pay attention to its SAPT block grant and to SAMHSA reporting requirements.

Interagency Relationships and Collaboration

- TCADA, with the Texas Department of Mental Health and Mental Retardation, oversees the highly visible NorthSTAR Medicaid managed behavioral health program, using an external, private-sector vendor to provide day-to-day operations and management.
- TCADA works with many other State agencies and views interagency collaboration as a second major tool to accomplish its mission, along with data collection and reporting. Collaborations include those with mental health, labor, child protective services, juvenile justice, education, the criminal justice system, judicial system, and law enforcement agencies.
- TCADA works collaboratively with SAMHSA is actively pursuing Federal grants.
- Interagency relationships, post reorganization, are implemented via Memoranda of Understanding.

Executive Leadership

- For the last four years, TCADA has had a stable, experienced and highly educated Executive staff, both at the Director level and at the senior management level. One member of the senior management team has participated extensively on the Texas government reorganization taskforce.
- TCADA has a statutorily required Statewide Service Delivery Plan outlining the most effective and efficient manner to address substance abuse service needs throughout Texas (TCADA also produced an extensive Annual Report in 2002).

- TCADA’s fourth Statewide Service Delivery Plan, promulgated in February 2004, is expected to remain in force under the reorganization. It focuses on six key strategies, including:
 - Enhancing needs’ assessment and data-based decision-making, and accessing Federal and foundation grants to better assess and address needs;
 - Implementing disease management programs’ and research-based practices for prevention and treatment;
 - Conducting a Statewide procurement of all prevention and treatment services, including new services, and achieving funding equity of services, and purchasing and monitoring services for quality and cost;
 - Adopting and implementing new rules, including uniform Standard of Care rules, for all clinical licensees;
 - Increasing focus on outcomes’ data for providers;
 - Providing leadership in partnerships with other agencies and organizations.

Although the essence of the 2004 plan will not change under the new structure, it may have to be adapted to address HHSC or DSHS issues and strategic priorities as they arise. In addition, TCADA has improved the substance abuse provider reimbursement rates.

Selected State Data from SAMHSA¹

STATE	2003 SAPT PER CAPITA BLOCK GRANT ALLOCATION ²	2002 - 2003 RATE OF ALCOHOL OR ILLICIT DRUG DEPENDENCE OR ABUSE ³	2002 - 2003 ILLICIT DRUG TREATMENT GAP ³	2002 PER 1000 SA TREATMENT ADMISSIONS ⁴	BLOCK GRANT LEVERAGE: SA ADMISSIONS PER 1000 BLOCK GRANT \$	RATIO OF ADMISSION RATE / DEPENDENCE RATE
UNITED STATES	\$7.04	9.22	2.66	8.1	1.15	0.88
TEXAS	\$7.80	8.98	2.47	2.1	0.27	0.23

1 The data used in this and other State tables do not constitute all SAMHSA state data, nor do they represent all of the data that states use in their operational analyses and planning efforts. These statistics should be interpreted with caution because there are a great variety of factors which affect their magnitude and implication.

2 The population denominator used here to calculate the per capita block grant for CA is 2003 Civilian Population Over Age 13, from US Bureau of the Census; this denominator is used in other SAMHSA calculations and is used for all other states in this report. However, it is used here illustratively only, not as the calculation factor for the SAPTBG itself. Further, it is not a representation of the denominator used by SAMHSA to actually allocate the SAPT Block Grant for each State, which is based on a complex formula that incorporates multiple factors, and uses as its denominator the population of persons aged 18-65.

3 SAMHSA (OAS) State Estimates of Substance Abuse From the 2002 - 2003 National Household Survey on Drug Abuse

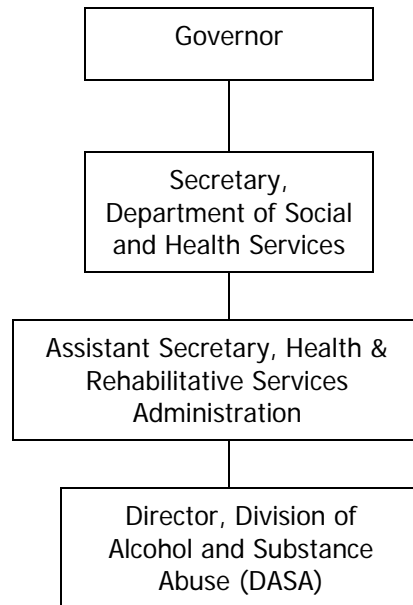
- Texas receives 10.8% more per capita from the SAPT block grant than the US average (2003).
- The rate of alcohol or illicit drug dependence or abuse in Texas is slightly less than the US average (2001).
- The rate of admissions to substance abuse treatment in Texas is substantially less than the US average (2002). Nevertheless, the SAMHSA-defined illicit drug treatment gap is 9% below the national average.

Texas Budget and Expenditure Data

- Information obtained from Texas indicates a 10.2% increase in substance abuse funding from the 2001 budget year to the 2003 State fiscal year, increasing from \$143.6 million to \$158.3 million.
- Substance abuse funds were \$9.25 per capita in State fiscal year 2003.
- Texas spends 37% of its funds for alcohol and drug abuse for primary prevention and HIV early intervention services.

WASHINGTON

Organizational Placement of AOD Agency



Organization of Services

- DASA contracts with 39 counties to deliver prevention and outpatient treatment services.
- DASA holds its own contracts directly with residential treatment providers and inpatient services, considered a statewide resource, as well as with Indian Tribes.
- Along with DASA, two other agencies have AOD prevention responsibility:
 - Community Trade and Economic Development (Byrne law enforcement funds, RSAT, Safe and Drug-Free Schools-governor's portion)
 - Superintendent of Public Instruction (Safe and Drug-Free Schools)

Core Strategic Initiative: Data and Information

- Data and information systems are the core strength of DASA and the foundation of its strategy to demonstrate impact of services, document

accountability and achieve credibility within its Department, with other agencies and within the State and U.S.

- The State utilizes a variety of mechanisms to measure substance abuse prevalence, trends, impact, prevention, treatment, and treatment outcomes. Among the data systems used are the following:
 - A reporting management information system required for treatment agencies providing public-sector contracted treatment services. Information is collected for each client to provide a baseline at admission to treatment and capturing changes to that baseline upon discharge.
 - A biannual survey of adolescent health behaviors conducted under the auspices of the Superintendent of Public Instruction.
 - A comprehensive hospital patient data abstract reporting system.
 - A variety of special studies and surveys conducted by DASA.
- Ongoing cost-offset studies produced by DASA have been a key strategy to document outcomes of substance abuse treatment in Washington State. Such offsets include avoiding crime and incarceration, limiting utilization of acute health care and psychiatric services, and reducing reliance on public assistance and getting people back to work, that is, employment.
- State legislators and other policy makers are more receptive to evidence based on Washington State data than on national or other State studies, so DASA's focus is on Washington State trends and reports.
- Annual DASA report - **Abuse Trends in Washington State** – a 325 page book - is an important accountability tool.
- DASA's MIS system, which tracks patients in the publicly funded system, is also used by the Department of Corrections to track individuals under its supervision who receive substance abuse treatment.
- DASA separated Policy and Planning from Research five years ago to facilitate focusing research on demonstrating the impact of AOD services.
 - Policy and Planning and legislative relations activities have 6 FTEs, who are responsible for Block Grant reports and similar activities
 - The research activity has 1 FTE plus 3 FTE's on "soft" (grant-funded) money

- The Director emphasized that stigma of substance abuse still extends to those who provide, manage and advocate for SA treatment. This stigma can only be addressed by being able to demonstrate the degree of effectiveness of SA treatment and its impact on other State systems and communities, using valid ongoing data collection and rigorous research techniques on topics of policymaking interest.

Sentencing Reform: A Significant Policy / Organizational Change in Previous Three Years

- Sentencing reform in Washington, enacted in 2002, reduced the length of sentences for heroin and cocaine possession or small-scale sales and provided that savings from reduced incarceration be used to fund drug treatment, including drug courts.
- This legislation was supported by DASA.
- The program was implemented despite a 10% DASA staff reduction in 2002.
- The initiative was supported by prosecutors and other components of the criminal justice system, including judges and the defense bar
- The program brought an infusion of funds to public substance abuse treatment, with an increase of about 4% annually.
- The client population for this initiative is primarily single men – not the population for which WA has developed the strongest evidence of the impact of AOD treatment through cost-offset studies.
- The initiative has significant accountability requirements and requires careful management.

Washington State “Drug Czar” Phased out in early 1990’s

Key AOD Issues in Washington State Today

- State Reorganization Plans

- Washington Governor Gary Locke, first elected in 1996, has announced that he will not seek re-election. A new Governor will be elected in November 2004 and may want to re-shape State government in order to address new priorities.
- Increase Penetration of Treatment
 - Develop an entitlement strategy through Medicaid for providing substance abuse treatment services to priority populations – pregnant women and SSI recipients.
- Evidence-based prevention
 - Increase the funding for State prevention activities that have strong scientific evidence of effectiveness.

Collaboration with other Entities

- Collaboration is considered necessary to accomplish the strategic objectives of the Division.
- It is expected that collaboration brings on workload. AOD staff are encouraged to “do the work” in collaborative efforts and allocate time accordingly. This strategy assures that DASA is able to incorporate its priorities and objectives when engaging in collaborative efforts.
- DASA staff is encouraged to collaborate with other public/State entities as well as private sector organizations, such as provider groups.

Access to Office of Governor and Legislature

- The DASA Director believes that substance abuse issues rarely rise to the top of DSHS priorities. DASA must take the lead in raising the visibility of SA issues.
- The stability of DASA’s leadership group and the strength of the DASA data system have facilitated productive connections with the Governor’s Office, other State/public agencies, and the Legislature.

- DASA staff have weekly contact with staff of the Governor’s Office and more frequent telephone calls.
- DASA has frequent contact with other agencies, including:
 - Key House legislator and staff;
 - Key Senate legislator and staff;
 - The Director of WA Association of Prosecuting Attorneys; and
 - The Director of the Department of Corrections.
- The frequency of meeting with external stakeholders is driven by policy and budget exigencies. The Governor’s Office has emerged as a key stakeholder, but two years ago legislators and legislative staff were key stakeholders.

Selected State Data from SAMHSA¹

STATE	2003 SAPT PER CAPITA BLOCK GRANT ALLOCATION ²	2002 - 2003 RATE OF ALCOHOL OR ILLICIT DRUG DEPENDENCE OR ABUSE ³	2002 - 2003 ILLICIT DRUG TREATMENT GAP ³	2002 PER 1000 SA TREATMENT ADMISSIONS ⁴	BLOCK GRANT LEVERAGE: SA ADMISSIONS PER 1000 BLOCK GRANT \$	RATIO OF ADMISSION RATE / DEPENDENCE RATE
UNITED STATES	\$7.04	9.22	2.66	8.1	1.15	0.88
WASHINGTON	\$7.13	9.48	3.08	10.6	1.49	1.12

1 The data used in this and other State tables do not constitute all SAMHSA state data, nor do they represent all of the data that states use in their operational analyses and planning efforts. These statistics should be interpreted with caution because there are a great variety of factors which affect their magnitude and implication.

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3 SAMHSA (OAS) State Estimates of Substance Abuse From the 2002 - 2003 National Household Survey on Drug Abuse

4 SAMHSA, Substance Abuse Treatment Admissions by State, 2002

- Washington receives slightly more per capita from the SAPT block grant than the US average (2003).
- The rate of alcohol or illicit drug dependence or abuse in Washington is 20% higher than the US average¹⁶.
- The rate of admissions to substance abuse treatment in Washington is about 31% higher than the US average¹⁷. Even so, the SAMHSA-defined illicit drug treatment gap is 19% above the national average¹⁸.

State Budget and Expenditure Data

- The Division of Alcohol and Substance Abuse had expenditures of \$93.4 million in State fiscal year 2003, or \$18.96 per capita. These figures include funds from Medicaid.
- State funds make up 60% of the DASA budget.

¹⁶ SAMHSA (OAS) State Estimates of Substance Abuse From the 2002 - 2003 National Household Survey on Substance Abuse

¹⁷ SAMHSA, Substance Abuse Treatment Admissions by State, 2002

¹⁸ SAMHSA (OAS) State Estimates of Substance Abuse From the 2002 - 2003 National Household Survey on Substance Abuse

TABLE IV

SUMMARY OF SELECTED STATE DATA FROM SAMHSA

STATE	2003 SAPT PER CAPITA BLOCK GRANT ALLOCATION ²	2002 - 2003 RATE OF ALCOHOL OR ILLICIT DRUG DEPENDENCE OR ABUSE ³	2002 - 2003 ILLICIT DRUG TREATMENT GAP ³	2002 PER 1000 SA TREATMENT ADMISSIONS ⁴	BLOCK GRANT LEVERAGE: SA ADMISSIONS PER 1000 BLOCK GRANT \$	RATIO OF ADMISSION RATE / DEPENDENCE RATE
UNITED STATES	\$7.04	9.22	2.66	8.1	1.15	0.88
CALIFORNIA	\$9.01	9.00	2.81	7.5	0.83	0.83
FLORIDA	\$6.83	8.80	2.83	6.3	0.92	0.72
GEORGIA	\$6.97	9.11	2.55	5.0	0.72	0.55
MAINE	\$6.04	8.81	2.84	10.9	1.80	1.23
MASSACHUSETTS	\$6.47	10.71	3.12	12.8	1.98	1.19
MICHIGAN	\$7.15	10.05	2.60	7.8	1.09	0.78
NEW YORK	\$7.41	8.88	2.74	20.0	2.70	2.25
NORTH CAROLINA	\$5.72	8.31	2.62	4.4	0.77	0.53
OHIO	\$7.22	9.56	2.61	4.9	0.67	0.51
OREGON	\$5.54	9.25	2.88	19.3	3.49	2.09
TEXAS	\$7.80	8.98	2.47	2.1	0.27	0.23
WASHINGTON	\$7.13	9.48	3.08	10.6	1.49	1.12

- 1 The data used in this and other State tables do not constitute all SAMHSA state data, nor do they represent all of the data that states use in their operational analyses and planning efforts. These statistics should be interpreted with caution because there are a great variety of factors which affect their magnitude and implication.
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- 3 SAMHSA (OAS) State Estimates of Substance Abuse From the 2002 - 2003 National Household Survey on Drug Abuse
- 4 SAMHSA, Substance Abuse Treatment Admissions by State, 2002

APPENDIX

DISCUSSION GUIDE AND STATE EXPENDITURE INFORMATION REQUEST

AOD ORGANIZATION STUDY

In this study, we are interested both in adults and children with AOD issues. Please address both of these populations in your responses to the questions on the following pages.

Proposed Informants for each State:

- SSA AOD Director
- SSA AOD Finance Chief
- SSA AOD Policy Chief or Department Staff Responsible for Legislative Issues
- Principal AOD Legislator; to be identified by AOD Director. This is the member of the State Legislature most responsible for AOD budget and policy issues. Although this individual may not be available during the timeframe for this initial study, we will attempt to obtain contact information for use in arranging a future interview.

These questions are intended to be asked either in person or over the telephone. Some questions will not apply to you or your organization. **Written responses are not requested.** We will request appropriate available documents and data in the course of our discussion.

INTERVIEW QUESTIONS

I. Position of SSA for AOD in State Organizational Structure

- A. To what State entity or official does SSA for AOD report directly? Is AOD a Cabinet level Department? Does AOD report to any of the following, and if so, please explain the relationship:
1. Governor
 2. Department of Human Services
 3. Department of Health
 4. Department of Mental Health
 5. Other
- B. Please provide an organizational chart showing the position and relationship of AOD, Mental Health and Health within the State structure.
- C. What changes in State organizational structure that affect AOD have taken place in each of the last three years?
1. 2001?
 2. 2002?
 3. 2003?
 4. 2004 to date?
- D. Who were the individuals most responsible for pushing any changes forward in each of the last three years? What are their backgrounds and titles, if relevant? Please explain the dynamics of any changes – proponents and their rationale; opponents and their rationale.

II. Organization of AOD Department

- A. Please provide an internal organizational chart for the AOD Department / Agency
- B. What are the most important changes in the internal organizational structure of the AOD Department / Agency that have occurred over the past three years?

III. Inter-Organizational Relationships

A. Relationship to Governor

1. How often does AOD Director meet with Governor?
 - Annually?
 - Semi-Annually?
 - Quarterly?
 - Monthly?
 - Other?
2. How often does AOD Director talk on telephone to the Governor or meet with Executive office senior staff?
 - Annually?
 - Semi-Annually?
 - Quarterly?
 - Monthly?
 - Other?

B. Relationship to Legislature

1. How often does Director of AOD meet with key legislator(s)?
 - Annually?
 - Semi-Annually?

- Quarterly?
 - Monthly?
 - Other?
2. How often does AOD Director meet with appropriations committee?
- Annually
 - Semi-Annually?
 - Quarterly?
 - Monthly?
 - Other?

C. Relationship to Department of Mental Health

1. How often does AOD Director meet with Director of Mental Health?
- Annually?
 - Semi-Annually?
 - Quarterly?
 - Monthly?
 - Other?
2. How often does AOD Director talk on telephone to the Director of Mental Health?
- Annually?
 - Semi-Annually?
 - Quarterly?
 - Monthly?
 - Other?

3. How many collaborative programs do the AOD Department and the Department of Mental Health have?
4. How many joint committees do the AOD Department and the Department of Mental Health have?

D. Relationship to the Executive Office of the Budget

1. With whom does the AOD Director interact on budget matters and decisions? If it is the State Budget Director, how often does AOD Director meet with Budget Director?
 - Annually?
 - Semi-Annually?
 - Quarterly?
 - Monthly?
 - Other?
2. How often does AOD Director talk on telephone to Budget Director?
 - Annually?
 - Semi-Annually?
 - Quarterly?
 - Monthly?
 - Other?

E. Other Relationships

1. What other collaborative relationships and programs does AOD have with other agencies / programs?
 - Social Services?
 - Criminal Justice / Corrections?
 - CDC?
 - Health?

IV. For States where there has been a change in the position of AOD in the State organizational structure:

A. Reasons for Change

1. What was the impetus for the change? Were there changes in each year from 2000-2004 or just this year?
2. Were external consultants involved in the change? Who were/are they?
3. Was there a single individual or interest group that was primarily responsible for the change?
4. Was information system consolidation a reason for the change?
5. Were State budget problems a reason for the change?
6. Were rising Medicaid costs a reason for the change?
7. Was change a result of a rethinking of the role of AOD services in the human services or health system?

B. Impact of the change in the position of AOD in the State organizational structure [fiscal (e.g., modification to reimbursement rates/contracts), programmatic (e.g., change in provider qualifications/expectations, or service delivery), or capacity (e.g., # of providers changed)]:

1. To what extent did the governance of the AOD department change as a result of restructuring?
 - How did mental health and AOD align potentially differing Federal and State statutory / regulatory authority?
2. What was the impact on AOD providers?
3. What was the impact on AOD programs?
4. Were any State-supported AOD programs opened or closed?
5. What was the impact on clients?
 - Men vs. Women?
 - Adults vs. Children

- Clients with Co-Occurring disorders?
 - Clients with primary AOD disorders?
6. What was the impact on AOD Department staff morale?
- Was there any impact on retention of senior civil service staff?
 - Were there voluntary or involuntary departures of key personnel? Is the Director of AOD a new staff member?
7. Was there any impact on the ability of the AOD department to comply with Federal regulations?
- Was there any impact on the ability of AOD to meet Federal MOE requirements? If so, how was this issue resolved?
8. Was there any impact on the relationships with and the access to key Legislators, the Governor and key members of the Executive department?
9. Was there any impact on inter-organizational relationships – the relationships of AOD to other agencies / departments?
- Was there any impact on the relationships between AOD and criminal justice, Medicaid, Public Welfare, or Mental Health?
10. Was there any impact on access to external resources?
- Consultants
 - Medical Experts
 - Other
11. Was there an impact on policy priorities?
- Within the AOD Department
 - Among HHS departments / agencies
12. Was there any impact on the quantity of services provided or offered to public program recipients?

13. Was there any impact on the quality of services provided or offered to public program recipients?
14. Were there any savings attributable to the organizational position change?
15. What was the impact of the change on outcomes?
16. What were the goals of the change and have they been met?
17. Was there an impact on the ability to access Federal resources, including the SAPT block grant?
18. Was there an impact on the ability to access State resources?
19. Was there an impact on the relationships with and the amount of collaboration with other State departments / agencies?
20. What impact did the change have on the relationship of the AOD Department with the MH Department?

V. Structure of Treatment System

A. Reliance on Methadone

1. What proportion of AOD expenditures are for medication-assisted treatment, including methadone treatment? What proportion for methadone treatment?
2. What is the distribution of public vs. private OTPs and treatment slots in your State?

B. County and local treatment

1. What is the role of county and local political structures in your treatment system? Do State and Federal AOD funds flow to county and local political entities?

State Expenditure Information Request

A. Please provide the total AOD expenditures for all departments of State and county / local government combined for the past three years, including expenditures from funds received from the Federal government. If possible, include expenditures from other departments, such as Social Services, Health, Mental Health, Corrections / Criminal Justice, and Public Welfare and Medicaid. Use the following categories of AOD spending:

1. Substance Abuse Treatment and Rehabilitation
2. Alcohol Treatment and Rehabilitation
3. Drug Treatment and Rehabilitation
 - Detoxification (24 Hour Care)
 - Residential (Hospital Inpatient, Short Term, Long Term)
 - Ambulatory / Outpatient
 - Methadone
 - Non-Methadone
 - IOP
 - Detox
4. Primary Prevention
5. TB Services
6. HIV Early Intervention Services
7. Administration (Excluding Program / Provider)

B. Please provide the total expenditures for the following State departments for the past three years, including expenditures from funds received from the Federal government. Please identify and specify AOD block grant funds.

1. AOD
2. Mental Health
3. Health