

# State Substance Abuse Treatment Efforts

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Evaluation Report  
December 2005

Office of Performance Evaluations  
Idaho Legislature



Report 05-04

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Maxine T. Bell  
Debbie S. Field  
Donna Boe

Rakesh Mohan, Director  
Office of Performance Evaluations

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Donna H. Boe

December 9, 2005

Joint Legislative Oversight Committee  
Idaho Legislature

Last March, you directed us to review state programs addressing substance abuse. You were concerned about the social and financial impact of substance abuse on the state.

We conclude in this report that state efforts to address substance abuse are fragmented. Multiple state entities are involved in providing substance abuse related services, but there is no formal mechanism to coordinate and guide those efforts. As a result, basic information about statewide treatment needs, capacity, services, and results is not available.

Our report recommends establishing an independent commission to oversee programs and activities of various state entities working to address substance abuse problems. The report offers eight additional recommendations to improve the management and quality of treatment services.

We appreciate the cooperation and assistance we received from the state agencies and the Judicial Branch in conducting this study. We also appreciate the input we received from the Office of the Governor, particularly First Lady Patricia Kempthorne.

Sincerely,

A handwritten signature in black ink that reads "Rakesh Mohan".

Rakesh Mohan

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## Executive Summary

# State Substance Abuse Treatment Efforts

*State efforts to address substance abuse are fragmented, in spite of Idaho Code requiring a comprehensive and integrated system. This fragmentation has contributed to the absence of statewide information necessary for state officials to answer the following basic questions for policymakers:*

- 1. What are the statewide needs for services to address substance abuse?*
- 2. What is the state's capacity to meet those needs?*
- 3. What types of services are being provided, to which groups of people, and to how many people?*
- 4. Which programs are working and which are not?*
- 5. Are state efforts making a difference?*

*This lack of statewide information is exacerbated by generally unreliable information about treatment services within individual agencies and inadequate processes to ensure the quality of those services. The Department of Health and Welfare is responsible for spending the largest portion of the state's funds for providing substance abuse treatment and prevention services. This report discusses the need for an independent commission responsible for overseeing state efforts to address substance abuse.*

## Multiple Agencies Address Substance Abuse

In Idaho, four state agencies provide treatment or prevention services to address substance abuse:

- Department of Health and Welfare
- Department of Correction
- Department of Juvenile Corrections
- Department of Education

Although not covered in this study, the state incurs other costs related to substance abuse in areas such as law enforcement, incarceration, and court activities.

For example, law enforcement activities by the Idaho State Police that are linked to substance abuse are estimated to cost about \$12 million annually, while the Idaho Transportation Department spends about \$500,000 of mostly federal funds to address impaired driving.

In addition, the Judicial Branch oversees drug court programs, which include a treatment component.

Our analysis of expenditure information (which necessitated some use of estimates) shows these agencies and the Judicial Branch collectively spent about \$27.5 million in fiscal year 2005 to address substance abuse.

## **Idaho Does Not Have a Coordinated System**

Idaho's Alcoholism and Intoxication Treatment Act establishes a Commission on Alcohol-Drug Abuse under the administration of the Department of Health and Welfare to coordinate the activities of multiple state agencies and develop a comprehensive approach for addressing substance abuse. The commission is charged with the following responsibilities:

- Planning and coordinating interagency substance abuse prevention and treatment efforts
- Providing fiscal oversight for the use of substance abuse funds
- Suggesting solutions and alternatives
- Reporting annually to the Legislature and the Governor

As part of an overall effort to reduce state costs, the Governor recommended cuts in 1995 that included elimination of funding for the Commission on Alcohol-Drug Abuse from Health and Welfare's budget. The Legislature accepted the Governor's recommendation, and the department disbanded the commission. Subsequently, Health and Welfare convened its own task force to determine a new structure for addressing substance abuse. This current structure focuses on community involvement, but does not ensure the involvement of pertinent state agencies to promote a coordinated statewide system of service delivery.

In recent years, policymakers have sought to better coordinate state treatment services, with limited success. Efforts include the Governor's Interagency Task Force and the Special Legislative Oversight Committee. The recently formed Access to Recovery Alliance is made up of a broad selection of stakeholders. The focus of the alliance, however, is limited to providing guidance on the use of Access to Recovery grant funds, and does not address the other substance abuse funds spent annually on treatment in Idaho.

Without a coordinated approach that includes participation from many state entities, the state does not have a comprehensive statewide plan, mechanisms to communicate best practices, strong fiscal oversight, or a readily available assessment of state efforts to address substance abuse.

## **Management of Treatment Programs Needs Improvement**

The Department of Health and Welfare is responsible for administering the federal Substance Abuse Prevention and Treatment Block Grant, and a three-year \$22 million Access to Recovery grant, which was recently awarded to the state. Health and Welfare has the primary role for ensuring the appropriate and effective use of the largest proportion of federal and state funds for substance abuse treatment in Idaho. Its responsibilities include monitoring a management services contract and approving individual treatment providers.

Our review of Health and Welfare's management shows that it has not:

- Adequately monitored the performance measures contained in the contract with the management services contractor
- Conducted independent audits of treatment providers as stipulated in the contract
- Adequately ensured that clients are treated only by state-approved providers

In addition, Health and Welfare's weak fiscal oversight resulted in a shortage of funds in fiscal year 2005. The federal agency that grants treatment funds is looking into the appropriateness of subsequent steps by the department to temporarily shift funds.

## **Treatment Data Is Not Reliable**

The Department of Health and Welfare has reported inconsistent statistics on treatment services. Different data sources—including a department annual publication, the department's data system, and the management services contractor's data system—contain discrepant information about the level of services provided.

Furthermore, information the department has received and entered into its data system has not been complete. Instead, the department has solely relied on reports from the management services contractor, which limits the department's ability to independently monitor the contractor.

The Department of Correction, the Department of Juvenile Corrections, and the Judicial Branch also have data weaknesses, including incomplete and unverified information about the participants in substance abuse programs. These weaknesses hinder an overall understanding of substance abuse related services provided through the state.

## **Better Processes Are Needed to Ensure Treatment Quality**

Our review of information available for a randomly selected sample of substance abuse treatment clients showed that fewer than a quarter of the clients beginning treatment through Health and Welfare’s program successfully completed treatment. This percentage is lower than the national rate of 39 percent. In addition, almost half of Idaho clients entering treatment chose to drop out, which is about 11 percent higher than that national rate.

Our review identified some issues likely to impact treatment quality:

- State funded substance abuse treatment providers in Idaho are not required to be certified, credentialed, or licensed as alcohol/drug counselors
- Health and Welfare has not established a threshold for acceptable or unacceptable levels of noncompliance with provider approval requirements
- In the most recent audit of providers’ case files, conducted by the management services contractor, 24 of 56 facilities scored less than 70 percent.

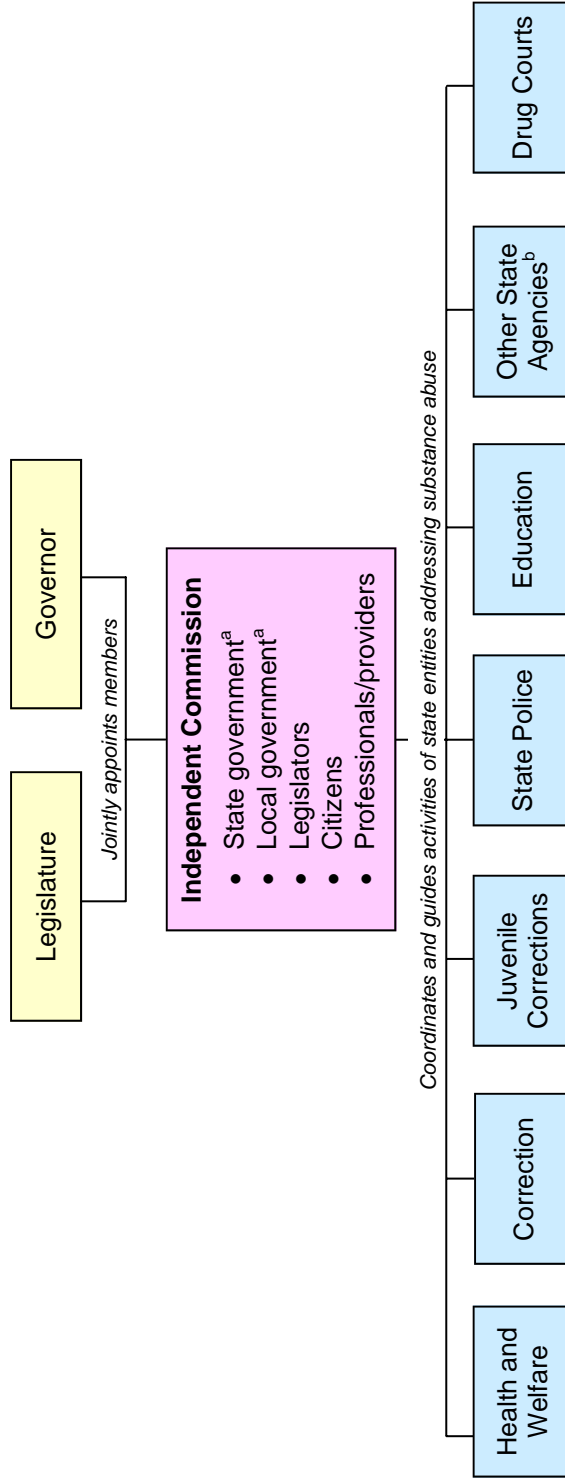
Neither the Department of Correction, the Department of Juvenile Corrections, nor the Judicial Branch have complete information about the outcomes of treatment services. State outcome information is limited as a result of entities not collecting data about treatment participants, only collecting data for a few programs, or relying on estimates.

## **Conclusion**

State efforts to address substance abuse in Idaho are fragmented. More strategic and concerted efforts are needed to effectively address substance abuse that includes creating a statewide system that can provide answers to questions about the need, capacity, and quality of services provided. An independent commission, jointly appointed by the Legislature and the Governor, would be the first step. The commission would be responsible for coordinating the use of all state and federal substance abuse funds by individual state agencies and the Judicial Branch. Exhibit A outlines the key components of the proposed commission.

The commission should include directors of state agencies involved with substance abuse efforts—Health and Welfare, Correction, Juvenile Corrections, Law Enforcement, and Education—as well as representation from the Judicial Branch. The commission should also include members of the Legislature, the professional community, relevant local government associations, and the public.

**Exhibit A: Proposed Structure for an Independent Commission to Oversee State Efforts to Address Substance Abuse**



<sup>a</sup> Representatives of entities receiving public funds to address substance abuse, including the Judicial Branch.

<sup>b</sup> Other state agencies receiving public funds to address substance abuse

Source: Office of Performance Evaluations' analysis of the state of Idaho's substance abuse treatment program.

The commission would be responsible for establishing a statewide, coordinated system that:

1. Assesses the statewide needs for services to address substance abuse
2. Determines the state's (and individual agencies') capacity to meet those needs
3. Plans and ensures needed services are delivered effectively and efficiently
4. Monitors the results and ensures the collection of reliable data
5. Evaluates the outcomes and reports annually to the Legislature and the Governor

If the commission carries out these responsibilities, the state would be able to answer the following basic questions:

1. What are the statewide needs for services to address substance abuse?
2. What is the state's capacity to meet those needs?
3. What types of services are being provided, to which group of people, and to how many people?
4. Which programs are working and which are not?
5. Are state efforts making a difference?

Appendix C includes issues found during the evaluation that would be appropriate for this commission to address.

## **Recommendations**

In addition to a recommendation for creating an independent commission, this report contains recommendations for improving management controls, treatment data, and quality of substance abuse treatment services. The recommendations are listed by chapter where additional details are discussed.

### ***Chapter 3***

- 3.1. To coordinate and guide activities of state entities addressing substance abuse, the Legislature should consider:
  - a. Establishing an independent commission, jointly appointed by the Legislature and the Governor, to include directors of state agencies involved with efforts to address substance abuse—Health and Welfare, Correction, Juvenile Corrections, Law Enforcement, and Education—as well as representation from the Judiciary. The commission should also include members of the Legislature, professional community, relevant local government associations, and the public.

- b. Addressing those parts of existing statute requiring a commission on alcohol and drug abuse to be consistent with step A of this recommendation.

#### **Chapter 4**

4.1. To ensure the management services contractor is meeting performance requirements, and that adequate services are administered by approved treatment providers, the Department of Health and Welfare should:

- a. Monitor its management services contract by periodically reviewing the contractor's performance against the measures identified in the contract.
- b. Conduct independent audits of a sample of treatment providers at appropriate intervals.
- c. Notify the management services contractor of current provider approvals and expirations on a *monthly basis*, and verify the use of approved providers during its independent auditing of the contractor.

4.2. The Department of Health and Welfare should strengthen its fiscal management of the program by:

- a. Ensuring that program staff have the necessary fiscal training and information to adequately monitor and understand the program's financial situation.
- b. Requiring contract language in the management services contract that limits the length of time providers have to submit billings to the contractor.

4.3. The Department of Health and Welfare should work with the Substance Abuse and Mental Health Services Administration of the US Department of Health and Human Services to ensure substance abuse services are provided in a manner consistent with the grant requirements and intent.

#### **Chapter 5**

5.1. To have necessary data for managing substance abuse programs, the Department of Health and Welfare, the Department of Correction, the Department of Juvenile Corrections, and the Judicial Branch should work individually, and collectively with relevant entities, to ensure the collection and analysis of the following information about their programs:

- a. Individuals served in each type of program and waiting for services.
- b. Individuals not served, or not provided the appropriate type of treatment.

- c. Completion, dropout, and relapse rates, overall and by provider.
  - d. Average length of stay in each type of program, overall and by provider.
- 5.2. To ensure that client data is complete and accurate, including capacity information, the Department of Health and Welfare should work with the management services contractor to:
- a. Accurately transfer data from the contractor to Health and Welfare's independent data system, and use the information to verify contractor performance.
  - b. Negotiate a change to the management services contract that would require the contractor to routinely (every 30–60 days) require providers to indicate which clients are actively participating in treatment and which have completed or discontinued treatment.
  - c. Complete the process of requesting capacity information from providers in the state network, and comply with the federal regulation to track facilities *as and when* they reach 90 percent capacity.

### **Chapter 6**

- 6.1. To ensure approved and qualified treatment providers are delivering services, the Department of Health and Welfare should:
- a. Develop criteria for the approval process of providers offering treatment to adults to include a more detailed description of levels of compliance that constitute approval, provisional approval, and failure to be approved.
  - b. Make recommendations to germane legislative committees on rule or statutory changes to strengthen treatment provider credentialing requirements for the statewide system in coordination with the proposed substance abuse commission.
- 6.2. Using Government Performance and Results Act interviews and other information, the Department of Health and Welfare should develop a plan to increase client retention in treatment.
- 6.3. The Department of Health and Welfare, the Department of Correction, the Department of Juvenile Corrections, and Judicial Branch should continue or begin to take measurable steps to gather, verify, and publish relevant information on the effectiveness of substance abuse programs.

## **Agency Responses**

We received written responses to this report from the Department of Health and Welfare, the Department of Correction, the Department of Juvenile Corrections, the Department of Education, the Idaho State Police, and the Idaho Supreme Court. We also received a response from the Office of the Governor. Those responses are included at the end of this report.

## **Acknowledgements**

We appreciate the assistance we received from the Department of Health and Welfare and its management services contractor, Business Psychology Associates, the Department of Correction, the Department of Juvenile Corrections, the Department of Education, the Idaho State Police, the Idaho Transportation Department, and the Idaho Supreme Court. We also appreciate the input received from Budget and Policy Analysis, Legislative Audits, the Office of the Governor, and First Lady Patricia Kempthorne.

Chris Shoop (project lead), AJ Burns, and Rachel Johnstone of the Office of Performance Evaluations conducted the study. Courtney Haines, an intern from Boise State University, assisted with research. Paul Headlee and Margaret Campbell performed the quality control and desktop publishing, respectively.

Additional assistance was provided by three consultants:

- Tedd McDonald, Ph.D., Associate Professor of Psychology, Boise State University
- Mary Pritchard, Ph.D., Director of Health Psychology Division, Boise State University
- Bob Thomas, Robert C. Thomas & Associates. Mr. Thomas is also Principal Management Auditor at the King County Auditor's Office in Seattle, Washington



# Chapter 1

## Introduction

*Substance abuse has devastating consequences for individuals, families, and society at large. It places a high demand on resources in many areas of state government. Lawmakers requested a study of state substance abuse treatment efforts to gain an understanding of services available and the costs of providing those services.*

### Legislative Interest

In March 2005, the Joint Legislative Oversight Committee directed the Office of Performance Evaluations to review state efforts to address substance abuse. The Oversight Committee assigned this project because lawmakers expressed interest in understanding:

- State costs of services to address substance abuse
- Efforts by state agencies to provide substance abuse treatment
- Efforts to implement services funded under the Access to Recovery (ATR) program, a federal grant

The scope of this study was developed after receiving input from individual legislators, and staff from the legislative Budget and Policy Analysis, the Office of the Governor, and the Division of Financial Management. This report addresses the following questions:

- Which state agencies provide substance abuse treatment and/or prevention services? What are the agency revenues and expenditures for these efforts?
- What substance abuse treatment options are currently available to Idaho citizens? Who is eligible for treatment programs offered through the state?
- What steps have been taken to oversee and coordinate agency efforts to address substance abuse? How effective have those efforts been?
- How well does the state implement its substance abuse treatment services? Are state programs consistent with state and federal

requirements and guidance? What steps have been taken to implement the Access to Recovery grant program?

- What information exists on the effectiveness of treatment services offered throughout the state?

## **Methodology**

To determine which state entities were pertinent to the study, we spoke with individual legislators, and staff from legislative Budget and Policy Analysis, the Office of the Governor, and various state departments. We reviewed applicable statutes and administrative rules, and examined the work of state agencies, drug courts, and various committees and task forces that have addressed substance abuse.

The principal focus of this report is substance abuse treatment services provided through state entities. The Department of Health and Welfare is designated as the State Substance Abuse Authority and is responsible for most of the state funded treatment services; therefore, we focused a large part of our review on analyzing its operations. Our review of Health and Welfare's substance abuse program included the following:

- Interviewed department officials, substance abuse program staff, and regional stakeholders
- Met with staff in Health and Welfare's other programs—Children's and Adult Mental Health, Child Protection, and Temporary Assistance for Families in Idaho
- Attended meetings of the Access to Recovery grant program and Substance Abuse Prevention and Treatment Block Grant program
- Reviewed applications, award documents, and other information pertinent to grant requirements
- Interviewed staff of the management services contractor used by Health and Welfare to provide treatment services, and reviewed the requirements of the corresponding contracts
- Analyzed general data about individuals who sought and received treatment services
- Observed the screening process of potential treatment clients by the management services contractor
- Reviewed information contained in the department's Financial Information System with Cost Allocation (FISCAL)
- Conducted site visits of several substance abuse treatment facilities

We spoke with officials from the Substance Abuse and Mental Health Services Administration, which is part of the US Department of Health and Human Services, to obtain clarification on federal grant requirements. We also attended the closing conference for the federal review of the Department of Health and Welfare's Access to Recovery grant program.

We surveyed all 117 voting members of the Regional Substance Abuse Authorities to capture their perceptions about the accessibility of state treatment services to certain populations, the availability of particular treatment options, and the delivery of services through state programs. The response rate was 56 percent, and a summary of responses is provided in appendix A.

We collected information from hospital and county officials in the state through questionnaires regarding the impact of treating indigent substance abusers. We also contacted all other states and the District of Columbia to determine the extent that states require substance abuse treatment providers to meet licensing and certification requirements.

In addition, we spoke with and obtained information from the following organizations:

- Idaho Hospital Association
- Idaho Association of Counties
- Association of Idaho Cities
- Idaho Catastrophic Health Care Cost Program
- Idaho Board for Alcohol/Drug Counselor Certification, Inc.
- Southworth Associates, LLC
- Treasure Valley Narcotics Anonymous
- Road to Recovery, Inc.
- Supportive Housing and Innovative Partnerships, Inc.
- Nimiipuu Health, Drug and Alcohol Program
- US Department of Veterans Affairs, Boise Veterans Affairs Medical Center

This evaluation also included a review of literature published by the following national organizations: Substance Abuse and Mental Health Services Administration, the National Institute for Drug Abuse, and the National Association of State Alcohol and Drug Abuse Directors.

## Report Organization

**Chapter 2** is an overview of state agencies and drug courts that provide services to address substance abuse. It includes a summary of expenditures relating to substance abuse treatment and prevention activities, information about treatment services offered, and eligibility requirements for citizens to receive treatment.

**Chapter 3** discusses the state's system for overseeing and coordinating activities to address substance abuse.

**Chapter 4** examines the Department of Health and Welfare's management of its substance abuse treatment program.

**Chapter 5** discusses the types and quality of treatment data available.

**Chapter 6** examines treatment outcomes and processes in place to ensure that adequate quality of treatment services are provided.

**Appendix A** summarizes the survey responses of voting members of the Regional Substance Abuse Authorities.

**Appendix B** provides profile information of individuals who requested treatment services through the Department of Health and Welfare in fiscal years 2004 and 2005.

**Appendix C** lists issues that should be addressed by the recommended independent commission on substance abuse.

**Appendix D** summarizes available information about the number of individuals receiving substance abuse treatment through the state's correctional agencies, as well as those participating in drug courts.

**Appendix E** lists the types of treatment services provided through the Department of Health and Welfare, and the number of individuals placed on a waiting list for services during fiscal years 2004 and 2005.

## Glossary

Assessment	Process to develop an individualized treatment plan by evaluating physical, psychological, and social status; support systems and resources; and contributing environmental forces.
Co-occurring disorders	The occurrence of both mental and substance abuse disorders, <i>formerly</i> known as dual diagnosis.
Halfway housing	Combination of housing and non-intensive treatment, addressing social and work reintegration; typically associated with the criminal justice system.
High-intensity residential treatment	Structured treatment (no fewer than 36 hours/week) with living accommodations for individuals with a significant lack of personal resources or ability to maintain sobriety.
Intensive outpatient treatment	Educational classes and individual/group counseling, 9 to 19 hours/week for an adult (6 to 19 hours for an adolescent). This is equivalent to intermediate treatment, as specified in Idaho Code § 39-204(2)(c).
Medical detoxification	Systematic service designed to treat the acute physiological effects of substance withdrawal, delivered under the care of a physician.
Outpatient treatment	Educational classes and individual/group counseling up to 8 hours/week for an adult (up to 5 hours for an adolescent).
Relapse prevention	Group addiction treatment focusing on behavioral self-control; typically associated with the criminal justice system.
Screening	Pre-admission process to determine financial and clinical eligibility.
Social detoxification	Community setting that facilitates substance withdrawal. Clients with severe symptoms are transported to external medical facilities.
Therapeutic Community	Treatment targeting offenders with chronic criminal and substance abuse histories and using the concept of community through peer influence and group sessions in a correctional setting.
Transitional housing	Combination of housing and non-intensive treatment for mothers and their children, addressing social and work reintegration, and supported by daycare, case management, and transportation services.

Source: Office of Performance Evaluations' analysis of Idaho Code, Idaho Administrative Rule, and information from the American Society of Addiction Medicine and the National Institute on Drug Abuse.



## Chapter 2

# Overview of State Funded Substance Abuse Treatment and Drug Courts

*In fiscal year 2005, four state agencies and the Judicial Branch spent \$27.5 million of state and federal funds on programs to address substance abuse through prevention and treatment services. Idaho Code charges the Department of Health and Welfare to function as the State Substance Abuse Authority, and it receives the largest share of funds used to provide these services. Therefore, this report primarily focuses on its programs and services. Health and Welfare is responsible for administering the federal Substance Abuse Prevention and Treatment Block Grant, and a three-year \$22.8 million Access to Recovery grant that was recently awarded to the state.*

### Cost of State Efforts to Address Substance Abuse

In Idaho, four state agencies provide treatment or prevention services to address substance abuse:

- Department of Health and Welfare
- Department of Correction
- Department of Juvenile Corrections
- Department of Education

In addition, the Judicial Branch oversees drug court programs that include a treatment component.

Substance abuse services are funded by a combination of federal grants, state dedicated funds, and state general funds. Exhibit 2.1 shows the state spent \$27.5 million—61 percent from state funds and 39 percent from federal sources, with more than half of those funds going to the Department of Health and Welfare—to address substance abuse through treatment and prevention efforts in fiscal year 2005.<sup>1</sup>

Although not covered in this study, the state incurs other costs related to substance abuse in areas such as law enforcement, incarceration, and court activities.

For example, law enforcement activities by the Idaho State Police that are linked to substance abuse are estimated to cost about \$12 million annually, while the Idaho Transportation Department spends about \$500,000 of mostly federal funds to address impaired driving.

<sup>1</sup> Because the financial systems of some state entities are not set up to capture the specific costs of activities to address substance abuse, estimates of costs were required in certain instances, and in other instances some cost information could not be determined.

### Exhibit 2.1: Statewide Estimated Expenditures to Address Substance Abuse, Fiscal Year 2005

<u>Treatment and/or Prevention</u>	<u>State General</u>	<u>State Dedicated</u>	<u>Federal</u>	<u>Total</u>
Department of Health and Welfare <sup>a</sup>	\$4,069,494	\$2,046,304	\$ 7,816,537 <sup>b</sup>	\$13,952,937 <sup>c</sup>
Department of Correction	2,004,127	47,895	104,141	2,156,163
Department of Juvenile Corrections	3,322,736	16,121	145,059	3,483,916
Department of Education	<u>0</u>	<u>4,235,713</u>	<u>2,042,587</u>	<u>6,278,300</u>
Subtotal	\$9,396,357	\$6,346,033	\$10,108,324	\$25,871,316
<u>Drug Courts</u>				
Judicial Branch	<u>75,197</u>	<u>872,961</u>	<u>703,966</u>	<u>1,652,124</u>
Total	\$9,471,554	\$7,218,994	\$10,812,290	\$27,523,440

<sup>a</sup> Amount includes expenditures for drug court and correctional treatment.

<sup>b</sup> Amount includes some Access to Recovery (ATR) grant funds.

<sup>c</sup> Amount includes \$20,602 miscellaneous fund sources.

Source: Office of Performance Evaluations' analysis of data from Department of Health and Welfare, the Department of Correction, the Department of Juvenile Corrections, the Department of Education, and the Judicial Branch.

The primary focus of this report is on treatment services provided in the state. In addition to Health and Welfare, the Departments of Correction and Juvenile Corrections provide treatment services.<sup>2</sup> This review also addresses drug courts as a substance abuse program.<sup>3</sup> The following is an overview of state efforts.

## Department of Health and Welfare

The Alcoholism and Intoxication Treatment Act in Idaho Code designates the Department of Health and Welfare as the State Substance Abuse Authority. In the act, the Legislature declared its intent that state agencies address prevention, treatment, and rehabilitation for alcoholics, intoxicated persons, and drug addicts "effectively and economically." To carry out this charge, statutes establish the Commission on Alcohol-Drug Abuse under the administrative direction of Health and Welfare. This commission is to establish "a comprehensive and coordinated program," and be made up of members appointed by the Governor.

<sup>2</sup> The State Department of Education provides prevention services only, and is therefore not a focus of this report.

<sup>3</sup> Drug courts mandate substance abuse treatment and monitor offender compliance.

Idaho Code further requires Health and Welfare to “establish a comprehensive and coordinated program for treatment of alcoholics, intoxicated persons and drug addicts.”<sup>4</sup>

Health and Welfare operates the substance abuse treatment program through a combination of program staff and a contractor. The substance abuse program has 7 full-time staff, 6 of whom have at least some responsibility for overseeing the implementation of substance abuse treatment activities. Treatment services are managed through a management services contractor, Business Psychology Associates. Services are provided to clients through a network of treatment facilities throughout the state, as illustrated in exhibit 2.2.

### **Treatment Services**

Working through the management services contractor and its corresponding network of treatment providers, Health and Welfare’s substance abuse program offers the following substance abuse treatment services:

- Social (or community) detoxification
- High-intensity residential treatment (adult and adolescent)
- Outpatient treatment
- Intensive outpatient treatment
- Halfway and transitional housing

### **Treatment Eligibility**

Idaho Code charges Health and Welfare with providing treatment that includes a “continuum” of treatment services to Idaho citizens.<sup>5</sup> Health and Welfare’s administrative rules provide substance abuse treatment (as long as facilities and counselors are available) for individuals whose income is less than 175 percent of the federal poverty guidelines, among other requirements.<sup>6</sup>

Health and Welfare policies for screening adolescent applications do not allow children under the age of 16 to access treatment unless the application is *initiated* and completed by a parent or guardian (adolescents 16 years old or older may apply for services independent of parental consent).<sup>7</sup> Appendix B provides information about individuals requesting substance abuse treatment services through Health and Welfare in fiscal years 2004 and 2005.

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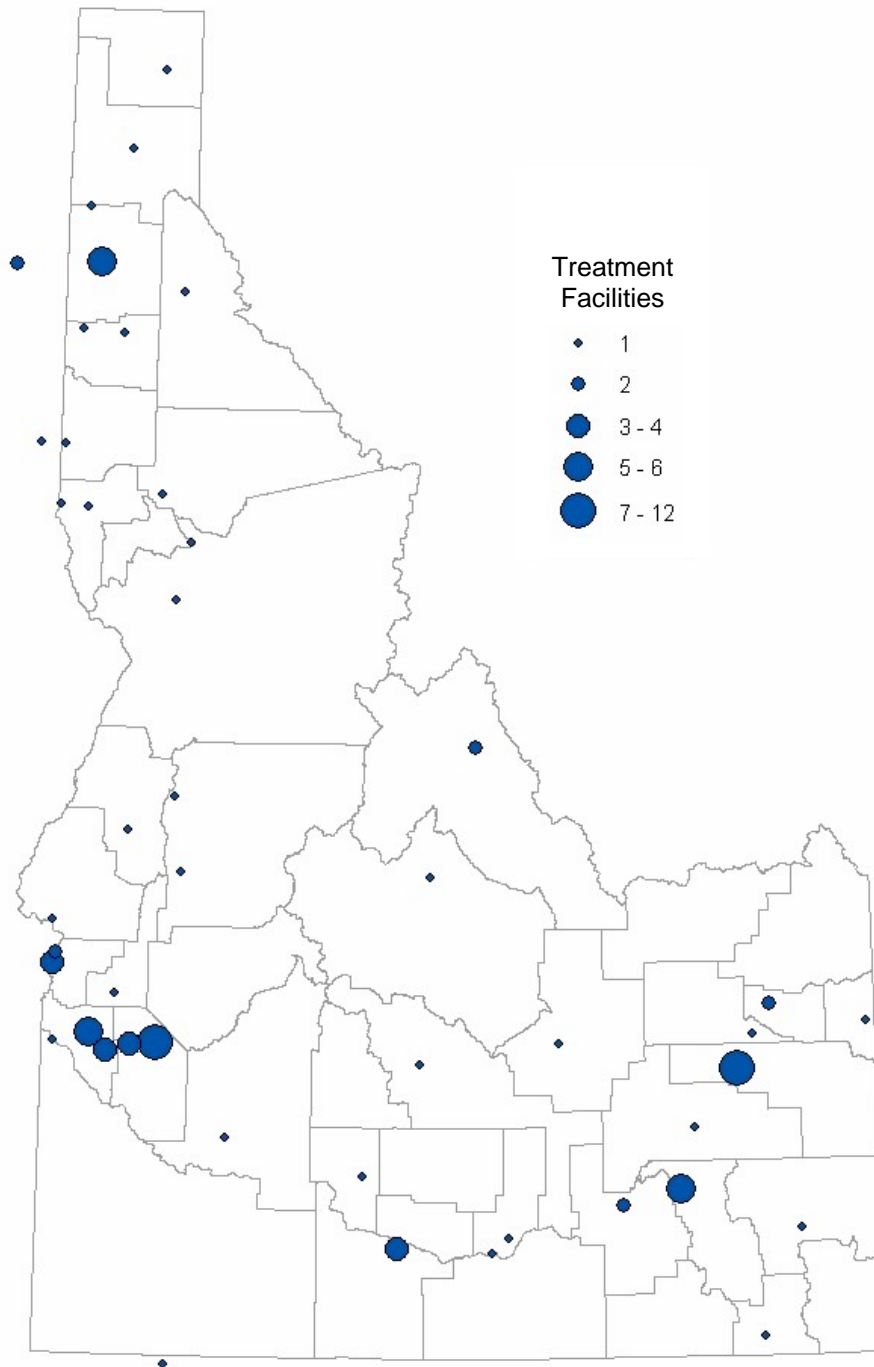
<sup>4</sup> IDAHO CODE § 39-301–304.

<sup>5</sup> IDAHO CODE §§ 39-306(5), 39-304. Health and Welfare is responsible for providing a treatment program that includes emergency detoxification and related medical treatment, inpatient treatment, intermediate treatment, outpatient treatment, and community detoxification services.

<sup>6</sup> IDAPA 16.06.03.071–073. The percent is adjusted for household size. To be eligible, a family of four in Idaho can earn no more than \$33,863 annually. For a single person, the maximum is \$16,748.

<sup>7</sup> IDAHO CODE § 39-307 states a minor may represent himself when applying for treatment, which is inconsistent with Health and Welfare policies.

### Exhibit 2.2: Substance Abuse Treatment Facilities Serving Health and Welfare Clients, July 2005



Note: As indicated, some state funded services are provided at out-of-state facilities.

Source: Office of Performance Evaluations' analysis of data from the Department of Health and Welfare, Division of Family and Community Services, substance abuse program management services contractor.

Health and Welfare is charged with collecting partial payment from clients for treatment services.<sup>8</sup> Only appropriately-screened clients participating in the Temporary Assistance for Families in Idaho (TAFI) program are exempt from liability for the cost of treatment.<sup>9</sup> For all participants in the substance abuse program, continued eligibility is dependent on the “ability and willingness” of both the program and the applicant, implying that without availability, there is no eligibility.<sup>10</sup>

**Temporary Assistance for Families in Idaho.** The Legislature amended laws governing TAFI to provide for substance abuse screening, testing, and treatment to “enhance the employability” of participants. Idaho Code and administrative rules stipulate that community-based, gender-specific treatment, as well as supportive transportation and child care be provided to recipients in need.<sup>11</sup>

Substance abuse screening is integral to the TAFI application process. Screenings are administrated by Enhanced Work Services contractors. Those TAFI participants scoring high are referred for formal assessment and treatment through the Health and Welfare substance abuse program.<sup>12</sup>

**Adult Mental Health Program.** Adults with a primary mental health disorder that has contributed to a substance abuse issue (self-medicated mental illness) might receive substance abuse treatment through Health and Welfare’s Adult Mental Health Program. Each region may have separate or per case arrangements for community services for persons with co-occurring mental health and substance abuse disorders. Regions 2, 3, and 7 offer such services only to persons with serious and persistent illness, whereas region 5 provides services to a wider population.

Although exact participation information is not tracked, the state hospitals also address co-occurring disorders in varied degrees:

- The State Hospital North (Orofino) has staff, certified by the Idaho Board of Alcohol-Drug Counselor Certification, who provide a variety of substance abuse treatments and education. In 2004, Health and Welfare reported to the federal government that although its voluntary chemical dependency program was eliminated in 1998 to accommodate increasing involuntary commitments under Idaho Code § 66-329, the hospital continued to provide substance abuse treatment to approximately 65 percent of all patients at the hospital.

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<sup>8</sup> IDAPA 16.06.03.074 specifies the proportion of treatment fees for which a client is liable is determined by a sliding scale established in department rules that ranges incrementally from 5 to 70 percent, according to income (see also IDAPA 16.06.03.033.03).

<sup>9</sup> IDAHO CODE § 56-209I.

<sup>10</sup> IDAHO CODE §§ 39-306–307, IDAPA 16.06.03.072.

<sup>11</sup> IDAHO CODE § 56-209i, -209I, IDAPA 16.06.08.124.

<sup>12</sup> IDAPA 16.03.08.119.

- Activities at the State Hospital South (Blackfoot) are contracted to a private provider and limited to education, evaluation, and referral services for patients with co-occurring disorders. According to hospital estimates, these services affected approximately 60 percent of all patients in calendar year 2004.

**Children’s Mental Health Program.** Under the Health and Welfare Children’s Mental Health Program, children with a primary mental health diagnosis or severe emotional disturbance and a co-occurring substance abuse problem may be referred for treatment to the Substance Abuse Program. Eligibility for these services is determined according to parental income.

**Medicaid.** Children may receive Medicaid-paid psychosocial rehabilitative services that may address a substance abuse disorder if the child also suffers a severe and primary mental disorder.<sup>13</sup> For adults, state rules do not allow direct coverage for substance abuse treatment under Idaho Medicaid.<sup>14</sup> At the same time, Health and Welfare deems adult Medicaid recipients to be financially ineligible for substance abuse treatment through the substance abuse program under the Division of Family and Community Services. In essence, there are no opportunities for state funded direct substance abuse treatment for adult Medicaid recipients. In our review of the records of the Substance Abuse Program management services contractor for fiscal year 2005, we found 100 adult Medicaid recipients who were refused treatment through Health and Welfare’s substance abuse program. This conflict could be addressed by an independent commission on substance abuse, as discussed in appendix C.

**Mental Health Parity.** According to the National Mental Health Association in May 2005, Idaho and Wyoming are the only states without laws or legislative mandates directing the insurance industry to provide coverage for mental health or affiliated substance abuse disorders that is equitable to coverage for “medical and surgical” benefits. Idaho’s Managed Care Reform statutes specifically exclude “mental health services or services for alcohol or drug abuse.”<sup>15</sup> This issue is discussed further in appendix C, as a matter for further study by an independent commission on substance abuse.

**Child Protective Services.** Health and Welfare’s Child Protective Services clients are eligible to receive substance abuse *assessments* at no charge, but are required to pay a portion of the cost of subsequent treatment.

### ***Access to Recovery Grant***

One new source of federal funding to treat substance abuse was recently awarded to the state through the Office of the Governor. Access to Recovery

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<sup>13</sup> IDAPA 16.03.09.450.01.

<sup>14</sup> IDAPA 16.03.09.001.02, 16.03.09.450.02.

<sup>15</sup> IDAHO CODE § 41-3903(1).

(ATR) is a competitive federal grant program, and Idaho was one of 16 states to be awarded funding.<sup>16</sup> The grant’s goals include enhancing client choice and providing options for faith-based recovery programs. The grant totals \$22.8 million, covering fiscal years 2005 through 2007.

The Office of the Governor asked Health and Welfare to manage the program, and formed the Access to Recovery Alliance to help administer the implementation of the grant program. This alliance is led by Idaho’s First Lady, and is made up of stakeholders including legislators, members of relevant state departments, treatment providers, and local officials. The alliance is designed to provide guidance to Health and Welfare during the grant period and to address options for sustainability of the services after the grant period ends.

The state’s application for the funds contained a detailed plan about the ways that funding would be used. It specified that grant funds would be targeted to serve Hispanics and Native Americans with limited access to treatment services.

<sup>16</sup> The federal government also awarded Access to Recovery funds to one tribal organization in California.

**Exhibit 2.3: Department of Health and Welfare Substance Abuse Expenditures, by Source and Fiscal Year**

	FY2003		FY2004		FY2005	
	Amount	Percent	Amount	Percent	Amount	Percent
State general funds	\$ 3,139,309	26%	\$ 4,062,505	28%	\$ 4,069,494	29%
State dedicated funds	1,393,676	11	1,561,000	11	2,046,304	15
Federal funds	7,704,272	63	8,857,445	61	7,816,537	56
Indirect costs <sup>a</sup>	<u>19,537</u>	<u>&lt;1</u>	<u>20,323</u>	<u>&lt;1</u>	<u>20,602</u> <sup>b</sup>	<u>&lt;1</u>
Total <sup>c</sup>	\$12,256,794	100%	\$14,501,273	100%	\$13,952,937	100%

Note: Expenditures include costs for activities to address substance abuse through the Substance Abuse, Temporary Assistance for Families in Idaho, and Child Protection programs. The amounts include the costs of treatment services provided by Health and Welfare to drug court and Correction clients. Because of data limitations, costs incurred for efforts to address substance abuse through the mental health and Idaho Child Care programs are not included.

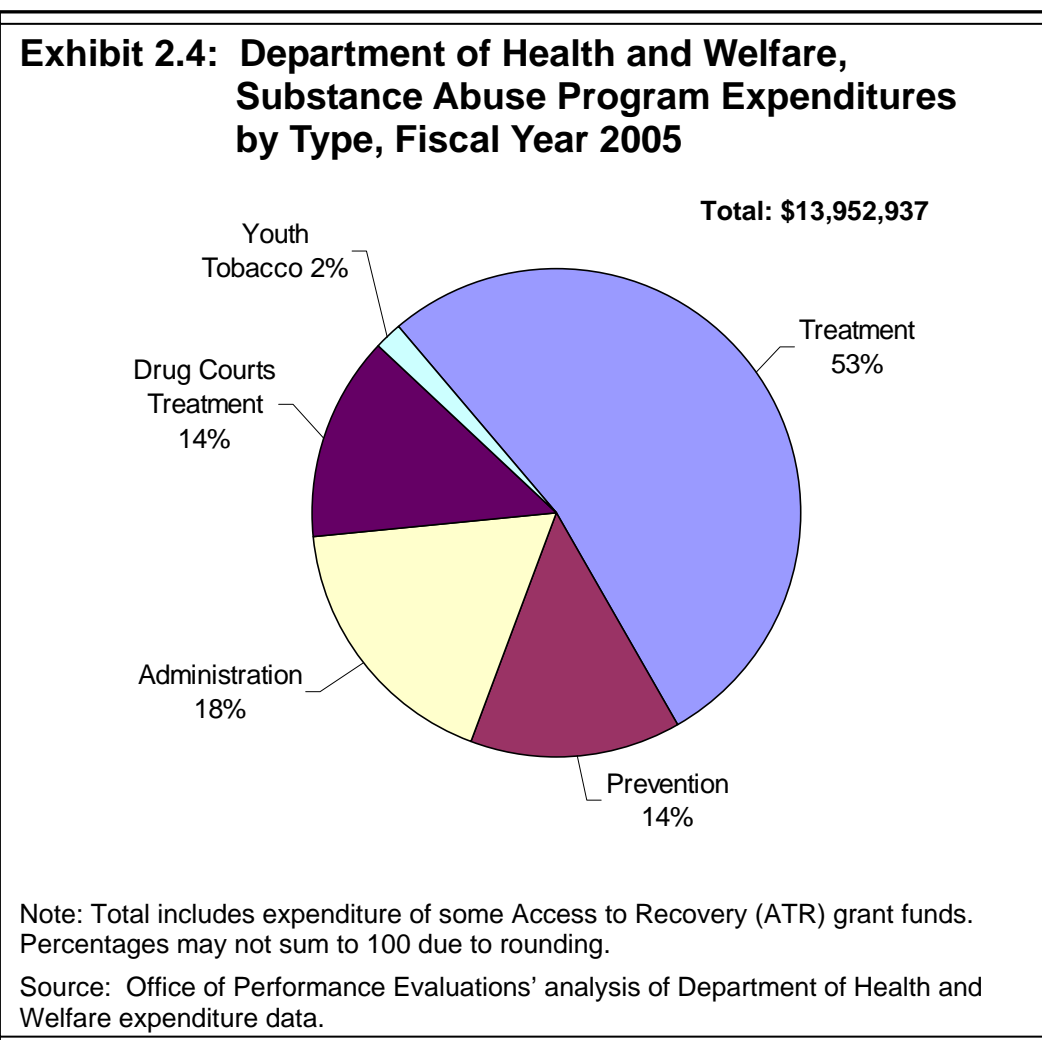
<sup>a</sup> Operating expenditures paid from multiple funding sources.  
<sup>b</sup> Amount includes some Access to Recovery (ATR) grant funds.  
<sup>c</sup> Percentages do not sum to 100 due to rounding.

Source: Office of Performance Evaluations’ analysis of Department of Health and Welfare expenditure data.

The Access to Recovery Alliance later added adolescents and court-supervised populations to these targets.

### **Substance Abuse Funding**

Health and Welfare receives federal and state funds to carry out substance abuse treatment programs. The main sources of federal funding are the Substance Abuse Prevention and Treatment Block Grant and the Access to Recovery grant. State general funds and dedicated funds from the state's Alcohol Intoxication Treatment Fund, supported by beer and wine taxes, are also used. Exhibit 2.3 lists the source of funds and amounts spent in the past three fiscal years. Exhibit 2.4 shows how these funds were spent in fiscal year 2005.



## Department of Correction

Offenders convicted and sentenced to state prison are subject to rules and regulations established by the Board of Correction, a component of the state's Department of Correction.<sup>17</sup> The Board of Correction has established policy for the department to “provide programs which promote offender change and successful reintegration into the community.”<sup>18</sup>

### ***Treatment Services***

Correction offers two main types of substance abuse treatment within its institutions, in addition to funding some treatment for offenders who live in the community under Correction's supervision. The first type is a institution-based program called Therapeutic Community, which consists of a group of inmates identified as needing treatment, and peer influence is used to affect “attitudes, perceptions, and behaviors associated with drug use.”<sup>19</sup> The second type of treatment is “relapse prevention,” an umbrella term for non-intensive substance abuse treatment, which at the discretion of the counselor may include cognitive therapies designed to help offenders restructure learning and thinking processes, but is not directly related to substance abuse.

Correction has recently added an equivalent “intensive outpatient” treatment and methamphetamine program to the types of care it offers to incarcerated offenders. Correction funded treatments offered in the community include intensive outpatient treatment, Therapeutic Community aftercare, relapse prevention, and programs targeted at methamphetamine abuse. Correction staff report substance abuse treatment services may be included as a part of offenders' structured re-entry into the community.

### ***Treatment Eligibility***

The Department of Correction measures the need for substance abuse services according to criminal risk factors with the aid of a number of assessment tools. This approach—to interpret addiction through measures of criminal behavior—parallels the eligibility criteria established in the Idaho Drug Court Act and guidelines established by the Idaho Supreme Court Drug Court Coordinating Committee.<sup>20</sup>

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<sup>17</sup> IDAHO CODE § 20-101, -201.

<sup>18</sup> Idaho Department of Correction, Operations, Programs: Directive 607.26.01.003.01.00.00, Treatment Matching and Offender Referral.

<sup>19</sup> Idaho Department of Correction, Division of Programs, *The Program Handbook* (January 2004), 14.

<sup>20</sup> IDAHO CODE § 19-5604.

An offender assessed as needing treatment is not necessarily placed on a substance abuse services waiting list or into treatment. Correction determines this treatment “need” according to established minimum assessment scores. For example, Correction policy states a combined substance abuse-chemical dependency score of “medium or greater” on a scale of low, medium, and high, “may indicate a referral for substance abuse programming.”<sup>21</sup>

### ***Substance Abuse Funding***

Correction’s accounting system is not designed to specifically track spending on activities that address substance abuse. Costs for staff and activities related to substance abuse cannot fully be distinguished from costs for other Correction programs.

To estimate the costs of activities that address substance abuse, Correction provided information on expenditures related to its drug and alcohol rehabilitation specialists, and its use of the treatment funds appropriated by the Legislature. However, Correction program staff, in addition to the drug and alcohol rehabilitation specialists, also provide substance abuse services. Because it cannot track the extent to which these staff provide substance abuse services, Correction believes the costs of the drug and alcohol rehabilitation specialists provide a conservative estimate of the true cost of its efforts to address substance abuse. Exhibit 2.5 shows the estimated costs by funding source of Correction’s efforts during the last three fiscal years to address substance abuse.

## **Department of Juvenile Corrections**

One focus of the Department of Juvenile Corrections is to provide programs and services that “will individualize treatment and control of the juvenile offender for the benefit of the juvenile and the protection of society.”<sup>22</sup> Statutes intend for the juvenile correction system to make treatment opportunities available, including day programs serving juveniles with substance abuse problems.

Juvenile Corrections administrative rule specifies that “as a minimum standard, programs must provide substance abuse education for all juveniles, and substance abuse treatment services as determined by assessment and indicated in the service implementation plan.”<sup>23</sup> Juvenile Corrections’ substance abuse prevention/education activities are outside the scope of this report, but its treatment services (including educational components) are discussed here.

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<sup>21</sup> Idaho Department of Correction, Operations, Programs: Directive 607.26.01.003.05.03.03, Treatment Matching and Offender Referral.

<sup>22</sup> IDAHO CODE § 20-501.

<sup>23</sup> IDAPA 05.01.01.278.02, 271.01(c).

**Exhibit 2.5: Department of Correction Substance Abuse  
Estimated Expenditures, by Source and Fiscal Year**

	FY2003		FY2004		FY2005	
	Amount	Percent	Amount	Percent	Amount	Percent
State general funds	\$1,593,524	87%	\$1,764,041	87%	\$2,004,127	93%
State dedicated funds	84,151	5	100,235	5	47,895	2
Federal funds	<u>153,277</u>	<u>8</u>	<u>159,101</u>	<u>8</u>	<u>104,141</u>	<u>5</u>
Total	\$1,830,952	100%	\$2,023,377	100%	\$2,156,163	100%

Note: Expenditures reflect cost of activities to address substance abuse that could be specifically identified through the department's accounting system. The department indicates other costs were incurred, but were not recorded in a clearly identifiable way. In addition, these expenditures do not include payments made to the Department of Health and Welfare for treatment services to Correction clients. These costs are reflected in the Department of Health and Welfare's expenditures (see exhibit 2.3)

Source: Office of Performance Evaluations' analysis of Department of Correction expenditure data.

***Treatment Services***

Juvenile Corrections provides appropriately-assessed juveniles treatment through twelve-step programs or Therapeutic Communities, as well as cognitive therapies designed to help juveniles restructure their learning and thinking processes. These services are delivered independently by Juvenile Corrections through regional state operated facilities, and through contracts with county detention centers and private institutions.<sup>24</sup>

***Treatment Eligibility***

Juvenile Corrections measures eligibility for treatment with a number of assessment tools that consider risk, level, and dependence factors of substance abuse, along with criminal risk factors when determining treatment placement. Because Juvenile Corrections combines these quantitative assessments with qualitative clinical interviews, it has not established minimum assessment scores as criteria for determining treatment placement.

<sup>24</sup> Juvenile Corrections employs 2 of the 47 drug and alcohol rehabilitation specialists statewide.

### Substance Abuse Funding

Like the Department of Correction, Juvenile Corrections does not have an accounting system that specifically distinguishes the costs of services to address substance abuse from other costs. To gain an understanding of Juvenile Corrections’ costs for addressing substance abuse, we reviewed expenditure information for individual facilities and activities that address substance abuse.

We included costs for Juvenile Corrections facilities that were specifically dedicated to treating offenders with substance abuse problems, and specific drug and alcohol training costs for Juvenile Corrections staff. Because Juvenile Corrections estimates that about 50 to 55 percent of offenders have a substance abuse problem, we also included half of the costs for clinical service staff, and about 50 percent of the costs for contractors that provide various treatment services. Exhibit 2.6 lists the overall estimated costs to the department over the last three fiscal years for addressing substance abuse.

**Exhibit 2.6: Department of Juvenile Corrections Substance Abuse Estimated Expenditures, by Source and Fiscal Year**

	FY2003		FY2004		FY2005	
	Amount	Percent	Amount	Percent	Amount	Percent
State general funds	\$3,289,693	96%	\$3,175,989	95%	\$3,322,736	95%
State dedicated funds	0	0	33,341	1	16,121	<1
Federal funds	<u>137,632</u>	<u>4</u>	<u>126,223</u>	<u>4</u>	<u>145,059</u>	<u>4</u>
Total <sup>a</sup>	\$3,427,325	100%	\$3,335,553	100%	\$3,483,916	100%

<sup>a</sup> Percentages may not sum to 100 due to rounding.

Note: Expenditures reflect costs of activities to address substance abuse that could be specifically identified or estimated through information in the department’s accounting system. Some other costs were incurred, but are not recorded in a clearly identifiable way.

Source: Office of Performance Evaluations’ analysis of Department of Juvenile Corrections expenditure data.

## Judicial Branch

Idaho Code authorizes the establishment of drug courts in each county of the state under standards that have been developed by the Idaho Supreme Court Drug Court and Mental Health Court Coordinating Committee.<sup>25</sup> Drug court programs are to be comprised of “graduated sanctions and rewards, substance abuse treatment, close court monitoring and supervision of progress, educational or vocational counseling,” along with other requirements. The statutory goals of drug courts are to:<sup>26</sup>

- Reduce the overcrowding of jails and prisons
- Reduce alcohol and drug abuse and dependency among criminal and juvenile offenders
- Hold offenders accountable
- Reduce recidivism
- Promote effective interaction and use of resources among the courts, justice system personnel and community agencies

## Treatment Services

As of May 2005, Idaho had 37 drug courts operated by 21 counties or county cooperatives. The majority of these drug courts coordinate treatment services for participants through the Department of Health and Welfare’s management services contractor. Treatment funded through the Access to Recovery grant is limited to outpatient and intensive outpatient care, along with “designated” recovery support services.

## Treatment Eligibility

The Idaho Drug Court Act of 2001 excludes violent felons from participating in drug courts. This basic eligibility criterion may be built upon by each district court according to its needs or aims.<sup>27</sup> In 2003, the Drug Court Coordinating Committee developed the *Idaho Adult Drug Court Guidelines for Effectiveness and Evaluation*. These guidelines elaborate further eligibility criteria, including drug court obligations to address prior relapses or current lack of motivation, indigence, mental health, and criminal risk through assessments.<sup>28</sup> Beyond this, placement requirements vary among individual drug courts. For example, not all

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<sup>25</sup> IDAHO CODE § 19-5603. This committee was previously known as the Idaho Supreme Court Drug Court Coordinating Committee. The Idaho Drug Court Act of 2001 was revised as the Idaho Drug Court and Mental Health Court Act of 2005.

<sup>26</sup> IDAHO CODE § 19-5602.

<sup>27</sup> IDAHO CODE § 19-5604.

<sup>28</sup> Idaho Drug Court Coordinating Committee, *Idaho Adult Drug Court Guidelines for Effectiveness and Evaluation* (September 26, 2003), 1.0–2.0.

drug courts allow individuals with prior convictions or incarcerations to participate.

A 2004 agreement between the Department of Health and Welfare and the Supreme Court states that Health and Welfare will accept the screening and eligibility criteria of the drug courts. As a result, drug court clients, unlike other clients receiving treatment through Health and Welfare's Substance Abuse Program, are not subject to Health and Welfare's established rates of financial liability. Drug court participants, however, may be required to pay monthly drug court fees.<sup>29</sup>

### ***Substance Abuse Funding***

Treatment costs for drug court participants are *primarily* covered by Health and Welfare. However, the Judicial Branch receives state general funds, state dedicated funds, and federal funds for drug court activities. These activities may include administration, testing, and some treatment. Exhibit 2.7 shows the expenditures for drug courts and services by funding source for the past three fiscal years. The dedicated funds include the Drug and Family Court funds and the Liquor Account, both supported by sales through the Liquor Dispensary. The Judicial Branch has also received funds through the US Department of Health and Human Services' Substance Abuse and Mental Health Services Administration and through grants from the US Department of Justice.

<sup>29</sup> IDAHO CODE § 31-3201E.

### **Exhibit 2.7: Judicial Branch Expenditures for Drug Courts, by Source and Fiscal Year**

	<u>FY2003</u>		<u>FY2004</u>		<u>FY2005</u>	
	<u>Amount</u>	<u>Percent</u>	<u>Amount</u>	<u>Percent</u>	<u>Amount</u>	<u>Percent</u>
State general funds	\$389,921	92%	\$71,697	7%	\$ 75,197	5%
State dedicated funds	–	0	706,862	72	872,961	53
Federal funds	<u>31,892</u>	<u>8</u>	<u>204,311</u>	<u>21</u>	<u>703,966</u>	<u>43</u>
Total <sup>a</sup>	\$421,813	100%	\$982,870	100%	\$1,652,124	100%

Note: Expenditures do not include payments made to the Department of Health and Welfare for treatment services to drug court clients. These costs are reflected in the Department of Health and Welfare's expenditures (see exhibit 2.3).

<sup>a</sup> Percentages may not sum to 100 due to rounding.

Source: Office of Performance Evaluations' analysis of Judicial Branch expenditure data.

## Chapter 3

# A Comprehensive and Integrated System for Addressing Substance Abuse

*State efforts to address substance abuse are fragmented, in spite of Idaho Code requiring a comprehensive and integrated system. This fragmentation has contributed to the absence of statewide information necessary for state officials to answer the following basic questions for policymakers:*

- 1. What are the statewide needs for services to address substance abuse?*
- 2. What is the state's capacity to meet those needs?*
- 3. What types of services are being provided, to which groups of people, and to how many people?*
- 4. Which programs are working and which are not?*
- 5. Are state efforts making a difference?*

*This chapter discusses the importance of establishing an independent commission to oversee state efforts to address substance abuse, which would help answer these basic questions.*

## Legislative Intent and Statutory Requirements

Reflecting the interest of policymakers to address substance abuse, the Alcoholism and Intoxication Treatment Act calls for treatment for Idaho citizens, specifying the Legislature's intent to "effectively and economically utilize federal and state funds" for research, prevention, treatment, and rehabilitation. Idaho Code § 39-303 states

It is necessary that existing fragmented, uncoordinated and duplicative alcoholism and drug treatment programs be merged into a comprehensive and integrated system for the prevention, treatment and rehabilitation of alcoholics.

Idaho Code established a Commission on Alcohol-Drug Abuse under the administration of the Department of Health and Welfare to coordinate the activities of multiple state agencies and develop a comprehensive approach for addressing substance abuse. According to statute, the Governor appoints up to

14 members to the commission that includes an advisory board made up of representatives from various agencies:

- Public health
- Mental health
- Education
- Public welfare
- Corrections
- Transportation
- Public safety
- Vocational rehabilitation
- Other public or private entities having an interest

In addition to the membership that is listed in statute, Health and Welfare rules specify the commission should consist of local representatives from judicial districts, associations representing counties and cities, treatment providers, and one member from each of Health and Welfare's seven regions.<sup>1</sup>

The commission is charged with general areas of responsibility that include:<sup>2</sup>

1. Interagency coordination, including information exchange on addiction prevention and treatment programs in all state agencies and ensuring that appropriate state agencies provide necessary forms of treatment and education without unnecessary duplication.
2. Comprehensive planning for addiction prevention and treatment services.
3. Advocacy and advice to promote best practices, alternatives, and solutions to the Governor and state agencies.
4. Monitoring and evaluating the use of funds available to achieve coordinated substance abuse services.
5. Annual reporting to Legislative Council and the Governor.

The commission is to be assisted by seven regional advisory committees. Members of these advisory committees are appointed by the regional Health and Welfare directors for the purpose of regional information exchange and service coordination, and to advise the commission on local substance abuse program needs.<sup>3</sup>

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<sup>1</sup> IDAPA 16.06.04.006.01.

<sup>2</sup> IDAHO CODE § 39-303.

<sup>3</sup> IDAHO CODE § 39-303A.

## **State Efforts Are Fragmented**

The efforts of state agencies to address substance abuse do not meet statutory intent to coordinate the activities of multiple agencies into a comprehensive and integrated system. As part of an overall effort to reduce state costs, the Governor recommended cuts in 1995 that included elimination of funding for the Commission on Alcohol-Drug Abuse from Health and Welfare's budget. The Legislature accepted the Governor's recommendation, and the department disbanded the commission.

According to the former executive director of the commission and Department of Health and Welfare staff, the commission operated for many years prior to its elimination. The executive director reported the commission was successful in bringing together many key stakeholders from around the state to generate ideas to address substance abuse, and to provide information and proposals to the Legislature and the Governor. He stated the commission was successful in taking the initial steps for Idaho correctional institutions to provide treatment. He indicated, however, the commission could have been more successful with greater support from legislative leaders, the Governor, and agency directors. With the ending of the commission, Idaho lost its mechanism for building a coordinated system to address substance abuse.

### ***State Substance Abuse Executive Council***

After funding for the commission was eliminated, Health and Welfare formed a task force, primarily made up of department staff and treatment providers, to make recommendations for a new management structure for Health and Welfare's substance abuse program. The task force recommended an approach that was similar in some ways to the statutorily required system, but this new approach was limited to Health and Welfare activities and did not contain a mechanism to include representation of other state agencies or the Judicial Branch.

The task force recommended creation of the State Substance Abuse Executive Council made up of Health and Welfare executives and the chairs of the Regional Substance Abuse Authorities, but it did not specifically indicate whether the council was to have decision-making authority or to serve the department in an advisory role. The council provides guidance on the distribution of substance abuse funds, including the state general fund and the federal Block Grant. Confusion over the council's role surfaced in a July 2005 meeting, where members voted to adjust the substance abuse budget by allocating additional funds to substance abuse prevention activities. Department staff told us, however, they were only required to take the council's decision under advisement.

### ***Idaho Access to Recovery Alliance***

After Idaho was awarded Access to Recovery grant funding, a committee was formed with the primary purpose of advising the department during implementation and operation of this grant, and to create a coalition to sustain the project beyond the completion of the grant. The Idaho Access to Recovery Alliance was developed through the Office of the Governor as a broad-based, stakeholder partnership, chaired by Idaho's First Lady.

The alliance is made up of 27 voting members, staffed by Health and Welfare, and has been meeting regularly since September 2004. The alliance originally developed nine subcommittees to address specific issues such as funding distribution and sustainability, communication, continuous quality improvement, and specific target population outreach efforts, and has since combined some and added another. These subcommittees bring recommendations to the alliance.

The alliance includes representation from many state agencies and other organizations working toward providing substance abuse treatment services, and it has the support of the Office of the Governor. The breadth of membership in this alliance promotes coordination among those with a stake in addressing substance abuse. However, many of these stakeholders are not part of the State Substance Abuse Executive Council, which provides guidance to Health and Welfare for the existing substance abuse program funded mostly by the Block Grant. A comprehensive statewide plan could have promoted the integration of the Access to Recovery grant with the existing state substance abuse program.

### ***Comprehensive Statewide Plan***

The state does not have a comprehensive plan for addressing substance abuse, as required by Idaho Code. Health and Welfare staff report they have not developed a comprehensive *statewide* plan for substance abuse services since June 1995, following the elimination of the Commission on Alcohol-Drug Abuse. Health and Welfare staff report using its annual application for the federal substance abuse Block Grant as a service plan. However, the application is limited to the department's efforts, and does not provide a comprehensive statewide approach to addressing substance abuse that incorporates related efforts of all relevant agencies.

### ***Promotion of Best Practices***

The Commission on Alcohol-Drug Abuse was to provide expertise about improving services to address alcohol and drug abuse, and to advocate and communicate alternatives and solutions for substance abuse programs and services. The absence of a commission with broad representation and a comprehensive statewide plan hinder the ability of the state to promote best practices. As illustrated in chapters 5 and 6, limited utilization and outcome data further impede the ability to understand what types of best practices may be useful or needed.

## **Spending and Fiscal Oversight**

State entities receive funds for specific purposes from many different sources, including federal grants and state dedicated funds.<sup>4</sup> The commission was to monitor and evaluate the use of funds available for coordinated substance abuse services.<sup>5</sup> In the absence of a statewide commission, the responsibility for monitoring the use of treatment funds has fallen to individual state entities. This limits opportunities to collaboratively plan the allocation of individual state entities' resources for the benefit of the state as a whole.

## **Annual Reporting**

Statutes call for an annual report on the state's "achievements and impact on alcohol-drug services, programs and policies."<sup>6</sup> Currently, there is no formal mechanism for the state to comprehensively evaluate the impact of substance abuse services and produce a statewide report. Problems with data quality discussed in chapters 5 and 6 also limit the information state entities can report. Absent a statewide report, policymakers do not have access to information that would assist them in making policy and budget decisions to comprehensively address substance abuse.

## **Treatment Activities Are Not Well Coordinated**

Lacking a mechanism for statewide coordination, state agencies and drug courts have primarily operated without an agreed upon *statewide* approach to providing services to address substance abuse. Although policymakers have encouraged cooperation through legislation, the Department of Correction, the Department of Juvenile Corrections, and the Judicial Branch have operated separately from the Department of Health and Welfare in a number of ways. In addition, levels of coordination vary among Health and Welfare programs.

## **Department of Correction**

In previous years, the Department of Correction signed agreements with Health and Welfare for the administration of a correctional budget for community-based substance abuse treatment for prisoners re-entering the community. Correction staff report the agreement was allowed to lapse at the close of fiscal year 2005; Correction and Health and Welfare staff disagree over the reasons for this action. Correction now arranges for institutional and community-based treatment through its own staff and contracts with private providers, independently of Health and Welfare's substance abuse program.<sup>7</sup>

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<sup>4</sup> Some funds may have restrictions prohibiting their collective use.

<sup>5</sup> IDAHO CODE § 39-303(c)(4).

<sup>6</sup> IDAHO CODE § 39-303(c)(6).

<sup>7</sup> The Department of Correction employs 45 of the 47 drug and alcohol rehabilitation specialists statewide.

Correction staff were unaware of statutes calling for Health and Welfare to approve public and private treatment facilities. Consequently, staff did not know that one of its five substance abuse treatment contractors was not approved.<sup>8</sup> The lack of state approval removes an important mechanism to ensure a level of quality exists in the services and facilities providing substance abuse treatment (see appendix C).

### ***Department of Juvenile Corrections***

The Department of Juvenile Corrections provides treatment independently through regional state operated facilities, and through contracts with county detention centers and private institutions. Juvenile Corrections' administrative rules guide the substance abuse programs of private providers contracting with Juvenile Corrections, but not for programs in regional correctional and county detention facilities. Although the rules do not detail requirements for publicly-operated facilities, Juvenile Corrections staff report that statute infers these facilities are held to the same requirements demanded of their contracted providers.<sup>9</sup>

Private providers are also subject to state licensing through a Health and Welfare licensing section that is separate from Health and Welfare's substance abuse program and its approval functions. However, Health and Welfare has standards for substance abuse treatment programs and personnel that are different from the standards established for substance abuse treatment programs and personnel in Juvenile Corrections administrative rules.<sup>10</sup> Qualified staff under Health and Welfare would not necessarily be qualified under Juvenile Corrections, and qualified Juvenile Corrections staff may not meet the requirements under Health and Welfare. Both Health and Welfare and Juvenile Corrections rules for children's substance abuse counselors, however, are much more stringent than Health and Welfare rules for staff providing substance abuse treatment to adults.

### ***Judicial Branch***

As with the Department of Correction, all drug court treatment providers have not been subject to the same facility approval requirements. Most drug courts use Health and Welfare treatment providers approved under the standards established in Administrative Code.<sup>11</sup> In Judicial District 4, Ada County provides treatment to nearly one quarter of all Idaho drug court participants through its own facility that is not a Health and Welfare approved treatment program. Without a uniform approval process, the state cannot ensure a standard

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<sup>8</sup> IDAPA 16.06.03.010.06; IDAPA 16.06.03.020.01–02 states that programs must be approved by the department of Health and Welfare in order “to receive referrals from the Department or any law enforcement officer and to receive any kind of state or federal reimbursement.”

<sup>9</sup> IDAHO CODE § 20-504(9), IDAPA 05.01.02.

<sup>10</sup> IDAPA 05.01.01, 16.06.02.

<sup>11</sup> IDAPA 16.06.03.010.24, 16.06.03.146.

level of quality in the services and facilities providing substance abuse treatment (see appendix C). Supreme Court staff report District 4 is in process of developing an application for Health and Welfare approval.

### ***Programs Within the Department of Health and Welfare***

Many programs within the Department of Health and Welfare are directly affected by substance abuse. These programs include Child Protection Services, Temporary Assistance for Families in Idaho (TAFI), and mental health. The department coordinates its substance abuse services with the Child Protection Services program, but needs to improve coordination with the others.

Health and Welfare has demonstrated that coordination is valuable and can be achieved. Using a grant from the American Humane Association, **Child Protection Services** provides substance abuse assessments in coordination with the substance abuse program, and intervention and motivational services for child protection clients who are unable to access treatment immediately. According to department staff, these arrangements have remedied some of the barriers to accessing treatment for some vulnerable citizens.

Coordination among other programs in Health and Welfare is not as effective. Health and Welfare staff were unable to provide assurances that persons receiving **TAFI** cash assistance were given appropriate access to substance abuse treatment and support services as required by statute.<sup>12</sup> Staff in the welfare division expressed concerns about ongoing coordination problems, and were unfamiliar with the procedures of the Division of Family and Community Services for referring clients through its substance abuse program.

Health and Welfare reports that in fiscal year 2005 approximately 360 participants in the TAFI program scored high enough on a substance abuse risk screening to qualify for treatment paid through the state's management services contractor. We determined through analysis of Health and Welfare contractor data that only 15 percent of these individuals were screened for services through the substance abuse program gateway, and less than 10 percent actually received treatment. This issue is discussed in appendix C as a matter for further attention.

Health and Welfare also lacks sufficient coordination among **mental health** programs and the substance abuse program. Access to either mental health or substance abuse treatment for individuals with co-occurring disorders is determined based on their primary diagnosis. The substance abuse program, however, does not track when or if individuals are referred for treatment from the adult or child mental health programs. Children's Mental Health Program staff were unaware of having received any referrals from the substance abuse program.

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<sup>12</sup> IDAHO CODE § 56-209i-1.

Integrated substance abuse and mental health treatment was identified as a significant issue in our survey of voting members of the Regional Substance Abuse Authorities. Forty-six respondents (71 percent) indicated a need for state funded services that integrate mental health and substance abuse treatments. A respondent to our survey identified the separation of mental health and substance abuse services as contributing to a treatment environment that is “difficult if not impossible for the client and the therapist to work with.” Substance abuse program staff admitted that few state contracted substance abuse providers—according to department records, less than 11 percent—are able to address co-occurring mental health and substance abuse disorders. This issue is also discussed in appendix C as a matter for further attention.

## **Statewide, Coordinated System Is Needed**

Idaho needs a statewide, coordinated system to effectively address substance abuse issues facing the state. Because the responsibility to address substance abuse lies with multiple state agencies and drug courts, those organizations should work in a collective and systematic way that includes:

- Assessing the statewide needs
- Determining the state’s capacity to meet those needs
- Planning and delivering needed services effectively and efficiently
- Monitoring the results and ensuring the collection of reliable data
- Evaluating the outcomes and reporting to the Legislature and the Governor

The framework of establishing a commission, as outlined in the state’s Alcoholism and Intoxication Treatment Act, is a good starting point. Key elements of the act are also supported by national organizations and other states. The US Department of Health and Human Services states in one of its technical reports that

To achieve the most positive outcomes, communication and coordination are essential. When various agencies and sectors work together, much more is accomplished than if those same professionals acted alone, within a vacuum.<sup>13</sup>

The technical report indicates that a planning process is one of the main elements needed for achieving coordination. In addition, it emphasizes the need for conducting evaluations of service delivery processes and outcomes, and providing the results to the Legislature for making policy decisions. Another

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<sup>13</sup> Department of Health and Human Services, *Treatment for Alcohol and Other Drug Abuse: Opportunities for Coordination* (1994), chap. 12.

report from the National Institute on Drug Abuse commented on the importance of “all interested parties” to come together to establish program components and goals. This process will provide the foundation for analyzing results and making appropriate changes.<sup>14</sup>

Other states have structured their efforts under state-level councils that coordinate their substance abuse systems. For example:

- In Washington, the Governor’s Council on Substance Abuse was established in its current form in 1995 to advise the governor and state agencies on actions to reduce substance abuse. The council is comprised of 26 members, including the directors of seven state agencies and four legislators.
- In Oregon, the Governor’s Council on Alcohol and Drug Abuse Programs was established in 1985. The council makes recommendations to the governor about a state plan, goals, priorities, funding, and needed improvements for addressing substance abuse treatment and prevention. The governor appoints 11 voting members to the council, and the house speaker and the senate president pro tem appoint one non-voting member each.

Recognizing the need for a statewide, coordinated system to address substance abuse, Idahoans have tried several collaborative efforts in recent years, though with limited success.

**Governor’s Interagency Task Force.** In 2000, the Governor formed an interagency task force to coordinate efforts to address substance abuse. The task force included the Superintendent of Public Instruction, and the directors of Health and Welfare, Correction, Juvenile Correction, Transportation, and Law Enforcement. In 2002, the task force recommended a statewide strategic plan and was the catalyst behind a data repository project to track the effects of substance abuse treatment programs.<sup>15</sup> In spite of these efforts, there is no statewide strategic plan currently in use and funding for the data repository project was discontinued after yielding limited information. The task force is no longer in place.

**Special Legislative Oversight Committee.** In 2001, the Idaho Legislature passed a bill that called for a special legislative oversight committee to operate through April 2006 and address state funded substance abuse treatment. The purpose of the committee was to “maintain a degree of continuous oversight on

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<sup>14</sup> National Institutes for Health, National Institute of Drug Abuse, *Measuring and Improving Cost-Effectiveness, and Cost-Benefit for Substance Abuse Treatment Programs* (1999), 11.

<sup>15</sup> Governor’s Interagency Task Force Subcommittee, *Substance Abuse Strategic Plan Recommendations* (2002).

the coordination of service delivery of state funded substance abuse treatment...”<sup>16</sup> The committee met one time after the bill was passed.

**Idaho Summit of Alcohol and Other Drug Issues.** In 2004, several state agencies—Health and Welfare, Correction, Juvenile Corrections—co-sponsored with other private and public entities the National Alliance on Model State Drug Laws Summit. This summit brought together stakeholders to develop recommendations for Idaho drug related statutes and programs. The recommendations included development of centralized oversight and interagency coordination. However, no action has yet been taken to develop interagency coordination.

## Recommendation

More strategic and concerted efforts are needed to collaboratively answer questions about the need, capacity, and quality of treatment services provided statewide. An independent commission, jointly appointed by the Legislature and the Governor, would be the first step. The commission would be responsible for coordinating the use of all state and federal substance abuse funds by individual state agencies and the Judicial Branch. Exhibit 3.1 outlines the key components of the proposed commission.

- 3.1. To coordinate and guide activities of state entities addressing substance abuse, the Legislature should consider:
  - a. Establishing an independent commission, jointly appointed by the Legislature and the Governor, to include directors of state agencies involved with efforts to address substance abuse—Health and Welfare, Correction, Juvenile Corrections, Law Enforcement, and Education—as well as representation from the Judiciary. The commission should also include members of the Legislature, professional community, relevant local government associations, and the public.
  - b. Addressing those parts of existing statute requiring a commission on alcohol and drug abuse to be consistent with step A of this recommendation.

## ***Fiscal Impact and Implementation Timeframe***

The fiscal impact of implementing the recommendation will include the cost of employing an executive director, administrative assistant, and 1–2 research analysts to help carry out the commission’s responsibilities. Some of the administrative costs may be offset in part by diverting funds that are currently

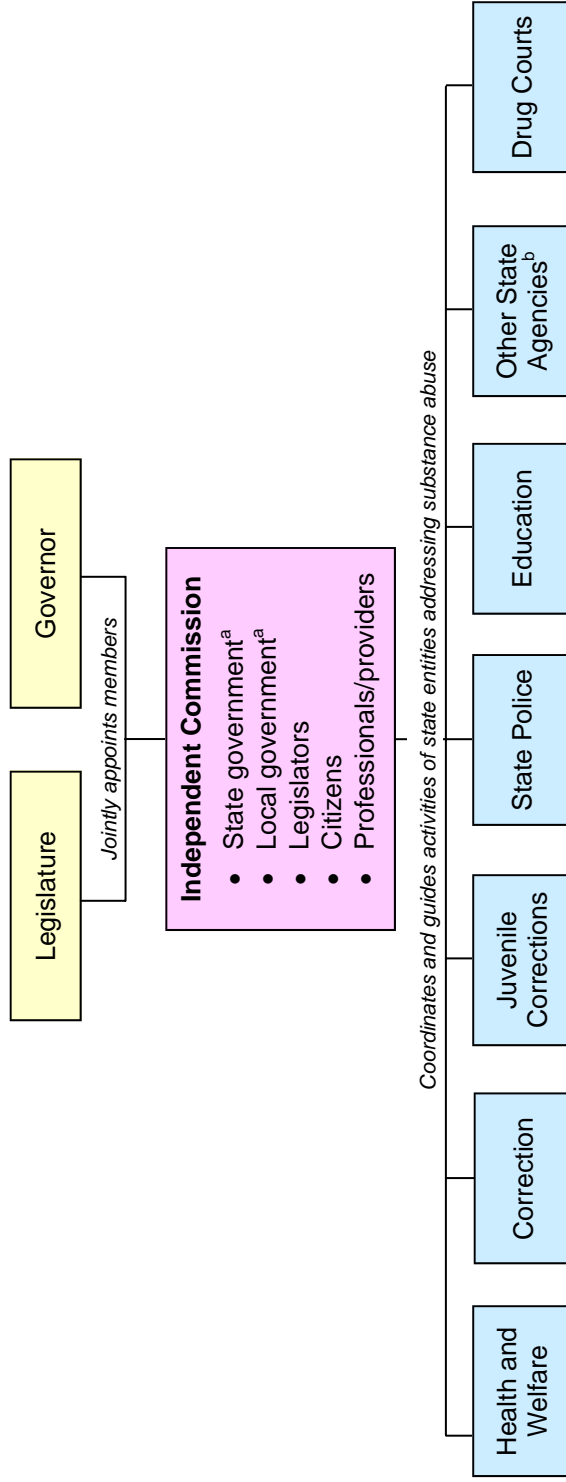
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<sup>16</sup> IDAHO CODE § 67-465.

used to cover the expenses of various entities responsible for advising or overseeing individual agency substance abuse efforts.

A discussion to establish such a commission should begin during the 2006 legislative session, and the implementation could begin as early as July 1, 2006.

### Exhibit 3.1 Proposed Structure for an Independent Commission to Oversee State Efforts to Address Substance Abuse



**The commission would be responsible for establishing a statewide system with these functions:**

1. Assesses the statewide needs for services to address substance abuse
2. Assesses the state's capacity to meet those needs
3. Plans and ensures needed services are delivered effectively and efficiently
4. Monitors the results and ensures collection of reliable data
5. Evaluates the outcomes and reports to the Legislature and the Governor

**From such a statewide system, we will be able to answer these questions:**

1. What are the statewide needs for services to address substance abuse?
2. What is the state's capacity to meet those needs?
3. What types of services are being provided, to which groups of people, and to how many people?
4. Which programs are working and which are not?
5. Are state efforts making a difference?

<sup>a</sup> Representatives of entities receiving public funds to address substance abuse, including the Judicial Branch.

<sup>b</sup> Other state agencies receiving public funds to address substance abuse.

Source: Office of Performance Evaluations' analysis of the state of Idaho's substance abuse treatment services.

## Chapter 4

# Health and Welfare's Management of Its Substance Abuse Treatment Program

*The Department of Health and Welfare has the responsibility for ensuring the appropriate and effective use of the largest proportion of federal and state funds for substance abuse treatment in Idaho. Its responsibilities include overseeing a management services contract and monitoring treatment providers. The department has not adequately fulfilled these requirements. In addition, the department's weak fiscal oversight resulted in a shortage of treatment funds.*

### Key Program Responsibilities

As the State Substance Abuse Authority, the Department of Health and Welfare may apply for and receive federal Substance Abuse and Mental Health Services Administration Block Grant funds. The department uses these funds to carry out its substance abuse treatment responsibilities, many of which are provided through a contract.

The Idaho Alcoholism and Intoxication Treatment Act directs Health and Welfare, independent of the Commission on Alcohol-Drug Abuse, to establish a comprehensive and coordinated program for the treatment of alcoholics, intoxicated persons, and drug addicts.<sup>1</sup> Health and Welfare also has specific responsibilities as a federal grant recipient. Federal requirements include identifying treatment needs, developing comprehensive plans for providing substance abuse treatment, and developing procedures for preventing waste, fraud, and abuse of treatment funds.<sup>2</sup> This chapter focuses on program planning, contract oversight, and fiscal management.

### Lack of a State Plan Impacts Program Implementation

Health and Welfare does not use a comprehensive statewide plan to guide the implementation of its existing substance abuse program and coordinate the services it provides with other state entities, as required in Idaho Code and in federal grant requirements.<sup>3</sup> Instead the department's approach has been to use

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<sup>1</sup> IDAHO CODE § 39-304(1).

<sup>2</sup> 45 CFR 96.84(c), 45 CFR 96.122.

<sup>3</sup> IDAHO CODE § 39-303(a); 45 CFR 96.122(g), .132(c).

regional budgets developed by each Regional Substance Abuse Authority as substance abuse planning tools.<sup>4</sup> Although reliance on the primarily community-based regional authorities and executive council promotes identification of local needs and coordination with local resources, this approach has not involved other state agencies that receive substance abuse funding.

The need for a comprehensive statewide plan has become more evident with the development of the new Access to Recovery grant program. A comprehensive statewide plan would have helped the state to develop an approach for using Access to Recovery funds in a way that would augment existing services. Many key issues inherent in developing substance abuse services, such as methods for providing services to rural areas and establishing program sustainability measures, would have required less initial planning effort by the Access to Recovery Alliance subcommittees had there already been a comprehensive plan in place.

The management services contractor, who manages treatment services for both the Block Grant and Access to Recovery grants, strongly supports the need for a statewide substance abuse treatment plan to make system-wide decisions and to operate the two grant programs effectively.

## **Oversight of the Contractor and Providers Is Not Adequate**

Treatment services for substance abuse are not directly provided by Health and Welfare, but instead by a network of privately-operated treatment providers located across the state. Health and Welfare contracts with an independent, licensed third party organization that acts as an intermediary between the department and the treatment providers. This organization is referred to as the management services contractor. Health and Welfare fulfills many of its substance abuse treatment responsibilities through the management services contractor, including ensuring treatment services are available in all areas of the state as needed, and that those services are accessible, appropriate, and acceptable, as defined by the department.

Because Health and Welfare contracts with a third party to administer treatment services, it has additional responsibilities to monitor the contractor and ensure services are provided appropriately. The federal regulations governing the administration of the Block Grant and Access to Recovery grant funds direct

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<sup>4</sup> After reviewing the first draft of this report, the department provided two separate documents that it indicated are representative of its strategic planning efforts. The department reports that one document “captures the strategic intent” of the request for proposals for the management services contract in 2003. The other document is a draft list of system-level outcomes and indicators developed by the State Substance Abuse Executive Council in 2001.

Health and Welfare to ensure the contractor has complied with laws and regulations.<sup>5</sup>

The contract between Health and Welfare and the management services contractor outlines duties and specific performance standards to ensure the contractor is meeting the terms and fulfilling the scope of the contract. Most contractor performance standards stipulate payment deductions for failure to meet the standards and gives Health and Welfare the ability to enforce contract requirements. These performance standards establish a framework to allow the department to monitor and evaluate the program administration by the contractor and the delivery of services by the treatment providers.

However, Health and Welfare is currently doing little to ensure the contractor is meeting the terms of the contract. The department's program manager reports Block Grant performance measures have not been monitored since the employee assigned to the task left in 2004. Further, department program staff report that limited contract monitoring has taken place for the Access to Recovery grant. It is difficult to confirm the contractor's level of compliance because the contract has not been monitored and requirements have been modified through oral negotiations and not all changes are reflected in written amendments to the contract.

The contract stipulates that Health and Welfare staff should examine the management services contractor's files to ensure services are provided to eligible clients. According to department substance abuse program staff, the department has not conducted this examination.

The department acknowledged that it was not formally monitoring the management services *contractor*, but staff report weekly contact with the contractor. In the absence of an effective contract monitoring process, the department has little assurance beyond the management services contractor's own reporting that the contractor is meeting the federal regulations and grant requirements, and providing adequate management services.

### ***Monitoring Treatment Providers***

Under the Block Grant and Access to Recovery contracts, both the department and management services contractor have responsibilities for monitoring the treatment providers. The Block Grant contract calls for Health and Welfare and the contractor to each independently conduct audits of providers on a quarterly basis, although the contract is not clear if both must audit all providers or may review a sample. The contract also requires Health and Welfare to compare its audit findings with the contractor's findings to verify the contractor's results. This verification helps to ensure the contractor's findings are not biased by potential conflict of interest in the provider review.

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<sup>5</sup> 45 CFR 96.31(b)(1-5).

The contractor performed an on-site audit of all providers in fiscal year 2004, and an audit of treatment charts in fiscal year 2005.<sup>6</sup> Health and Welfare staff participated in the contractor's 2004 audit. Health and Welfare's program staff indicated the department has not conducted *independent* audits of treatment providers under the current contract and neither contract has been modified to reflect an official change of policy. They reported that in the first year of the contract, Health and Welfare was satisfied with the contractor's provider auditing practices and subsequently chose not to participate in the process. By not performing independent provider audits and relying solely on the contractor's audits of providers, Health and Welfare cannot independently ensure clients are receiving adequate services.

### ***Ensuring Use of Approved Facilities***

Health and Welfare's contract with the management services contractor requires the contractor to use treatment providers that have been approved by the department. The approval process helps the department ensure providers are delivering quality treatment services. The contract calls for a comparison of the current list of approved treatment providers with a list maintained by department staff to determine compliance.

According to the contract, Health and Welfare is responsible for sending the contractor copies of department letters granting provider approval, which includes the approval expiration date. Both the department and contractor reported that information regarding provider approvals is routinely exchanged. However, the contractor was unable to produce documentation for current approval status of 7 of the 11 cases we reviewed.

Although the department reports that it updates its approved treatment provider list, we found the department's *master* list was at least 6 months out of date. If Health and Welfare maintained an updated list and shared it routinely with the management services contractor, this process would help ensure clients are receiving services from approved facilities.

## **Weak Fiscal Oversight Caused Questionable Program Changes**

Health and Welfare's fiscal management practices resulted in a shortage of funds for the substance abuse program during fiscal year 2005. The problem was caused by several factors, including an inaccurate projection of program expenditures, no time limit for the submission of billings, and the change to a new contractor. These factors contributed to a new management services contract for a greater amount of money than the department could fund.

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<sup>6</sup> The 2005 chart audit did not involve site visits.

In fiscal year 2004, Health and Welfare's spending rate for Block Grant funded treatment services increased compared to prior years. However, the increased spending was not taken into account when the department wrote the fiscal year 2005 management services contract. Instead, the amount of the contract was based on the assumption that there would be a similar level of unspent funds as in prior years.<sup>7</sup> Regional budgets were established based on the (incorrect) contracted amount, and the management services contractor proceeded to provide services in accordance with the contract.

The increased spending during fiscal year 2004 was partly due to fiscal year 2003 billings from the previous contractor. Health and Welfare continued to receive billings from the prior contractor until February 2004 (seven months after the end of the contract). The department's agreement with the prior contractor did not include a time limit on submission of billings for services rendered by the treatment providers.

Health and Welfare staff did not anticipate untimely billings at the end of the contract year, partly because program management was not tracking actual monthly services delivered. Health and Welfare substance abuse program management has typically relied on having a certain amount of unspent funds each year. Because they paid for outstanding 2003 expenditures in fiscal year 2004, the amount of unspent funds available for fiscal year 2005 was less than expected.

It was not until the end of September 2004 (14 months later) that program staff determined the new management services contract had been written for approximately \$1.6 million more than was available. As a result of the shortfall in anticipated funding, Health and Welfare asked providers to curtail spending where possible, and placed all new clients, except the highest priority populations, on a waiting list for service.

Health and Welfare relied on the management services contractor to develop new budgets and approaches to manage the funding shortfall. The contractor also developed methods to more actively monitor and manage the number of clients receiving services. Health and Welfare decided not to interrupt clients already receiving treatment and anticipated that, with the number of clients being served, funding would be expended approximately two months before the end of the fiscal year.

Faced with exhausting the treatment funds two months early, Health and Welfare decided to use the newly awarded Access to Recovery grant funds to fill the funding gap. Although this helped ensure the continuation of treatment services,

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<sup>7</sup> Health and Welfare staff report that prior to fiscal year 2004 the department's spending rate was fairly consistent, and the department usually had unspent funds at the end of the year. As the department developed yearly contract amounts for the management services contractor, it typically estimated the amount of unspent funds and added it to the contract.

the approach raised questions about complying with federal requirements, as discussed in the following section.

### ***Compliance with Federal Requirements***

Our review determined that Health and Welfare paid for treatment services with Access to Recovery funding for many individuals that did not meet the grant's requirements of a priority population, and switched clients that had been receiving services funded through the Block Grant to the Access to Recovery grant. Federal officials told us the Access to Recovery grant was not meant to replace other funding sources, but rather to serve specific target populations outlined in the grant application. They also indicated that using Access to Recovery funds to serve individuals that are not in a priority population is not appropriate without prior approval. Federal officials said that further review was needed to determine if there was a violation of federal restrictions.

The substance abuse program manager reports discussing the general approach with a federal Access to Recovery official soon after the grant was awarded, in November 2004. However, federal officials told us this type of change would require the department to request written consent to proceed. Federal Block Grant and Access to Recovery officials we spoke with were concerned that department staff had not notified them of the pending shortfall in Block Grant treatment funds, nor requested permission to deviate from the intended use of the Access to Recovery funds.

A team from the federal agency visited Idaho to review the Access to Recovery program in September 2005. The department has requested written opinions from the federal Center for Substance Abuse Treatment clarifying the appropriateness of shifting clients from the Block Grant to Access to Recovery grant funds, and funding services for non-priority populations. In its November 2005 response to the federal government, the department reported that it would move approximately \$184,000 to relieve any suspicion about the inappropriate use of Access to Recovery dollars.<sup>8</sup>

## **Recommendations**

- 4.1. To ensure the management services contractor is meeting performance requirements, and that adequate services are administered by approved treatment providers, the Department of Health and Welfare should:
  - a. Monitor its management services contract by periodically reviewing the contractor's performance against the measures identified in the contract.

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<sup>8</sup> The department is completing further analysis. Any additional adjustments will be noted in the amended first year Access to Recovery grant financial report filed by the department.

- b. Conduct independent audits of a sample of treatment providers at appropriate intervals.
  - c. Notify the management services contractor of current provider approvals and expirations on a *monthly basis*, and verify the use of approved providers during its independent auditing of the contractor.
- 4.2. The Department of Health and Welfare should strengthen its fiscal management of the program by:
- a. Ensuring that program staff have the necessary fiscal training and information to adequately monitor and understand the program's financial situation.
  - b. Requiring contract language in the management services contract that limits the length of time providers have to submit billings to the contractor.
- 4.3. The Department of Health and Welfare should work with the Substance Abuse and Mental Health Services Administration of the US Department of Health and Human Services to ensure substance abuse services are provided in a manner consistent with the grant requirements and intent.

### ***Fiscal Impact and Implementation Timeframe***

The additional costs of implementing recommendations 4.1–4.3 should be minimal. Activities described in these recommendations are typical responsibilities of management and program staff. Implementation of these recommendations should be completed by July 1, 2006.



## Chapter 5

# Substance Abuse Treatment Data

*Idaho statutes and federal guidance convey the importance of using high quality data to monitor and evaluate the state's efforts to address substance abuse. The Department of Health and Welfare has not maintained reliable data and has depended solely on information obtained from the management services contractor. The Department of Correction, the Department of Juvenile Corrections, and the Judicial Branch also have data weaknesses that hinder an overall understanding of treatment services provided through the state.*

### **Accurate Data Is Necessary to Effectively Manage a Program**

Idaho Code § 39-303(b) requires that state activities to address substance abuse be monitored and evaluated, and the results be annually reported to the Legislature and the Governor. As indicated by the US Department of Health and Human Services, “armed with knowledge and accurate information...legislators can ensure the goals and objectives...are advanced in a manner that is productive for a state's entire constituency.”<sup>1</sup>

Substance abuse program managers should use data to anticipate budgetary and resource needs, examine trends, identify areas for improvement, manage wait lists, meet federal requirements, and report results to policymakers. According to the federal Block Grant agency, ready access to basic information is needed to tailor the program to meet Idaho's unique substance abuse treatment needs, and to ensure the services provided are effective. Based on federal requirements and best practices, the agency responsible for administering programs to address substance abuse should have ready, independent access to the following information:<sup>2</sup>

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<sup>1</sup> US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Treatment for Alcohol and Other Drug Abuse: Opportunities for Coordination* TAP 11, DHHS Pub. SMA 94-2075, (1994) [www.treatment.org/Taps/index.html](http://www.treatment.org/Taps/index.html).

<sup>2</sup> *Ibid.*; 45 CFR 96.122; US Department of Health and Human Services, Center for Substance Abuse Treatment, Division of State and Community Assistance, *Uniform Application FY 2005 Substance Abuse Prevention And Treatment Block Grant*, OMB No. 0930-0080; US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers*, TAP 22, DHHS Pub. SMA 95-3173 (1998), [www.treatment.org/Taps/index.html](http://www.treatment.org/Taps/index.html).

- Individuals served in each type of program and waiting for services
- Individuals not served, or not provided the appropriate type of treatment
- Completion, dropout, and relapse rates, overall and by provider
- Average length of stay in each type of program, overall and by provider

Access and use of this management information would assist state government in providing a comprehensive and clinically-appropriate system of care for needy and priority populations.

## **Health and Welfare Does Not Have Reliable and Independent Treatment Data**

Department information about individual treatment services obtained from different sources is not consistent and raises questions about its reliability. Exhibit 5.1 compares data from three sources for fiscal year 2004:

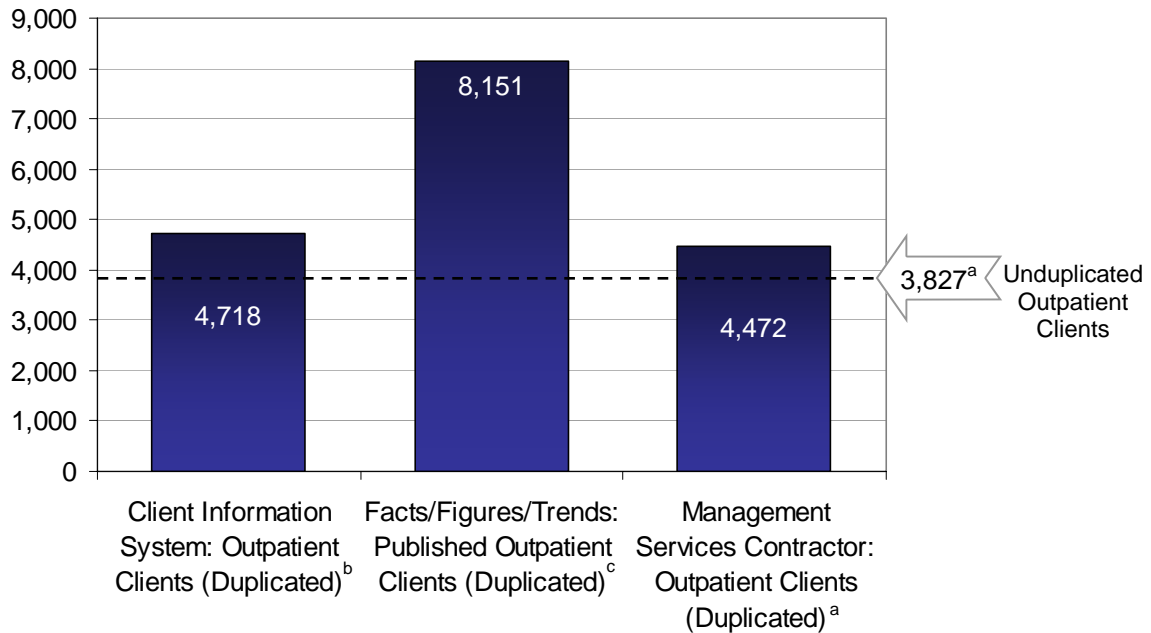
- Health and Welfare's Client Information System
- Health and Welfare's publication *Facts/Figures/Trends 2004–2005* that Health and Welfare staff claim is based on the Client Information System
- Management services contractor's data system, as analyzed by OPE

As shown in the exhibit, information reported through these information sources varied in the same fiscal year. These sources should be consistent. Although Health and Welfare staff said the numbers published in the 2004–2005 edition of *Facts/Figures/Trends* were derived from Health and Welfare's Client Information System or from the data systems of the management services contractor, neither database verifies the published information. *Facts/Figures/Trends 2004–2005* shows 8,151 duplicated clients were provided outpatient treatment in fiscal year 2004, compared to 4,472 duplicated clients found in our analysis of the management services contractor's data system.<sup>3</sup> Furthermore, Health and Welfare's Client Information System, which is intended to mirror the contractor's data system, indicates 4,718 duplicated clients received outpatient or intensive outpatient services in fiscal year 2004. Each system has problems that impact data reliability.

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<sup>3</sup> Idaho Department of Health and Welfare, *Facts/Figures/Trends 2004–2005* IDHW-1,000-61771-01/05 (January 2005), 47. Our analysis of management services contractor data indicated that 3,827 *unduplicated* individuals received outpatient and/or intensive outpatient treatment in fiscal year 2004.

**Exhibit 5.1: Discrepancy Among Health and Welfare Treatment Data, Fiscal Year 2004**



<sup>a</sup> Based on paid intensive and non-intensive outpatient treatment data from the management services contractor's system.

<sup>b</sup> Includes those receiving intensive and non-intensive outpatient treatment.

<sup>c</sup> *Facts/Figures/Trends 2004-2005* reports clients receiving residential (adult and adolescent) and detoxification services, as well as outpatient treatment (included here).

Note: Similar discrepancies were found in previous years' data disseminated by the Department of Health and Welfare, including that reported to the federal government.

Source: Office of Performance Evaluations' review of data from the Department of Health and Welfare, Division of Family and Community Services, and the substance abuse program management services contractor.

### **Client Information System**

To assist in its oversight responsibilities and federal data reporting obligations, Health and Welfare requires the management services contractor to collect client profile and treatment information. The data is then electronically transferred into Health and Welfare's Client Information System.

Health and Welfare has experienced difficulty in maintaining the integrity of its Client Information System as a result of ongoing technical problems associated with the data transfer. Two years into the contract, this data transfer was still problematic. Health and Welfare staff estimated in May 2005 that about 80 percent of the data was transferring correctly. Both Health and Welfare and contractor's staff report the delay in finalizing the electronic data transfer

capability was partially due to loss of critical staff and limited Health and Welfare resources to devote to the project, as well as being a lower priority than other Health and Welfare programs. As of November 2005, Health and Welfare reports these data transfer problems have been remedied.

Health and Welfare relied solely on the contractor for information about its treatment services because the Client Information System did not contain reliable data. As a result, the department was unable to independently verify reports received from the contractor. Maintaining an independent, current, and reliable client data system would provide Health and Welfare with a number of benefits:

- Ready access to program management information
- Ability to identify clients receiving other Health and Welfare services
- Ability to verify client information provided by the management services contractor

Since the Client Information System of Health and Welfare recently began receiving complete data from the contractor's system, Health and Welfare should be able to begin producing independent reports for analysis and verifying contractor performance.

### ***Management Services Contractor Claims Data***

According to the US Substance Abuse and Mental Health Services Administration, Health and Welfare should ensure the management services contractor has a data system to “collect, manage, and maintain” information important to assess program performance.<sup>4</sup> Although some initial profile data about clients seeking treatment is collected by the management services contractor, much of the data about treatment services is obtained directly from providers through the billing process. Appendices B and E provide summaries of client profile and treatment information we obtained from the management services contractor's data system.

The management services contractor told us the 2004 provider audit revealed that providers had only submitted discharge information for three percent of the clients reviewed. The contractor had hoped providers would keep discharge records up-to-date, because the opportunity to take on additional clients would be a financial incentive for providers to dismiss clients no longer receiving services.

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<sup>4</sup> US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers*, TAP 22, DHHS Publication No. SMA 95-3173, (1998) [www.treatment.org/Taps/index.html](http://www.treatment.org/Taps/index.html).

If this incentive system was operating as intended, we would expect all services provided (excluding those within the 90-day payment timeframe) to have a paid bill, and all services with paid bills to have complete client information. However, in a review of the records from a statistically-representative sample of clients, we found a number of cases that raise questions about the adequacy of relying solely on the providers to ensure completeness and accuracy of the information:<sup>5</sup>

- Clients were not discharged from treatment by the provider, even though some had not participated in treatment for more than 6 months
- Clients did not have a record of paid services, but had been discharged as successfully completing treatment

The contractor reports that treatment providers have twice been sent a list of clients and asked to submit discharge information for those not actively participating in treatment. The number of errors have declined substantially since sending out these lists. However, this is not a routine process. If this type of follow-up with treatment providers was routinely conducted, the process would help ensure the department has more complete, accurate, and timely data to monitor treatment services.

### ***Monitoring Treatment Capacity***

In 2004, Health and Welfare told federal officials that “all [Idaho] providers have the capacity to expand services if the state were able to purchase more services,” a view also held by the management services contractor. This means the determination for whether an individual is placed on a waiting list for services is made based on available funding, rather than whether providers have beds or counseling hours available.

A facility’s capacity should be based on the number of staff available to provide treatment. Idaho administrative rules establish minimum staffing levels for state approved facilities that determine treatment capacity. For example, facilities providing outpatient treatment must have at least one staff member for every 30 clients.<sup>6</sup> Therefore, Health and Welfare should work with the contractor to consider staffing levels when developing a picture of capacity.

The contractor has recently initiated self-assessments of treatment capacity from state providers. As of July 2005, the contractor could report estimates on the treatment capacity of approximately one-third of facilities contracted to treat

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<sup>5</sup> We reviewed a statistically-representative sample of records for 375 clients randomly selected from 12,089 individual clients approved for services during fiscal year 2004 and fiscal year 2005. The error rate represents 70 missing discharge dates in 1,886 treatment records (4 percent). These errors occurred in records for 67 of the 375 clients (18 percent).

<sup>6</sup> IDAPA 16.06.03.143.03.

state clients. Using these capacity estimates and wait list information, we were not able to determine the need for different types of services, such as residential or outpatient treatment. Monitoring capacity and needs would allow program managers to identify service gaps and address those through planning.

For example, federal regulations require that Health and Welfare track when facilities treating intravenous drug users reach 90 percent of their capacity.<sup>7</sup> This requirement is intended to determine where resources are being spent and at what rate services are needed and used, and to ensure the most vulnerable persons receive timely treatment.<sup>8</sup> Although Health and Welfare reported to the federal government that it had established a log system to track facilities reaching 90 percent of their capacity, staff told us this system has been replaced by the waiting list—which is driven by available funding, or budget decisions, rather than physical capacity (e.g., available beds or counseling hours).

## **Data Management by Other State Agencies and the Judicial Branch Needs Improvement**

Although Health and Welfare has been the primary focus of this report, access to accurate and timely data across other state agencies and drug courts is also needed to coordinate and understand services statewide. Inconsistent and incomplete data hinders a comprehensive understanding of treatment services, including the capacity of state entities to treat Idaho citizens.

The **Department of Correction** provides community-based substance abuse treatment services to probationers and parolees through Correction contractors. These probationers and parolees can also receive treatment services through Health and Welfare. Currently, Health and Welfare and Correction do not formally coordinate information about these services. A cooperative understanding between the two agencies regarding providers' capacity to take on new clients is key to efficient management of statewide services. Appendix D summarizes Correction's substance abuse treatment data and discusses some of its limitations.

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<sup>7</sup> 42 USC 300x-23(a); 45 CFR 96.126, .122(f)(3)(vii), .122(g)(4).

<sup>8</sup> The department has additional responsibilities that elevate the importance of appropriate waiting list management, including assurance that clients of Child Protection Services and persons receiving cash assistance through the Temporary Assistance to Families in Idaho (TAFI) program are given access to treatment with little or no delay. Child Protection Services staff report that clients' service plans are linked to completion of substance abuse treatment in some cases, and failure to access timely treatment could impact the reunification of families. Under the Adoption and Safe Families Act of 1997 (PL 105-89), the state is required to "move to terminate" parental rights if a child is in foster care for 15 out of 22 months. 42 USC 670note, 675(5)(E), 45 CFR 1356.21(i)(i). Recognizing the workforce impact of substance abuse, the Idaho Legislature provided for screening, testing, and treatment for TAFI participants in IDAHO CODE § 56-209i.

Our survey of voting members of the Regional Substance Abuse Authorities found juvenile services as an area of significant need in Idaho (discussed further in appendix C). Because the **Department of Juvenile Corrections** (which operates services independently of Health and Welfare) has not consistently maintained its contracts with private providers or county detention centers, it is unable to readily describe the extent it provides substance abuse treatment. The most recent information available from Juvenile Corrections (provided in appendix D) indicates the number of juveniles treated for substance abuse disorders has remained relatively unchanged. Juvenile Corrections has taken important steps toward systematically measuring outcomes related to substance abuse. These efforts are discussed further in chapter 6.

The Supreme Court of the **Judicial Branch** gathers information on participation in Idaho drug courts in the form of monthly participation tallies from each drug court, as required by the *Adult Drug Court Guidelines*. Participation information from these reports is included in appendix D. Although this information can be used to gain a general understanding of drug court participation, inconsistencies limit its usefulness for accurately identifying the total number of individual (unduplicated) participants in a given year. In addition, the Supreme Court has not received participant services information from Health and Welfare's contractor (who coordinates drug court treatment for five of seven judicial districts). The Supreme Court does not collect treatment data, and instead relies on the Department of Health and Welfare to monitor treatment quality indicators.

## Recommendations

- 5.1. To have necessary data for managing substance abuse programs, the Department of Health and Welfare, the Department of Correction, the Department of Juvenile Corrections, and the Judicial Branch should work individually, and collectively with relevant entities, to ensure the collection and analysis of the following information about their programs:
  - a. Individuals served in each type of program and waiting for services.
  - b. Individuals not served, or not provided the appropriate type of treatment.
  - c. Completion, dropout, and relapse rates, overall and by provider.
  - d. Average length of stay in each type of program, overall and by provider.

- 5.2. To ensure that client data is complete and accurate, including capacity information, the Department of Health and Welfare should work with the management services contractor to:
- a. Accurately transfer data from the contractor to Health and Welfare's independent data system, and use the information to verify contractor performance.
  - b. Negotiate a change to the management services contract that would require the contractor to routinely (every 30–60 days) require providers to indicate which clients are actively participating in treatment and which have completed or discontinued treatment.
  - c. Complete the process of requesting capacity information from providers in the state network, and comply with the federal regulation to track facilities *as and when* they reach 90 percent capacity.

### ***Fiscal Impact and Implementation Timeframe***

For Health and Welfare, the costs of implementing recommendations 5.1 and 5.2(a) should not require additional resources because these are existing program functions. Recommendations 5.2(b) and (c) may require additional resources because they fall outside the scope of the management services contract. However, the cost should be minimal because much of the infrastructure is already in place to accomplish these tasks.

For the Judicial Branch and state agencies other than Health and Welfare, the costs of implementing recommendation 5.1 will vary and require some additional resources. New data elements may be incorporated into existing data systems maintained by agencies and the Judicial Branch.

Implementation of these recommendations should be complete by January 1, 2007.

## Chapter 6

# Quality of Substance Abuse Treatment

*The quality of a statewide system that treats substance abuse is measured by its management processes, treatment outcomes, and treatment provider qualifications. Data suggests that fewer than a quarter of clients beginning treatment through the Department of Health and Welfare’s program successfully complete treatment, which is less than the national rate of 39 percent. The quality of treatment could be improved by strengthening the department’s administrative rules and its process for approving treatment providers.*

### State and Federal Funding Sources Call for Accountability and Quality Services

Idaho Code § 39-301 requires state government to “effectively and economically utilize federal and state funds” for substance abuse treatment. The code further requires accountability about substance programs through an annual report to the Legislature and the Governor outlining the “achievements and impact on alcohol and drug services, programs, and policies.”<sup>1</sup>

According to the federal Substance Abuse and Mental Health Services Administration, the quality of a substance abuse treatment system can be measured in three general areas:<sup>2</sup>

- **Process.** Measures the activities and methods used to ensure services are provided, including the quality of administrative, clinical, and client utilization processes
- **Structure.** Measures areas believed to increase the opportunity for providers to deliver quality services such as facility licensing and provider accreditation standards
- **Outcome.** Measures the effectiveness of the treatment services provided

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<sup>1</sup> IDAHO CODE §39-303(c)(6).

<sup>2</sup> US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Contracting for Managed Substance Abuse and Mental Health Services: A Guide for Public Purchasers* TAP 22, DHHS Pub. SMA 95-3173, (1998) [www.treatment.org/Taps/index.html](http://www.treatment.org/Taps/index.html).

Earlier chapters discussed the management of substance abuse treatment services. This chapter focuses on two other areas of measuring quality: available treatment outcomes, and assurance that providers are qualified and approved to deliver services.

## **Available Information Raises Concerns About Treatment Quality**

To get a general indication of treatment quality, we reviewed data on client completion rates and compared them to available national rates, and we obtained the results of provider audits conducted by the management services contractor. The limited information available raised concerns about the quality of treatment services provided.

### ***Treatment Completion Rates***

The federal Substance Abuse and Mental Health Service Administration suggests outcome evaluations are “useful to program personnel in making decisions about continuing or modifying services,” and could help program managers understand the factors influencing the effectiveness of treatment programs.<sup>3</sup> One basic approach to measuring program effectiveness reported by the federal agency is examining program completion and drop out rates.

To develop an understanding of Idaho’s treatment services, we selected a statistically-representative random sample of 375 clients from more than 12,000 in the management services contractor’s client database. These clients were all approved to receive some level of service through either the Block Grant or Access to Recovery grant programs, or were placed on waiting lists between July 2003 and July 2005.<sup>4</sup> Exhibit 6.1 lists the reasons clients in our sample were discharged from treatment during fiscal years 2004 and 2005.

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<sup>3</sup> US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, *Treatment for Alcohol and Other Drug Abuse: Opportunities for Coordination* TAP 11, DHHS Pub. SMA 94-2075 (1994), chap. 10, [www.treatment.org/Taps/index.html](http://www.treatment.org/Taps/index.html); National Institute on Drug Abuse, *Measuring and Improving Cost, Cost-Effectiveness, and Cost-Benefit for Substance Abuse Treatment Programs: a manual* (1999), 66.

<sup>4</sup> Because the current management services contractor has only had the contract for two years, the information we reviewed was limited to services approved for new clients during that time and to those clients who were already receiving treatment services at the beginning of the contract. The sample size is representative at the 95 percent confidence level, plus or minus 1.73 percent.

### Exhibit 6.1: Discharge Reasons for a Representative Sample of Clients Receiving Substance Abuse Treatment, Fiscal Years 2004–2005

Treatment ended	<u>Clients</u>	
<i>Successfully completed</i>	54	(18.6%)
<i>Discharge reason not specified by provider</i>	49	(16.8%)
<i>Data not sufficient to determine discharge reason</i>	12	(4.1%)
<i>Provider discontinued services</i>	16	(5.5%)
<i>Client discontinued services</i>	137	(47.1%)
<i>Incarceration/court intervention</i>	7	(2.4%)
<i>Other (change in eligibility, etc.)</i>	<u>16</u>	(5.5%)
<i>Subtotal</i>	<b>291</b>	
<b>Currently in treatment (no discharge)</b>	<b><u>84</u></b>	
<b>Total</b>	<b>375</b>	

Source: Office of Performance Evaluations' analysis of Department of Health and Welfare, Division of Family and Community Services, Substance Abuse Program management services contractor data.

To provide context to Idaho's results we also examined national substance abuse treatment program discharge information.<sup>5</sup> The analysis method we used to develop exhibit 6.1 differed slightly from the approach used to generate the national data, so only general conclusions can be made from the comparison.<sup>6</sup>

<sup>5</sup> Substance Abuse and Mental Health Services Administration, Office of Applied Studies, *Treatment Episode Data Set (TEDS): 1992–2001; National Admissions to Substance Abuse Treatment Services* DASIS Series: S-20, DHHS Pub. SMA 03-3778 (Rockville MD 2003), [www.dasis.samhsa.gov/teds01/TEDS2K1Index.htm](http://www.dasis.samhsa.gov/teds01/TEDS2K1Index.htm). A review of client admissions characteristics (from discharge data of 22 states) suggests clients in the discharge study are similar to those in all states. Clients entering treatment twice in one year are counted twice in the data.

<sup>6</sup> Idaho's data had more complete information about the reasons a client left treatment than the national data set, allowing us to include clients who dropped after they transferred to a new program. Also, the national data set had few individuals with missing or invalid discharge reasons (2 percent), and did not include those individuals in the analysis. Our analysis included individuals with missing information because they represented almost 20 percent of the clients reviewed.

Our analysis indicates that about 19 percent of Idaho clients discharged were reported by the treatment provider as having successfully completed their treatment program. If the national analysis method is used, however, the successful completion rate is closer to 24 percent. Regardless of the analysis method used, a lower percentage of Idaho clients are successfully completing treatment compared to the national rate of 39 percent (the most recent year data is available).

As illustrated in exhibit 6.1, the reason for discharge could not be determined in 21 percent of the clients reviewed because it was not specified by the provider, or the data was insufficient to determine the outcome, making it difficult to gain a full understanding of Idaho's completion rates. The management services contractor reports that based on work with our office during the course of the evaluation, it has accelerated quality control and lowered the rate of missing data.

### Client Drop Out

Keeping clients engaged in treatment is a challenge for substance abuse treatment systems. As shown in exhibit 6.1, almost half (47 percent) of Idaho clients entering treatment chose to discontinue treatment before it was complete. National data indicates up to 36 percent of treatment clients chose to drop out of treatment before completion.<sup>7</sup>

Comparing Idaho's completion and drop out rates for various types of treatment with national trends would help Health and Welfare make decisions about the ability of Idaho programs to retain clients in treatment. For example, 153 of the 375 clients were discharged from the least intensive level of outpatient treatment. Of those 153 clients discharged, 28 percent successfully completed treatment, compared to the national rate of 34 percent for the same level of care.

This type of information, in conjunction with other treatment data, can be used to determine where improvement is needed to the delivery of services. For example, high drop out rates could indicate a need for provider training in client retention.

### Government Performance and Results Act Interviews

In accordance with Government Performance and Results Act (GPRA) of 1993 and Access to Recovery grant requirements, Health and Welfare has begun conducting interviews of all substance abuse clients to collect specific treatment outcome data. Information gathered through these interviews will address treatment outcomes such as drug use, employment, housing status, and criminal justice status. These interviews are intended to provide additional tools to assess

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<sup>7</sup> This national rate includes 25 percent of clients coded as having dropped out, in addition to 11 percent of clients who were discharged after transfer to another program, but who showed no record of further treatment. It is not clear how many of this 11 percent group of clients dropped out of treatment.

the success of treatment programs and to provide a standard reporting format for comparison with other states.

As of September 2005, the Idaho management services contractor reported that treatment providers had conducted almost 3,000 interviews that will then be submitted to the Substance Abuse and Mental Health Services Administration for analysis. The federal agency estimates the outcome information will be available sometime in 2006.

### **Audit Results**

Health and Welfare and the management services contractor are required to perform periodic provider audits. They have developed an audit checklist that measures each provider's adherence to administrative rule and accepted best practice standards. Health and Welfare's performance goal is for providers to score 95 percent or better on their review. According to a jointly issued report by Health and Welfare and the contractor, results of the 2003 baseline audit supported "considerable need for improvement," because no providers scored above 90 percent and only 6 of 51 (12 percent) scored 80 percent or above.<sup>8</sup> The report also notes that the provider audit check list is new and may need refinement.

In response to the 2004 audit findings, Health and Welfare offered provider training in the areas of most need: clinical documentation, clinical supervision, and use of the American Society of Addiction Medicine assessment tool. The subsequent chart audit in 2005 found that 69 percent of the providers increased their score, with about a third scoring 80 percent or higher and one provider scoring higher than 90 percent. However, 24 of the 56 providers scored below 70 percent. These results suggest that provider quality continues to need improvement.

## **State Credentialing Requirements and Approval Process Are Not Sufficient to Promote Treatment Quality**

Ultimately, the effectiveness of the substance abuse service system depends on the quality of the treatment services offered by Idaho's privately operated providers. In the absence of adequate treatment outcome data, the state has two mechanisms in place to ensure providers included in the state funded substance abuse system deliver high quality services: state credentialing requirements and Health and Welfare's provider approval process.

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<sup>8</sup> Business Psychology Associates, Inc. and Idaho Department of Health and Welfare, *Substance Abuse Treatment System Provider Audit 2003* (March 2004).

### ***Provider Credentialing***

In 2004, the National Alliance for Model State Drug Laws recommended that Idaho establish licensing of drug and alcohol counselors.<sup>9</sup> Although substance abuse counselors may voluntarily obtain certification from the Idaho Board of Alcohol-Drug Counselor Certification, the state does not offer or require occupational licensing or registration specifically for addiction treatment. Individuals providing counseling for substance abuse disorders in for-profit facilities are required to have some kind of professional license, although this is not specific to addiction treatment. Individuals providing substance abuse treatment in non-profit facilities are not required to have any professional license.<sup>10</sup>

In a review of 49 states and the District of Columbia, we found 31 states—including 5 of Idaho’s 6 neighbors—required individuals who practice substance abuse, chemical dependency, or addictions counseling to be licensed, certified, or registered as a substance abuse treatment provider.<sup>11</sup>

Health and Welfare administrative rules governing treatment programs broadly define *qualified professionals* and provide minimal definition of *trained staff* for detoxification facilities, but do not provide staffing guidance for halfway housing facilities.<sup>12</sup> The requirements for residential, inpatient, outpatient, and drug court services include as little as six months supervised experience and a bachelor’s degree in a related field.<sup>13</sup>

### ***Provider Approval Process***

Minimal treatment provider credentialing requirements make Health and Welfare’s provider approval process critical to ensure the state delivers high quality treatment services. Health and Welfare currently approves and renews adult treatment facilities providing services through the state program every two years, based on the process prescribed in administrative rules.<sup>14</sup> These rules govern many aspects of facility operation and delivery of appropriate treatment

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<sup>9</sup> National Alliance for Model State Drug Laws, *Idaho Summit on Alcohol & Other Drug Issues: Report of Recommended Actions* (May 2004).

<sup>10</sup> IDAHO CODE §§ 54-3402(4), -2303, -3214(3); 45 CFR 96.135(a)(5). The department is required by federal regulation to deliver treatment services solely through publicly-run or non-profit private providers.

<sup>11</sup> Of 49 states and the District of Columbia, 30 require statewide, public and private occupational licensing, certification, or registration for therapists/counselors for substance abuse, chemical dependency, alcohol-drug, or other addiction therapies as a prerequisite to practice substance abuse treatment. One state is in the process of implementing licensing requirements, and 19 states do not have requirements, or only have requirements for either public *or* private practice.

<sup>12</sup> IDAPA 16.06.03.010.63, .140.03(a–b), .144.03.

<sup>13</sup> IDAPA 16.06.03.010.63.

<sup>14</sup> IDAPA 16.06.03.023.01(b).

services. Health and Welfare has one staff member responsible for reviewing nearly 100 facilities.

We accompanied Health and Welfare during a site visit to a substance abuse treatment provider with multiple facilities to review operations for potential renewal of its status as an approved program. The review was conducted with a checklist of the elements required in administrative rule. We observed numerous instances where the provider was out of compliance, including missing client treatment plans, progress notes, and fire safety procedures. The provider, however, was assured by Health and Welfare staff that these deviations would not jeopardize the provider's approval.

Health and Welfare has the ability to grant full or provisional approval, or deny approval. However, it does not have criteria outlining the extent of provider deficiencies that would result in approved, provisional, or denied approval. Without criteria, approval status is based solely on staff judgment. Facilities given provisional approval are required to address identified deficiencies within six months. Any corrective actions identified for *fully approved* facilities, however, are not checked for compliance until the next two-year site visit. Health and Welfare staff did not recall an instance when a provider lost approval status based on a provider approval review.

## **Treatment Outcome Information Provided by Other Agencies and Drug Courts Is Limited**

State agencies and the drug courts are collecting data for only a few programs, relying on estimates, or not collecting data about participants. Therefore, it is not possible to determine the effectiveness of substance abuse treatment statewide, or compare treatment programs across agencies.

### ***Department of Correction***

Other than its Therapeutic Community programs, the Department of Correction does not track outcome information about its institutional or community-based substance abuse programs separately from other programs. This limits Correction's ability to determine the impact that treatment has on addiction recovery and reintegrating offenders into the community. Because of coding limitations, Correction could provide only general estimates of the number of incarcerated offenders who completed (77 percent) or failed (9 percent) its Relapse Prevention programs since 2000, or were transferred from one facility to another before completing (12 percent). Correction reported in its *Annual Statistical Report* for fiscal year 2004 that offenders who completed Therapeutic Community programming between fiscal years 1999 and 2002 revoked their paroles less often (36 percent) than offenders who were unsuccessful in the program (44 percent).

### ***Department of Juvenile Corrections***

The Department of Juvenile Corrections tracks some outcome information about the substance abuse treatment components of its institutional programs. These include several indicators that measure whether juveniles are referred to an appropriate level of substance abuse treatment while in correctional centers, and whether juveniles are referred to treatment after release from custody. For instance, Juvenile Corrections found the number of state facility residents, whose records indicate they had received the substance abuse treatment prescribed by their individual treatment plans, had increased from 58 percent in April 2003, to 90 percent in April 2005.

### ***Judicial Branch***

Idaho Code describes effective drug courts as those that “closely supervise, monitor, test and treat substance abusers” and establishes a statutory goal to reduce “alcohol and drug abuse and dependency among criminal and juvenile offenders.”<sup>15</sup> However, Supreme Court staff report the Judicial Branch does not have the responsibility or means to collect data on the effectiveness of the substance abuse treatment component of drug courts, but rather is responsible for assessing the overall effectiveness of the drug court program.

Idaho Code directs the district court of each county implementing a drug court program to annually evaluate its effectiveness, and to report to the Supreme Court upon request.<sup>16</sup> A Supreme Court survey found that 14 percent of drug courts are not collecting and reviewing evaluation data about performance and outcomes.<sup>17</sup> The Supreme Court gathers and records monthly participation counts from each drug court, which are used to fulfill the statutory evaluation requirement.

In 2003, the Judicial Branch released an evaluation of the overall effectiveness of drug courts for two counties (Ada and Kootenai). Results of the Kootenai County evaluation showed no statistically significant difference between the re-arrest rates of all clients who participated in the drug court (41 percent), and those who did not (53 percent). Conversely, in Ada County, there was a statistically significant reduction in recidivism for drug court participants (46 percent of participants recidivated; 65 percent of non-participants recidivated).<sup>18</sup> An outcome evaluation of additional drug courts is due to be completed in September 2006.

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<sup>15</sup> IDAHO CODE § 19-5602.

<sup>16</sup> IDAHO CODE § 19-5605. Code further requires the Supreme Court to report annually to the Legislature and the Governor on the effectiveness of drug courts statewide. The Court has fulfilled this requirement in various forms since the 2002 legislative session.

<sup>17</sup> Idaho Supreme Court, *Idaho Drug Court Teams Self-Assessment of Operations* (2004).

<sup>18</sup> Center for Criminal Justice Research, University of Cincinnati, *The Kootenai and Ada County Drug Courts: Outcome Evaluation Findings* (April 2003).

## Recommendations

- 6.1. To ensure approved and qualified treatment providers are delivering services, the Department of Health and Welfare should:
  - a. Develop criteria for the approval process of providers offering treatment to adults to include a more detailed description of levels of compliance that constitute approval, provisional approval, and failure to be approved.
  - b. Make recommendations to germane legislative committees on rule or statutory changes to strengthen treatment provider credentialing requirements for the statewide system in coordination with the proposed substance abuse commission.
- 6.2. Using Government Performance and Results Act interviews and other information, the Department of Health and Welfare should develop a plan to increase client retention in treatment.
- 6.3. The Department of Health and Welfare, the Department of Correction, the Department of Juvenile Corrections, and Judicial Branch should continue or begin to take measurable steps to gather, verify, and publish relevant information on the effectiveness of substance abuse programs.

### ***Fiscal Impact and Implementation Timeframe***

The costs of implementing recommendations 6.1 and 6.2 will take some additional staff time, but the fiscal impact should be minimal. Activities described in these recommendations are typical responsibilities of management and program staff.

For the Judicial Branch and state agencies, the costs of implementing recommendation 6.3 will vary. The Judicial Branch and state agencies may be able to use existing data reporting systems, and minimize additional costs by avoiding duplication of efforts among entities.

Implementation of recommendations 6.1 should be complete by July 1, 2007. Implementation of recommendation 6.2 should be completed by July 1, 2006. Agencies should take measurable steps to implement recommendation 6.3 by July 1, 2006, and should publish verified information on the effectiveness of substance abuse programs by July 1, 2007.



# Appendix A

## Treatment Survey of Regional Substance Abuse Authorities

Of 117 surveys sent out to Regional Substance Abuse Authority (RSAA) voting members, 66 (56.4 percent) were returned in time to be included in our analysis. All seven Health and Welfare regions were represented, along with various occupations. This appendix summarizes the main findings of the survey.

### Accessibility of Treatment Services

1. In your opinion, among those people in your community needing substance abuse treatment, how accessible is treatment for those people who are

	No <u>Access</u>	Limited <u>Access</u>	Adequate <u>Access</u>	Don't <u>Know</u>
a. Eligible for state funded treatment (income at or below 175% of federal poverty guidelines)	2 (3.1%)	46 (71.8%)	14 (21.9%)	2 (3.1%)
b. Ineligible for state funded treatment, but with limited/poor financial means and no private insurance coverage for substance abuse treatment	25 (39.1%)	33 (51.6%)	5 (7.8%)	1 (1.6%)
c. Ineligible for state funded treatment, but with private insurance coverage for substance abuse treatment	9 (14.1%)	24 (37.5%)	27 (42.2%)	4 (6.3%)
d. Ineligible for state treatment, but have sufficient financial means to pay for private treatment	1 (1.6%)	11 (17.2%)	45 (70.3%)	7 (10.9%)

2. List populations that you believe are in need of substance abuse treatment services in your community but have the **most** limited access (top four responses).

a. Juveniles	33 (50.8%)
b. Low-income	14 (21.5%)
c. Hispanic	12 (18.5%)
d. Single adults	10 (15.4%)

## State Funded Substance Abuse Treatment Services

3. For persons eligible for state funded substance abuse treatment services, which of the following do you believe are needed, but are currently not sufficiently available in your community?

53.8%	Early intervention	32.3%	Outpatient treatment
55.4%	Social setting detoxification	53.8%	Intensive outpatient treatment
49.2%	Medical setting detoxification	55.4%	Residential treatment (low-intensity)
18.5%	Opiate substitution	60.0%	Residential treatment (medium-intensity)
46.2%	Recovery support services	60.0%	Residential treatment (high-intensity)
56.9%	Halfway housing	30.8%	Emergency treatment services
52.3%	Transitional housing for pregnant women/women with children	41.5%	Medically managed intensive inpatient treatment (hospital-based)
70.8%	Integrated substance abuse and mental health treatment	40.6%	Relapse prevention
3.1%	Don't know	12.3%	Other <sup>a</sup>

4. Please list the services you believe are the **most** needed for persons eligible for state funded substance abuse treatment but are currently not sufficiently available in your community (top four responses).

a.	Residential treatment	25 (39.1%)
b.	Detoxification	23 (35.9%)
c.	Early intervention	19 (29.7%)
d.	Halfway housing	18 (28.1%)

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<sup>a</sup> Of 6 responses, one reported a need for adolescent treatment, two reported a need for culturally appropriate treatment (e.g., Spanish track treatment), one reported lack of Alcoholics Anonymous, one reported tracking of IV users while they await treatment, and one reported affordable and accessible rural services.

5. For those eligible for state funded substance abuse treatment (income at or below 175% of federal poverty guidelines), which of the following services, if any, do you believe are of **sufficient quality** to allow participants to succeed?

9.2%	Early intervention	40.0%	Outpatient treatment
3.1%	Social setting detoxification	24.6%	Intensive outpatient treatment
10.8%	Transitional housing for pregnant women/women with children	12.3%	Residential treatment (high-intensity)
6.2%	Halfway housing	7.7%	Don't know
18.5%	Recovery support services	9.2%	Other <sup>b</sup>

6. In your opinion, when compared to substance abuse treatment services available privately, the quality of state funded treatment is generally

Worse	Similar	Better	Don't Know
12 (19.3%)	31 (50.0%)	5 (8.1%)	14 (22.6%)

Please indicate your level of agreement with the following statements.

	Strongly Disagree	Disagree	Agree	Strongly Agree	Don't Know
7. The process for accessing state funded substance abuse treatment is clearly understood by the referral sources (local officials with corrections, law enforcement, judiciary, education, health and welfare programs, etc.) in your community	16 (25.4%)	33 (52.4%)	9 (14.3%)	—	5 (7.9%)
8. Co-pays required through state funded treatment programs are generally affordable	1 (1.7%)	16 (26.7%)	25 (41.7%)	3 (5.0%)	15 (25.0%)
9. State funded treatment services are able to meet the cultural and language needs of my community	9 (14.8%)	28 (45.9%)	19 (31.1%)	—	5 (8.2%)

<sup>b</sup> Of 4 responses, one reported that none of the services were of sufficient quality, two reported that the drug court was of sufficient quality, and one indicated that juvenile residential treatment in Kuna was accessible.

## Overall Availability of Treatment (Public or Private)

10. In your community, which of the following services do you believe are needed, but currently **not** sufficiently available publicly or privately?

53.2%	Early intervention	35.5%	Outpatient treatment
59.7%	Social setting detoxification	48.4%	Intensive outpatient treatment
58.1%	Medical setting detoxification	59.7%	Residential treatment (low-intensity)
32.3%	Opiate substitution	59.7%	Residential treatment (medium-intensity)
38.7%	Recovery support services	62.9%	Residential treatment (high-intensity)
59.7%	Halfway housing	33.9%	Emergency treatment services
59.7%	Transitional housing for pregnant women/women with children	41.9%	Medically managed intensive inpatient treatment (hospital-based)
67.7%	Integrated substance abuse and mental health treatment	40.3%	Relapse prevention
3.1%	Don't know	9.7%	Other <sup>c</sup>

11. List the substance abuse treatment services you believe are **most** needed overall but are currently not sufficiently available in your community (top four responses).

a.	Detoxification	23 (37.7%)
b.	Residential treatment	18 (29.5%)
c.	Halfway housing	17 (27.9%)
d.	Early intervention	13 (21.3%)

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<sup>c</sup> Of 5 responses, one reported that culturally appropriate services were not available, one reported that affordable and accessible rural services were not available, one reported that residential treatment services for adolescents were not available, one reported that Alcoholics Anonymous was not available, and one reported that the ability to track IV users awaiting treatment was not available.

## Coordination of Treatment Services

	Ineffective	Somewhat Effective	Effective	Don't Know	
12. In your opinion, how effective is the coordination among the state agencies charged with delivering state funded substance abuse treatment to those who need it?	12 (20.0%)	38 (63.3%)	8 (13.3%)	2 (3.3%)	
13. In your opinion, how effective is the coordination between the central office of the Department of Health and Welfare and the Regional Substance Abuse Authorities at the local level?	14 (23.3%)	24 (40.0%)	18 (30.0%)	4 (6.7%)	
14. In your opinion, how effective is the coordination between Business Psychology Associates (BPA) and the Regional Substance Abuse Authorities at the local level?	16 (26.2%)	34 (55.7%)	9 (14.8%)	2 (3.3%)	
15. As a RSAA member, do you feel the RSAAs' roles and responsibilities are clearly defined in the state's substance abuse treatment system?	Unclear 13 (21.3%)	Somewhat Clear 32 (52.5%)	Very Clear 15 (24.6%)	Don't Know 1 (1.6%)	
16. Based on your experience as a RSAA member, to what extent do the RSAA's have a role in the decisions made regarding state funded substance abuse treatment services?	None 3 (5.0%)	Minimal 24 (40.0%)	Some 22 (36.7%)	Considerable 9 (15.0%)	Don't Know 2 (3.3%)

## Coordination of Treatment Services (*cont.*)

17. Please list what you see as the greatest strengths and weaknesses to the state substance abuse treatment system (top four responses in each category).

### Strengths

- a. 11 (22.9%) RSAA commitment
- b. 11 (22.9%) Community involvement
- c. 10 (20.8%) Good providers
- d. 9 (18.8%) Helps low income citizens access services

### Weaknesses

- a. 15 (27.3%) Lack of communication/coordination among DHW, BPA, RSAAs, and the State Substance Abuse Executive Council
- b. 13 (23.6%) Limited number of providers/lacking availability of services
- c. 12 (21.8%) Lack of services in rural areas/access to transportation to travel to treatment is limited by geography
- d. 12 (21.8%) Funding freezes/fiscal management

Source: Office of Performance Evaluations' survey.

## Appendix B

# Profile of Individuals Requesting Health and Welfare Substance Abuse Treatment

The following table provides general information about individuals who requested substance abuse treatment services from the Department of Health and Welfare in fiscal years 2004 and 2005. The information is collected as part of the application process to determine eligibility for services.

	<u>FY04</u>	<u>FY05</u>
<b>Individual Clients Screened</b>		
Male	3,774	3,923
Female	2,271	2,689
Unspecified	<u>119</u>	<u>112</u>
Total	6,164	6,724
<b>Eligibility for Treatment Services</b>		
Eligible	6,119	6,323
Ineligible	42	381
Eligible or ineligible (at different times)	<u>3</u>	<u>20</u>
Total	6,164	6,724
<b>Individuals' Treatment History<sup>a</sup></b>		
First time in treatment	2,984	3,488
Prior treatment history	3,008	2,895
<b>Primary Substance Abused<sup>a</sup></b>		
Alcohol	2,556	2,546
Methamphetamines	1,932	2,251
Marijuana/hashish	1,407	1,150
Other opiates and synthetics	103	154
Cocaine/crack	64	64
Heroin	46	81
Other	107	111

	<u>FY04</u>	<u>FY05</u>
<b>Age at Screening<sup>a, b</sup></b>		
12	0	3
13–17	596	593
18–24	1,774	1,817
25–29	939	1,122
30–39	1,413	1,597
40–49	1,118	1,247
50 and older	344	369
<b>Clients in Selected Grant Priority Populations<sup>a</sup></b>		
Pregnant females	99	83
Females with children	945	1,165
Intravenous drug users	922	652
Hispanic	506	740
Native American	116	222
Adolescent	596	593
Court supervised	4,278	3,846
<b>Other Populations<sup>a</sup></b>		
Adult male	2,692	2,603
Adolescent male	593	296
Adults reporting a mental health diagnosis <sup>c</sup>	720	1,295
Youth reporting a mental health diagnosis <sup>c</sup>	78	145
Adult females without children	748	492
Adolescent females without children	256	178

<sup>a</sup> Data only reported for clients with known status. Reported numbers may include duplicates.

<sup>b</sup> If the client was screened more than once, and was at least a year older when screened the second time, the client was counted in each age group.

<sup>c</sup> Mental health diagnosis is based on any mental health issue reported by client and may not indicate need for dual treatment.

Source: Office of Performance Evaluations' analysis of data from the Department of Health and Welfare, Division of Family and Community Services, substance abuse program management services contractor.

## Appendix C

# Future Work for the Proposed Commission on Substance Abuse

In the absence of a functioning statewide commission on substance abuse, no single body has addressed the legislative intent of the Alcoholism and Intoxication Treatment Act. An independent, statewide commission (proposed in chapter 3 of this report) should exercise its authority to implement changes that are currently beyond the scope of the State Substance Abuse Executive Council and its Regional Substance Abuse Authorities (RSAAs). The list below outlines specific issues we identified in the course of our review and analysis, and/or were raised as matters of concern by voting members of the RSAAs, treatment professionals, and state and federal officials.

1. **Juvenile Services.** The commission should address the need for juvenile services, specifically, the lack of interagency coordination (departments of Health and Welfare, Juvenile Corrections, and Education) and the lack of integrated services for families (parents and children).
2. **Co-occurring Disorders and Insurance Parity.** The commission should play a key role in defining *and* coordinating effective and efficient services for clients with co-occurring mental health and substance abuse disorders. According to the National Mental Health Association, as of May 2005, Idaho and Wyoming were the only states without parity laws or legislative mandates addressing equitable insurance coverage for mental health services.
3. **Medicaid.** The commission should clarify the extent of Medicaid coverage for substance abuse treatment. According to Idaho Code, Medicaid may cover treatment of secondary substance abuse disorders for children suffering serious emotional disturbances, but does not provide this coverage for adults.<sup>a</sup> Health and Welfare's website listing state approved substance abuse treatment providers suggests that Medicaid covers substance abuse treatment in Idaho. However, in fiscal year 2005, 100 adult Medicaid recipients were refused treatment through the Health and Welfare's Substance Abuse Program.

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<sup>a</sup> IDAHO CODE §§ 56-209d, 41-3903(1); IDAPA 16.03.09.001.02, 16.03.09.450.01-02.

4. **Coordination of Health and Welfare Programs.** The commission should address the coordination of substance abuse treatment for participants in other state programs, including but not limited to: Temporary Assistance for Families in Idaho (TAFI), and child protection and mental health services. Health and Welfare was unable to provide assurances, for example, that in fulfillment of Idaho Code, persons receiving TAFI cash assistance were given appropriate access to treatment and supportive services.<sup>b</sup>
5. **Medical Detoxification.** The commission should address the discrepancy between the types of treatment required by Idaho Code, specifically emergency medical detoxification services, and those currently offered.<sup>c</sup> The lack of detoxification treatment was identified by the Department of Correction as one of the major treatment issues affecting the department. Idaho Code requires Health and Welfare to fund emergency services, such as medical detoxification.

Clients needing these services, however, are currently directed outside the system, to hospital emergency rooms that bear this financial risk in compliance with the federal Emergency Medical Treatment and Active Labor Act.<sup>d</sup> These costs are then passed on to Idaho counties, and eventually to the state, under Idaho Code provisions for hospitals for indigent sick.<sup>e</sup> The commission should formally address the rationale of Health and Welfare for not complying with statute in regards to the provision for medically-managed services (including cost-benefit figures) and the impact of this policy on other public funds and agencies.
6. **Common Approach to Treatment.** The commission should facilitate statewide definition and identification of outcome information which would complement other state entities. The commission should also address the need for a *series* of uniform substance abuse and chemical dependency assessments for all state agencies, drug courts, boards, and commissions. This need has been identified by the Department

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<sup>b</sup> IDAHO CODE § 56-209i–209l; 2000 Idaho Sess. Law 467 (fiscal note).

<sup>c</sup> IDAHO CODE § 39-304(1)–(2). Nearly half (49 percent) of the Regional Substance Abuse Authority members (32) responding to our survey indicated that state funded medical detoxification was among the services most needed, but was currently unavailable. Twenty-seven members (40.9 percent) indicated a need for state funded hospital-based intensive inpatient treatment.

<sup>d</sup> 42 USC 1395dd. Of 12 Idaho hospitals responding to our inquiry, 8 indicated that providing detoxification services to indigent clients was a moderate or high burden.

<sup>e</sup> IDAHO CODE § 31-3501–3521. In response to our questionnaire about the impact on Idaho counties, officials from 8 of 18 counties indicated the financial burden of *direct* substance abuse treatment was high or disproportionately high; 12 of 17 officials also reported the financial burden of *indirectly* related to substance abuse was high or disproportionately high.

of Correction, as well as local drug court staff and treatment providers, as an issue affecting efficient delivery and appropriateness of services. In line with legislative intent to ensure statewide coordination of treatment, the commission should play a key leadership role in determining a common language for substance abuse treatment, as well as assessment criteria.<sup>f</sup>

Recognizing the importance of accountability in public programs, the National Association of State Alcohol and Drug Abuse Directors found an “imperative” need for a common language for public agencies providing substance abuse treatment systems

One cannot, for example, determine treatment access...for medically indigent clients unless all the components of the service delivery system serving those clients can be identified. Worse, such information, drawn from only an unknown portion of a service delivery system, can be misleading.<sup>g</sup>

- 7. Statewide Facility Approval.** The commission should facilitate the development of a coordinated approval process for treatment providers serving state clients. This coordination should include addressing the extent of Health and Welfare’s approval process and its application to other state agencies providing treatment. Currently, Health and Welfare does not interpret its provider approval process to apply to other agencies providing substance abuse treatment, although this view is not expressly supported by its administrative rules.<sup>h</sup>

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<sup>f</sup> IDAHO CODE § 39-303(b)(1)–(3).

<sup>g</sup> NATIONAL Association of State Alcohol and Drug Abuse Directors, *Identification and Description of Multiple Alcohol and Other Drug Treatment Systems, Final Report* (August 2002), 15.

<sup>h</sup> IDAPA 16.06.03.001.02, 16.06.03.020.01.



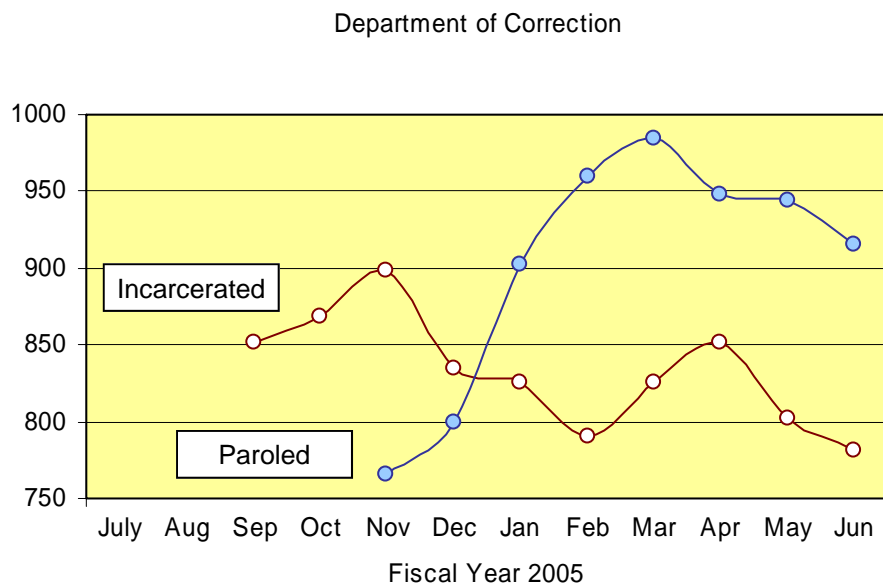
## Appendix D

# Participation in Correctional Treatment Programs and Drug Courts

This appendix summarizes available information about the number of individuals participating in treatment programs of the state’s correctional agencies and in drug courts.

### Department of Correction

The chart illustrates available information about participation in the Department of Correction’s treatment programs, both within the institutions and in the community. Monthly enrollment data for the Therapeutic Community program provided to incarcerated individuals was available for fiscal year 2005.<sup>a</sup> Correction staff



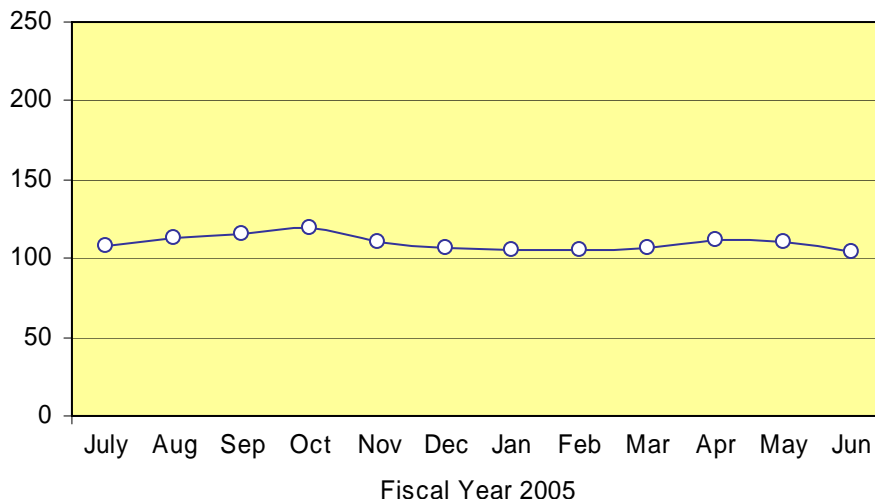
some estimates for enrollment in its Relapse Prevention program (in and outside of prison). However, Correction staff report these estimates were based on data of limited quality. For instance, community treatment participation data may include duplicated individuals.

<sup>a</sup> Annual statistics, which do not show monthly trends, are available from 1999. Data for offenders awaiting placement in a Therapeutic Community was only available for May 2005 and was not included in this chart. There were 452 offenders on the waiting list for Therapeutic Community that month.

### Department of Juvenile Corrections

Information on the number of juvenile offenders who received substance abuse treatment through the Department of Juvenile Corrections is available for a greater span of time than numbers for adult correction or drug court programs. Between fiscal years 2001 and 2005, the department provided treatment to an average of 105 juveniles in any given month. The accompanying chart shows the number of juvenile offenders receiving treatment each month during fiscal year 2005.

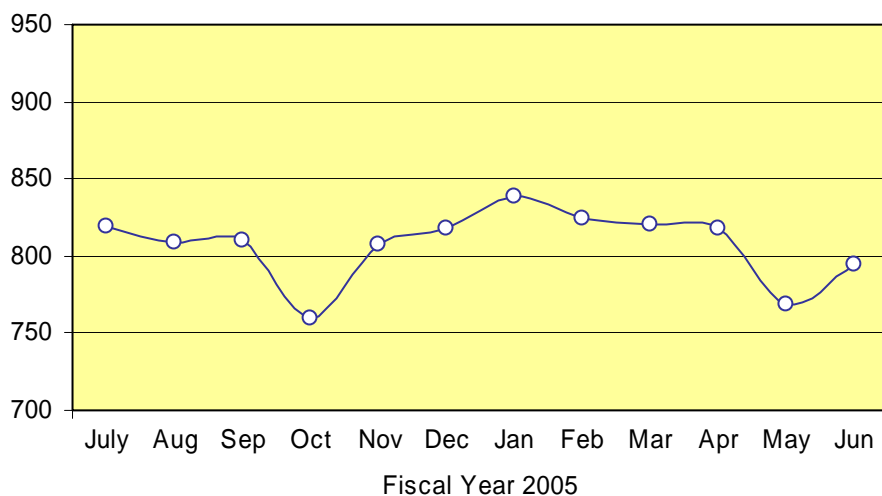
Department of Juvenile Corrections



### Judicial Branch

Participation figures for Idaho drug courts are based on self-reported monthly tallies. Although this information can be used to gain a general understanding of drug court participation, inconsistencies limit its usefulness for accurately identifying the total number of individual (unduplicated) participants in a given year. The accompanying chart shows the total number of participants in all Idaho drug courts each month during fiscal year 2005. Rates of drug court participation varied among individual judicial districts.

Idaho Drug Courts



## Appendix E

# Clients Receiving Health and Welfare Substance Abuse Treatment

The following tables provide information about the types of substance abuse treatment services and individuals receiving those services in fiscal years 2004 and 2005. These include individuals funded with state and federal funds (both Block Grant and some ATR). The data are based on the number of clients for which treatment providers have submitted and received payment. Information may be incomplete, particularly assessment data, because providers sometimes incorporate assessments as part of the actual treatment and do not report it separately.

Wait list information had only been electronically collected for a few months at the time of the evaluation. The information is included here as an indication of needed treatment capacity.

**Table 1: Number of Clients Placed on a Waiting List, by Type of Service, Fiscal Years 2004–2005**

	<u>FY04</u>	<u>FY05</u>
Assessment	n/a	123
Outpatient treatment	n/a	1,140
Intensive outpatient treatment	n/a	393
Transitional housing	n/a	14
Detoxification	n/a	55
Residential treatment	n/a	<u>632</u>
Total <sup>a</sup>		2,357

<sup>a</sup> This total includes some duplicates because some clients may have been placed on a waiting list for more than one type of treatment service.

n/a = not available

**Table 2: Number of Clients with Paid Treatment Services, Fiscal Years 2004–2005**

	<u>FY04</u>	<u>FY05</u>
Total (unduplicated) clients served <sup>a</sup>	5,943	5,496

<sup>a</sup> These clients may have received more than one type of treatment service.

**Table 3: Number of Clients Receiving Treatment, by Type of Service, Fiscal Years 2004–2005**

	<u>FY04</u>	<u>FY05</u>
Assessment	3,928	3,052
Outpatient treatment while in transitional housing	27	0
Outpatient treatment	3,460	2,794
Intensive outpatient treatment	531	1,050
Intensive outpatient treatment while in transitional housing	22	0
Halfway housing	37	19
Transitional housing for females with children <sup>a</sup>	63	48
Detoxification	279	242
Residential treatment	637	500
Case management services	20	16
Screening	1	0
Transportation	2	7
Drug testing	0	22
GPRA interview <sup>b</sup>	0	1,487
Sign language/oral interpreter	0	1
Early intervention	1	0

Note: This information is based on paid claims for service as of July 15, 2005. Fiscal year 2005 data may not be complete because treatment providers have 60 days to file the claim and the state has another 30 days to pay the claim at the end of the fiscal year (June 30, 2005).

<sup>a</sup> Includes pregnant females

<sup>b</sup> GPRA = Government Performance and Results Act

Source: Office of Performance Evaluations' analysis of data from the Department of Health and Welfare, Division of Family and Community Services, substance abuse

# **Responses to the Evaluation**





DIRK KEMPTHORNE  
GOVERNOR

December 5, 2005

Mr. Rakesh Mohan, Director  
Office of Performance Evaluations  
Joe R. Williams Building  
PO Box 83720  
Boise, Idaho 83720-0055

Dear Rakesh:

Thank you for this opportunity to respond to the state substance abuse treatment study and report.

I appreciate the opportunity for participation you afforded to the Governor's Office, the Division of Financial Management and the agencies during the report's development. I believe your report fairly assesses the current efforts to provide substance abuse treatment in Idaho and the need for coordination to address the fragmentation inherent in service delivery.

I commend you and your staff for the thoroughness and attention this study was given.

Sincerely,

A handwritten signature in black ink, appearing to read "David Lehman", written in a cursive style.

David Lehman  
Policy Director





IDAHO DEPARTMENT OF  
HEALTH & WELFARE

DIRK KEMPTHORNE - Governor  
KARL B. KURTZ - Director

OFFICE OF THE DIRECTOR  
450 W. State Street, 10th Floor  
P.O. Box 83720  
Boise, ID 83720-0036  
PHONE 208-334-5500  
FAX 208-334-6558

November 30, 2005

Mr. Rakesh Mohan, Director  
Office of Performance Evaluations  
Joe R. Williams Building  
Lower Level, Suite 10  
P.O. Box 83720  
Boise, Idaho 83720-0055

Dear Mr. Mohan:

The Department of Health and Welfare sincerely appreciates the interest of the Joint Legislative Oversight Committee and Office of Performance Evaluation (OPE) in gaining a better understanding of statewide efforts to address growing needs for substance abuse treatment. We enclose our response to the OPE report, "State Substance Abuse Treatment Efforts."

This response supports the recommendation for legislative authorization of an independent, statewide commission on alcohol and drug abuse. It also indicates the Department's completion of, or substantial progress in meeting recommendations addressed to the Department. We caution, however, that accomplishment of all OPE recommendations within the targeted time frames requires resources beyond those projected by OPE.

We understand that this response will be included in the body of the final OPE report, to be released to the Joint Legislative Oversight Committee on Tuesday, December 13. Ken Deibert, Administrator of the Family and Community Services Division, will represent the Department and respond to any committee questions at the meeting.

Please feel free to contact Mr. Deibert or me if you have any questions. Thank you.

Sincerely,

KARL B. KURTZ  
Director

KBK/db

**Department of Health and Welfare's Response to the Office of Performance Evaluation's Report, State Substance Abuse Treatment Efforts**  
**November 2005**

The Department of Health and Welfare (DHW) sincerely appreciates the interest of the Legislature and Office of Performance Evaluation (OPE) in gaining a better understanding of statewide efforts to address growing needs for substance abuse treatment and recovery support. This OPE report does provide a sound basis for establishing a strong, centralized authority to effect greater coordination among all state agencies in the delivery and evaluation of treatment and recovery services. We believe that this report produces ample justification for an independent, statewide commission on alcohol and drug abuse and suggests, at a high level, the requisite management tasks of such a commission.

Among the ten recommendations, the most critical one is directed to the Legislature while seven are directed to DHW and two to the set of state departments involved with substance abuse treatment. Our response below supports the call for legislative authorization of an independent commission and outlines achievement of or substantial progress on the other nine.

**Recommendation # 3.1**

The Department strongly endorses the recommendation for legislative authorization of an independent commission on alcohol and drug abuse. As the OPE report indicates, collaborative efforts to effect statewide coordination, since the disbanding of the Commission on Alcohol and Drug Abuse in 1995, have been short-lived and ultimately ineffective. OPE appropriately concludes (on page 27), "With the ending of the commission, Idaho lost its mechanism for building a coordinated system to address substance abuse."

The Governor's Interagency Task Force, the Special Legislative Oversight Committee, and the Idaho Summit of Alcohol and Other Drug Issues, attempted to bridge gaps in statewide planning and services. Each found, however, that its efforts were undermined by lack of a strong, centralized authority over all of the statewide agencies: DHW and the Departments of Corrections and Juvenile Corrections.

The past and current challenges to coordination do emanate from the legislature's decision to eliminate funding for the commission. To "pick up the pieces," DHW did create the seven Regional Substance Abuse Authorities and the Statewide Substance Abuse Executive Council as well as join the Governor's Office in applying for and implementing the Access to Recovery grant. But, to quote from the OPE report itself (on page 2), "This current structure focuses on community involvement, but does not ensure the involvement of pertinent state agencies to promote coordinated statewide service delivery."

The wording in the OPE report unfairly criticizes DHW for failing to achieve statewide coordination “in spite of Idaho Code requiring a comprehensive and integrated system.” This charge is unwarranted in that DHW can not implement code when it lacks the requisite authority to direct other state agencies in planning and coordinating substance abuse prevention and treatment. While DHW concedes that some improvements in its data collection and management practice are necessary, such advances by DHW alone are insufficient to effect inter-agency coordination. Only an independent, centralized commission with decision-making power over all agencies can achieve this.

While concurring with this recommendation, DHW believes it needs further elaboration in terms of outlining the commission’s authority and funding. The projected responsibilities for this commission are too formidable to be staffed by only one or two research analysts envisioned by OPE. OPE’s reference to commissions in Oregon and Washington do not appear to be helpful in that they are described as advisory, a role far weaker than what this recommendation calls for.

#### **Recommendation # 4.1**

The Department is already acting on this recommendation for improved monitoring and evaluation of the management services contractor. Formal reviews of the contractor’s performance against the measures identified in the contract are guided by a formal protocol and are scheduled for January and June 2006 and every six months thereafter. While DHW has collaborated with the management services contractor in monitoring treatment providers, it will supplement this with independent audits. We are refining the audit tools and developing a schedule for these independent audits. DHW currently meets the last part of the recommendation regarding monthly notice to the management services contractor on provider facility approvals and revocations.

#### **Recommendation # 4.2**

The Department certainly agrees that its program staff should have “the necessary fiscal training and information to adequately monitor and understand the program’s financial situation.” In responding to fiscal problems based on a faulty projection of State Fiscal Year 2005 expenditures, program staff did gain the necessary knowledge to prevent future budgeting problems. DHW has collaborated with the management services contractor in developing better census management methods and revising corresponding budgets. DHW is amending its contract with the management services contractor to limit the time in which providers submit billings to the contractor.

#### **Recommendation # 4.3**

The Department regards this recommendation as superfluous. It is DHW’s normal practice to consult with the federal Substance Abuse and Mental Health Administration

(SAMHSA) on compliance with grant requirements. If any issues emerge from the recent (September 2005) federal review, DHW will surely resolve them expeditiously. In response to ambiguous guidance from federal officials on the appropriate use of Access To Recovery (ATR) funds, DHW acted quickly to eliminate any appearance of impropriety by shifting costs from the ATR Grant to the Substance Abuse Block Grant.

**Recommendation # 5.1**

DHW has already implemented this recommendation to collect and analyze “key details” about its substance abuse programs. The following are the standard reports, along with frequency, which correspond with the “key details” outlined in the recommendation:

<b><u>Key Detail</u></b>	<b><u>Relevant Reports</u></b>	<b><u>Frequency</u></b>
Individuals participating in programs	Utilization Management and Grant Data	Quarterly
Individuals waiting for or needing each type of level of service	Wait List Report Wait List Summary	Weekly Quarterly
Individuals who successfully complete programs, at each stage	Treatment Completion Data	Quarterly
Individuals who receive Services at a different level than determined as needed by a formal assessment	Care Management Utilization Review	Monthly
Length of time individuals wait for placement, when applicable	Utilization management and grant data	Quarterly
Length of time taken to complete programs, at each stage and overall	Length of stay report	Quarterly
Reason for discharging an individual from a program	Treatment Completion Data GPRA Data	Quarterly As needed

DHW looks forward to similar collection and analysis of data from the Departments of Corrections and Juvenile Corrections and the Judicial Branch. The collection and analysis of this treatment data from all state agencies should be a primary responsibility of the proposed Commission on Alcohol and Drug Abuse.

### **Recommendation # 5.2**

Action on this recommendation to ensure the accuracy and timeliness of client data is nearly complete. During the past several months, the management services contractor has followed DHW directives to resolve discrepancies between its transmitted data and those of DHW's internal Client Information System. The interface error rate as of November 15, 2005 was 0.4% in episode and authorization data, 3.3% in eligibility data, and 2.1% in service data.

DHW has already negotiated a change to the management services contract that will require the contractor to ensure timely provider reports on a.) clients actively participating in treatment; b.) clients who have completed treatment, and c.) clients who have discontinued treatment. Similarly, the current Residential Capacity Report enables DHW to comply with the federal regulation to track facilities *as and when* they reach 90% capacity.

### **Recommendation # 6.1**

This recommendation for DHW to indicate greater detail in its specification of criteria for provider compliance appears unnecessary. In DHW's judgment, current rules provide sufficient guidance to ensure client safety and distinguish among approval, provisional approval, and denial. In the interest of clarity, however, DHW will articulate more detailed criteria and comply with this recommendation.

### **Recommendation # 6.2**

The Department is currently addressing this recommendation to strengthen treatment provider credentialing requirements. DHW is raising credential requirements through training and treatment protocols that go into effect on December 1, 2005. We concur that the proposed Commission on Alcohol and Drug Abuse should make recommendations on rule or statutory changes and ensure application of such to all state agencies.

### **Recommendation # 6.3**

The recommendation for DHW to develop a plan to increase client retention in treatment will be achieved through practices already specified in the Management Services Contract. DHW will be able to report on success of this plan through the Treatment Completion Data and GPRA Data reports cited above in the response to Recommendation 5.1.

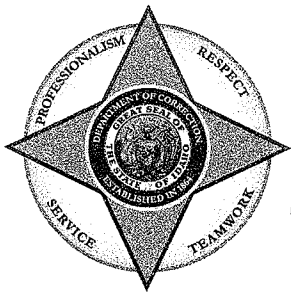
#### **Recommendation # 6.4**

The Department's progress in generating reports on the effectiveness of substance abuse programs, as outlined in the above response to Recommendation 5.1, substantiates our agreement with and continuing pursuit of this recommendation. Again, the establishment of a strong, centralized Commission on Alcohol and Drug Abuse will facilitate needed observance of this recommendation by all state agencies.

#### **Summary**

The Department agrees that the most significant advances in the coordination of statewide substance abuse treatment will come from the Legislature's adoption of Recommendation 3.1 – the establishment of a strong, centralized Commission on Alcohol and Drug Abuse. We encourage OPE to assist the Legislature by providing more specific guidance on the authoritative powers needed for such a commission as well as requisite resources in terms of staffing and funding.

The Department's actions on all other recommendations are either complete or representative of substantial progress. DHW initiated most of the management improvements cited in the recommendations in advance of this study. Accordingly, DHW regards Recommendations 4.3 and 5.1 as superfluous because it has already met them. DHW is aggressively pursuing full compliance with all other recommendations.



# IDAHO DEPARTMENT OF CORRECTION

*"Protecting You and Your Community"*

DIRK KEMPTHORNE  
Governor

THOMAS J. BEAUCLAIR  
Director

---

December 1, 2005

Rakesh Mohan, Director  
Office of Performance Evaluation  
700 W. State St. Lower Level Suite 10  
Boise, Idaho 83720-0055

Mr Mohan:

We have reviewed the draft of "State Substance Abuse Treatment Efforts" dated November 23, 2005 and concur with the conclusions of the report. The Department supports the recommendation to create and maintain a jointly appointed independent commission on substance abuse treatment services. We hope to play an integral role in the interagency coordination of these services statewide.

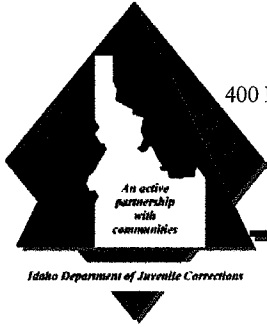
The limited reliability of treatment data and outcomes underscores the need for additional staffing resources to implement and maintain the Correctional Integration System (CIS). This electronic database currently maintains all treatment and case planning records, in addition to probation/parole supervision field contacts, notes, and summaries. The system is designed to eventually encompass all aspects of offender management, in prison as well as in the community. The Department currently has only two full-time positions dedicated to this project, another nine positions are currently being requested in a Decision Unit. The Department has made tremendous strides in data collection and reporting in the past five years. To continue our transition to an outcome-driven system, the Department must have the necessary resources to establish and maintain an effective data collection infrastructure.

I want to emphasize the importance of the need for additional community treatment options. The need for substance abuse treatment is consistently outpacing the Department's ability to meet those needs with current staffing resources. Limited treatment options result in more inmates in county jails and prisons. In addition, timely access to treatment is critical, as delays in treatment access also lead to incarceration. Improvements related to increased treatment options will have a significant impact on diverting offenders away from prison and into treatment, as well as better preparing offenders to transition from prison into our communities.

Respectfully,

Thomas Beauclair  
Director, Idaho Department of Correction





# Idaho Department of Juvenile Corrections

400 N. 10<sup>th</sup> Street, 2<sup>nd</sup> Floor P.O. Box 83720 Boise, ID 83720-0285 Phone: (208) 334-5100 Fax: (208) 334-5120

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DIRK KEMPTHORNE  
Governor

BRENT D. REINKE  
Director

November 30, 2005

Mr. Rakesh Mohan, Director  
Office of Performance Evaluations  
PO Box 83720  
Boise, ID 83720-0055

Dear Rakesh:

Thank you for the opportunity to review and respond to the State Substance Abuse Treatment Efforts report. I have read the study and want to express my appreciation for the diligence by your staff to address the complexities surrounding this topic. I look forward to sharing the findings and recommendations with my staff.

The Department will work with other state agencies and community stakeholders to improve treatment efforts through implementation of recommendations included in this report.

I commend you and your staff for the detail included in this study and look forward to future studies and recommendations on substance abuse in the state of Idaho.

Sincerely,

Brent D. Reinke  
Director

BDR:zb



THE STATE OF IDAHO  
SUPREME COURT



DANIEL T. EISMANN  
JUSTICE

P.O. BOX 83720  
BOISE, IDAHO 83720-0101  
(208) 334-2149

November 29, 2005

Rakesh Mohan, Director  
Office of Performance Evaluation  
Statehouse Mail

Dear Mr. Mohan,

We appreciate and commend the interest shown by the joint legislative oversight committee in directing this important and timely study of Idaho's public system for providing substance abuse treatment. We encourage continued attention to the report and its recommended system improvements. We also want to express our appreciation to you and your staff for the extensive work represented by this important report. We believe that the report thoughtfully examines current efforts to deliver needed substance abuse treatment and highlights useful ideas and strategies for strengthening Idaho's response to alcohol and drug addiction.

Judges across Idaho deal with the devastating impacts of alcohol and drug addiction on a daily basis. In response, District Judges have identified community-based residential substance abuse treatment as the most needed sentencing alternative. Chief Justice Schroeder brought this need to the attention of Governor Kempthorne as recently as December 2004. Further, our Idaho Judges who hear juvenile cases recently ranked the need for community-based residential treatment and appropriate options for transitional alcohol and drug free housing as their number-one needed sentencing alternative, as well. We hope that this report will be a positive step in responding to these needs.

In specific response to the findings and recommendations in this report, we fully support cooperative statewide efforts to improve the quality of treatment services. We hope the report provides the impetus to successfully integrate substance abuse and mental health services for individuals, both adults and juveniles, who experience co-occurring mental and substance use disorders. We believe these efforts will improve the rate of retention of treatment participants in treatment; a factor that drug court clearly demonstrates is key to successful outcomes. Finally we concur with the recommendations to strengthen data

collection and analysis to provide the foundation of a more effective and responsive system.

Idaho's drug court judges, together with their drug court teams, will continue to dedicate time and energy to the drug and mental health court mission. They stand prepared to expand these efforts as additional treatment and court-related resources become available. We are very appreciative of the Legislature's support for drug courts and most recently for mental health courts. Continued legislative support, as well as our ongoing operational efforts, depends upon having access to an evidence-based and competent treatment system that is responsive to the special needs of the substance abusing offender population. For this reason, we particularly endorse the report's focus on the importance of coordination among the multiple agencies that expend public resources to address treatment for this population. Our experience with the statutory Statewide Drug Court and Mental Health Court Coordinating Committee convinces us of the value of having an organized group of stakeholders to provide guidance, to assure coordination, and to avoid fragmentation.

We intend to provide this report to our coordinating committee and to seek their guidance as to how we might implement those recommendations that could improve our operations and strengthen both our accountability and our outcomes.

Respectfully,

A handwritten signature in black ink, appearing to read "Daniel Eismann", with a long horizontal flourish extending to the right.

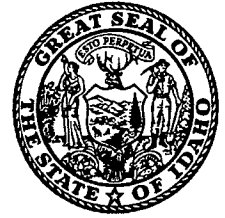
Justice Daniel Eismann, Chair  
Statewide Drug Court and Mental  
Health Court Coordinating Committee



# Idaho State Police

Service since 1939

November 28, 2005



Colonel R. Dan Charboneau  
Director

Dirk Kempthorne  
Governor

Mr. Rakesh Mohan  
Office of Performance Evaluations  
P.O. Box 83720  
Boise, Idaho 83720-0055

Dear Mr. Mohan:

Thank you for including the Idaho State Police in your research regarding substance abuse programs in Idaho. While we understood that the effort necessarily focused on the treatment component, we were pleased you chose to include some mention of ISP's education and enforcement efforts.

It is my strong personal belief that only by attacking the issue on multiple fronts will the state of Idaho be able to effectively impact substance abuse.

Substance abuse affects all of Idaho's communities and individual citizens. It reaches across all levels of state, county and city government and results in child endangerment, domestic abuse, broken homes, workplace disruption, overuse of emergency medical services and a host of criminal activities.

The ISP is a strong partner in Idaho's substance abuse prevention efforts through its enforcement activities. Community and special interest group education also is an important component of ISP's role in preventing substance abuse. In its focus on methamphetamine ISP delivers an aggressive information campaign to alert retail business owners and employees to the commonly available precursor ingredients typically purchased in large quantities to manufacture meth.

I am also particularly proud of the Drug Endangered Children program, which focuses on children endangered by their presence in drug manufacturing and use environments. Drug endangered children are at risk from primary dangers such as explosives, solvents, acids and the end product of manufacture, and secondary dangers such as abuse and neglect because of their caretakers' drug-oriented behaviors.

The DEC program partners law enforcement, prosecutors, Department of Health & Welfare and community medical providers in a protocol to work together to address the variety of needs of children found in meth manufacturing and use environments. It began in north Idaho in 2000. Over the years the program has spread to the Magic Valley and ISP continues to host DEC conferences to strengthen the protocol partnerships and provide Idaho's teams with cutting-edge information.

There is much work for all of us in combating substance abuse and its toll on our communities. I hope your report will move Idaho forward in dealing with this pervasive issue.

Sincerely,

Colonel R. Dan Charboneau  
Director

P.O. Box 700, Meridian, Idaho 83680-0700 • (208)884-7000 • Fax (208)884-7090

EQUAL OPPORTUNITY EMPLOYER





**STATE OF IDAHO**  
OFFICE OF  
STATE SUPERINTENDENT OF PUBLIC INSTRUCTION  
**BOISE**

DR. MARILYN HOWARD

(208) 332-6811  
FAX (208) 334-2228

November 29, 2005

Rakesh Mohan, Director  
Office of Performance Evaluations  
Statehouse  
Boise, ID 83720

RE: Response to OPE Evaluation Report, "State Substance Abuse Treatment Efforts"

Dear Mr. Mohan:

I write in response to the Office of Performance Evaluation Final Report on State Substance Abuse Treatment Efforts. The focus of this report is on substance abuse treatment throughout the state and the various agencies that provide treatment services.

As the SDE noted in its initial response to you, we want to be clear – and the report to be clear – that the **State Department of Education's public school (K-12) substance abuse program is not a treatment program, nor do the public schools offer or provide treatment services.** The public school program is an educational and prevention program only.

If your report is intended to cover all aspects of substance abuse education, prevention, and treatment services, then the State Department of Education (and the other agencies mentioned) has much, much more information, including historical information, that ought to be included.

Sincerely,

A handwritten signature in cursive script that reads "Marilyn Howard".

Marilyn Howard  
State Superintendent of Public Instruction

MH:lrh



# OPE's Comments to the Department of Health and Welfare Response

We appreciate the efforts of everyone who reviewed the report and provided feedback. We are providing comments that offer clarity and perspective to the responses of the Department of Health and Welfare.

1. Agency Statement: "DHW has already implemented this recommendation [5.1] to collect and analyze 'key details' about its substance abuse programs. The following are the standard reports, along with frequency, which correspond with the 'key details' outlined in the recommendation." (Reports are listed on page 3 of the department's response.)

*OPE Comment:* We commend the department for beginning to develop the reports listed in the department's response. In its November 17, 2005 correspondence to us, the department noted that three of the reports listed were still in the process of being developed. Development of these reports may take some time because they are dependent on improvements to the quality of the discharge data mentioned in chapter 5.

2. Agency Statement: "Accordingly, DHW regards Recommendations 4.3 and 5.1 as superfluous because it has already met them."

*OPE Comment:* Recommendation 4.3 cannot be considered complete until the federal agency provides a formal response to the department's request for clarification on the appropriateness of shifting Access to Recovery funds. Recommendation 5.1 cannot be considered complete until all needed data elements and reports have been collected and developed (see OPE comment above). The department should still coordinate collection and analysis of this information with other state agencies and the Judicial Branch.



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<u>Pub. #</u>	<u>Report Title</u>	<u>Date Released</u>
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02-02	Management of State Agency Passenger Vehicles: A Follow-up Review	November 2002
02-03	A Review of the Idaho Child Care Program	November 2002
03-01HHW	Return of Unused Medications from Assisted Living Facilities	January 2003
03-01F	Agency Response to <i>Management of State Agency Passenger Vehicles: A Follow-up Review</i>	February 2003
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04-03F	Timeliness and Funding of Air Quality Permitting Programs	June 2004
04-04F	Idaho Child Care Program	June 2004
04-05F	Idaho’s Medicaid Program	June 2004
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05-01	Public Education Technology Initiatives	January 2005
05-02	Child Welfare Caseload Management	February 2005
05-01HTD	Use of Social Security Numbers for Drivers’ Licenses, Permits and Identification Cards	February 2005
05-01F	Management of Correctional Data	March 2005
05-03	Idaho School for the Deaf and the Blind	October 2005
05-04	State Substance Abuse Treatment Efforts	December 2005

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