

initiative 2

Reallocate Resources Toward Drug Treatment and Prevention

- ▶ **Increase the proportion of the federal drug control budget allocated to demand reduction (treatment and prevention) from 32.6% (Fiscal Year 1999) to 50% in the near-term, and thereafter to 65%.** Data source: Office of National Drug Control Policy budget

- ▶ **Each state should provide the number of publicly funded treatment slots indicated by that state's SAPT Block Grant Needs Assessment study.** Data source: Office of Applied Statistics, Center for Substance Abuse Treatment

“ It is time for a new emphasis in our national drug policy by substantially refocusing our investment in the prevention and treatment of harmful drug use. This requires reallocating resources toward drug treatment and prevention.”

initiative 2 ————— *Reallocate Resources Toward Drug Treatment and Prevention*

POLICY RECOMMENDATIONS

- **Increase the proportion of the federal drug control budget allocated to demand reduction (treatment and prevention) from 32.6% (Fiscal Year 1999) to 50% in the near-term, and thereafter to 65%.**

Data source: Office of National Drug Control Policy budget

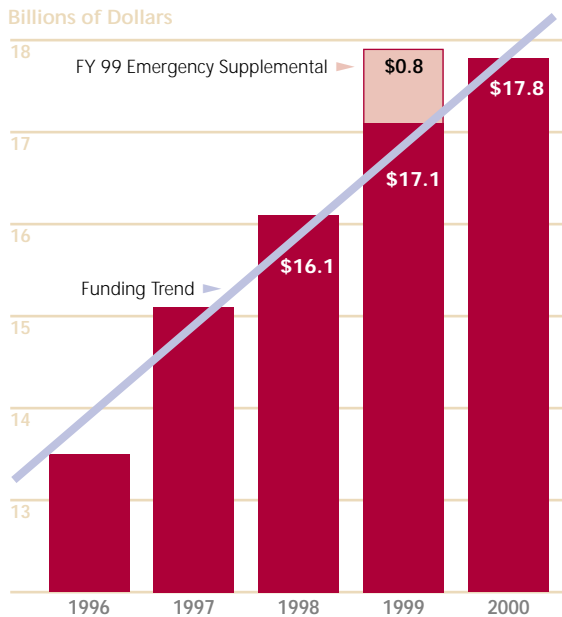
- **Each state should provide the number of publicly funded treatment slots indicated by that state's SAPT Block Grant Needs Assessment study.** Data source: Office of Applied

Statistics, Center for Substance Abuse Treatment

BACKGROUND AND REFERENCES

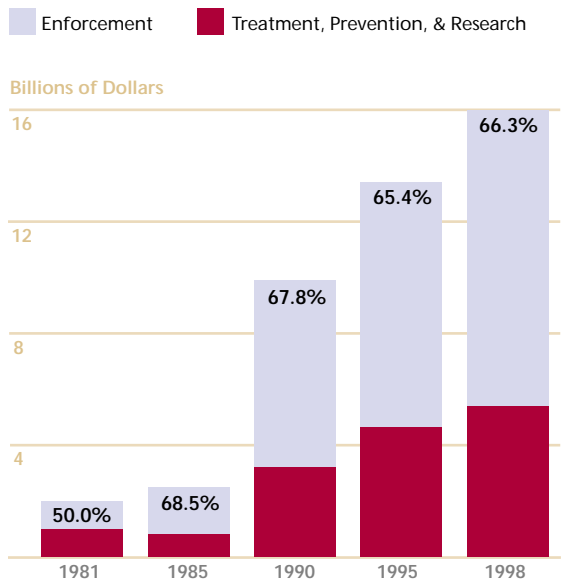
An estimated five million Americans are in need of treatment for drug abuse, and less than one-fourth of those needing treatment get it.¹ A major study commissioned by the US Army found that law enforcement costs fifteen times more than drug treatment to achieve the same degree of benefit in reduced cocaine consumption, reduced crime, and reduced violence.²

National Drug Control Budget Funding Trend



National Drug Control Budget Funding. Adapted from: Office of National Drug Control Policy, *National Drug Control Strategy 1999*.

Federal Drug Control Budget



Growth in budgeted expenditures, 1981 to 1998

Total drug control budget	800%
Enforcement	1060%
Treatment, prevention, and research	540%

Federal Drug Control Budget. Adapted from: Drucker E, Drug Prohibition and Public Health: 25 Years of Evidence, *Public Health Reports* 114(1): 14-29 (1999).

The nation's current drug control budget allocates two-thirds of its funding to law enforcement and interdiction efforts, twenty-two percent to treatment and twelve percent to primary prevention programs.³ Despite steadily increasing expenditures, especially on enforcement, drug use has been remarkably resistant to change in all age groups,⁴ drug availability has been unaffected,⁵ and drug-related deaths have increased.⁶ Increased funding for treatment and prevention may be justified in part because these approaches have been shown to have a cost-effective impact on drug problems in our communities.⁷ The major emphases of the national drug control budget are evident in the Office of National Drug Control Policy (ONDCP) National Drug Control Strategy (see chart at left).⁸

A recent report by Join Together, an organization that helps communities battle drugs and crime, examined the current state of drug treatment and recovery. The report emphasized that there are large numbers of drug abusing or addicted individuals who are not offered treatment due to a lack of funding or resources, while there remains a heavy focus on supply reduction measures.⁹ After providing a background on the efficacy of treatment and the potential savings for society, the report defined six recommendations for drug abuse policy:

- 1 Parity for addiction treatment
- 2 Creation of a broad-based national campaign to educate the public and build political support
- 3 Increased addiction and treatment research and increased accessibility of the results
- 4 Education and training on addiction and treatment for all health, mental health, social service, and justice system professionals
- 5 Monitoring of treatment programs by independent treatment managers to ensure efficacy

6 Integration of diagnosis, treatment, and long-term recovery into a coordinated, community-wide strategy dealing with substance abuse issues

Any “community-wide strategy” for “dealing with substance abuse issues” must begin by educating that part of our population who are most at risk: our youth. As one expert in the field of adolescent substance abuse notes, “From a public health standpoint, adolescent drug abuse has far-reaching social and economic ramifications, particularly when its onset is early. . . . Adverse consequences associated with problematic youth drug abuse include psychiatric comorbidity and suicidality, mortality from drug-related traffic crashes, risky sexual practices, and substantial direct health care costs.”¹⁰ Studies like the National Household Survey on Drug Abuse¹¹ have found that adolescent substance abuse has begun to level off and, in some cases, decrease. However, youths continue to use both legal and illegal substances and, despite decreasing rates overall, the National Household Survey also reported increased rates for some substances. For example, in 1993, the number of youths 12-25 who began using heroin doubled from the previous year; by 1996, the number of youths initiating heroin use was more than five times as high as it had been from 1980-1992. In fact, in 1996, youths were initiating heroin use at the highest rate since the early 1970s. Such research suggests that further prevention efforts must continue to be a priority for all of our communities.

The Physician Leadership on National Drug Policy National Project Office (1998), with the assistance of Henrick J. Harwood, PhD, has analyzed the relative costs of treatment programs as compared to the cost of incarceration. That data is provided as a chart on the next page and explained below. Since a range of treatment modalities is required to address the different needs of drug dependent and abusing individuals, various programs have been included in the analysis.

The National Treatment Improvement Evaluation Study (NTIES), conducted by the Center for Substance Abuse Treatment, estimates the average cost of regular outpatient treatment to be \$1,800, based on \$15 per day, for 120 days.¹² Outpatient treatment at Level I, as defined by the American Society of Addiction Medicine (ASAM) Patient Placement Criteria, typically involves one or more group or individual sessions with up to 9 hours of services per week.¹³ Charges for one group session can be as high as \$30 to \$50 and typically last from one hour to several hours. Intensive outpatient treatment, Level II of the ASAM criteria, ranges from 9 hours of structured services per week (as seen in some evening programs) to more than 20 hours for day programs. The average cost estimate of \$2,500 includes six months of weekly maintenance care group sessions after completion of the intensive phase of the treatment. The NTIES estimates a methadone maintenance cost of \$13 per day for an average of 300 days, or \$3,900 per person. Costs during the first year of methadone maintenance may be considerably higher due to additional assessments, closer monitoring, and group sessions that are required at the initiation of methadone treatment.

The average costs for short term residential care are \$130 per day, for 30 days, yielding a treatment cost of about \$4,000. An additional \$400 for 25 weekly group sessions is added to the NTIES estimate because research has shown that six months of ongoing care yields better outcomes. Charges for short term residential treatment vary widely depending upon the nature of the clients served and the total package of services provided. Private sector treatment programs include costs of service delivery plus indirect expenses such as capitol debt retirement and typically range from \$6,000 to \$15,000. These programs usually include up to a year of weekly maintenance care group sessions and/or provision of any other necessary service in the event of relapse. The NTIES estimates the average cost for long term residential care to be \$49 per day for an average of 140 days or a total of \$6,800.

- ▶ Treat 1/3 more clients for the same amount of money;
- ▶ Control costs (costs for the Fund increased less than 7% from 1989-1992 compared to 28% for other medical care);
- ▶ Increase access to specialized programs for those with special needs.

The Minnesota Department of Health combined all state, federal, and local funds into one Consolidated Fund that allowed “the dollar to follow the client” to the program that could best meet their needs, based on standard, uniform placement criteria administered by independent assessors. The local match was equalized for all placements, and state programs were placed in competition with private programs. The result was a 10% increase in the use of outpatient programs and a decrease in the use of expensive, hospital-based programs. Excellent client outcomes were maintained, at less cost per client.¹⁵ Also, 80% of the cost of treatment was offset in one year by reductions in medical and psychiatric hospitalizations, detox admissions, and arrests.¹⁶

Another issue that needs further discussion and clarification is the relationship between treatment “need” and the “demand for treatment.” People often use these terms interchangeably, but they are not the same thing. Many people who clinically “need” treatment (i.e., meet accepted diagnostic criteria) do not “demand” it or access the system, even if slots and funding are available. Chemical dependency is an illness characterized by denial, and few people volunteer for treatment. Some form of coercion is usually involved (from an employer, family member, or the criminal justice system).

A recent survey in Minnesota¹⁷ found that only one in four adults who need treatment receive it, even though that state has enough treatment capacity to accommodate them. The biggest barrier to getting treatment was people’s perception that they did not need it. Of those people identified to need treatment

who did not seek it, 9 out of 10 did not believe they needed help. Only 1 out of 10 cited practical barriers to treatment, such as lack of insurance or transportation.

These considerations need to be taken into account in implementing recommendations such as the one at the outset of this section: “Each state should provide the number of publicly funded treatment slots indicated by that state’s SAPT Block Grant Needs Assessment study.” Just providing more treatment slots may not be the answer to closing the gap between treatment need and actual access to treatment. Other approaches may be needed, either in addition to or instead of simply increasing treatment slots, such as re-thinking and changing the current funding system and its restrictions; helping people look critically at their behavior; more public understanding that treatment is available and effective; and improved screening in health care, social service, and criminal justice settings.

ENDNOTES: INITIATIVE # 2

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- 3 Office of National Drug Control Policy, *National Drug Control Strategy, 1998: A Ten Year Plan* (Washington, DC: Executive Office of the President, Office of National Drug Control Policy, 1998) <<http://www.whitehousedrugpolicy.gov/policy/98ndcs/contents.html>>.
- 4 National Institute on Drug Abuse, *The Monitoring the Future Survey 1998* (Washington, DC: US Department of Health and Human Services, 1998) <<http://www.isr.umich.edu/src/mtf/mtfdat98.html>>.
- 5 National Institute on Drug Abuse, *The Monitoring the Future Survey 1998* (Washington, DC: US Department of Health and Human Services), Table 11 (Long-Term Trends in Perceived Availability of Drugs, Twelfth Graders).
- 6 Duncan D, Drug Law Enforcement Expenditures and Drug-Induced Deaths, *Psychological Reports* 75: 57-58 (1994); Office of Applied Studies, Substance Abuse and Mental Health Services Administration, *Drug Abuse Warning Network Annual Medical Examiner Data 1996* (Rockville, MD: U.S. Department of Health and Human Services, 1998) <<ftp://ftp.samhsa.gov/pub/dawn/me96rpt.pdf>>.

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- 8 Office of National Drug Control Policy (ONDCP), *The National Drug Control Strategy Progress Report*, (Washington, DC: Executive Office of the President, ONDCP, January 13, 1999); Office of National Drug Control Policy, *The National Drug Control Strategy: 1999* (Washington, DC: Executive Office of the President, ONDCP, 1999) <<http://www.whitehousedrugpolicy.gov/policy/99ndcs/contents.html>>.
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- 11 Substance Abuse and Mental Health Services Administration (SAMHSA), Office of Applied Studies, *1998 National Household Survey on Drug Abuse* (Rockville, MD: SAMHSA, U.S. Department of Health and Human Services, 1999) <<http://www.samhsa.gov/NHSDA.htm>>.
- 12 Center for Substance Abuse Treatment, *1997 National Treatment Improvement Evaluation Study (NTIES)* (Rockville, MD: CSAT, 1997) <<http://www.health.org/nties97/index.htm>>.
- 13 American Society of Addiction Medicine, *Patient Placement Criteria for the Treatment of Substance-Related Disorders*, Second Edition (Washington, DC: American Society of Addiction Medicine, 1996).
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- 15 Minnesota Department of Human Services, Background about Minnesota's Consolidated Chemical Dependency Treatment Fund, *Research News* (MN Department of Human Services, January 1994).
- 16 Minnesota Department of Human Services, Study of Chemical Dependency Treatment Shows Most Costs are Offset within One Year by Savings to the Health Care and Criminal Justice Systems, *Research News* (MN Department of Human Services, July 1996).
- 17 Minnesota Department of Human Services, Study Finds Most Adults with Chemical Abuse Problems Fail to Seek Treatment, Press Release (MN Department of Human Services, October 1, 1998).