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

Operating Budget Data

($ in Thousands)

	FY 07 Actual	FY 08 Working	FY 09 Allowance	FY 08-09 Change	% Change Prior Year
General Fund	$84,677	$89,833	$94,081	$4,248	4.7%
Special Fund	18,314	17,750	17,953	203	1.1%
Federal Fund	31,206	31,441	32,349	908	2.9%
Reimbursable Fund	4,059	4,108	4,108	0	
Total Funds	**$138,256**	**$143,132**	**$148,491**	**$5,359**	**3.7%**

- The fiscal 2009 budget for the Alcohol and Drug Abuse Administration (ADAA) increases almost $5.4 million (3.7%) over the fiscal 2008 working appropriation.

- Since most of ADAA's budget consists of grants and contracts for substance abuse prevention and treatment, the impact of employee and retiree health insurance and Other Post Employment Benefits liability funding on budget growth is slight, moderating growth to just under $5 million (3.5%).

- The budget includes major funding increases to support a 1.5% provider rate adjustment, expansion of treatment slots for court-committed individuals, and additional buprenorphine programming.

Personnel Data

	FY 07 Actual	FY 08 Working	FY 09 Allowance	FY 08-09 Change
Regular Positions	65.00	63.00	62.00	-1.00
Contractual FTEs	2.62	5.00	5.00	0.00
Total Personnel	**67.62**	**68.00**	**67.00**	**-1.00**
Vacancy Data: Regular Positions				
Turnover, Excluding New Positions		3.41	5.50%	
Positions Vacant as of 12/31/07		6.00	9.52%	

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

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- The fiscal 2009 budget reflects the loss of one vacant regular position, abolished by the Board of Public Works in January 2008.

Analysis in Brief

Major Trends

Prevention: The total number of people served in prevention programming continues to fall, although people served in more intensive programming increased between fiscal 2006 and 2007.

Treatment: The number of ADAA-funded admissions to certified alcohol and drug treatment programs fell slightly in fiscal 2007. Overall, however, outcomes continue to be positive.

Pay for Performance: ADAA implemented a pay for performance outpatient pilot program in fiscal 2007, building on its pay for performance residential contracts. In all, ADAA estimates that 40% of its fiscal 2007 treatment awards had a performance compensation component.

Issues

The Formula Workgroup Proposal: The workgroup seeking to develop a formula for the allocation of new local prevention and treatment funding concluded its work. However, the State Drug and Alcohol Abuse Council is still considering the recommendations.

Local Prevention and Treatment Grant Award Utilization: While less of an issue than in recent years, a review of local prevention and treatment grant award utilization reveals that a significant amount of these awards (at least in dollar terms if not as a percentage of total awards) are not utilized as planned.

Recommended Actions

		Funds
1.	Add language restricting funds pending receipt of a report detailing actions to be taken to maximize the utilization of prevention and treatment awards.	
2.	Reduce funding for the expansion of buprenorphine therapy.	$ 850,000
	Total Reductions	**$ 850,000**

Updates

The Integration of Child Welfare and Substance Abuse Treatment Act: Budget bill language added in the 2005 session restricted funding for an independent evaluation of the program developed under this Act. That evaluation has been completed but at the time of writing was still unavailable.

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

Operating Budget Analysis

Program Description

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

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

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

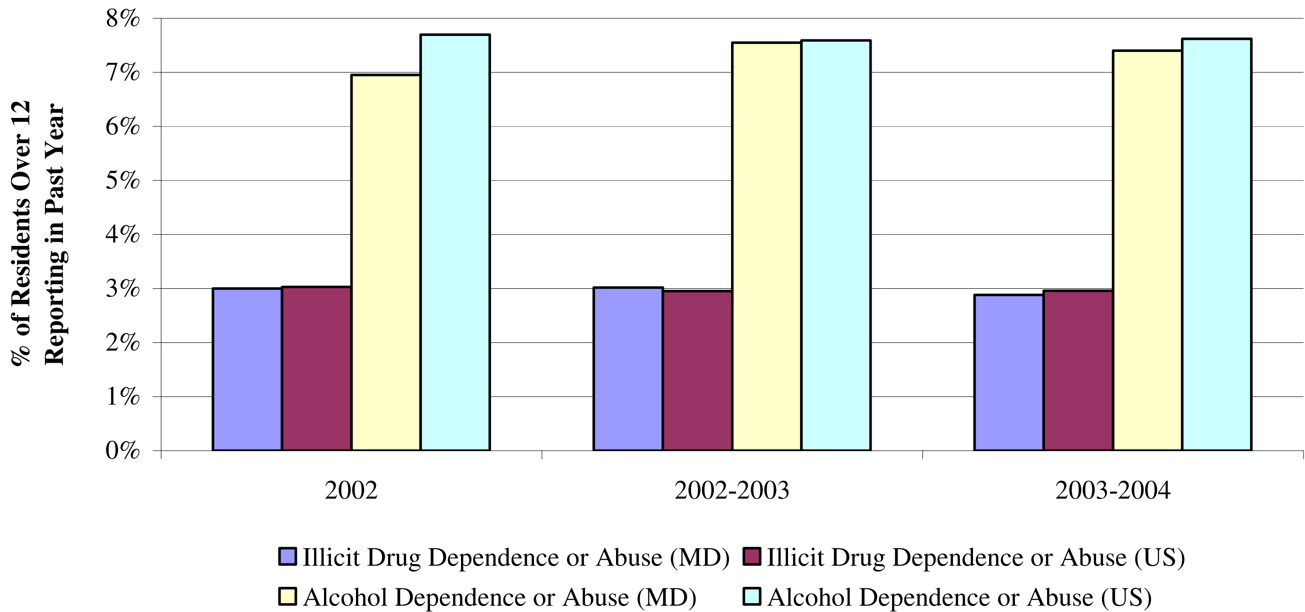
Performance Analysis: Managing for Results

Background

Exhibit 1 is intended to provide some insight into the extent of the addictions problem in Maryland. Based on survey data, the exhibit notes that:

- For the periods shown, about 3.0% of those surveyed in Maryland reported illicit drug dependence or abuse in the past year. This percentage was reasonably stable in the time-frame shown and was similar to the United States as a whole. Dependence and abuse was prevalent among 18-25 year-olds (8.72% in 2003 and 2004 surveys). The highest rate of dependence and abuse was found in Baltimore City, the lowest rate in Montgomery County.

Exhibit 1
Drug and Alcohol Use
Maryland and the United States
Survey Data Based on Use and Dependence within the Past Year
Various Times



Source: Alcohol and Drug Abuse Administration; the Center for Substance Abuse and Research (CESAR), University of Maryland, College Park

- For alcohol dependence or abuse, the numbers are somewhat higher, between 7.0% and 7.5% of those surveyed in Maryland, slightly lower than reported for the United States as a whole. Again, dependence and abuse was highest among 18-25 year-olds (16.82% in 2003 and 2004 surveys). The highest rate of dependence and abuse was again in Baltimore City, the lowest rate in Montgomery County.

Prevention

ADAA prevention services are provided through two types of programming:

- Recurring prevention programming, *i.e.*, with the same group of individuals for a minimum of six separate occasions and with programming that is an approved Substance Abuse and Mental Health Services Administration (SAMHSA) model. In fiscal 2007, a total of 477 recurring prevention programs were offered across the State.

- Single service programs such as presentations, speaking engagements, training, etc., that are provided to the same group on less than six separate occasions. Participant numbers are either known or estimated. In fiscal 2007, 1,489 single service prevention activities were offered in Maryland.

As shown in **Exhibit 2**, ADAA prevention programming served just over 211,000 clients in fiscal 2007. As also shown in the exhibit, the number served by prevention programs has fallen sharply in the past five fiscal years. Funding for prevention has also fallen in recent years (although in the fiscal 2008 budget, a combination of executive and legislative action provided a significant boost to prevention funding, and the fiscal 2009 budget provides a small additional increase over the fiscal 2008 level).

In addition to less funding for prevention programming, another reason offered for the decline in overall numbers served is a move to more sophisticated programming requirements (specifically, for recurring prevention activities, the implementation of SAMHSA model programs). Even though the numbers served in recurring prevention programming showed a slight upward tick in fiscal 2007 after falling from between fiscal 2005 and 2006, they are still below fiscal 2005 levels. ADAA believes that as providers establish an infrastructure to provide model programming, more people will be served in recurring prevention programs. The additional funding provided in fiscal 2008 and again in fiscal 2009 should help in that regard.

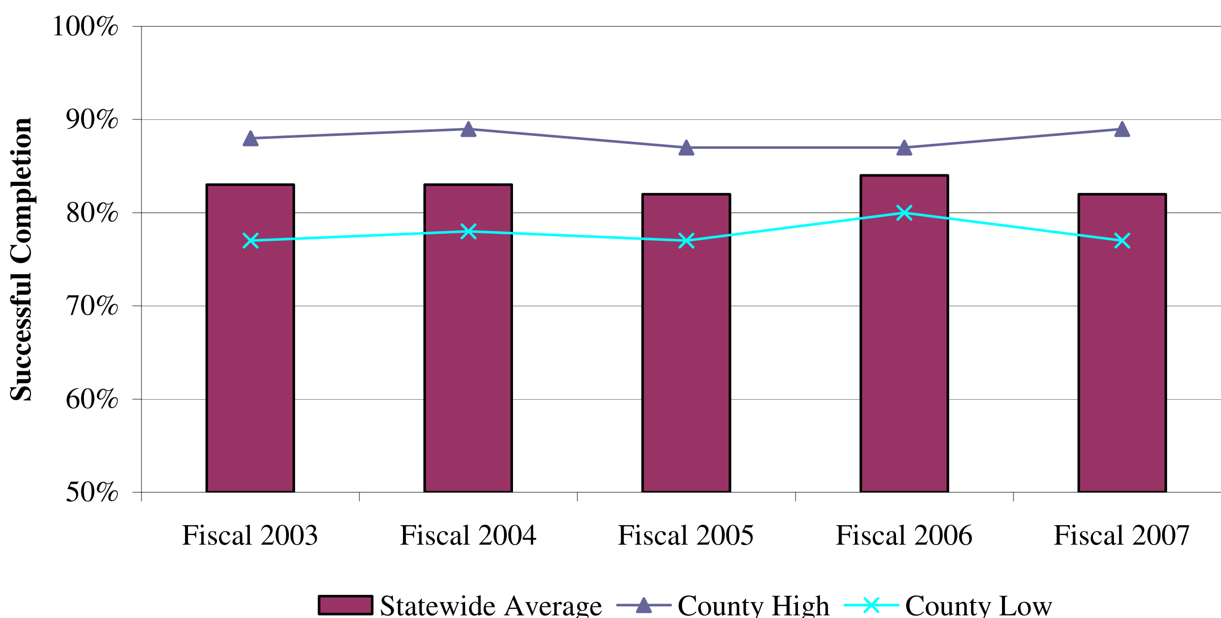
Exhibit 2
ADAA – Prevention Programming
Clients Served and Funding Levels
Fiscal 2003-2007

	Fiscal 2003	Fiscal 2004	Fiscal 2005	Fiscal 2006	Fiscal 2007
Prevention Funding ($ in Millions)	$5.066	$5.159	$5.127	$4.974	$4.877
Single Service Programs	288,418	273,479	260,974	232,566	182,472
Recurring Programs	15,367	27,734	30,879	27,988	28,762

Source: Alcohol and Drug Abuse Administration

As shown in **Exhibit 3**, ADAA reports that in fiscal 2007, 82% of participants in recurring prevention programs successfully completed the program, slightly lower than in fiscal 2006. As also shown in this exhibit, there is variation by county among programs in terms of successful completion. In fiscal 2007, for example, the successful completion rate varied from 89% in Talbot County to 77% in Washington County (which had the highest successful completion rate in fiscal 2006). It should be noted that since programming varies from one jurisdiction to the next, there is no universal definition of what is considered a "successful completion."

Exhibit 3
ADAA – Recurring Prevention Programs
Successful Completion Rate
Fiscal 2003-2007



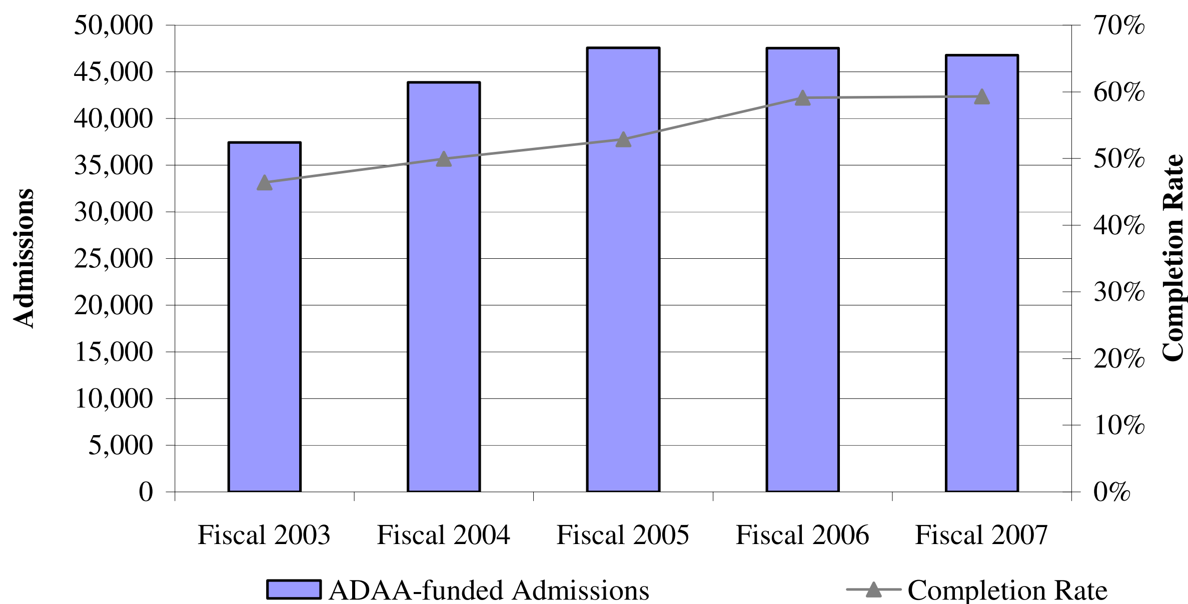
Source: Alcohol and Drug Abuse Administration

Treatment

As shown in **Exhibit 4**, admissions to ADAA-funded treatment services increased steadily between fiscal 2003 and 2005 before seemingly reaching a plateau in fiscal 2006 and falling by 1.6% in fiscal 2007. However, completion rates (program completion and discharge without the need for further treatment or program completion with appropriate referral to the next level of treatment) have risen steadily over the past five years, although the rate of growth slows down between fiscal 2006 and 2007.

Generally speaking, about two-thirds of individuals admitted to ADAA-funded treatment programs have prior admissions, a percentage that has been growing in recent years. However, ADAA attributes this growing number of prior admissions to a greater reliance on the continuum of care offered and a progression from one level of care to another (for example, residential to outpatient) rather than to lack of treatment success.

Exhibit 4
Admissions to ADAA-funded Treatment Programs and Completion Rates
Fiscal 2003-2007

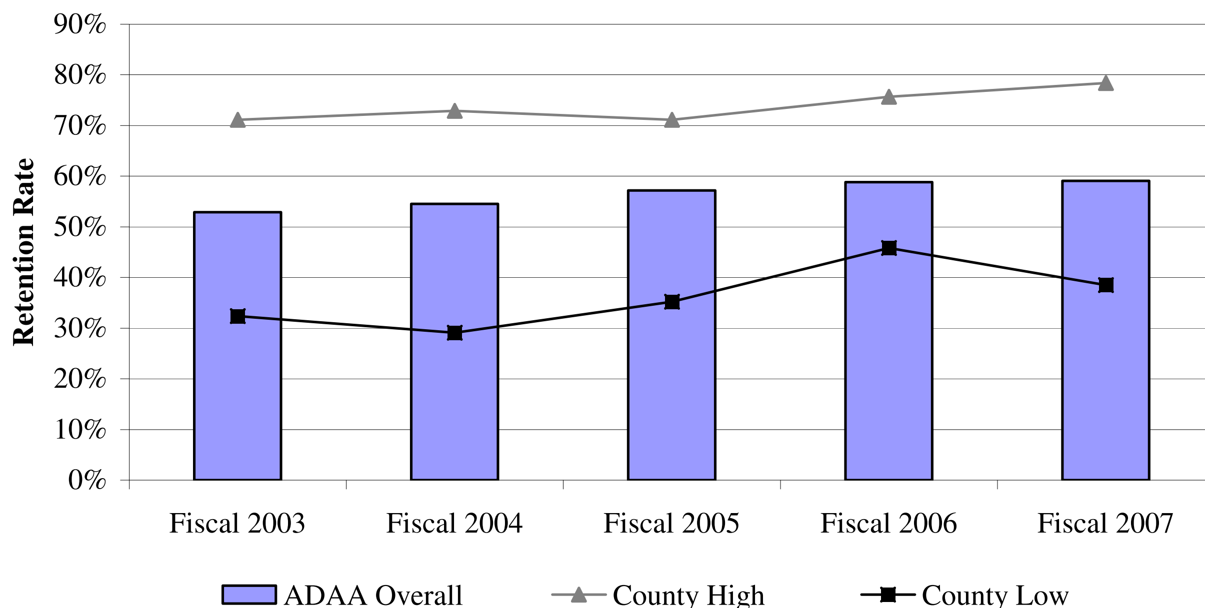


Source: Alcohol and Drug Abuse Administration

In terms of outcomes, a key outcome measure is retention rate within a program. Research as well as Maryland experience demonstrates a strong relationship between retention rates and successful outcomes. In outpatient treatment, for example, keeping a person in a program for longer than 90 days is considered an important benchmark. As shown in **Exhibit 5**, for fiscal 2003 to 2007, the retention rate beyond 90 days in ADAA-funded Level I (outpatient) programs has gradually improved. There remains wide variation among programs.

As noted in the same exhibit, for fiscal 2007 the highest retention rate for ADAA-funded programs is over 78% (St. Mary's County), while the lowest retention rate is just above 38% (Garrett County). The variation between programs which had shrunk in fiscal 2006 grew again in fiscal 2007. ADAA is actively investigating all of the different variables that might contribute to this variation. Out of this analysis may come additional ways to measure program performance.

Exhibit 5
Level I Retention Rates
Percent Retained More Than 90 Days
Fiscal 2003-2007



Source: Alcohol and Drug Abuse Administration

Retention in program is one of two measures used by ADAA in its Pay for Performance Outpatient Incentive Pilot program. In fiscal 2007, the pilot was based on the period January through April 2007, with performance payments appropriately pro-rated (in a full year, the annual incentive would range from $15,000 to $30,000 depending on the number of clinics in a jurisdiction). Under this program ADAA pays an incentive bonus to a local jurisdiction if outpatient programs (excluding adolescents and jail-based populations):

- retain 65% or more patients for a period of at least 90 days; and

- have a successful completion rate of 50% or higher.

Jurisdictions that meet both standards receive a 100% performance payment, for one standard a 50% performance payment is made. ADAA indicates $93,000 in performance payments will be made in fiscal 2008 based on fiscal 2007 performance.

As shown in **Exhibit 6**, 11 jurisdictions received a performance payment: 6 jurisdictions received a 100% payment; 5 received a 50% payment. The initial results from this pilot raise a couple of issues:

- It appears that the jurisdictions with 7 or more outpatient clinics in a jurisdiction found it more difficult to attain the performance payment: 5 of the 11 jurisdictions with 1-2 clinics received some form of payment; 5 of 8 jurisdictions with 3-6 clinics received some form of payment; while only 1 of 4 jurisdictions with 7 or more clinics received a payment (in this case a 50% payment). At this point, no definitive conclusion should be made based on only a partial year's experience. Nevertheless, the notion of providing a larger bonus for jurisdictions with more clinics did stem from an understanding that this difficulty might arise. However, it is likely only one factor in terms of jurisdictional performance.

- Cecil County, which met the 65% retention rate, had a relatively low completion rate (37.1%). Indeed only four other jurisdictions had a lower completion rate although only four other jurisdictions had a better retention rate. This relates to a constraint of the Cecil County system which has limited options beyond outpatient care and is thus providing what care it can, but probably not at the appropriate level for many individuals.

Exhibit 6

Outpatient Incentive Pilot

Fiscal 2007

	No. of Clinics	65% Retention at Least 90 Days	50% Completion
Caroline	1-2	68.1	52.7
Charles	1-2	72.9	58.2
Carroll	3-6	66.9	54.7
Somerset	3-6	73.8	50
St. Mary's	3-6	78.7	65.2
Washington	3-6	74.3	57.5
Allegany	1-2	63.5	57.9
Cecil	1-2	68.2	37.1
Talbot	1-2	60.7	53.6
Montgomery	3-6	67.9	45.5
Baltimore County	7+	63.3	51.2
Statewide Average		**59.1**	**53.7**

Note: See text for fuller explanation. Jurisdictions below the line with shaded data did not meet the performance standard required to receive a payment and received only a 50% payment.

Source: Alcohol and Drug Abuse Administration

Finally, it is obviously important that clients are not only retained in (and successfully complete) programs, but that during the course of treatment, other outcomes improve. For example, relevant outcomes include:

- clients that have a declining incidence of substance abuse;
- clients are able to obtain employment; and
- clients have less involvement in the criminal justice system.

As shown in **Exhibit 7**, for ADAA-funded treatment programs, outcomes for fiscal 2003 through 2007 are positive: clients are abusing at a lower rate on discharge than admission, and more clients were employed at discharge than at admission. Although the employment rate at discharge has fallen from a high of 38.6% in fiscal 2005, the total gain in employment in fiscal 2007 between admission and discharge was actually the largest in the period shown.

Exhibit 7 shows a new statistic for criminal justice involvement (arrests 30 days prior to admission and discharge as opposed to prior years when the data shown was arrests in the two years prior to admission and arrests during treatment). This new statistic is consistent with data collected through the National Outcomes Measures program through SAMHSA.

Indeed, it should be noted that based on the most recent data available through the National Outcomes Measures program, clients in Maryland show higher levels of abstinence from alcohol and drugs at program discharge, higher levels of employment at discharge, and lower levels of criminal justice involvement in comparison to the national average derived from reporting states.

Exhibit 7
ADAA-funded Programs – Selected Outcomes
% of Total Patient Population

	Substance Abuse			Employed			Criminal Justice Involvement (Patient Arrests)		
	At Admission	At Discharge	Change	At Admission	At Discharge	Change	30 Days Prior to Admission	30 Days Prior to Discharge	Change
Fiscal 2003	71.0%	48.7%	-22.3%	30.8%	35.7%	4.9%			
Fiscal 2004	69.0%	51.5%	-17.5%	29.9%	36.1%	6.2%			
Fiscal 2005	68.3%	49.9%	-18.4%	32.1%	38.6%	6.5%			
Fiscal 2006	68.5%	40.9%	-27.6%	32.1%	38.0%	5.9%	8.6%	2.4%	-6.2%
Fiscal 2007	69.4%	37.2%	-32.2%	30.6%	37.5%	6.9%	8.6%	2.5%	-6.3%

Source: Alcohol and Drug Abuse Administration

Fiscal 2008 Actions

Impact of Cost Containment

In July 2007, the Board of Public Works (BPW) reduced ADAA's budget by $842,000, all general funds. The most significant reduction was $750,000 from the Governor's fiscal 2008 expansion of funding for buprenorphine. Other reductions were to various operational expenses spread throughout the budget.

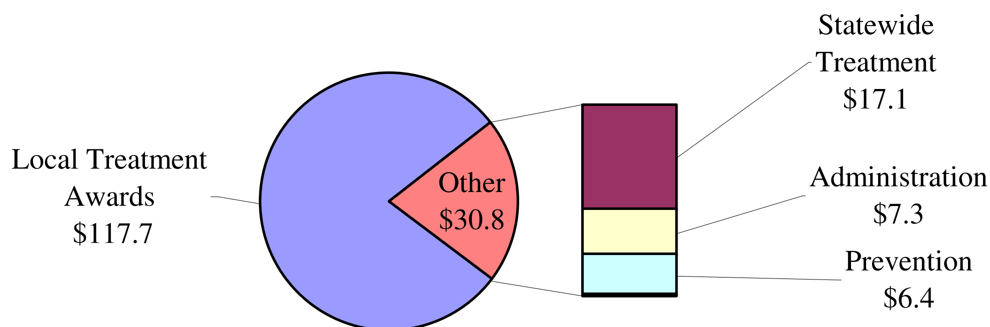
Governor's Proposed Budget

Exhibit 8 breaks ADAA's fiscal 2009 budget into its major components. Of the almost $148.5 million provided in the budget:

- $117.7 million (79%) is awarded to local jurisdictions for substance abuse treatment;
- $17.1 million (12%) is dedicated to a variety of statewide treatment contracts and programming;
- $6.4 million (4%) is for local and statewide prevention programming, the bulk of this again awarded to local jurisdictions; and
- $7.3 million (5%) is for administration and oversight of the system, including the administration's data-reporting systems.

Final fiscal 2009 awards to local jurisdictions will not be made until after budget deliberations. However, **Appendix 2** provides data on fiscal 2008 local prevention and treatment grants.

Exhibit 8
ADAA – How the Money Gets Spent
Fiscal 2009 Allowance
($ in Millions)



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

As shown in **Exhibit 9**, the fiscal 2009 budget for ADAA increases almost $5.4 million (3.7%) over the fiscal 2008 working appropriation. Since most of ADAA's budget consists of contracts for substance abuse prevention and treatment, the impact of employee and retiree health insurance and Other Post Employment Benefits (OPEB) liability funding on budget growth is slight, moderating growth to just under $5.0 million (3.5%).

Exhibit 9

Governor's Proposed Budget

DHMH – Alcohol and Drug Abuse Administration

($ in Thousands)

How Much It Grows:	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
2008 Working Appropriation	$89,833	$17,750	$31,441	$4,108	$143,132
2009 Governor's Allowance	94,081	17,953	32,349	4,108	148,491
Amount Change	$4,248	$203	$908	$0	$5,359
Percent Change	4.7%	1.1%	2.9%		3.7%

Where It Goes:		
Personnel Expenses	**$369**	
Health insurance – pay-as-you-go costs		$213
Health insurance – reduce long-term Other Post Employment Benefits liability		203
Increments and other compensation		78
Other fringe benefit adjustments		-1
One full-time equivalent abolished position		-46
Workers' compensation premium assessment		-78
Administration	**-$250**	
Fiscal 2008 needs assessment funding		-250
Prevention Programming	**$175**	
Prevention program funding expansion required to meet block grant minimum funding level for prevention (federal funds)		175
Treatment Programming	**$4,843**	
Provider 1.5% provider inflationary increase (includes prevention)		1,943
Statewide contract – additional 20 co-occurring court-committed residential slots		1,100
Buprenorphine – expansion beyond program level identified in 2007 ADAA report		850
Buprenorphine – annualization of fiscal 2008 initiative to level provided for in 2007 ADAA report		750
Carroll County – additional six court-referred/court-committed residential slots		200
Prior Year Grant Activity	**$200**	
Prior year grant activity		200
Other		22
Total		**$5,359**

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

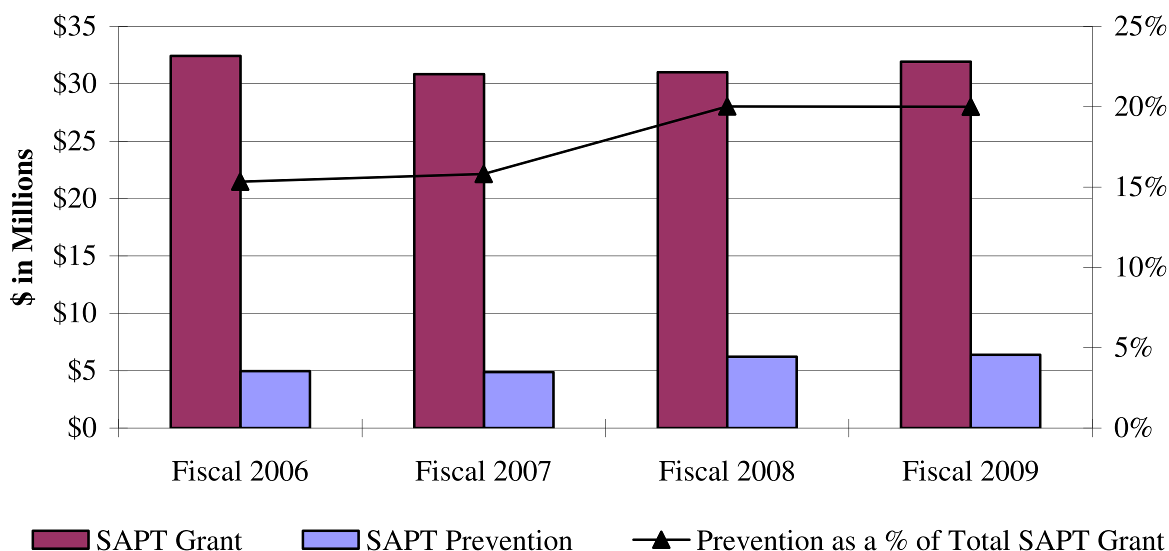
Administration

Other than increases in personnel expenses (associated with health insurance, OPEB liability, and increments), administrative funding at ADAA is falling. The most significant decline is $250,000 associated with a needs assessment being undertaken in fiscal 2008 but not in fiscal 2009 (Chapter 82 of 2007 which requires ADAA to undertake a needs assessment calls for an assessment every three years).

Prevention

Prevention programming funding increases by $175,000 in federal funds. This increase is necessary to meet the requirement that at least 20% of Substance Abuse Prevention and Treatment (SAPT) block grant is spent on prevention activities (see **Exhibit 10**). Prior to fiscal 2008, ADAA was not meeting the threshold under the currently used narrow definition of prevention activities. Rather, ADAA was using an expansive definition of prevention to include early intervention activities. Federal auditors noted that the more narrow definition should be used, and in fiscal 2008 ADAA began to move towards the 20% threshold. Through subsequent legislative budget action, the threshold was met in fiscal 2008.

Exhibit 10
Prevention Funding and the SAPT Block Grant
Fiscal 2006-2009



SAPT: Substance Abuse Prevention and Treatment

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

Treatment

The major increase in ADAA's budget is for treatment, just over $4.8 million. A provider inflationary increase of 1.5% to all treatment and prevention activities adds almost $2.0 million to the budget. This 1.5% is consistent with most of the discretionary increases being provided to providers in the Department of Health and Mental Hygiene (DHMH) budget in fiscal 2009.

ADAA providers (many of which are local health departments) did not receive an inflationary increase in fiscal 2008, although a small increase was provided in fiscal 2007. At the same time, providers face the same operational inflationary increases that State agencies face, for example in utilities, rent, building maintenance, and personnel costs, as well as the same issues related to recruitment and retention of staff.

Interestingly, as noted below in Issue 1, the formula workgroup in its draft final report recognized the need for regular inflationary adjustments to maintain the current services base through its recommendation that for any new local treatment and prevention funding an amount equal to 2% of the current services base be added to existing grant awards as an inflationary adjustment. The fiscal 2009 budget does not quite meet that 2% level but acknowledges the need to maintain the base infrastructure.

In addition to the inflation adjustment, the budget contains funding for two major program expansions:

- **Court-committed and Court-referred Residential Slots.** The budget includes $1.1 million to add 20 residential slots for court-committed defendants with co-occurring disorders through the existing statewide contract for co-occurring services, and $200,000 for six residential slots for court-referred clients at the Carroll County long term treatment facility.

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

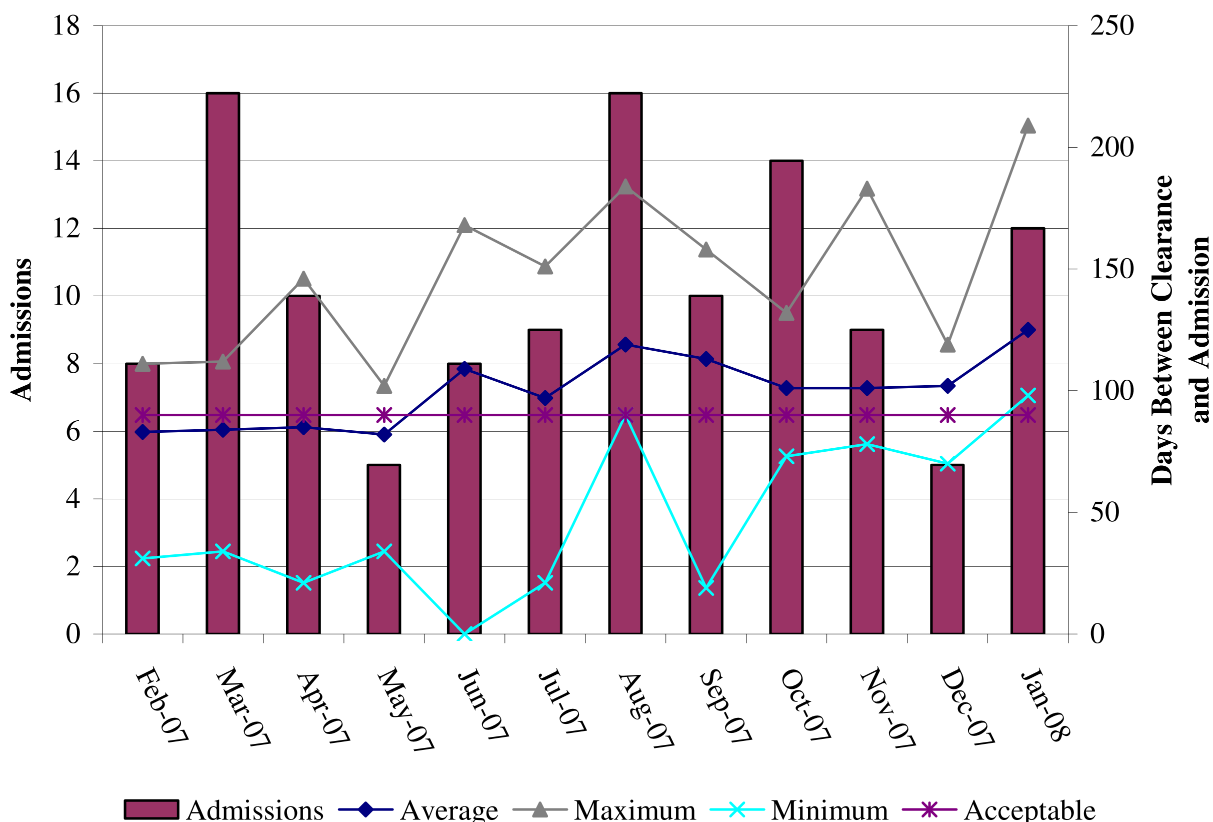
  Although the statute notes that the department shall provide services required, it is generally considered that this service provision is subject to the availability of funds provided for in the budget. Certainly a review of the legislative history associated with these provisions would indicate that. In other words, this section is not "treatment on demand" for all individuals that the courts find have an alcohol and drug dependency and are suitable for, and agree to, commitment to the department.

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

Indeed, one of the reasons ADAA re-bid its three statewide residential contracts in calendar 2005/2006 was to expand the number of residential slots that could serve this population. The existing contracts for women and children (45 beds) and co-occurring disorders (50 beds) are not exclusively for court-involved individuals although generally serve such clients. The third, and largest, contract is exclusively for court-ordered individuals (120 beds).

However, in recent months, the Judiciary again noted delays in the placement of individuals under Section 8-507. As shown in **Exhibit 11**, which presents data only for individuals with co-occurring disorders who require level III.3 (residential) treatment, the time taken from a defendant being cleared for service under Section 8-507 and admission to the program has increased steadily in recent months. For the second half of 2007, that "acceptable" 90-day limit has not been met and actually reached a high of an average 125 days in January 2008.

Exhibit 11
Clearance to Admission Times for Co-occurring Level III.3 Treatment
February 2007 – January 2008



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

Further, ADAA notes that in addition to those individuals who are on the waiting list that have been cleared, others are in the process of being cleared *i.e.*, there is an additional list of individuals who are in process to get on the waiting list.

The additional residential capacity in Carroll County is not limited to individuals with co-occurring illness, although they will be both court-committed and court-referred clients. According to ADAA these additional slots are available both to Carroll County residents and non-residents. The program is performance-based, modeled on the performance incentives in ADAA's statewide and other residential grants and contracts (which, like the outpatient pay for performance program, utilize retention and completion benchmarks).

- **Buprenorphine Expansion.** Buprenorphine, like methadone, is used in substitution maintenance therapy for opioid dependence. Such therapy involves the substitution of heroin or other opioid drugs with a pharmacologically related therapy that has the capacity to prevent the emergence of withdrawal symptoms, reduces craving, is long-lasting to reduce the frequency of administration, and can be administered in a manner that reduces the risk of infections associated with the use of illicitly used opioids.

  The Governor proposed a major $5 million expansion of buprenorphine therapy in the fiscal 2008 allowance. Prior to fiscal 2008, ADAA's treatment grants were being used to some limited extent for buprenorphine therapy if localities chose to fund it. For example, in fiscal 2007, Baltimore City spent $643,000 of ADAA funds on buprenorphine-related expenditures. Other jurisdictions also spent ADAA funding for buprenorphine therapy, but in much smaller amounts.

  Ultimately the legislature approved $3.0 million in funding for buprenorphine expansion, an amount, as noted above, reduced to $2.25 million by the Governor through cost containment. In accordance with budget bill language in Chapter 487 of 2007, ADAA submitted a plan for buprenorphine expansion. That plan assumed an annualized cost of $3.0 million for the treatment of 1,000 individuals.

  ADAA's plan for buprenorphine expansion (using the $3.0 million annualized costs provided in the report) is broken into two parts. First, $2.1 million will be made available to jurisdictions based on that region's proportion of unmet need for opiate addiction treatment. As shown in **Exhibit 12**, the bulk of the unmet need (and therefore funding) is in Baltimore City. Further, as is also clear from Exhibit 12, for most jurisdictions, the new funding will be minimal. Funds will be released to local jurisdictions only after local plans are approved that include case management services, buprenorphine induction sites, and adequate counseling services.

Exhibit 12
Proposed Annualized Jurisdictional Funding of Buprenorphine Therapy

Region (Jurisdictions)	Percent of Unmet Need (%)	Funding ($)
Western (Allegany, Garrett, Frederick, and Washington)	4	$84,000
Suburban (Montgomery and Prince George's)	4	84,000
Southern (Calvert, Charles, and St. Mary's)	2	42,000
Lower Shore (Dorchester, Somerset, Wicomico, and Worcester	2	42,000
Upper Shore (Caroline, Cecil, Kent, Queen Anne's, and Talbot)	2	42,000
Central (Anne Arundel, Baltimore, Carroll, Harford, and Howard)	23	483,000
Baltimore City	63	1,323,000
Total	**100**	**$2,100,000**

Source: Alcohol and Drug Abuse Administration

The second part of ADAA's plan involves $900,000 in funding to be held by the administration to provide for physician training, information technology upgrades, the direct purchase of buprenorphine to supplement local medication budgets, and supplemental grants to rural and smaller jurisdictions given that allocations provided under Exhibit 12 may not be adequate to operate a program. The fiscal 2008 budget assumes a $1.65 million/$600,000 split between the two components of ADAA's plan.

As noted above, the fiscal 2009 budget includes an additional $1.6 million for buprenorphine therapy: $750,000 of the funding annualizing fiscal 2008 costs per the submitted ADAA plan with $850,000 for expansion (potentially serving an additional 250 to 300 individuals).

There are two policy questions about the proposed expansion. The first, and perhaps more substantive, is the same issue raised around the initial fiscal 2008 initiative: the earmarking of funding to address one particular form of addiction and for one particular therapy runs counter to the policy direction established in the 2004 legislation creating the local drug and alcohol abuse planning process. Under that process, localities determine local priorities through the development of local strategic plans and subsequent implementation updates with additional treatment funding provided to meet those priorities. If the new administration is choosing to fund treatment programming using different priorities, that of course is the prerogative of the administration, but it calls into question the utility of the local planning process.

The second issue concerns recent media reports over the illicit diversion of buprenorphine. These reports were driven by reporting about small but persistent problems associated with illegal sales. A recent study on the problem in Vermont conducted for SAMHSA for example, concluded that:

- Buprenorphine abuse and diversion was not widespread, but rather concentrated in certain small populations. The study noted that this abuse and diversion may have to do more with a lack of access to treatment as some of this activity reflected an attempt to self-medicate when formal treatment was unavailable.

- Vermont has a relatively high rate of buprenorphine consumption in terms of prescribed drugs. However, this may be related more to the successful recruitment of physicians to prescribe the drug and meet a goal of office-based treatment of opioid addiction, the relative high level opioid addiction in the state, and the large number of out-of-state residents being treated for opioid addiction in Vermont rather than a diversion and abuse problem.

A broader study, also conducted for SAMHSA, confirmed that there are areas where buprenorphine diversion and abuse is an issue. Further, while the largest part of the diverted drug supply does come from buprenorphine prescribed by physicians, either for addiction or pain, there is also some illegal importation occurring.

Most significantly, the broader study noted that abuse of buprenorphine appeared to occur at a much lower level than other drugs such as Oxycontin, hydrocodone, oxycodone, methadone, morphine, hydromorphone, or fentanyl.

Nevertheless, mindful of these issues, as noted above ADAA is requiring approval of local plans for buprenorphine programming prior to implementation and those plans, in addition to such things as outlining coordination of care between counseling and medication, include a specific diversion control element that includes at a minimum:

- toxicology specimens to test for the presence of buprenorphine as well as the absence of alcohol/illicit drugs;

- ongoing patient education about the need to properly secure medications and the consequences of diversion;

- appropriate staff education; and

- appropriate physician education.

Given the amount of funding for the expansion of buprenorphine therapy being devoted to Baltimore City, the comments of the Baltimore City Health Commissioner on this issue seem pertinent. While accepting that some illegal street sales of buprenorphine does occur, the commissioner has noted that such illegal sales appear to be limited in the city for a variety of

reasons including the widespread availability of other drugs, and the unpleasant withdrawal symptoms precipitated by buprenorphine in persons abusing other opiates. Nonetheless, in establishing buprenorphine programs in the city, a long list of protocols intended to safeguard against diversions are being instituted including:

- assessment and evaluation before treatment admission to ensure buprenorphine therapy is appropriate;
- enrollment in intensive behavioral therapy;
- the use of the Center of Substance Abuse Treatment's clinical guidelines for clinical practice with buprenorphine;
- direct observation of medication intake at the start of treatment;
- increasing prescription lengths only as clients demonstrate appropriate use of medication;
- random medication recalls and pill counts;
- drug testing for buprenorphine;
- case management services;
- provider roundtables to discuss issues and trends; and
- for primary care physicians as they agree to participate: introductory briefings; drug testing in primary care settings; appropriate referrals back to the drug treatment system; and available verification of counseling attendance.

It is conceded that these measures will not prevent all diversion. However, the sentiment is that the risks associated with diversion are far less than the health and public safety risks associated with heroin use.

SAPT Block Grant Availability

An important element of the budget growth in fiscal 2009 is an increase of over $900,000 in the use of SAPT block grant funds. As shown in **Exhibit 13**, this increase is not based on any expectation of significant increases in block grant attainment. While fiscal 2009 attainment levels are slightly greater than fiscal 2008, they are almost $1.4 million below fiscal 2007 levels. The increase is essentially derived by ADAA planning to have no year-end fund balance. This strategy as conceived, while appropriate using federal funds ahead of general funds as required in budget bill language, will make it difficult to sustain federal fund support for programming at current levels in fiscal 2010 absent an increase in the block grant award and/or reserving a lower amount for use in the subsequent fiscal year (which avoids the immediate pain but would eventually have to be addressed).

Exhibit 13
SAPT Block Grant Availability
Fiscal 2007-2010

	Fiscal 2007	Fiscal 2008	Fiscal 2009	Fiscal 2010
Beginning Balance/Prior Year Reserve	$8,621,922	$10,156,334	$9,250,167	$7,899,917
Attainment	33,036,201	31,617,130	31,663,552	
Subtotal	**$41,658,123**	**$41,773,464**	**$40,913,719**	
Reserved for Subsequent Year	-7,967,230	-7,904,282	-7,899,916	
Transferred Out	-670,722	-1,505,442	-1,088,082	
Expenditures	-30,831,067	-31,017,855	-31,925,720	
Ending Balance	**$2,189,104**	**$1,345,885**	**$1**	

Source: Department of Health and Mental Hygiene

Issues

1. The Formula Workgroup Proposal

As noted above in Exhibit 8, the bulk of ADAA's budget is awarded to local jurisdictions for prevention and treatment. Those awards are distributed based on historical allocations, earmarks, statute, as well as formula. The formula, which consists of three variables (HIV incidence; drug and driving while intoxicated (DWI) arrests; and an estimate of treatment need), is applied to any new undesignated funding. However, allocations made based on that formula in subsequent years become part of a jurisdiction's historical allocation. In fiscal 2009, for example, no funding would be allocated by this formula, rather it is all earmarked (although the additional buprenorphine funds would most likely be allocated based on an estimate of need).

In fiscal 2007 budget deliberations, the legislature added budget bill language requesting the Maryland State Drug and Alcohol Abuse Council develop a formula for the allocation of all prevention and treatment funding granted to local jurisdictions for implementation in fiscal 2010. That formula was to be developed by February 1, 2007, and take into consideration:

- the need to equitably fund prevention and treatment services in all jurisdictions;
- the need to hold jurisdictions harmless in the implementation of any new formula as the application of any formula to the **total** funding granted to local jurisdictions would inevitably mean that some jurisdictions would gain funds at the expense of others;
- the need to account for regionally based treatment provided by a single jurisdiction; and
- a funding schedule to fully implement the formula by fiscal 2010.

February 2007 Report and 2007 Session Action

A workgroup of the Maryland State Drug and Alcohol Abuse Council was established to undertake this formula revision, working closely with a consultant. On February 1, 2007, the council submitted the workgroup's report with a recommendation to extend the deadline for the development of a formula until December 1, 2007.

That extension request was granted and additional budget bill language was added during fiscal 2008 budget deliberations to that end. Additionally, the budget bill language aimed to resolve the thorniest issue in the workgroup's discussions during 2006, namely the implementation of a hold harmless provision. Under virtually any formula scenario, it was hard to imagine that the implementation of any formula for all prevention and treatment funding would not result in sharp redistributions of funding. Such redistributions might result in more equitable funding but would have a detrimental impact on the service delivery infrastructure that has developed under current funding

streams. It was generally agreed that this should be avoided, and no jurisdiction would lose funds under any new formula.

Thus, budget bill language clarified that the intent of the legislature was to apply the formula to new funding provided to local jurisdictions for the expansion of prevention and treatment.

Final Workgroup Report

The formula workgroup delivered its draft final report to the State Drug and Alcohol Abuse Council in December 2007. The recommendations of the workgroup as to the allocation of new funds for prevention and treatment services were as follows:

- Prior to any expansion of services, to allocate an amount sufficient to provide a 2% inflationary adjustment based on prevention and treatment funding levels.

- Of the remaining funds, 80% should be allocated to treatment as follows: 95% allocated among all jurisdictions by formula based on a jurisdiction's substance abuse prevalence and the population below 200% of the Federal Poverty Level (FPL); and 5% split equally between federally designated rural jurisdictions (Allegany, Caroline, Dorchester, Garrett, Kent, Somerset, St. Mary's, Talbot, and Worcester counties).

- The remaining 20% should be allocated to prevention as follows: 95% allocated by formula among all jurisdictions based on a jurisdiction's total population and the population below 200% of FPL; and 5% split equally between federally designated rural jurisdictions.

At the same time that the workgroup delivered its product to the State council, the Baltimore City local drug and alcohol abuse council submitted an alternative proposal which did not so much recommend an alternative formula as a methodology for developing an alternative formula. Some of the concerns expressed by the council (which was represented on the formula workgroup) were actually taken into consideration by the formula workgroup and already incorporated into the final draft proposal, considered and not included, or in some instances not taken up during workgroup discussions.

Additionally, the Judiciary voiced concern over funding for court-ordered treatment under Section 8-507 of the Health General Article. Specifically, a proposal was offered to:

- carve out all funding related to court commitments from formula consideration and fund them directly; or

- include in the formula factors that would lend themselves to full funding of court-ordered treatment.

Next Steps

The State Drug and Alcohol Abuse Council postponed any action on the workgroup report or the recommendations made by other parties. Specifically, the council is awaiting the results of the needs assessment being undertaken as a result of Chapter 82 of 2007. ADAA contracted with researchers at Harvard University and CESAR for this needs assessment, and a final report is anticipated at the end of February.

At this point the only thing that is clear is that nothing has been resolved on this issue. In the two budget submissions since this latest discussion on funding allocations was raised, ADAA's funding increases have all been earmarked for specific initiatives. While those initiatives address identifiable problems, for the most part they also clearly benefit certain jurisdictions and certain addictions over others. Thus, the starting-point for this two-year discussion, are local prevention and treatment dollars appropriately distributed, is no closer to being answered. Perhaps a clearer answer will be at hand with the completion of the needs assessment. However, there is no guarantee that future funding streams will follow what the assessment reveals.

2. Local Prevention and Treatment Grant Award Utilization

As shown in **Exhibit 14**, in any given year, a significant amount of funds from local prevention and treatment grant awards are unutilized by the grant recipients. As also shown, this typically represents a small percentage of total statewide awards, between 2%-3%, with some jurisdictions spending a significantly smaller percentage of their awards while others utilize all of the awards.

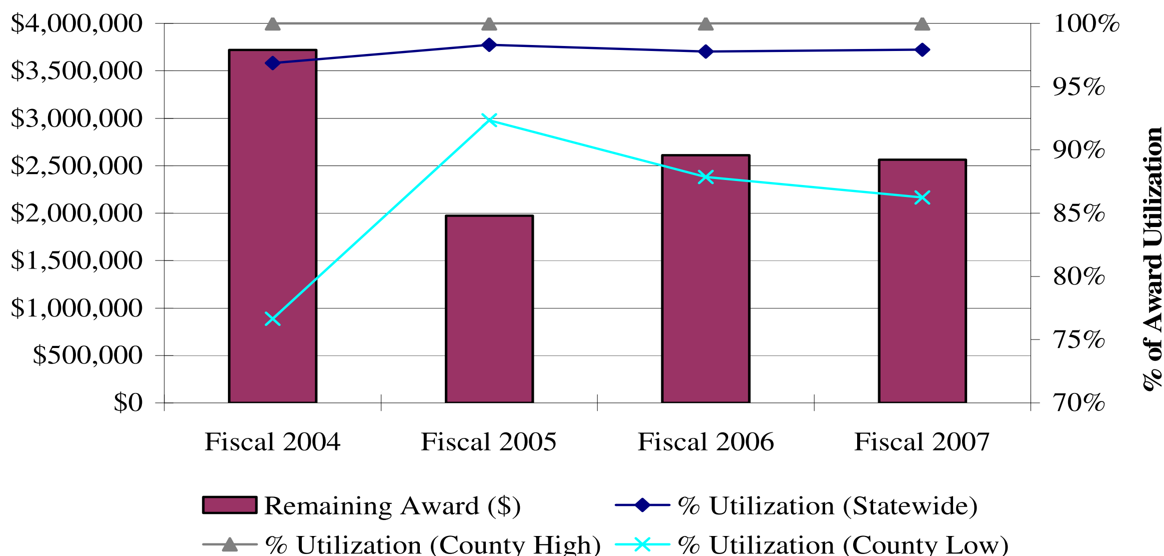
Typically ADAA reviews grant awards late in the fiscal year to identify where funds will not be spent. Funds are then redeployed to:

- other areas of need in ADAA (typically other grantees);
- other areas of need in DHMH through the close-out process (although the amount of ADAA general funds used for this purpose has not been great in recent years); and
- reversions to the general fund or cancellations.

ADAA also goes through a final reconciliation/audit process and any funds returned as a result of this process are recovered and any jurisdictions entitled to additional funds are paid out of those recoveries (this process makes up the prior year grant activity noted in Exhibit 9).

The fiscal 2007 reconciliation process is still in process. However, in fiscal 2006, for example, there was just over $2.6 million in unspent funds. Over $900,000 was subsequently re-appropriated for prior year grant activity, $700,000 in general funds was reverted (a reversion that would not appear in the current/prior reconciliation included in the budget analysis as the reversion relates to prior year accruals), and the remaining combination of special and federal funds were cancelled.

Exhibit 14
Local Prevention and Treatment Grant Award Utilization
Fiscal 2004-2007
Various Data



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

Exhibit 15 provides specific jurisdictional data in terms of award utilization for fiscal 2007, as well as a four-year fiscal 2004 through 2007 average of awards remaining at the end of the fiscal year and the average percentage of awards utilized by jurisdiction.

From Exhibits 14 and 15 a couple of points can be made:

- Given the constant refrain about lack of dollars for addiction prevention and treatment, it is unfortunate any dollars are unspent, although it should be noted that the current reallocation methodology has, according to ADAA, reduced overall levels of reversions/cancellations.

- It is unclear why ADAA does not spend down the SAPT block grant funds appropriated in any given fiscal year. Notwithstanding the concern noted earlier about the sustainability of expenditures supported by federal funds, budget bill law requires agencies to spend down federal funds before general funds. According to DHMH, this relates primarily to the need to prudently spend-down these funds during a period when federal grants have been falling.

Exhibit 15

Alcohol and Drug Abuse Administration

Local Prevention and Treatment Grant Award Utilization
Fiscal 2007 and 2004-2007 – Four-year Averages
Various Data

Jurisdiction	Total FY 2007 Award	Total FY 2007 Expenditures	Total Award Remaining	% of Award Expended	Four-year Average 2004-2007 Award Remaining	Four-year Average 2004-2007 % Expended
Allegany	$5,706,760	$5,702,097	$4,663	99.92%	$31,856	99.42%
Anne Arundel	5,415,712	5,319,493	96,219	98.22%	89,023	98.24%
Baltimore	7,799,615	7,647,003	152,612	98.04%	140,840	98.03%
Calvert	1,203,021	1,137,657	65,364	94.57%	69,746	94.05%
Caroline	718,891	710,997	7,894	98.90%	4,054	99.39%
Carroll	4,222,784	4,222,784	0	100.00%	29,869	99.28%
Cecil	1,530,147	1,438,134	92,013	93.99%	86,655	93.98%
Charles	2,474,993	2,427,803	47,190	98.09%	52,204	97.77%
Dorchester	2,092,208	2,092,208	0	100.00%	8,995	99.55%
Frederick	2,745,139	2,512,523	232,616	91.53%	202,861	92.32%
Garrett	1,118,015	1,118,015	0	100.00%	5,247	99.52%
Harford	2,386,649	2,377,262	9,387	99.61%	8,630	99.60%
Howard	1,924,057	1,849,596	74,461	96.13%	70,449	96.14%
Kent	2,054,499	2,052,067	2,432	99.88%	14,885	99.25%
Montgomery	5,265,177	5,136,882	128,295	97.56%	122,883	97.54%
Prince George's	11,628,634	11,142,557	486,077	95.82%	475,421	95.80%
Queen Anne's	881,194	799,313	81,881	90.71%	115,834	86.24%
Somerset	1,109,440	1,109,440	0	100.00%	2,673	99.75%
St. Mary's	3,118,274	3,110,986	7,288	99.77%	111,962	96.17%
Talbot	968,916	968,916	0	100.00%	3,282	99.65%
Washington	4,033,438	4,033,438	0	100.00%	13,397	99.66%
Wicomico	2,350,539	2,203,317	147,222	93.74%	141,980	93.75%
Worcester	3,380,054	3,378,047	2,007	99.94%	1,538	99.95%
Baltimore City	48,720,080	47,810,639	909,441	98.13%	897,604	98.13%
ATOD Centers	545,281	530,140	15,141	97.22%	14,914	97.22%
Total	**$123,393,517**	**$120,831,312**	**$2,562,205**	**97.92%**	**$2,716,801**	**97.72%**

ATOD: Alcohol, Tobacco, and Other Drugs

Note: Shaded cells indicate where the jurisdiction has over the period fiscal 2004-2007 utilized below the State average for award utilization. Award amounts include some funds re-allocation during the fiscal year and also, in some jurisdictions, funding for statewide services.

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

- Given that the award of local prevention and treatment funding is primarily based on historical allocation, it is unclear why ADAA continues to make awards based on historical award levels to those jurisdictions that consistently under-utilize award funds either in a dollar-sense (for example, Baltimore City), as a percentage of total award utilized (for example, Cecil, Queen Anne's and Wicomico counties), or both (for example, Frederick and Prince George's counties).

  While ADAA works to align grant awards with expenditures and with jurisdictional outcomes, there is still some mismatch. The current system does provide an opportunity to move funds from one jurisdiction to another mid-year based on actual utilization during the course of a year. Further, because allocations are based on initial award, a jurisdiction can have some comfort that losing dollars in one year will not result in a reduction to awards in the next.

  However, this does not diminish the concern of granting dollars to jurisdictions that consistently under-utilize their awards (with an emphasis on those that proportionally under-spend their award). ADAA notes the need to have practical and open business discussions with jurisdictions that have a history of leaving money on the table. Clearly, given the historical data shown in Exhibit 15, this needs to happen. **DLS recommends restricting funds pending the receipt of a report detailing specific actions, by jurisdiction, to further diminish the problem of award under-utilization. If the problem cannot be resolved, ADAA should consider using a three-year award utilization history when making future award allocations.**

Recommended Actions

1. Add the following language to the general fund appropriation:

   , provided that $100,000 of this appropriation may not be expended until the Alcohol and Drug Abuse Administration submits a report to the budget committees outlining actions it intends to take to maximize the utilization of local addictions prevention and treatment awards. The actions should be specific to individual jurisdictions as appropriate. The report shall be submitted by December 1, 2008, and the budget committees shall have 45 days to review and comment.

   Explanation: There are a number of jurisdictions that regularly under-utilize their local addictions prevention and treatment awards. The Alcohol and Drug Abuse Administration (ADAA) notes that it is working with all jurisdictions in order to both maximize the utilization of awards and also to ensure that these dollars are spent as efficaciously as possible. However, some jurisdictions regularly leave funding unspent. The language restricts funds until ADAA reports back to the budget committees on actions that will occur, specific to relevant jurisdictions, to resolve this problem.

Information Request	**Author**	**Due Date**
Maximizing the utilization of local prevention and treatment awards	ADAA	December 1, 2008

	Amount Reduction	
2. Reduce funding for the expansion of buprenorphine therapy. The fiscal 2008 legislative appropriation included $3.0 million to expand the utilization of buprenorphine therapy. The Board of Public Works subsequently reduced this initiative to $2.25 million in July 2007. The fiscal 2009 budget includes $750,000 in funding to annualize the fiscal 2008 initiative as outlined by the Alcohol and Drug Abuse Administration in a 2007 plan submitted to the legislature, but also $850,000 for further expansion in fiscal 2009. The proposed reduction of $850,000 still provides support for a $3.0 million plan, or a funding level 33% above planned expenditures in fiscal 2008.	$ 850,000	GF
Total General Fund Reductions	**$ 850,000**	

Updates

1. The Integration of Child Welfare and Substance Abuse Treatment Act

The Integration of Child Welfare and Substance Abuse Treatment Act, established in Chapter 551 of 2000 was designed to improve the provision of substance abuse treatment services to parents in the child welfare system. The program – operated jointly by the Department of Human Resources and DHMH – places addictions specialists in social service offices to assess the treatment needs of parents with children entering out-of-home placements.

The Act called for a comprehensive statewide program with addictions specialists placed in all child welfare offices. With funding significantly below the amounts intended in the legislation, the departments implemented the program on a trial basis in fiscal 2002 with the hiring of seven addictions specialists in Baltimore City and two addictions specialists in Prince George's County. Funding has remained relatively stable since that time at $2.3 million, which provides for addictions counselors, assessment, and substance abuse treatment in the two targeted jurisdictions.

Chapter 551 also required an independent results-based evaluation by December 2004. However, the funding required to perform the evaluation was deleted in 2003.

Budget bill language added in the 2005 session restricted $250,000 in funds intended for this program for an independent evaluation of the program. According to ADAA, a research committee has developed the necessary research protocol, and the Institutional Review Boards of both DHMH and the University of Maryland (which will undertake the evaluation) approved the protocol in November and December of 2006, respectively. According to ADAA, the final report has been submitted to DHMH. However, at the time of writing, the evaluation was still unavailable.

Appendix 1

Current and Prior Year Budgets

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

	General Fund	Special Fund	Federal Fund	Reimb. Fund	Total
Fiscal 2007					
Legislative Appropriation	$84,832	$17,635	$31,678	$3,363	$137,508
Deficiency Appropriation	0	0	160	0	160
Budget Amendments	-155	1,121	0	696	1,662
Reversions and Cancellations	0	-442	-631	0	-1,074
Actual Expenditures	**$84,677**	**$18,314**	**$31,206**	**$4,059**	**$138,256**
Fiscal 2008					
Legislative Appropriation	$90,622	$17,748	$31,441	$3,363	$143,174
Cost Containment	-842	0	0	0	-842
Budget Amendments	53	3	0	745	801
Working Appropriation	**$89,833**	**$17,750**	**$31,441**	**$4,108**	**$143,132**

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

Fiscal 2007

The fiscal 2007 legislative appropriation for ADAA was increased by $748,000 as follows:

- A federal fund deficiency appropriation added $160,000. This funding was to assist in the development of systemic practice improvement protocols for licensed service providers.

- Budget amendments increased the legislative appropriation by almost $1.7 million. This increase consisted of:

  - a reduction of $155,000 in general funds. This reduction consisted of a $50,000 increase that represented ADAA's share of the fiscal 2007 cost-of-living adjustment (COLA) originally budgeted in the Department of Budget and Management that was more than offset by over $200,000 transferred out of ADAA into other programs in DHMH as part of fiscal 2007 close-out;

  - an increase in just over $1.1 million in special funds almost entirely derived from prior year grant recoveries used to offset the same amount of increased costs in other prior year grant awards; and

  - a $696,000 increase in reimbursable funds received from the Judiciary for treatment of drug court participants. This treatment will be provided through local health departments.

- Special and federal fund cancellations did much to offset the increase to the legislative appropriation from the deficiency appropriation and budget amendments. These cancellations total almost $1.1 million. The special fund cancellations related to lower than anticipated prior year grant expenditures, $390,000; and lower than anticipated expenditures for training and education, $52,000. The federal fund cancellations related to a variety of lower than budgeted expenditures in the following grants: the Substance Abuse Prevention and Treatment Block Grant, $402,000; the State Outcomes Measurement and Management System grant, $130,000; and State Epidemiological Outcome Workgroup grant, $100,000.

Fiscal 2008

To date, the fiscal 2008 legislative appropriation has been decreased by $42,000:

- The most significant change is an $842,000 general fund cost containment reduction made by BPW in July 2007.

- This cost containment reduction is partially offset by a $745,000 increase in reimbursable funds received from the Judiciary for treatment of drug court participants and $56,000 ($53,000 general funds, $3,000 special funds) representing ADAA's share of the fiscal 2008 COLA.

Appendix 2

Fiscal 2008 Local Prevention and Treatment Grant Awards

	Prevention	Treatment	Total
Allegany	$222,769	$2,220,048	$2,442,817
Anne Arundel	276,994	5,245,940	5,522,934
Baltimore County	400,819	7,494,198	7,895,017
Calvert	78,301	1,002,322	1,080,623
Caroline	72,912	650,276	723,188
Carroll	89,228	1,727,270	1,816,498
Cecil	68,067	1,477,629	1,545,696
Charles	127,876	2,348,289	2,476,165
Dorchester	107,326	1,379,837	1,487,163
Frederick	355,062	2,552,060	2,907,122
Garrett	238,900	808,232	1,047,132
Harford	101,452	2,294,204	2,395,656
Howard	82,057	1,830,213	1,912,270
Kent	97,750	1,058,717	1,156,467
Montgomery	476,243	4,983,559	5,459,802
Prince George's	479,586	11,443,325	11,922,911
Queen Anne's	83,255	805,427	888,682
St. Mary's	93,300	2,976,610	3,069,910
Somerset	89,701	1,024,140	1,113,841
Talbot	98,063	931,238	1,029,301
Washington	234,317	3,817,242	4,051,559
Wicomico	339,663	2,174,090	2,513,753
Worcester	102,371	3,303,721	3,406,092
Baltimore City	979,338	48,991,441	49,970,779
Subtotal	**$5,295,350**	**$112,540,028**	**$117,835,378**
Statewide	915,005	16,340,591	17,255,596
Total	**$6,210,355**	**$128,880,619**	**$135,090,974**

Note: Local award amounts exclude funding for statewide services that may be added to those awards.

Source: Alcohol and Drug Abuse Administration

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

Object/Fund	FY07 Actual	FY08 Working Appropriation	FY09 Allowance	FY08-FY09 Amount Change	Percent Change
Positions					
01 Regular	65.00	63.00	62.00	-1.00	-1.6%
02 Contractual	2.62	5.00	5.00	0	0%
Total Positions	**67.62**	**68.00**	**67.00**	**-1.00**	**-1.5%**
Objects					
01 Salaries and Wages	$ 4,032,733	$ 4,234,508	$ 4,602,297	$ 367,789	8.7%
02 Technical and Spec. Fees	86,501	122,596	123,467	871	0.7%
03 Communication	17,347	18,678	16,894	-1,784	-9.6%
04 Travel	86,957	91,718	79,406	-12,312	-13.4%
07 Motor Vehicles	3,709	3,049	2,816	-233	-7.6%
08 Contractual Services	133,829,797	138,597,135	143,597,135	5,000,000	3.6%
09 Supplies and Materials	74,578	46,368	50,421	4,053	8.7%
10 Equip. – Replacement	72,845	0	0	0	0.0%
11 Equip. – Additional	6,200	0	0	0	0.0%
13 Fixed Charges	45,261	18,434	18,858	424	2.3%
Total Objects	**$ 138,255,928**	**$ 143,132,486**	**$ 148,491,294**	**$ 5,358,808**	**3.7%**
Funds					
01 General Fund	$ 84,676,611	$ 89,832,940	$ 94,080,825	$ 4,247,885	4.7%
03 Special Fund	18,313,940	17,750,254	17,953,312	203,058	1.1%
05 Federal Fund	31,206,296	31,440,925	32,348,790	907,865	2.9%
09 Reimbursable Fund	4,059,081	4,108,367	4,108,367	0	0%
Total Funds	**$ 138,255,928**	**$ 143,132,486**	**$ 148,491,294**	**$ 5,358,808**	**3.7%**

Note: The fiscal 2008 appropriation does not include deficiencies.

Fiscal Summary
DHMH – Alcohol and Drug Abuse Administration

Program/Unit	FY07 Actual	FY08 Wrk Approp	FY09 Allowance	Change	FY08 - FY09 % Change
K101 Executive Direction	$ 629,998	$ 731,472	$ 701,084	-$ 30,388	-4.2%
K102 Grants, Contracts, and Management	700,914	786,622	909,742	123,120	15.7%
K103 Continuous Quality Improvement	441,431	671,135	715,056	43,921	6.5%
K104 Management Information Services	1,005,009	1,076,859	1,157,745	80,886	7.5%
K105 Education and Training	445,361	423,132	453,195	30,063	7.1%
K107 S.S.I. Drug and Alcohol	73,070	73,070	73,070	0	0%
K108 Criminal Justice	435,525	396,702	441,120	44,418	11.2%
K109 Policy, Planning, and Development	100,000	200,000	200,000	0	0%
K110 Special Populations	20,486	150,000	150,000	0	0%
K111 Program Consultation	762,422	728,896	812,528	83,632	11.5%
K113 Administration and Operations	2,208,922	1,103,624	868,483	-235,141	-21.3%
K115 M.A.T.C.	179,723	0	0	0	0%
K117 Drug Abuse Target Cities Treatment Im	797,440	800,000	800,000	0	0%
K201 Group Home Rev. Loan	4,876,925	6,210,355	6,385,144	174,789	2.8%
K202 Addictions Treatment Services (GF)	71,144,971	74,587,630	77,254,131	2,666,501	3.6%
K203 Sapt Block – Substance Prevention and Treatment Block	24,795,409	23,428,886	24,013,846	584,960	2.5%
K204 Cigarette Restitution Funds (Sf)	17,052,620	17,056,150	17,048,197	-7,953	0%
K206 Drug Treatment Court Commission of MD –RF	1,440,583	1,745,272	1,745,272	0	0%
K207 NIDA Data Collection	1,950	0	0	0	0%
K219 SB 512 – Children in Need of Assistance Drug Affects	1,656,553	1,656,599	1,656,599	0	0%
K220 Substance Abuse Treatment Outcomes Partnership Fund	6,207,625	6,433,718	6,433,718	0	0%
K221 HB7 Integration of Child Welfare and Substance Abuse	2,351,990	2,322,364	2,322,364	0	0%
K225 Buprenorphine Funding	0	2,250,000	3,850,000	1,600,000	71.1%
K298 Grant Activity – Prior Fiscal Years	927,001	300,000	500,000	200,000	66.7%
Total Expenditures	**$ 138,255,928**	**$ 143,132,486**	**$ 148,491,294**	**$ 5,358,808**	**3.7%**
General Fund	$ 84,676,611	$ 89,832,940	$ 94,080,825	$ 4,247,885	4.7%
Special Fund	18,313,940	17,750,254	17,953,312	203,058	1.1%
Federal Fund	31,206,296	31,440,925	32,348,790	907,865	2.9%
Total Appropriations	**$ 134,196,847**	**$ 139,024,119**	**$ 144,382,927**	**$ 5,358,808**	**3.9%**
Reimbursable Fund	$ 4,059,081	$ 4,108,367	$ 4,108,367	$ 0	0%
Total Funds	**$ 138,255,928**	**$ 143,132,486**	**$ 148,491,294**	**$ 5,358,808**	**3.7%**

Note: The fiscal 2008 appropriation does not include deficiencies.

Appendix 4