

Treatment on Demand:

A Public Policy Initiative
of the
City of Detroit

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Prevention

Treatment

Recovery

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Detroit Marriott Renaissance Center
Detroit, Michigan

Detroit: Drug Abuse Patterns and Trends

- *Cocaine* is the foremost primary illicit drug of abuse among admissions to treatment programs.
- Users tend to be over 30, African-American or White, and of low socioeconomic status.
- Cocaine (including crack) was involved as either primary, secondary, or tertiary drug) in **52%** of all treatment admissions in Detroit/Wayne County in FY2002, and **50%** in FY2003.

Brief Profile: City of Detroit ("A County Within a County")

- Population: 951,270 (largest city in the State of Michigan)
- Racial/Ethnic Composition: 82% African-American, 10% White, 5% Hispanic, 1% Asian, <1% American Indian
- Estimated Number of People Addicted: 10-12% (or 90,000-108,000)

Detroit: Drug Abuse Patterns and Trends (cont'd)

- *Heroin* is the second foremost primary illicit drug of abuse among admissions to treatment programs.
- Users are typically male, over the age of 30, African-American and of low socioeconomic status.
- Heroin was involved as the primary drug in **29%** of all treatment admissions in Detroit/Wayne County in both FY2002 and FY2003.

Detroit: Drug Abuse Patterns and Trends (cont'd)

- *Marijuana* also accounts for admissions to treatment programs in the city of Detroit.
- Users are typically adolescents or young adults, and predominantly male.
- Marijuana was involved (as primary, secondary, tertiary) drug in **29%** of all treatment admissions in Detroit/Wayne County in FY2003.

Detroit Coordinating Agency (CA)

- Coordinates substance abuse treatment and prevention services through the current network of 45 treatment and 33 prevention providers.
- One of 15 specialized local public or quasi-public entities called *Coordinating Agencies*.
- The Detroit CA (that is, the Bureau of Substance Abuse Prevention, Treatment and Recovery) is organizationally placed within the Detroit Department of Health and Wellness Promotion (DHWP).
- The Michigan Medicaid behavioral health “carve-out” model has been in existence since 10/1/98.

Detroit CA: Types of Treatment Services Provided Through Its Provider Network

• Block Grant

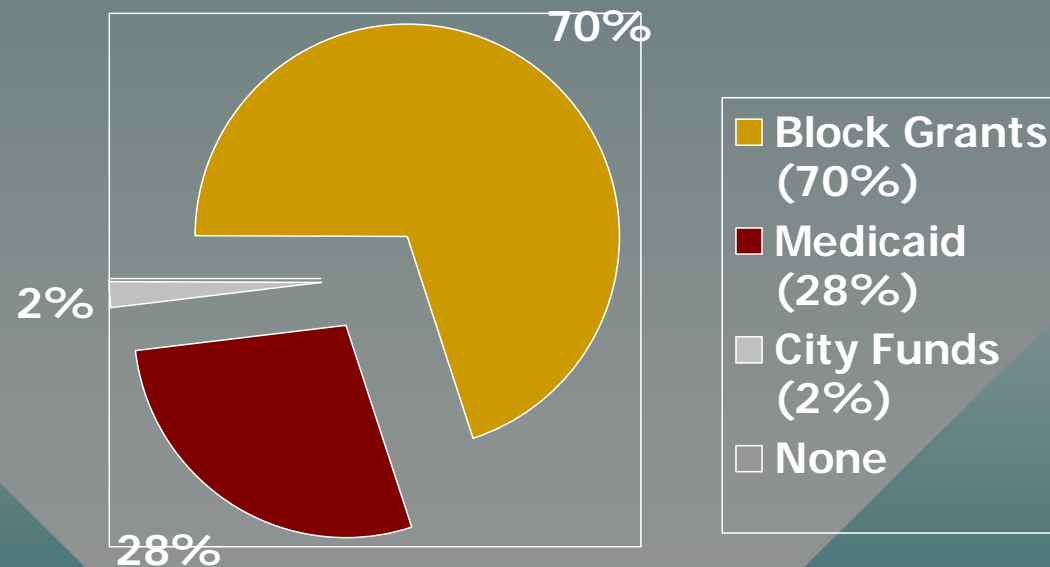
- Outpatient Drug Free
- Outpatient Methadone
- Detox
- Residential Intensive
- Residential Therapeutic
- Residential Recovery
- Intensive Outpatient
- Intensive Outpatient w/room and board

• Medicaid

- Outpatient Methadone
- Intensive Outpatient w/room & board
- Intensive Outpatient
- Outpatient Drug Free

Detroit Coordinating Agency: FY 2004 Budgetary Allocations for Treatment

- FY 2004 budgetary allocations for treatment totaled \$27M.
- Of which, \$19M (Block Grants), \$7.5M (Medicaid), and \$.5M (City Funds).



Treatment on Demand: Framework for Discussion

- **Genesis:** *What was the impetus for instituting a demand-treatment policy?*
- **Infrastructure:** *How has it affected capacity?*
- **Economics:** *Were economies of scale achieved?*
- **Funding Streams:** *How has it been funded?*
- **Quality of Services:** *How has client satisfaction levels improved?*
- **Outcomes:** *What has been the policy's impact?*

Detroit's Definition of Treatment on Demand

- Giving clients what they need and when they need it;
- Having zero waiting lists;
- Providing high quality services at minimum cost.

Treatment on Demand: Genesis

- *Genesis: How did demand-treatment get started throughout the city of Detroit?*
- Before 1998, funding was based on the slot system or performance based;
- Is a consequence of the statewide Medicaid Managed Care Program that required no waiting lists and was based on a fee-for-service reimbursement.

Treatment on Demand: Infrastructure (Capacity)

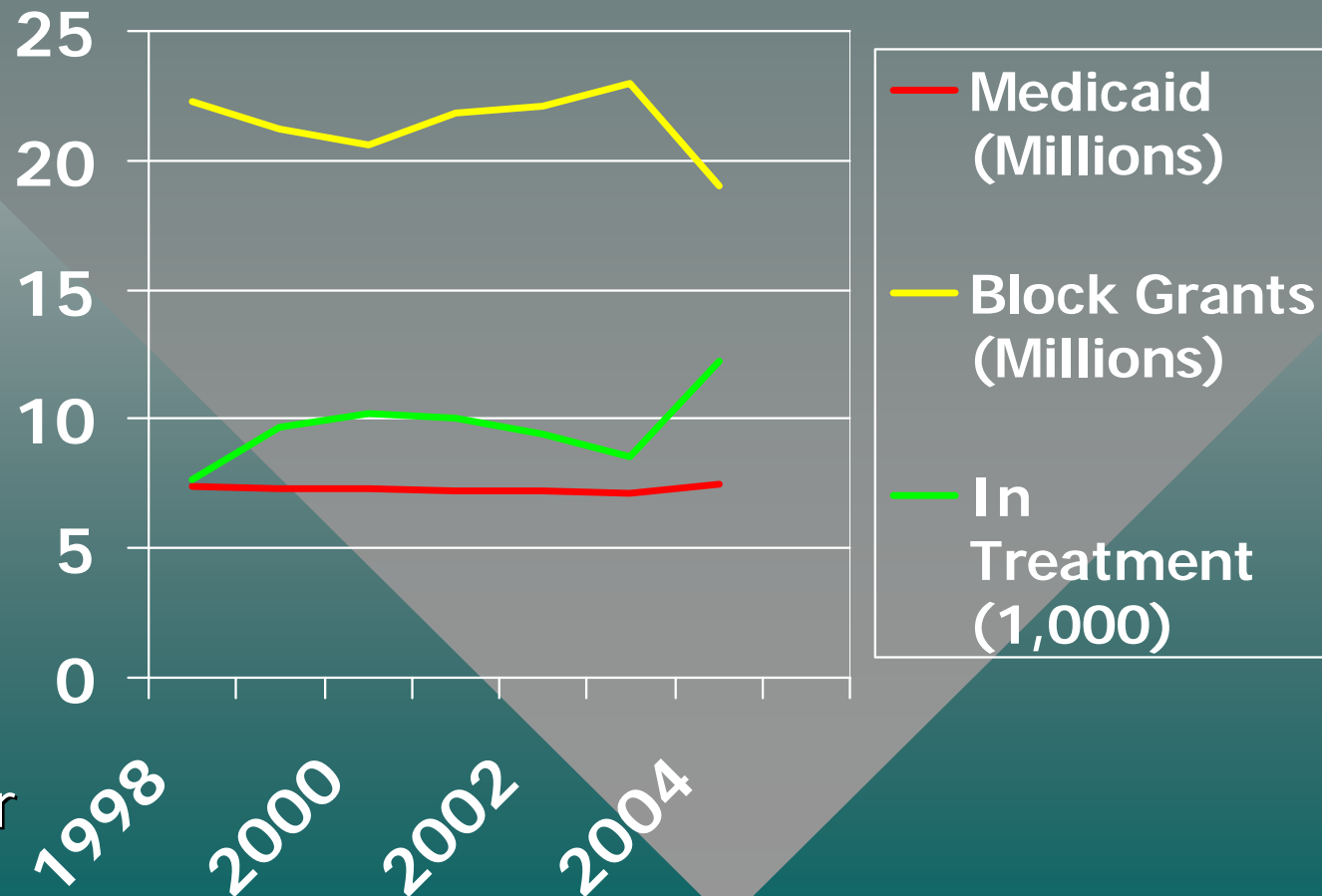
- *Infrastructure: How did demand-treatment change capacity throughout the city of Detroit?*
- When shifted from slot management to fee-for-service, providers had *capacity* to treat more clients.

Treatment on Demand: Economics

- *Economics: How were efficiencies achieved?*
 - Economies of scale/efficiencies were achieved throughout the provider network.
 - Redistributed funds among providers, that is, shifted from those less productive to those more productive.

Economic Efficiencies Achieved

- Medicaid budgetary allocations remained about the same and block grant allocations decreased, although number in treatment increased over time.



Treatment on Demand: Funding

- *Funding: How has it been funded?*
- Treatment on demand has been possible without increased funding.
- By implementing fee-for-service and by having both funding streams (Block grant and Medicaid), Detroit could be flexible and creative with its financing strategies.

Treatment on Demand: Quality of Services

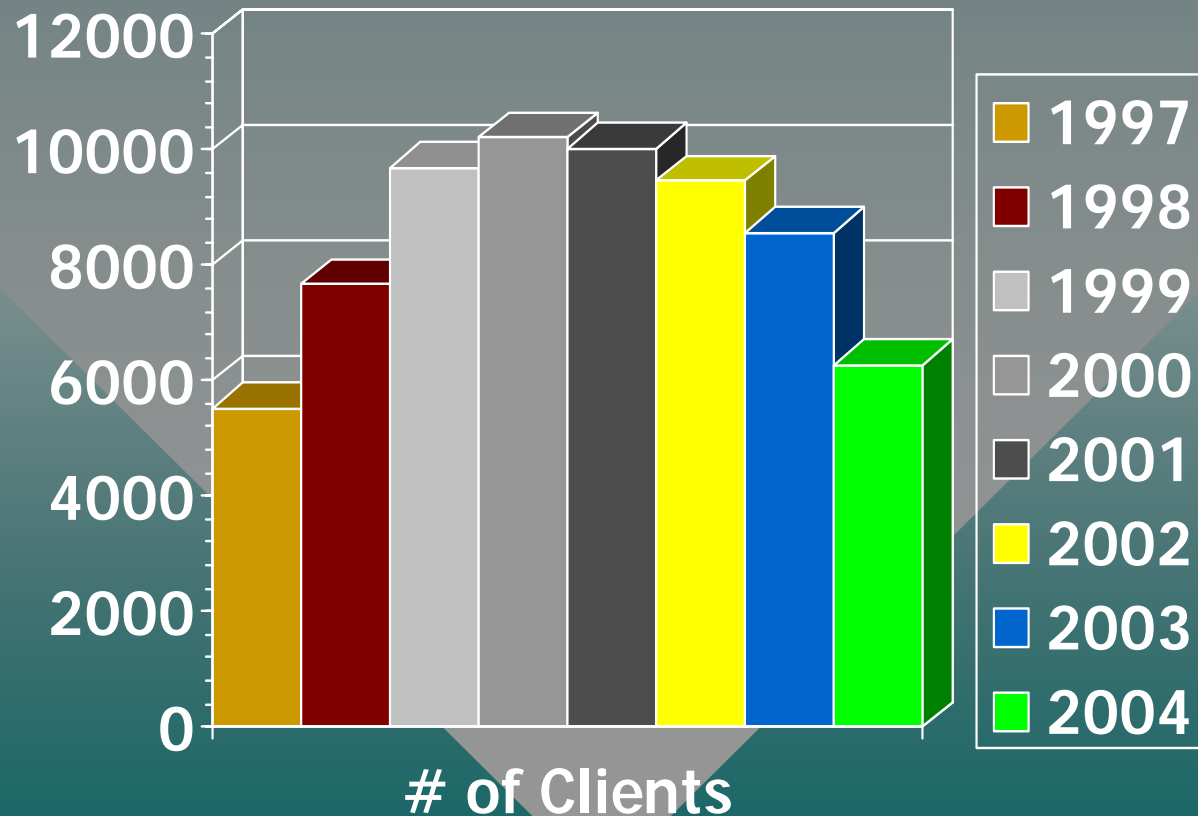
- *Quality of Services:*
How has levels of client satisfaction improved?
- On average, 94% of clients receiving treatment, report being satisfied with treatment received throughout the provider network.

Treatment on Demand: Impact

- *Outcomes: What impact has treatment on demand produced?*
- Number of treatment episodes increased from 6,798 (1997), to 9,196 (1998) during inception of managed care, to 11497 (2003).

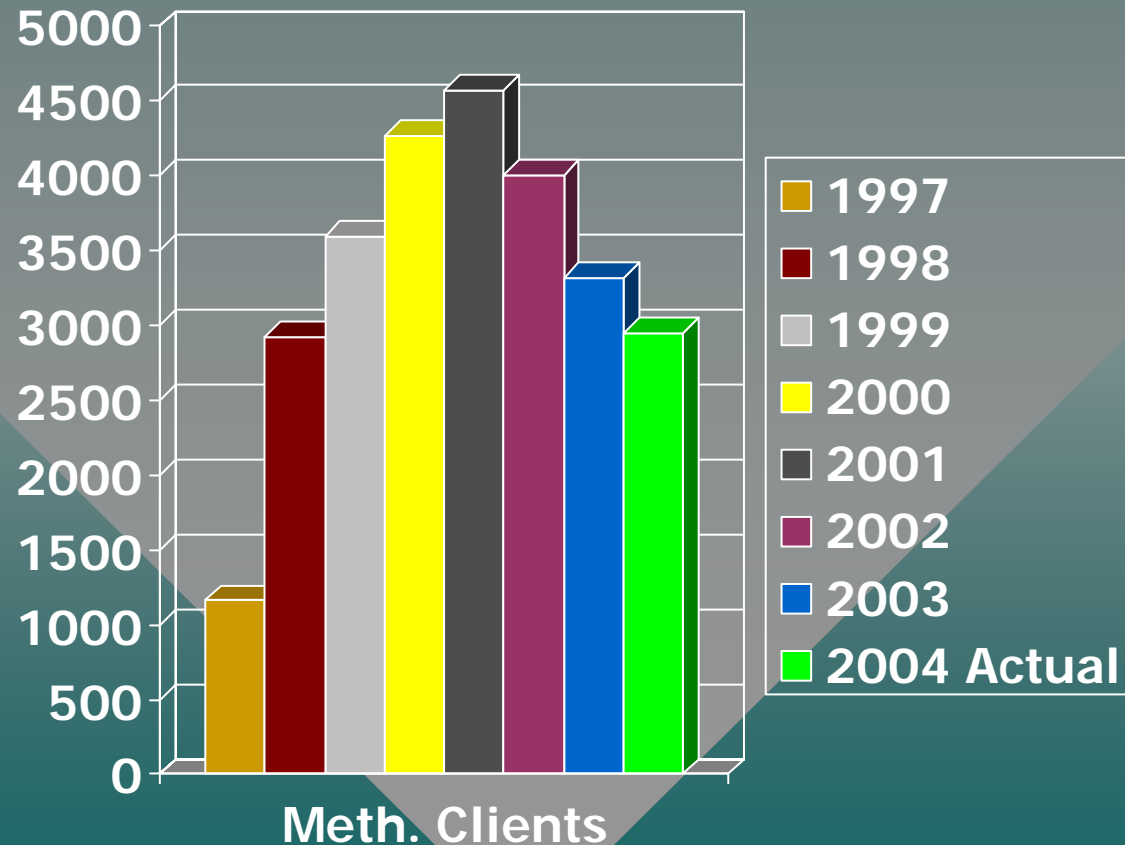
Total Number of Unduplicated Clients in Treatment During the 7.5 Year Period (1997- 6/2004)

- In 1997, number of clients totaled 5,532, then peaked to 10,211 in 2000.
- However, based on our first six months experience in 2004, total treatment may peak to a record high of 12,520.



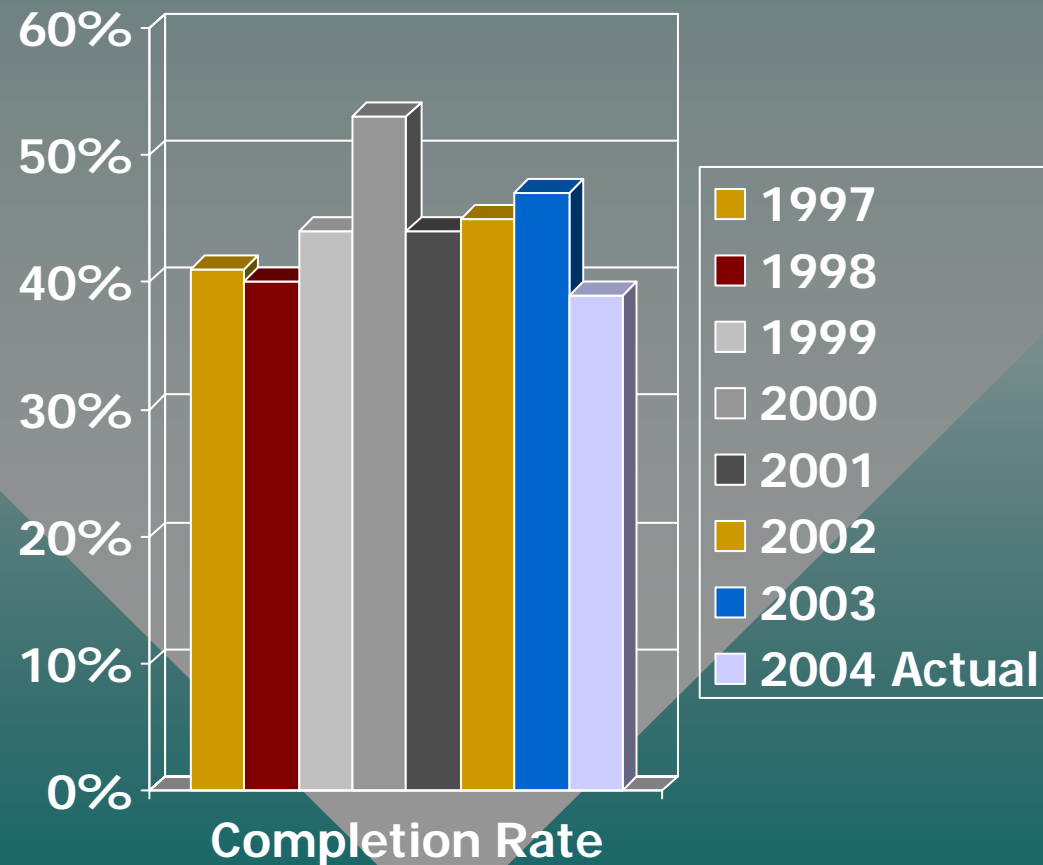
Total Number of Unduplicated *Methadone* Clients in Treatment During the 7.5 Year Period (1997- 6/2004)

- In 1997, number of *methadone* clients totaled 1,162, then peaked to 4,576 in 2001.
- However, based on our first six months experience in 2004, total treatment may peak to a record high of 5,894.



Proportion of Clients Completing Treatment During the 7.5 Year Period (1997- 6/2004)

- In 1997, 41% of clients completed treatment, then peaked to 53% in 2000.
- Our first six months experience in 2004 indicates a 39% completion rate.

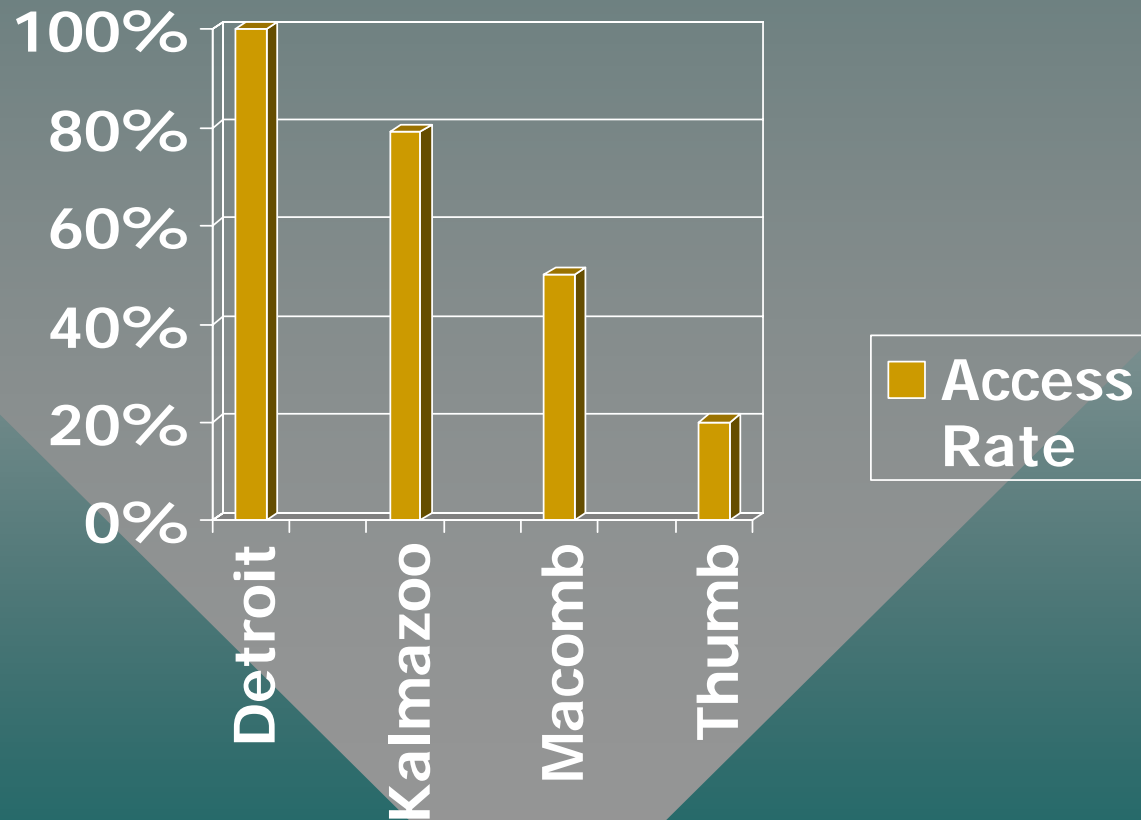


Treatment on Demand: Other Outcomes

- *Outcomes: What impact has treatment on demand produced?*
- No waiting lists. Wait manager position deleted.
- Anyone who wants treatment can receive it within 24-48 hours.

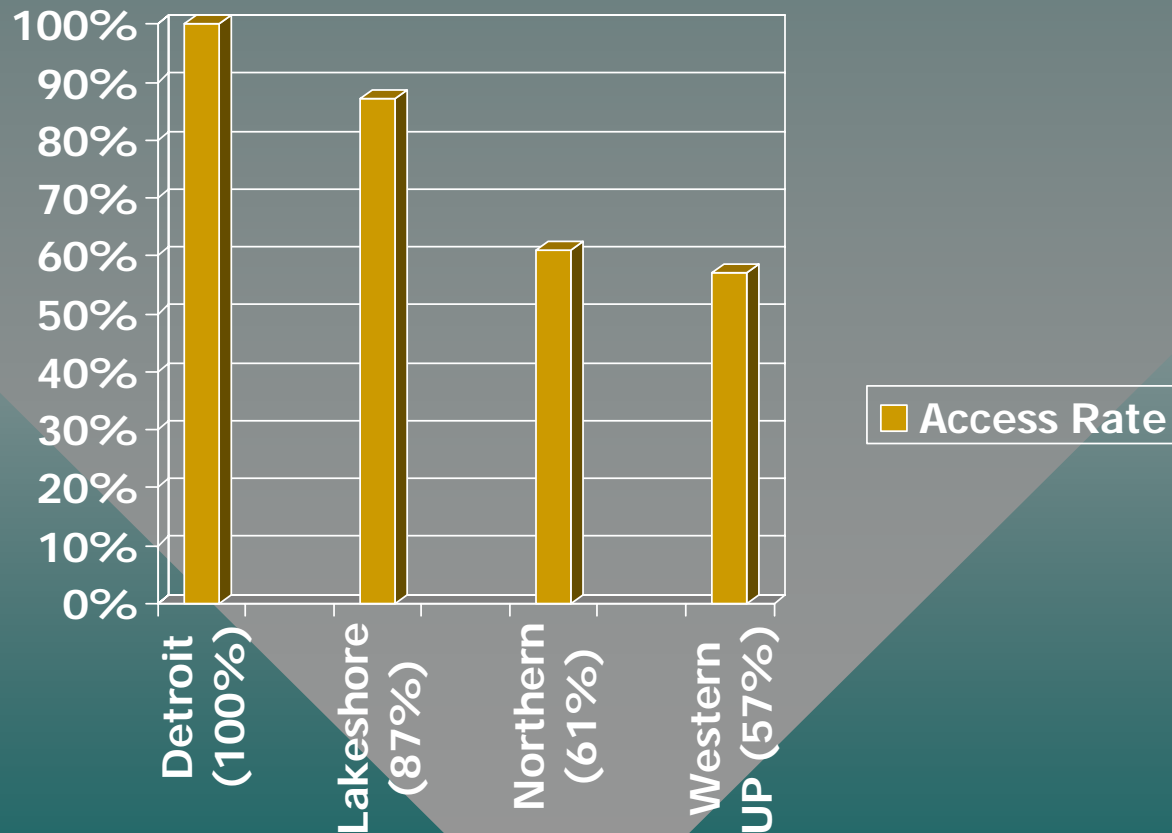
Comparison of Coordinating Agencies: % of Medicaid Persons Receiving an Assessment Within 24 Hours for Urgent Situations

- *Data Source:*
Michigan
Department of
Community
Health, FY2004
2nd Quarter
Performance
Indicator Report



Comparison of Coordinating Agencies: % of Medicaid Persons Receiving an Assessment Within 24 Hours for Non- Urgent Situations

- *Data Source:*
Michigan
Department of
Community
Health, FY2004
2nd Quarter
Performance
Indicator Report



Detroit's Concluding Story

- Treatment on Demand has been an achievable public policy for the city of Detroit.
- *Necessary Condition:* Full control of funding streams to allow for flexibility and creativity in establishing “safety nets”.
- High levels of client satisfaction can be produced.

Detroit's Concluding Story

- Treatment on Demand can be a contributing factor in reducing crime. Some findings of the Trent and Anthony Study (2003) revealed that:
- As the *number of clients in substance abuse treatment* **increased** in the city of Detroit, the *number of homicides* **decreased**. (correlation coefficient = - .980, $p < .01$)

Detroit's Concluding Story

- More findings of the Trent and Anthony Study (2003):
- As the *number of methadone clients in substance abuse treatment* **increased** in the city of Detroit, the *number of larceny cases* **decreased**. (correlation coefficient = $-.913$, $p < .05$)

Detroit's Concluding Story

- More findings of the Trent and Anthony Study (2003):
- As the *number of substance abuse treatment episodes* **increased** in the city of Detroit, the *number of carjacking cases* **decreased**. (correlation coefficient = $-.954$, $p < .05$)

Detroit's Concluding Story

- Greater *access* to substance abuse treatment can help in producing greater behavioral health and public health outcomes.

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