Colorado Department of Human Services Office and Division of Behavioral Health

The Costs and Effectiveness of Substance Use Disorder Programs in the State of Colorado (C.R.S. 27-80-110) and Reporting Annual Accounting of Forfeited Property Dollars (C.R.S. 16-13-701)

Report to the General Assembly House and Senate Health and Human Services Committees

November 2012

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INTRODUCTION

The Colorado Department of Human Services, Office and Division of Behavioral Health (the unit in the Department of Human Services that administers public, community behavioral health programs and services) submits this report entitled, "The Costs and Effectiveness of Substance Use Disorder Programs in the State of Colorado" to the General Assembly House Health and Environment Committee and Senate Health and Human Services Committee in compliance with:

A) Colorado Revised Statute 27-80-110 as amended by House Bill 00-1297

"27-80-110. Reports. The unit shall submit a report not later than November 1 of each year to the health and human services committees of the senate and house of representatives, or any successor committees, on the costs and effectiveness of alcohol and drug abuse programs in this state and on recommended legislation in the field of alcohol and drug abuse."

B) Colorado Revised Statute 16-13-701 (4) as amended by Senate Bill 03-133

"16-13-701. Reporting of forfeited property. (4) The unit in the department of human services that administers behavioral health programs and services, including those related to mental health and substance abuse, shall prepare an annual accounting report of monies received by the managed service organization pursuant to section 16-13-311 (3) (a) (VII) (B), including revenues, expenditures, beginning and ending balances, and services provided. The unit in the department of human services that administers behavioral health programs and services, shall provide this information in its annual report pursuant to section 27-80-110, C.R.S."

STATEMENT OF PROBLEM

National and Colorado Data

The federal Substance Abuse and Mental Health Services Administration (SAMHSA) [1] has declared four action items to devote leadership and resources regarding behavioral health: 1) behavioral health is essential to overall health; 2) prevention works; 3) treatment is effective; and 4) people recover. SAMHSA's key role is to reduce the impact of substance abuse and mental illness on America's communities. According to SAMHSA:

- By 2020, behavioral health disorders will surpass all physical diseases worldwide as a major cause of disability.
- Nearly 5,000 deaths are attributed to underage drinking each year.
- Each year, tobacco use results in more deaths (444,000) than AIDS, unintentional injuries, suicide, homicide, and alcohol and drug abuse combined.
- Among persons aged 12 years or older who used pain relievers non-medically in the past 12 months, 55.9 percent received the pain relievers from a friend or relative for free.
- The total economic costs of substance use and mental health disorders among youth are approximately $247 billion.

According to the 2010 National Survey on Drug Use and Health (NSDUH), 52% of Americans aged 12 years or older reported being current drinkers of alcohol. Of these self-identified drinkers, 58.6 million (23%) were binge drinkers (defined as five or more drinks on one occasion) and 16.9 million (6.7%) were heavy drinkers as defined by binge drinking on five or more days in a month. In addition, an estimated 22.6 million Americans (8.9% of the total U.S. population aged 12 years or older) were classified as current illicit drug users. There were 7.0 million current users of prescription-type psychotherapeutic drugs taken non-medically.[2]

According to *State Estimates of Substance Use and Mental Disorders* from the 2008-2009 National Surveys on Drug Use and Health, there are an estimated 486,000 Coloradoans aged 12 years and above that used illicit drugs in the past month.[3] According to the average findings across age groups, Colorado ranked in the top five, among all 50 states for the 12 or older age group as follows:

- 2nd for alcohol use in the past month;
- 2nd for first-time marijuana use;
- 3rd for marijuana use in the past year;
- 3rd for cocaine use in the past year;
- 5th for marijuana use in the past month;
- 5th for dependence on or abuse of illicit drugs or alcohol in the past year;
- 5th for persons needing but not receiving treatment for alcohol use in the past year; and
- 5th for alcohol dependence or abuse in the past year.

In addition, substance use epidemiology has documented that the lower the perception that use involves risk, the higher the probability of use. Colorado was among five states with the lowest proportions who perceived smoking marijuana once a month as a great risk. Colorado was also among 14 states with the lowest proportion of those aged 12 to 17 years old that perceived having five or more drinks once or twice a week as having great risk.[3]

Treatment and Service Gaps

According to the 2008-2009 *National Surveys on Drug Use and Health* (NSDUH) [3], Colorado ranks fifth (fourth in the 2007-2008 report) among states nationwide in the proportion of persons aged 12 years and older needing but not getting treatment for alcohol use in the past year, and fifteenth (fourth in the 2007-2008 report) among all states in the proportion of persons 12 years and older needing but not getting treatment for illicit drug use in the past year.

The Colorado Division of Behavioral Health completed a comprehensive analysis of the statewide behavioral health service delivery system. The 2009 Colorado "Population in Need" study[4] examines the substance use disorders (and mental health) prevalence, service utilization, and unmet need for Coloradans living at or below 300% of the Federal Poverty Level:

- An unduplicated count of 169,751 adults in Colorado exhibit serious behavioral health disorders (both mental health and substance use disorders).
    - Of these, 65,990 adults have a substance use disorders only.
    - Of these, only 28,599 received treatment.

By knowing how many Coloradans presently need public behavioral health services and how many are currently accessing these services, the Division can estimate how many persons need public services, would benefit from them, and have not yet accessed them. Furthermore, an understanding of this population based on age, race, gender, marital status, education, poverty, and residence, enables the State and its behavioral health stakeholders to effect positive change in public policy, develop targeted plans for service, better advocate for the needs of special populations, improve access to services by underserved groups, evaluate the outcomes of services, and contract and finance services based on need, capacity, and performance. Overall the study provides an excellent foundation for achieving the mission of addressing the behavioral health needs within Colorado.

SOCIETAL COSTS OF SUBSTANCE USE

The National Center on Addiction and Substance Abuse (CASA) at Columbia University calculated that in 2005 federal, state and local government spending as a result of substance use disorders and addiction was at least $467.7 billion: $238.2 billion, federal; $135.8 billion, state; and $93.8 billion, local.[5] Nationwide, $27 per U.S. resident is spent on publicly funded substance use treatment compared to $7.50 spent per resident in Colorado.[6]

For every dollar federal and state governments spent on substance use disorders and addiction in 2005, 95.6 cents went to responding to the societal impact of substance use and only 1.9 cents on prevention and treatment, 0.4 cents on research, 1.4 cents on taxation or regulation and 0.7 cents on interdiction.[15] Substance use drives multiple indirect societal costs, including expenses related to criminal behavior, enforcement of drug laws, incarceration, unemployment and lost productivity, property loss from vehicular crashes, domestic violence, child welfare, illness and premature death, and health care.[7]

Coloradans are affected by the societal costs of substance use in many ways. The magnitude of public funds spent on the direct and indirect consequences of substance use and abuse is staggering, and dozens of Colorado public agencies play a part in controlling substance use or dealing with its consequences. [8] It is estimated that one-fourth of all people admitted to general hospitals have alcoholism and 30% of emergency room patients are problem drinkers or drug users. These individuals are seeking medical attention for alcohol or drug-related illness or injury, not for their addiction problem.[9]

In 2009 there were 6,212 emergency room visits related to alcohol in Denver and 1,678 alcohol-related visits by youth under the age of 21.[10] It is estimated that one emergency room visit costs $1318[11] and people with untreated alcoholism seek emergency room attention 60% more often than the rest of the population.[17] They are also nearly twice as likely to be hospitalized overnight, and stay in the hospital three days longer. Further, in 2010, there were 7,124 hospitalized inpatients with a diagnosis of "alcohol/drug use and alcohol/drug-induced organic mental problems," totaling 48,816 patient days. The hospital charges for these patients added up to $153,824,189; a cost per case of $21,592.[12]

Criminal justice-related costs associated with substance use are equally compelling. According to the Colorado Bureau of Investigation (2011), there were 25,789 adult Driving Under the Influence (DUI) arrests and 357 juvenile DUI arrests.[13] Alcohol-impaired fatalities in Colorado totaled 127 in 2010. This represents 28% of total fatalities in the state.[14] Based on 2011 daily prison costs of $88.61[15] for adult offenders ($167.62 for youth offenders[16]), the total cost per day for incarcerating adult offenders with substance use disorders can be estimated at $704.27 or $257 million a year. When compared to offenders without substance use disorders, offenders with substance use disorders demonstrated higher levels of treatment needed in the areas of education, employment, and mental health, as well as this population was significantly more likely to have a clinical diagnosis of serious mental illness and/or developmental disability.

Another substance use related cost involves family violence. Among men with alcohol use disorders, 50-60% have been violent toward a female partner in the year before treatment and alcohol use is involved in 30% of child abuse cases.[17]

Fetal Alcohol Syndrome (FAS) is the leading preventable cause of birth defects and mental retardation in the nation. It is estimated that the total lifetime cost for a child born with FAS in 2002 is approximately $2 million[18]. Based on the 2011 number of live births in Colorado[19] (65,052) and a FAS prevalence rate of 0.5

to 2.0 per 1000 births[20], Colorado would realize between 33 and 130 FAS births per year at an estimated lifetime cost of $46 million to $182 million.

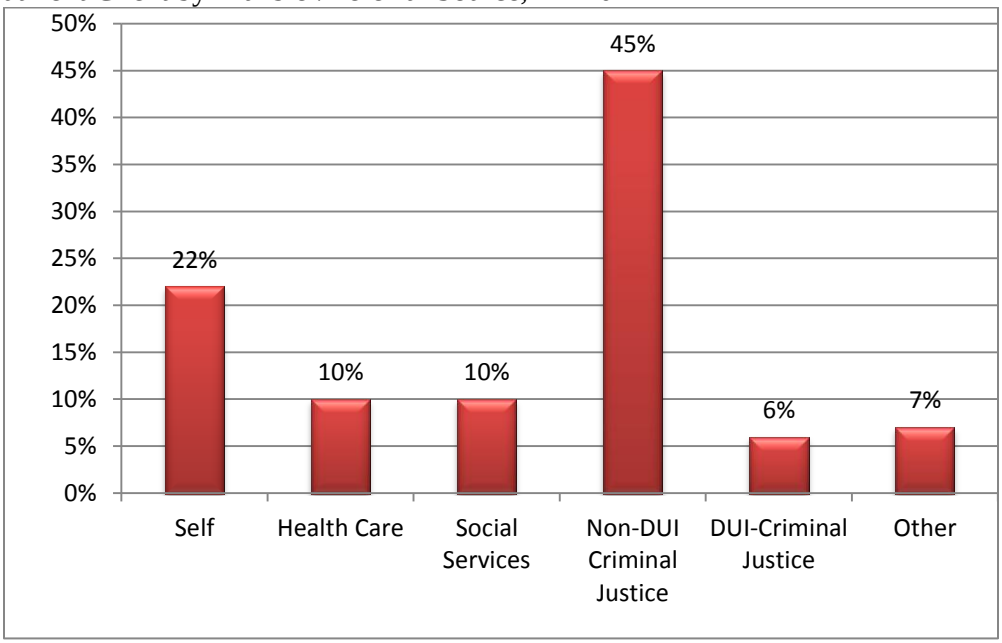
A BRIEF OVERVIEW OF PERSONS SERVED IN TREATMENT, DETOXIFICATION AND DRIVING UNDER THE INFLUENCE (DUI) SERVICES AND PROGRAMS

While certain sections of this report are based on the number of Drug/Alcohol Coordinated Data System (DACODS)[21] discharges for fiscal year 2011-12 (n=104,387)[1], the following demographic data are based on the number of unduplicated clients in each service category.

Treatment Clients

Of 26,225 discharges from substance use disorder treatment in fiscal year 2011-12, 22,478 were unique clients. Forty-five percent (45%) of treatment clients were referred for treatment by the criminal justice system (not related to DUI). See Figure 1. Approximately 27% worked full-time and 73% achieved a high school education or higher. Thirty-six percent (36%) had dependent children for a total of 15,706 children.

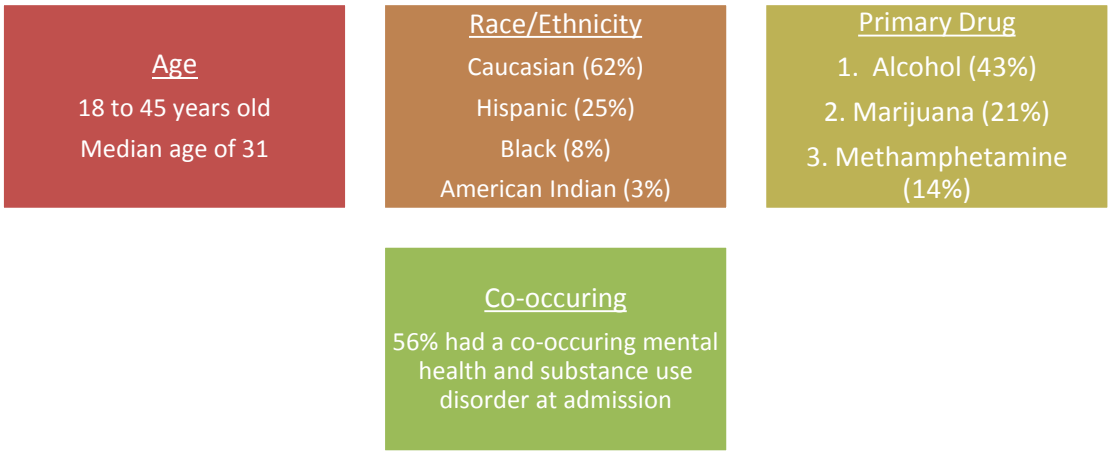
Figure 1. Treatment Client by Transfer/Referral Source, FY 2011-12



Treatment clients were more likely to be adult men (67%) between the ages of 18 and 45 years old with a median age of 31 years. The largest proportions of clients discharged from treatment in fiscal year 2011-12 were White. Hispanics made up 25%, and American Indians comprised 3% of the clientele, representing a higher percentage than the general population. On average, clients had been using their primary drug for approximately 15 years, and 64% reported starting their primary drug before the age of 18. Of the substance use disorder treatment discharges, 56% had a co-occurring mental health and substance use disorder at admission. See Figure 2.

[1] Numbers and percentages are rounded to the nearest whole number.

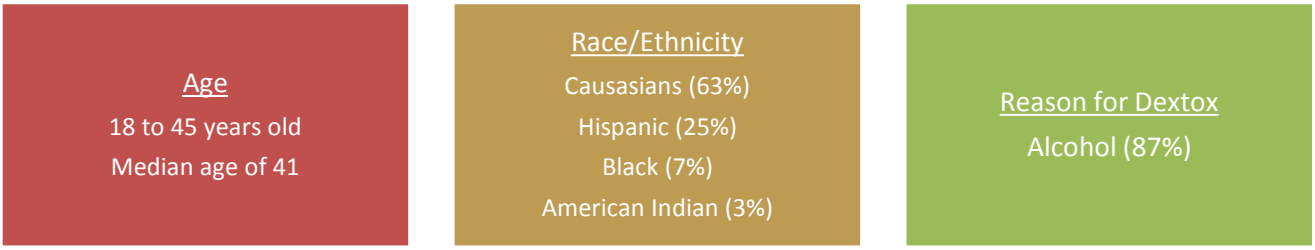
Figure 2. Characteristics of Persons Served in Treatment with Substance Use Disorder, FY 2011-12



Detoxification Clients

There were 53,407 discharges from detoxification services (excluding treatment and DUI services), 29,654 of which were unique clients. While 23% of clients in detox were within the 18-24 year old age category, the median age for detox was 41. The largest proportions of clients discharged from detox were Caucasian. American Indians were over-represented and comprised 3% of the clientele. Nearly all (87%) were in detox for alcohol abuse, which they typically started using before the age of 18 (58%). Detox clients had been using their primary substance for an average of 20.5 years. The proportion of males discharged from detox comprised 73%. Eighty-three percent achieved a 12th grade education or higher and 33% worked full-time. Twenty-three percent had dependent children for a total of 13,522 children. See Figure 3.

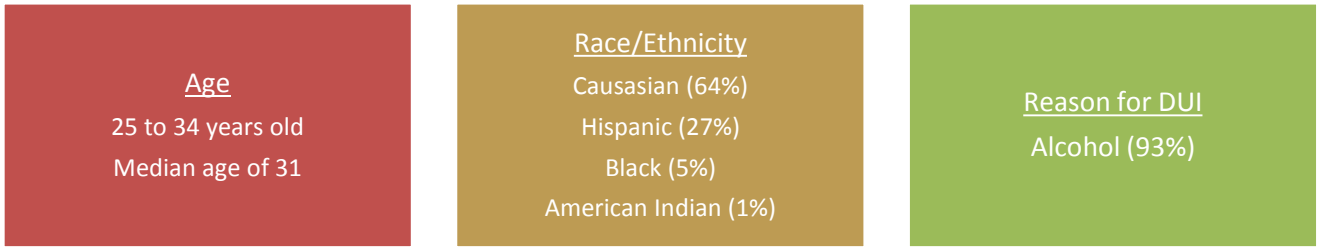
Figure 3. Characteristics of Persons Served in Detoxification with Substance Use Disorder, FY 2011-12



Driving Under the Influence (DUI) Clients

There were 24,755 discharges from DUI services (excluding other treatment and detox services), of which 22,988 were unique clients. Thirty-three percent (33%) of DUI clients were within the 25 to 34 years old age group and 26% were within the 18 to 24 year age group. Their median age was 31 years old. The majority of clients discharged from DUI were male (73%) and Caucasian (64%). Hispanics again were over-represented with 27% of discharges. Ninety-three percent (93%) received their DUIs for being under the influence of alcohol. These clients started using their primary substance before the age of 18 years (59%) and had been using for an average of 17 years. This group was more likely to have a 12th grade education or higher (85%) and work full-time (57%). Thirty-three percent (33%) of DUI clients were responsible for children for a total of 14,515 children dependent upon DUI clients.

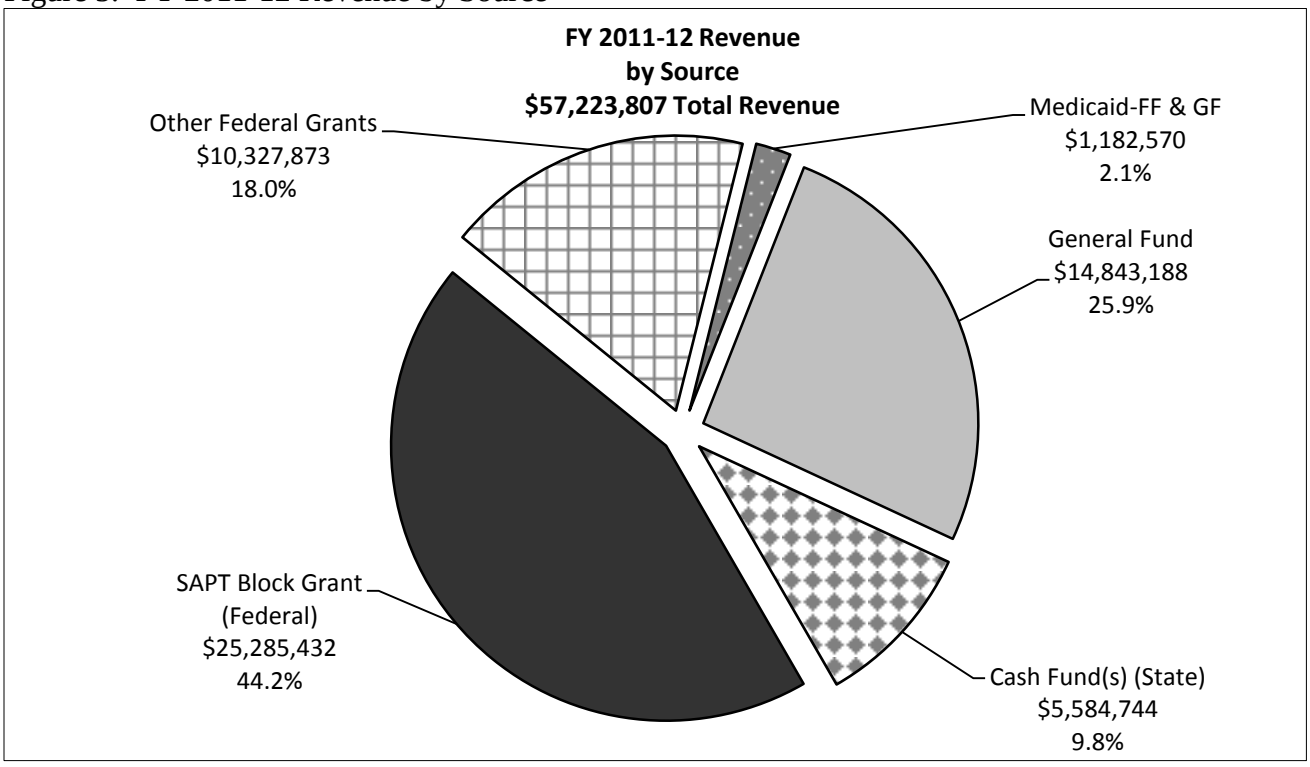
Figure 4. Characteristics of DUI Persons Served with Substance Use Disorder, FY 2011-12



SUBSTANCE USE DISORDER PREVENTION AND TREATMENT RESOURCES - FISCAL YEAR 2011-12

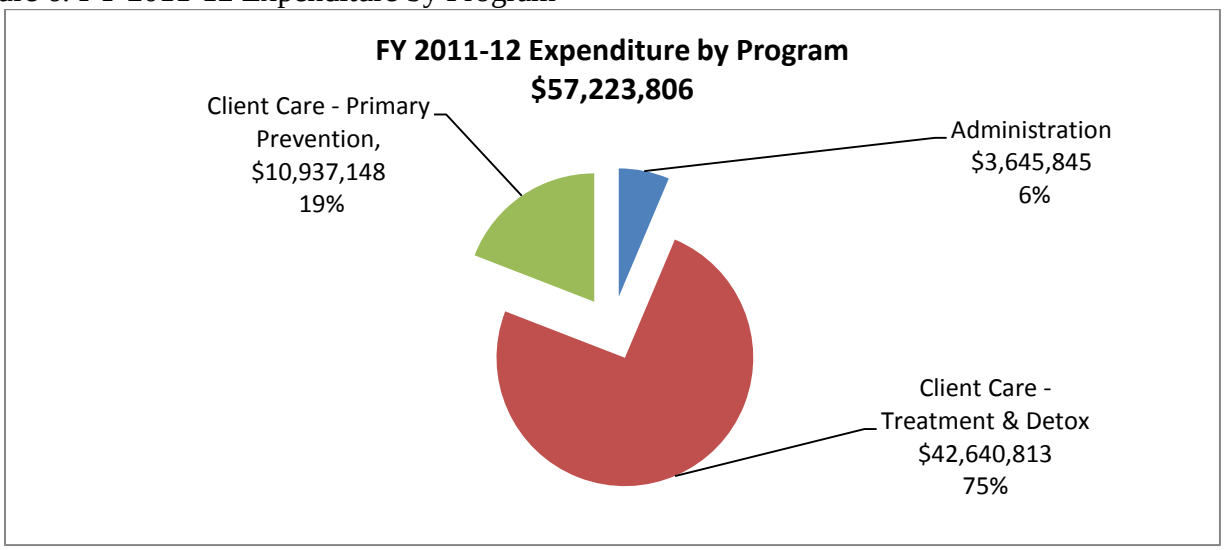
The figure below illustrates the funding sources received by the Division to provide substance use disorder prevention, intervention, treatment and recovery services in Colorado.

Figure 5. FY 2011-12 Revenue by Source



The figure below illustrates the FY 2011-12 expenditures for client care – primary prevention; client care treatment and detoxification; and administration.

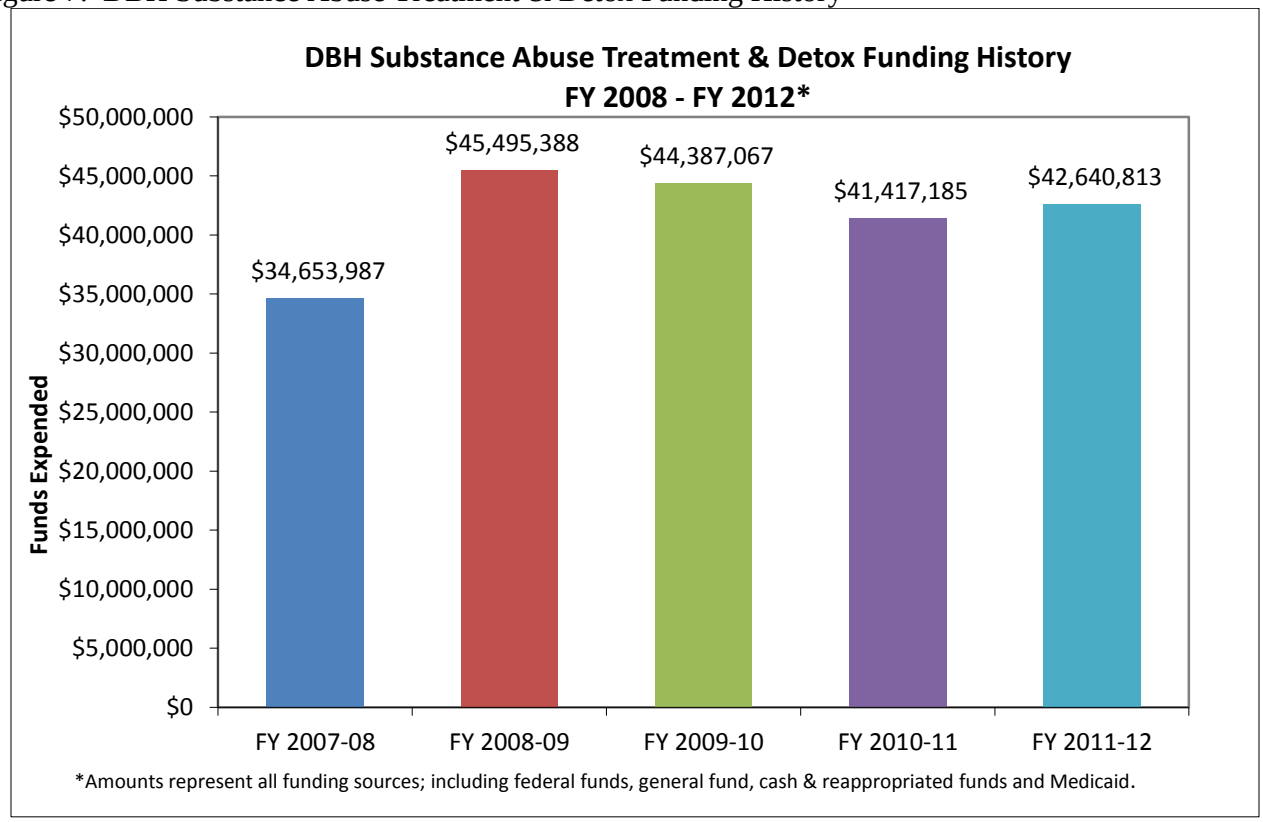
Figure 6. FY 2011-12 Expenditure by Program

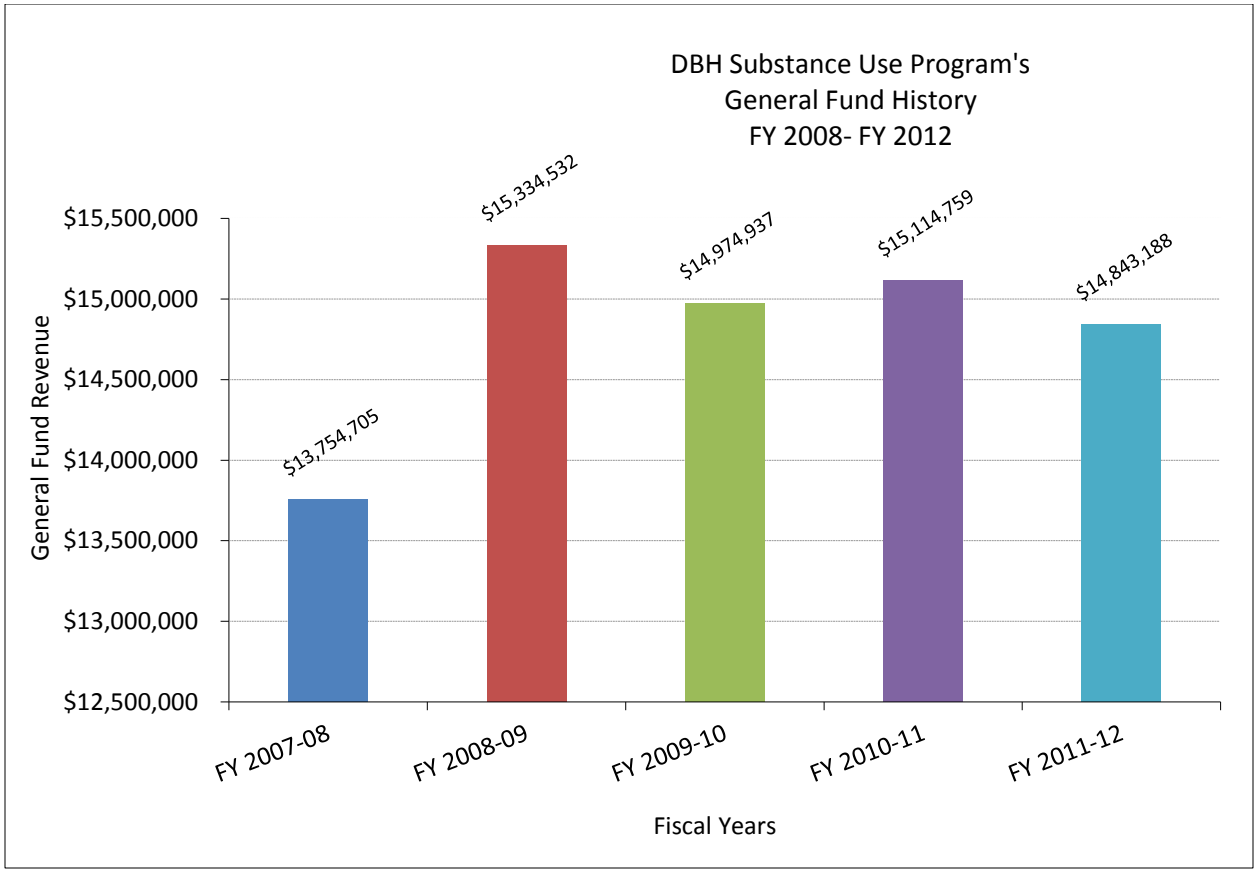


The following charts demonstrate:

- The Division's funding history - substance use disorder treatment, fiscal years 2007 through 2011
- History of the Divisions' General Fund dollars

Figure 7. DBH Substance Abuse Treatment & Detox Funding History





SUBSTANCE USE DISORDER PREVENTION AND TREATMENT SERVICE COSTS

The table below illustrates the service cost related to substance use disorder prevention, intervention, treatment and recovery services in Colorado.

Average Cost Per Client By Year for Treatment Services funded by the Division

Year	Division's* Average Cost/Client	Total** Average Cost/Client
2012	$667	$1,460
2011	$775	$1,729
2010	$936	$1,732
2009	$893	$1,661
2008	$809	$1,543
2007	$774	$1,509
2006	$759	$1,497
2005	$721	$1,948

Note: Detoxification services and costs are excluded.

*Data were generated from the Division's funding database, using number of clients treated with the Division monies.

**Data reflects all clients funded by the Division and by self-pay or insurance.

THE BENEFITS AND OUTCOMES OF SUBSTANCE USE DISORDER PREVENTION AND TREATMENT SERVICES

The Office of National Drug Control Policy (ONDCP) has documented a direct correlation between increases in drug prevention investments and decreases in the prevalence of use/abuse. Prevention programs show cost-benefit ratios in the range of 8:1 to 15:1 in reduced costs in crime, school and work absenteeism, as well as reduced need for and costs of substance abuse treatment.[15]

According to the National Institute on Drug Abuse, the return on investing in substance use disorder treatment alone may exceed 12:1. That is, every dollar spent on treatment can reduce future burden costs by $12 or more in reduced drug-related crime and criminal justice and health care costs.[13] The Economic Benefits of Drug Treatment: A Critical Review of the Evidence for Policy Makers (2005)[22] cites nearly two decades of research finding that:

- Substance use disorder treatment achieves clinically significant reductions in substance use and crime, and improvements in personal health and social function for many clients;
- Treatment effects include significant gains to both the client and to society;
- Available cost-benefit studies consistently found that economic benefits exceed treatment costs;
- Treatment benefits include reduced criminal behavior and health care costs and increased employment;
- Residential prison treatment is cost-effective only in conjunction with post-release aftercare services; and
- National studies have examined the impact of substance use disorder treatment relative to tax dollar savings, hospital readmission rates, and prevention activities.

Colorado

Based on the client outcomes in relation to cost, overall the data reflects positive marginal effectiveness depending of focus area (as detailed below under the Prevention and Treatment Outcomes section).

Prevention Services for FY 2011-12

Services are delivered to multiple populations. *Direct Services* target an identifiable group of participants (e.g., school curricula), while *Indirect Services* support population-based prevention programs and environmental strategies (e.g., media campaigns).

- Total People Served: 2,012, 224*
- Total People Served by Gender: Male 1,004,222 *(50%)*; Female 1,007,704 *(50%)*; Transgender 288 *(<1%)*; Missing 10 *(<1%)*
- Total People Served by *Direct Services*: 74,355
- Total People Served by *Indirect Services*: 1,937,869
- Total *Direct Services*: 18,309
- Total *Indirect Services*: 1,707

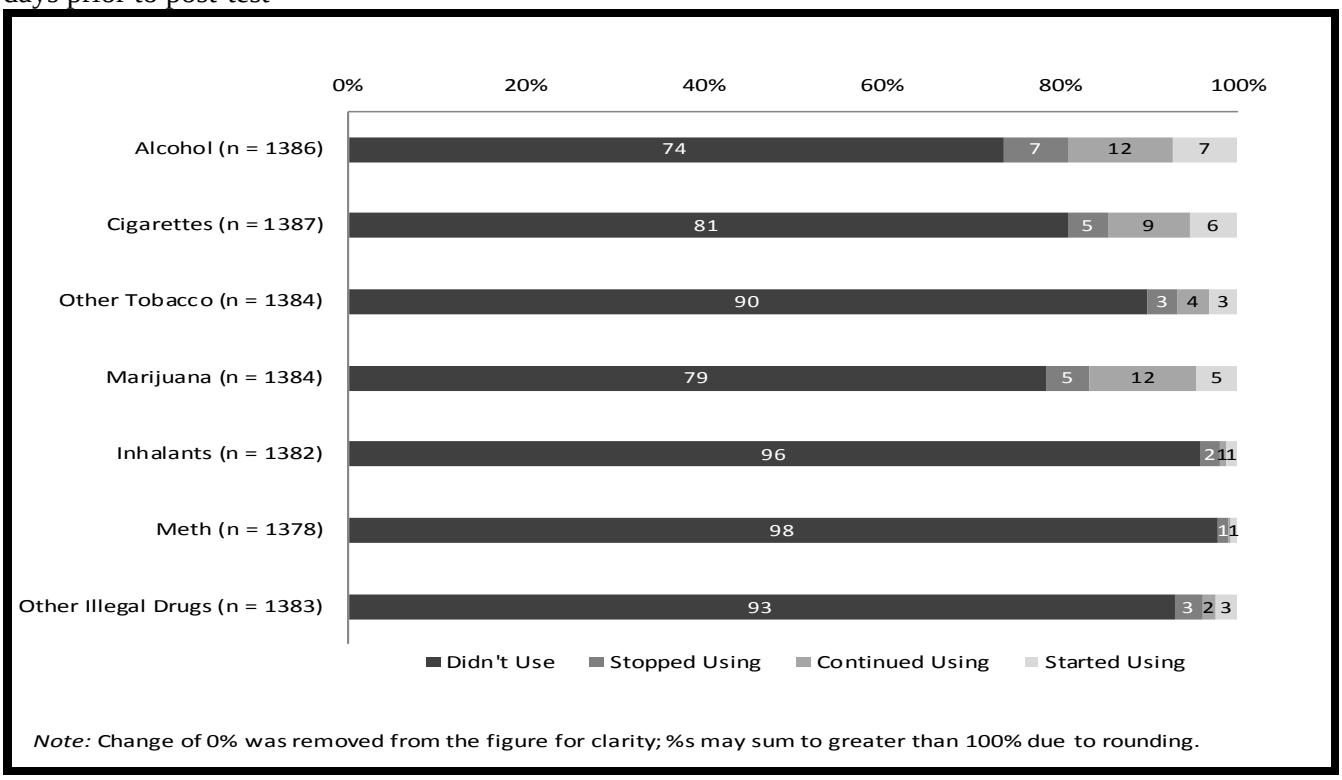
*This count reflects a SAMHSA-promoted measurement strategy that is inclusive of all participants in programming that receives any DBH funding. The count may include duplicates.

Prevention Outcomes FY 2011-12

1. Perceived Risk of Harm
    - There were slight increases in perceived risk of harm associated with alcohol, cigarette and marijuana use, and the average perceived risk of harm across all three substances. These increases did not reach statistical significance, but this may be explained in part by perceptions of moderate to great risk reported at pre-test leaving little room for increased perceived risk at post-test.
2. Attitudes Toward Substance Use
    - There was a statistically significant ($p < .05$) decrease in participants' disapproval of cigarette and marijuana use. However, at both pre- and post-test participants' attitudes toward using these substances were disapproving; on average, participants reported attitudes between slight and strong disapproval.
    - While there were no other statistically significant changes in attitudes toward substance use from pre- to post-test, at pre-test participants reported high levels of disapproval of all substances (alcohol, cigarettes and marijuana) which were maintained at post-test.

The following data reflects changes in participants' substance use in the 30 days prior to pre-test versus the 30 days prior to post-test. Participants who did not use the substance in the 30 days prior to pre- or post-test were categorized as *didn't use*. Participants who used 1+ days prior to pre-test but did not use prior to post-test *stopped using*. Participants who used 1+ days prior to pre-test and 1+ days prior to post-test *continued using*. Participants who did not use prior to pre-test but used 1+ days prior to post-test *started using*. The desired outcome is high values in the *didn't use* and *stopped using* categories compared to the *continued using* and *started using* categories.

Figure 9. FY 2011-12 Change in participants' substance use in the 30 days prior to pre-test versus the 30 days prior to post-test



Note: Change of 0% was removed from the figure for clarity; %s may sum to greater than 100% due to rounding.

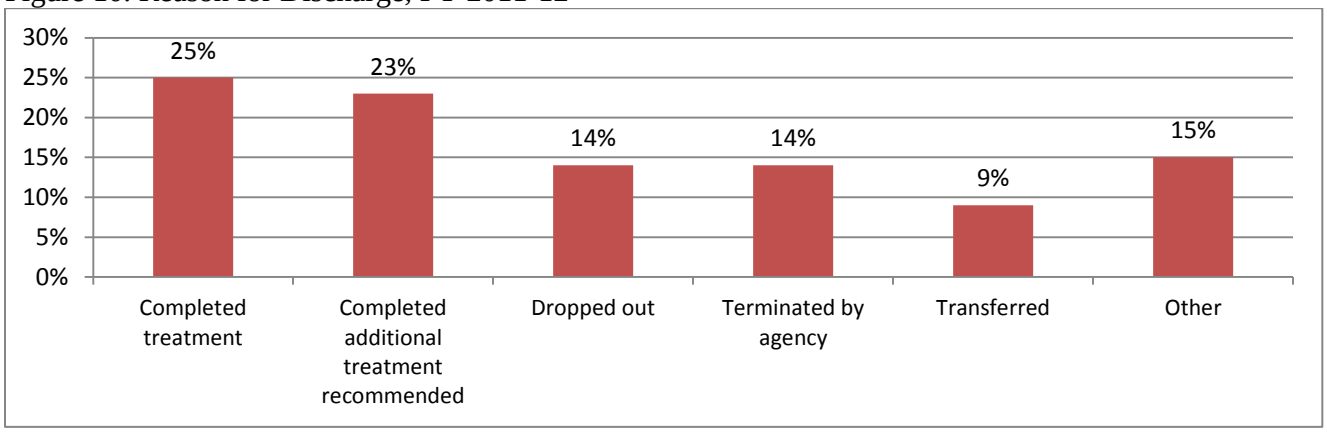
Treatment Outcomes Fiscal Year 2011-12

Based on Drug/Alcohol Coordinated Data System (DACODS), client discharges from treatment modalities (e.g., residential, intensive outpatient, outpatient treatment modalities) were used to calculate change from admission to discharge. Detoxification (detox) was an excluded treatment modality because its primary goal is to provide a safe, short-term environment in which the client may detoxify and then be referred to treatment. Driving Under the Influence (DUI) programs were excluded as a treatment modality because DUI focuses primarily on reducing the practice of driving while intoxicated, rather than reducing substance use behavior exclusively. Based on these exclusions, the total number of discharges was 26,225.[7]

Reason for Discharge

Twenty-five percent (25%) of discharges completed their treatment with no further treatment recommended; 23% completed treatment at that agency with additional treatment recommended; 14% left against professional advice; 14% were terminated by the agency and 9% did not complete their treatment at the agency. Six percent (6%) of clients were incarcerated. See Figure 10.

Figure 10. Reason for Discharge, FY 2011-12

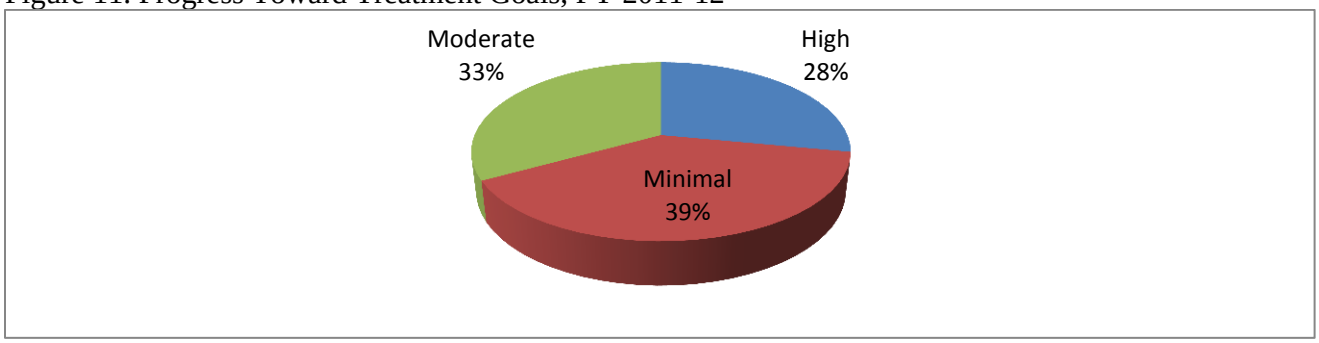


The following outcome measures exclude clinical assessments from the analysis (n=25,829).

Progress Toward Treatment Goals

During the treatment process, addiction counselors partner with their clients to develop individualized treatment plans. These plans identify goals clients wish to attain from their treatment. At time of discharge, counselors and clients assess progress made toward these goals. In fiscal year 2011-12, 61% of all treatment clients had made moderate to high progress toward their goals. See Figure 11.

Figure 11. Progress Toward Treatment Goals, FY 2011-12

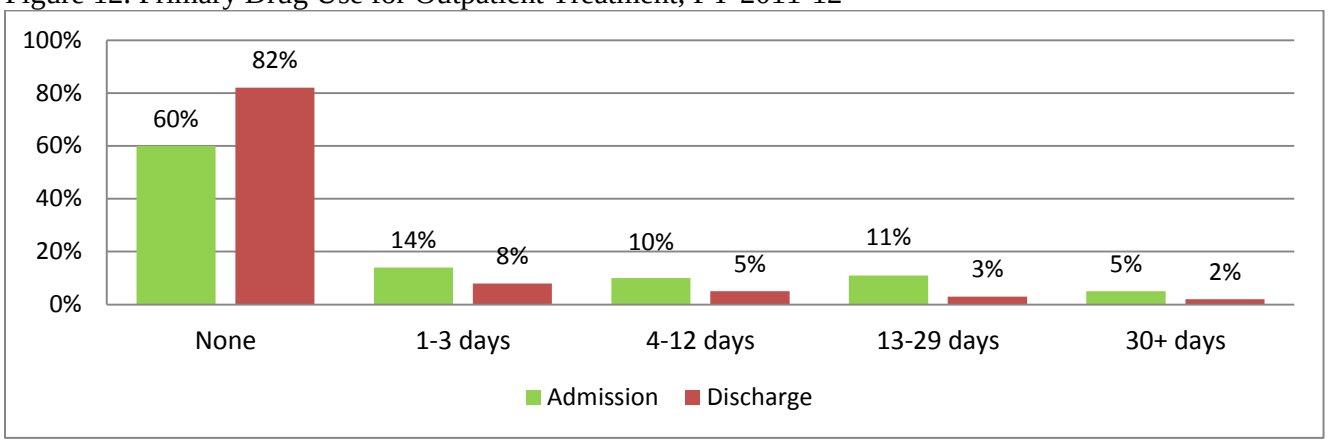


Use of Primary Drug at Admission and Discharge

Perhaps the most critical measure of substance use disorder treatment success is the change in frequency of drug use from admission to discharge. In fiscal year 2011-12, there was a decline from 47% to 19% (admission to discharge) in the proportion of all treatment clients reporting any substance use in the previous 30 days. These results were similar to those from fiscal year 2010-11.

Since outpatient treatment clients have more opportunity to engage in substance use than residential treatment clients, an additional analysis of drug use frequency was restricted to outpatient treatment clients (n=18,942). Figure 9 shows that in fiscal year 2011-12, the proportion of outpatient clients who reported use of their primary substance decreased from 40% likely to use an addictive substance at admission to 18% at discharge.

Figure 12. Primary Drug Use for Outpatient Treatment, FY 2011-12

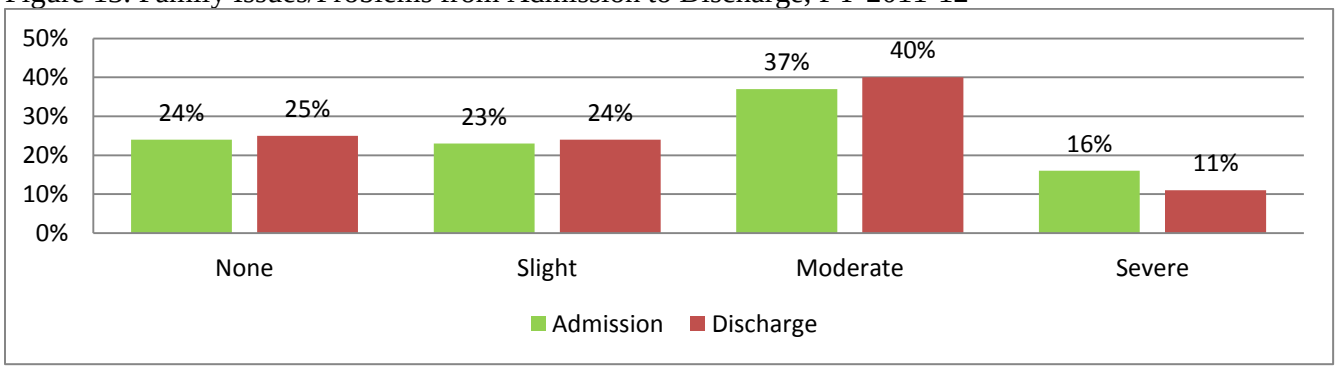


Clinicians assess the severity of the clients' issues or problems at both admission and discharge, using terms defined in the DACODS User Manual. Overall, the percentage of clients with severe issues identified at admission decreased at discharge. Those clients who rated the following issues as none, slight, or moderate at admission often report staying the same or slightly increased at discharge. Treatment likely raises awareness for clients about issues related to their substance use disorder.

Family Issues/Problems

Family Issues/Problems are defined as the degree of family issues and problems the client is currently experiencing with or within the family. The percentage of clients with severe family issues decreased whereas the percentage of clients with moderate family issues increased at discharge. See Figure 13.

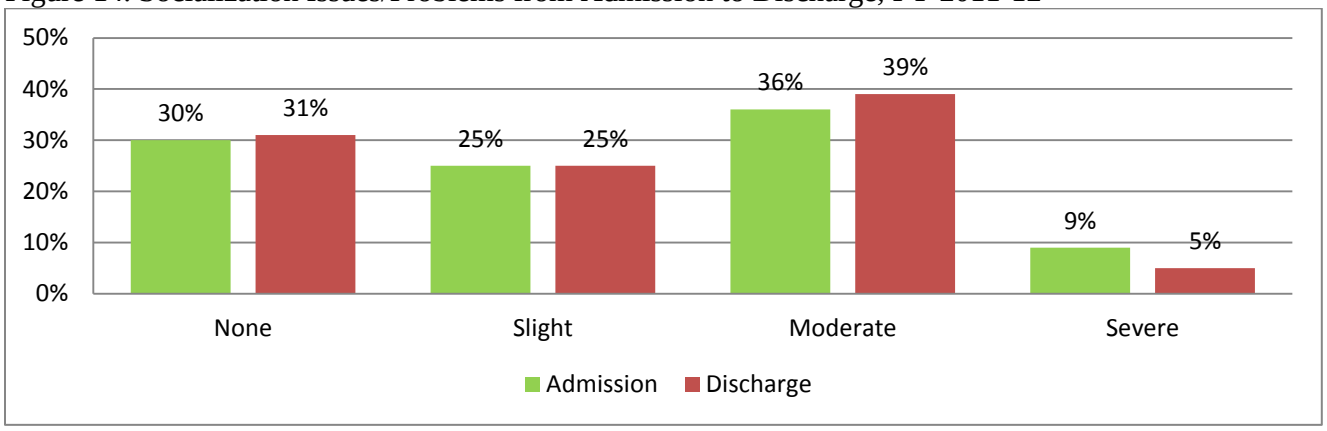
Figure 13. Family Issues/Problems from Admission to Discharge, FY 2011-12



Socialization Issues

Socialization is defined as having the ability and social skills to form relationships with others. The percentage of clients with severe problems at admission decreased at discharge. See Figure 14.

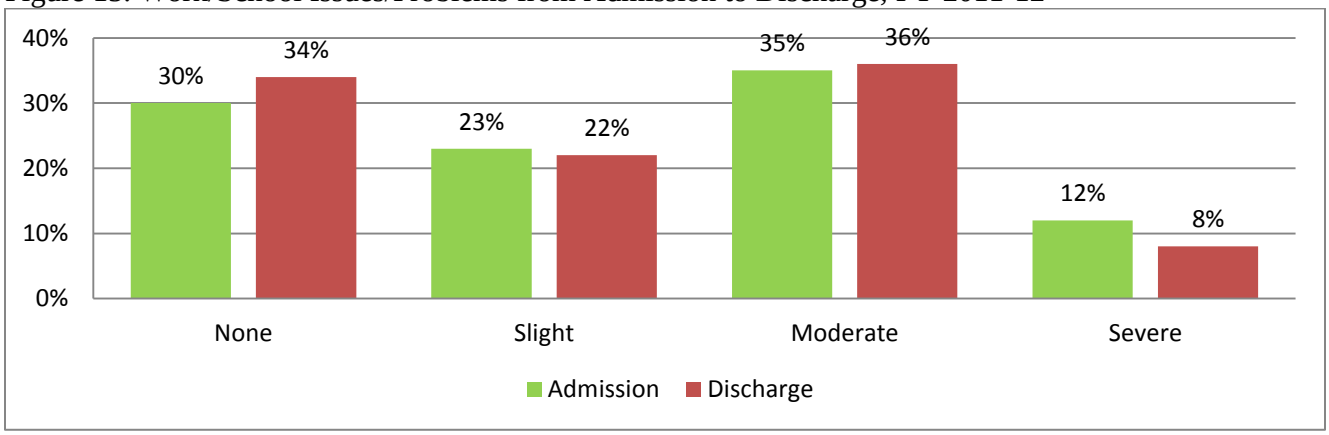
Figure 14. Socialization Issues/Problems from Admission to Discharge, FY 2011-12



Education/Employment Issues

The number of clients who reported slight or severe problems at admission for either work or school issues decreased at discharge. See Figure 15.

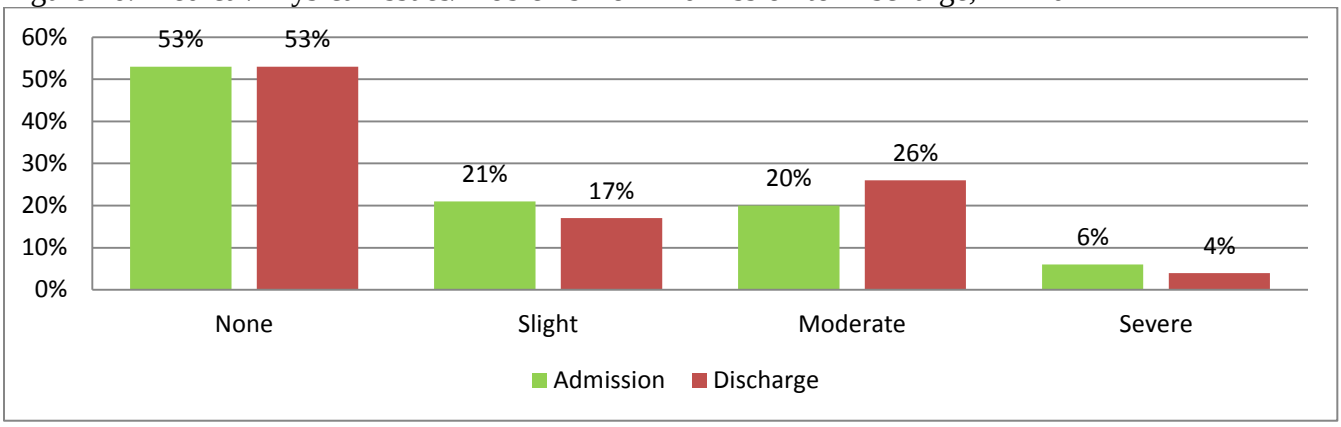
Figure 15. Work/School Issues/Problems from Admission to Discharge, FY 2011-12



Medical/Physical Issues

The proportion of clients without medical/physical problems at discharge increased from admission to discharge. The proportion of clients with severe problems slightly decreased at discharge. See Figure 16.

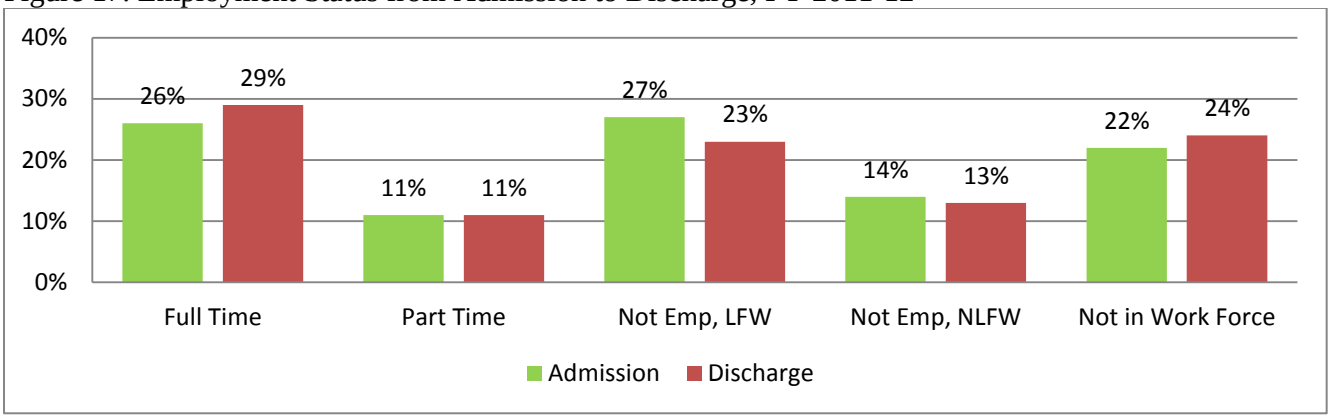
Figure 16. Medical/Physical Issues/Problems from Admission to Discharge, FY 2011-12



Employment Status and Living Situation

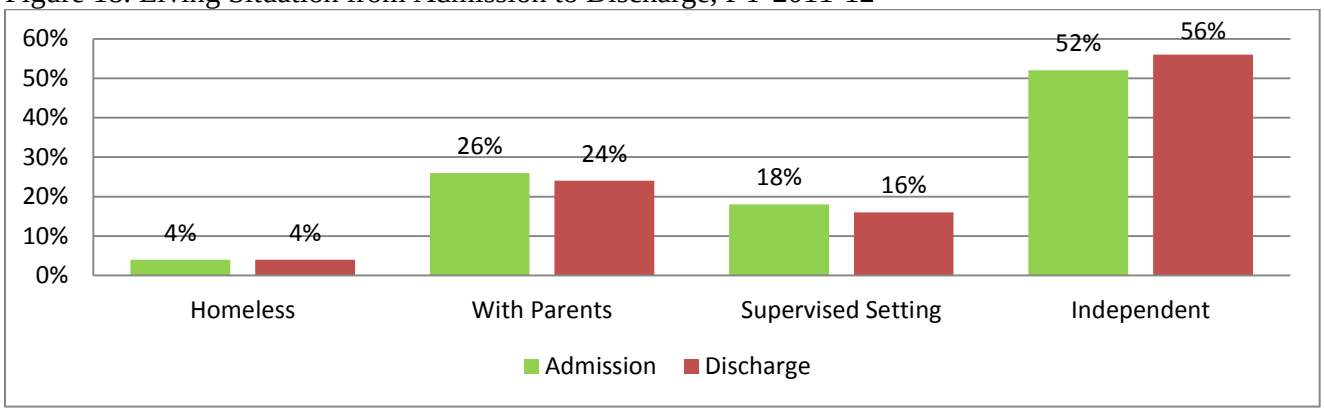
Slight increases occurred from admission to discharge in the proportions of clients working full-time and living independently. See Figure 17 and Figure 18.

Figure 17. Employment Status from Admission to Discharge, FY 2011-12[2]



[2] Not Emp, LFW = Not Employed, Looking For Work; Not Emp, NLFW = Not Employed, Not Looking For Work

Figure 18. Living Situation from Admission to Discharge, FY 2011-12



Arrests, Emergency Room and Hospital Admissions

From admission to discharge from treatment, decreases were noted in Driving Under the Influence/ Driving While Ability Impaired (DUI/DWAI) and other arrests, medical hospital visits and medical emergency room visits. See Table 4.

Table 4. Proportions of Clients at Admission and Discharge with Arrests, Emergency Room (ER) Visits or Hospital Admissions, Fiscal Year 2011-12

Outcome Measure		**Admission (%)**	**Discharge[3] (%)**
DUI/DWAI Arrests in the last 30 days prior to . . .	None	98.4	99.4
	1-2	1.6	0.5
	3+	0.0	0.1
Other Arrests in the last 30 days prior to . . .	None	94.4	95.7
	1-2	5.3	4.2
	3+	0.3	0.1
Medical ER visits during 6 months prior to . . .	None	78.0	86.7
	1-2	18.0	10.7
	3+	4.0	2.6
Medical Hospital Admissions during 6 months prior to. . .	None	90.7	94.2
	1-2	8.4	5.2
	3+	0.9	0.6
Psychiatric ER visits during 6 months prior to . . .	None	96.4	97.7
	1-2	3.2	2.1
	3+	0.4	0.2
Psychiatric Hospital Admission 6 months prior to . . .	None	96.6	97.6
	1-2	3.2	2.2
	3+	0.2	0.2

The Division of Behavioral Health (DBH) is also part of a new Colorado Department of Human Services (CDHS) initiative called C-Stat, which was implemented in January 2012. C-Stat is a management strategy that analyzes performance using the most current available data. C-Stat allows Divisions within CDHS to pinpoint performance areas in need of improvement and then improve those outcomes, helping to enhance the lives of the populations that CDHS serves and to provide the best use of dollars spent.[23] Some of the C-

[3] Discharge variable for arrest data=DUI/DWAI arrests and other arrests during treatment or in the past 30 days of treatment

Stat measures are similar to those in this report; however, the methodology differs slightly given the scope of this state-wide effort which encompasses mental health and substance use disorder outcome measures. There is a CDHS C-Stat summary report available on-line with the DBH measures outlined on pages 6-14 of the report: http://www.colorado.gov/cs/Satellite/CDHSEmp/CBON/1251630279941.

TRACKING CIVIL FORFEITURE (Senate Bill 03-133) FOR Fiscal Year 2011-12

As legislated by Senate Bill 03-133 [C.R.S. 16-13-311 (3)(a) (VII) (B) and 16-13-701 (4)], the designated Managed Service Organizations (MSOs) allocate monies to substance use disorder treatment and detoxification programs in the Judicial Districts in which forfeiture proceedings were prosecuted. These monies are in addition to the appropriated funds through the Department of Human Services, Division of Behavioral Health and the MSOs. The following table details the reporting of civil forfeiture funds for fiscal year 2012 by three Colorado MSOs, as required by Senate Bill 03-133. One of the four MSOs, Boulder County Public Health Department, did not receive any funds from civil forfeiture.

MSO Provider / Description	Signal	West Slope	AspenPointe	Total All	Prior Year	Change $ (CFY to PFY)	Change % (CFY to PFY)
Beginning Balance	$ 17,870	$11,600	$403,526	$432,996	$543,449	($110,453)	-20.3%
Distribution	($229,704)	$0	($121,733)	($351,436)	($314,151)	($37,285)	11.9%
Revenue Received	$254,744	$ 3,439	$ 19,617	$277,800	$204,752	$73,048	35.7%
Ending Balance	$42,910	$15,039	$301,410	$359,360	$434,050	($74,690)	-17.2%

Summary

Signal Expenditures - Signal expended $229,704 of forfeiture funds during the year. Of this $199,842 on treatment and detox services and $29,862 for administrative cost (13% of total funds distributed). West Slope Casa - West Slope Casa had no reported disbursements for services during the year from forfeiture funds. AspenPointe -AspenPointe (JD #4) reported disbursing $1,643 of forfeiture funds for provider treatment costs; of which $270 was for Client Incentives for Recovery Care Management, $119,952 for TeleCare Recovery Care Management Program and $137.34 for MSO administrative fee .1%.

For fiscal year 2011-12, $277,800 in forfeiture revenues were collected and a total of $351,436 were expended on treatment and detoxification services (including administrative charges). The revenue received represents a 36% increase from the previous year.

RECOMMENDED LEGISLATION IN THE FIELD OF ALCOHOL AND DRUG ABUSE

The Department is recommending combining three separate statutory processes for conducting mental health and substance abuse involuntary civil commitments by creating one statutory process. This would ensure the State has a consistent and fair legal process that protects against potential abuse of an individual's civil liberties. The consolidation of the three statutes would integrate mental health and substance abuse involuntary civil commitment process into one seamless process, to make the approach more consumer focused and treat the entire needs of the individual.

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