



Impacts of Realignment of Substance Use Disorder Services 2018 Report to the Legislature

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Overview

The annual Impacts of Realignment of Substance Use Disorder (SUD) Services 2018 report from the Department of Health Care Services (DHCS) provides an overview of the impact of the 2011 Realignment of SUD program services. This report illustrates the amount of realigned funds expended for SUD treatment services, unique counts of Drug Medi-Cal (DMC) service recipients, and the treatment outcomes of service recipients. The intent of this report is to assist in monitoring changes over time and the degree to which programs are meeting state- and county-defined outcome measures. Outcome measures are based on data from three sources:

1. County reported treatment expenditures from cost reports (Substance Abuse Prevention and Treatment Block Grant (SABG) funding, and DMC funding);
2. Data from the Short-Doyle Medi-Cal Remediation Technology (SMART) system; and
3. Service recipient data reported through the California Outcomes Measurement System Treatment (CalOMS Tx).

Background

Enactment of 2011 Public Safety Realignment (2011 Realignment) marked a significant shift in the State's role in administering programs and functions related to SUD services. Prior to 2011 Realignment, many public SUD programs and services were provided locally by counties with the program policy authority and funding responsibilities residing with the State. The Fiscal Year (FY) 2011-12 Budget Act, through Senate Bill (SB) 1020 (Committee on Budget and Fiscal Review, Chapter 40, Statutes of 2011) and Proposition 30 of November 2012, resulted in the realignment of these programs to the counties. It is the intent of this report to provide information to the Legislature, the public, and SUD services stakeholders regarding the impact of 2011 Realignment over the period of time it has been in effect.

Data Considerations

Treatment Expenditure Data

Expenditures reflect funding for treatment services from both 2011 Realignment and federal funding, including the SABG, and DMC funding. The expenditure data is based on cost reports for actual treatment services claims submitted by counties for FY 2011-12 through FY 2013-14. This report provides the most current cost report data, which was finalized in March 2017. This data has not changed from the 2017 Realignment Report because the FY 2014-15 cost report data will not be completed until fall 2018. This data does not separately track each individual funding source that was established by the 2011 Realignment in the Behavioral Health Services Account (i.e., Women's and Children's Residential Treatment Services, Drug Courts, DMC and non-DMC), as these subaccounts existed only for one fiscal year and were then combined in 2012 into the broader Behavioral Health Subaccount. Therefore, all expenditure data included in this report are in the aggregate.

Appendix A provides treatment expenditures for each county and statewide. It provides details on the changes to treatment expenditures over the three-year period. Refer to Appendix D for definitions of the funding sources and service types. SUD treatment includes the following treatment services:

- Outpatient Methadone Detoxification (Detox)

- Inpatient Methadone Detox
- Naltrexone Treatment
- Outpatient Narcotic Treatment Program (NTP) Maintenance
- Outpatient Drug Free (ODF) Detox
- Interim Treatment Services
- NTP Narcotic Replacement Therapy
- Intensive Outpatient
- Rehabilitative Ambulatory Detox (non-methadone)
- Free Standing Residential Detox
- Perinatal and other Residential Treatment – Short-Term and Long-Term Residential Treatment
- Hospital Inpatient Detox (24 hours)
- Hospital Inpatient Residential (24 hours)
- Chemical Dependency Recovery Hospital
- Drug Court and Other Treatment Related Services

SMART: Unique Counts of Drug Medi-Cal Treatment Service Recipients

The unique DMC client data for FY 2012-13 through FY 2014-15 was collected from the SMART system. “Unique” service recipient counts in Appendix B are defined as the number of individuals who received a DMC treatment service as opposed to the total DMC services provided. Data for Sutter and Yuba Counties are combined and displayed as one county in both Appendix A and Appendix B.

CalOMS Tx: Service Recipient Outcomes

The CalOMS Tx system collects outcome data measures, at the time of the recipient’s admission and discharge from publicly-funded SUD treatment services and/or licensed NTPs. CalOMS Tx collects a variety of treatment service recipient outcome measures in seven life domains: Alcohol Use, Other Drug Use, Employment/Education, Legal/Criminal Justice, Medical/Physical Health, Mental Health, and Social/Family. Outcome measures collected in these areas indicate the impact of treatment services. These CalOMS Tx measures, along with the percentage of administrative discharges (i.e., the service recipient left treatment prior to their planned discharge and could not be reached for discharge data collection), can be used to measure and compare service recipient outcomes across multiple years. CalOMS Tx does not track data on the specific funds used to provide services, but for purposes of consistency, the CalOMS Tx data are included for FY 2010-11 through FY 2015-16. Outcomes are only reported at the statewide level. The historical outcomes reporting methodology did not accurately reflect all recipients’ actual outcomes because counties vary substantially in the number of discharges reported that are absent of client data regarding level of functioning. These discharge data are necessary to provide generalizable and comparable outcomes across counties. See Appendix C for details. DHCS is looking to develop and utilize statistical reports that indicate the number of administrative discharges by provider in each county. DHCS is still in the initial stages of developing these reports and intends to share the reports with the counties in early 2019.

Findings

Treatment Expenditures

The treatment expenditures data has not changed from the 2017 Realignment Report because the FY 2014-15 cost report data will not be completed until fall 2018. From FY 2011-12 to FY 2013-14, treatment expenditures increased by \$13.1 million at the statewide level; an increase of four percent. Treatment expenditures statewide in FY 2011-12 were \$331,717,082 compared to \$344,892,619 in FY 2013-14. This increase is due in part to two additional counties that provided treatment services during this timeframe: Amador and Plumas. Approximately 79 percent of counties showed an increase in treatment expenditures, with five counties more than doubling expenditures from FY 2011-12 to FY 2013-14. Treatment expenditures for 11 of the 57 counties decreased ten percent or more from FY 2011-12 to FY 2013-14, with two counties showing a decrease of more than 80 percent (see Appendix A). The two counties showing this decrease completed an allowable shift in SABG funds from ODF services to county support and prevention services.

Counties Administering DMC and Unique DMC Client Counts

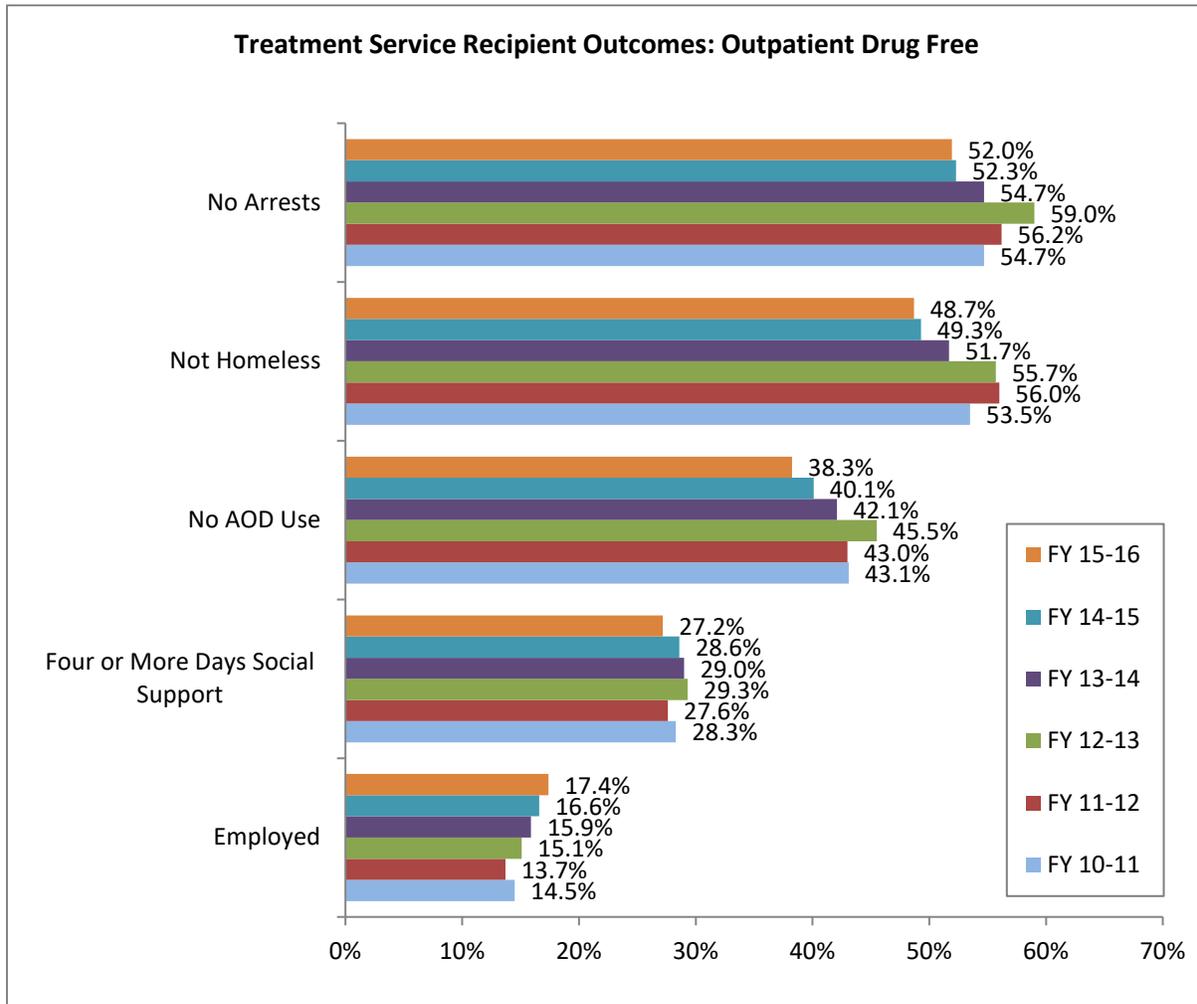
The number of counties administering the DMC program increased from 44 counties in FY 2012-13 to 45 counties in FY 2014-15. Of the 45 counties administering the DMC program in FY 2014-15, only two had substantial decreases (10 percent or more) in unique counts of DMC service recipients: Los Angeles and Lassen counties. Los Angeles County experienced a dramatic decrease in the number of provider sites administering services (from 270 sites in FY 2011-12 to 116 sites in FY 2013-14). This was due to fraud investigations resulting in the termination of multiple provider site certifications. Lassen County's decrease was caused by having two contracted provider sites in FY 2011-12, then reducing to only one in FY 2013-14. Conversely, 41 counties had substantial increases (10 percent or more) in unique counts of DMC service recipients, with increases more than doubling for 16 counties. The overall number of unique DMC service recipients increased by 20.9 percent, from 65,575 in FY 2012-13 to 79,257 in FY 2014-15 (see Appendix B).

Treatment Service Recipient Outcomes

Treatment service recipient data included in this report are for ODF services. This service type represents the largest proportion of treatment admissions to publicly-monitored treatment programs. In addition, ODF is typically the last service type in an episode of treatment (i.e., when a service recipient progresses from more intensive to less intensive treatment services). The five key measures for outcomes in the chart on page four provides service recipient outcomes by year for ODF services. From FY 2010-11 through FY 2015-2016, CalOMS Tx data indicated that ODF service recipient outcomes showed improvement in employment, whereas no improvement was made for the remaining outcomes measures (No Arrests, Not Homeless, No Alcohol and Other Drug (AOD) Use, and Four or More Days Social Support).

While percentages for the "Four or More Days Social Support" outcome have remained relatively stable across fiscal years, the "No Arrests" measure shows a slight improvement from FY 2010-11 to FY 2012-13 of about four percentage points, but then drops by seven percentage points from FY 2012-13 to FY 2015-16. The "Not Homeless" measure also shows a slight improvement from FY 2010-11 to FY 2011-12 of about two percentage points, but then drops by seven percentage points from FY 2012-13 to FY 2015-16. "No AOD Use" shows a slight increase of about two percentage

points from FY 2010-11 to FY 2012-13, but then drops over seven percentage points from FY 2012-13 to FY 2015-16. The only positive outcome is in “Employed,” where participants have shown a slight, but steady, improvement from FY 2011-12 to FY 2015-16 of about four percentage points. Again, the main challenge in attempting to analyze and measure these trends is the continual percentage increase in missing outcomes data (see Appendix C).



Future Updates

Future reports will continue to include updates to the summary treatment expenditure and service recipient outcomes to support the ongoing monitoring of 2011 Realignment impacts.

Appendix A
Treatment Expenditures by County and California FYs 2011-12 through 2013-14

County	A FY 11-12	B FY 12-13	C FY 13-14	Difference A-C	Percentage Change A-C
Mariposa	\$351,112	\$64,642	\$47,537	-\$303,575	-86.5%
Lassen	\$590,753	\$170,514	\$104,858	-\$485,895	-82.3%
Inyo	\$93,742	\$85,646	\$41,963	-\$51,779	-55.2%
Calaveras	\$263,944	\$230,126	\$127,417	-\$136,527	-51.7%
Trinity	\$292,099	\$203,999	\$197,869	-\$94,230	-32.3%
Glenn	\$226,877	\$197,883	\$172,504	-\$54,373	-24.0%
Riverside	\$12,950,925	\$11,915,880	\$10,464,010	-\$2,486,915	-19.2%
Los Angeles	\$129,947,446	\$147,762,925	\$105,163,428	-\$24,784,018	-19.1%
Sutter/Yuba	\$1,219,656	\$1,091,112	\$990,391	-\$229,265	-18.8%
El Dorado	\$445,876	\$818,662	\$362,068	-\$83,808	-18.8%
Mendocino	\$535,172	\$413,901	\$470,519	-\$64,653	-12.1%
Madera	\$546,863	\$582,910	\$540,196	-\$6,667	-1.2%
Ventura	\$5,996,740	\$6,025,113	\$6,026,997	\$30,257	0.5%
Mono	\$253,179	\$258,119	\$258,119	\$4,940	2.0%
Modoc	\$380,679	\$306,983	\$394,476	\$13,797	3.6%
California	\$331,717,082	\$375,449,978	\$344,892,619	\$13,175,537	4.0%
Sacramento	\$15,535,593	\$15,955,473	\$16,261,345	\$725,752	4.7%
Humboldt	\$979,783	\$986,041	\$1,048,606	\$68,823	7.0%
Marin	\$2,505,273	\$2,367,338	\$2,689,005	\$183,732	7.3%
Kings	\$653,559	\$573,066	\$704,746	\$51,187	7.8%
Kern	\$8,413,548	\$7,797,269	\$9,165,203	\$751,655	8.9%
San Mateo	\$4,587,970	\$5,916,770	\$5,002,732	\$414,762	9.0%
Tuolumne	\$340,685	\$326,370	\$372,255	\$31,570	9.3%
Napa	\$1,172,504	\$1,152,187	\$1,290,665	\$118,161	10.1%
San Francisco	\$16,310,123	\$18,064,098	\$18,384,301	\$2,074,178	12.7%
Nevada	\$679,425	\$729,495	\$767,626	\$88,201	13.0%
Contra Costa	\$8,524,320	\$9,502,151	\$9,647,295	\$1,122,975	13.2%
Alameda	\$14,041,122	\$16,590,199	\$15,910,980	\$1,869,858	13.3%
Placer	\$2,143,248	\$2,385,884	\$2,442,804	\$299,556	14.0%
Fresno	\$15,080,818	\$17,178,509	\$17,229,181	\$2,148,363	14.2%
Stanislaus	\$4,625,619	\$4,566,104	\$5,308,228	\$682,609	14.8%
Sonoma	\$4,200,389	\$4,318,930	\$4,822,299	\$621,910	14.8%
San Diego	\$16,125,347	\$17,437,152	\$19,157,824	\$3,032,477	18.8%
Tulare	\$4,020,558	\$4,203,176	\$4,780,654	\$760,096	18.9%
San Bernardino	\$10,514,561	\$11,752,087	\$13,051,347	\$2,536,786	24.1%

Orange	\$15,573,479	\$18,157,407	\$19,460,803	\$3,887,324	25.0%
Santa Barbara	\$4,906,745	\$5,383,356	\$6,165,940	\$1,259,195	25.7%
Tehama	\$351,334	\$352,793	\$446,572	\$95,238	27.1%
Colusa	\$147,110	\$245,973	\$188,572	\$41,462	28.2%
Del Norte	\$193,385	\$200,875	\$249,646	\$56,261	29.1%
Santa Clara	\$7,771,176	\$10,127,921	\$10,127,039	\$2,355,863	30.3%
Santa Cruz	\$2,977,959	\$3,291,029	\$4,000,575	\$1,022,616	34.3%
Shasta	\$941,644	\$934,920	\$1,281,048	\$339,404	36.0%
Solano	\$1,962,865	\$2,300,901	\$2,798,126	\$835,261	42.6%
Sierra	\$43,006	\$47,418	\$62,773	\$19,767	46.0%
Yolo	\$526,120	\$750,445	\$803,667	\$277,547	52.8%
Monterey	\$1,972,465	\$2,979,892	\$3,183,220	\$1,210,755	61.4%
Imperial	\$386,911	\$482,589	\$636,196	\$249,285	64.4%
Butte	\$1,781,668	\$2,865,954	\$2,934,920	\$1,153,252	64.7%
Merced	\$1,848,899	\$2,285,028	\$3,401,499	\$1,552,600	84.0%
Lake	\$415,841	\$606,544	\$784,143	\$368,302	88.6%
San Benito	\$274,504	\$393,574	\$592,244	\$317,740	115.8%
San Luis Obispo	\$1,290,070	\$2,097,635	\$2,900,441	\$1,610,371	124.8%
Siskiyou	\$155,080	\$236,688	\$380,531	\$225,451	145.4%
San Joaquin	\$3,646,051	\$9,593,657	\$10,799,605	\$7,153,554	196.2%
Alpine*	\$1,262		\$26,355	\$25,093	1988.4%
Amador**		\$53,104	\$64,580	\$64,580	
Plumas**		\$131,566	\$204,676	\$204,676	

*Small numbers result in increased differences (i.e. percent change)

**Although funds were allocated, the county did not indicate expenditures for treatment services in one or more fiscal years

Appendix B
Unique Drug Medi-Cal Service Recipients by County and California
FYs 2012-13 through 2014-15

County	A FY 12-13	B FY 13-14	C FY 14-15	Difference A-C	Percentage Change A-C
Los Angeles	26,989	19,420	15,070	-11,919	-44.2%
Lassen	115	99	92	-23	-20.0%
Fresno	5,261	5,119	5,273	12	0.2%
California	65,575	69,651	79,257	13,682	20.9%
Sacramento	4,293	4,562	5,609	1,316	30.7%
Imperial	613	699	823	210	34.3%
Mendocino	98	117	134	36	36.7%
Glenn	61	84	85	24	39.3%
Lake	231	266	326	95	41.1%
Yolo	138	180	197	59	42.8%
Tulare	1,136	1,499	1,643	507	44.6%
Santa Barbara	1,737	2,318	2,551	814	46.9%
Santa Clara	1,440	1,444	2,206	766	53.2%
Riverside	2,668	3,033	4,205	1,537	57.6%
Stanislaus	754	936	1,209	455	60.3%
Mariposa	52	70	84	32	61.5%
Nevada	284	396	467	183	64.4%
Yuba/Sutter	353	469	582	229	64.9%
Monterey	318	459	530	212	66.7%
San Francisco	1,989	2,760	3,382	1,393	70.0%
Sonoma	920	1,274	1,604	684	74.3%
Alameda	2,233	3,068	3,936	1,703	76.3%
Contra Costa	899	1,259	1,588	689	76.6%
Kern	1,623	2,140	2,995	1,372	84.5%
San Joaquin	1,581	2,295	2,936	1,355	85.7%
San Bernardino	2,056	2,851	3,842	1,786	86.9%
Ventura	1,431	1,984	2,755	1,324	92.5%
Butte	656	983	1,286	630	96.0%
Solano	518	721	1,022	504	97.3%
Placer	506	763	1,050	544	107.5%
Santa Cruz	323	498	679	356	110.2%
Merced	396	645	835	439	110.9%
Humboldt	150	236	330	180	120.0%

San Mateo	221	357	502	281	127.1%
El Dorado	139	128	317	178	128.1%
Marin	89	140	215	126	141.6%
Madera	104	169	252	148	142.3%
Inyo	19	45	47	28	147.4%
San Benito	76	124	195	119	156.6%
San Diego	2,502	4,289	6,459	3,957	158.2%
Shasta	364	661	942	578	158.8%
Orange	695	1,249	1,940	1,245	179.1%
San Luis Obispo	377	964	1,202	825	218.8%
Napa	67	194	254	187	279.1%
Kings	73	208	342	269	368.5%
Trinity			42	42	

Note: Service-recipients may have received service from more than one county. So, there may be some individuals counted more than once.

*Small numbers result in increased difference (i.e. percent change).

**Numerator or denominator missing, cannot calculate percent change.

Appendix C

Data Quality Considerations for Treatment Outcomes

Historically, SUD treatment outcomes referred to measured changes in service recipient functioning in seven life domains: Alcohol Use, Other Drug Use, Employment/Education, Legal/Criminal Justice, Medical/Physical Health, Mental Health, and Social/Family. The same measures of service recipient functioning (e.g., frequency of primary drug use in the past 30 days) are collected at two points in time: at admission to treatment and at discharge. Changes in service recipient functioning were determined by comparing admission and discharge data, through the different responses at the two points in time, and then quantifying the changes (e.g., percent change) in responses. For simplicity, responses were often categorized into two groups: “positive” actions (e.g., no drug use) and “negative” actions (e.g., used drugs one or more times). These measured changes in service recipient functioning were referred to as “service recipient outcomes.”

This outcome measurement method was historically used to develop all basic outcome statistics for a given time period (e.g., a fiscal year), county, or a specific SUD treatment service type (e.g., residential, outpatient).

During FY 2011-12 and FY 2012-13, a collaborative effort between the former County Alcohol and Drug Program Administrators Association of California, Treatment Data/Outcomes Subcommittee, and other stakeholders found that for some CalOMS Tx recipient outcome measures, functioning in the 30 days prior to treatment discharge offers a better indication of service recipient functioning; rather than the quantified change between admission and discharge, as calculated by the percent change between data captured 30 days prior to admission and 30 days prior to discharge. For example, since many service recipients are coming from controlled environments (e.g., jail, prison) or other SUD treatment services, many service recipients report not using drugs in the month prior to admission, which does not accurately reflect their true drug utilization. Additionally, social support recovery activity participation is more important during the 30-day period prior to discharge from treatment, when the service recipient is moving in the continuum of care from treatment to longer-term recovery (e.g., disease management). Similar to data collection regarding drug use at admission, some service recipients also report little to no participation in social support recovery activities at the beginning of treatment. Therefore, measuring social support recovery activity participation is more appropriately measured in the month prior to discharge.

An “administrative discharge” is a type of discharge that is used when a service recipient leaves the treatment program and the provider is unable to contact them (in person or by phone). Minimal data are required to “administratively” report the close of the corresponding CalOMS Tx admission record, which would indicate that the service recipient is no longer in the program. Since the service recipient cannot be located, no outcome (i.e., service recipient functioning) data are collected. In contrast, when a service recipient remains in treatment as planned, and is available for discharge interview (in person or by phone), a standard discharge report is completed which contains all the necessary service recipient functioning data to measure outcomes.

There are substantial variations in the percentage of “administrative” discharges found across years, counties, and specific treatment service types. In general, it is reasonable to assume that the outcomes for service recipients discharged administratively would be worse than for those with planned discharges. Thus, generalizing outcomes of all treatment service recipients from the outcome

data collected in the standard discharges (from the service recipients with planned discharges) creates a positive bias. Counties (or fiscal years) with a larger percent of administrative discharges may appear to produce more positive outcomes since the outcomes would be generated from service recipients with completed standard discharge reports. Outcome measurement bias and variability are reduced when the administrative/missing discharge data are factored into comparisons across years and between counties or providers. Based on these findings, this methodology of examining the desired level of client functioning in the 30 days prior to discharge is used for the five outcome measures shown in this report (see page 4).

Example:

During a given time period, County A has 1,200 total discharge records. Of those 1,200 records, 10.5 percent (or 126) are missing data. The 1,074 discharge records (1,200 minus 126) with data show that 201 clients are employed and 873 are not. Dividing 201 by 1074 equals approximately 19 percent who are employed. County B has 83 total discharge records, with 81.9 percent (or 68) of the discharge records missing data. The 15 discharge records (83 minus 68) with data show that five clients are employed and ten are not employed. Dividing 5 by 15 equals approximately 33 percent employed. Since the records with missing data are excluded from the denominator when calculating percentages, these comparative statistics erroneously show that County B has better employment outcomes than County A.

If the records with the missing data are included in the denominator, then more objective outcome comparisons across counties can be made. For example, County A had 1,200 total discharge records with 201 of them documenting employment at discharge. Therefore, County A shows 16.7 percent employed at discharge (201 divided by 1,200). County B had 83 total discharges, with 5 documenting employment. Therefore, County B shows 6 percent employed at discharge (5 divided by 83).

This example underscores the importance of ongoing data quality monitoring and management. The State must continue to work with the counties and direct service providers to improve data quality and minimize the number of administrative discharges.

Appendix D Definitions

Chemical Dependency Recovery Hospital (CDRH): Treatment programs located in a CDRH facility licensed by the California Department of Public Health.

Drug Courts: A permissible use of funding in the Behavioral Health Services subaccount. “Drug courts” or “drug court operations” refers to the provision of intensive drug treatment services, and close supervision to promptly address relapses for individuals whose involvement in the court system is a result of substance abuse. Drug court program administration was realigned under SB 1014 (Chapter 36, Statutes of 2011) and historically included the following programs: Comprehensive Drug Court Implementation Act, Drug Court Partnership, and Dependency Drug Court services.

Drug Medi-Cal (DMC): SUD treatment services provided as a carve-out from other standard Medi-Cal services. These SUD treatment services are provided to Medi-Cal beneficiaries through the statewide DMC program. The DMC program is currently administered in 46 counties through contracts between DHCS and the county SUD administration office or between DHCS and a DMC certified provider. DMC SUD treatment services include the following SUD treatment service types: outpatient drug free, intensive outpatient treatment, narcotic treatment program, naltrexone treatment (oral tablets) and perinatal residential treatment.

Hospital Inpatient Detox (24 hours): Hospital and non-hospital detoxification services. Hospital detoxification services (Hospital Inpatient Detoxification – 24 Hours) are provided in a licensed hospital where participants are hospitalized for medical support during the planned SUD withdrawal period. Non-hospital detoxification services (Free-Standing Residential Detoxification) are provided in a residential facility and support to assist the participant during a planned SUD withdrawal period.

Hospital Inpatient Residential (24 hours): Non-detoxification medical care provided in a hospital facility in conjunction with treatment services for substance use disorders.

Inpatient Methadone Detox: Rendered in a controlled, 24-hour hospital setting. Provides narcotic withdrawal treatment to service recipients undergoing a period of planned withdrawal from narcotic dependence.

Intensive Outpatient: Provision of counseling and rehabilitation services that last two or more hours, but less than 24 hours per day, three days per week.

Interim Treatment Services (CalWORKS): Services designed to determine need for more intensive SUD treatment. This includes provision of up to eight weeks of group and/or individual counseling sessions, in a nonresidential/outpatient setting until such time SUD treatment service needs are determined and available.

Naltrexone Treatment: Use of Naltrexone (Trexon) to block effects of heroin, other narcotics, or opiates. Services include medication, medical direction, medically necessary urine screens for substance use, counseling, and other appropriate activities or services.

Non-DMC: SUD treatment programs and services funded with sources other than DMC, such as Substance Abuse Prevention and Treatment Block Grant dollars from the federal Substance Abuse and Mental Health Services Administration.

Outpatient Drug Free (ODF): Treatment or recovery services provided in an outpatient setting. SUD treatment services include individual and/or group counseling that may or may not include medication.

ODF Detox: Rendered in less than 24 hours that provide for safe withdrawal in an ambulatory setting. Services are designed to support and assist participants undergoing a period of planned withdrawal from SUD dependence, and develop plans for continued service. Administration of prescribed medication may be included in this type of service.

Outpatient Methadone Detox: Rendered in less than 24 hours that provide narcotic withdrawal treatment to service recipients who are undergoing a period of planned withdrawal from narcotic dependence.

Outpatient Narcotic Treatment Program (NTP) Maintenance/NTP Narcotic Replacement Therapy (NRT): Outpatient treatment and recovery services that include the provision of NRT medication, such as methadone or naltrexone in an outpatient setting and include individual and/or group counseling.

Rehabilitative Ambulatory Detox (non-methadone): Outpatient treatment services rendered in less than 24 hours that provide for safe withdrawal in an ambulatory setting (pharmacological or non-pharmacological).

Perinatal and Other Residential Treatment: Short-term (<30 days) and long-term (>30 days) treatment services provided in a residential setting. Services may include the following elements: personal recovery and treatment planning, educational sessions, social and recreational activities, individual and group sessions, and assistance in obtaining health, social, vocational, or other community services.

Women's and Children's Residential Treatment Services (WCRTS): One of the funding sources within the Behavioral Health Services subaccount is the WCRTS special account. The term refers to the funding source as well as the WCRTS program. WCRTS includes women's treatment programs, perinatal certified programs, women's and children's programs (services for both mother and child), family services, and comprehensive family-centered treatment programs.